Primary Care Registered Nurse

Organization: Red Deer Primary Care Network (RDPCN)

Location: Red Deer Primary Care Network (RDPCN)Patient's Medical Home and Primary Clinic

Clinical Leadership

- Complex Care: Nurse Practitioner Lead Complex Care
- MINT Clinic: Nurse Practitioner Lead MINT Clinic
- Workshops: Mental Health and Health Promotion Manager

Operational Leadership: (Oversight, Master schedule, budget, policies, strategic plans)

- Patient Medical Home, Complex Care, Pregnancy & Babies Manager

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A. Position Summary

As a key member of the Red Deer Primary Care Network (RDPCN) team, the Primary Care Registered Nurse (PCRN) provides complex and comprehensive, person-centred nursing care within the Patient Medical Home (PMH). Acting as a specialty generalist, the PCRN delivers primary nursing care across the lifespan in collaboration with primary care providers (PCPs). In this largely autonomous role, employees have significant independence in their daily work within a clear framework of support, coaching, and accountability.

The PCRN in this role functions as a **Generalist**, providing care across a wide range of patient needs. Each nurse also has one or more **Specialty Focused roles** that require specialized education and/or experience.

A. ***Complex and Comprehensive Care***
B. ***Certified Diabetes Educator (Certified Diabetes Educator Certification (CDE) Required)***
C. ***Pregnancy and Babies***
D. ***MINT Memory Clinic (Annual MINT education Certification required)***
E. ***Workshop and Group Facilitation***

This position also provides opportunities for professional growth, allowing RNs to expand into other areas of clinical focus based on patient population needs, organizational priorities, and individual interests or expertise.

B. Generalist Role Competencies and Skills

1. Core Competencies (apply to all PCRNs)

a) Interdisciplinary Team Member

- Fosters collaboration and teamwork across the health system.
- Provides patient-centred care in partnership with PCPs and other providers.
- Acts as a clinical resource, promote PCN services, and support education.
- Builds strong relationships to ensure continuity and integrated patient support.

b) Communication & Professional Relationships

- Communicates respectfully and effectively with patients, families, and health professionals.
- Uses evidence-informed approaches to support patient goals.
- Builds health literacy, self-advocacy, and resilience for patients and care partners.

c) Continuous Quality Improvement

- Contributes to service development, monitoring, and evaluation using best practices and data.
- Adheres to policies while promoting a culture of safety and continuous improvement.
- Integrates relevant research and evidence-informed practices to strengthen clinical decision-making in primary care.

- Reflects on professional practice regularly and through annual Future Focus conversation with leadership to set goals and a plan for the following year.

d) Health Promotion & Prevention

- Promotes wellness and prevention through patient education, screening, early detection, and technology-supported programs.
- Empowers patients to actively participate in their health and well-being.

e) Comprehensive, Patient-Centred Care & Case Management

- Delivers care guided by primary health care principles.
- Assesses and addresses complex physical, psychological, social, cultural, and equity-related needs.

- Develops and adapts individualized care plans using strategies such as motivational interviewing.
- Demonstrates cultural sensitivity and awareness, acknowledging the influence of diverse cultural backgrounds — including Indigenous ways of knowing — on the determinants of health.

- Maintains accurate documentation, confidentiality, and ethical standards.

f) Navigation and Referral

- Supports patients in accessing and navigating the health system.
- Facilitates continuity, smooth care transitions, and appropriate referrals.
- Connects patients to resources, programs, and community services.
- Educates patients on self-management tools and technology-supported programs.

2. **Skills** (apply to all PCRNs)

- Able to adapt, develop new skills, and apply evidence-based practice.
- Works effectively both independently and within a team environment.
- Thrives in a complex, unstructured, and dynamic setting.
- Demonstrates initiative, problem-solving skills, and flexibility.
- Strong communication, organizational, and critical thinking skills.
- Proficient with electronic medical records and Microsoft Teams.
- Strong knowledge of clinical prevention and management strategies, including patient education.
- Skilled in motivational interviewing, behaviour change support, and self-management coaching.

C. Specialty Competencies

1. Complex & Comprehensive Care

Typical Referrals Include: Diabetes, Cognitive Screening, Weight Management, Frailty, Malnutrition, Tobacco Reduction/Cessation, Asthma, COPD, Hypertension, Dyslipidemia, Metabolic Dysfunction-Associated Steatotic Liver Disease, Complex Care Plan and General Navigation

a) Generalist Competencies and Skills

- as listed in Generalist Competency section

b) Interdisciplinary team member

- Serves as a resource to team members in supporting patients with complex and comprehensive care needs.

c) Education and Health Promotion

- Provides education on self-management: nutrition, physical activity, medication, monitoring, and prevention of complications.

d) Continuous Quality Improvement

- Participates in Complex Care Team Meetings and PCN Community of Practices for strategic planning and CQI.
- Contributes to Complex & Comprehensive Care pathways development.

e) Health Promotion & Prevention

- Promotes wellness and prevention through patient education, screening, early detection, risk reduction strategies and technology-supported programs.
- **Empowers** patients across the lifespan to actively participate in their health and well-being.

f) Comprehensive, Patient-Centred Care & Case Management

- **Conducts** holistic assessments, including history, physical parameters, psychosocial factors, and chronic disease-related risks.
- **Provides** case management for patients with multiple or complex chronic conditions.
- **Collaborates** with PCPs, specialists, and interdisciplinary team members to optimize care plans and support patients at risk for or living with chronic conditions.
- **Monitors** patient progress, identifies barriers, and adjusts interventions as needed.
- **Delivers** individualized education, counselling, and support to enhance patient understanding, self-management, and quality of life.
- **Participates** in interdisciplinary case reviews and contributes to the development of evidence-based care pathways

g) Clinical Procedures

- Performs capillary blood glucose, , interstitial blood glucose monitoring via continuous glucose monitoring, blood pressure monitoring, and foot assessments.

h) Navigation and Referral

- Connects patients with chronic and complex conditions to community resources and supports.

2. Certified Diabetes Educator

Typical Referrals Include: Medication Management of Type 2 Diabetes. Complex Type 2.

Note: Maintain currency Certified Diabetes Educator Certification (CDE) required

a) Generalist Competencies and Skills

- as listed in Generalist Competency section

b) Interdisciplinary team member

- **Serves as a resource** to team members in supporting patients with Type 2 Diabetes.
- **Provides** consultation, mentorship, and capacity-building support to colleagues, strengthening diabetes knowledge and management across the team.

c) Education and Health Promotion

- Provide advanced education on self-management: nutrition, physical activity, medication, monitoring, and prevention of complications.
- **Contributes** to group education programs and community outreach events to enhance diabetes awareness and prevention.

d) Continuous Quality Improvement

- Participates in Complex Care Team Meetings and PCN Community of Practices for strategic planning and CQI.
- Contributes to Complex & Comprehensive Care pathways development.

e) Comprehensive, Patient-Centred Care & Case Management

- Conducts holistic assessments, including history, physical parameters, psychosocial factors, and diabetes-related risks.
- Develops, implements, and monitors individualized diabetes care plans.
- Supports initiation/titration of medications under collaborative protocols.
- Monitors progress, identify barriers, and adjust care.

f) Clinical Procedures

- Performs capillary blood glucose testing, interstitial glucose measurement with continuous glucose monitoring, blood pressure monitoring, and foot assessments.

g) Navigation and Referral

- Triages diabetes referrals.
- Connects patients with PCN and community programs.
- Facilitates referrals to specialty services (endocrinology, ophthalmology, podiatry).

3. Pregnancy & Babies

Typical Referrals Include: Pre/Postnatal, Preconception, Vaccine Hesitancy, Pregnancy and Infant Loss.

a) Generalist Competencies and Skills

- as listed in Generalist Competency section

b) Interdisciplinary Team Member

- **Serves as a resource** to team members in supporting care of patients for pre-conception education, pre/postnatal support, concerns of vaccine hesitancy, and/or pregnancy and infant loss.

c) Education and Health Promotion

- Provides education on preconception, prenatal, perinatal mental health, first year postpartum, lactation, vaccination, and newborn/infant care.
- Offers preventative education about gestational diabetes; when patient has a diagnosis they are referred to Healthy Living Program/Diabetes Specialty clinic.
- Delivers trauma-informed education and family supports.
- **Contributes** to community outreach events to collaborate with community agencies to promote maternal health, such as Maternal Mental Health Steering Committee

d) Continuous Quality Improvement

- Participates in Pregnancy and Babies PCN Community of Practices for strategic planning and CQI.
- Contributes to Pregnancy and Babies program development

e) Comprehensive, Patient-Centred Care & Case Management

- Conducts assessments addressing physical, emotional, social, and perinatal factors.
- Manages common prenatal/postpartum concerns, refer to PCP or other Healthcare Provider as needed.
- Screens for perinatal/postpartum mental health concerns.
- Provide grief/bereavement support and facilitate Pregnancy & Infant Loss Group (H.E.A.R.T.S.) .
- Support families experiencing substance use or addiction through harm reduction education and collaborative care.

f) Navigation and Referral

- Supports Low-Risk Maternity Referral Program.
- Collaborates with interdisciplinary teams to strengthen continuity of care.
- Facilitates access to appropriate mental health supports.

4. MINT Memory Clinic

Typical Referrals Include: Detection and management of dementia. Comprehensive assessment including driving and frailty.

a) Generalist Competencies and Skills

- as listed in Generalist Competency section

b) Interprofessional Team Member

- Works collaboratively within a interprofessional team made up of physicians, nurse practitioners, pharmacists, mental health clinicians and a representative of the Alzheimer's Society to establish diagnoses, coordinate care and connect patients and families with appropriate community resources.

c) Education and Health Promotion

- Provide up-to-date education on dementia, treatments, and brain health.

d) Continuous Quality Improvement

- Participates in MINT training, team meetings, and professional development.
- Participates in MINT team meetings for strategic planning and CQI.
- Contributes to MINT program development.
- Attends annual MINT education.

e) Comprehensive, Patient-Centred Care & Case Management

- Conducts dementia-focused assessments (history, collateral information, risk factors).
- Performs cognitive, physical, and mental health assessments during Initial/Follow-Up visits.
- Develops individualized care plans with the MINT NP, physician, pharmacist, mental health clinician, and Alzheimer Society representative.
- Supports patients/families in navigating dementia care.

f) Navigation & Referral

- Triages MINT referrals.
- Consults with the MINT NP on complex cases.
- Facilitates access to Alzheimer Society, Home Care, and other community supports/ resources.

5. Workshop and Group Facilitation

Workshops include:

- **ADHD (4 WK) – 18+:** Awareness, self management strategies, treatment options
- **Anxiety to Calm (4/8 WK):** Mild to moderate anxiety
- **Anxiety to Calm for Youth (6 WK):** Mild to moderate anxiety (12-17 years old)
- **Journeying Through Grief (8 WK):** Loss of loved one
- **Menopause (4 WK):** Awareness, self management strategies, treatment options
- **Moving on with Persistent Pain (4/8 WK):** Biological/psychological/social
- **My Way to Health (4/8 WK) *(Foundational Workshop)*:** Lifestyle, weight, activity, CV risk
- **Pathways to Happiness for Youth (6 WK):** For languishing, mild to moderate depression
- **Pathways to Happiness (4/8 WK):** For languishing, mild to moderate depression
- **Relationships in Motion (4/8 WK):** All types of relationships
- **Sleep (1 WK with 5 WK sleep diary feedback):** Insomnia
- **Strong & Steady (5 WK):** Fall prevention

- H.E.A.R.T.S. (Pregnancy & Infant Loss Peer Support Group)

a) Generalist Competencies and Skills

- as listed in Generalist Competency section

b) Interdisciplinary Team Member

- Leads workplace wellness initiatives aligned with organizational health promotion goals.
- Conduct training for RDPCN staff, PCPs, and community partners on health promotion and wellness.

c) Education & Health Promotion

- Delivers workshops to youth and adults that support healthy living and self-management.
- Applies evidence-based techniques: stages of change, motivational interviewing, single concept

d) Continuous Quality Improvement

- Develops patient Workshops that support healthy living and self-management.

e) Navigation and Referral

- Navigates workshop participants to other PCN programs and resources

E. Qualifications

Education

- Bachelor of Science in Nursing (BScN) or. Bachelor of Nursing (BN). PCRNs without a baccalaureate currently working in this position would be exempt.
- Current registration and good standing with the College of Registered Nurses of Alberta (CRNA) with annual proof of registration.
- Certified Diabetes Educator (CDE) designation required for CDE-assigned roles.

Experience

- Minimum five years of experience preferred in a similar role within primary care or community health.

F. Compensation & Benefits (see RDPCN Compensation Framework)

- Pay Scale: *United Nurses of Alberta (UNA): (Exp. Mar 24)*
- Role Classification: Registered Nurse / Registered Psychiatric Nurse
- Benefits Classification: Employee
- Staffing Classification for PPHS Reporting: Direct Care Provider
- **Do not include this section in job postings**