Anna Moller
Georgian Bay
General Hospital

Michelle Acorn
Lakeridge Health

CARING FROM START TO

Enhanced powers for NPs translate into more timely,

Last fall, Tom* was admitted to the complex care unit at Georgian Bay General Hospital. He had suffered a stroke, but also had a number of other pre-existing health concerns. In the year preceding his admission, Tom had one foot amputated due to infection. He had coronary artery bypass surgery, after which he had congestive heart failure. And he suffered from hypertension and required appointments with an ophthalmologist in Toronto for diabetic retinopathy, an eye disease that causes blindness.

Nurse practitioner Anna Moller says she wasn't sure Tom was ever going home. "He had so many health concerns, we didn't even know if he was going to survive."

Moller co-ordinates care on the unit where Tom was admitted, and plays a key role on the interdisciplinary team. She was responsible for assessing Tom's emotional wellbeing, monitoring his liver and kidney diseases and ensuring treatment was provided quickly if he showed any signs of heart failure.

Moller says the team worked hard to make his dream of returning home possible. Five months after arriving, he was almost ready for discharge. But before he could go, Moller had to make sure the right community supports were in place. She connected him with a prosthetic podiatrist and a social worker, and made arrangements for his transportation to the ophthalmologist. She also referred him to a specialist who would treat his hypertension.

While NPs have long been involved in the process of preparing patients for discharge, they have not always been able to give the order to go home. July marked one year since that changed.

Prior to July 1, 2011, Ontario physicians delegated discharge orders to NPs by way of medical directives. Changes to Regulation 965 of the *Public Hospitals Act, 1990*, and subsequent regulatory changes by the College of Nurses of Ontario, now allow NPs to discharge hospital in-patients within their scope of practice. NPs with hospital privileges working in the community can also discharge their patients from hospital. RNAO and one of its expert groups, the Nurse Practitioners' Association of Ontario (NPAO), played a central role in these milestones, advocating for a number of years, and appearing before a government committees that examined the proposed changes. This advocacy led to the changes a year ago, and also to changes in July that allow NPs in Ontario to admit and treat in-patients, the first jurisdiction in North America to legally authorize these enhanced powers.

The changes have made a difference on many hospital units, such as surgical units. In the past, NPs may have had to wait hours for surgeons to finish operating before discharge orders could be issued. Being able to discharge a client means more timely care, which Moller says means faster access for those who are waiting for beds.

The less time a patient like Tom has to spend in hospital, the better, she adds, because a faster discharge also means less exposure to infection and superbugs such as MRSA and VRE. "Patients don't want to be in a hospital," she adds. "They want to be home."

** A pseudonym has been used to protect privacy.*

Pam Hubley
Toronto's Hospital
for Sick Children

Vanessa Burkoski
London Health
Sciences Centre

FINISH

direct and efficient care, faster access, and greater accountability. **BY MELISSA DI COSTANZO**

Nationwide, Ontario has the largest number of NPs (2,064) working in the health-care system. These nurses have the authority to diagnose and treat illnesses, and, as of October 2011, can perform additional care acts and treatment procedures like setting/casting bone fractures and prescribing most medications – all without a medical directive.

RNAO and NPAO are thrilled with the legislative changes that took effect last year, and with the newest change – the ability to admit and treat in in-patient hospital units – that came into effect July 1. But both have always known that NPs are capable of taking on much more responsibility, and have advocated strenuously for the removal of roadblocks that prevent NPs from practising to their full scope. The work has paid off. In 2010, when the government announced NPs would eventually be able to discharge in-patients, it also confirmed they can order lab tests, diagnostics and treatments for hospital in-patients, and order insured services for their patients.

No one knows the value of these changes better than Michelle Acorn.

Acorn was president of NPAO when the province announced it was introducing admit and discharge changes that would enhance her capacity as an NP. "They formally recognized the role," she says. "They transformed health-care leadership and empowered nursing and advanced practice nursing."

Acorn says the enhanced abilities to admit, treat and discharge in-patients allow NPs to conduct their role in a more direct, efficient manner. And she has many examples to back up her claim.

Before the changes came into effect, Acorn could only provide in-patient care through doctors' orders. NPs working in emergency or an out-patient clinic didn't need medical directives for specific acts that were under their scope of practice, she explains. "But as soon as they went on the elevator to in-patient care, they had to have medical directives. Their practice was not even recognized." These barriers were frustrating, restrictive, and didn't recognize the knowledge and skill NPs possess, she says. The changes have "altered my practice significantly" because they've made work seamless, and cleared the red tape.

Acorn is the advanced practice nurse professional practice leader at Lakeridge Health in Durham region. Given her 13 years of experience as an NP, she was asked to co-chair an RNAO-led nurse practitioner expert panel, which was formed in response to the legislative changes to the role. The group was charged with developing a toolkit that provides documents, communication strategies, and presentations that assist with NP implementation and evaluation in hospitals.

Lakeridge, she says, has a strong NP presence. In fact, NPs began admitting and discharging patients five years ago because the hospital is a leader in maximizing the NP role in complex care and rehabilitation. They were doing so, however, under a shared care plan. This means Acorn and a physician would be listed on admit and discharge orders.

College of Nurses of Ontario numbers from 2011 indicate there were 900 primary care NP positions, compared to 122 in acute care, and 106 in emergency care. There were also 128 positions in geriatrics, 95 in education, and over 700 in other areas.

Beginning July 1 of this year, Acorn became the sole practitioner listed on an admission order, which she says translates to consistent care. Previously, NPs with no admitting privileges at a hospital would send their patient to the ER to be admitted. After being triaged, the patient would wait to be admitted by someone who wasn't familiar with their ongoing health needs. Now, an NP who is familiar with their client's history can admit and follow their care, in and out of the hospital.

This change also means NPs are more accountable to their patients, which causes Acorn to caution: just because you can, doesn't mean you should, unless you have the competency, knowledge and skill. She suggests nurses ask themselves: "what does it take to improve that competence to match my confidence?" This question can be answered with the help of nursing leadership, she says. Chief nursing executives and chief nursing officers must keep abreast of role changes to ensure everyone is on the same page and supported.

Changes to the position, Acorn says, have been "very rewarding." She has heard from many patients who have expressed gratitude for the timely care she has provided. "That's really the best measure, isn't it?" The proof also lies in the outcomes. In a 2008 survey of 91 patients at Lakeridge, 92 per cent said they received prompt treatment from an NP, and 97 per cent indicated an NP was easily accessible to patients and families. Ninety-two per cent of respondents said they were comfortable with their NP's care decisions.

Given it is a leader when it comes to enabling NPs to work to their full scope of practice, Lakeridge has had time to anticipate the changes, and has implemented the role of professional practice leader and lead NP (roles held by Acorn), and amended the bylaws, rules, regulations, policies and procedures to embrace full scope of practice. Other Ontario hospitals are still trying to understand what the change means for NPs in their facilities.

Toronto's Hospital for Sick Children is still thinking through the change, says Pam Hubley, Chief, Professional Practice and Nursing. It's safe to say, she adds, that the legislative changes have increased the authority of the NP to improve flow within the system.

Hubley, who was a member of RNAO's nurse practitioner expert panel, agrees that enhancements to the NP role will improve continuity of care and caregiver, particularly in remote and rural communities. The NP, who is often the main provider in a smaller town, can assess a patient in a community clinic, determine the need for hospital care, admit the patient to a local hospital, work with a team to provide care, and then discharge the patient.

"The power to admit, treat and discharge in in-patient hospital units is groundbreaking, and is optimizing the role of the NP in Ontario's health-care system," says RNAO CEO Doris Grinspun, who, like others, believes there is still more work that needs to be done. A handful of items under *Bill 179*, the *Regulated Health Professions Statute Law Amendment Act,* have not yet been proclaimed, including permitting NPs to: order CT scans; perform point-of-care lab tests; and apply forms of energy such as a defibrillator or electrocoagulation treatment.

NPs are one step closer to prescribing controlled substances. To read more, visit www.RNAO.ca/NPprescribing

Vanessa Burkoski, vice-president of professional practice and chief nursing executive at London Health Sciences Centre, co-chaired the NP expert panel alongside Acorn. The RNAO board member was also Ontario's provincial chief nursing officer (2007-2011). She is confident these items will be passed, especially with the powerful advocacy of RNAO and NPAO.

In the meantime, the panel, with the support of RNAO Nursing Policy Analyst Sara Clemens, will monitor, collect, and evaluate data related to patient and hospital outcomes as a result of NPs' enhanced abilities. The panel is developing a quality improvement project for hospitals that have adopted the discharge piece, and will identify processes that have led to success.

Burkoski says she will continue to advocate for the role because the future for NPs is brighter than ever. These changes acknowledge NPs' critical role in the system and "enable NPs to do what they've always done – take the lead in advocating for what patients need." **RN**

MELISSA DI COSTANZO IS STAFF WRITER AT RNAO

CALENDAR

SEPTEMBER

September 20–22
RNAO ASSEMBLY AND BOARD OF DIRECTORS MEETINGS
Hyatt Regency on King and RNAO home office
Toronto, Ontario

September 27
PRECEPTORSHIP FOR NURSES WORKSHOP
Toronto, Ontario

September 30–October 5
HEALTHY WORK ENVIRONMENTS INSTITUTE
Hockley Valley Resort
Orangeville, Ontario

OCTOBER

October 15
LEADERSHIP FOR NEW GRADS WORKSHOP
Windsor, Ontario

October 17–19
LONG-TERM CARE LEAGUE OF EXCELLENCE
Toronto, Ontario

Unless otherwise noted, please contact events@RNAO.ca or call 1-800-268-7199 for more information