وزارة الصحة
Ministry of Health

FAMILY NURSE PRACTITIONER overview

CLINICAL PRACTICE GUIDELINE

General Department of Nursing, 2021

Ministry of Health

MOH Agency for Therapeutic Services

This is an ongoing and developing guidance that is subject to change as more evidence accumulates. A regular update will be considered whenever needed. The guidance should be used to assist nurses to the best available practice in regards to family nursing care according to the best available and current evidence.

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American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th edition). American Nurses Association.

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Approved by:	**Mohammed G. Alghamdi, RN, PhD, NE-BC** General Director, General Department of Nursing Affairs Deputyship of Therapeutic Services, Ministry of Health, Saudi Arabia
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Workgroup Members

Fatimah S. Alotaibi, RN, MSN, BSN Supervisor of Performance Department ,General Directorate of Nursing. MoH Agency for Therapeutic services, Ministry of Health, Riyadh.

Reem M. Alhumaidan, RN, MSN, BSN Supervisor of Performance Department ,General Directorate of Nursing. MoH Agency for Therapeutic services, Ministry of Health, Riyadh.

Iman M. Alshammry, RN, MSN, BSN Director of Performance Department, General Directorate of Nursing. MoH Agency for Therapeutic services, Ministry of Health, Riyadh.

Sanaa Salem Alanazi, RN, MSN, BSN Supervisor of the Nursing Rights Unit in the Nursing Human Resources Department General Directorate of Nursing. MoH Agency for Therapeutic services, Ministry of Health, Riyadh.

Abdulrhman Albukhodaah , RN, MSN, BSN Supervisor of Performance Department ,General Directorate of Nursing. MoH Agency for Therapeutic services, Ministry of Health, Riyadh.

Dina Alsamti, RN, BSN Supervisor of Performance Department ,General Directorate of Nursing. MoH Agency for Therapeutic services, Ministry of Health, Riyadh.

Jehan Aljumeah, RN,BSN Director of Nursing Internal Communication Department, General Directorate of Nursing. MoH Agency for Therapeutic services, Ministry of Health, Riyadh.

External Reviewers

Dr. Monir Almotary, RN, PHD, AGACNP-BC
Assistant Professor of Nursing at the College of Nursing at King Saud University.

Dr. Hamza Moafa, RN, PhD, FNP
Assistant Professor of Nursing at the College of Nursing at King Saud University

Please address correspondence to:
Fatimah S. Alotaibi
Nursing Performance Development Supervisor
General Department of Nursing
Digital City, PJVP+2M
An Nakheel, Riyadh 12382, Saudi Arabia
Phone: +966112125555
Email: nursing@moh.gov.sa

Glossary Index

APN	Advanced Practice Nurse
CNP	Certified Nurse Practitioner
FNP	Family Nurse Practitioner
GNA	General Nursing Administration
NP	Nurse Practitioner
SCHS	Saudi Commission Health Specialist
SNA	Saudi Nursing Association

ARN/CNP/Advanced Practice Registered Nurse – A registered nurse who has completed an accredited graduate-level education programme to prepare the nurse for special licensure and practice for one of the four recognised APRN roles: certified registered nurse anaesthetist, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner (American Nurses Association [ANA], 2021, p.109).

Graduate-level Prepared Registered Nurse – A registered nurse prepared at the master's or doctoral educational level; has advanced knowledge, skills, abilities, and judgement; functions at an advanced level, as designated by elements of the nurse's role; and is not required to have additional regulatory oversight (ANA, 2021, p.112).

Advanced practice – where nurses incorporate professional leadership, education, research, and support of systems into their practice. Their practice includes relevant expertise, critical thinking, complex decision-making, and autonomous practice, and is effective and safe. Advanced practice nurses work within a generalist or specialist context and they are responsible for and accountable in managing people who have complex healthcare requirements.

Core competencies – a standard set of performance domains and their corresponding behavioural standards, which a nurse is required to demonstrate.

Competence – performing successfully at an expected level (ANA, 2014).

Competency – an expected level of performance that integrates knowledge, skills, abilities, and judgement (ANA, 2014).

Competent – being able to demonstrate the necessary ability, knowledge, skills, and attitudes across the domains of competencies at a standard that is determined to be appropriate for the level at which a nurse is being assessed.

Standards of Professional Performance – a competent level of behaviour in the professional role.

Specialists – those who elect to focus their professional practice on their identified specialty.

Nursing Specialty – encompasses a specified area of 21 discrete areas of study, research, and practice as defined and recognised by the profession (ANA, 2017).

Specialty Nursing Standards of Practice – include specialty nursing standards of practice and professional performance modelled on the SCHS Standards of Professional Nursing Practice.

Standards of Practice – describe a competent level of nursing practice demonstrated by the critical thinking model known as the nursing process. These standards encompass significant actions taken by registered nurses and form the foundation of nurses' decision making and action (ANA, 2021, p.114).

Standards of Professional Nursing Practice – authoritative statements of the actions and behaviours that all registered nurses, regardless of role, population, specialty, and setting, are expected to competently perform (ANA, 2021, p.114).

Standards of Professional Performance – describe a competent level of behaviour in the professional role (ANA, 2021, p.114).

NSPS – Nursing's Social Policy Statement is a document that articulates the parameters of the relationship between the profession of nursing and society (ANA, 2015).

Certifying Bodies – organisations that develop and administer certification programmes that may include examinations and other mechanisms, such as a portfolio review. The Saudi Commission Health Specialist Nursing Credentialing Centre is an example of a certifying body that confers a delineated credential for a designated time period.

Accrediting Organisations – specialised accrediting agencies accredit specific educational programmes that prepare students for entry into a profession, such as nursing. These organisations establish operating standards for educational or professional institutions and programmes, determine the extent to which the standards are met, and publicly announce their findings.

Nursing Process – a critical thinking model used by nurses that is represented as the integration of the singular, concurrent, iterative actions of these six components: assessment, diagnosis, identification of outcomes, planning, implementation, and evaluation (ANA, 2021, p.113).

Domain – an organised cluster of competencies in nursing practice.

Performance criteria – descriptive statements that can be assessed and that reflect the intent of a competency in terms of performance, behaviour, and circumstance.

Reliability – the extent to which a tool will function consistently in the same way with repeated use.

Prescribing – defined as the steps of information gathering, clinical decision making, communication, and evaluation that results in the initiation, continuation, or cessation of a medicine (Nursing and Midwifery Board of Australia, 2021).

Chapter One

Introduction

According to the Saudi Healthcare Transformation Strategy, the population of the Kingdom continues to grow and age. Our population is expected to rise from 36.1 million in 2022 to 39.5 million by 2030. Therefore, nursing care needs to be advanced and focused more closely on care for senior citizens and primary care in general. Increasing healthcare costs, growing populations, and a shortage of human resources create challenges in meeting the demand for quality patient care worldwide. Saudi Arabia is grappling with a severe shortage of nurses, particularly those with advanced qualifications, due to a host of cultural, educational, and governmental barriers. World Health Organization (2013) reports also reveal encouragement for advanced nursing practice through its development to cover the global shortage of nurses. Nearly three decades ago, the United Kingdom (UK) reported that senior clinical nurses are equal to physicians in terms of providing medical treatment to individuals. Moreover, in the United States (US), the Institute of Medicine allowed nurses, along with medical doctors, to structure the healthcare system. Here, we examine the role of nurse practitioners and consider how they might be integrated into Saudi Arabia's healthcare system in order to increase access to quality patient care (Hessa A. Almutairi ,elt ,2020)

An Advanced Practice Nurse (APN) is one who has acquired, through additional education, the expert knowledge base, complex decision-making skills and clinical competencies for expanded nursing practice – the characteristics of which are shaped by the context in which they are credentialed to practice (APRN Consensus Work Group, 2008). In addition to an overall nursing shortage, there is a severe shortage of nurses with advanced qualifications in clinical nursing. Although several studies have shown the importance of APRNs in the healthcare system, advanced nursing practice is still not implemented actively in Saudi Arabia, except in a tertiary hospital (King Faisal Specialist Hospital and Research Centre), which hires experienced expatriates for this role. The Cardiac Center at King Abdulaziz Medical City in Riyadh has implemented this role since 2000, but with a different tile (they call it a nurse specialist) with comparable scope of practice to many US states. In fact, it falls within the reduced scope of practice.

Development Timeline of advanced practice nursing in Saudi Arabia

Table 1: Development Timeline of advanced practice nursing in Saudi Arabia

Date	Event	Progression
1980s	KFSHRC Job Descriptions for Specialty Practice	Stoma, Wound, Continence, Pain, Infection Control, Palliative Care
1990s	KFSHRC APN Job Description	Developed without nursing credentialing or a privileging framework
1990s	KFSHRC Policy on Non-Physician Prescribing	For pharmacists and nurses
Mar 2008	KFSHRC Clinical Ladder	Aimed at growing nurses in specialty practice from novice to expert, including APN and NC (Figure 2)
Jun 2010	Recognition by the SCFHS of the Enterostomal Therapy Diploma Programme	A 12-month full time programme, incorporating both theoretical and clinical components, aimed at developing Saudi nurses to care autonomously for patients with stomas, incontinence, defecatory dysfunction, and wounds, including nurse-led clinics
Oct 2011	KFSHRC tasked APN proposal	Both general and specialty APN pathways were proposed, along with nursing credentialing and privileging
Jun 2012	Publication: Specialist Nursing in Saudi Arabia	Perspectives on specialist nursing in Saudi Arabia: A national model for success
Jan 2013	KFSHRC Nurse Credentialing & Privileging Committee	Nurse credentialing and privileging committee established
Jan 2013	SCFHS Dialogue	Started dialogue with SCFHS
Jan 2014	Invited publication: ICN/APN Education Committee	Addressing issues impacting advanced nursing practice worldwide
Jan 2015	Invited publications: series based on the provision of specialty nursing services	1. Developing enterostomal therapy as a nursing specialty in Saudi Arabia: which model fits best? 2. The development of nurse-led bowel dysfunction clinics in Saudi Arabia: Against all odds
Mar 2015	1st APN Thought Leadership Event, Riyadh	KFSHRC nurse and physician leaders and APNs, aimed at opening a local dialogue
Oct 2015	1st Nursing Symposium aimed at APN in Saudi Arabia	KFSHRC Riyadh Biennial Nursing Symposium main theme APN. Nurses from Saudi Arabia, the Gulf and invited international experts shared their experiences.
Oct 2015	1st Inaugural Saudi APN leadership meeting	Aimed at starting a national APN dialogue
Oct 2015	Chair, SCFHS, Nursing Scientific Committee, announces support from SCFHS	Dr. Ahmad Aboshaiqah (Chair, Nursing Scientific Committee, SCFHS) announced his and the SCFHS support for discussion and planning for APN in Saudi Arabia, in particular the community NP role
Jan 2016	First two KFSHRC Saudi nurses appointed as APNs	Ms. Hajer AlSabaa and Ms. Haifaa Hussain returned from scholarships in the USA after gaining their APN Master's degree,

		employed in APN positions (Colorectal and Paediatric populations)
Sept 2016	ICN/APN Hong Kong podium presentations include Saudi Arabian perspective	1. An international forum to share innovation strategies and creative modalities in advanced practice. 2. A survey of clinical education of APN: A global perspective. Beachesne, M., Scanlon, A., Carryer, J., Debout, C., East, L.A., Hibbert, D., Honig, J.

Rationale

- Nursing's Social Policy Statement: It is about the relationship – the social contract –between the nursing profession and society and their reciprocal expectations. This arrangement authorises nurses as professionals to meet the needs involved in care (ANA, 2015).
- Life expectancy is increasing, leading to an increased ageing population and high proportion of patients living with chronic health conditions; this requires a workforce with advanced skills to meet capacity.
- As nursing practice evolves and the healthcare needs of the population change, new CNP/ANP roles or population foci may evolve over time.
- Healthcare systems globally are under transformation and face restructuring.
- Innovation and changes in nursing as a profession are dynamic, with changes to education aiding disease prevention and health promotion.
- An opportunity is created for more autonomy in patient care and a growing number of career options.
- FNPs are able to care for a large variety of patients: they can be found in nearly every care setting and in the wider healthcare industry.
- Increased access to healthcare services, such as primary care. See the comment below about this part.
- Increased professional development opportunities in the clinical arena/field.

Objectives and outcome

- As part of the "Vision 2030", healthcare provision needs to be focused on promoting preventive rather than curative care.
- Advancing nursing roles and promoting specialised practice in primary healthcare.
- Procedural guide for the specialised nursing programme for workers in primary healthcare centres.
- Partnership with the Ministry of Education.
- Enhancing the integrated efforts with the SCFHS in adopting nursing certifications and credentialing nurse practitioners.
- ANP long-term relationships with patients and working in partnership with them to achieve optimum health.

Advanced Nurse Practitioner Scope of Practice statement

An advanced nurse practitioner is one who has a minimum of a master's degree in nursing, ideally with a doctorate in advanced nursing, from an accredited academic institute/programme. ANPs practice both independently and in collaboration with other healthcare professionals, completing clinical and didactic work accredited by the Saudi Commission for Health Specialists.

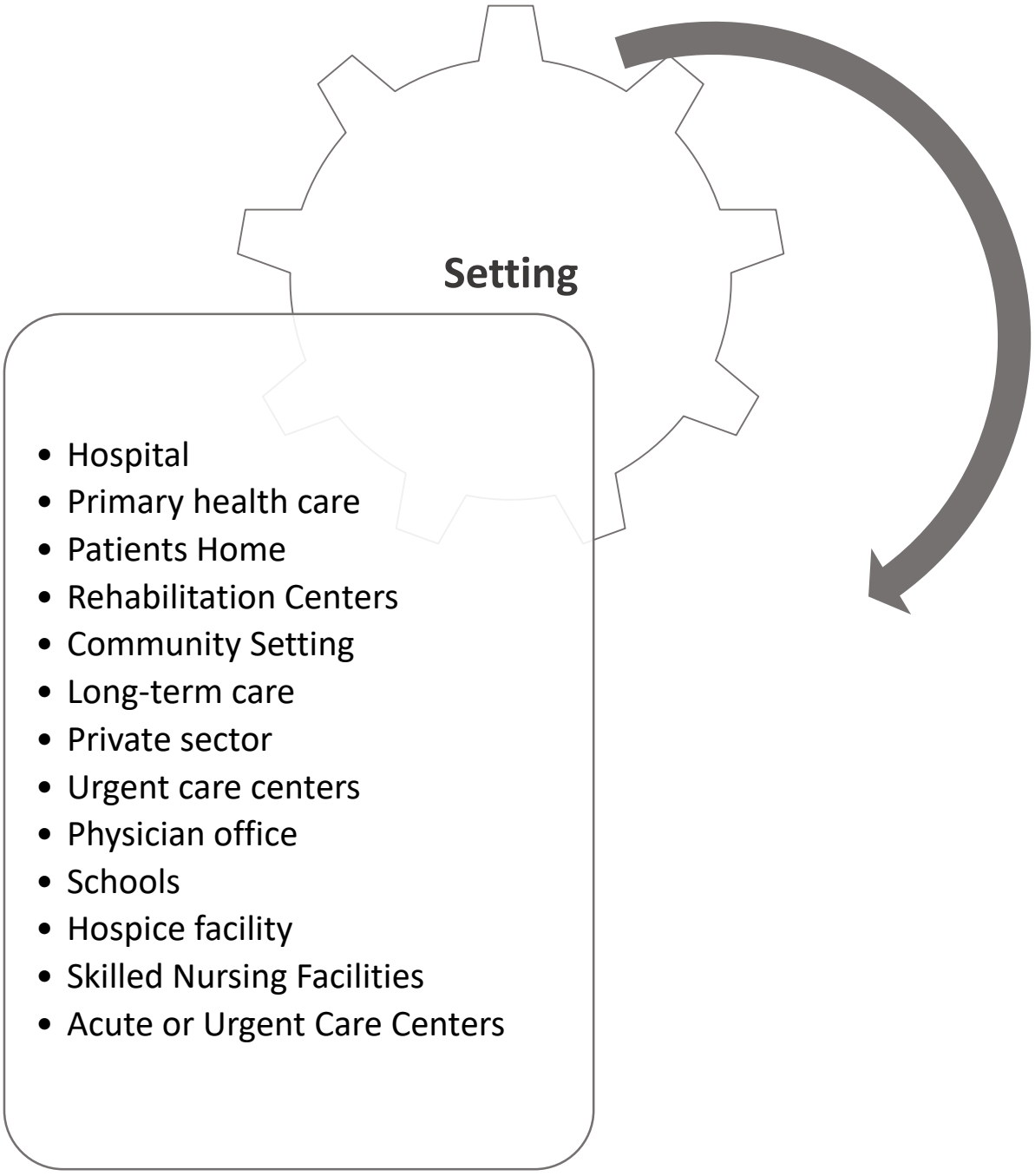
Job description: Comprehensive healthcare practice, including autonomous examination and assessment of patients that includes initiating treatment and developing a management plan. Management commonly includes the authority to prescribe medications and therapeutics, conduct referrals, and monitor acute and chronic health issues, primarily in direct healthcare services. Practice includes the integration of education, research, and leadership in conjunction with an emphasis on direct clinical care.

Family Nurse Practitioner Scope of Practice statement

An FNP is a registered nurse at a master's or doctoral level who has acquired an expert knowledge base, complex decision-making skills, and clinical competencies for expanding practice nursing. FNPs provide a wide range of family-focused primary healthcare services and can perform independently or in collaboration with a treatment team. These nurses provide health promotion and disease prevention measures as well as providing treatment to individuals and their families, and help them to manage chronic conditions in primary care, acute and long-term care facilities, physicians' offices, private clinics, urgent care clinics, community health centres, public health departments, occupational health settings, and ambulatory care settings.

FNPs have a broad scope of clinical practice, such as education, health promotion, and disease prevention, focusing across the entire life span – the population in family practice includes new-borns, infants, children, adolescents, adults, pregnant and postpartum women, and seniors. The focus of care is the family health unit and the influence of mental health, sexuality, gender, values, value systems, ethnicity, environment, psychosocial factors, economic factors, and cultural issues on health and illness, and the impact on individuals and families. FNPs work with all aspects of family healthcare, perform health screening and physical examinations, order diagnostic tests, establish diagnoses, prescribe medications, and educate patients and family members on health, illness, and treatment plans using clinical judgement, critical thinking, and leadership skills (ICN, 2020).

Figure 1: Setting of Family Nurse Practitioner



Advanced Family Nurse Practitioner Standards of Practice

The registered nurse competencies are the core entry level. Nursing standards of practice and professional performance include competencies and skills for each standard. This domain contains competencies related to independent and collaborative advanced level practice in delivering and managing client care.

A set of accompanying measurement criteria have been added to each standard to provide further evidence of the standard being met.

There are five domains of competence related to FNP. Evidence of safety to practise as a family nurse practitioner is demonstrated when the applicant meets the competencies within the following domains:

Clinical domain: Direct comprehensive care and management of individuals/families through nursing process

Focused physical examinations on patients of all ages (including developmental and behavioural screening, physical exam and mental health evaluations). Demonstrates advanced clinical decision-making processes for:

Assessment

- Assess the client's health status and make differential, probable, and definitive diagnoses.
- Assess the complex and/or unstable healthcare needs of the person receiving care through synthesis and prioritisation of historical and available data.
- Assess the impact of comorbidities, including the effects of co-existing conditions, multiple pathologies, and prior treatments in the assessment of the person receiving care.
- Order diagnostic tests (including laboratory tests) to help with differentials in clinical examination including physical, mental health, and social, ethnic, and cultural dimensions.
- Assess the impact of acute and/or chronic illnesses or common injuries on the family.

Diagnosis

- Implement appropriate systematic decision-making process.
- Analyse the collected health history data and any diagnostic information and apply diagnostic reasoning.
- Form a differential diagnosis from history, physical examination, and diagnostic test results.
- Identify health and psychosocial risk factors of patients of all ages and families at all stages of the family life cycle.
- Order and interpret additional diagnostic tests as necessary.

Development of a comprehensive plan of care

The family nurse practitioner, together with the patient and family, establishes an evidence-based, mutually acceptable, cost effective plan of care that maximises health potential or end of life decisions. Formulation of the plan of care includes:

- Setting priorities to address the healthcare needs of the individual, family, and/or community.
- Prescribing or ordering appropriate pharmacological and non-pharmacological interventions.
- Developing a patient education plan based on the patient's health literacy abilities/learning needs.
- Ordering consultations or referrals based on evidence and professional standards, and sharing decisions with patients and families.

Implementation of the plan:

Interventions are based upon established priorities and are consistent with education and clinical practice. Actions by family nurse practitioners are:

- Individualised, recognising the patient's preferences and abilities.
- Consistent with the appropriate plan for care.
- Based on scientific, evidenced based principles, theoretical knowledge, and clinical expertise.
- Inclusive of teaching and learning opportunities.

Evaluation:

During the follow-up and evaluation of the patient status, the nurse practitioner maintains a process for systematic follow-up by an evaluation of patient care outcomes and determination of the effectiveness of the plan of care.

The plan should be re-evaluated and modified as necessary to meet the health outcomes and goals of the individual and the family.

Research and education domain

- Maintenance of current knowledge by attending continuing education programmes.
- Develops new practice approaches based on the integration of research, theory, and practice knowledge.
- Translates research and other forms of knowledge to improve practice processes and outcomes.
- Analyses data and evidence to improve advanced nursing practice.

Education and coaching domain

Through advocacy, modelling, and tutoring, the coaching function involves the skills of interpreting and individualising therapies by:

- Demonstrating knowledge and skills in dealing with sensitive topics with family members, such as sexuality, finances, mental health, terminal illness, and substance abuse.
- Providing information about the family and patient's healthcare goals, perceptions, and resources.
- Assessing and teaching educational needs of individuals and families.
- Assisting the patient and family with self-care through anticipatory guidance, teaching, counselling, and education.

Professional responsibility and leadership domain

- Practices within a nursing model to apply advanced nursing practice in the provision of healthcare services to individuals/families.
- Establishes and maintains a climate of mutual respect and shared values with individuals from other professions.
- Roles of the Family/Lifespan NP: healthcare provider, coordinator, consultant, educator, coach, advocate, administrator, researcher, and leader.
- Participates in continuous professional and interprofessional development to improve team performance.

Support of system domain

- Participates in developing standards, policies, procedures, or practice guidelines to improve family healthcare.
- Uses quality indicators to monitor and measure the effectiveness of strategies, services, and interventions to promote safe practice and use this data to improve practice.
- Interprets variations in outcomes.
- Organisational delivery subsystems (e.g., electronic prescription writing, pharmacy software).

Implication for practice environment

- Hospitals, acute care or ambulatory care settings.
- Outpatient settings.
- Long-term care facilities and nursing homes.
- Private homes providing healthcare services.
- Hospice and palliative care services.

Interpersonal and interprofessional care and quality improvement domain

- Continuously improves the quality of clinical practice using the best available evidence.
- Professional development and the maintenance of professional competence and credentials: studies the relationship between access, quality, and safety in healthcare and how these factors impact healthcare.
- Analyses how organisational structure, care processes, financing, marketing, and policy decisions affect the quality of healthcare.
- Utilises peer review to promote a culture of excellence.
- Takes proactive measures to ensure quality by anticipating variations in practice.
- Participates in quality assurance reviews, including the systematic, periodic review of records and treatment plans.

Standards of professional performance

These standards describe a competent level of behaviours in the professional role, as demonstrated by the code of ethics.

FNP endorsement process

The demand for more expert health practitioners has increased due to the increasing number of advanced nurse practitioner graduates in the field and the growth of community needs. As nursing evolves and specialty practice becomes ever more apparent, certification and credentialing have become an increasingly important mechanism for ensuring quality. This includes, but is not limited to, continuing education, specialty certification, and advanced degrees.

The process of recognition, approval of specialty scope and standards, accreditation, and acknowledgement is paramount. Figure 1 shows the steps that are followed for nursing specialty approval, according to the Consensus Model for APRN Regulation (American Association for Nurse Practitioners, 2019).

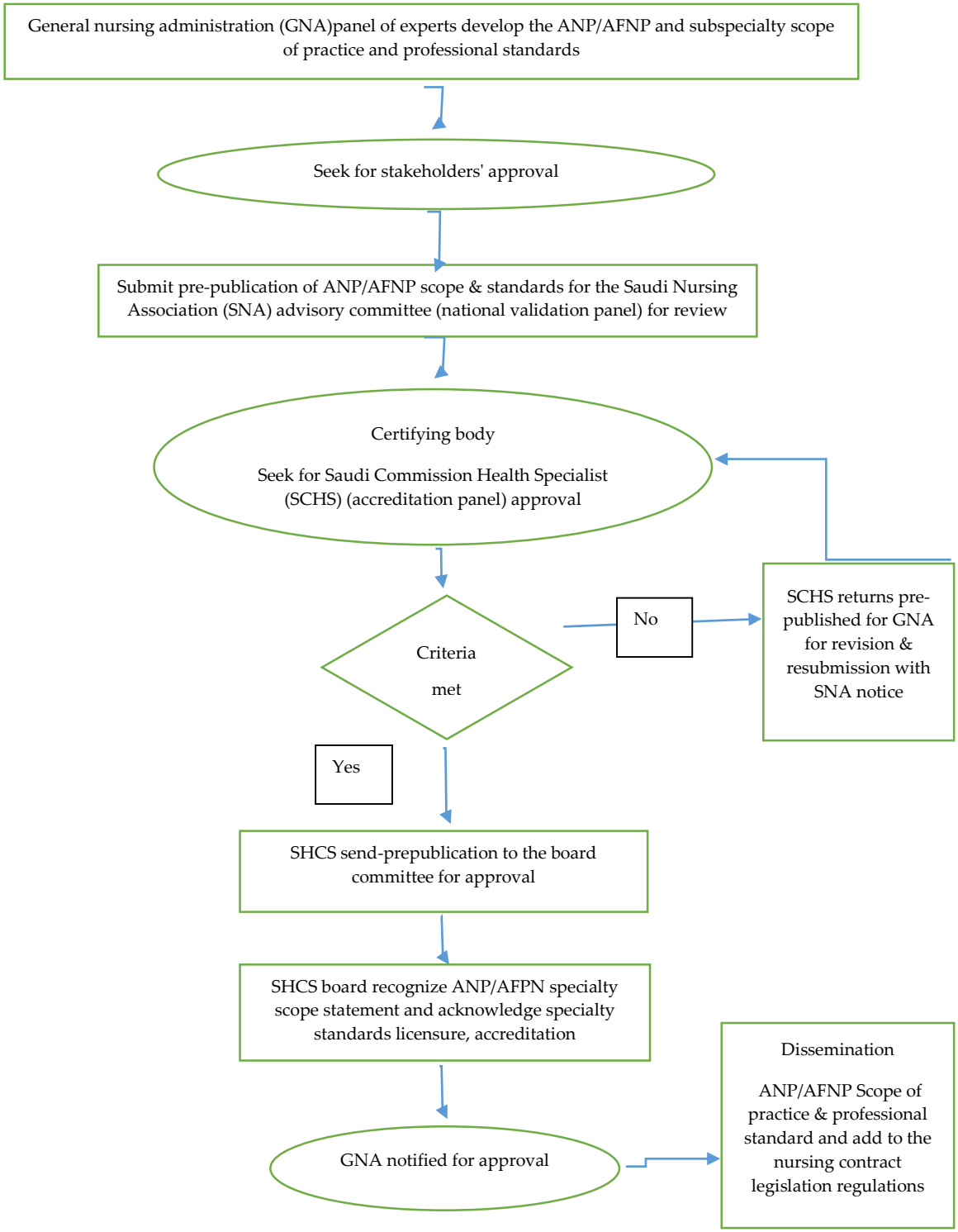


Figure 2 Process for recognition of specialty and approval of specialty scope and acknowledgment of standards

The Importance of Family Nurse Practitioners

- Limited access to healthcare services due to shortage of specialised healthcare providers.
- Increasing numbers of patients with complex health conditions.
- FNP will have considerable financial impact, which will drive healthcare service levels from the more expensive specialist provider to more cost-effective providers.
- Studies found that utilisation of NPs as primary care providers resulted in fewer unnecessary hospitalisations, increased access to healthcare, and improved health outcomes.
- Evidence suggests that APN care results in higher patient satisfaction.

Barriers to Incorporating APRNs into the Saudi Healthcare System

The World Health Organization (WHO) has acknowledged the need for APRNs in the Middle East, including Saudi Arabia [20]. However, various regulatory, institutional, and cultural barriers restrict the practice of APRNs. According to Hibbert et al. [21], reasons for the APRN shortage include a lack of higher education programmes, low pay, and a negative image of clinical nursing in Saudi Arabia. Barriers included policy restrictions on practice, poor physician relations, poor administrator relations, and others' lack of understanding of the APRN role. Barriers correlate with job dissatisfaction and increased intent to leave job (Lori Schirle,Allison A. Norful,Nancy Rudner and Lusine Poghosyan, 2020)

Characteristics of Family Nursing Practitioners (FNP)

Job description

A family nurse practitioner is a registered nurse with advanced training, specialisation, and certification. FNPs also have additional clinical practice and formal education requirements. FNPs are trained to provide treatment and care to children as well as adults. They generally work in the field of family practice, and may work with the same patients from childhood through to adulthood.

Qualifications

- Completion of accredited master's, post-master's, or doctoral degree in nursing with a focus on the Family or Primary Nurse Practitioner (FNP/PNP) specialty is required.

There are several separate educational requirements, as well as comprehensive graduate-level courses in:

  - Advanced physiology/pathophysiology, including general principles that apply across the life span.
  - Advanced health assessment, which includes assessment of all human systems, advanced assessment techniques, concepts, and approaches.
  - Advanced pharmacology, which includes pharmacodynamics, pharmacokinetics, and pharmacotherapeutics of all broad categories of agents.

- Current certification as a Family Nurse Practitioner (FNP).
- Current active licensure to practice as an advanced nurse.

Family Nurse Practitioners can, in addition to other duties:

- Identify the health needs of individuals, families, and the community.
- Conduct routine health assessments and family histories, and perform physical examinations.
- Provide comprehensive chronic condition care characterised by a long term relationship between the patient and the FNP, and create patient care plans.
- Order and review diagnostic tests (including laboratory tests) and interpret the results.
- Refer for consultation when an issue is outside the scope of their practice or level of expertise/experience.
- Share decision making with patients and their family members regarding the provision of healthcare and health education.
- Manage patient documents and records.
- Diagnose and treat patients of all ages.
- Promote optimal heath and provide preventive healthcare services.
- Treat minor acute injuries and illnesses.
- Oversee women's health requirements, including contraception, preconception, and prenatal care.
- Prescribe acute/chronic pharmacological and non-pharmacological treatments.
- Provide immunisations.

FNP roles and responsibilities

Nurse practitioners play an important role in increasing access to healthcare services, especially for people with complex health needs. Nurse practitioners have extensive roles, including assisting patients in decision-making, promoting patient and family engagement, providing continuity of care, improving patient satisfaction, improving interpersonal communication and professional relationships, decreasing morbidity and mortality rates, increasing treatment compliance, improving productivity, and reducing healthcare costs.

The role of the nurse practitioner is essential to meet current healthcare demands. A study found that physicians and nurse practitioners provide similar types of services. Yet, although their services are similar, nurse practitioners convey more information to patients regarding health monitoring.(The Future of Nursing: Leading Change, Advancing Health,2011)

Models of Nurse Practitioner

The concept of the NP was initiated in 1965 in the USA based on a public health model to provide primary healthcare (PHC) to children lacking access to healthcare services. The role was based on a person-centred, holistic approach to care with the addition of diagnostic, treatment, and management responsibilities previously limited to physicians. However, it was distinct from the medical model in that it also focused on prevention, health and wellness, and patient education (Dunphy et al., 2019). In the mid-1970s, Canada and Jamaica followed the USA's development, aiming to improve access to PHC for vulnerable populations in rural, remote, and underserved communities. In the 1980s in Botswana, as the country responded to healthcare reform and the population needs of the country spiralled, a Family Nurse Practitioner role was launched.

At King Faisal Specialist Hospital and Research Centre, the nursing professional practice model is patient centric care, which is further supported by the other characteristics of the model: organisational priorities, quality aims, EBP and research, education, and professional practice/credentialing. The NP is expected to participate in divisional, national, and international forums within their area of expertise and as leaders within the organisation, Saudi Arabia, and the Gulf Region. The NP is a licensed independent practitioner who provides the highest level of care for the patients of King Faisal Specialist Hospital and the Kingdom of Saudi Arabia.

Chapter Two

Definitions

Ethics: the moral principles that govern a person's behaviour or the conducting of an activity.

Nursing Ethics: a branch of applied ethics that concerns itself with activities in the field of nursing. Nursing ethics shares many principles with medical ethics, such as beneficence, non-maleficence, and respect for autonomy. It can be distinguished by its emphasis on relationships, human dignity, and collaborative care.

Nursing Code of Ethics: a guide for carrying out nursing responsibilities in a manner consistent with quality in nursing care and the ethical obligations of the profession.

Informed consent: the process by which a patient learns about and understands the purpose, benefits, and potential risks of any procedures, including clinical research trials, and then agrees to receive the treatment or participate in the trial.

Ethical Aspects

Nurses may strive to ensure patient autonomy and rights through appropriate participation in the informed consent process. Nevertheless, compliance with legal and regulatory requirements as well as ethical and patient family concerns can make the concept of informed consent challenging.

As patient advocates and direct care providers, nurses have a unique opportunity to meaningfully advocate for mutual decision making, a process that promotes:

- Patient Autonomy
- Patient Education
- Patient Comprehension
- Self-Determination.

Patient Autonomy

Expressing respect for patients' autonomy means acknowledging that patients who have decision-making capacity have the right to make decisions regarding their care, even when their decisions contradict their clinician's recommendations.

It is evident that some nursing care procedures have the potential to infringe patient autonomy if undertaken without consent. Furthermore, these procedures may not be easily identifiable.

Self-Determination

The ethical principle of self-determination is a subset of autonomy.

Patient Education

Consent forms are potential meaningful education tools that nurses may use as springboards into important discussions about what to expect before and after a nursing procedure. Nurses, as healthcare professionals, may, within the scope of the informed consent process, move beyond simply informing a patient of risks to actually educating a patient. Approaching the informed consent process for a nursing procedure using an educational model may result in liability reduction by serving to develop an alliance between the patient and the nurse.

Patient Comprehension

Comprehension of the information provided is a precondition for obtaining a valid informed consent. Ideally, a patient would demonstrate full comprehension, but the practical application of that ideal can be problematic in implementation. Important factors such as (a) the disease itself, (b) anxiety, (c) pain, and (d) various therapeutic interventions can hinder a patient's ability to participate in shared decision making.

To maximise comprehension, information should be carefully provided in a manner that increases the patient's understanding of what is being explained. Nurses could contribute toward maximising comprehension by using a repeat-back process on comprehension after informed consent discussions by asking patients to recount what they had learned in the informed consent discussion. The repeat-back methodology has been shown to have an effect on patients' comprehension of information disclosed during informed consent for nursing procedures.

Legal Aspects

An 'informed consent' signed by the patient, from a legal standpoint, is not actual consent, but rather evidence that the patient is consenting to a particular procedure at a given time.

Legally, no one has the right to touch, let alone treat, another person without permission. This would be classified as 'battery' — physical assault — and is punishable by law. From this, one might say obtaining consent is necessary for anything other than a routine physical examination.

The only time consent is not necessary is in the event of an emergency, in which case a doctor may have to operate in the absence of consent to save the life of the patient.

A patient has to be given the opportunity to ask questions and clarify all doubts. There must not be any kind of pressure. Consent must be voluntary, and a patient should have the freedom to revoke the consent. If consent is given under fear of intimidation, or if it includes misconceptions or the misrepresentation of facts, it can be considered invalid. Where there may be doubt that the consent is legal because of the capacity of the patient (e.g., a person under 18 years of age or with a significant mental health condition), then the opinion of the treating practitioner (that the patient is able to consent) should be documented.

Nurses should keep the following principles in mind when in doubt about how to interpret the legislation:

- Clients have a legal and ethical right to information about their care and treatment, and a right to refuse that treatment.
- Regardless of whether consent has been obtained by the nurse, nurses should always explain to the client the treatment or procedure they are performing.
- Nurses should not provide a treatment if there is any doubt about whether the client understands and is capable of consenting. This applies whether or not there is an order, or even if the client has already consented.
- Consent can be withdrawn at any time.
- Nurses need to advocate for clients' access to information about care and treatment if it is not forthcoming from other care providers.
- Informed consent does not always need to be written, but can be oral or implied.

Conclusion

Family Nurse Practitioners are trained to treat all ages of patient populations, from infants to the elderly, as primary care providers in primary and specialty care. Family Nurse Practitioners are able to operate with autonomy and work independently. Completion of an accredited master's or post-master's degree from a Family Nurse Practitioner (FNP) programme is an important part of becoming a nurse practitioner. In general, FNPs focus on identifying and dealing with the health needs of individuals, families, and the community. When all credentials, training, and professional development needs are met, it is possible to have a meaningful and fulfilling job as an FNP in healthcare centres in the Kingdom of Saudi Arabia.

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Appendices

TABLE 1: Family nurse practitioner Model

Model Definition	Essential Steps	Salient Points to Consider
Iowa Model of EBP (Titler et al., 2001). The Iowa Model focuses on the entire healthcare system (e.g., patient, practitioner, infrastructure) to implement and guide practice decisions based on best available research and evidence.	Identify either a "problem-focused trigger" or "knowledge-focused trigger" that will generate the need for a practice change. Determine whether the "trigger" is a healthcare organisation priority. Reflect a team's topic of interest and include interested stakeholders. The team will search, appraise, and synthesise literature related to the topic. Evaluate the availability and merit (e.g., level of evidence, quality of evidence) of evidence. If evidence availability and merit are lacking, conduct research. If credible and reliable evidence is available, pilot the practice change. Appraise pilot for level of success. If pilot is successful, disseminate findings within the organisation and implement recommended change into practice.	Recommended for use at organisational systems level. Uses pragmatic problem-solving approach to EBP implementation Detailed flowchart (see Chapter 11) guides decision-making process. Clearly identified decision points and feedback loops throughout the model. Emphasises necessity of pilot project before initiating system-wide project. Designed for interprofessional collaboration. Has sustained test of time. Implementation of evidence-based practice (EBP) is essential for ensuring high-quality health care at minimum cost. Although all nurses have a responsibility to implement EBP at an individual patient level, nurse practitioners (NPs) as clinical leaders have additional responsibilities in leading and collaborating with transdisciplinary teams to implement EBP across patient

		groups and embed practice change into routine care.
Stetler Model (Ciliska et al., 2011; Stetler, 2001). The Stetler Model enables practitioners to assess how research findings and other pertinent evidence are implemented in clinical practice. The model examines how to use evidence to create change that fosters patient-centred care.	Steps in this model are referred to as phases. Phase I. Preparation: Identify a priority need. Identify the purpose of the EBP project, context in which the project will occur, and relevant sources of evidence. Phase II. Validation: Assess sources of evidence for level and overall quality. Determine whether source has merit and goodness of fit and whether to accept or reject the evidence in relation to project purpose. Phase III. Comparative Evaluation/Decision Making: Evidence findings are logically summarised and similarities and differences among sources of evidence are evaluated. Determine whether it is acceptable and feasible to apply summation of findings to practice. Phase IV. Translation/Application: Develop the "how to's" for implementation of summarised findings. Identify practice implications that justify	Designed to encourage critical thinking about the integration of research findings. Promotes use of best evidence as an ongoing practice. Helps lessen errors in critical decision-making activity. Allows for categorisation of evidence as external (e.g., research) or internal (e.g., organization outcome data). Emphasises use by single practitioner but may include groups of practitioners or other stakeholders. The Stetler Model, which in its original development focused on research utilisation, has been updated and refined to fit in the EBP paradigm. The model emphasises the critical thinking process and although practitioner-oriented, is also used by groups for implementing formal organisational change. An important assumption for the model revision is that internal factors such as the characteristics of individual EBP users and organisational practices influence implementation of evidence along

	application of findings for change. Phase V. Evaluation: Identify expected outcomes of the project and determine whether the goals of EBP were successfully achieved.	with external factors that include formal research and organisational standards and protocols. The Stetler Model consists of five phases. **Phase I,** preparation, includes definition of the purpose, contextual assessment and search for sources of evidence. **Phase II** is validation of the evidence found. **Phase III** is comparative evaluation/decision-making, where the evidence found is critiqued, synthesised, and a decision for use is made with consideration of external and internal factors. **Phase IV** refinements provide implementation/translation guidance for change in practice. **Phase V** is evaluation, which includes outcomes met and the degree to which the practice change was implemented. Steps for Using Method/Tool The Stetler model of evidence-based practice consists of five phases (Stetler, 1994; Stetler, 2001; Stetler, 2010). Each phase is designed to:

		• facilitate critical thinking about the practical application of research findings; • result in the use of evidence in the context of daily practice; and • mitigate some of the human errors made in decision making.
Ottawa Model of Research Use (Graham & Logan, 2004 Graham et al., 2006). The Ottawa Model is an interactive model that depicts research as a dynamic process of interconnected decisions made and actions taken by stakeholders.	The model is composed of three phases: (a) Assess barriers and supports. (b) Monitor intervention and extent of use. (c) Evaluate outcomes. Subsumed under the three phases are six designated primary elements that must be considered when integrating research into practice. **Assess barriers and supports:** Evidence-based innovation: Clearly identify what the innovation is and what the implementation will involve. Potential adopters: Identify potential adopters with characteristics that could influence the adoption of the innovation (see Rogers' Change Theory in Chapter 7).	Patients are central to the model's process and their health outcomes are the primary focus. The model focuses on the unit-level environment instead of the entire healthcare organisation. The prescriptive aim of the model is to assess, monitor, and evaluate. To improve performance of a family nurse practitioner by implementing a research-based family assessment instrument. Objectives included providing a structure for evaluating families and fostering the healthcare relationship.

	The practice environment: Identify leaders, formal and informal, who can inspire change. Assess environment for needed resources. **Monitor intervention and extent of use:** Implementation of intervention strategies: Select appropriate strategies to increase awareness of implementation and provide necessary education and training for conducting the implementation. Adoption of innovation: Determine the extent of adoption of implementation. **Evaluate outcomes:** Evaluate the impact of innovation on patients, practitioners, stakeholders, and healthcare organisation.	
Promoting Action on Research Implementation in Health Services (PARiHS) Framework (Rycroft-Malone, 2004). The PARiHS Framework provides a method to implement research into practice by exploring the interactions among three key elements: (a) evidence, (b) context, and (c) facilitation.	**Evidence:** Search for and identify the best available evidence from research, clinician experience, patient values, organisation data, and information. **Context:** This is the local environment where the practice change will occur. Adoption of practice change is dependent on contextual features such as	Explicitly uses facilitation as a factor impacting integration of research findings into practice. Does not address generation of new knowledge. Focus is on unit settings more than system-wide environment. Codified (e.g., research data) and noncodified (e.g., practitioner experience) sources of evidence used.

	organisational culture and level of acceptance, leadership investment, and evaluation of desired outcomes. **Facilitation:** Organisational participants use their knowledge and skills to foster implementation of practice change.	Implementation of this model will support the family nurse practitioner's role and responsibilities.
ACE (Academic Center for Evidence-Based Practice) Star Model of Knowledge Transformation© (Kring, 2008; Stevens, 2004). As a framework, the ACE Star Model aids in systematically integrating best evidence into practice. The model has five major stages that depict forms of knowledge in relative sequence. Research moves through the cycles to combine with other forms of knowledge before integration into practice occurs.	**Five Stages:** **Discovery:** This stage involves searching for new knowledge found in traditional quantitative and qualitative methodologies. **Evidence Summary:** The primary task is to synthesise the body of research knowledge into a meaningful statement of evidence for a given topic. This is a knowledge-generating stage, which occurs simultaneously with new findings that may arise from the synthesis. **Translation:** The aim of translation is to provide clinicians with a practice document (e.g., clinical practice guideline) derived from the synthesis and summation of research findings. **Integration:** Practitioner and healthcare organisation	Focus on promoting use of EBP for direct care nurses. Includes use of qualitative evidence. Primary goal of model is knowledge transformation. Does not incorporate non-research evidence (patient values, practitioner's experience). Identifies factors that impact adoption of innovation. Implementation of this model will support family nurse practitioners' training and education role.

	practices are changed through formal and informal channels. **Evaluation:** An array of EBP outcomes is evaluated on impact, quality, and satisfaction.	
Advancing Research and Clinical Practice Through Close Collaboration (ARCC) (Melnyk & Fineout-Overholt, 2015).	Assess the healthcare organization for readiness for change and implantation of EBP project. Identify potential and actual barriers to and facilitators of EBP project. Identify EBP champions to work with direct care nurses or specific clinical units. Implement evidence into practice. Evaluate EBP outcomes.	Promotes use of EBP among advanced practice nurses and direct care nurses. Identifies a network of stakeholders who are supportive of the EBP project. Cognitive behavioural theory underpinnings. Emphasis on healthcare organisational readiness and identification of facilities and barriers. Encompasses research, patient values, and clinical expertise as evidence. Implementation of this model will support family nurse practitioners' role, responsibilities, and scope of services.
Johns Hopkins Nursing Evidence-Based Practice Model (JHNEBP) (Newhouse, Dearholt, Poe, Pugh, & White, 2007). The JHNEBP Model applies a problem-solving approach to clinical decision making. The model is designed to meet the EBP needs of direct care nurses using an uncomplicated three-step process	**Practice Question:** Using a team approach, the EBP question is identified. **Evidence:** The team searches, appraises, rates the strength of evidence, describes quality of evidence, and makes a practice recommendation on the strength of evidence.	Emphasises individual use. Well-developed tool kit that provides nurses with guide for question development, evidence-rating scale, and appraisal guide for various forms of evidence. Implementation of this model will support family nurse practitioners'

referred to as PET: (a) Practice Question, (b) Evidence, and (c) Translation.	**Translation:** In this stage, feasibility is determined, an action plan is created, and change is implemented and evaluated. Findings are presented to the healthcare organisation and broader nursing community.	role, responsibilities, and clinical practice.
Knowledge-to-Action (KTA) Process Framework (Graham et al., 2006). The KTA is a model of knowledge creation and knowledge integration.	**Phases:** Identify problems that need to be addressed and begin searching for evidence and research about the identified problem. Adapt the knowledge use to a local context. Identify barriers to use of knowledge. Select, adapt, and implement interventions. Monitor the use of implanted knowledge. Evaluate outcomes related to knowledge use. Sustain appropriate knowledge use.	Adapts well for use with individuals, teams, and healthcare organisations. Is grounded in planned action theory, which makes the model adaptable to a variety of settings. Breaks knowledge-to-action process into manageable sections. This model supports the family nurse practitioner's implementation of high-quality health services involving the right care, at the right time, responding to the service users' needs and preferences, while minimising harm and resource waste.

TABLE 2: Family Nurse Practitioner Job description

Ministry of health **Saudi Arabia** **Agency of therapeutic services** **General directorate of nursing affairs** JOB DESCRIPTION	

ADMINISTRATION/DIVISION TITLE
Nursing Performance Department
General directorate of nursing affairs

REPORTED TO	**POSITION TITLE**
Nursing Director	Family Nurse Practitioner

POSITION SUMMARY
Family Nurse Practitioner is deliver preventive care services and treat acute and chronic conditions with an emphasis on a holistic approach to patient care. Include conducting patient examination, developing treatment plans and prescribing medications.

ESSENTIAL FUNCTIONS/ RESPONSIBILITIES
1. Perform complete comprehensive physical examination 2. Performs medical assessments including history and physical assessments and consults with physician regarding findings/changes in patient condition

3. The Advanced Nurse Practitioner (NP), must be able to obtain patient histories and perform physical examinations
4. Performing complete comprehensive physical examination
5. Performing routine interim physical examinations on patients that are risk specific, and as outlined in the agency's Medical Policies and Procedures Manual
6. Build and follow your own primary care panel of patients
7. Practice and contribute to the development of evidence-based medicine
8. Participate in quality improvement initiatives and educational enrichment such as Grand Rounds
9. Be part of a multi-disciplinary practice that offers a blend of individual and population based care
10. Be supported by a strong team of Medical Assistants and RNs and work in an innovative practice environment utilizing Advanced Access scheduling
11. Be on call no more than one in four nights and weekends
12. Obtain and/or reviews/evaluates a patient's medical and psychosocial history
13. Perform screening procedures including Pap Smears, GC cultures, Chlamydia tests and Wet preps
14. Facilitate related services for health center patients as appropriate with respect to their confidentiality and privacy
15. Evaluate individual patients and prescribes appropriate medications, treatments, referrals consistent with current standards of care
16. Provide continuous care to patients and management of common and important clinical problems encountered in a primary care setting
17. Perform complete gynecological histories and physical examinations, as indicated
18. Elicit comprehensive health histories, perform complete physical examinations, order and/or perform diagnostic tests, analyze data and formulate problem lists, develop and implement plans of care, collaborate with other health professionals and refer patients as appropriate
19. Provide comprehensive primary care by obtaining patient history
20. Help conduct Physician examinations and treatment

21. Serve as the primary care provider for members of the organization's program
22. Coordinate patient care with specialists and help patients navigate the larger healthcare system
23. Provide direct primary patient care with the appropriate use of conventional and alternative methods to facilitate the body's innate healing
24. Communicate with patients in person, in groups, by telephone, via email or Skype
25. Build a strong partnership between patient and practitioner in the healing process
26. Consider all factors that influence health, wellness, and disease
27. Performs a physical examination appropriate to patient age and history
28. Other basic urgent care procedures
29. Participate in a multi-disciplinary practice that offers a blend of individual and population-based care
30. Collaborate with a team of Medical Assistants and RNs
31. Help women during pregnancy, labor and childbirth
32. Provide care for women with health issues concerning their reproductive system
33. Educate patients on healthcare
34. Provide information on treatments from birth control to mammograms
35. Performing Family Practice or Adult Medicine health assessments
36. Prescribing treatment modalities
37. They practice in an expanded role to provide healthcare wellness and prevention to individuals, families and \or groups in a variety of settings including but not limited to homes, institutions, and private clinics
38. Coordinates patient care in collaboration with the multi-disciplinary team around the family unit
39. Assists and provides consultation in the preparation of capital and operational budget reports
40. Maintains professional growth and development through attendance at professional conferences, symposia, and through ongoing continuing education
41. Order and /or perform diagnostic and therapeutic procedures

42. Skills in direct delivery of clinical care, and the ability to work with all levels of the multidisciplinary team to continuously improve process to enhance patient outcomes
43. Able to communicate effectively and respond appropriately to changes in patient condition
44. Obtaining and/or reviewing / evaluating a patient's medical and psychosocial history
45. Performing screening procedures, including Pap Smears, GC cultures, Chlamydia tests and Wet preps
46. Facilitating related services for health center patients as appropriate with respect to their confidentiality and privacy
47. Providing continuous care to patients and management of common and important clinical problems encountered in a primary care setting
48. Consulting with physician(s) regarding problems not encountered in the standing orders (Policies & Procedures Manual) or as necessary
49. Making referrals to appropriate sources/consultants for medical and/or social problems
50. Participating in patient education and counseling services, especially about family planning, STD'S/HIV, preventive health and nutrition
51. Interpreting laboratory data
52. Perform other duties determined as necessary by FNP Supervisor
53. Meets all competency requirements annually per department standards, which will include age specific-growth and development competencies
54. Provide medical care to Pediatric, Adolescent and Adult patients
55. Take relevant patient history
56. Develop and implement treatment plans using diagnostic data
57. Complete medical forms and documentation related to patient care
58. Make and track all referrals to other agencies and providers, with follow-up care provided
59. Assist with immunizations and/or phlebotomy, as needed, to ensure smooth patient flow
60. Work collaboratively with Physicians and Specialists for consultation and referral purposes

61. Create treatment plans
62. Collaborate on improvement in care delivery and service with management and other physicians and staff
63. Participate in Patient-Centered Medical Home (PCMH) and Accountable Care Organization (ACO) initiatives
64. Provide on call coverage within the primary care group
65. See patients independently
66. Urgent care appointments

QUALIFICATIONS

Education and/or Experience Required at Entry:

Skills, Abilities, Special Licenses or Certificate:

- Family nurse practitioner certificate / Nursing Advance (MSN)
- Bachelor of Science in nursing (BSN)
- Registered Nurse(RN)
- Professional License
- Special training on Family nurse practitioner
- Safe Patient Handling is an advantage
- BLS, ACLS & NRP preferred.
- Arabic and English language.
- Writing prescriptions for medications without the co-signature of a Physician
- Ability to use computer and clinic software, and to document in EHR, ensuring
- Demonstrated knowledge of the principles of growth and development over the life span as pertains to scope of practice

• Position consists of pre-screening patients, chart organization, prescription management
Receipt and Acknowledgment:
Signature below acknowledges that I have received a copy of my job description and my supervisor has discussed it with me.

Employee Name, Signature &Date:	**Supervisor Name, Signature & Date:**

TABLE 3: Family Nurse Practitioner Physical Assessment Form

Family Nurse Practitioner Name _____

Date Completed _____ Date of Birth _____

Health Care Practitioner Physical Assessment guide

You will need a stethoscope, penlight, and reflex hammer to complete the physical exam.
FNP Approach to Patient
Logical Exam Sequence
Initiated / Ended Exam well
Explained exam to patient
Assembled proper equipment
Provided for privacy
Professional, and mature
Used correct terminology and pronunciation

Assessment is the first and most critical phase of the nursing process. Incorrect nursing judgment arises from inadequate data collection and may adversely affect the remaining phases of the nursing process: diagnosis, planning, implementation, and evaluation. Get the complete picture of your patient's health with this comprehensive head-to-toe physical assessment guide.

What is Head-to-Toe Assessment

A head-to-toe assessment is a comprehensive physical assessment data collection method to gather patient data and determine the patient's health status. It involves examining the entire body from head to toe in a systematic and thorough manner to identify health issues the patient may be experiencing.

Assessment Techniques

To make your head-to-toe assessment systematic, you need to know about the four basic assessment techniques. These techniques are inspection, palpation, percussion, and auscultation.

- **Inspection** involves using the senses of vision, smell, and hearing to observe and detect any normal or abnormal findings.
- **Palpation** consists of using parts of the hand to touch and feel for the following characteristics: texture, temperature, moisture, mobility, consistency, the strength of pulses, size, shape, and degree of tenderness.
- **Percussion** involves tapping body parts to produce sound waves. These sound waves or vibrations enable the examiner to assess underlying structures.
- **Auscultation** involves the use of a stethoscope to listen for heart sounds, movement of blood through the cardiovascular system, movement of the bowel, and movement of air through the respiratory tract.

Physical Assessment Guide **NOTE:** Remember to use the **COLDSPA mnemonic** (Character, Onset, Location, Duration, Severity, Patterns, and Associated Factors) to investigate and collect information for each symptom the client shares.	
1. General Appearance/Survey	The general survey includes the overall impression of the client, mental status exam, and vital signs.
2. Chief Complaint	It is the symptom or problem that is most concerning to the patient and is the focus of their visit.
3. Health History	The importance of health history lies in its ability to provide information that will assist the examiner in identifying areas of strength and limitation in the individual's lifestyle and current health status.
4. Assessment of the Integument	**History of present health concern:** Skin Hair and Nails Past health history Family history Lifestyle and health practices

5. Assessment of the Head and Neck Lymph nodes of the head and neck Palpation • Palpate the preauricular nodes, postauricular nodes, occipital nodes. There should be no swelling or enlargement and no tenderness. • Palpate the tonsillar nodes. Palpate the tonsillar nodes at the angle of the mandible on the anterior edge of the sternomastoid muscle. • Palpate the submental nodes, which are a few centimeters behind the tip of the mandible. • Palpate the superficial cervical nodes in the area superficial to the sternomastoid muscle. • Palpate the posterior cervical nodes in the area posterior to the sternomastoid and anterior to the trapezius in the posterior triangle. • Palpate the deep cervical chain. • nodes deeply within and around the sternomastoid muscle. • Palpate the supraclavicular nodes by hooking your fingers over the clavicles and feeling deeply between the clavicles and sternomastoid muscles.	**History of present health concern:** Assess for pain Other symptoms Past health history Family history Lifestyle and health practices

6. Assessment of the Eye and Vision Evaluation of Vision: • Test distant visual acuity. • Test near visual acuity. • Test visual fields for gross peripheral vision. External eye structures: • Inspect the eyelids and eyelashes. • Observe the position and alignment of the eyeball in the eye socket. • Inspect the bulbar conjunctiva and sclera. • Inspect the palpebral conjunctiva. • Inspect the lacrimal apparatus. • Inspect the cornea and lens. • Test pupillary reaction to light. • Test accommodation of pupils. • Palpate the lacrimal apparatus. Internal eye structures • Inspect the optic disc. • Inspect the retinal vessels. • Inspect retinal background. • Inspect the fovea (sharpest area of vision) and macula. • Inspect the anterior chamber.	History of present health concern: Visual Problems Past health history Family history Lifestyle and health practices

7. Assessment of the Ear External ear structures: • Inspect the auricle, tragus, and lobule. • Palpate the auricle and mastoid process. Internal ear structures • Inspect the external auditory canal. • Inspect the tympanic membrane (eardrum). • Perform Weber's test if the client reports diminished or lost hearing in one ear. • Perform the Rinne test. • Perform the Romberg test.	History of present health concern: Changes in Hearing Other Symptoms Past health history Family history Lifestyle and health practices
8. Assessment of the Mouth, Throat, Nose, Sinus: Mouth • Inspect the lips. • Inspect the teeth and gums. • Inspect the buccal mucosa. • Inspect and palpate the tongue. • Assess the ventral surface of the tongue. • Inspect for Wharton's ducts. • Observe the sides of the tongue. • Check the strength of the tongue. • Check the anterior tongue's ability to taste • Inspect the hard (anterior) and soft (posterior) palates and uvula. • **Note odor**. While the mouth is wide open, note any unusual or foul odor. • Assess the uvula. • Inspect the tonsils.	History of present health concern: Tongue and Mouth Nose and Sinuses Throat Past health history Family history Lifestyle and health practices

• Inspect the posterior pharyngeal wall. Nose • Inspect and palpate the external nose • Check the **patency of airflow** • Inspect the internal nose Sinuses • Palpate the sinuses. • Percussion • Percuss the sinuses. Transillumination • Transilluminate the sinuses.	

9. Assessment of the Thoracic and Lung Posterior thorax • Inspect for nasal flaring and pursed lip breathing • **Observe the color of the face, lips, and chest.** • **Inspect the color and shape of the nails.** • Inspect configuration. • Observe the use of accessory muscles. • Inspect the client's positioning. • Palpate for tenderness and sensation. • Palpate for crepitus. Crepitus, also called subcutaneous emphysema, • Palpate surface characteristics. • Palpate for fremitus. • Assess chest expansion. • Percuss for tone. • excursion. • Auscultate for breath sounds. • Auscultate for adventitious sounds. • Auscultate voice sounds. Other Assessment Techniques • Egophony • Whispered Pectoriloquy Anterior thorax • Inspect for shape and configuration. • Inspect the position of the sternum. • Inspect the slope of the ribs.	History of present health concern: Difficulty of breathing Chest pain Coughing GI symptoms Past health history Family history Lifestyle and health practices

• Observe the quality and pattern of respiration. • Inspect intercostal spaces. • Observe for use of accessory muscles. • Palpate for tenderness, sensation, and surface masses. • Palpate for fremitus. • Palpate anterior chest expansion. • Percuss for tone. • Auscultate for anterior breath sounds, adventitious breath sounds, and voice sounds.	

10. Assessment of the Breast and Lymphatic System Female breasts • Inspect size and symmetry. • Inspect color and texture. • Inspect superficial venous pattern. • Inspect the areolas. • Inspect the nipples. • Inspect for retraction and dimpling. • Palpate texture and elasticity. • Palpate tenderness and temperature. • Palpate for masses. • Palpate the nipples. • Palpate mastectomy or lumpectomy site. Axillae • Inspect and palpate the axillae. Male breasts • Inspect and palpate the breasts, areolas, nipples, and axillae.	History of present health concern: Past health history Family history Lifestyle and health practices

11. Assessment of the Heart and Neck Vessels Neck Vessels • Observe the jugular venous pulse. • Evaluate jugular venous pressure. • Auscultate the carotid arteries. • Palpate the carotid arteries. Heart • Inspect pulsations. • Palpate the apical pulse. • Palpate for abnormal pulsations. • Auscultate heart rate and rhythm. • If you detect an irregular rhythm, auscultate for a pulse rate deficit. • Auscultate to identify S1 and S2. Auscultate the first heart sound (S1 or “lub”) and the second heart sound (S2 or “dub”). • Auscultate for extra heart sounds. • Auscultate for murmurs. • Auscultate with the client assuming other positions.	History of present health concern: Chest pain **and Palpitations** **Other Symptoms** Past health history Family history Lifestyle and health practices

12. Assessment of the Peripheral Vascular System Arms • Observe arm size and venous pattern; also look for edema. • Observe the coloration of the hands and arms. • Palpate the client's fingers, hands, and arms, and note the temperature. • Palpate to assess capillary refill time. • Palpate the radial pulse. • Palpate the ulnar pulses. • Palpate the brachial pulses if you suspect arterial insufficiency. • Palpate the epitrochlear lymph nodes. • Perform the Allen test. Legs • Observe skin color while inspecting both legs from the toes to the groin. • Inspect the distribution of hair. • Inspect for lesions or ulcers. • Inspect for edema. • Palpate edema. • Palpate bilaterally for the temperature of the feet and legs. • Palpate the superficial inguinal lymph nodes. • Palpate the femoral pulses. • Auscultate the femoral pulses. • Palpate the popliteal pulses. • Palpate the dorsalis pedis pulses. • Palpate the posterior tibial pulses. • Inspect for varicosities • Check for Homan's sign.	History of present health concern: Past health history Family history Lifestyle and health practices

13. Assessment of the Abdomen Abdomen • Observe the coloration of the skin. • Note the vascularity of the abdominal skin. • Note any striae. • Inspect for scars. • Assess for lesions and rashes. • Inspect the umbilicus. • Inspect abdominal contour. • Assess abdominal symmetry. • Inspect abdominal movement when the client breathes. • Observe aortic pulsations. • Observe for peristaltic waves. • Auscultate for bowel sounds. • Auscultate for vascular sounds. • Auscultate for a friction rub over the liver and spleen. • Percuss for tone. • Percuss the span or height of the liver by determining its lower and upper borders. • Percuss the spleen. • Perform blunt percussion on the liver. • Perform light palpation. • Deeply palpate all quadrants to delineate abdominal organs and detect subtle masses. • Palpate for masses. • Palpate the umbilicus and surrounding area for swellings, bulges, or masses. • Palpate the aorta. • Palpate the liver. • Palpate the spleen.	History of present health concern: Abdominal Pain Indigestion Nausea and Vomiting Appetite Bowel Elimination Past health history Family history Lifestyle and health practices

• Palpate the kidneys. • Palpate the urinary bladder.	

14. Assessment of the Female Genitalia External female genitalia • Inspect the Mons Pubis. • Observe and palpate inguinal lymph nodes. • Inspect the labia majora. • Inspect the labia minora, clitoris, urethral meatus, and vaginal opening. • Palpate Bartholin's glands. • Palpate the urethra. Internal female genitalia • Inspect the size of the vaginal opening and the angle of the vagina. • **Inspect the vaginal musculature.** • Inspect the cervix. • Inspect the vagina.	History of present health concern: Menstrual Cycle Menopause Vaginal discharge, pain, masses Urination Sexual Dysfunction Past health history Family history Lifestyle and health practices

15. Assessment of the Male Genitalia Penis • Inspect the base of the penis and pubic hair. • Inspect the skin of the shaft. • Palpate the shaft. • Inspect the foreskin. • Inspect the glans. • Palpate the urethral discharge. Scrotum • Inspect the size, shape, and position. • Inspect the scrotal skin. • Palpate the scrotal contents. • Continue examination of a scrotal mass by auscultating with a stethoscope. Transillumination • Transilluminate the scrotal contents. Inguinal area • Inspect for inguinal or femoral hernia. • Palpate for inguinal hernia and inguinal nodes. • Palpate inguinal lymph nodes. • Palpate for femoral hernia. • Inspect and palpate for scrotal hernia.	History of present health concern: **Pain** **Lesions** **Discharge** **Urination** **Sexual Dysfunction** Past health history Family history Lifestyle and health practices

16. Assessment of the Anus, Rectum, Prostate Anus and rectum • Inspect the perianal area. • Inspect the sacrococcygeal area. • Palpate the anus. • Palpate the rectum. • Palpate the peritoneal cavity. Prostate gland • In male clients, palpate the prostate. • Inspect the stool.	History of present health concern: Bowel Patterns Itching and Pain Stool Past health history Family history Lifestyle and health practices

17. Assessment of the Musculoskeletal System Gait • **Observe gait.** Observe the client's gait as the client enters and walks around the room. • **Assess for the risk** of falling backward in the older or handicapped client by performing the "nudge test". Stand behind the client and put your arms around the client while you gently nudge the sternum. Temporomandibular joint • **Inspect and palpate the TMJ.** Have the client sit, and put your index and middle fingers just anterior to the external ear opening. Ask the client to open the mouth as widely as possible; move the jaw from side to side; and protrude and retract the jaw. • **Test range of motion.** Ask the client to open the mouth and move the jaw laterally against resistance. Next, as the client clenches the teeth, feel for the contraction of the temporal and masseter muscles to test the integrity of cranial nerve V. Sternoclavicular joint • With the client sitting, **inspect the sternoclavicular joint** for location in midline, color, swelling, and masses. Then palpate for tenderness or pain. Cervical, thoracic, lumbar spine	History of present health concern: Past health history Family history Lifestyle and health practices

• **Observe the cervical, thoracic, and lumbar curves from the side and then from behind.** Have the client standing erect with the gown positioned to allow an adequate view of the spine. Observe for symmetry, noting differences in height of the shoulders, the iliac crests, and the buttock areas. • **Palpate the spinous processes** and the paravertebral muscles on both sides of the spine for tenderness or pain. • **Test ROM of the cervical spine.** Test ROM of the cervical spine by asking the client to touch the chin to the chest and to look up at the ceiling. • **Test ROM of the thoracic and lumbar spine.** Ask the client to bend forward and touch the toes. Observe for symmetry of shoulders, scapula, and hips. • **Test for back and leg pain.** • **Measure leg length.** *Shoulders, arms, elbows* • **Inspect and palpate shoulders and arms.** With the client standing or sitting, inspect anteriorly and posteriorly symmetry, color, swelling, and masses. Palpate for tenderness, swelling, or heat. • **Test ROM.** Ask the client to stand with both arms straight down at the sides. Nest, ask him to move the arms forward and then backward with elbows straight. Then have the client bring both hands together overhead, elbows straight, followed by	

moving both hands in front of the body past the midline with elbows straight. • **Inspect for size, shape, deformity, redness, or swelling.** Inspect elbows in both flexed and extended positions. • **Test ROM.** Ask the client to flex the elbow and bring the hand to the forehead, straighten the elbow, hold the arm out, turn the palm down, then turn the palm up. *Hands, wrists, fingers* • **Inspect wrist size, shape, symmetry, color, and swelling.** Then palpate for tenderness and nodules. Palpate the anatomic snuffbox (the hollow area on the back of the wrist at the base of the fully extended thumb. • **Test ROM.** Ask the client to bend their wrist down and back. Next, have the client hold the wrist straight and move the hand outward and inward. • **Test for carpal tunnel syndrome.** Perform Phalen's test. • **Inspect size, shape, symmetry swelling,** and color. Palpate the fingers from the distal end proximally, noting tenderness, swelling, bony prominences, nodules, or crepitus of each interphalangeal joint. • **Test ROM.** Ask the client to spread the fingers apart, make a fist, bend the fingers down and then up, move the thumb away from other fingers, and touch the thumb to the base of the small finger.	

Hips **Inspection** and **Palpation** • **With the client standing, inspect the symmetry and shape of the hips.** Palpate for stability, tenderness, and crepitus. • **Test ROM.** With the client supine, ask the client to: Raise the extended leg; flex the knee up to the chest while keeping the other leg extended; move an extended leg away from the midline of the body as far as possible and then toward the midline of the body as far as possible. Bend the knee and turn the leg inward and then outward. *Knees* • With the client supine and then sitting with knees dangling, **inspect for size, shape, symmetry, swelling, deformities, and alignment.** • **Test for swelling.** • **Perform the ballottement test.** • **Test ROM.** Ask the client to bend each knee up toward the buttocks or back, straighten the knee, and walk normally. • **Test for pain and injury.** *Ankles and feet* • With the client sitting, standing, and walking, **inspect position, alignment, shape, and skin.**	

• **Palpate ankles and feet for tenderness, heat, swelling, and nodules.** • **Test ROM.** Ask the client to point toes upward then downward, turn soles outward then inward, rotate foot outward then inward, turn toes under foot and then upward.	

18. Assessment of the Neurologic System *Neurological status, Mental status, and LOC* • **Observe the level of consciousness.** Call the client's name and not the response. If the client does not respond, call the name louder. If necessary, shake the client gently. If the client still does not respond, apply a painful stimulus. • **Observe posture and body movements.** Be alert for tense, nervous, fidgety, and restless behavior, which may be seen in anxiety or may simply reflect the client's apprehension during a physical examination. • **Observe dress, grooming, and hygiene.** Keep the examination setting and the reason for the assessment in mind as you note the client's degree of cleanliness and attire. • **Observe facial expressions.** Note particularly eye contact and affect. • **Observe speech.** Observe and listen to the tone, clarity, and pace of speech. • **Observe mood, feelings, and expressions.** Ask the client, "How are you feeling today?" and "What are your plans for the future?" • **Observe thought processes and perceptions.** Observe thought processes for clarity, content, and perception by inquiring about the client's thoughts and perceptions expressed.	History of present health concern **Numbness and Tingling** **Seizures** **Headaches** **Dizziness** **Senses** **Difficulty Speaking** **Difficulty Swallowing** **Muscle Control** Memory Loss Past health history Family history Lifestyle and health practices

• **Observe cognitive abilities.** Ask for the client's name and names of family members, the time, and where the client lives or is now. Note the client's ability to focus and stay attentive to you during the interview and examination. Ask the client, "What did you have to eat today?" or "What is the weather like today?". Ask the client, "When did you get your first job?" or "When is your birthday?" Ask the client to repeat four unrelated words. The words should not rhyme, and they cannot have the same meaning. Have the client repeat these words in 5 minutes, again in 10 minutes, and again in 30 minutes • **Perform the Mini-Mental State Examination** if time is limited and a quick standard measure is needed to evaluate or reevaluate the cognitive function. *Cranial nerves* **Inspection** • **Test CN I (olfactory).** For all assessments of the cranial nerves, have the client sit in a comfortable position at your eye level. Ask the client to clear the nose to remove any mucus, then to close their eyes, occlude one nostril, and identify a scented object that you are holding. • **Test CN II (optic).** Use the Snellen chart to assess vision in each eye. Ask the client to read a newspaper or magazine paragraph to assess near vision. Assess the visual fields	

of each eye by confrontation. Use an ophthalmoscope to view the retina and optic disc of each eye. • **Assess CN III (oculomotor), IV (trochlear), and VI (abducens).** Inspect the margins of the eyelids of each eye. Assess extraocular movements. If nystagmus is noted, determine the direction of the fast and slow phases of movement. Assess pupillary response to light and accommodation in both eyes. • **Assess CN V (trigeminal).** Test motor function. Ask the client to clench the teeth while you palpate the temporal and masseter muscles for contraction. Test sensory function. Tell the client: "I am going to touch your forehead, cheeks, and chin with the sharp or dull side of this safety pin or paper clip. Please close your eyes and tell me if you feel a sharp or dull sensation. also, tell me where you feel it." • **Test CN VII (facial).** Test motor function. Ask the client to smile, frown and wrinkle the forehead, show teeth, puff out cheeks, purse lips, raise eyebrows, and close eyes tightly against resistance. • **Test CN VIII (acoustic/vestibulocochlear).** Test the client's hearing ability in each ear and perform the Weber and Rinne tests to assess the cochlear (auditory) component of cranial nerve VIII. • **Test CN IX (glossopharyngeal) and X (vagus).** Test motor function. Ask the client to open their mouth wide and say "ah" while	

you use a tongue depressor on the client's tongue. Test the gag reflex by touching the posterior pharynx with the tongue depressor. • **Test CN XI (spinal accessory).** Ask the client to shrug the shoulders against resistance to assess the trapezius muscle. Ask the client to turn the head against resistance, first to the right and then to the left, to assess the sternocleidomastoid muscle. • **Test CN XII (hypoglossal).** To assess the strength and mobility of the tongue, ask the client to protrude the tongue, move it to each side against the resistance of a tongue depressor, then put it back in the mouth. *Motor and cerebellar systems* • **Assess the condition and movement of muscles.** Assess the size and symmetry of all muscle groups. Assess the strength and tone of all muscle groups. • **Evaluate balance.** To assess gait, ask the client to walk naturally across the room. • **Assess coordination.** *Sensory systems* • Assess light touch, pain, and temperature sensations. • Test vibratory sensation. • Test sensitivity to position. • Assess tactile discrimination (fine touch).	

Ex: 1.* Current Medical and Psychiatric History. Briefly describe recent changes in health or behavioral status, suicide attempts, hospitalizations, falls, etc., within the past 6 months.	
2.* Briefly describe any past illnesses or chronic conditions (including hospitalizations), past suicide attempts, physical, functional, and psychological condition changes over the years.	
3. Allergies. List any allergies or sensitivities to food, medications, or environmental factors, and if known, the nature of the problem (e.g., rash, anaphylactic reaction, GI symptom, etc.). Please enter medication allergies here and also in Item 12 for medication allergies.	
4. Communicable Diseases. Is the resident free from communicable TB and any other active reportable airborne communicable disease(s)? (Check one) Yes No If "No," then indicate the communicable disease: _____ Which tests were done to verify the resident is free from active TB? PPD Date: _____ Result:_____mm Chest X-Ray (if PPD positive or unable to administer a PPD) Date: _____ Result_____	
5. History. Does the resident have a history or current problem related to abuse of prescription, non-prescription, over-the-counter (OTC), illegal drugs, alcohol, inhalants, etc.? (a) Substance: OTC, non-prescription medication abuse or misuse 1. Recent (within the last 6 months) Yes No 2. History Yes No (b) Abuse or misuse of prescription medication or herbal supplements 1. Currently Yes No	

2. Recent (within the last 6 months) Yes No (c) History of non-compliance with prescribed medication 1. Currently Yes No 2. Recent (within the last 6 months) Yes No (d) Describe misuse or abuse: _____	
6.* Risk factors for falls and injury. Identify any conditions about this resident that increase his/her risk of falling or injury (check all that apply): *orthostatic hypotension *osteoporosis *gait *problem *impaired balance *confusion *Parkinsonism *foot deformity *pain *assistive devices *other (explain) _____	
7.* Skin condition(s). Identify any history of or current ulcers, rashes, or skin tears with any standing treatment orders. _____	
8.* Sensory impairments affecting functioning. (Check all that apply.) (a) Hearing: Left ear: Adequate Poor Deaf Uses corrective aid Right ear:*Adequate *Poor *Deaf *Uses corrective aid (b) Vision: *Adequate *Poor *Uses corrective lenses *Blind (check all that apply) - *R *L (c) Temperature Sensitivity: *Normal *Decreased sensation to: *Heat *Cold	
9. Current Nutritional Status. Height inches Weight lbs. (a) Any weight change (gain or loss) in the past 6 months? Yes No (b) How much weight change? lbs. in the past months (check one) Gain Loss (c) Monitoring necessary? (Check one.) Yes No	

If items (a), (b), or (c) are checked, explain how and at what frequency monitoring is to occur: _____ (d) Is there evidence of malnutrition or risk for undernutrition? Yes No (e)* Is there evidence of dehydration or a risk for dehydration? Yes No (f) Monitoring of nutrition or hydration status necessary? Yes No If items (d) or (e) are checked, explain how and at what frequency monitoring is to occur: _____ (g) Do you have medical or dental conditions affecting: (Check all that apply) *Chewing *Swallowing *Eating *Pocketing food *Tube feeding (h) Note any special therapeutic diet (e.g., sodium restricted, renal, calorie, or no concentrated sweets restricted): _____ (i) Modified consistency (e.g., pureed, mechanical soft, or thickened liquids):_____ (j) Is there a need for assistive devices with eating (If yes, check all that apply): Yes, No *Weighted spoon or built up fork *Plate guard *Special cup/glass (k) Monitoring necessary? (Check one.) Yes, No If items (g), (h), or (i) are checked, please explain how and at what frequency monitoring is to occur: _____	
10.* Cognitive/Behavioral Status. (a)* Is there evidence of dementia? (Check one.) Yes, No (b) Has the resident undergone an evaluation for dementia? Yes, No	

(c)* Diagnosis (cause(s) of dementia):* Alzheimer's Disease *Multi-infarct/Vascular *Parkinson's *Disease Other (d) Mini-Mental Status Exam (if tested) Date _____ Score _____ 10(e)* Instructions for the following items: For each item, circle the appropriate level of frequency or intensity, depending on the item. Use the "Comments" column to provide any relevant details. Item 10(e) Cognition* I. Disorientation* II. Impaired recall (recent/distant events) II. Impaired judgment* IV. Hallucinations* V. Delusions Communication* VI. Receptive/expressive Aphasia Mood and Emotion * VII. Anxiety* VIII. Depressio Behaviors* IX. Unsafe behaviors* X. Dangerous to self or others* XI. Agitation (Describe behaviors in comments section) 10(f) Health care decision-making capacity. Based on the preceding review of functional capabilities, physical and cognitive status, and limitations, indicate this resident's highest level of ability to make health care decisions. (a) Probably can make higher level decisions (such as whether to undergo or withdraw life-sustaining treatments that require understanding the nature, probable consequences, burdens, and risks of proposed treatment). (b) Probably can make limited decisions that require simple understanding. (c) Probably can express agreement with decisions proposed by someone else. (d) Cannot effectively participate in any kind of health care decision-making.	

11.* Ability to self-administer medications. Based on the preceding review of functional capabilities, physical and cognitive status, and limitations, rate this resident's ability to take his/her own medications safely and appropriately. (a) Independently without assistance (b) Can do so with physical assistance, reminders, or supervision only (c) Need to have medications administered by someone else	
PRESCRIBER'S MEDICATION AND TREATMENT ORDERS AND OTHER INFORMATION Allergies (list all): ___ Note: Do you require medications crushed or in liquid form? Indicate in 12(a) with medication order. If medication is not to be crushed, please indicate. 12(a) Medication(s). Including PRN, OTC, herbal, & dietary supplements. Include dosage route (p.o., etc.), frequency, duration (if limited). 12(b) All related diagnoses, problems, conditions. Please include all diagnoses that are currently being treated by this medication. 12(c) Treatments (include frequency & any instructions about when to notify the physician). Please link diagnosis, condition or problem as noted in prior sections 12(d) Related testing or monitoring. Include frequency & any instructions to notify physician.	

12(a) Medication(s). Including PRN, OTC, herbal, & dietary supplements. Include dosage route (p.o., etc.), frequency, duration (if limited). 12(b) All related diagnoses, problems, conditions. Please include all diagnoses that are currently being treated by this medication. 12(c) Treatments (include frequency & any instructions about when to notify the physician). Please link diagnosis, condition or problem as noted in prior sections. 12(d) Related testing or monitoring. Include frequency & any instructions to notify physician Prescriber's Signature _____ Date ____ Office Address _____ Phone____	

Proposed phases and timeline