May 2004

Nursing NEWS Special Edition

Model of Nursing Clinical Practice (MoNCP)... Part III

Continues to buzz with Activity

Message from Wendy Nicklin

The last group of clinical units is entering the implementation phase of our Model of Nursing Clinical Practice – a very meaningful time. This *Special Edition* Newsletter is well timed to provide you with an update as to the progress made to date.

First and foremost, to those staff working on units who have completed implementation or are in the process of implementation, thank you. Change, no matter for what reason, is challenging. Progressing through this critical phase is an achievement unto itself.

As you know the model is based on principles. There is

no "cookie cutter" formula as to how to implement the model within a specific area. We can learn from each other and build on that learning, however each area within which the model is implemented must review the principles and apply the model so as to meet the needs of your particular patient populations and the particular idiosyncrasies of your unit. Every unit team modifies the model to a certain degree, adhering to the principles, in order to ensure alignment. As the model is aligned, as the wrinkles are ironed out, the benefits are becoming increasingly evident. We have seen some very creative and innovative approaches arising from the planning and implementation.

Those of you within the final implementation group of clinical units have the benefit of learning from those who have preceded you while ensuring consideration of the unique features of your area. Ongoing support for the implementation will be provided.

Several years ago, we embarked on this significant project in order to address the #1 priority identified by TOH nurses… that of aligning our model of clinical practice, for both patient care and professional reasons. It has likely turned out to be far more work and effort than initially conceived, however, we have not lost sight of the goals and the rationale for this important initiative. Your commitment, participation and support throughout this period and on into this final implementation phase is truly appreciated.

Wendy Nicklin, Vice-President, Nursing

Message from Ginette Rodger

In this third special edition of the Nursing News featuring the Model of Nursing Clinical Practice (MoNCP) we are highlighting questions that have been raised during the fall and early winter implementation. They are the clinical expert assignment, the scope of practice of Registered Practical Nurses (RPN), the role of the patient care assistant (PCA), the accountability of nurses, to name a few.

By the summer most units will have implemented the Model with a few exceptions. These exceptions are related to specific challenges such as Friesen unit… these units will also be implemented at a later date.

As we continue on our journey of enhancing the professional practice environment at TOH we are mindful of all of our partners who contributed and supported this journey. Several sub-groups of the Model such as RPN, PCA and Multidisciplinary Work Groups continue to work on resolving questions as they arise during the implementation. We thank them for their contribution towards the implementation of the MoNCP.

The Model Facilitators, the Research Coordinator and the Corporate Coordinator of Nursing Clinical Practice have worked closely with many teams to provide support and guidance. We thank them for their hard work and dedication. The Human Resources Department, ONA and CUPE have also created an environment to facilitate changes and we are grateful for their contribution to improve patient care.

The greatest thank-you must go to all clinical nurses who have worked diligently at reviewing the organization of their professional practice on their unit, made decisions to improve the work environment and are implementing a Model that supports best nursing practice.

Your partners the Clinical Managers, Nurse Educators, Clinical Directors, the physicians and other health professionals have supported this effort and their contribution is greatly appreciated.

Congratulations to all for building a foundation that will contribute to an enhanced TOH professional practice environment and improve patient care.

Ginette Rodger, Chief, Nursing

Professional Accountability and the MoNCP

By Evelyn Kerr,
Corporate Coordinator of Nursing Clinical Practice, NPPD

Introduction

As professionals reporting to a College (College of Nurses of Ontario) nurses have always been accountable to our patients and employer for the care we deliver. This accountability extends not only to the delivery of care but also the documentation of that care. Since the amalgamation at TOH, nurses have asked that there be consistency in our approach to accountability both in our approach to and documentation of nursing care delivery at The Ottawa Hospital.

As we come to a milestone in the roll-out of the MoNCP we pause to reflect about questions that have been raised about professional accountability. More specifically related to certain roles that are pivotal to the success of the implementation of the model.

How is the Clinical Expert different from the current Team leader Role?

Currently in some units in the hospital there are positions entitled Team Leader. The current role of the Team Leader has two distinct areas of responsibility:

1) to provide administrative assistance to the Clinical Manager
2) to provide some clinical assistance/advice to the nursing staff.

In the **new Model of Clinical Nursing Practice**:

1) the administrative assistance component is transferred to either the Clinical Manager or a Care Facilitator role.
2) the clinical expertise support will now be accommodated by the Clinical Expert Assignment.

The new role entitled Clinical Expert Assignment was developed to support clinical nurses.

Does this "Clinical Expert Assignment" make the nurse MORE accountable?

The answer is no.

Prior to the implementation of the Model, nurses naturally sought out other nurses at the expert level in an informal manner. The model does not change this; it only recognizes these expert nurses in a formal way. The Clinical Expert Assignment identifies the nurse to whom novice nurses and new staff etc. can go to for advice regarding a patient related clinical issue. (See page 4 for a description of the CEA role).

What is the legal opinion on this?

When assuming the Clinical Expert Assignment, nurses have raised questions about their perceived increased liability. According to Ethyllyn Phillips, a nurse and lawyer at the Canadian Nurses Protective Society, nurses who offer advice are accountable for the advice that they give, whether they are a clinical expert or novice. From a legal point of view, this has always been the case.

What does the College of Nurses of Ontario have to say about this?

According to the CNO, "each nurse is accountable to the public and responsible for ensuring that his/her practice and conduct meets legislative requirements and the standards of the profession". The "Code of Ethics for Nurses from the C.N.A. states that "Nurses are answerable for their practice, and they [must] act in a manner consistent with their professional responsibilities and standards of practice".

Nurses have been and remain accountable for their practice regardless of what role/assignment/position/ they have.

How is a nurse identified to assume the Clinical Expert Assignment?

What makes you say: "She is such an expert!!!" What do these words mean and what behaviours would the nurse exhibit for someone to describe them as a clinical expert? Dr. Benner's internationally acclaimed "From Novice to Expert" theory may help us here. Let's read on!

Dr. Benner researched the process through which nurses develop expertise. She described a developmental process with five levels: 1) Novice, 2) Advanced Beginner, 3) Competent, 4) Proficient and 5) Expert. As nurses move through the five levels, they evolve professionally from relying on abstract principles to relying on concrete experience. Expert nurses also develop their intuitive knowledge and are able to integrate both conceptual knowledge and clinical knowledge in the delivery of nursing care.

RN Scope of Practice Assessment Tool

The RN Scope of Practice Assessment Tool was developed by the RN scope of Practice MoNCP subgroup to be used as an objective guide to identify Clinical Experts. The tool can be used by an RN to self-evaluate their ability to practice within the full scope of her/his practice. It is based on TOH's "Nursing Professional Practice Model definitions" and the CNO's "Profile of Practice Expectations for RNs and RPNs" and "Competency Review Tool for Nurses in Direct Practice" (CNO, 2001). The categories used are those of the Clinical Practice Development Model developed by Haag-Heitman and Kramer (1998) and built around Benner's (1984) Novice to Expert theory.

Categories used in the RN Scope of Practice Assessment Tool:

LEVEL	SKILL AND KNOWLEDGE
EXPERT	► **Analysis, synthesis, application, highly skilled performance** • Extensive exposure, with deep understanding of situation • Able to rapidly and consistently identify actual and potential assessment changes • Able to rapidly change priorities under all conditions • Able to keep personal values in perspective and therefore able to encourage and support patient and family choices
PROFICIENT	► **Conceptual understanding, proficient performance** • Extensive exposure in most situations • Able to anticipate potential assessment changes • Able to prioritize in response to changing situations • Able to interpret the patient and family experience from a wider perspective and can envision possibilities
COMPETENT	► **Conceptual understanding and skill performance, competent** • Varied exposure to many situations • Able to identify normal and abnormal findings • Able to prioritize under stable conditions • Increased awareness of patient and family viewpoints
ADVANCED BEGINNER	► **Conceptual understanding, minimal clinical experience** • Limited exposure to clinical situations • Able to identify normal findings • Guided by what they need to do, rather than patient responses
NOVICE	► **Marginal conceptual understanding, minimal clinical experience** • Seeks assistance in making clinical decisions

**For a copy of the entire RN Scope of Practice Assessment Tool, please contact the Nursing Professional Practice Department (NPPD) Office at ext. 14976 or ext. 78749

He that would have the fruit must climb the tree.

(Thomas Fuller)

MoNCP
"Clinical Expert Assignment"

Title

The subgroup recommended that the title be Clinical Expert Assignment. This title highlights the fact that this is an assignment and not a position.

Purpose of the Clinical Expert Assignment

The purpose of the Clinical Expert Assignment is to ensure timely access to professional clinical expertise.

Responsibilities

The nurse functioning in a Clinical Expert Assignment will, as required:

1. provide assistance with assessing clinical skills
2. provide assistance to critical thinking i.e. when to contact other disciplines
3. provide immediate support for crises in the clinical area
4. identify resources to nurses
   - clinical
     – nurse colleagues, educators, advanced practice nurses, liaison nurses
     – multidisciplinary colleagues
   - references – manuals, other departments
5. assist with decision making
6. provide guidance for clinical skills
7. assist in developing a plan of care
8. provide consultation to other units for off service patients

Attributes of Nurse Assigned To Clinical Expert Assignment

The nurse functioning in the Clinical Expert Assignment should have the following attributes:

- functions autonomously at proficient or expert level of clinical practice
- demonstrates strong clinical knowledge of the specialty(s) of the typical patient population (evidenced-based practice)
- demonstrates leaderships skills
- efficiently adapts to different clinical situations
- prioritizes rapidly and determines appropriate actions
- communicates clearly in a supportive manner
- demonstrates effective interpersonal skills
- understands available resources (CCAC, policies and procedures)
- in general will have been employed a minimum of six months on the specific unit before assuming this assignment

Criteria for Determining Whether Clinical Expert Nurse Assignment Required

The following guiding principles will assist the unit in determining whether a Clinical Expert Assignment would be appropriate. The factors that should be taken into consideration are:

- level of expertise on unit (i.e. ratio of expert to novice nurses)
- unit typically hires new graduates (i.e. medical/surgical inpatient units)
- nurse turnover rate
- support resources available
- several specialties on a unit

Assignment Scenarios

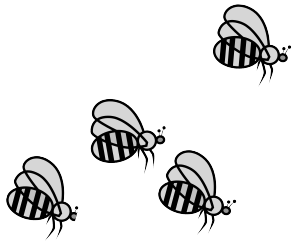
In order for the Clinical Expert Assignment to be successful, the following prerequisites are required:

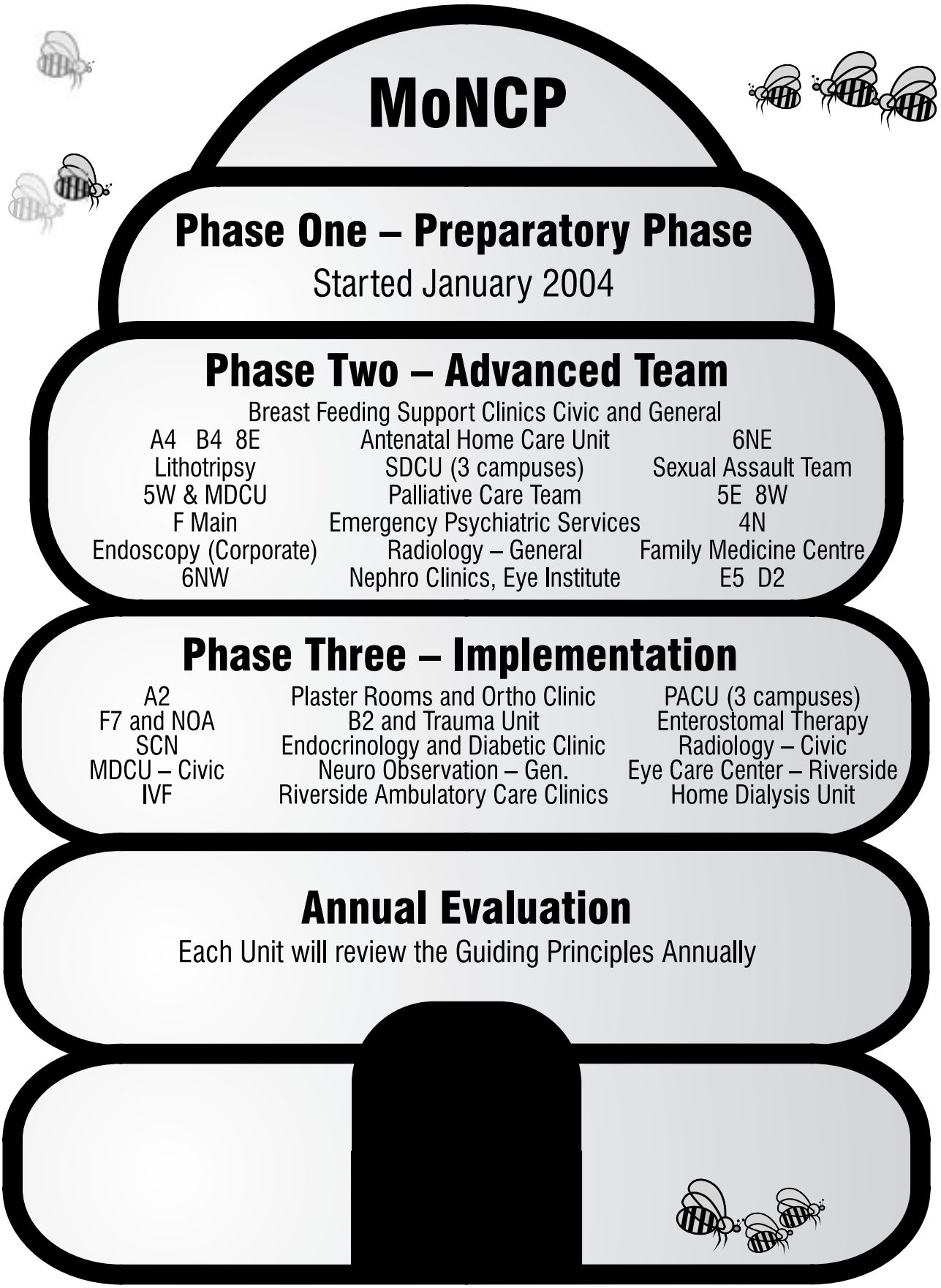
- Critical mass of experienced staff
- Balanced distribution of staff (across the rotation) with the attributes required to function in the Clinical Expert Assignment
- Nurses functioning at full scope of practice
- All team members educated regarding the responsibilities of the Clinical Expert Assignment.

Guiding Principles for the Determining Patient Assignment of the Nurse with the Clinical Expert Assignment

The following guiding principles will assist the unit in determining the appropriate patient assignment for a person functioning in a Clinical Expert Assignment:

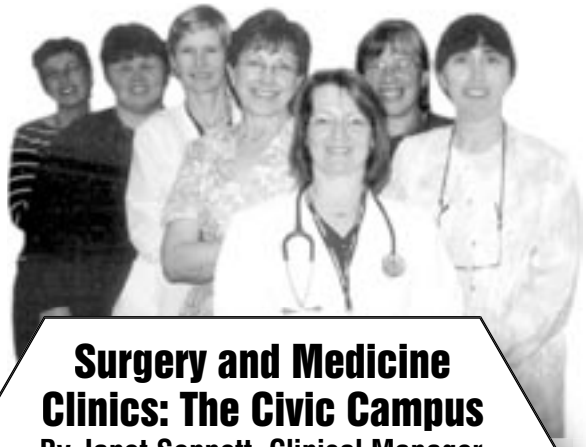
- In general, the person in the Clinical Expert Assignment will have a patient assignment
- The patient assignment must have a workload that will enable the nurse to meet the responsibilities of the Clinical Expert Assignment. Consequently, there is no prescription for the number of patients assigned to the nurse with the Clinical Expert Assignment. It will be determined by the unique situation of each unit.





Proverb: "The diligence of the hive produces the wealth of honey."

MoNCP Implementation *Testimonials*



Surgery and Medicine Clinics: The Civic Campus

By Janet Sennett, Clinical Manager

The Surgery and Medicine Clinics at the Civic Campus implemented the Model of Care in June, 2003. The advanced team met for two full days, rather than for shorter meetings, which worked well for the clinical areas. The implementation did not really change the quality of the care for our patients because we already had the appropriate providers in all clinics. We identified that the RPN Skill List had to be revised to include complex dressings providing the Physician is present. Without an educator assigned to the outpatient clinics, it became very evident that one is needed to ensure nurses education needs are met.

Eye Care Centre: The Riverside Campus

By Patty Mitchelmore, Clinical Manager

With the assistance of our facilitator, Jennifer Wainman-McNaught, four nurses, each one representing a different area of the Riverside Campus Eye Care Centre, the Nurse Educator and Clinical Manager reviewed the Guiding Principles. The completed document reinforced that all the ECC nursing staff are currently working to their full scope of practice. A review of the Guiding Principles was completed over two staff meetings. A few changes to our practice were necessary. These changes were quickly implemented and endorsed by everyone involved. In addition, a joint unit nursing clinical practice committee was established for all Eye Care Centre staff and the first meeting has been held. January 20, 2004 was our scheduled implementation date. Working on this model was a positive experience.

"Clinics on the Move"

Ambulatory Care Department: The General Campus

By Carolyn Welch, Clinical Manager

In May 2003, nursing staff from modules G, K, L, M, O and the Pain Management Unit at the General Campus got together to begin the process of implementing the new MoNCP into the Ambulatory Care setting. As the new manager for a group that had recently been reassigned under a common portfolio, it was a great opportunity for me not only to look at nursing practices within the clinics but also to work on some team building.

After reviewing the Guiding Principles, it was quickly identified that the department needed to establish a common clinic schedule to be able to provide clinic staff with the time needed to hold and attend essential meetings and educational in-services. Each module was set up differently, so re-organizing and standardizing clinic schedules was our biggest hurdle to overcome. Physicians had to be given advance notice about their changing clinic schedules and templates. Patient appointment times and nursing schedules also needed to be changed. With much effort and support, we were able to establish regularly scheduled time for in-services and staff meetings and to create a Unit Council. The feedback from staff on these initiatives has been very positive, especially with respect to the new Unit Nursing Clinical Practice Committee.

The implementation process has been a positive experience overall. The Ambulatory Care nurses have identified many strengths in the model (e.g. many clinical experts and a wide variety of expertise) and have established a list of priorities to work on over the next few months.

MoNCP Research Project: Update

The MoNCP Research Study Nurse and Patient survey periods are now complete for Year 0, with Year 1 and Year 2 to follow. Nurse and patient response rates have been very good and the study has generally been very well received. Below are the answers to the most commonly asked questions from nurses. Thank you for your ongoing participation. In the future, study updates will be found in the regular editions of the Nursing News and on the study's website.

1. What makes this study so special?

This is a longitudinal study tracking changes in patient outcomes and nurse psychosocial health over a three-year period (i.e. surveying pre-implementation Y0, and post-implementation at Y1 and Y2).

2. Why should I bother filling out the survey?

This study invites nurses and patients to have their opinions captured, and the individual impact of this major organizational change documented. Through analysis and subsequent publication this has the potential to 'benchmark' and improve nurse/patient outcomes in other health care facilities.

3. Is it really confidential?

Yes, absolutely. The research ethics boards at The Ottawa Hospital and at The University of Western Ontario review the study protocol, amendments and any changes on an ongoing basis to protect the integrity and confidentiality of all of the data and participants.

4. What will happen to all of the data?

It will be collected and sent off-site for analysis.

5. Why is the Nurse Questionnaire so long?

Each of the tools used in the nursing questionnaire captures essential data, which will give the analysts necessary information to gain an accurate overall picture of the psychosocial health of nurses before and after the implementation of the new model.

6. Can I complete the survey twice if I work on two units?

No. The questionnaire should be received and answered on the unit where you work the highest number of hours.

7. How do all of the stakeholders know what is happening with the progress of the study?

The study team is mandated by its funders to provide regular comprehensive updates to all of its internal and external stakeholders. A chart reflecting this reporting structure is available on request.

8. How can I contact the Principal Investigators and Research Coordinator?

Principal Investigator
Dr. Mickey Kerr
University of Western Ontario
1-905-888-9999

Co Principal Investigator
Dr Ginette Lemire-Rodger
Chief of Nursing
The Ottawa Hospital
1-613-761-4000

Research Coordinator
Wendy Diegel
The Ottawa Hospital
613-798-5555 ext. 16349

It is good to have an end to journey towards but it is the journey that matters in the end.

(Ursula K. Le Guin)

Updates: "Raising the Bar of Professionalism"

As the Model has rolled out, ideas and issues have surfaced for discussion and action.

PCA

The PCA group met to review the roles and responsibilities of PCAs across TOH. The group will reconvene to discuss the varied responsibilities that have been delegated to the Unregulated Care Provider (UCP). In addition, the group will be reviewing the process of delegation.

Evelyn Kerr

RPN

The RPN group reconvened to review the Scope of Practice and the skills list of RPNs, particularly in the clinic setting. The skills list was subsequently updated to include such skills as complex wound dressing in the clinical setting under the direction of the physician.

Verbal Orders

Through the review of the Model in the clinic setting, verbal orders were raised as an area of concern for nursing. The CNO Medication Standard 2003 states "Verbal orders are accepted only in emergency situations or where the prescriber cannot document her/ his orders, such as in the operating room. Perscribers are accountable for signing verbal orders as necessary". (CNO Medication Standards 2003, page 5).

A group has been established to review PP&P that include reference to verbal, telephone, direct reprinted orders and Medical Directives.

Plan of Care – How do you do it?

Much discussion has evolved around how nurses develop and communicate the patient's plan of care or care plan. It is clear in the CNO Nursing Documentation Standards Revised 2002 that nurses are the professionals that develop the patient's plan of care. These standards state that "Care Plans are written outlines of care for individual clients. They are part of the permanent health record. Effective care plans are up-to-date and clearly identify the needs and wishes of the client. When the care plan is not evident in the documentation, the nurse should ensure a separate formal plan of care is retained. **A nurse meets the standards by:**

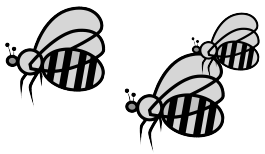
- Keeping the care plan clear, current and useful; and,
- Individualizing care plans to meet the needs and wishes of the individual patients."

Multidisciplinary Communication Sub Group Update:

"Interdisciplinary communication is in fact the centre of our world… in which the flow of information needs to be effectively managed in order to get patients safely back home."

The sub-group is comprised of representatives from almost every discipline within The Ottawa Hospital and its members are highly committed to enhancing the effectiveness of our clinical team, while recognizing the central role of nursing in the delivery and coordination of care. The multidisciplinary sub group has been asked to further develop implementation plans for several of our recommendations:

1. **Interdisciplinary Kardex**: This has now been through several drafts. We expect to recommend that this be used on all inpatient medical and surgical units. This will promote continuity and consistency between inpatient units. Specific program needs may require some adjustments to meet the specialties need for interdisciplinary communication. CNCPC has provided feedback that will be integrated into the tool.
2. **Integrated Progress Notes**: Allied Health Chiefs have now identified the discipline specific charting requirements for each discipline within TOH **Integrated Progress Notes**. An educational package will be developed to incorporate the learning needs of all disciplines.
3. Other Recommendations for **improved interdisciplinary communication** on units are:
   - implementation of interdisciplinary rounds
   - consistent use of standardized Clinical Pathways
   - communication binders
4. **Patient signage and Alerts**, fundamental to patient safety, will require a thorough review and evaluation in light of recent changes in privacy legislation.



The Whirl Wind of Change

Turbulence is a life force. It is opportunity. Let's embrace the turbulence and use it's energy for change.

Adapted by Ramsey Clark