A Guide to the Implementation of the Nurse Practitioner Role in Your Health Care Setting

Developed by:
The Advanced Practice Nursing Steering Committee

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Introduction
The introduction and support of the nurse practitioner (NP) provides an exciting opportunity to improve access to health care for the public and enhance quality of care. The lengthy experience of using NPs worldwide can provide health systems with the needed confidence to take this step within Manitoba. NPs have repeatedly demonstrated their ability to provide high quality, cost-effective health care services, while contributing to the health of disadvantaged and high-risk groups through targeted collaborative efforts.

Across Canada, provincial jurisdictions have succeeded in the introduction of this health care provider, formally through changes to the various legislative acts, and politically through the funding of additional NP positions. While each province may have some differences in educational requirements, title, or scope of practice, all parties have discovered NPs provide safe, quality care. NPs can and do improve access as that vital “first contact” with the health care system.

Within Manitoba, NPs have practiced for more than 20 years in Community Health Centres and in northern communities. Constrained by existing legislation, delegation agreements, policies and procedures were implemented. The Extended Practice Regulation legislation change now creates the opportunity for NPs to practice fully within their legislated scope of practice and be recognized professionally through a process, which will ensure the nurse practitioner has appropriate education, knowledge and competencies. Employers must now ensure the NP works within a health environment that supports quality care and capitalizes on all members of the multi-disciplinary teams.

The purpose of this implementation guide is to provide health care settings with information, tools and strategies to fully realize the potential of the NP in the delivery of comprehensive care. The guide has been divided into the following sections:

- **Needs Assessment:** This section provides an overview of the needs assessment process

- **Site Readiness:** Legislation and regulations specific to the registered nurse in primary care and NPs is provided. Insurance and liability issues are highlighted with reference materials. Organizational culture and physical space are other considerations for site readiness.

- **People:** Is the health care team ready to consider the introduction of a NP? Leadership within the site must be defined and provider and consumer receptiveness assessed. Recruitment considerations are explored, as these will vary with the personality of the site and the needs of the population to be served. Once hired, what change management strategies are being used? Planned and purposeful communication strategies ensure all members of the health care team understand the role of the NP and develop effective working relationships. Addressing these types of human resource issues will help to ensure retention of NPs.

- **Practice:** This section includes information about collaboration, standards and scope of practice and competencies. Information about practice development, the model of practice, as well as consultation and referral is also provided.

- **Support Structures:** Support structures need to be established locally and regionally to successfully integrate the NP. These include administrative support, information management, shadow billing, revenue generation as well as regional policies and procedures.

- **Evaluation:** This section is under development and will be informed by the work of the Canadian NP Initiative as well as input from Manitoba Health. A section on economic analysis is included.
Before beginning, it is important to distinguish between two advanced practice nursing roles: the clinical nurse specialist or CNS and the nurse practitioner or NP. The distinctions between the CNS and NP are in their education, their roles and domains of practice, and regulated authority. While both have graduate degrees in nursing, NP educational programs focus on primary health care and require additional clinical hours. CNSs and NPs function in each of the domains of practice (direct care, education, research, leadership, administration) differently and with varying degrees of expertise. Lastly, those registered on the RN(EP) Register have the regulated authority to perform acts or services that fall outside traditional scope of nursing practice. The CNS role does not typically engage in activities such as diagnosing and prescribing, and unlike the NP does not require additional regulatory authority (College of Nurses of Ontario, CNO, 2003a). Proposed position descriptions for each role are provided in Appendices A and B.
Needs Assessment

In advance of introducing a NP, WRHA sites and agencies will engage in a needs assessment process. Needs assessment will provide the site with the opportunity to speak with the existing health care team about the needs of the practice population and the potential contributions of a NP. Following is a tool to assist employers in determining the most appropriate practitioner to meet the patient/resident/community care needs.

A needs assessment is an activity designed to:
- determine a community’s or population’s service needs
- identify utilization patterns of health care service
- identify gaps in service provision
- establish priorities for the creation of service programs.

Purpose
- Provides a rational basis for planning services and allocating resources.
- Identifies service needs and alternatives for meeting these needs.
- Permits involvement of users of the health service in health planning thereby avoiding over-reliance on care providers’ perceptions

Process Issues
Questions that need to be addressed:
- What is the purpose of this particular needs assessment?
- Who are the stakeholders?
- What types of data are required?
- How will the data be collected?
- How will the data be analyzed?

A needs assessment should be done:
- Before a program begins – to determine if a new program or service is required.
- After a program has been implemented – to determine if there is a need to continue or modify the program.

Needs Assessment Process
1. Identify Stakeholders:
   - Current or potential consumers of service
   - Service providers
   - Professional organizations
   - Decision makers

2. Identify Population:
   - Social indicators
     - demographic
     - socioeconomic
     - geographic
   - Characteristics of clients
     - Major health care needs (i.e. diabetes rate in community, perinatal care)
3. Define Service Provided:
   - Type and range of services provided
   - Use and demand for service
   - Problems addressed by the service
   - Sources of referrals
   - Accessibility and affordability (if applicable) of services
   - Waiting list

4. Identify informal and formal patterns of service utilization
   - Develop algorithms to demonstrate patterns

5. Assessment of met and unmet needs
   - Utilize key informant surveys (for their perception) and data already gathered to answer the questions:
     - Who has the need?
     - How many have the need?
     - Why does the need exist?
     - Is the need met adequately with current services?

6. Determine potential goals and outcomes to meet the identified needs, both met and unmet.
   - Prioritize needs identified.

7. Identify skill set requirements and competencies to achieve the desired goals.

8. Examine potential solutions.
   - Identify current mix of providers including funded positions.
   - Identify gaps in current mix (example, region has five funded physician positions and three of the positions are filled leaving 2 vacant).
   - Look at the skills required to fill the needs and determine the provider who might be able to fill the identified gap, considering:
     - Scope of practice
     - Resources
     - Unique program needs
   - Determine if current funding will be adequate for proposed additional providers
   - Consider the scope of practice and ensure that the practitioner selected has the opportunity to practice within the range of their scope and does not have unnecessary limitations placed on their practice

9. Decision and program / service planning.
   - Role definition
   - Process for incorporation of new/additional role

10. Implementation
    - Determine trial period allowing adequate time for implementation of necessary changes to occur

11. Evaluation
    - Based on the goals and outcomes identified previously.

12. Revision and ongoing evaluation.

Appendix F is an example of how to use the needs assessment guide. An algorithm is provided to summarize the steps in the needs assessment process.
Needs Assessment Algorithm

Identify Stakeholders
- current or potential consumers
- service providers
- professional organizations
- decision makers

Identify Population
- outline social indicators
- characteristics of clients

Define Service Provided
- Type and range of service
- use and demand for service
- sources of referrals
- accessibility and affordability
- waiting lists

Identify Informal and Formal Patterns of Service Utilization
- develop algorithms to demonstrate

Assess Needs (Met and Unmet)
- Key Informant Survey to ask their perceptions on:
  - who has the need?
  - how many have the need?
  - why does the need exist?
  - is the need met adequately with current services?

Determine Potential Goals and Outcomes to Meet the Needs
- Prioritize them

Identify Skills and Competencies to Meet Desired Goals

Examine Potential Solutions
- scope of practice

Decision and Program/Service Planning

Implementation

Evaluation

Revision/Ongoing Evaluation

Process Complete
Site Readiness

Once a needs assessment has been conducted, site readiness must be addressed. To successfully introduce a NP into an existing practice, site readiness is a vital consideration. Four aspects of site readiness will be discussed:

a) Legislation and regulations;
b) Insurance and liability issues;
c) Space; and
d) Organizational culture.

Legislation and Regulation

In 1999, a new Registered Nurses Act was introduced in Manitoba and proclaimed in force August 15, 2001. This Act represented an expansion of the scope of nursing practice. Under Part Two the “Practice of Nursing”, an additional section 2(2) called “included practices” was added. These “included practices” were:

- Order and receive reports of screening and diagnostic tests designated in the regulations.
- Prescribe drugs designated in the regulations.
- Perform minor surgical and invasive procedures designated in the regulations.

Prior to this legislation and until the regulations were established, a nurse may have provided these functions, under a delegation agreement with a physician. The changes in the Registered Nurses Act would allow nurses to perform these included practices without delegation agreements, provided these nurses met the regulations specified by the CRNM.

The Registered Nurses Act is available at www.crnm.mb.ca/downloads/act.pdf

In 2001, the College of Registered Nurses of Manitoba began developing regulations to clarify the registered nurse who could provide these additional services to the public. In March 2005, the College of Registered Nurses of Manitoba introduced the Extended Practice Regulation that came into effect June 15, 2005.

The Extended Practice Regulation is the regulatory framework that enables the CRNM to establish a RN(EP) register. The designation RN(EP) refers to a registered nurse who is registered on the extended practice register of the College. It signifies that the RN has completed advanced education (or has substantially equivalent education and experience), and has passed an approved examination demonstrating extended practice competencies. Only an RN on the extended practice register can use the title Registered Nurse (Extended Practice) or RN(EP).

The Extended Practice Regulation is available at www.crnm.mb.ca/downloads/extended_practice_regulation.pdf

When on the Extended Practice Register, an RN(EP) can provide these health services as part of their scope of practice. A delegation agreement will only be required to provide services beyond what is specified in the Extended Practice Regulation.

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Insurance & Liability Issues

Insurance and liability issues are commonly raised when NPs are introduced into new settings. The Canadian Nurse Protective Society (CNPS) provides legal information to assist in understanding liability and insurance issues. The following fact sheets are available through CNPS:

- Nurse Practitioners (February 2003)
- Independent Practice: Legal Considerations (September 1995)
- Vicarious Liability (April 1998)
All NPs should have personal liability protection for malpractice claims as members of a professional association or college that is a participating member of CNPS (in Manitoba CRNM). NPs are automatically eligible for personal occurrence-based professional liability protection.

Is additional protection necessary? If the NP is an employee, the employer should carry primary insurance coverage for this role. (i.e. HIROC is the insurer for the Winnipeg Regional Health Authority). Additional malpractice insurance should not be necessary. The HIROC Liability policy does not provide coverage or cover legal fees for disciplinary defense costs, criminal charges, inquests, judicial inquiries, it is a liability policy that responds to defense claims made for damages (defense costs and settlement/awards) subject to the terms and conditions of the policy.

Liability issues extend beyond simple insurance coverage for NPs. Physicians have raised numerous concerns about their professional liability in collaborative practice settings. Fortunately, in June 2004 correspondence between the Canadian Nurse Protective Society and Canadian Medical Protective Association have clarified issues of the NP as an employee, the NP in independent practice and the issue of “tail coverage”.

For a more detailed summary see www.cnps.ca/joint_statement/English_CMPA_CNPS_joint_stmt.pdf

**Space**

The NP will have similar space requirements to other primary care providers, such as physicians. Minimally, a fully equipped clinic room should be available to the NP during clinic hours (See Appendix G). In addition, the NP will require assigned workspace, access to a private telephone/voice mail, computer access with email, and administrative support. Co-location of the NP with other primary care providers may enhance teamwork and collaborative practice.

Many personal care homes may need additional equipment and tools, such as debridement equipment or biopsy equipment. These requirements will require identification up front and a plan for how to acquire/access. Possible solutions may be a partnership with a neighboring primary care clinic, hospital or through the attending physician’s clinic/office.

**Organizational Culture**

The organizational culture will contribute to the successful introduction of the NP. During the needs assessment process, involvement and discussions with the health care team is required. Any issues or concerns should be obtained, discussed and resolved in the early stages of planning for a NP position. Considerations regarding organizational culture should include:

- To what extent is the introduction of the NP consistent with the values, attitudes, beliefs and goals of the practice environment?
- To what degree does the culture support change?

Providing enhanced access, servicing a vulnerable population/group or focusing on specialty care are examples of the different values of practice settings. How does the introduction of the NP support these aims? Identify examples of recent changes introduced into the practice environment. Were these changes successful? Was change a slow process?

- To what extent do the leaders within the practice environment support (both visibly and behind the scenes) the implementation of the NP?

Identify the leaders (both formal and informal) within the practice environment. Are they supportive of the introduction of the NP? How are they prepared to show their support? Is there support from the medical, nursing and administrative leadership? The roles and responsibilities of the leaders need to be clearly defined.

- Is there enough staff to support the change process? To what extent is staff motivated to introduce the NP?
Examine the current capacity of staff to support the change process. Is the staffing complement stable or changing? Are there other priorities within the setting that will compete with the initiative? Is there resistance or support to the NP role?

- Are there positive relationships and trust amongst the disciplines that will be involved or affected by the introduction of the NP?

The introduction of the NP will impact on the existing relationships between disciplines, in particular between medicine and nursing. Assess the existing relationships between disciplines to identify potential areas for success or areas that may require additional attention.

- What is the experience of staff working with NP?

Research suggests that physicians who have had direct experience working with a NP are more receptive to collaborative practice arrangements with NPs. Other members of the health care team may also have experience working with NPs in different capacities. An understanding of these experiences will assist in planning for the introduction of the NP. Consider inviting a physician and NP who have established practices in a collaborative environment to speak about their experiences and practices.

- What is the understanding of the staff in terms of the knowledge and skills of the NP?

The term Nurse Practitioner has been used in Canada since the early 1980s and only recently have professional associations introduced legislation and regulations to define extended or expanded practice. A current understanding of the knowledge and skills of the NP will enhance collaborative practice, identify misconceptions and help to clarify expectations. Again, an experienced NP can assist in addressing knowledge gaps and questions related to their competencies and practice.

- What are the current needs of the practice population?

Identification of the current needs of the practice population will be part of the needs assessment process. Internal discussions with the health care team about practice needs may also identify challenging or complex situations that may benefit from the services of a NP.

- What are potential roles of the NP in meeting current needs of the practice population?

Translating practice needs into the types of services required will assist in the identification of potential roles for the NP. Discussions of potential roles will help to engage the health care team and assist in the recruitment process.

Organizational culture is a key component of site readiness. As legislation and regulation have now been introduced in Manitoba, and insurance and liability issues initially addressed through CNPS and CMPA, site readiness will focus on the organizational culture.
People
Introduction and support of the NP requires close attention to the human resource or people aspect of health care delivery. Minimally, the following aspects must be addressed:

- Leadership
- Provider Receptiveness
- Consumer Readiness
- Recruitment and availability of NPs
- Retention
- Communication
- Change Management
- Unionization

Leadership
Site leadership is required to successfully introduce the NP. Leaders or champions who are prepared to commit the time and effort to support the NP must be identified. Nursing and medical leadership and support is critical. There is a need for strong medical leadership to work collaboratively with the NP as well as communicate and support the NP role to physician colleagues and other health care team members. Administrative leadership (i.e. Team Manager) is also necessary and must be present to reinforce the importance of the NP to the health care team and demonstrate commitment to problem solving implementation issues on a timely basis. Within the PCH program, agreement and leadership from the Medical Director, Director of Care and Executive Director are required.

Once the key leaders are identified, establish and formalize the roles of all three parties (medical, nursing and administrative) in writing. This process will help to clarify responsibilities, identify areas where joint problem solving is needed, and solidify commitment to the process. Regular meetings amongst the leadership team and NP are required, especially during the first six months. Ideally, the leadership team will provide support for the NP during the orientation period and ongoing integration of the role.

Provider Receptiveness
In the needs assessment process, examination of provider receptiveness is warranted. The primary care providers must be open and receptive to a NP and understand the NP role and how it differs from a primary care nurse role. Factors that enhance provider receptiveness to an NP include:

- Previous positive experience working with an NP
- Early involvement in needs assessment process
- Education about role of NP and potential contributions to client care
- Positive and effective working relationships within the team
- Advanced planning with the team to lay the foundation for success

Primary care nurses and other allied health providers may have questions about the role of the NP and how the role of the NP will affect their practice. These questions must be solicited and addressed on a timely basis. Strategies to encourage provider receptiveness include inviting a NP and primary care colleague (i.e. physician) to speak to your team about their experiences and providing an information package about the role of the NP (Go to the Canadian Nurse Practitioner Initiative @ www.cnpi.ca.)

Consumer Readiness
The needs assessment process is essential to identify the existing health care needs of the practice population and the gap(s) in service that the NP will fill. Within certain settings, such as the PCH environment, it may also be appropriate to talk with families and residents in advance of providing NP services. Within the primary care environment, a comprehensive communication plan for clients will support consumer readiness and receptiveness to the NP (see Communication Strategies).
Recruitment & Availability of NPs
Establishment of the Extended Practice Register through the College of Registered Nurses of Manitoba will assist in the recruitment process for NPs and help determine the availability of NPs. All applicants to WRHA will need to be on the register or qualify to be on the register to work, as NPs. Consideration will be given to a transition period as defined by employers. The employer will also be able to inquire as to the number of individuals on the Register.

In the recruitment process, clinical experience, leadership skills and educational background will be considered. Experience suggests that in the early stages, a NP with both excellent clinical skills and leadership qualities is needed for the position to work and be successful. Depending on the practice setting and current composition of the health care team, types of clinical experience may need to be evaluated. If the position is geared towards a particular client population, such as individuals in long-term care, specific clinical experience, such as geriatric experience, will be required. If a NP will be providing general primary care services, the ability to establish a collaborative relationship with a primary care physician may be a key skill. A clinical evaluative component to the selection process can also provide a good sense of the candidates’ clinical skill. For example, in the PCH environment, the assessment/interview of a resident and then formulation of a diagnosis and intervention plan and completion of a written case study have been used. See Appendix H for examples of interview questions for the NP working in long term care.

Certain personality traits have been identified as important for the success of a collaborative relationship (OMA & RNAO, 2003). These traits include:

- Confident
- Knowledgeable
- Forthright
- Good communication skills
- Comfortable with scope of practice
- Flexibility
- Organized
- Realistic
- Good clinical skills, or the ability to acquire them quickly

The WRHA Nurse Practitioner position description is available in Appendix A.

Retention
What factors will assist in the retention of NPs?

Within Canada, there are few available studies identifying retention factors. Fair and adequate compensation, a supportive work environment, good collegial relationships and opportunities for continuous learning are examples of general strategies, which contribute to retention of staff. The ability to work within the full scope of practice has been identified as an element of NP job satisfaction. Creation of a work environment that can provide the opportunity for the NP to work within the full scope of practice is therefore a priority for the employer.

The WRHA has adopted the Strong model (Ackerman et al, 1996) as a framework to support the implementation of the NP. This model will encourage retention of the NP as it supports the development of a supportive environment for professional growth (see Practice Section – Model of Practice).

Communication Strategies
Because the introduction of the NP is a relatively new concept at many sites, a comprehensive communication strategy needs to be developed and implemented. General information should be provided to all staff about the NP. Team meetings to follow-up this communication can answer questions and solicit support, awareness and cooperation. Meetings with key informants may be helpful to understand any concerns or issues in advance.
Upon arrival, the NP will be introduced to site staff and formally introduced to the health care team. The role, expectations and a general plan for integration of the NP into the team setting must be delineated. The health care team members should negotiate the integration plan so all team players understand the transition. Opportunities for questions, suggestions and feedback will be provided. The NP will play a key role in communicating about their role and responsibilities to other health care team members. It is important to allow the NP to introduce his/her skill set and background and take a lead informing others.

Education of the administrative staff about the role of the NP is also important as they may be fielding general inquiries from clients and the public. A script, which briefly explains the NP role, may be helpful for front line administrative staff to use. Clerical staff involved in booking appointments is critical to the success of the NP as they are the front line and can impact the appointments if they do not understand the role clearly.

A written pamphlet about the NP (i.e. WRHA pamphlet) is another communication means to assist clients and families in their understanding of the NP role. Posted information within the site can also contribute to the understanding of the NP role. Communication about the role of the NP within the WRHA could also be posted on the WRHA website or be included in the publication Aspire.

Within the PCH setting, a strategy to communicate the NP role to residents and families needs to be developed and implemented. There should be an initial education/information session for residents/families during the needs assessment phase. Once the NP positions has been established, information about the role and how the NP will interact with residents and families should be provided. This information can be offered in a number of ways: resident council meetings, family information sessions and printed information. Families/residents should be presented with a choice in the provision of primary care services (NP-MD care or MD only).

Communication strategies to solicit feedback from the health care team about the integration of the NP will be required. Individual meetings may be appropriate to provide a forum for discussion. Team meetings can encourage feedback and identify issues. A regular meeting between the NP, administrative leader (Team Manager), nursing and medical leaders to review the orientation plan provides another opportunity to identify communication needs and develop appropriate strategies. There may need to be special considerations if a NP is a former registered nurse on the team, as the NP must both assume a new role and break out of a previous role.

**Change Management**

Introduction of the NP into the primary care setting will require attention to change management processes within the primary care site. While often the focus of the introduction of the NP is the physician-NP relationship, the entire health care team may be viewed as an entity to be attended to for the purposes of implementation. One study (Grady et al, 1996) found that it is essential to recognize that the development of group collaboration occurs in four stages:

- **Forming phase:** comprises inquiry and exploration. During this stage, provision of information to all parties is encouraged. Questions that may arise about role, scope of practice, or liability concerns need to be explored and addressed with factual information.

- **Storming phase:** where groups conflict on goals and relationships. As the NP begins to practice, there may be conflict or disagreement on the role or function. A constructive conflict resolution process is needed to address challenging situations. Leadership and support from administration and the identified medical leader can assist in identifying the issues and potential solutions.

- **Norming phase:** follows guidelines and collaboration is visible. As working relationships are developed among the health care team, collaboration becomes more evident. Guidelines, protocols and agreements will be developed where necessary.

- **Performing phase:** evidence of individual and group initiative. In this final stage, the NP is functioning as a member of the health care team, working both within the full scope of individual practice and collaborating appropriately with team members.
The stages of group development do not always progress in a linear fashion. For example, the health care team may progress to the performing phase, however, in new and challenging situations *storming* may occur. The key to change management is recognition of the change, effective communication and leadership.

**Unionization**

Within the WRHA, there presently are NPs working in a variety of employer/employee relationships. The NP may be working under a collective agreement, such as the Manitoba Nursing Union/CUPE or in a non-unionized position. It is best to check the site-specific union contract, where this exists. As additional NPs are hired within the WRHA and across the health care system, issues related to job responsibilities may require human resource expertise for resolution.
Practice
Delivery of services by the NP within the health care setting is influenced by a number of factors — and these factors will vary across regions and provinces. Current literature and research confirms that the key to utilization of the skills of a NP is the ability to define roles and responsibilities amongst team members and to then work collaboratively to best meet the needs of the clients attending the site.

The Practice section is divided into the following topics:
- Collaboration
- Standards and Scope of Practice
- Competencies
- Roles
- Practice development/training/ongoing support
- Model of Practice
- Consultation
- Referral
- In Hospital Care
- After Hours Coverage

Collaboration
Collaborative practice is not a new concept, however, with rapid changes in health care and legislation supporting new providers (such as midwives and NPs) the implementation of collaborative models of care becomes a necessity. “Collaborative practice is an inter-professional process for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided” (Way, Jones & Busing, 2000). Collaboration is often synonymous with positive working relationships among professionals when in reality collaboration is a strategy to effectively utilize provider resources to deliver comprehensive primary care in a cost-effective manner.

Essential elements for a successful collaborative practice have been identified in the literature (Way, Jones & Busing, 2000). These elements include:

- Responsibility and accountability
- Coordination
- Communication
- Cooperation
- Assertiveness
- Autonomy
- Mutual trust and respect

(Additional reading see “Implementation Strategies: Collaboration in Primary Care – Family Doctors & Nurse Practitioners Delivering Shared Care (May 2000))

The collaborative relationship works best when both partners have a thorough understanding of the scope of practice.

Standards & Scope of Practice:
The Standards of Practice for Registered Nurses apply to all registered nurses working in primary care including NPs www.crnm.mb.ca/downloads/standardsofpractice_web.pdf. Determining the scope of practice of an individual registered nurse is an individualized process, which must consider a number of factors. The College of Registered Nurses has developed a fact sheet to assist practitioners and managers in decision-making specific to a registered nurse’s scope of practice.

Please see: www.crnm.mb.ca/downloads/scopeofpracticeofrn_web.pdf
The Registered Nurse’s Act enables NPs to provide a number of services as part of their own scope of practice. In legislation, these services are referred to as “included practices.” If on the extended practice register (meaning the registered nurse meets all of the regulation requirements), the NP may do the following in the course of engaging in the practice of nursing:

- order and receive reports of screening and diagnostic tests designated in the regulations
- prescribe drugs designated in the regulations
- perform minor surgical and invasive procedures designated in the regulations.

The standards of practice for registered nurses on the extended practice register have been defined by CRNM (www.crnm.mb.ca/downloads/rn(ep)standards_web.pdf). NPs who are registered as RN(EP) will be expected to meet these practice standards in addition to the standards of practice for the registered nurse.

To assist the health care team to make safe, appropriate decisions regarding the overlapping scopes of practice of physicians and registered nurses joint guidelines have been developed by the College of Registered Nurses of Manitoba and the College of Physicians & Surgeons of Manitoba (www.crnm.mb.ca/downloads/guidelines_shared_competencies.pdf). These guidelines also specify the process for delegated physician services. Delegated physician services are those functions unique to the practice of physicians, which can be delegated to registered nurses provided the principles for delegation are satisfied. In addition to these guidelines, the WRHA Delegation of Physician Services policy must be adhered to. The NP will only use the WRHA delegation policy to cover procedures that do not fit within the included practices.

**Competencies:**

Competence is defined as the specific knowledge, skills, judgment, attitude, and values required for a nurse to practice. A Continuing Competence program has been established. This safeguard helps to ensure that every registered nurse has the ongoing ability to practice safely and ethically in a designated role and setting (www.crnm.mb.ca/downloads/continuingcompetence_web.pdf). It is the professional responsibility of the RN(EP) to define and communicate the boundaries of their scope of practice to the team and seek consultation as appropriate.

All NPs must meet the entry-level competencies of registered nurses to practice within Manitoba www.crnm.mb.ca/downloads/entrylevelcompetencies(feb_05).pdf. NPs must meet additional competencies specified by the CRNM in each of the four areas:

1. Assessment and Diagnosis of Client Health/ILLness Status;
2. Pharmacotherapeutics and other Therapeutic Interventions in Client Care Management;
4. Professional Responsibilities and Accountabilities.

For further detail on the Competencies for the RN(EP) go to: www.crnm.mb.ca/downloads/rn(ep)competencies_web.pdf. The Canadian Nurse Practitioner Core Competency Framework developed by the national nursing body is available at: www.cnpi.ca/documents/pdf/CNPE_Core_Comptency_Framework_e.pdf
Roles

The process for determining the roles and functions of the NP needs to consider what work needs to be done and decisions about who is best suited to perform that component of care. In settings that include family physicians, NP’s as well as primary care nurses and other providers, careful planning and consideration is needed to ensure the best use of expertise and resources.

There needs to be a clear understanding of roles, especially between the family physician and NP. Unless both parties agree and understand who does what, there is likely to be dissatisfaction. A process to clearly define the role of the NP may include the following (IBM, 2003):

- Spend time identifying the client and patient needs that the NP is expected to meet.
- Ensure understanding of health care team members’ practice styles and readiness for integrating the NP role.
- Identify the role of the NP in writing and circulate and discuss it widely to obtain buy-in to the position and facilitate education about the role.
- Develop guidelines and position description for the role and practice of the NP and distribute it to members of the interdisciplinary team. It is important that there is an understanding of what the NP can and cannot do. Refer to the WRHA NP position description.
- Allow the NP time to establish rapport with physicians and other members of the health care team to become familiar with each other’s practice styles.

The NP should take a lead in the process of role development as it provides the NP with the opportunity to develop relationships with the health care team and become familiar with the client population to be served.

Assignment of clients in a health care setting also influences the role the NP assumes. There are a variety of ways to develop the NP’s practice in a primary care setting such as:

1. NP takes all new clients until their practice fills up. New clients with issues beyond her scope of practice are referred elsewhere. Doctor retains existing client base. This option has been identified as the best option in those communities needing to extend care to more people.
2. NP takes all clients (new and existing) within their scope of practice. Doctor’s practice becomes restricted to more complex cases. This assignment strategy has been viewed as the most efficient option. It requires the physician to review all cases and to actively transfer care.
3. NP restricts their practice to specific areas such as well woman care. Doctor has a more varied practice. Some NPs like this option, others find it limiting, however, this option may best meet the needs of the population.
4. NP and Doctor both take on varied patients. New intakes are distributed evenly and some care transfer occurs. Consultation occurs as required. This model is usually the most satisfying for both practitioners. (OMA & RNAO, 2003)

These options have advantages and disadvantages depending on the practice requirements and providers. The specific role of the NP will then be developed based on client needs.

Within the Personal Care Home (PCH) program, a maximum caseload of 200 residents has been established. The NP-MD collaborative primary care service delivery model is discussed with families/residents and the NP then provides care for all existing and new residents in the PCH, in collaboration with the attending MD. Consultation occurs on a regular basis (i.e., weekly rounds) dependent upon the PCH needs. Physicians would provide sole care for residents/families who request MD only involvement.

Within the primary care environment, the size of a patient roster for an NP is largely unknown at this time.
Practice Development/Training/Ongoing Support:
Practice development begins with a planned and coordinated orientation to the practice setting. The orientation period generally takes approximately six months, although, the literature supports a variable orientation period depending on the NP’s practice experience. If the nurse is new to the NP role, more time may be required to develop confidence and skills.

In the initial stages of orientation, it is important that the NP acquire a comprehensive understanding of the health care setting including the programs and services provided as well as the roles of the other providers within the team. Shadowing and observation are good strategies, which allow the NP to be introduced to both the team and the clients.

Identification of a physician colleague who will work with the NP is an early step in orientation and practice development. Ideally, the NP will be paired with one physician agreeable to support the NP as teacher, mentor and colleague. In addition to this physician, an administrative leader is appropriate to support and guide the orientation process. Regular meetings between this triad will facilitate the integration of the NP into the practice setting as well as serve as a forum for problem solving and support. Open and honest communication between all parties will build success. An orientation plan that identifies the NP’s competencies and learning needs will be developed and implemented.

Training and practice development for the NP will vary depending on the NP’s style of learning and availability of resources and supports. Clinical skill acquisition can be supported through a process of theory and practice experience. Theoretical knowledge can be accessed through learning resources available from the organization, university or professional organizations. Practice experience may be available through the existing site or negotiated with another health care site.

Sites and employers should support and encourage collegial support networks via local (such as the Nurse Practitioner Association of Manitoba (www.nursepractitioner.ca) and national interest groups (Canadian Association of Advanced Practice Nurses) and connections with NP colleagues in similar settings.

Model of Practice:
There are advanced practice nurses working throughout the WRHA. The Nursing Leadership Council of the WRHA supports the Strong Model as the framework that guides and describes advanced nursing practice in all settings, whether the nurse is working as a NP or a Clinical Nurse Specialist. The differentiation comes in the amount of time and focus spent on each of the five main areas of practice. NPs spend a majority of their time and effort in direct patient care, whereas Clinical Nurse Specialists will focus more time in the other areas of practice. The focus of each Advanced Practice Nurse will change over time and in response to needs and with individual strengths and situations.

The Strong Model of Nursing Practice was developed in 1994 at the University of Rochester Medical Center. This model defines five domains of practice that comprise the Advanced Nursing Practice (APN) role: direct comprehensive care, support of systems, education, research, publication and professional leadership (Ackerman et al, 1996). The fulfillment of each of the domains varies with the individual Advanced Nursing Position and is dependent on the needs of the population served, the practice setting, and the individual APN interests and strengths. These domains are not mutually exclusive, as some aspects of practice may fall within the bounds of more than one domain. Conceptual strands of collaboration, scholarship and empowerment, which describe the attributes of practice, the approach to care and the professional attitude are included. These strands are circular and unifying threads that envelop the domains of practice. They influence each of the domains including direct and indirect care activities. Benner’s principles of professional advancement are also built into the model to illustrate the five levels of proficiency: novice, advanced beginner, competent, proficient, and expert. Although most advanced practice nurses begin in the role as clinical experts there is a progression from novice to expert in the provision of advanced care in the five domains.
Five Areas of Advanced Practice

1. Direct Comprehensive Care: Patient focused activities that include assessments, procedures, interpretation of data and patient counseling.

2. Support of Systems: Professional contributions to standards, quality initiatives, and development of policies, procedures and practice guidelines to optimize nursing practice within the institution.

3. Education: Contributions to caregiver, student and public learning related to health and illness.

4. Research: Practice that challenges the status quo and seeks better patient care through scientific inquiry and incorporating evidence-based practice into direct patient care.

5. Publication and Professional Leadership: Promotion and dissemination of nursing and health care knowledge beyond the individual practice setting.

Underlying Processes of Advanced Practice

A. Collaboration: Supporting the belief that the unique skills and abilities of various care providers in combination, contribute to the goal of excellent patient care. Reflects the multidisciplinary nature of provision of care in complex clinical situations or settings.

B. Scholarship: Signifies the constant inquiry that underlies every nursing action and decision.

C. Empowerment: The authority to identify and analyze relevant problems and to develop, implement and evaluate a plan of action.

The Strong Model of Advanced Practice
Consultation
Consultation is key to the collaborative relationship between the NP and the family physician. An Ontario study (OMA & RNAO, 2003) revealed a number of interesting observations about consultation. Physicians have two somewhat inconsistent perspectives on consultation. They worry they are not being consulted enough, however, physicians do not want to be consulted about issues that fall squarely within the NP’s scope of practice. At the beginning, doctors want and expect to be consulted more frequently. As the NP gains confidence in her role and in the relationship, consultations appear to appropriately decrease. It should be noted that NPs in Ontario are mandated by their regulations to consult at particular points of care and this may in fact, influence their consultation patterns.

There are a variety of consultation methods that may be used between the NP and family physician. In person contacts between providers include hallway consultation, planned meetings and patient examination. Telephone consultation is another method of accessing consultation with the physician. These telephone calls may be scheduled discussions or emergency phone consultations. Written consults often occur where doctors and NPs share patients yet are frequently not on-site at the same time. These written consults may take the form of binders, charts or notes appended to the chart. All consultations must be documented by the NP. Consultation expectations, patterns and methods should be discussed and established upfront.

Referrals to Physicians and other Specialists
Nurse Practitioners on the Extended Practice Register are assigned inactive billing numbers by Manitoba Health. NPs can send referrals, consultations to physicians and specialists by quoting their billing number on the referral/consultation letter. Manitoba Health treats payment for consultation requests from an RN(EP) no differently than it would treat payment for consultation requests from a General Practitioner.

In-Hospital Care
To be determined.

After Hours Coverage
To be determined.
Support Structures
Support structures for NPs will include:

- Administrative support
- Information Management
- Shadow Billing
- Revenue Generation
- Regional policies and procedures

Administrative Support
NPs will require administrative support similar to the primary care physician. In a shared practice environment, a minimum administrative requirement would be 0.5 EFT (plus relief). Within a solo practice, full time administrative support would be needed. If the NP has a satellite clinic in a community setting, administrative support is required during clinic hours. Provision of adequate administrative support will ensure the NP can focus on delivery of services instead of administrative tasks.

What are the types of functions the administrative support provides?
Clerical personnel must be available to set up appointments and manage client intake. Screening client calls is another function that will be required. Depending on the use of information systems, pulling client files for appointments and managing the client filing system is needed. Correspondence, faxing and mailing information to other health care professionals will require administrative support. This includes handling lab samples and requisitions (labeling and sending); processing test results, diagnostic test requisitions and results; completing reports and referrals; and shadow billing. The extent of required administrative support will vary based on the available information technology, the extent of automation, and the setting.

Information Management
All WRHA employed staff must attend a PHIA orientation session and sign the required PHIA documentation. In the delivery of health care services requiring collaboration, however, the NP may be involved and working with personal health information collected by different trustees. For example, the NP may be a WRHA employee providing services to individuals in a private physician practice or personal care home. In such circumstances, agreements would be required by both trustees to ensure compliance with the existing personal health information legislation. The goal of such an agreement is to have the NP recording on the same patient/client/resident record as all other providers.

MIS Reporting in Primary Care Settings: Primary Care providers (i.e.: physicians, nurses, NPs, and dieticians) working at WRHA sites (i.e.: Aikins St., Access River East) report on a monthly basis to Manitoba Health their statistics on direct client services that have therapeutic value and that can be documented. Providers working in Community Health Agencies (i.e.: Mount Carmel Clinic; Klinik, Nine Circles) also report these statistics monthly to Manitoba Health. Each site or agency has its own system for compiling the providers' statistics and sending them to the appropriate agency. However, the MIS categories and definitions are standardized between all of the WRHA funded Primary Care sites.

The statistics that providers are presently required to report include

- number of direct in-clinic contacts with clients
- number of direct contacts in the home, in the community, and in groups (and number of participants) with clients.
- number of indirect contacts
- number of agency contacts

NPs in Primary Care record these statistics on a daily basis and submit monthly. For further information about MIS statistical reporting, refer to the WRHA MIS Orientation Manual. Currently, mandatory reporting requirements for the NP working in the PCH environment have not been established.
Within the acute care emergency room environment, information about the activities of the NP is extracted from the Health Sciences Centre Admission/Discharge/Transfer. Currently, this information is being utilized in preliminary evaluation of the NP role.

**Shadow Billing**
Recently there have been developments to include NPs as providers who can shadow bill. Shadow billing is the process currently used by primary care physicians under salaried or contract remuneration to account for their activity using the existing fee-for-service billing system. Manitoba Health will provide NPs on the Extended Practice Register with inactive billing numbers. The NP will use the specific assigned billing number to capture or bill the direct services provided using the existing tariff codes. Some additional nursing codes have been added to the tariff codes to help reflect the NP’s activity. This system will provide a mechanism for the NP to reflect the direct service component of practice. Manitoba Health has initially provided the NPs and administrative staff with in-services so accurate shadow billing can occur.

**Revenue Generation: Third Party Billing — Worker’s Compensation Board/Blue Cross**
Mechanisms will need to be established to ensure the NP may provide services eligible for third party billing, specifically WCB and Blue Cross. Dialogue with Manitoba Health and the College of Registered Nurses of Manitoba may be beneficial in prioritizing this issue.

**Regional policies & procedures**
Within the WRHA, there has been significant work to establish regional policies to support the delivery of primary care services. Specifically, a draft delegation of function policy in primary care was developed regionally and is under final revision. The delegation of function policy is consistent with guidelines established by the College of Registered Nurses of Manitoba and the College of Physicians and Surgeons. See: www.crnm.mb.ca/downloads/guidelines_shared_competencies.pdf

NPs have been providing clinical services in their expanded role under delegation agreements. Once registered on the Extended Practice Register, these agreements are unnecessary. The exception to this are those delegation agreements pertaining to procedures outside the Included Practice Regulations.

Collaborative practice agreements are agreements traditionally developed between a nurse and physician explaining how both parties will work together in the delivery of primary care services. These are not legal requirements but rather delineations of roles and responsibilities. With the further development of multidisciplinary teams, the integration of a NP into a team environment provides the opportunity for all members to participate in the development of collaborative practice agreement within the setting. All team members that serve to enhance collaboration may then adopt this agreement formally. Elements that need to be discussed in collaborative practice agreements include:

- Scope of practice of team members
- Standards of practice
- Utilization of clinical practice guidelines
- Scope of services provided
- Delegation of clinical services (if in place) & competency for delegated clinical services
- Expectations of consultation & referral
- Integrative problem solving
- Written documentation
- Continuity of care
- Practice coverage

When a NP is working in a private physician setting, the development of a collaborative practice agreement is strongly recommended.
Evaluation
(Under Development)

The following elements have been identified to be included under the evaluation of the NP:

- Client/provider satisfaction
- Efficiency and improved access
- Economic analysis
- Clinical outcomes

The evaluation section will be further developed with input from Manitoba Health and CNPI.

Client/provider satisfaction
Potential tools that may be used in this section include: WRHA Satisfaction Questionnaire or an adapted Trust in Physicians tool.

Efficiency & improved access
(To be developed)

Economic analysis
Projected costs related to hiring a NP include the resources required for successful implementation into the selected practice site. Some expenses will be applicable for some sites and not others. A sample budget template is attached (Appendix I). Discussion of the various costs for sites to take into consideration is outlined below.

"Most available cost-effectiveness data are focused on nurse practitioner/physician collaborative primary care models," (Canadian Nurses Association) and when compared to physician only services, costs of using a NP/physician team have been found to be lower (Mundinger, 1994). In the United States the cost of an office visit with a NP was found to be between 10 and 40 percent lower than the cost of primary care services provided by a physician (Fitzgerald, 1995).

The planning for evaluation of implementation of NPs into practice sites should include an assessment of the cost effectiveness of providing this service. In addition to volume of client visits and NP shadow billing, other dimensions of economic analysis are important to include in analysis like: improved access to primary care services and reduction in ER visits, hospital admissions and length of hospital stay are potential cost savings/avoidance resulting from introduction of an NP into a community or practice. Client and provider satisfaction rates are also important elements to include in the evaluation process. There are long-term client health benefits associated with the NP role because NPs evaluate illness differently, emphasize disease prevention, health education and health promotion (Mundinger, 1994). For the individual clinic, inclusion of an NP in the interdisciplinary team of providers increases the number of clients who can access services at the site and provides opportunities for physicians to focus on more medically unstable clients.

Literature review did not reveal established methods elsewhere in Canada to evaluate the cost effectiveness of providing NP services. One approach to examining NP costs is suggested here:

1. Compute the compensation and operating costs of providing NP services per EFT per day (keep in mind that approximately 80 percent of the NP’s time can be devoted to direct client services). See example, Appendix J.

2. Review the top five billing codes used by family medicine physicians and NPs to estimate a reasonable number of billings by the NP per visit or per day. Approximately 30 to 40 percent of physicians’ gross billable income is spent on overhead (rent, admin, etc.) and NPs is about 16 percent.

3. Compute the number of billings per day by the NP that would be required to cover the cost of NP services.
It will be important to estimate the number of client visits that a NP will be able to reasonably accommodate each clinic day and the average number (and dollar value) of billings per visit. For example, if the average visit is 30 minutes in length and the NP has seven hours of clinic time per day, he/she would be able to book fourteen clients per day in the clinic. This approach will assist funding organizations and management to examine service volumes and costs, and therefore cost effectiveness of NP services over time. However, with this method of cost analysis, it is essential to note that it does not reflect all of the NP’s work since it only includes those activities on the shadow-billing list.

**Compensation**

When determining the number of EFT positions required, it is important to keep in mind that NPs practice often is comprised of 80 percent clinical (direct care) and 20 percent in the other domains of NP practice (Support of Systems, Education, Research and Publication and Professional Leadership). Once the population that will receive NP services is determined through the needs assessment process, one can estimate the volume of client care and the EFT required.

**Potential Additional NP Salary Costs**

In some circumstances, in-scope NPs may be entitled to additional compensation so the following points/questions are important to consider when budgeting salary costs:

- Will the NP be on-call? After hours? During regular hours?
- Will the NP be providing after hours hospital or home visits?
- Will the NP be working evenings or weekends?
- Effective scheduling will improve efficiency and therefore cost effectiveness of the NP in the clinic.

**Outstanding Issues**

- For recruitment and retention of NPs, permanent NP positions are preferable to term positions so it will be essential to secure permanent funding.
- Collective agreements for NP will require review to ensure they are responsive to the unique role of the NP. Some stakeholders may view the agreements as barriers to integrating NPs into health care teams.

**Administrative Support**

- Will there be additional costs for the provisions of administrative support for the NP practice? This will be important to ensure that the NP can spend the majority of time providing direct clinical care to clients.
- Depending on the clinic location, administrative support functions required may include, but not be limited to:
  - Reception, switchboard
  - After hours service
  - Office support (filing, faxing, copying, completing lab requisitions, making appointments, etc.)
  - Ordering supplies and equipment and arranging for equipment repair
  - Billing (shadow billing, third party billing)
- The EFT of administrative support per NP will vary depending on the location and size of the clinic. A larger clinic/practice may only require a 0.5 EFT of additional administrative support per EFT NP, while a smaller clinic may require 1.5 EFT.
Operating Expenses
A number of operating expenses are included in the attached sample budget. Some questions/points to consider when developing the budget:

- Depending on location and type of practice site, will there be additional courier costs related to the addition of an NP to the site? For example, to send laboratory specimens to the lab.
- Estimate additional laboratory and diagnostic testing costs.
- What will annual printing costs be (e.g. client education materials, pamphlets)?
- Will the NP be based in a clinic or inpatient setting or will he/she be providing services to clients in their homes or other community based sites? This will affect the NP’s travel/mileage expenses, and the need for cell phone, pager and mobile equipment.
- Maintenance, replacement and repair of medical equipment purchased for the NP are expenses that must be considered. Replacement of medical equipment may be required approximately every three to five years, depending on the type of equipment.

One Time Operating Costs
- The cost of purchasing and setting up a computer and telephone for the NPs use may be necessary.
- The medical equipment required will depend on what already exists in the practice site available for the NP to use. In most cases, some medical equipment will have to be purchased.
- Implementation costs will include orientation for the NP to the practice Site, Regional Health Authority, hospitals, laboratory services, etc. Other costs of implementation will include, but not necessarily be limited to, orientation of other practitioners to the NP role and scope of practice and interdisciplinary team planning and development related to integration of the NP role.

One Time Capital Costs
Questions to consider:
- Are renovations necessary to accommodate the addition of the NP’s practice at the site?
- Is a new or renovated clinic room required? If so, what furniture is necessary?
- What medical equipment needs to be purchased? If the NP is providing client services away from the clinic, they will also require medical equipment to take with them in addition to equipment in the clinic room.
- Is additional storage space needed?
- Is development of office space required?
- Is office furniture needed?

Clinical Outcomes
Potential tools that may be used in this section include:
- Quality of Life Indicators
- Health care utilization data (cost avoidance such as prevention of ER visits)
References


Appendix A

POSITION DATA

Position Title: Nurse Practitioner
Position Number: 
Department: 
Supervisor Position Title: 
Supervisor Position Number: 

STATEMENT OF QUALIFICATIONS

Education

- Masters of Nursing, Nurse Practitioner Stream or equivalent educational preparation as approved by CRNM

Language (To be determined by the facility. State if applicable i.e. designated bilingual positions.)

Experience (To be determined. State any clinical experience that is required/considered to be an asset for the position.)

Occupational Certification (To be determined by the facility. State any certification/registration required for the position or considered to be an asset/preferred.)

- Responsible to maintain and provide proof of active registration on the RN Extended Practice (EP) Register of the CRNM.

Knowledge (To be determined by the facility. State knowledge required for the position. This may include but is not limited to:)

- College of Registered Nurses of Manitoba Standards of Practice for Registered Nurses on the Extended Practice Register
- Canadian Nurses Association Code of Ethics for Registered Nurses
- Scope of practice as documented in the Registered Nurses Act
- Advanced nursing care knowledge related to health assessment, diagnostics, pharmacotherapeutics and invasive and minor surgical procedures
- Regional/Facility/unit policies, procedures, protocols, and guidelines.
- Personal Health Information Act (PHIA), Protection of Persons in Care Act, Mental Health Act, Workplace Hazardous Material Information System (WHMIS), Principles of Routine Practices (Universal Precautions) and other legislated acts
- Principles of collaborative practice
- Roles and responsibilities of members of the health care team
Abilities and Skills (To be determined by the facility. State skills and abilities considered necessary to perform the position. These may include but are not limited to:)

- Demonstrates effective oral and written communications skills.
- Knowledge of computer systems; word processing and email applications
- Ability to work independently and take initiative
- Ability to perform independently and as a member of the health care team.
- Demonstrates leadership ability
- Ability to adapt quickly to changing situations.
- Ability to function in a demanding and stressful environment.
- Demonstrates effective conceptual, organizational, interpersonal, critical thinking/problem-solving and decision-making skills.
- Ability to plan, manage and implement change effectively.
- Ability to foster inter-personal relationships including effective negotiation and conflict resolution
- Demonstrates effective group facilitation skills

PURPOSE OF POSITION

Under the general direction of XXXX, as part of the multidisciplinary team, the NP applies advanced nursing and medical theory to the provision of clinical care, autonomously ordering and interpreting diagnostic tests, prescribing pharmacologic agents and performing minor invasive procedures. Applies current/relevant nursing and medical theory, which allows for contribution to knowledge, development and involvement in advancing the nursing profession. Incorporates medical knowledge and advanced nursing knowledge; integrates this knowledge and experiential base into clinical practice. Demonstrates competence to practice autonomously in the implementation of strategies to promote health and prevent illness, is proficient in planning, implementing and evaluating complex care, and demonstrates competence to teach others. Provides for problem solving among staff or between staff and patients/residents/clients and with physicians and multidisciplinary team. Applies skills in consultation, collaboration and systems management in providing effective care. Complements physician services in the delivery of comprehensive health care.

STATEMENT OF RESPONSIBILITES

Direct Comprehensive Care

- Performs advanced comprehensive and focused health assessments. Synthesizes health assessment information and uses critical thinking and decision making to identify health concerns and risks, normal and abnormal states of health and formulate differential diagnoses.
- Orders appropriate screening and diagnostic investigations and interprets reports of these investigations based on sound clinical reasoning, scientific evidence and critical thinking.
- Communicates with patients/residents/clients about health findings and discusses outcomes and prognoses.
- Collaborates with patients/residents/clients and, where applicable their families and other members of the health care team to share decision making and set priorities for the management of diseases, disorders or conditions.
- Determines and prescribes treatments based on theory and evidence based practice for the specific client population and assists patients/residents/clients to incorporate treatment plan into their daily lives.
- Continually monitors, with patient/resident/client, the response to the chosen plan of treatment and makes adjustments as indicated.
- Uses sound clinical reasoning skills and established outcome criteria to evaluate initial and ongoing outcomes of the plan of care, including consultation/referral, and revises plan of care based on findings of evaluation.
- Documents clinical care in a timely, accurate and relevant manner.
- Assesses, diagnoses, manages and evaluates health/illness concerns of the patients/residents/clients within the context of the patient/resident/client's experience and determinants of health. Applies accepted theories of family dynamics, interactions and role expectations while managing the care of individuals and families.
- Applies principles of pharmacology in selecting and prescribing drugs for as part of treatment plan. Monitors and discusses with the patient/resident/client their response and adherence to drug therapy and makes changes necessary to achieve the desired affect.
- Uses health teaching principles when prescribing, educating and supporting patients/residents/clients in recommended drug use.
- Carries out advanced therapeutic interventions, such as minor surgical and invasive procedures, essential for clinical management.
- Coordinates and facilitates care by liaising with other health care providers, agencies and community resources.
- Provides counseling and education to patients/residents/clients and their families.
- Demonstrates cultural competence, making resources available to those from diverse backgrounds.
- Recognizes the ethical issues inherent in the delivery of health care and facilitates client decision making about their health.
- Acts as a clinical expert/resource to establish, maintain and improve patient/resident/client care delivery.
- Demonstrates expert skills in the formal and informal consultation with nursing and all disciplines.
- Provides specialized knowledge regarding patient/resident/client/family problems and practice issues through consultation with physicians, nurses and other members of the health care team, patient/resident/clients and their families.
- Determines the need for health promotion and primary and secondary prevention strategies for individuals, families and groups and implements same.
• Collaborates with clients, interdisciplinary teams, and community members in assessing health promotion and illness prevention needs of clients, families and community outcomes.
• Uses a population health and community development approach in planning, developing and implementing health promotion and illness prevention and health management strategies/programs.

Research
• Identifies and/or develops research questions.
• Participates and contributes to research relevant to practice.
• Critically analyzes research literature and applies relevant research to practice.
• Integrates evidence based nursing, medicine and critical inquiry into practice.
• Facilitates utilization of research findings in clinical practice by all health team members.

Education
• Participates in professional development of nursing peers and other health professionals.
• Identifies learning needs of various care providers and contributes to the development of educational programs/resources to assist them to identify, prioritize, and provide quality care for defined populations.
• Provides clinical supervision, education and mentoring for graduate nursing students, medical interns and residents.

Publication and Professional Leadership
• Disseminates specialty knowledge of research findings through presentation and/or publications at local, regional, national and international level.
• Explains and promotes the role of nurse practitioner to patients/residents/clients, the public and other health care professionals.
• Participates in committees to develop policy and procedures that promote NP practice within a collaborative practice model.
• Models collaborative practice among team members.
• Acts as a resource person, educator, role model, advocate and/or mentor for students, health care professionals and the community.
• Provides leadership to promote analysis of key issues and participates in a broad range of policy making activities to influence practice, health services and healthy public policy.
• Demonstrates leadership skills, expertise, and in-depth knowledge bases consistent with advanced nursing practice.

Support of Systems
• Participates in strategic planning to support the implementation and evaluation of advanced practice nursing in area of specialty
• Provides support to individuals, families, groups and communities for the development of programs and services, which reflect their health needs and priorities.
• Provides consultation to other health care institutions, educational institutions, and policy makers regarding the delivery of quality patient/resident/client care.
• Provides consultation to community groups and patient/resident/client populations regarding health care issues within area of expertise.

Other Responsibilities
• Develops and implements an education plan to maintain clinical competency

POSITION ELEMENTS

Environmental Conditions
• Flexible working hours.
• Position involves physical activities.
• May encounter exposure to disease, radiation, toxic materials, noise, allergens, etc.
• May encounter aggressive and/or agitated individuals.

Impact of Error
• Inappropriate/insensitive communication, action or poor judgment may adversely affect patient/resident/client care, or negatively impact the hospital/organization/program’s reputation.
• Non-adherence to hospital/organization/program’s policies and procedures may cause harm to individuals, equipment or property.

Working Relationships
Collaborates with Physician and other members of the health care team; patient/resident/clients and families.

Authority
• Nurse practitioners have the authority to provide extended practice nursing care if they are competent to provide that care, the care is endorsed in the practice setting and is within the scope of nursing practice as defined by the CRNM.
Appendix B

POSITION DESCRIPTION

POSITION DATA
Position Title: Clinical Nurse Specialist
Position Number:
Department:

Supervisor Position Title:
Supervisor Position Number:

STATEMENT OF QUALIFICATIONS

Education
Masters of Nursing with graduate course work in research methods

Language (To be determined by the facility. State if applicable i.e. designated bilingual positions.)

Experience Minimum five years of recent clinical experience in a variety of nursing roles relevant to the position.

Occupational Certification (To be determined by the facility. State any certification/registration required for the position or considered to be an asset/prefereed.)
- Responsible to maintain and provide proof of active registration on the register of practicing nurses as per The Registered Nurses Act.

Knowledge (To be determined by the facility. State knowledge required for the position. This may include but is not limited to:)
- College of Registered Nurses of Manitoba Standards of Practice for Registered Nurses
- Canadian Nurses Association Code of Ethics for Registered Nurses
- Scope of practice as documented in the Registered Nurses Act
- Regional/Facility/unit policies, procedures, protocols, and guidelines.
- Personal Health Information Act (PHIA), Protection of Persons in Care Act, Mental Health Act, Workplace Hazardous Material Information System (WHMIS), Principles of Routine Practices (Universal Precautions) and other legislated acts
• Principles of collaborative practice
• Advanced nursing care knowledge related to clinical area
• Roles and responsibilities of members of the health care team
• Principles of delegation

**Abilities and Skills** *(To be determined by the facility. State skills and abilities considered necessary to perform the position. These may include but are not limited to:)*

- Demonstrates effective oral and written communication skills
- Knowledge of computer systems; word processing and email applications
- Ability to work independently and take initiative
- Ability to perform independently and as a member of the health care team.
- Demonstrates leadership ability
- Ability to adapt quickly to changing situations.
- Ability to function in a demanding and stressful environment.
- Demonstrates effective conceptual, organizational, interpersonal, critical thinking/problem-solving and decision-making skills.
- Ability to plan, manage and implement change effectively.
- Ability to foster inter-personal relationships including effective negotiation and conflict resolution
- Demonstrates effective group facilitation skills
- Ability to teach at individual and group level.
- Knowledge of the research process and ability to apply research to clinical practice
- Project management skills

**PURPOSE OF POSITION**

Under the general direction of XXX, as part of the multidisciplinary team, the CNS provides leadership in promoting excellence in the delivery of relevant nursing services through the application of advanced knowledge of nursing care, research methodologies, evidence based practice and program evaluation. The CNS addresses key clinical issues and program priorities by participating in or directing clinical practice, consultation, education, research, support of systems, publication and professional leadership. The priorities of the CNS are directed by program priorities. The CNS provides leadership and direction related to nursing practice, standards, program development and evaluation, quality and research.

**STATEMENT OF RESPONSIBILITIES**

*Direct Comprehensive Care*

- Acts as a clinical expert/resource/consultant to establish, maintain and improve patient/resident/client care delivery.
- Determines the need for health promotion and primary and secondary prevention strategies for individuals, families and groups and develops and implements same.
• Collaborates with patients/residents/clients, interdisciplinary teams, and community members in assessing health promotion and illness prevention needs of clients, families and community outcomes.

• Provides direct or participates in the development of, specialized comprehensive nursing services emphasizing health promotion, disease prevention and collaborative management strategies to positively affect health outcomes.

• Assesses, implements nursing care and evaluates health/illness concerns of the patient/resident/client within the context of the patient/resident/client’s experience and determinants of health. Applies accepted theories of family dynamics, interactions and role expectations while providing care for individuals and families.

• Demonstrates expert knowledge and synthesis of expert nursing practice within a clinical specialty.

• Performs health assessment and demonstrates advanced clinical decision making within a clinical specialty.

• Initiates referrals and coordinates care with other health care providers and community agencies.

• Provides counseling and education to patient/resident/clients and their families.

• Monitors and documents clients’ response to treatment and interventions, health status and outcomes.

• Participates in a variety of intra/inter-agency and community networks, partnerships and committees to promote nursing knowledge and contribute to population health promotion.

• Fosters an environment that encourages reflective practice.

• Coordinates/facilitates interdisciplinary plan of care

• Acts as a consultant and expert in standards to improve delivery of patient/resident/client care

• Develops/participates in the assessment of patient/resident/client response to therapy.

• Develops/participates in the outcome evaluation data to improve the delivery of patient/resident/client care.

• Plans, provides and coordinates patient/resident/client/family teaching for a defined group of patient/resident/clients.

• Demonstrates expert skills in the formal and informal consultation with nursing and all disciplines.

• Demonstrates cultural competence, making resources available to those from diverse backgrounds.

Research

• Acts as a principle investigator or participates in research relevant to area of responsibility.

• Critically analyzes research literature and recommends changes in the clinical practice and/or program delivery services within the appropriate forum.

• Integrates evidence based nursing, medicine and critical inquiry into practice.

• Demonstrates knowledge of qualitative and quantitative research methods.
• Demonstrates and promotes a spirit of critical inquiry with regards to client care matters.
• Assesses and identifies relevant researchable clinical practice problems with staff.
• Provides consultation to nurses, other health care professionals and community members regarding research activities.
• Complies with relevant codes of ethics when participating in research projects.
• Evaluates the impact of various programs and interventions upon the health of the population and on nursing practice.
• Facilitates utilization of research findings into clinical practice by health team members.

**Education**

• Participates in learning needs assessment to promote professional development of nursing peers and other health professionals
• Contributes to the development of educational programs/resources to assist nursing peers and other health professionals to identify, prioritize, and provide quality care for defined populations.
• Assists in the skill development of nurses including clinical, problem solving, critical thinking and leadership.
• Identifies individual and system facilitators and barriers to professional education.
• Monitors and evaluates the effect of professional educational activities in collaboration with management on the quality of patient/resident/client care.
• Provides clinical supervision, education and mentoring for undergraduate and graduate nursing students.
• Acts as a resource and support for educators and/or educational initiatives within the program.

**Publication and Professional Leadership**

• Disseminates specialty knowledge of research findings through presentation and/or publications at local, regional, national and international level.
• Engages in activities to promote role of CNS.
• Contributes to the development of theoretical base for nursing care by communicating practice experience and/or research findings via the literature.
• Demonstrates leadership skills, expertise, and in-depth knowledge bases consistent with advanced nursing practice.
• Acts as a role model and clinical expert in the area of clinical specialty.
• Participates and provides leadership on committees related to care delivery, policy and procedure development, clinical practice guideline development, research, education and professional development.
• Anticipates future changes (needs, technology, changing system, professional development) and recommends appropriate changes/implications.
• Identifies and facilitates quality improvement initiatives related to clinical practice.
Support of Systems

- Participates in local and national decision-making around health policy issues.
- Collaborates in the development of strategic and program planning and evaluation to foster innovation.
- Assists management with the development, implementation and evaluation of standards of nursing practice for a defined group of patient/resident/clients.
- Provides specialized knowledge and skills to assist in clarifying issues, exploring options, and facilitating change.
- Provides consultation to other health care institutions, educational institutions, and policy makers regarding the delivery of quality patient/resident/client care.
- Provides consultation to community groups and patient/resident/client populations regarding health care issues within area of expertise.
- Uses a population health, community development approach in planning, developing and implementing health promotion and illness prevention strategies/programs.
- Works collaboratively with individuals and groups to improve the health and well being of the population by engaging in a broad range of community development strategies including organizational capacity building, intersectoral networking and local area development.

Other Responsibilities

- Develops and implements an education plan to maintain clinical competency.

POSITION ELEMENTS

Environmental Conditions

- Flexible working hours.
- Position involves physical activities.
- May encounter exposure to disease, radiation, toxic materials, noise, allergens, etc.
- May encounter aggressive and/or agitated individuals.

Impact of Error

- Inappropriate/insensitive communication, action or poor judgement may adversely affect patient/resident/client care, or negatively impact the hospital/organization/program’s reputation.
- Non-adherence to hospital/organization/program policies and procedures may cause harm to individuals, equipment or property.

Working Relationships

Collaborates with nursing colleagues, management, other members of the health team and links with patients/residents/client/population.
**Authority**

The CNS has the authority to make recommendations related to nursing practice standards that ensure evidence based nursing care.

The CNS shall be involved in all discussions related to nursing standards of care/clinical practice guidelines within a specialty.
Dear [insert name],

The office of the Chief Nursing Officer has received verification of the registration of [insert name] with the College of Registered Nurses on the Extended Practice Register.

[insert name] area of practice is [insert clinical area] and the billing number is [insert billing number].

Effective June 15, 2005, the Extended Practice Regulation came into effect to allow registered nurses, who meet the College of Registered Nurses of Manitoba (CRNM) qualifications, to independently order diagnostic tests, prescribe drugs and perform minor medical procedures. The Registered Nurse (RN) Extended Practice (EP) Register was established by the CRNM in mid-July with nurses being placed on the roster as they meet the requirements.

The authority of extended practice nurses to order test is described in Regulation 43/2005 under the Registered Nurses Act, as follows:

**Ordering Tests**

5(1) For the purpose of clause 2(2)(a) of the Act, a registered nurse (extended practice) may order and receive reports of the screening and diagnostic tests specified in Schedule A.

5(2) A registered nurse (extended practice) may also order and receive reports of screening and diagnostic tests other than those specified in Schedule A if

(a) the nurse is an employee of a regional health authority or health care facility and is permitted to order the tests by a written policy of the authority or facility; or

(b) the test is required to monitor a patient’s chronic illness or injury and the nurse has consulted with the patient’s physician whose name appears on the test requisition.

The diagnostic tests and laboratory procedures specified in Schedule A are listed at [http://web2.gov.mb.ca/laws/statutes/index.php](http://web2.gov.mb.ca/laws/statutes/index.php). Click on Table of Regulations and scroll down to R40. The Registered Nurses Act, to locate the Extended Practice Regulation 43/2005. For further information regarding the scope and role of an Extended Practice nurse the following website addresses are available for your information:

http://www.crnm.mb.ca/downloads/rnep_web.pdf,
http://www.crnm.mb.ca/downloads/what_is_an_rnep_web.pdf,

This letter confirms that (insert name) is on the Extended Practice Register and is therefore authorized to independently order diagnostic tests and receive reports as specified in the regulation.

If you have any questions concerning this process, please feel free to contact my office at (insert phone number).

Yours truly,

Site CNO name

cc: (insert name)
Employee File
(Program Team)
(Site name), Director of Medical Information, (insert site name)
(Site name), Vice-President and Chief Medical Officer (insert site name)
(other appropriate cc’s)
Dear (name),

The office of the Chief Nursing Officer has received verification of the registration of (insert name) with the College of Registered Nurses on the Extended Practice Registry.

(insert name) area of practice is (insert clinical area) and the billing number is (insert billing number).

Effective June 15, 2005, the Extended Practice Regulation came into effect to allow registered nurses, who meet the College of Registered Nurses of Manitoba (CRNM) qualifications, to independently order diagnostic tests, prescribe drugs and perform minor medical procedures. The Registered Nurse (RN) Extended Practice (EP) register was established by the CRNM in mid-July with nurses being placed on the roster as they meet the requirements.

The authority of extended practice nurses to order laboratory tests is described in Regulation 43/2005 under the Registered Nurses Act, as follows:

**Ordering tests**

5(1) For the purpose of clause 2(2)(a) of the Act, a registered nurse (extended practice) may order and receive reports of the screening and diagnostic tests specified in Schedule A.

5(2) A registered nurse (extended practice) may also order and receive reports of screening and diagnostic tests other than those specified in Schedule A if

(a) the nurse is an employee of a regional health authority or health care facility and is permitted to order the tests by a written policy of the authority or facility; or

(b) the test is required to monitor a patient's chronic illness or injury and the nurse has consulted with the patient's physician whose name appears on the test requisition.

The diagnostic tests and laboratory procedures specified in Schedule A are listed at [http://web2.gov.mb.ca/laws/statutes/index.php](http://web2.gov.mb.ca/laws/statutes/index.php). Click on Table of Regulations and scroll down to R40. The Registered Nurses Act, to locate the Extended Practice Regulation 43/2005. They are also attached. For further information regarding the scope and role of an Extended Practice nurse the following website addresses are available for your information:

This letter confirms that (insert name) is on the Extended Practice Register and is therefore authorized to independently order diagnostic tests and receive reports as specified in the regulation.

If you have any questions concerning this process, please feel free to contact my office at (insert phone number).

Yours truly,

Site CNO Name & site name

CC: (insert name of EP)  
Employee File  
Dr. Jim Dalton Diagnostic Services Manitoba  
(insert appropriate Program Team)  
(Site), Director of Medical Information (insert site name)  
(Site), Vice-President and Chief Medical Officer (insert site name)  
(insert other appropriate cc’s)
PART 2: LABORATORY PROCEDURES

BACTERIOLOGY

• Antibiotic level, serum
• Antibiotic Sensitivity

Cultures

• blood, aerobic and anaerobic
• throat swab
• urine
• cervical
• vaginal
• urethral
• bowel contents for enteric organisms
• pus for other sites
• body fluids (e.g. ascitic, pleural, spinal fluids, etc.)
• other than above
• tuberculosis
• Dark Field Examination
• Microscopic Examination of Smears and Wet Preparations, trichomonads
• fungi
• pinworms (Scotch Tape Method)
• parasites (stool)
• Screening test for bacteruria, spoon or agar slide technique
• Microscopic examination of synovial fluid under polarized light for uric acid crystals

BIOCHEMISTRY

• Alcohol
• Ammonia
• Amylase
• Phenobarbital
• Bilirubin, direct and total
• total
• Calcium
• Carbon monoxide, quantitative
• Chlorides
• Creatine phosphokinase (CPK)
• Creatinine
• Gamma Glutamyl Transferase
• Glucose, quantitative
• tolerance test up to and including five (5) bloods and five (5) urines
• Hemoglobin, chromatography or electrophoresis
• Glycosated hemoglobin - Hbg A1
• Iron, binding capacity
• Iron, serum
• Ketones (quantitative)
• Ketones (qualitative)
• Lactic acid
• Lactose tolerance
• Lead-serum-diagnostic excluding environmental and occupational screening
• Lipase
• Lipids, cholesterol, total
• cholesterol, high density lipoprotein (HDL)
• triglycerides
• Magnesium
• Osmolality - blood or urine
• pCO2
• pH of blood
• pO2
• All three (3) above combined
• Phosphatase, acid
• alkaline
• Phosphorus
• Potassium, serum or urine, any method
• Potassium and sodium, serum or urine when done together, any method
• Protein, total
• serum albumen, quantitation
• electrophoresis (to include total protein)
• Salicylates
• Serum Quinidine Blood Level
• Serum Lithium Determination
• Sodium, serum or urine, any method
• Transaminase (S.G.O.T.)
• Transaminase (S.G.P.T.)
• Urea quantitative
• Uric Acid

CYTOLOGY AND TISSUES

Cytology

• Cervico-vaginal smear
• Other submitted smears prepared by the clinician from body fluids
• preparation and examination of smears from fluids submitted when direct smears are made in the laboratory
• preparation and examination of smears from submitted specimens requiring centrifugation and/or filtration
• preparation and examination of smears from submitted specimens requiring centrifugation and/or filtration and preparation of cell blocks
• Seminal fluid, complete analysis
• Sperm, search, post vasectomy or in vaginal fluid

**Tissues**
• Surgical specimens X with paraffin sections

**FECES**
• Blood, occult

**HEMATOLOGY**

**Automated Hematology**
• platelet count
• red cell count (Electric Counter)
• reticulocyte count
• White cell count
• White cell differential count and cell morphology
  • count
  • prothrombin, consumption
  • thrombin time
  • time, partial
• Examination with report, of blood smear by a
  Pathologist, or by a Hematologist who has not seen the patient in formal consultation, when specifically requested by a registered nurse (extended practice)
• Hematocrit
• Hemoglobin (photoelectric)
• Malaria, or other parasites
• Sedimentation rate
• Sickle cell identification

**SEROLOGY**

• Antibody determination, precipitin test
• Antinuclear antibodies (to include positive and negative controls)
• Antistreptolysin titre
• Cold agglutnins
• Coombs tests, direct and indirect
  • direct only
  • C-reactive protein
• Heterophile antibodies, screen (single tube or single slide test)

**URINE**
• Albumen, biuret
• Amylase
• Bence-Jones protein
• Bilirubin
• Coproporphyrin or uroporphyrin, quantitative
• Creatine, quantitative
• Creatinine, quantitative
• clearance
• Glucose, quantitative (not stick, tablet or tape)

**HORMONES**
• chorionic gonadotropins (pregnancy test) immunological
  • quantitative titration
  • 17-ketogenic steroids
  • 17-ketosteroids
  • Lead (quantitative)
• Porphobilingen (Watson-Schwartz test)
• Porphorins, fractional
• Growth hormone
• Stone analysis
• Urinalysis, stick, tape or tablet for sugar, protein, ketones, urobilinogen, bilirubin or blood, or any other qualitative assessment not listed elsewhere
• Urinalysis, complete, including microscopic examination of centrifuged specimen

**RADIOASSAY AND LIGAND ASSAY**
• Chorionic Gonadotropin
• Cortisol
• Digoxin
• Dilantin (phenytoin)
• Folic Acid
• F.S.H. (Pituitary Gonadotropins)
• Immunoglobulin
• Insulin
• L.H. (Luteinizing hormone)
• Progesterone
• Testosterone
• Vitamin B5
• Estradiol
• Ferritin
• Carcino-embryonic antigen
• 17-Hydroxyprogesterone
• Prolactin

**Thyroid Function Tests**
• Thyroxine T-4 (Free or Total)
• T-3 Uptake
• Thyroid Stimulating Hormone (TSH)

**OTHER TESTS**
• Albumin creatinine ratio
• Breath Urea Test
• CK-MB
• Creatine Kinase (CK)
• DHEAS dehydroepiandrosterone sulfate
• Parathyroid hormone (PTH)
• Vitamin D
• Vitamin E, A, K
• Alphafetoprotein screen
• HCG, AFP, Estradiol
• PSA
• Fat Studies (feces)
• Troponin
• Drug Monitoring
• Drug Screening
• INR
• Lactate dehydrogenase
• Myoglobin
• Blood Grouping/Cross Match
Appendix E

Type on letterhead

(insert current date)

Site Managers
Pharmacy Program
Site Name & Address

Dear Name,

The office of the Chief Nursing Officer has received verification of the registration of (insert name) with the College of Registered Nurses on the Extended Practice Register.

(insert name) area of practice is (insert clinical area) and the billing number is (insert billing number).

Effective June 15, 2005, the Extended Practice Regulation came into effect to allow registered nurses, who meet the College of Registered Nurses of Manitoba (CRNM) qualifications, to independently order diagnostic tests, prescribe drugs and perform minor medical procedures. The Registered Nurse (RN) Extended Practice (EP) Register was established by the CRNM in mid-July with nurses being placed on the roster as they meet the requirements.

The authority of extended practice nurses to prescribe is described in Regulation 43/2005 under the Registered Nurses Act, as follows:

Prescribing drugs
6(1) For the purpose of clause 2(2)(b) of the Act, a registered nurse (extended practice) may (a) prescribe any drug or device referred to in Schedule B, and distribute samples of them; (b) prescribe drugs or devices other than those referred to in Schedule B, if the nurse is an employee of a regional health authority or health care facility who is permitted to do so by a written policy of the authority or facility; and (c) prescribe any non-prescription drug in order to permit the patient to access a drug plan that covers non-prescription drugs.

6(2) A registered nurse (extended practice) may renew prescriptions for drugs in addition to those referred to in clause(1)(a), but only for patients who are being managed collaboratively with another health care provider with authority to prescribe the drug.

6(3) This section is subject to the restrictions set out in the Controlled Drugs and Substances Act (Canada) and the regulations under that Act.
Prescribing vaccines

7 For the purpose of clause 2(2)(b) of the Act, a registered nurse (extended practice) may prescribe the following vaccines:
(a) a vaccine listed in the Specified Drugs Regulation;
(b) a vaccine not listed in the Specified Drugs Regulation that may be dispensed through a retail pharmacy;
(c) a vaccine or biologic used in a provincial immunization program when required to be prescribed for persons who do not meet the provincial criteria for free vaccine;

The diagnostic tests and laboratory procedures specified in Schedule A are listed at http://web2.gov.mb.ca/laws/statutes/index.php. Click on Table of Regulations and scroll down to R40., The Registered Nurses Act, to locate the Extended Practice Regulation 43/2005.

This letter confirms that (insert name) is on the Extended Practice Register and is therefore authorized to independently order diagnostic tests and receive reports as specified in the regulation. They are also attached. For further information regarding the scope and role of an Extended Practice nurse the following website addresses are available for your information: http://www.crnm.mb.ca/downloads/rn_ep__faq_web.pdf, http://www.crnm.mb.ca/downloads/rnep_web.pdf, http://www.crnm.mb.ca/downloads/what_is_an_rnep_web.pdf, http://www.crnm.mb.ca/downloads/extended_practice_regulation.pdf

If you have any questions concerning this process, please feel free to contact my office at (insert phone number).

Yours truly,

Insert site CNO name & site name

CC:  (insert name of EP)
Employee File
Dr. Brock Wright COO Health Sciences Centre, VP/CMO WRHA
(Appropriate Program Team)
(Site), Director of Medical Information, (site name)
(Site), Vice-President and Chief Medical Officer, (site name)
(Other appropriate cc’s)
WRHA Regional Program Director Pharmacy
SCHEDULE B

1. Any drug or device listed in Part 1 or 2 of the Specified Drugs Regulation under The Prescription Drugs Cost Assistance Act.

2. The following drugs:
   • Apo-Naproxen EC
   • Celebrex
   • Mobicox
   • pms-Meloxicam
   • ratio-Meloxicam
Appendix B

An Example of the use of the Needs Assessment Guide

Definition
- Determine a community’s or population’s service needs
  Immigrants and refugees living in the community of St. Vital – have not accessed health care services for screening or immunization since their arrival in the country
- Identify utilization patterns of health care services
  Prior to having knowledge of community health services or how the Canadian health care system works, these populations go without care or access primary care through Envoy.
  Once a CHN or a community development officer identifies them in the community, they are referred to the NP at the community health centre for health screening and or comprehensive primary care services. Referral to specialists as needed: the TB surveillance program, colposcopist, psychiatry, etc.
- Identify gaps in service provision
  The Immigration Department encourages screening for all immigrants and refugees without making it mandatory, therefore their exposure to health care can be delayed until such time as a crisis arises.
  Walk-in clinics and Envoy offer medical care only
- Establish priorities for the creation of service programs
  In collaboration with the community development officer and CHNs: community kitchens, parenting programs, pap clinics

Purpose
- Provides a rational basis for planning services and allocating resources
  Population who is under serviced and under screened in need of culturally sensitive care
- Identifies service needs and alternatives for meeting these needs
  Applying the principles of PHC re: accessibility, therefore, offering the right service by the right person at the right time. Also applying a collaborative model of care whereby there is one care plan adhered to by different disciplines to meet the needs of the patient or client (family, population)
- Permits involvement of users of the health service in health planning thereby avoiding over-reliance on care providers’ perceptions
  Applying the principles of community development, whereby the client drives the care depending on the needs that were self identified or identified with the assistance of an NP.

Process Issues
- Purpose of needs assessment
  Important to identify what type of health care provider is needed for the job: CNS, NP or M.D.
- Stakeholders
Clients and other members of the same culture, health care system (Manitoba Health, various other disciplines who are involved in the care of the individuals), Immigration Department, Housing, Education.

- **Required data**
  Statistics reflecting the number of immigrants and refugees living in the community are required
  Any health record they may have, e.g., immunization record, TB surveillance letter requiring immediate follow-up, cervical cancer screening histories through the Registry.

- **How will the data be collected?**
  Through Dept. of Immigration, MLA’s office
  Community Health Centre’s record keeping, i.e., charting, and database.

- **How will the data be analyzed?**
  Determine number of clinic visits; number of home visits, number of follow-ups, adherence to specialists’ visits and follow-ups, attendance at community programs (community kitchens).
  Compare number of immigrants and refugees accessing health care to the number that is not and using that information to determine needs.

**Needs assessment process**

1. **Identity stakeholders**
   - Current or potential consumers of service
   - Service providers
   - Professional organizations
   - Decision makers

2. **Identify population**
   - Social indicators
   - Characteristics of clients

3. **Define service provided**
   - Type and range of services provided
     Comprehensive primary care, including diagnostics, prescriptions, minor invasive procedures.
   - Use and demand for service
     An information session to increase their awareness of their right to health care and importance of screening generates the demand for the service.
   - Problems addressed by the service
   - Primary and secondary prevention
   - Sources of referrals
     Self-referral
     Community development agent
     Other nurses or allied health professionals, e.g. counsellor
     Other sectors, e.g. Family Centre of Winnipeg
   - Accessibility and affordability of services
     When the care services are community-based, accessibility is less of a problem
     Transportation is sometimes a barrier
Language barriers can be a challenge to accessibility
Affordability: dental and optometrist is not covered
- Waiting lists
4. Identify informal and formal patterns of service utilization
- Develop algorithms to demonstrate patterns
5. Assessment of met and unmet needs
- Utilize key informant surveys and data already gathered to answer the questions:
  Who has the need?
  Why does the need exist
  Is the need met adequately with current services?
6. Determine potential goals and outcomes to meet the identified needs, both met and unmet
- Prioritize needs identified
7. Identify skill set requirements and competencies to achieve the desired goals
  Advanced nursing practice skills-Masters prepared
8. Examine potential solutions
- Which health care discipline can best help client meet unmet needs
  This reflects collaborative practice
9. Decision and program or service planning
- Role definition
- Process for incorporation of new or additional role
10. Implementation
- Allow trial period
  Would have to develop criteria or success indicators
11. Evaluation
- Process
- Referral
  Culturally sensitive environment: use of interpreters, respecting religious holidays, respecting religious beliefs
- Outcome
  Communicable disease outbreaks
  TB
  Abnormal pap follow-ups
12. Revision and ongoing evaluation
Appendix G

Primary Care Clinical Standardized Equipment List
(Required equipment for a clinic room & home visit)

Items Per Clinic Room

- Alcohol Based Hand Rub Dispenser
- BP Cuff – adult obese – 1/ machine
- BP Cuff – pediatric – 1 / machine
- Container(s) for Cotton/Q tips, Tongue depressors, etc.
- Exam Light – halogen - Wall mounted
- Exam Table – regular
- Garbage Can
- Illiterate E Chart
- Monofilament – 10 gram
- Oto/Opthalmoscope – wall mounted
- Footstool – without support handles
- Pillow (plastic covered)
- Reflex Hammer
- Snellen Eye Chart
- Soap Dispenser – Foot Control-Disposable Reservoir
- Soap Dispenser – Wall mount
- Sphygmomanometer/Aneroid – Wall mounted
- Swivel Stool – with wheels
- Thermometer: Wall mounted

Home Visit Equipment

- Oto/Opthalmoscope
- Mobile BP inflation system
- Stethoscope
- Reflex Hammer
- Phlebotomy equipment
- Thermometers

This does not include equipment for a complete primary care clinic or the urgent/emergent equipment required in the event of a medical emergency.
Appendix H

Examples of Nurse Practitioner Interview Questions

1. GENERAL
   Tell us about the strengths or talents you would bring to this position.
   How would your co-workers describe you?
   How would your supervisor describe you?
   Everyone has their areas of strengths and areas for improvement. What do you see as your areas for improvement?

2. EXPERTISE IN CLINICAL PRACTICE
   Tell us about your experience as a nurse practitioner. Which settings have you practiced in and what client populations have you provided care for? (i.e., any experience in LTC or with geriatric populations).

   What would you consider to be four key indicators of resident/client-focused care? How would you incorporate them into your practice as an NP?

   As a NP, you will be providing direct, comprehensive primary care to PCH residents with complex and specialized needs. The next few questions address situations that are likely to present to you as a NP working in the PCH setting.

   Situational:
   You have received a call from a PCH asking for advice on management of a resident’s deteriorating respiratory condition. The staff is concerned and states the family is insisting on sending the resident to the ER for assessment. How would you address this situation?

   You have received a call from a PCH regarding a resident who has become very aggressive, disruptive and agitated and has already struck a staff member. The PCH staff feels they are not able to safely provide care to this resident. How will you respond to this situation?

   You have been notified of an alleged abusive situation towards a resident in the PCH. Describe how you would address this situation.

3. EXPERTISE AS AN EDUCATOR
   How would you address the learning needs of PCH staff in relation to clinical practice issues?

   A secondary component of the NP role is to assist in the skill development of nurses, including critical thinking, problem solving, and leadership skills. Describe the strategies you would use to promote the development of these skills.
In your role of NP, how would you facilitate/meet the educational needs of residents and families?

4. COMMUNICATION SKILLS

What strategies would you use to ensure effective communication with physicians, PCH staff and interdisciplinary team members?

The introduction of the NP will be a new role for the Personal Care Homes involved in this initiative. Describe strategies that you will use to establish and refine your role within the resident care team.

Establishing relationships and communication processes with neighboring acute care centers and Emergency Departments will be a pivotal role for this NP position. Provide some examples as to how you might go about this.

Provide an example of a conflict situation you have been involved in where you demonstrated effective use of your interpersonal and communication skills to resolve the conflict.

Describe your experience with:
   - Computerized systems, including type of software you have used.
   - Data analysis
   - Report writing

5. LEADERSHIP

An important aspect of the NP role is to disseminate research and promote best practices in care. Give an example of how you have applied research findings to your area of practice.

Provide an example of an illness prevention, health promotion or health maintenance strategy that could be used to enhance the care of PCH residents.

As a NP for the PCH Program, you will be involved in developing and monitoring evaluation criteria and outcome indicators to track information and outcomes in relation to the NP role. Provide examples of evaluative indicators that you would deem important to establish and monitor.

At WRHA, we value innovation and creativity. Tell us about the most innovative project you have undertaken or recommended for implementation.

What individuals or groups would you consider to be important partners to network with in this position?
## Appendix I

### Sample NP Budget Template

**Nurse Practitioner template**  
*Fiscal Year 2005/06*

<table>
<thead>
<tr>
<th>Classification</th>
<th>EFT</th>
<th>Annual Salary</th>
<th>2005/06 Total Cost</th>
</tr>
</thead>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>1.0</td>
<td>$79,036</td>
<td>$79,036 Note # 1</td>
</tr>
<tr>
<td>Benefits (15.15%)</td>
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<td></td>
<td>$11,974</td>
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<tr>
<td>H&amp;E Levy (2.15%)</td>
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<td></td>
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<tr>
<td><strong>Total NP Compensation</strong></td>
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<td>Secretary/Admin Assistant</td>
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<td>Benefits</td>
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<tr>
<td>H&amp;E Levy</td>
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</tr>
<tr>
<td><strong>Total Compensation</strong></td>
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<td></td>
<td>**</td>
</tr>
</tbody>
</table>

| **Operating Expenses**          |     |               |                    |
| General Office Supplies         | 1.0 | $665          | $665               |
| Postage/Courier                 | 1.0 | $265          | $265               |
| Medical Supplies                | 1.0 | $6,000        | $6,000             |
| Telephone                       | 1.0 | $510          | $510               |
| Cell Phone                      | 1.0 | $350          | $350               |
| Pager                           | 1.0 | $120          | $120               |
| Staff Development               | 1.0 | $600          | $600               |
| Reference Materials             | 1.0 | $600          | $600               |
| Professional Fees               | 1.0 | $400          | $400               |
| Rent                            | 1.0 | $4,800        | $4,800             |
| IT Support                      | 1.0 | $3,000        | $3,000             |
| Travel                          | 1.0 | $1,000        | $1,000 Note # 3    |
| Laboratory Costs                | 1.0 |               | ** Note # 4        |
| Equipment Replacement/Repair    | 1.0 | $2,000        |                    |
| **Total Operating Expenses**    |     |               | $20,310            |

**Total On-going Operating Requirements**  
$113,020 Note # 5

**One Time Operating Costs**

<table>
<thead>
<tr>
<th>Description</th>
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<th>2005/06 Total Cost</th>
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<tbody>
<tr>
<td>Computer</td>
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<tr>
<td>IT and Phone/Wiring and Set up</td>
<td>1</td>
<td>$1,160</td>
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<tr>
<td>Medical Equipment</td>
<td></td>
<td>** Note # 6</td>
</tr>
<tr>
<td>Implementation Costs</td>
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<td>** Note # 7</td>
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<td><strong>Total</strong></td>
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<td>$3,160</td>
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© Winnipeg Regional Health Authority, 2006
One time Capital Costs

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<tr>
<th>Item</th>
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<tbody>
<tr>
<td>Furniture</td>
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<tr>
<td>Renovations</td>
<td>** Note # 9</td>
</tr>
</tbody>
</table>

Notes:

1. Annual Salary is based on step 4 of 5; Salary increases follow the MNU contract increases
2. Secretary Salary amounts will depend on the applicable collective agreement and whether this can be accommodated within existing staff at the site
3. IT support is a standard WRHA IT cost and is transferred to IT upon budget approval
4. This budget assumes that the Nurse Practitioner will be traveling
5. Laboratory costs to be determined depending on practice site
6. This amount does not include the costs that will differ depending on the practice site
7. Purchase of medical equipment will depend on what is existing at the site and whether the NP will be providing care at other sites (e.g. satellite clinics, client’s home)
8. Implementation costs will depend on the needs specific to the site
Appendix J

PRIMARY CARE NURSE PRACTITIONER COST ANALYSIS

(Using Manitoba Health billing codes to guide analysis and based on actual workload of a NP at a WRHA Primary Care Clinic)

Monday:
- 10 patients seen
- 4 no shows/cancellations
- 9 x 26.00 = 234.00 (8529)
- 1 x 58.15 = 58.15 (8498)
- 5 x 25.00 = 125.00 (8141)
- Total: 417.15
- 53.83 per hour (based on 7.75 hours)

Tuesday (afternoon only):
- 5 patients seen
- 1 no show
- 4 x 26.00 = 104.00 (8529)
- 1 x 35.15 = 35.15 (8471)
- 4 x 25.00 = 100.00 (8141)
- 2 x 2.30 = 4.60
- Total: 244.10
- 69.74 per hour (based on 3.5 hours)

Wednesday:
- 13 patients seen
- 2 no shows
- 9 x 26.00 = 234.00 (8529)
- 2 x 31.70 = 63.40 (0254)
- 2 x 24.35 = 48.70 (8401)
- 1 x 58.15 = 58.15 (8498)
- 6 x 25.00 = 150.00 (8141)
- Miscellaneous: 24.05 (injections/lab tests in office)
- Total: 578.35
- 74.63 per hour (based on 7.75 hours)

Thursday:
- 7 patients seen
- 3 no shows
- 4 x 26.00 = 104.00 (8529)
- 1 x 42.25 = 42.25 (0253)
- 1 x 35.15 = 35.15 (8470)
- 1 x 24.35 = 24.35 (8401)
- 3 x 25.00 = 75.00 (8141)
- 1 x 2.30 = 2.30
- Total: 283.05
- 36.64 per hour (based on 7.75 hours)

Friday (afternoon only):
- 6 patients seen
- 3 x 26.00 = 78.00 (8529)
- 1 x 58.15 = 58.15 (8498)
- 1 x 24.35 = 24.35 (8401)
- 1 x 18.50 = 18.50 (0171)
- 2 x 25.00 = 50.00 (8141)
- 1 x 2.30 = 2.30
- Total: 231.30
- 66.09 per hour (based on 3.5 hours)

Miscellaneous:
- Telephone calls (estimate): 25? X 10.00 = 250.00

Summary:
- Total ‘billings’: 2003.95
- 51.71 per hour based on 38.75 hour week (this includes 7.75 hours of non-clinic activities, i.e. Administrative tasks, meetings)
- 64.64 per hour based on 31.00 hour week (only direct patient care activities included)
- Break even point against NP salary and benefits is 47.64/hour