



Diffusing Innovative Roles Within Ontario Hospitals: Implementing the Nurse Practitioner as the Most Responsible Provider

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Table 2.

Decision-making stages and LHW-specific process examples

Stage	LHW-specific process examples
<p>Knowledge: Expose adopters to the innovation</p> <p>Explain: – What it is – How it works – Why it works</p>	<p>Hospital-employed NP-as-MRP model encompasses autonomous and consistent care from in-patient admission, during treatment, until discharge or death, without physician supervision</p> <p><i>How it works:</i> A full NP complement (3 FTE) covers patient care</p> <ul style="list-style-type: none"> • Each NP has an admission capacity of 24–26 patients with surge capacity • NPs work 0800–1600 weekdays • On-call processes (hospitalists) within the hospital cover evenings and weekends • Seniors to be admitted to geriatric rehabilitation and alternative level of care /complex continuing care are admitted with the NP as the MRP • Formal medical consults for specialists are made by the NP using their specific Ontario Health Insurance Plan number. For the unlikely situation that a consultation is refused, the Medical Director or delegate will act in a liaison capacity • NPs are credentialed with the College of Nurses of Ontario to prescribe controlled drugs and substances • Diagnostics such as computed tomography, magnetic resonance imaging, and point of care testing remain outside the scope of NP practice at this time. The Medical Director authorizes medical directives for the NPs to allow timely care requests. Application of physical restraints requires consultation with the Medical Director <p><i>Why it works:</i></p> <ul style="list-style-type: none"> • NPs are self-regulated and accountable to ensure professional competencies regarding their knowledge, skill and judgment to ensure safe practice and a quality work environment • The model improves timeliness and continuity of care by reducing inconsistencies in care delivery experienced with multiple MRPs in the physician model • The model meets the need of enhancing senior healthcare, and chronic disease management optimization • Value-add aspects of NP leadership and education enhance staff capacity to adhere to best, and evidence-based, practice and improve team cohesion • Value-add aspects of NP research knowledge allow for quality improvement initiatives such as reducing polypharmacy, minimizing physical restraints, reducing falls and use of urinary catheters
<p>Persuasion: Develop perceptions of the innovation</p> <p>Reduce uncertainty by encouraging questions</p> <p>Address the risks and benefits</p> <p>Disseminate knowledge locally and externally</p>	<p><i>What specific actions addressed uncertainty?</i></p> <ul style="list-style-type: none"> • Model plan was developed collaboratively between the Lead NP, Director of Medical Affairs, the Chief Nursing Executive, Program Director and Medical Director • Review of hospital by-laws required a clear definition of MRP that was inclusive of NPs, dentists and midwives • NP medical directives were simplified to address only those items limited to physicians • Connection with HIROC. Presentation of the NP-as-MRP model (HIROC conference) • A Professional Practice NP role with dedicated time to support NP role implementation and ongoing effective utilization • Lead NP participation with professional organizations (OHA, RNAO) on development of NP-as-MRP toolkits <p><i>What risks and benefits were addressed?</i></p> <ul style="list-style-type: none"> • Renegotiation of medical support for diagnostic testing and other aspects of care outside current NP scope of practice, as either medical directive or direct referral (impact decreasing with ongoing legislation changes) • Formal consultation negotiation with the Medical Director for prescribing substance not authorized for NPs (minimal impact since April 2017) • Transfer of accountability processes to emergency departments developed: NPs would clearly identify themselves as the MRP, provide their NP OHIP billing number and give a concise patient report. Repatriation of the stabilized patient is assured <p><i>Plans for early dissemination</i></p> <ul style="list-style-type: none"> • Local newspaper, Toronto Star and television spotlights (CTV, TVO Agenda, Rogers TV). Local and provincial conference presentations
<p>Decision: Choice to adopt or reject the innovation</p> <p>Create faith that the innovation is possible by offering a trial</p>	<p><i>What is the decision? (adopt, trial, adopt later, reject)</i></p> <ul style="list-style-type: none"> • Trial adoption with reassessment at 18 months, and now at 5 years for sustainability <p><i>What will the trial look like?</i></p> <ul style="list-style-type: none"> • Two-stage trial plan on two specific in-patient units (staging based on staged legislated authority). As of July 1, 2012, the full NP-as-MRP model includes in-patient admission, full accountability for care decisions and discharge
<p>Implementation: Put the plan into action</p> <p>Identify potential problems and provide potential solutions prior to implementation</p> <p>Address actual problems and collaborate on solutions in a timely manner</p> <p>Plan evaluation</p>	<p><i>What potential problems and solutions were considered?</i></p> <ul style="list-style-type: none"> • Patient or family member refusal to be admitted with NP as their MRP. <i>Solution:</i> Discussion in advance of admission. Provision of clearly written brochures of NP-as-MRP model expectation upon transfer to facility • Interprofessional team members not working collaboratively with NP. <i>Solution:</i> shift in language where the “P” (in MRP for example) shifts from “physician” to “provider,” “practitioner” or “prescriber” throughout hospital language. Continued role clarity education • Negative talk of the NP-as-MRP model within the unit or within the hospital. <i>Solution:</i> NP acceptance to build, maintain and enhance trust in self as confident and not opportunistic, and in the NP role as competent (Hurlock-Chorostecki et al. 2014) <p><i>What measurement was planned?</i></p> <ul style="list-style-type: none"> • Patient demographics (age, sex, capacity) • Patient dispositions per quarter (admissions, transfers, deaths and discharges) • Patients, family members and staff satisfaction survey with NP-as-MRP care
<p>Confirmation: Adopters will continue to seek information in the form of reinforcement</p> <p>Decision choices: – Continue – Adopt later – Discontinue the adoption – Continue the rejection</p>	<p><i>What continued supportive information was provided?</i></p> <ul style="list-style-type: none"> • The NP-as-MRP model at LHW received provincial and federal government recognition as the province’s first implementation • Quarterly reports of gathered statistics to senior leadership • Measurement revealed the NPs prescribed appropriately and responded promptly to changing patient conditions. Satisfaction survey indicated patient care was timely, effective and based on best practice. The NP-as-MRP model offers seniors quality and safe care and staff valued working in the NP-as-MRP model (Acorn 2015) • International attention networked Israel and Australia with LHW to explore the NP-as-MRP model <p><i>Re-evaluation – what decisions are being made today?</i></p> <ul style="list-style-type: none"> • NP on-call is being considered