In my expert opinion, the nursing staffing model in the OSMH Pre-Admission Clinic should be two (2) Registered Nurses.

I strongly disagree with the recommendation of my colleagues on the Independent Assessment Committee (IAC) regarding the Staffing Model in the Pre-Admission Clinic that "does not rule out a role of the RN" in the Pre-Admission Clinic (PAC) over and above that of having a Resource Nurse in the Day Surgery Unit available to the RPN for consultation.

This recommendation is weak, vague and supported by insufficient evidence; and does not address the issues and nursing care and practice concerns presented to the IAC in any meaningful way as related to the current staffing model in the PAC, which is 1–2 RPNs/shift.

After reviewing the Three Factor Frame Work from the College of Nurses of Ontario, consulting with both the Ontario PeriAnesthesia Nurses Association (OPANA), and the National Association of PeriAnesthesia Nurses of Canada (NAPAN©), and reviewing data comparing Industry Standards for Pre-Admission/Assessment Clinics in other Ontario Hospitals; I have no choice but to conclude that my IAC colleagues have not considered nor provided me with **documented evidence based on best practices** to support their recommendation related to the nursing staffing model in the PAC.

1. Review of the **Three Factor Frame Work,** according to the **College of Nurses of Ontario** (CNO) in relation to its application to the Pre-Admission Clinic:

Client Factors:
In my view it is inaccurate of the IAC to characterize Pre-Admission Clinic (PAC) patients prior to surgery or anesthesia, as being "less complex" at the time of their Pre-Admission appointment.

The Nurse responsible for performing the comprehensive surgical pre-assessment must assess patients for their status level according to the American Society of Anesthesiologists (ASA) Patient Status Classification, which includes co-morbidities and overall health status, and the ability to withstand anesthesia and surgery with the focus of reducing negative risks/outcomes for that particular surgical patient. The nurse is assessing for potential surgical and anesthetic risks, and the assessment is systematic, intensive and complex utilizing a variety of secondary sources. This assessment includes the need to recognize when to refer for anesthetic and/or other consultations, the need for laboratory and diagnostic testing, and the appropriate post operative care that can be anticipated to be necessary upon discharge to the community.

The need for an RPN to consult with an RN increases as the client's situation becomes more complex. The more complex the care requirements, the greater the need for consultation and/or the need for an RN to provide the full spectrum of care.

OPANA states that the PeriAnesthesia Nurse's interviewing and assessment skills identify actual or potential problems that may adversely affect patient care during the surgical and anesthetic experience. The Canadian Nurses Association (CNA) states in their article Nursing Staff Mix: A Key Link to Patient Safety *"The consequences of uninformed and cost-driven decision-making can be serious: the nursing staff mix itself may create the conditions that could lead to clinical errors and result in negative outcomes for patients, nurses and organizations."* (CNA, 2005)

The outcome of an inadequate assessment of any patient in the Pre-Admission Clinic may result in a negative outcome for the patient if she/he is not properly optimized for surgery. The Union's submission to the IAC outlined several incidences (documented on PRWRFs and RMPs) where surgeries have been delayed or cancelled as a direct result of inadequate assessment of patients in the Pre-Admission Clinic. The IAC has failed to appropriately consider this evidence.

Nurse Factors:

Autonomous practice is described as the ability to make decisions and independently carry out nursing responsibilities. RPNs have greater autonomy to care for clients with less-complex conditions, while RNs can autonomously provide care to clients regardless of the complexity of their conditions. *"The more complex the client situation and the more dynamic the environment, the greater need for the RN to provide the full range of care, assess changes, re-establish priorities and determine the need for additional resources."* (CNO, 2011, p.11).

Pre-Admission Clinic nursing assessments require critical inquiry skills, an in-depth knowledge of pathophysiology and experience in all types and techniques of anesthesia and surgery.

Examples would be but not limited to:
- Further assessment and knowledge of those at high risk for perioperative hypothermia and perioperative nausea and vomiting can prevent the incidence of either with their resulting effects/outcomes (surgical site infections, aspiration, dehiscence of wounds, etc.).
- Hemodynamic instability in relation to existing co-morbidities and the effects of each type of anesthesia/surgery on each co-morbidity
- Respiratory status/distress and the effects of existing co-morbidities on airway management including history of obstructive sleep apnea
- Neurological status in relationship to pre-existing co-morbidities, and the effects of anesthesia/surgery on these, renal status, etc.
- Knowledge of all types of anesthesia/surgical risks and negative outcomes of each is necessary in order to best instruct the patient on the type of anesthesia that will be offered to them, including postoperative pain management and the event of rescue analgesia, effects and side-effects of long-term neuraxial anesthesia versus regional blocks and effects/side-effects of prolonged regional anesthesia.

The Nurse in the Pre-Admission Clinic must be educated and trained on the efficient, effective and safe patient optimization for surgery and anesthesia, which includes knowing when and how to refer for consultation, what type of testing and investigations are required, with sufficient planning for post operative care including community resources in place prior to surgery.

The IAC commented that the CNO's 'Entry to Practice Competencies for Ontario Registered Practical Nurses' describe the use of critical thinking skills by RPNs. The IAC states *"it would be a display of a gap in critical thinking to make assumptions of the staff member's ability to apply critical thinking, based on whether the nurse has "RN" or "RPN" designation beside their signature."*

The IAC is making this statement out of context as they have failed to consider or include the CNO's 'National Competencies in the context of Entry Level Registered Nurse Practice' which state that RNs use critical inquiry. *"This term expands on the meaning of critical thinking to encompass critical reflection on actions. Critical inquiry means a process of purposive thinking and reflective reasoning where practitioners examine ideas, assumptions, principles, conclusions, beliefs and actions in the context of nursing practice. The critical enquiry process is associated with a spirit of inquiry, discernment, logical reasoning and application of standards."* (CNO, 2009, p.22) As such, the IAC has failed to differentiate the level of depth and breadth between the practice of RNs and RPNs, and the use of critical inquiry by RNs vs. critical thinking by RPNs.

Overall, critical and scientific inquiry is required by nurses assessing patients in the PAC. The patients presenting to the PAC require the advanced assessment skills of an autonomously practicing RN.

Environmental Factors:
The CNO describe the environmental factors as including practice supports, consultation resources and the stability/predictability of the environment.   The availability and accessibility of consultative resources must be considered. Depending on the complexity of client care needs, consultation may result in receiving advice or transferring care. An RN must be immediately available to consult and collaborate with an RPN, or to assume transfer of care.

"The less stable these factors are, the greater the need for RN staffing. The less available the practice supports and consultative resources are, the greater the need for more in-depth nursing competencies and skills in the areas of clinical practice, decision-making, critical thinking, leadership, research utilization and resource management." (CNO, 2011, p. 11)

The Hospital has not implemented the required practice supports, and this is supported by the IAC. The IAC goes as far as to state *"Unless the practice environment and its respective supports substantially increase having a RN present in the Pre Assessment Clinic may be beneficial"*, yet they fail to make a meaningful recommendation addressing this issue.

While the IAC acknowledges that there are recurrent issues around consent processes, they fail to adequately address the lack of sufficient practice supports in the PAC. The IAC has ignored the importance of the advanced assessment and interviewing skills of the RN in ensuring accurate and informed consent.

Further, a Registered Nurse is not immediately available to consult with or to assume transfer of care. The "Resource Nurse" to the RPN carries a full patient assignment, and is physically located in Day Surgery on a different floor of the Hospital. I would also like to highlight that since the implementation of the RPNs into the Pre-Admission Clinic, it has been extremely rare for an RPN to consult with an RN regarding the assessment of the Surgical Patient. This is despite documented evidence on both PRWRFs and Risk Monitor Pros (RMPs) related to ongoing inadequate nursing assessments in the PAC. This concerns me greatly, and signals a lack of knowledge regarding self-recognition of limitations of individual competence, and the need/requirement to consult with RNs when this limit is exceeded. The IAC has agreed with this perspective, and has stated: *"The IAC was also concerned with hearing from Day Surgery RNs who assume the role of Resource Nurse for the Pre-Assessment Clinic (PAC) that they do not receive calls for collaboration from PAC. While the IAC could accept that calls may not be required on an hourly or even daily basis, the total absence of calls was seen as of concern in the context of patient care."* However, the IAC has failed to make any meaningful recommendations to address this concern.

Overall, an analysis of the CNO's Three Factor Framework indicates that the appropriate category of care provider in the Pre-Admission Clinic is the Registered Nurse.

<u>2. Consultation with the Ontario PeriAnesthesia Nurses Association (OPANA) and the National Association of PeriAnesthesia Nurses of Canada (NAPAN©)</u>

Nurses are expected to adhere to **industry standards, best practices and or professional standards, which are written and approved by Health Care Professionals.** The standard of care that nurses will need to meet is an objective standard, a standard that is generally accepted by other nursing professions. (*Canadian Nurse and the Law*; JJ Morris, second edition p. 154)

This is supported by the IAC report in the section titled Standards of Practice for Perioperative RNs:
"The OPANA, NAPAN and ORNAC Standards of Practice provide a framework for competency development for Peri-Anesthesia/Operative Nursing practice. A <u>standard </u>is a desired and achievable level of performance against that which can be measured as actual performance…Standards are written evidence based, best practices defining the performance of specific "specialty" nursing practice that is predetermined and acceptable to authority".

The CNA Position Statement: Staff Mix Decision-making Framework for Quality Nursing Care (CNA, 2012) highlights that decisions concerning staff mix must reflect nurses' scope of practice, and conform to legislation and professional standards. The use of outcome

measurement data must be rigorously used by administrators to inform decision making regarding safe and effective staffing practices.

Neither the Hospital nor my IAC colleagues should arbitrarily choose to follow only some of the OPANA and NAPAN© Standards to suit their means and/or operating budgets. **Professional Association Standards** are **best practices** founded upon and grounded in **evidence-based** research and expert opinion, and should be **supported in their totality** to ensure the delivery of safe, ethical and competent nursing care.

My findings as a result of my consultation with OPANA and NAPAN©, which I shared with the IAC, are described below:

Ontario PeriAnesthesia Nurses Association (OPANA):
The Ontario PeriAnesthesia Nurses Association (OPANA) President has advised me in an e-mail that the current 6th edition of the standards are currently under review. She was unable to share any potential revisions with me at this time, as once the Standards Committee has completed their work; all standards will be reviewed by professional advisors to OPANA (medical and nursing) and by the OPANA Board of Directors.

Despite this, the IAC has stated *"In a recent conversation by an IAC member with the OPANA it was understood that it should come as no surprise that the next issue of the standards will align with the CNO's in that using the term 'nurse' will be applicable to both the RN and RPN."*

It is dangerous for the IAC to place any weight on such a theoretical and vague statement which can only be described as hearsay, and to assume that this means that there will be no differentiation between the role of the RN and the RPN as currently exists in the OPANA Standards, simply because OPANA might, in future, use the term "nurse" to describe both categories.   The CNO uses the term "nurse" to describe both categories, but clearly delineates both the similarities and differences in practice expectations between RNs and RPNs.

Thus to date, there is no concrete evidence regarding what content might or might not be contained in the next version of the OPANA Standards, and it is irresponsible and unacceptable of the IAC to make assumptions, and base their recommendations on those assumptions.

It is important to note that the Hospital's brief, the OSMH's unit policies and the IAC make references to OPANA standards continuously, yet they choose to deliberately ignore the one pertinent component that has brought the parties to the forum of an Independent Assessment Committee Hearing. **The 2009 OPANA Standards clearly state that Registered Practical Nurses are not the appropriate care provider in the Pre-Admission Clinic. OPANA only refers to the PeriAnesthesia Nurse as a care provider within this unit, who they have made very clear is a Registered Nurse. OPANA Standards only reference the RPN as "may" be considered part of the nursing care team in Phase II recovery and beyond, and further**

rule out autonomous RPN practice in those environments, stating that they must never work alone. (OPANA, 2009. p. ix, 54, and 197)

National Association of PeriAnesthesia Nurses of Canada (NAPAN©):
The president of NAPAN© has advised me in writing, in an official capacity on behalf of the NAPAN© Executive, that they are currently revising their 2011 standards, and will publish again in May, 2014. Further, NAPAN© indicates that OPANA is the only provincial association that continues to write/publish standards. Should they continue to do so, NAPAN© states that OPANA must align their Standards with the National Standards for Practice, or show clear evidence that their revised Standard is correct, and that the National Standard is incorrect. To date, the OPANA Board has not indicated or disclosed any specific details regarding revising their standards of practice to the NAPAN© Board of Directors. In any event, OPANA agreed to, and approved of, the National Standards for Practice, 2011 (2nd edition).

I refer you to the attached letter dated February 13th 2013, from the NAPAN© President regarding NAPAN©'s position on R/LPNs working in Pre-Admission/Assessment Units. **NAPAN© clearly states that it seems unreasonable to consider the R/LPN for a role in the Pre-Admission Clinic. Further, NAPAN© states that there is a wealth of qualitative and quantitative evidence supporting the autonomous role of the RN in the PAC, and it would not be best practice to include R/LPNs in this unit.** The letter concludes that *"It seems unlikely that NAPAN© will revise the standards to recommend that this role will now be taken on by R/LPNs who do not have the assessment skills to perform the kind of in-depth assessment required of the PeriAnesthesia Nurse".*

There is no ambiguity in NAPAN©'s written position, and it is troubling and unacceptable that my IAC colleagues are failing to give NAPAN©'s expert opinion any weight in their deliberations. NAPAN© is comprised of the provincial associations, and an Associate member of the Canadian Nurses Association (CNA). NAPAN© worked with CNA to implement the designation of PeriAnesthesia Nursing as a Specialty in June, 2010, and on the formation of the content of the certification examination, which is based on the National Standards for Practice (NAPAN©, 2011, 2nd edition).

By declining to consider NAPAN©'s expert written position, and by giving more consideration to unsubstantiated, theoretical and vague potential changes to the OPANA Standards (which can only be best described as hearsay), my IAC colleagues are failing to recommend a model of care in the Pre-admission Clinic that provides for safe, ethical and competent patient care and ensures patient safety and optimal patient outcomes.

Both the OPANA and NAPAN Standards describe the in-depth and advanced interview and systematic assessment skills required by nurses in the Pre-Admission Clinic, and the level of critical inquiry necessary to assess and evaluate surgical and anesthetic risks that may adversely affect patient care. **Overall, an analysis of both the OPANA and NAPAN© Standards currently clearly outline that the PeriAnesthesia Nurse working in the Pre-Admission Clinic is a Registered Nurse.**

3. The Comparison of Industry Standards for Pre-Admission/Assessment Clinics in other Ontario Hospitals:

The ONA submission to the IAC outlined at page 66-69 their survey of all Ontario Hospitals which showed:
- 117 Hospitals report having a Pre-Admission Clinic, and of these:
- 101 report an all RN skill mix model = 86%
- 13 reported an RN/RPN mix = 11%
- 3 reported an all RPN skill mix = 3%

The IAC has chosen to ignore this data that shows unequivocally that OSMH is not meeting industry standards or best practices in regards to their staffing model of their Pre-Admission Clinic, as an **overwhelming 86%** of Ontario Hospitals with PACs utilize an **all RN skill mix**.

4. Conclusion:

For the reasons above I strongly dissent to any and all references pertaining to the Pre-Admission Clinic (PAC) Staffing Model within the IAC Report. My recommendation is to revert back to an all RN model of care in the Pre-Admission Clinic at the OSMH to ensure optimization of the surgical patient and decrease the risks of negative outcomes.

Dated in Sault Ste Marie Ontario, March 17, 2013

ONA Nominee Glenda Hubley RN CPN © RNFA

Attachment: Letter from NAPAN©

1506 Craigleith Road,
Oakville, ON, L6H 7W3.
T/F: (905) 257-7522
info@napanc.org; www.napanc.org

February 13, 2013.

To Whom It May Concern:

RPNs in the PreAdmission Unit: NAPAN©'s Position

The National Association of PeriAnesthesia Nurses of Canada (NAPAN©) is an Associate member of the Canadian Nurses Association (CNA). The CNA represents Registered Nurses and Nurse Practitioners only, and does not represent the RPN or LPN.

As such, NAPAN© is a Canadian national association for **Registered Nurses** working in all domains of the PeriAnesthesia environment. The NAPAN© *Standards for Practice,* 2nd ed. (2011) reflect practice guidelines for Registered Nurses only.   This document is entirely evidenced-based. NAPAN© does not include RPNs/LPNs in these standards, since it is the role of the RN to work in all perianesthesia areas. In the NAPAN© *Standards for Practice*, the "PeriAnesthesia nurse" is defined as a "Registered Nurse" (see definitions) throughout the document.

As per the NAPANc Mission Statement (2011):
"The National Association of PeriAnesthesia Nurses of Canada (NAPAN©) promotes *leadership to PeriAnesthesia nurses in education, research and adapting to evolving practices in client and health services needs within the Canadian health care system* by:

- Advancing professional, **competent**, efficient, compassionate PeriAnesthesia **nursing** practice through ongoing educational opportunities that identify current, comprehensive practice **standards."**

"Nurse" is defined in the "Definitions" section of the *Standards for Practice* 2nd ed., 2011, as "**Nurse:** Refers to a Registered Nurse in this document" (NAPANc, 2011, p. 241).

Historically, the initial assessment now being completed in the PreAdmission unit (PAU), was completed by the Anesthesiologist the night prior to surgery with the client who was admitted to hospital for preoperative assessment, diagnostic testing, and if required, treatment (i.e. blood transfusion, medication, etc.) to optimize the client undergoing anesthesia. In the 1990's with the introduction of day surgery procedures and admission on the day of surgery this role was transitioned to the Registered Nurse who received extensive training and education in

assessment, evaluation and identification of client needs. Although, initially there was some mistrust by the Anesthesiology community, confidence in the role of the RN to perform this vital and autonomous role has developed over time. It seems unreasonable now to consider the RPN for this role.

There is a wealth of qualitative and quantitative research available in the literature comparing the RN to R/LPN care throughout multiple health care settings, which all indicate that best practice and best client outcomes are met with an all RN staff, and secondly to higher ratios of RN:RPN nurse staff mixes. The evidence supports the autonomous role of the RN in the PAU. To include R/LPNs in this location of the hospital would not be best practice. It would also create a burden on the RN staff to monitor the practice of the R/LPN while performing other client assessments. We would refer you to the Canadian Nurses Protective Society website:

"Because the nurse is responsible for evaluating nursing care by monitoring patient outcomes, she must supervise workers to whom she has delegated. Supervision entails initial direction, periodic inspection and corrective action when needed." (CNPS, 2013: Retrieved from http://www.cnps.ca/index.php?page=90)

We have attached literature to support our findings. We could find nothing which points to the R/LPN role in PAU or other ambulatory setting. There is no evidence-based research to support the R/LPN role showing improvement in client outcomes. The opposite is the case: increased surgical cancellations, missed information, and increased hospital admissions following surgery.

It seems unlikely that NAPAN© will revise the standards to recommend that this role will now be taken on by R/LPNs who do not have the education or assessment skills to perform the kind of in-depth assessment required of the PeriAnesthesia nurse.

The next and 3rd edition of the NAPAN© *Standards for Practice* are due for publication in May 2014.

Sincerely,

Paula Ferguson, President NAPANc 2009-14,

on behalf of the NAPANc Executive, 2013.