**Key questions for hospitals to consider when implementing NP inpatient authority and FAQs**

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Hospitals considering implementing or expanding nurse practitioner (NP) authority relating to admission, treatment, and discharge are encouraged to complete an impact analysis that considers issues of:

* Access
* Flow,
* Patient experience
* Outcomes in terms of both quality and cost-effectiveness.

To guide this impact analysis, hospitals are encouraged to consider the following questions:

1. **Organizational profile:**
2. What is the average length of time that patients spend in the emergency department before being admitted?
   1. What is the source of delays?
   2. What is the patient impact when delays occur?
   3. What is the cost incurred by the organization for delays?
   4. What is the system impact when delays occur?
3. How are patients ranking the quality of their inpatient stay?
   1. How do patients feel about the continuity of care they’ve received?
4. How often is discharge delayed because an authorized provider is unavailable?
   1. What is the patient impact when delays occur?
   2. What is the cost incurred by the organization for delays?
   3. What is the system impact when delays occur?
5. How would you rate your organization’s performance in the following areas:
   1. 30-day hospital re-admission
   2. 30-day mortality
6. Using your answers to the above, consider:
   1. How is your organization’s performance trending over time?
   2. How does your organization’s performance compare to similar facilities that are utilizing NPs?
7. Is your organization a RNAO Best Practice Spotlight Organization® (BPSO®)?
   1. Have you considered how the NP role can improve the adoption of evidence-based practices?
   2. Does your organization use Nursing Quality Indicators for Reporting and Evaluation® (NQuIRE®)[[1]](#footnote-2) to collect, report and analyze quality improvement data?
   3. Have you considered how the implementation of NPs can improve nursing-sensitive quality indicators submitted to NQuIRE®?
8. **How are NPs currently being utilized in your hospital?**
9. How would you describe the practice setting? (e.g., in-patient/out-patient, combination, etc).
10. What are two-three key indicators that your organization is focusing on?
    * 1. Consider the evidence-based impact that maximizing the utilization of NPs within your organization will have on these indicators.
11. How many NPs are currently employed and privileged at your hospital?
    1. How many FTEs does this equate to?
    2. How many NPs are forecasted to become credentialed and privileged?
12. What is the model of care delivery current in place specific to NPs?
    1. Most Responsible Provider (MRP)?
    2. Shared/collaborative care?
    3. Consultative?
13. Is there currently a requirement for developing and authorizing medical directives or other documents to enable NP practice to meet the needs of the patient population they currently serve?
    1. Have you archived medical directives no longer required with authorized scope of practice changes?
14. How will admission capacity be supported by NPs to improve patient care?
    1. Consider length of time and patient experience.
15. How do NPs currently participate in treatment and discharge practices?
16. **How will the authority to admit, treat and discharge patients influence NP practice?**

Recent legislative and regulatory amendments remove barriers and enhance accountability to enable NP practice (see section of this toolkit entitled "Key drivers").

1. What barriers to implementation exist in your hospital?
2. What enablers for implementation exist in your hospital?
3. What innovation is possible with NPs' new authority, both now and in the future?
4. **What is the state of “NP readiness” to adopt admission, treatment and discharge roles that are consistent with recent legislative and regulatory changes?**
5. Are there frameworks and policies in place to articulate the role and responsibilities of NP practice?
6. Are existing frameworks and policies consistent with the revised regulatory standards?
7. What is the level of understanding of NPs around authorizing mechanisms and legislative changes related to their practice?
8. What supports are in place for NPs, (e.g., mentors, continuing education, NP professional practice leaders) to optimize outcomes?
9. What is the current credentialing and privileging process for NPs who are practising in the community and are not employed by your hospital?
10. **What is the state of organizational readiness to adopt NP admission, treatment and discharge roles that are consistent with recent legislative and regulatory changes?**
11. What is the level of understanding of the organization (e.g., administration, management, staff) regarding the legislative and regulatory changes? What strategies should be implemented to enhance the organization’s level of understanding?
12. Are there policies in place to define specific safety reporting procedures (e.g., for abnormal or critical laboratory and diagnostic values after hours)?
13. Is there language in hospital bylaws / rules and regulations that require amendments in order to enable NPs to admit, treat and discharge inpatients?
14. Are there relevant inter-professional practice policies that need to be developed or revised?

**Frequently Asked Questions (FAQs) that may be encountered during impact analysis:**

**Is there evidence to support the cost-effectiveness of NPs caring for hospital patients?**

Yes, there is evidence in the literature to suggest NPs provide safe, cost-effective care for hospital patients. Much of the literature is from the U.S., where the NP role in hospitals is well established. For further details, as well as a sample cost-benefit analysis, please see the section of this toolkit called "Economic Analysis".

**Who is accountable to meet patient care needs?**

NPs are accountable for all clinical assessments, orders and decisions they make. NPs work within their legal scope of practice based on their knowledge, skill and judgment to meet patient care needs while collaborating with others as needed. If NPs care for patients for whom a physician colleague is the Most Responsible Provider (MRP), NPs practice collaboratively within an autonomous scope to provide the best possible care.

**What are the liability implications for the hospital?**

NPs are hospital employees, similar to RNs, physiotherapists and others for whom the hospital also shares vicarious liability. In addition, NPs who are members of RNAO have $10 million personal liability protection through the Canadian Nurses Protective Society.

**Do all NPs need to be privileged?**

According to Regulation 965 of the *Public Hospitals Act, 1990*, NPs who are employed by hospitals do not require privileging or credentialing, whereas NPs who are not employed by the hospital do require privileging and / or credentialing in order to admit, treat or discharge inpatients. Furthermore, hospital boards must identify the criteria for appointment and reappointment of NPs. This may require amendments to professional staff by-laws.Having an NP on your privileging and credentialing committee is considered advantageous. Key linkages with the Chief Nursing Executive may further support the quality of NP practice.

For further information, please see the section of this toolkit called `NP Admission`

1. NQuIRE helps organizations track nursing sensitive indicators. For more information, please see the section of this toolkit called "Tools for Evaluation" [↑](#footnote-ref-2)