**INTEGRATING PRIVILEGED NURSE PRACTITIONERS INTO THE LAKERIDGE HEALTH**

**NURSE PRACTITIONER PROGRAM**

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Table of Contents

[EXECUTIVE SUMMARY: 3](#_Toc330459015)

[DEFINITIONS: 4](#_Toc330459016)

[THE CURRENT OPPORTUNITY: 5](#_Toc330459017)

[THE CONTEXT: MAXIMIZING FULL SCOPE OF NURSE PRACTITIONER PRACTICE: 5](#_Toc330459018)

[INTEGRATION OF NP PRIVILEGED STAFF INTO EXISTING ORGANIZATIONAL STRUCTURES 7](#_Toc330459019)

[CATEGORIES OF NP PRIVILEGED STAFF 9](#_Toc330459020)

[SKILLS & QUALIFICATIONS REQUIRED FOR MEMBERSHIP NP PRIVILEGED STAFF: 10](#_Toc330459021)

[APPLYING FOR APPOINTMENT 11](#_Toc330459022)

[Appendix A – Lead NP Role Description 12](#_Toc330459023)

Appendix B - Recruitment/Selection Process For Privileged NPs [14](#_Toc330459024)

[Appendix C - Annual Performance Review 15](#_Toc330459025)

Appendix D - Most Responsible Practitioner, Consultants and Practitioner On-Call Policy..16

[Appendix E - APN/NP Role Description: 25](#_Toc330459110)

[Appendix F - Privilege Application Checklist 28](#_Toc330459111)

# EXECUTIVE SUMMARY:

Lakeridge Health has embraced enabling the Nurse Practitioner role for almost 15 years. Their advanced knowledge and decision-making skills enhance their autonomous collaborative practice within the inter-professional team in providing quality patient care and leadership contributions to the quality agenda.

This framework for the Nurse Practitioner Model integrates non-employee NPs into the pre-existing NP employee structure and has been developed in accordance with applicable provincial legislation and regulations and is consistent with privileged staff bylaws and the rules and regulations of Lakeridge Health (LH).

# DEFINITIONS:

**NURSE PRACTITIONER (NP) EMPLOYEES:** NP Employees means those advanced practice nurses who:

* Are employed by LH
* Are qualified to practice as Primary Health Care, Adult, or Pediatric NPs
* Hold a current, valid specialty certificate of Extended Class Registration with the College of Nurses of Ontario.
* Do not require any form of privileging for the admission, treatment or discharging patients.

**NURSE PRACTITIONER PRIVILEGED STAFF:** NP Privileged Staff means those advanced practice nurses who:

* Are not employees of LH
* Have been granted Privileges by the LH Board
* NP Privileged Staff may only provide care to patients in accordance with the privileges granted by the Board
* Are qualified to practice as Primary Health Care, Adult, or Pediatric NPs
* Hold a current, valid specialty certificate of Extended Class Registration with the College of Nurses of Ontario.

**LEAD NURSE PRACTITIONER:** The NP who is designated to represent advanced practice nursing and nurse practitioners within the Hospital or community at designated meetings/committees, which include but are not limited to Pharmacy & Therapeutics, Interprofessional Council, Leadership Councils, Quality Councils and MAC subcommittees. (See Appendix 1 – Role Description)

**PRIVILEGE:** Medical, dental, midwifery, clinical scientist or nurse practitioner activity (outpatient or inpatient) in the Hospital sanctioned by the Board.

# THE CURRENT OPPORTUNITY:

LH has historically embraced the role of the NP; NPs at LH are well integrated and practice on inter-professional teams to the benefit of patients, LH and the healthcare system.

Within the context of the recently enabled NP practice in Ontario described below there continues to be an interest in maximizing the role of the NP.

The opportunity for LH is to be appropriately positioned for potential future models of care that consider both employee and non-employee NPs as equal partners in a team with physicians and other professionals as indicated by the patients’ condition.

Guided by the newly revised LH Privileged Staff By-Laws and relevant policy and procedures, this document attempts to define a structure that effectively integrates privileged nurse practitioners into the LH Nurse Practitioner program.

# THE CONTEXT: MAXIMIZING FULL SCOPE OF NURSE PRACTITIONER PRACTICE:

Nurse Practitioners are Registered Nurses in the Extended Class who have additional nursing education and experience. NPs have, and demonstrate in practice, the competencies to use their legislated authority to diagnose and treat/manage health, order and interpret diagnostic tests, prescribe pharmaceuticals, and perform procedures.

The listt below summarizes the new authorizations approved for NPs, the effective date of the change to practice, and the legislation that was amended to support the change.

New authorizations for NPs

* Admit persons to hospitals. Effective July 1, 2012, Regulation 965 under the Public Hospitals Act
* Provide client care orders to be implemented by RNs and RPNs for procedures related to diagnosing and treating clients (e.g., venipuncture to obtain blood samples). Effective October 1, 2011, Nursing Act, 1991
* Broadly prescribe drugs appropriate for client care (i.e., NPs no longer have to prescribe from a list of drugs). Effective October 1, 2011, Nursing Act, 1991 and Regulation 275/94
* Dispense, compound, and sell drugs in keeping with the regulation. Effective October 1, 2011 Nursing Act, 1991 and Regulation 275/94
* Set or cast a fracture of a bone or dislocation of a joint. Effective October 1, 2011, Nursing Act, 1991
* Order any laboratory test appropriate for client care (i.e., NPs no longer have to order from a list of laboratory tests). Effective July 1, 2011, Regulation 682 under the Laboratory and Specimen Collection Centre Licensing Act
* Order treatments for hospital in-patients and discharge patients from hospital Effective July 1, 2011, Regulation 965 under the Public Hospitals Act
* Order services for which patients are insured. Effective July 1, 2011, Regulation 552 under the Health Insurance Act

As of July 17, 2012, the following amendments relating to NP practice have not been proclaimed:

* Removing the restrictions on the diagnostic tests that NPs can order (i.e., eliminate the diagnostic test list of x-rays/CTs and ultrasounds)
* Permitting NPs to perform point of care laboratory tests
* Permitting NPs to apply specified forms of energy (e.g., defibrillation)
* Permitting NPs to order additional forms of energy (e.g., Magnetic Resonance Imaging)
* Permitting NPs, RNs, and RPNs to perform psychotherapy as a controlled act
* Federal legislation for prescribing Controlled drugs and Substances

It is anticipated that the regulatory amendments needed to proclaim these remaining provisions in Bill 179 that affect nursing practice will be in place by the fall of 2012.

# INTEGRATION OF NP PRIVILEGED STAFF INTO EXISTING ORGANIZATIONAL STRUCTURES

1. Organizational Structure for NP Practice:

**Chief Nursing Executive**

Representative at MAC Exec and MAC for NP related issues, including privileging

**Department Chief**

Accountable for the professional practice and quality of care provided by privileged staff within the Department. Makes recommendations to MAC Exec and MAC based on the input of the Lead NP

**Lead NP**

In addition to providing professional practice leadership for employed NP staff, assumes the Section Chief role for privileged NPs until critical mass of privileged NPs reached.

Enables the safe and effective delivery of clinical services by both privileged and employed NPs. Representative at Inter-professional Practice Council; on invitation addresses NP related issues at MAC Exec and MAC

**Employed NPs**

Fulfills the role of the advanced practice nurse in accordance with established standards and applicable legislation and regulations

**Privileged NPs**

Fulfills the role of the advanced practice nurse in accordance with established standards and applicable legislation and regulations

The duties of privileged staff are as outlined in the privileged staff By-Laws, Rules and Regulations and policy and procedures.

**Chief of Staff**

Accountable to the Board for professional practice and conduct and for quality of practice for privileged staff

**NP Section Chief**

Potential to develop NP Section Chief Positions when a critical mass of privileged NPs develop within any one Department

1. Role of the Lead NP in the support of Privileged NP Practice

In conjunction with the Department Chief, Lead NP (refer to Appendix A for the Lead NP role description) plays a central role in the recruitment and ongoing performance management of NP Privileged staff:

* Participation in determining/defining a vacancy
* Participation in the Recruitment and Selection Process (See Appendix B)
* Delegate for the completion of reference checks in accordance with the Credentialing and Privileging of LH Privileged Staff Policy and Procedures.
* Delegate for the completion of the recommendation report to the Medical Advisory Executive Committee (acts as the Credentials Committee)
* Assigned monitor for the new privileged staff member with related support and reporting responsibilities
* Provides the Chief input on the annual performance review linked with reapplication (refer to Appendix C)
* Supports ongoing performance monitoring and assists with remediation
1. Role of the CNE in the support of Privileged NP Practice
* Provides representation on Medical Advisory Committee for the purpose of advocating for interprofessional and NP contributions and relationship building.
* Provides formal representation on privileging and credentialing committee
* Provides oversight for the supervision of NP practice
1. NP Privileged Staff will align with the most appropriate Privileged Staff Department for their practice (Example Pediatrics, Emergency Medicine); attending appropriate meetings and participating in quality and other initiatives.
2. If a critical mass of related privileged NPs is achieved; consideration to forming an NP section (with a designated NP Section Chief) within one or more of the current privileged staff departments will be made.
3. In support of standardization and quality practice, NP Privileged Staff will align with the employee NP group.
4. The recruitment, selection and credentialing processes for privileged NP staff are as outlined in Privileged Staff By-Laws and the Credentialing and Privileging of LH Privileged Staff Policy and Procedures. The recruitment, selection and credentialing processes are supported through Medical Affairs and are linked with Program operational planning.

# CATEGORIES OF NP PRIVILEGED STAFF

The categories of privilege staff are as described in the LH Privileged Staff Bylaws – and delineate the types of privileges that may be granted NPs by the Board. The types of privileges granted are in large part dictated by the specific requirements of any given privileged NP vacancy and/or role. The descriptions below are fully aligned with privilege categories for Medical Staff, Midwives and Dental Staff.

1. Active;
* have admitting privileges unless otherwise specified in their appointment;
* attend patients and undertake treatment and operative procedures only in accordance with the kind and degree of privileges granted by the Board;
* be responsible to the Chief of Department to which they have been assigned for all aspects of patient care;
* act as a supervisor of other members of the Nurse Practitioner Privileged when requested by the Chief of Staff/Chair of the Medical Advisory Committee/CNE or delegate or the Chief of the Department to which they have been assigned;
* Fulfill such on-call requirements as may be established by each Department or Section in accordance with the Privileged Staff Human Resource Plan and the Rules and Regulations.
1. Associate;
* have admitting privileges unless otherwise specified in their appointment;
* work under the supervision of an Active Staff member named by the Chair of the Medical Advisory Committee or delegate to whom he or she has been assigned;
* undertake such duties in respect of patients as may be specified by the Chair of the Medical Advisory Committee or delegate, and, if appropriate, by the Chief of the relevant Department to which they have been assigned;
* Fulfill such on call requirements as may be established by each Department or Section and in accordance with the Privileged Staff Human Resources Plan and the Rules and Regulations and Policies.
1. Courtesy;
* have such limited privileges as may be granted by the Board on an individual basis;
* attend patients and undertake treatment and operative procedures only in accordance with the kind and degree of privileges granted by the Board;
* be responsible to the Chief of Department to which they have been assigned for all aspects of patient care.
1. Supportive;
* Provide support to the patient and/or members of the patient’s family and act as a liaison between the most responsible practitioner and the patient.
* visit their patients in hospital and review the health record;
* Document information relevant to the care of the patient on the patient record and progress notes but cannot make or record any orders.
* Note: Medical Affairs and Health Information Management facilitates computer access to the health information record without the requirement for formal privileging (in-progress).

5. Locum Tenens;

* Work under the supervision of an Active Staff member assigned by the Chair of the Medical Advisory Committee or delegate; and
* Attend patients and undertake treatment and operative procedures only in accordance with the kind and degree of privileges granted by the Board.

In general terms Active and Associate privileges would be only considered appropriate for NPs and other providers in a position to act as and fulfill the responsibilities of Most Responsible Practitioner as defined in the Most Responsible Practitioner, Consultants and Practitioner On-Call Policy (Appendix D).

Courtesy privileges would be appropriate for individuals who are meeting a more limited or specific service need.

Supportive privileges allow NPs and other providers the opportunity to engage and liase with the LH health team in support of patients and/or members of the patient’s family.

# SKILLS & QUALIFICATIONS REQUIRED FOR MEMBERSHIP NP PRIVILEGED STAFF:

The minimum qualifications to practice at Lakeridge Health (additional requirements are outlined in By-Law and policy) are as follows:

1. Demonstrated ability and willingness to provide patient care with the appropriate level of quality and efficiency
2. Demonstrated ability and willingness to practice within appropriate standards and to govern him or herself in accordance with established requirements
3. Baccalaureate Nursing Degree from a recognized University, Masters/Graduate preferred
4. Post-Baccalaureate Nurse Practitioner Specialty Program
5. Canadian Nurses Association Specialty Certification, if applicable
6. Certifications, if pertinent --- BCLS, ACLS, PALs, NRP, etc.
7. Clinical experience in a specialized area or field
8. Provincial membership in RNAO/NPAO which provides malpractice insurance of 10 million (Canadian Nurses Protective Society)
9. Registration with the College of Nurses of Ontario – Extended Class in good standing
10. College of Nurses of Ontario Annual Quality Assurance Program participation.
11. Up to date immunizations

# APPLYING FOR APPOINTMENT

Application processes for NPs applying for appointment and reappointment at LH are in accordance with the Public Hospitals Act and are outlined in the LH Privileged Staff By-Laws and in LH Policy. The overall process is outlined in Appendix B; a checklist of required information for that application for privileges is provided in Appendix E.

# Appendix A – Lead NP Role Description

**Lakeridge Health Position Profile**

**Position: Lead NP/NP Section Chief** **Effective Date:** (Draft)

**Reports to:** **Department Chief Revised:**

**Purpose of Position: (**Why does the position exist)?

The Lead NP/NP Section Chief, under the general direction of the Department Chief is the senior responsible practitioner for a privileged staff section or service. Primary responsibility is to support and enable the safe and effective delivery of high quality clinical services by the section/service a manner that is consistent with LH core values, and leadership and management competencies.

**Essential Duties of Position:** (How is purpose achieved?)

**Roles and Responsibilities** (additional detail is found in the LH Departmental Rules and Regulations)

***Quality of Care and Clinical Performance***

1. Ensures the organization of the members within the section/service in order to provide continuity of care and services.
2. Identifies, acts on and/or refers privilege staff professional practice and other practice/ operational issues to the Department Chief
3. Works with the Department Chief/CNE to implement any necessary corrective actions in circumstances where any patient is not receiving appropriate medical care;
4. Leads the development of the Quality Agenda for the section/service, linkage with CNE as appropriate
5. Supports the effective integration of Hospital clinical services within the larger regional framework by providing information, advice, and support to the development of regional services plans where requested.

***Sustainability***

1. Collaborates with the Department Chief/CNE in identifying the privileged staff human resource needs of the section/service;
2. Participates in the recruitment of new nurse practitioners and their subsequent orientation and monitoring.

***Culture and People***

1. Acts as a role model through the provision of leadership that demonstrates clinical knowledge, and expertise through positive relationships with Chief of Staff/CNE Department Chiefs and Program and Medical Directors;
2. Ensures regular two-way communication with nurse practitioners to convey expectations and resolve concerns and with patients/families/healthcare team members to convey/discuss patient issues;
3. Develops a monitoring process for Associate staff in association with the Department Chief;
4. Contributes to annual performance review and privileges granted for members of the section/service;
5. Promotes professional growth of the nurse practitioners within the section/service in order to improve the quality of care.

***Innovation and Learning***

1. Supports nurse practitioners implement and measure evidence-based best practices within the Section/service;
2. Champions innovative ideas and responsible risk taking.

**Qualifications Required to Perform at Full Working Level:** (Indicate mandatory credentials)

* Active member of LH Privileged staff (In the absence any qualified NP’s on active staff, this requirement would be waived)
* Education relating to leadership or commitment to complete
* Maintains active membership in relevant professional organizations and demonstrates responsibility for own professional development.
* High clinical standards and commitment to quality in healthcare.
* Working knowledge of hospital and privileged staff functions.
* Ability to communicate effectively
* Ability to create a team environment
* Demonstrates the following core competencies of Lakeridge Health: Competence, integrity, Consistency, Courage, Humility, Nurturing, Adaptability, and Communication
* Minimum two years of clinical experience.

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**Chief of Staff Chief Nursing Executive**

**Chief Nurse**

**CNE -------------------------------------------------------------------------------------------------------------**

 **Date**

**B**

**A** **= Human Resource Planning Processes** (Program Director, Medical Director, Lead NP Department Chief, Medical Affairs)

**B** = **Impact Analysis Process** (Program Director, Medical Director and Department Chief)

The Department Chief in partnership with the Lead NP leads the recruitment and selection process, with the support of Medical Affairs (MA). Note: For employed NPs – a traditional hiring process, with similar steps is led by the relevant program and supported by HR is followed.

1. Recruitment needs are informed by Privileged Staff HR Planning activities and/or occurs in response to a specific, verified need.
2. Selection committee is formed (refer to Selection Committee Terms of Reference); Composition includes:
	* Chair: Dept. Chief/designate.
	* Lead NP/ designate
	* At least one member from another department/section.
	* Program Director or designate
	* Other members as appropriate.
3. MA supports a range of recruitment activities; formal advertising is encouraged.
4. Initial Screening (based on needs and skill set requirements) of CV’s; potential candidates are flagged. The Chief or Lead NP conducts secondary screen; written references are requested from candidates who meet basic qualifications.
5. Interview process should addresses alignment and fit with LH and Department/program directions.
6. And 7. The Department Chief or Lead NP completes the verbal reference checks for preferred candidates. The reference process addresses clinical and behavioral competence (template available)
7. Candidates are be offered positions; service agreements are initiated (See D), conditional on receiving privileges
8. The Lead NP and the Department Chief complete the Department Chief Recommendation Report; which forms the basis of credentialing discussions going forward.

**C = Appointment/Credentialing Process**

* Application form issued; process supported by MA
* Review and recommendation at MAC Exec (Credentials) to MAC, to the Board

**D = Service Agreement Developed (**Process supported by MA)

* Appropriate in most circumstances but very important when position is linked to resources
* Ensure a common understanding of commitments and accountabilities

3. Engage in a range of recruitment activities

**Yes**

**No**

6. Preferred Candidate(s) identified

8. Candidate is considered suitable to fill the position

**No**

1. Determine need for specific specialty (ies) and skill set(s) Role description developed

4. Qualified Candidates identified, suitability verified through written references

7. Verbal reference checks completed (3)

**D**

**Yes**

**A**

2. Selection Committee Formed

5. Interviews completed

**C**

9. Candidate is offered and ‘accepts’ the position

10. Department Chief Recommendation Report is completed

APPENDIX B: RECRUITMENT/SELECTION PROCESS FOR PRIVILEGED NPs

Appendix C Annual Performance Review **– (Current (May, 2012) version (under review))**

**SECTION 5 – ANNUAL REVIEW (Not required for Courtesy Computer Access Only)**

**Good:** Consistently meets requirements

**Needs Improvement:** Improvement needed. Plan for improvement should be made in conjunction with the Department Chief or Service Lead, if applicable.

**Not Evaluated:** Performance criteria does not apply OR there is insufficient information to evaluate

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Good** | **Needs Improvement** | **Not Evaluated** |
| Maintenance and updating of professional skills and knowledge |  |  |  |
| Interpersonal relations (e.g. communication with patients, family, other multidisciplinary team members) |  |  |  |
| Appropriate utilization of resources |  |  |  |
| Health Record keeping |  |  |  |
| Contribution/attendance at Department Meetings and Rounds |  |  |  |
| Contribution/attendance at Medical/Hospital Committees |  |  |  |
| Response to on-call |  |  |  |
| Compliance with Most Responsible Practitioner (MRP) Policy |  |  |  |

**Lead NP Comments**:

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**Department Chief Comments**:

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**Plan of Improvement**:

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Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Privileged Staff Comments:**

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**I have reviewed the above evaluation**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note: **Signing off on the performance evaluation is a requirement to process your reapplication**. Signing off indicates that you have read the evaluation and does not necessarily indicate your agreement with it. If you would like to appeal this evaluation please refer to the **Privileged Staff Annual Performance Evaluation Policy** posted on the WAVE.

# Appendix D - Most Responsible Practitioner, Consultants and Practitioner On-Call Policy (draft)

|  |  |
| --- | --- |
| **Description: H:\My Pictures\Lakeridge Health logo.jpg** | **Most Responsible Practitioner, Consultants and Practitioner On-Call Policy** |
| Manual: Privileged Staff Manual | Document No.: |
| Section:  | Original Date: December 14, 2004 |
| Developed by:Medical Affairs | Revision Date(s): ~(current version is out for consultation – anticipated approval – October, 2012 |
| Approved by: Medical Advisory Committee  | Review Date: |
| Cross Reference to:  |
| Document Applies to: All Privileged Staff  |
| ***A printed copy of this document may not reflect the current, electronic version on Lakeridge Health’s Intranet, ‘The Wave.’ Any copies of this document appearing in paper form should ALWAYS be checked against the electronic version prior to use.*** |

**Purpose**

The provision of hospital based health care services requires that privileged staff be available to attend to patient care needs on a 24/7 basis.

As part of the responsibilities of appointment to the privileged staff, it is required that those with relevant privileges participate in the provision of Most Responsible Practitioner (MRP) and/or participate on call for MRP/consultant services. At LH, authorized Nurse Practitioners (NPs) may also fulfill these roles.

The purpose of this policy is to delineate and standardize the MRP, consultant and practitioner on-call key accountabilities and responsibilities in order to order to facilitate, accountability for patient care, patient safety and medical quality, effective team functioning and communication and appropriate bed allocation, patient flow and discharge planning.

**Policy**

The MRP is integral to the provision of quality health care, to the promotion of continuity of care and to the delivery of appropriate medical services. When appropriate to the care of the patient, the MRP will request a consultation with another Privileged staff member/LH NP.

Every patient admitted for care and treatment at LH (in-patient and registered outpatient) must have a designated MRP whose name is clearly identified in the patient’s health care record at all times during the patient’s hospitalization period.

All practitioners who are appointed to the active or associate staff participate in the provision of on-call services. Courtesy staff may be asked to participate or, in recognition of their access to hospital resources, be required to provide coverage by the Department Chief. NP on call resources will be considered when critical mass or needs and supports as required are determined.

Privileged Staff may as a result of age, disability or years of service apply to their section or department for reduced on call responsibilities. The section/department must consider the impact on future recruitment; the ability of the other members to provide on-call coverage and other relevant factors and only reducing the member’s on call responsibilities if coverage can be maintained and is sustainable. The section/department decision can be revisited as circumstances change.

Privileged staff who reduce their on call commitment should expect to have a proportional reduction in access to elective resources. (Refer to Departmental Rules and Regulations)

**Definitions**

**Most Responsible Practitioner** is the Physician, Midwife or Nurse Practitioner member of the LH privileged staff, with the appropriate privileges or a LH Nurse Practitioner that has primary responsibility for coordinating and directing the care of a specific patient.

**Consultant/Consulting Practitioner** is the member of the LH privileged staff, with the appropriate privileges or a LH Nurse Practitioner attending the patient at the request of the MRP unless/until care is transferred by physician/NP order and accepted.

**Procedures**

# **Designating MRP**

# Patients Admitted Directly To The Hospital, Day Surgical Unit Or Outpatient Clinics

# The Physician/NP who orders the admission will be designated the MRP.

# Patients presenting to the Emergency Departments (ED)

# Patients who present themselves will be seen by the Emergency Room (ER) Physician/NP who will be the MRP until care of the patient is transferred to another Physician/NP, or the patient is discharged from the ED.

# If a practitioner who is not the on duty ER Physician/NP arranges to assess a patient in the ED directly, then he/she must contact the ED prior to the patient’s arrival and will be expected to attend the patient within a reasonable period of time. This Physician/NP will be the MRP.

# Where an ER Physician/NP consults with another member of the privileged staff/LH NP and the consultant recommends admission of the patient the consultant will become the MRP, if agreeable after discussion with the Emergency Physician/NP.

# If the consultant, after assessing the patient, is of the view that the patient would be more appropriately cared for by another Specialty they will discuss this personally with the Physician/NP on-call for the other Specialty and arrange for admission with the acceptance of that physician/NP and the agreement of the referring ED physician/NP. In the interim, the ER Physician/NP will continue to be the MRP. The consultant must provide suggestions for care and ongoing management of the patient to the ER Physician/NP and the accepting physician/NP.

#

# When the consult referral is from a LH site other than the consultant’s primary hospital site, either (as appropriate) a telemedicine consult will be arranged or the patient will be transferred or will present to the consultant’s site ED. As per 1.2.2., the consultant must contact the ED prior to the patient’s arrival and will be expected to attend the patient within a reasonable period of time. This Physician/NP will be the MRP for the patient.

# The practitioners admitting patients through the ER should, through the team, remain in contact with the patient flow coordinator in order to ensure maximum efficiency of resource utilization.

# If the admission cannot occur on that site, as MRP, the consultant should arrange the admission of the patient and transfer of care to a colleague on an alternative site.

# When resources preclude the provision of care within LH then, as MRP, the on-call consultant is expected toassist in arranging for assessment of the patient at a facility outside Lakeridge.

# A transfer of accountability will occur for all patients in the ED that have not been discharged or transferredto an accepting MRP at the time of the ER physician/NP shift change. This transfer of accountability will take place upon the acknowledgement of the accepting ER physician/NP during a verbal discussion between the transferring and accepting ER physicians/NPs. The transferring ER physician/NP is responsible to document the name of the accepting ER physician/NP, along with the date and time of the transfer in the chart.

# At some sites the ER Physician/NP may continue as the MRP of the patient once the patient has been admitted.

# Patients registered or admitted for Dental Procedures

# If a Dentist is performing an outpatient dental procedure without an attending Physician/NP, the Anesthetist performing the anesthetic will be responsible for carrying out the duties of the MRP in the Operating Room and Post-Operative area.

# If a patient is admitted to an Inpatient Unit for a dental procedure the Dentist will arrange for a Practitioner with appropriate hospital privileges to assume the role of MRP. This Practitioner may be the patients Family Physician/NP, a hospitalist, or specialist as appropriate.

# **Responsibilities of the MRP**

# The MRP is responsible for directing and coordinating all medical care required by a patient while registered with/admitted to LH.

# The MRP is responsible for ensuring that they are available in person or by appropriate communication channels, 24 hours a day, 7 days a week or clearly articulate the delegation to an appropriate individual or group.

# As MRP, a practitioner will:

# Be identified throughout a patient’s hospitalization.

# Be aware of each patient for whom they are responsible. When accepting care from the transferring MRP, review with the transferring MRP the current medical orders for care of the patient.

# Assess and examine the patient, document his/her findings on the chart and issue the applicable order(s) for the patient as warranted by the patient’s initial condition (within 24 hours of admission or acceptance of transfer of care or sooner)

#

# Indicate the admitting diagnosis of the patient upon admission and ensure discharge planning is initiated from the day of admission and communicated to the patient/family and health care team.

# Take the lead in coordinating care of the patient by attending to the patient as frequently as their condition warrants, (minimum daily for acute patients), including appropriate and timely assessment, diagnosis, ordering necessary tests and procedures; reviewing and acting on test results and documenting plan of care, outcomes and treatment and discharge plans.

# Complete decisions, treatment plans and progress, in accordance with LH documentation standards - with the appropriate frequency to accurately reflect the changing clinical condition of the patient.

# Actively communicate and collaborate with the interdisciplinary team and consultants as necessary to optimize patient care through rounding and other means.

# Respond appropriately to new urgent problems and take accountability for the patient’s need while MRP (even if not related to original reason for registration/admission).

# Communicate effectively and collaborate with the patient, their family and/or other support systems, and the substitute decision maker as appropriate.

# Take the lead in managing ethical issues related to the care of the patient.

# Complete requests for consultations with clear rationale, baseline information and the reason for the consultation. (Refer to Section 5. Consultations)

# Communicate, transferring accountability for care, with physicians "on call" for him or her

# Designate patient as Alternate Level of Care (ALC) in accordance with provincial policy.

# Respond, within a reasonable time period, to requests for input on continuing medical problems.

# Discharge patient from hospital to another facility (including LH Complex Continuing Care or Rehabilitation) or home/LTC, with appropriate instructions/prescriptions and referrals for community support and care and timely completion of the final note/Discharge Summary.

#

# **Short Term Transfer of MRP Responsibility; after hours and weekend coverage**

# The MRP may transfer responsibility for the care of a patient to another appropriately credentialed member of the LH Privileged Staff or a LH Nurse Practitioner. The MRP shall advise the members of the health care team of the delegation and document the delegate’s name and position on the patient’s health record unless the MRP is designated as a service.

# The MRP can be designated as a service rather than an individual if it fulfills the criteria in terms of coverage and notification and is appropriate for the hospital and patient care.

# **Full Transfer of Care to another MRP**

# The transfer of a patient’s care may be necessary to ensure continuity of care and access to appropriate medical services. This should occur only if necessary during the acute care stay.

# Refer to Section 1.2 Designating MRP for transfer of care relating to patients admitted through the EDs

# Where an in-patient transfer of care is deemed appropriate by the MRP, the MRP shall personally contact the intended accepting practitioner to obtain an agreement to accept transfer of care. Personal notification is expected in all circumstances.

# The potential MRP should be notified as far in advance as possible, preferably 24 hours prior to the possible transfer.

# The potential MRP should notify a team member covering for him/her of possible transfer, particularly if the weekend is the likely time of transfer

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# The transfer of care takes place upon the acknowledgement of the accepting practitioner during verbal discussion between the transferring MRP and the accepting MRP. The transferring MRP is responsible to document the name of the accepting MRP (either for self or on behalf of the group/service), along with the date and time of the verbal discussion that has occurred between the two practitioners in the chart.

# The MRP assuming responsibility shall acknowledge acceptance of the transfer by written notation on the order sheet. Until notification and acceptance of the patient is confirmed by the accepting MRP, the responsibility for the patient remains with the transferring MRP, including care and documentation in the health record

# The accepting MRP or designate shall assess and examine the patient, document the findings and issue applicable order(s) assoon as warranted by the patient’s condition but not longer than 24 hours after accepting the transfer.

# Refer to section 3, Responsibilities of the MRP for ongoing accountabilities

#

# **Consultations and the Role of the Consultant**

# Physician/NPs are encouraged to obtain appropriate consultations that facilitate and enhance patient care. In the event a consultation is requested, the MRP shall:

# Where possible, notify the patient and/or the patient’s family/legal guardian of the purpose of the consultation and the name of the consultant.

# Communicate directly with the consultant physician/NP, or their designate, for any patients requiring an in-hospital consultation unless there is an approved automatic consultation process for a specified service in place.

# Ensure that the reason(s) and purpose for the consultation request is appropriately documented on the patient’s health record.

# The consultant or designate shall assess, examine the patient and document the findings, opinions and recommendations on the patient’s health care record as soon as warranted by the patient’s condition but not longer than 24 hours from receipt of notification unless otherwise arranged.

# Parameters for the role of the consultant are outlined below:

# Consultation Only - Consultant asked to make an assessment and provide management suggestions. Suggestions will be written within the consult note and/or progress notes. The consultant is not expected to write ongoing orders or to provide follow-up. The MRP remains the same; the consultant does not write orders.

#

# Consultation with Directive Care - The consultant assists with the ongoing care of the patient including writing appropriate orders and follow-up. The consultant is not the MRP; the referring physician/NP remains MRP. Clarification of any orders will first be the responsibility of the physician/NP writing the orders with the MRP responsible for final clarification if necessary.

# Consultation with Continuing Care/Transfer of Care - Consultant assumes care of the patient and becomes the MRP. This initiates a transfer of care and the consultant accepts care of the patient as the MRP.

# In the absence of clear direction as to the intent of the consult, direct communication by the consultant with the MRP should be undertaken for clarification. The default obligation of the consultant is an appropriate review, examination and recommendations only.

# If a consultant has been referred a patient and it is the opinion of that consultant that the patient would be best assessed by another member of their service or by a different specialty then the consultant should directly contact the second consultant when requested by the referring MRP.

# Refer to Section 1.2 for additional information relating to consultations to the ED

# **Identifying the MRP On The Patient Care Units**

# MRP will be documented on the Doctor’s order sheet.

# The census reports will indicate the MRP.

# MRP will be recorded and updated in Kardex.

# **On-Call Procedures**

# MRPs and Consultants on call should have one system to be contacted when on call. The long range pager is made available to physicians/NPs by the hospital for this purpose. This, or another approved device (i.e. personal device with a LH phone network compatible carrier) is the preferred method.

# For services where MRP responsibility is shared by a group, the Department or Section Chief/Lead NP or an identified delegate will be responsible for ensuring that a schedule of coverage for the service is made readily available to the health care team.

* 1. Similarly, each Consultation Service is expected to provide a roster of appropriately privileged staff/LH NPs available for emergency consultations.

# The on-call schedules of coverage will be posted/published in advance, through locating and any changes made to the schedule will updated immediately by locating upon notification.

# It is the responsibility of the individual physician/NP to find a replacement if they will not be available to cover their shift.

# It is the responsibility of the privileged staff member making the change to notify Locating who will then update the on call file

# **Accessing MRPs and Consultants; Paging and Escalation Procedures**

# Practitioner is on-call: Page the physician/NP via Locating (3200). If there is no reply within a reasonable amount of time (15 minutes), page a second time.

# If there is still no reply after a reasonable amount of time (additional 15 minutes), page the Section Chief/lead NP or their delegate. If there is no Section Chief identified or no response from the SectionChief/delegate (within 15 minutes), then page the Department Chief or their delegate. The Section/Department Chief/lead NP or their identified delegate will be responsible for providing/arranging coverage for the service.

# If there is no response from Section/Department Chief /Lead NPor their delegates, page the Chief of Staff or their delegate. The Chief of Staff or his/her identified delegate will be responsible for arranging coverage for the service.

# If there is no response from the Lead NP or their delegates, page the Chief Nursing Executive or their delegate. The Chief Nursing Executive or his/her identified delegate will be responsible for arranging coverage for the service.

# Practitioner is not on-call: Page the practitioner via Locating. If there is no reply within a reasonable amount of time, page the practitioner who is on-call for that service.

# **Response time**

# An appropriate response time to a page or text either in person, (electronically) or by telephone is 15 minutes or less.

# The decision of how urgently the patient needs to be seen will be determined as a joint decision of the team member requesting input/attendance, the MRP and on-call privileged staff member or the referring privileged staff member and the consultant after face to face, telephone (or electronic) discussion.

# **Dispute Resolution**

# Disputes relating to designating the MRP status that cannot be resolved between the involved Practitioners will be referred to the Section or Department Chief(s), lead NP of the Section(s)/Department(s) involved, or if necessary, to the Chief of Staff or in the case of an NP the Chief Nursing Executive.

# In the event that there is disagreement between a member and their section/department, around a request for exemption from providing on-call services, the on-call schedule or another related matter, a privileged staff member and/or Department Chief may request that MAC review the situation and recommend an appropriate resolution.

# Appendix E - APN/NP Role Description:

Competencies are the specific knowledge, skills, judgment and personal attributes required for a registered nurse to practice safely and ethically in a designated role and setting (CNA, 2005).

**Core competencies for advanced nursing practice** are based on an appropriate depth, breadth and range of nursing knowledge, theory and research, enhanced by clinical experience.

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| --- | --- |
| **Clinical** | An advanced practice nurse integrates extensive clinical experience with theory. Research and in-depth nursing and related knowledge to:* Develop multiple advanced assessment and intervention strategies within a client-centred framework for individual clients, communities and populations;
* Use qualitative and quantitative data from multiple sources, often in ambiguous and complex situations. when making clinical decisions and initiating and managing change;
* Analyze the complex interaction of sociological. psychological and physiological processes, determinants of health and clients' lived experience;
* Anticipate and explain the wide range of client responses to actual or potential health problems and recommend action;
* Guide decision-making in complex clinical situations;
* Engage clients and other team members in resolving issues at the individual, organizational and health -care system levels;
* Identify and assess trends or patterns that have health implications for individuals, families. groups or communities;
* Generate and incorporate new nursing knowledge and develop new standards of care, programs and policies;
* Plan, initiate, coordinate and conduct educational programs based on needs. priorities and organi2.1tional resources; and
* Manage a wide range of patient responses to actual and potential health problems.
 |
| **Research** | An advanced practice nurse is able to:* Identify and implement research-based innovations for improving client care, organizations or systems;
* As either primary investigator or collaborator with other members of the health-care team or community, identify, conduct and support research that enhances or benefits nursing practice;
* Evaluate current practice at individual and system levels in light of research findings;
* Collect data on, and evaluate the outcomes of, advanced nursing practice for clients, the nursing profession and the health-care system;
* Critique, interpret, apply and disseminate evidence-based findings; and
* Contribute to nursing and the health-care system by disseminating new knowledge through formal and informal channels, including presentation and publication at the local, regional, national and international levels.
 |
| **Leadership** | An advanced practice nurse demonstrates leadership by:* Advocating for individuals, families, groups and communities in relation to treatment, the health-care system and policy decisions that affect health and quality of life;
* Identifying the learning needs of nurses and other members of the health-care ream and finding or developing programs and resources [0 meet those needs;
* Mentoring and coaching nursing colleagues. other members of the healthcare team, and students;
* Advocating for and promoting the importance of health-care access and advanced nursing practice to nurses and other health professionals, the public, legislators and policy-makers:
* contributing to and advocating for an organizational culture that supports professional growth, continuous learning and collaborative practice;
* Evaluating programs in the organization and the community and developing innovative approaches to complex issues;
* Understanding and integrating the principles of resource allocation and cost-effectiveness in organizational and system -level decision-making;
* Identifying gaps in the health-care system and developing partnerships to facilitate and manage change;
* Developing and clearly articulating a vision for nursing practice, influencing and contributing to the organization's and the health -care system's vision and implementing approaches to realize that vision;
* Advising clients, colleagues, the community, health-care institutions and policy-makers on issues related to nursing. health and health care;
* Identifying problems and initiating change to address challenges at the individual, organizational or system level; and
* Understanding legislative and socio-political issues that influence health policy and building strategies to improve health, health-care access and healthy public policy.
 |
| **Consultation/****Collaboration** | A nurse in advanced practice is able to:* Initiate timely and appropriate consultation, referrals and collaboration with other health-care providers;
* Consult and collaborate with members of the health-care ream to develop quality-improvement and risk-management strategies;
* work with others to gather and synthesize qualitative and quantitative information on determinants of health from a variety of sources;
* Practice collaboratively and build effective coalitions;
* Apply theories related to group dynamics, roles and organizations;
 |

# Appendix F - Privilege Application Checklist

**LAKERIDGE HEALTH CORPORATION**

**NURSE PRACTITIONER**

**Required Information to Apply for Privileges**

Completed Application Form

 Current CV

Scope of Practice/Job Description

Current College of Nurses of Ontario Registration/extended practice – in good standing

Specialty Certification Courses

 University Degree(s)

 Postgraduate/Baccalaureate Nurse Practitioner Diploma(s)

 RNAO/NPAO Memberships/Malpractice Insurance

Three References (verbal and written) (NP, leadership, interprofessional)

 Completed Medical Surveillance Form