SEIU NURSING DIVISION Healthcare

Quality Assurance Workbook 2012

Opening Comments

"Nurses display care by healing touch, by advocacy on behalf of patients and by ethical practice, all of which reflect the respect with which we hold those placed in our care."

Dear colleagues,

On behalf of my Sisters and Brothers at SEIU Local 1 Canada, I am honoured to wish you a very happy 2012 Nursing Week! We celebrate you, our valued Nursing Professionals and your important contributions to our healthcare system.

Indeed, there is no profession as challenging, exhilarating and rewarding as being a Nursing Professional. It can also be exhausting, uplifting, emotionally draining and yet, still wonderful.

This Nursing Week, I hope you take extra pride in the work you do; I know your union does!

As you are aware, the College of Nurses of Ontario (CNO) requires that every Nursing Professional in our province complies with its Quality Assurance Program. To assist you with this, SEIU has put together this user-friendly workbook. It is your responsibility to complete the two standards modules identified by the CNO. You must keep this completed workbook for two years as the College conducts yearly random audits.

In addition to the Practice Standards, we have also included pertinent updated regulations from the Regulated Health Professionals Act from which our profession evolves.

Again, I want to wish you all a happy Nursing Week. I sincerely thank you for the work you do.

In Solidarity,

Carol McDowell
Nursing Division President
SEIU Local 1 Canada

THE REGULATED HEALTH PROFESSIONS ACT

History of the Regulated Health Professions Act

The Regulated Health Professions Act (RHPA, 1994) has been in the making since 1982, when the Health Professions Legislation Review Committee was formed. First Reading of the RHPA was given to the Ontario Legislature on April 2, 1991 by then Health Minister Evelyn Gigantes. A similar Act was introduced in 1990 by then Health Minister Elinor Caplin, but the subsequent provincial election stopped the "Regulated Health Professions Act" (RHPA, 1994) from proceeding.

Following first and second readings of the RHPA it was referred to the Standing Committee on Social Development for public hearings, clause-by-clause examination, and amendment. The College of Nurses of Ontario made two submissions to the Standing Committee on Social Development. The RHPA replaces eight pieces of legislation that govern eighteen professions. It replaced the Health Disciplines Act and became law December 31, 1993.

In 2009, *The Regulated Health Statute Law Amendment Act (2009)* (Bill 179) receive Royal Assent in 2009. The amendments introduced greater accountability and oversight mechanisms to the RHPA to (gave more power to the "regulate the regulators") most notably through the supervisors and the auditor provisions. Unlike previous powers of the state under the RHPA these are directed beyond the councils to potentially include staff and committees. The minister has however indicated that this would only be used in situations whereby "as a last resort in the event patient safety is compromised."

Why was the RHPA Implemented?

When the review of the health professions legislation began in 1982, there was pressure from various stakeholders to change the existing regulatory legislation, *The Health Disciplines Act.* Members of the public were expressing doubts about the openness and responsiveness of governing bodies. There was a move towards a more interdisciplinary approach to health care and therefore a need for regulatory system that allowed the consumer a greater freedom of choice. Several unregulated health care groups were pressuring the Ministry of Health to become regulated. Health professions regulated by outdated statues were seeking to be regulated under the Health Disciplines Act. Health care administrators were expressing a sense of frustration with the rigidity that the existing regulatory system imposed on their ability to employ the most efficient and cost-effective mix of health care providers. Finally, it was recognized within government itself that the existing legislation made policy direction coordination difficult to achieve for the health care professionals.

Presently, increasing health care costs with less financial resources existing in health care today, places new demands on a system for change. This means that with this financial crisis a new system needed to be created so that alternatives to health care delivery could be pursued.

The overall purpose of the RHPA (1994) is to unite twenty-three professional groups into a selfregulating framework to achieve the following:

1. Protect the public interest
2. Recognize professional provider autonomy
3. Ensure professional competence is achieved and maintained, and
4. All professionals contribute towards health care.

(Regulated Health Professions Act: An Overview for Nursing. RHPA Information Sessions (1994, 1997).

HISTORY OF THE RHPA

- Initiated in 1982 - Health Professions Legislation Review Committee
- First Reading - April 2, 1991
- Replaced Health Disciplines Act
- Became law - December 31, 1993
- Revised , The Regulated Health Statute Law Amendment Act (2009) (Bill 179)

RHPA - WHY THE CHANGE?

- increase openness & responsiveness of health care system
- consumer freedom of choice
- greater public participation in regulation of health care professions
- recognize provider autonomy
- improve government's ability to coordinate health care policy
- self-regulating framework to protect public
- flexibility in care delivery
- cost-effective skill mix

(Regulated Health Professions Act: An Overview for Nursing. RHPA Information Sessions (1994, 1997).

Artemis Nurse Consultant/Rothwell Nurse Consultant (2006)

THE LEGISLATION	KEY PROVISIONS
Regulated Health Professions Act (RHPA)	• Establishes Minister of Health's powers • Establishes Health Professions Regulatory Advisory Council • Establishes Health Professions Board • Established 13 Controlled Acts • Requires all Colleges to prepare and submit annual report
REGULATIONS UNDER RHPA	• Authorizes regulations prescribing forms of energy, identifies exemptions of controlledacts
NURSING ACT	**PROCEDURAL CODE**
Elements prescribed in the Procedural Code which apply to all health regulatory Colleges	• Establishes College Councils • Establishes statutory committees: Complaints, Discipline, Patient Relations • Permits College to recommend regulations • Requires College to provide French language
NURSING ACT SPECIFICS	• Determines nursing's scope of practice • Established three authorized acts for nursing • Provides title protection
REGULATIONS UNDER THE NURSING ACT	• Authorizes regulations including those related to Committee members, election of Council, entry to practice fees and professional misconduct guidelines.

WHY IS UNDERSTANDING SELF-REGULATION IMPORTANT TO ME AS A PROFESSIONAL NURSE?

As a professional nurse, understanding the concept of self-regulation is important because of its definition. Self-regulation defines the practice of any given profession, and describes the parameters within which it should function, including the requirements and qualifications to practice the nursing profession. The College of Nurses of Ontario's ultimate responsibility is to protect public interest from unqualified, incompetent and unethical health care providers. There are two important aspects about self-regulation. First, the consumer rights must be protected and promoted through the advocacy role of the nurse. Secondly, the public lacks the specialized knowledge about their health and the health care system. Therefore, because of this unequal balance of knowledge and power, health care professionals have be monitoring their own professions to insure the public of ethical and safe practice.

WHAT IS SELF-REGULATION?

For any profession, there are two approaches to regulation. The first one is regulation by the government (or third party); and self regulation by the profession.

With self-regulation, the government delegates to a profession the power to regulate its members/peers. The intent is not to advance the profession, but to promote and protect the public interest.

In 1989, a report entitle, "Striking a New Balance", was prepared by the Health Professions Legislation Review (HPLR), to create a comprehensive review of the regulation of health professionals in Ontario. The fundamental principle of this report is outlined below:

> *"The public is the intended beneficiary of regulation, not the members of the professions. Thus the purpose of granting self-regulation to a profession is not to enhance its status or to increase the earning power of its members by giving the profession a monopoly over the delivery of particular health services."*
>
> *(Health Professions Legislative Review: Striking a New Balance, 1989)*

The foundation of self-regulation rests with the concept that the profession has a commitment to the philosophy that public protection comes first. This regulation assures the public that they are receiving safe and ethical care from competent, ethical and qualified nurses. It defines the practice boundaries of the nursing profession, including the requirements and qualifications to practice. Self-regulation allows a professional body to act on behalf of the government in regulating its members. The government realizes that the profession has unique knowledge necessary to establish standards of practice and evaluate its membership.

Quality Assurance – College of Nurses of Ontario (2012)

The College of Nurses of Ontario (CNO,2012) bases its QA Program on the principle that lifelong learning is essential to continuing competence. The Regulated Health Professions Act, 1991 requires that each health regulatory college develop, establish and maintain a quality assurance program that:

- promotes continuing competence and continuing quality improvement to one's nursing practice
- addresses changes in the practice environment
- incorporates standards of practice, advances in technology, entry-to-practice competencies and interprofessional care.

The CNO meets this obligation through its QA Program, which includes the following components:

1. Self-Assessment
2. Practice Assessment and
3. Peer Assessment.

Component 1: Self Assessment

All members participate in this 2 step process

Part A:

This process involves:

- Reflecting on your practice
- Obtaining peer input to determine your strengths and areas for improvement
- Developing your learning goals

Part B: developing and maintaining a learning plan to meet your learning goals

If randomly selected you participate in components 2 and 3

Component 2: Practice Assessment

- Submit your learning plan to the college
- Participate in specified assessments

Component 3: Peer Assessment

A college assigned peer assessor will:

- Review your learning plan and practice assessment results
- Make recommendations to the QA Committee

The QA Committee will then decide if you are requires to participate in remedial activities.

COLLEGE OF NURSES OF ONTARIO QUALITY ASSURANCE (2012) COMPONENT 1 – SELF-ASSESSMENT

Self-Assessment is a self-directed, two-part process that results in a Learning Plan. You must participate in this component. Through the Self-Assessment process, you identify your learning needs in relation to the two practice documents selected for the QA Program. The practice documents for 2012 are:

- Therapeutic Nurse Client Relationship Revised (CNO, 2006)
- Documentation Standard (CNO, 2008)

Part A: Practice Reflection

Determining your strengths and areas you need to improve by reflecting on your practice and obtaining peer input will help you to continually improve your competence as a nurse. Peer input builds on practice reflection by providing greater awareness of your strengths and opportunities for learning. Use the results of Practice Reflection to create your learning goals.

Part B: Developing and maintaining a Learning Plan to meet your learning goals

The results of Practice Reflection will form the basis of your Learning Plan. Your Learning Plan is a record of your ongoing participation in activities that help maintain your competence as a nurse. The plan outlines how you relate practice standards to your nursing practice. It articulates learning goals based on your Practice Reflection, and the activities you will undertake to achieve those goals. The College expects you to continually update your Learning Plan and to keep each Learning Plan for two years.

SEIU Healthcare has created the two (2) following selfassessment tools for you to review your practice as it relates to the Therapeutic Nurse Client Relationship (2006) and Documentation (2008) practice standards.

PRACTICE STANDARD

COLLEGE OF NURSES OF ONTARIO
ORDRE DES INFIRMIÈRES ET INFIRMIERS DE L'ONTARIO
THE STANDARD OF CARE.

Therapeutic Nurse-Client Relationship, Revised 2006

Table of Contents

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario

THE STANDARD OF CARE.

OUR MISSION is to protect the public's right to quality nursing services by providing leadership to the nursing profession in self-regulation.

OUR VISION is excellence in nursing practice everywhere in Ontario.

Therapeutic Nurse-Client Relationship, Revised 2006 Pub. No. 41033

ISBN 1-897308-06-X

First published March 1999 as *Standard for the Therapeutic Nurse-Client Relationship*
Reprinted January 2000, October 2000, October 2002
Reprinted January 2005 as *Therapeutic Nurse-Client Relationship*
Revised June 2006 as *Therapeutic Nurse-Client Relationship, Revised 2006.* Reprinted May 2008. Updated June 2009.
Updated footnote May 2013.

Additional copies of this document may be obtained by contacting CNO's Customer Service Centre at 416 928-0900 or toll-free in Ontario at 1 800 387-5526.

College of Nurses of Ontario
101 Davenport Rd.
Toronto, ON M5R 3P1

www.cno.org

Ce fascicule existe en français sous le titre : *La relation thérapeutique, revisée 2006* n° 51033

Nursing standards are expectations that contribute to public protection. They inform nurses of their accountabilities and the public of what to expect of nurses. Standards apply to all nurses regardless of their role, job description or area of practice.

— College of Nurses of Ontario

Introduction

At the core of nursing is the therapeutic nurse-client relationship. The nurse[1] establishes and maintains this key relationship by using nursing knowledge and skills, as well as applying caring attitudes and behaviours. Therapeutic nursing services contribute to the **client's**[2] health and well-being. The relationship is based on trust, respect, empathy and professional intimacy, and requires appropriate use of the power inherent in the care provider's role.

This document replaces the 1999 *Therapeutic Nurse-Client Relationship* practice standard, and provides greater clarity and direction on:

- giving gifts to and receiving gifts from clients;
- accepting power of attorney on behalf of clients;
- setting appropriate **boundaries** for the relationship;
- identifying and dealing effectively with unacceptable and/or abusive behaviour in nurse-client relationships; and
- exercising professional judgment when establishing, maintaining and terminating a therapeutic relationship.

The College of Nurses of Ontario's (the College's) practice standards apply to all nurses, regardless of their role or practice area. The College publishes practice standards to promote safe, effective, ethical care, and to:

- outline the generally accepted expectations of nurses and set out the professional basis of nursing practice;
- provide a guide to the knowledge, skill, judgment and attitudes required to practise safely;
- describe what each nurse is accountable for in practice; and
- provide guidance in the interest of public protection.

Components of the nurse-client relationship

There are five components to the nurse-client relationship: trust, respect, professional intimacy, empathy and power. Regardless of the context, length of interaction and whether a nurse is the primary or secondary care provider, these components are always present.

Trust. Trust is critical in the nurse-client relationship because the client is in a vulnerable position.[3] Initially, trust in a relationship is fragile, so it's especially important that a nurse keep promises to a client. If trust is breached, it becomes difficult to re-establish.[4]

Respect. Respect is the recognition of the inherent dignity, worth and uniqueness of every individual, regardless of socio-economic status, personal attributes and the nature of the health problem.[5]

Professional intimacy. Professional intimacy is inherent in the type of care and services that nurses provide. It may relate to the physical activities, such as bathing, that nurses perform for, and with, the client that create closeness. Professional intimacy can also involve psychological, spiritual and social elements that are identified in the plan of care. Access to the client's personal information, within the meaning of the *Freedom of Information and Protection of Privacy Act*, also contributes to professional intimacy.

Empathy. Empathy is the expression of understanding, validating and resonating with the

[1] In this document, *nurse* refers to a Registered Practical Nurse (RPN), Registered Nurse (RN) and Nurse Practitioner (NP).

[2] Bolded words are defined in the glossary on page 4.

[3] (Hupcey, Penrod, Morse & Mitcham, 2001)

[4] Based on a 1998 interview with Carla Peppler, NP, and Cheryl Forchuk, RN.

[5] (American Nurses Association, 2001; Milton, 2005)

meaning that the health care experience holds for the client. In nursing, empathy includes appropriate emotional distance from the client to ensure objectivity and an appropriate professional response.[6]

Power. The nurse-client relationship is one of unequal power. Although the nurse may not immediately perceive it, the nurse has more power than the client. The nurse has more authority and influence in the health care system, specialized knowledge, access to privileged information, and the ability to advocate for the client and the client's **significant others**.[7] The appropriate use of power, in a caring manner, enables the nurse to partner with the client to meet the client's needs. A misuse of power is considered **abuse**.

Therapeutic Nurse-Client Relationship, Revised 2006 includes four standard statements with indicators that describe a nurse's accountabilities in the nurse-client relationship. Use the decision tree on page 11 to determine whether an activity or behaviour is appropriate within the context of the nurse-client relationship.

Glossary

This section defines terminology as used in this practice standard.

Abuse. Abuse means the misuse of the power imbalance intrinsic in the nurse-client relationship. It can also mean the nurse betraying the client's trust, or violating the respect or professional intimacy inherent in the relationship, when the nurse knew, or ought to have known, the action could cause, or could be reasonably expected to cause, physical, emotional or spiritual harm to the client. Abuse may be verbal, emotional, physical, sexual, financial or take the form of neglect. The intent of the nurse does not justify a misuse of power within the nurse-client relationship. For behaviours considered abusive, refer to Appendix A on page 16.

Boundary. A boundary in the nurse-client relationship is the point at which the relationship changes from professional and therapeutic to unprofessional and personal. Crossing a boundary means that the care provider is misusing the power in the relationship to meet her/his personal needs, rather than the needs of the client, or behaving in an unprofessional manner with the client.[8] The misuse of power does not have to be intentional to be considered a boundary crossing.

Client. A client may be an individual, family, group or community.

Client-centred care. In this approach, a client is viewed as a whole person. Client-centred care involves advocacy, empowerment and respect for the client's autonomy, voice, self-determination and participation in decision-making.[9] It is not merely about delivering services where the client is located.

Culture. Culture refers to the shared and learned values, beliefs, norms and ways of life of an individual or a group. It influences thinking, decisions and actions.[10]

Psychotherapeutic relationship. A psychotherapeutic relationship involves planned and structured psychological, psychosocial and/or interpersonal interventions aimed at influencing a behaviour, mood and/or the emotional reactions to different stimuli.[11]

Significant other. A significant other may include, but is not limited to, the person who a client identifies as the most important in his/her life. It could be a spouse, partner, parent, child, sibling or friend.

[6] (Kunyk & Olson, 2001)

[7] (Newman, 2005)

[8] (Smith, Taylor, Keys & Gornto, 1997)

[9] (Registered Nurses' Association of Ontario, 2002)

[10] (Leininger, 1996)

[11] (World Health Organization, 2001)

Standard Statements

There are four standard statements, each with accompanying indicators, which describe a nurse's accountabilities in the nurse-client relationship. The indicators are not all-inclusive; rather, they're broad statements that nurses can modify to their particular practice reality. The indicators are not listed in order of importance.

1) Therapeutic communication

Nurses use a wide range of effective communication strategies and interpersonal skills to appropriately establish, maintain, re-establish and terminate the nurse-client relationship.

Indicators

The nurse meets the standard by:

a) introducing herself/himself to the client by name and category[12] and discussing with the client the nurse's and the client's role in the therapeutic relationship (for example, explaining the role of a primary nurse and the length of time that the nurse will be involved in the client's care, or outlining the role of a research nurse in collecting data);
b) addressing the client by the name and/or title that the client prefers;[13]
c) giving the client time, opportunity and ability to explain himself/herself, and listening to the client with the intent to understand and without diminishing the client's feelings or immediately giving advice;[14]
d) informing the client that information will be shared with the health care team and identifying the general composition of the health care team;
e) being aware of her/his verbal and non-verbal communication style and how clients might perceive it;
f) modifying communication style, as necessary, to meet the needs of the client (for example, to accommodate a different language, literacy level, developmental stage or cognitive status);
g) helping a client to find the best possible care solution by assessing the client's level of knowledge, and discussing the client's beliefs and wishes;
h) considering the client's preferences when encouraging the client to advocate on his/her own behalf, or advocating on the client's behalf;
i) providing information to promote client choice and enable the client to make informed decisions (see the College's *Consent* practice guideline);
j) listening to, understanding and respecting the client's values, opinions, needs and ethnocultural beliefs and integrating these elements into the care plan with the client's help;
k) recognizing that all behaviour has meaning and seeking to understand the cause of a client's unusual comment, attitude or behaviour (for example, exploring a client's refusal to eat and finding that it's based in the client's **cultural**/religious observations);
l) listening to the concerns of the family and **significant others** and acting on those concerns when appropriate and consistent with the client's wishes;
m) refraining from self-disclosure unless it meets a specific, identified therapeutic client need, rather than the nurse's need;
n) reflecting on interactions with a client and the health care team, and investing time and effort to continually improve communication skills; and
o) discussing, throughout the relationship, ongoing plans for meeting the client's care needs after the termination of the nurse-client relationship (for example, discharge planning with the client and/or referral to community organizations).

[12] For more information, refer to the College's *Professional Misconduct* reference document at **www.cno.org/publications**.

[13] (Bowie, 1996)

[14] Based on a 1998 interview with Carla Peppler, NP, and Cheryl Forchuk, RN.

2) Client-centred care

Nurses work with the client to ensure that all professional behaviours and actions meet the therapeutic needs of the client.

Indicators

The nurse meets the standard by:

a) actively including the client as a partner in care because the client is the expert on his/her life,[15] and identifying the client's goals, wishes and preferences and making them the basis of the care plan;
b) gaining an understanding of the client's abilities, limitations and needs related to his/her health condition and the client's needs for nursing care or services;
c) discussing expectations with the client and the realistic ability to meet those expectations in the context of the client's health and the available resources;
d) negotiating with the client both the nurse's and the client's roles, as well as the roles of family and significant others, in achieving the goals identified in the care plan;
e) recognizing that the client's well-being is affected by the nurse's ability to effectively establish and maintain a therapeutic relationship;
f) acknowledging biases and feelings that have developed through life experiences, and that these attitudes could affect the nurse-client relationship;
g) reflecting on how stress can affect the nurse-client relationship, and appropriately managing the cause of the stress so the therapeutic relationship isn't affected;
h) demonstrating sensitivity and respect for the client's choices, which have grown from the client's individual values and beliefs, including cultural and/or religious beliefs (see the College's *Culturally Sensitive Care* practice guideline);
i) acknowledging difficulty establishing a therapeutic relationship with a client, and requesting a therapeutic transfer of care when the relationship is not evolving therapeutically (for example, when a nurse is unable to establish a trusting relationship with a client, she/he may consult with the manager to request that another nurse provide care);
j) committing to being available to the client for the duration of care within the employment boundaries and role context;[16] and
k) engaging the client in evaluating the nursing care and services that the client is receiving.

[15] (Registered Nurses' Association of Ontario, 2002, p. 19)

[16] (Forchuk et al., 2000; Peplau, 1991)

3) Maintaining boundaries

Nurses are responsible for effectively establishing and maintaining the limits or boundaries in the therapeutic nurse-client relationship.

Indicators

The nurse meets the standard by:

a) setting and maintaining the appropriate boundaries within the relationship, and helping clients understand when their requests are beyond the limits of the therapeutic relationship;
b) developing and following a comprehensive care plan with the client and health care team that aims to meet the client's needs;
c) ensuring that any approach or activity that could be perceived as a boundary crossing is included in the care plan developed by the health care team (for example, a health care team in a mental health setting may determine that having coffee with a particular client is an appropriate strategy that all nurses will consistently use when counselling the client);
d) recognizing that there may be an increased need for vigilance in maintaining professionalism and boundaries in certain practice settings[17] (for example, when care is provided in a client's home, a nurse may become involved in the family's private life and needs to recognize when her/his behaviour is crossing the boundaries of the nurse-client relationship);
e) ensuring that she/he does not interfere with the client's personal relationships;
f) abstaining from disclosing personal information, unless it meets an articulated therapeutic need of the client (for example, disclosing a personal problem may make the client feel as if his/her problems/feelings are being diminished or that the client needs to help the nurse);
g) continually clarifying her/his role in the therapeutic relationship, especially in situations in which the client may become unclear about the boundaries and limits of the relationship (for example, when an identified part of a nurse's role includes accompanying a client to a funeral to provide care);
h) ensuring that co-existing relationships do not undermine the judgment and objectivity in the therapeutic nurse-client relationship[18] (for example, a nurse providing care to a child who is a close friend of her/his child needs to be aware of the potential effect the dual relationship has on nursing care);
i) abstaining from engaging in financial transactions unrelated to the provision of care and services with the client or the client's family/significant other;
j) consulting with colleagues and/or the manager in any situation in which it is unclear whether a behaviour may cross a boundary of the therapeutic relationship, especially circumstances that include self-disclosure or giving a gift to or accepting a gift from a client;
k) ensuring that the nurse-client relationship and nursing strategies are developed for the purpose of promoting the health and well-being of the client and not to meet the needs of the nurse,[19] especially when considering self-disclosure, giving a gift to or accepting a gift from a client;
l) documenting client-specific information in the client's record regarding instances in which it was necessary to consult with a colleague/manager about an uncertain situation (non-client related information, such as a letter of summary or incident report, should be documented on the appropriate confidential form); and
m) considering the cultural values of the client in the context of maintaining boundaries, including situations that involve self-disclosure and gift giving.

[17] (Walker & Clark, 1999)

[18] (Nadelson & Notman, 2002)

[19] (Peterneij-Taylor & Yonge, 2003)

Giving and accepting gifts

The nurse meets the standard by:

a) abstaining from accepting individual gifts unless, in rare instances, the refusal will harm the nurse-client relationship. If the refusal could be harmful, consult with a manager and/or the College and document the consultation before accepting the gift;

b) accepting a team gift or an individual gift if the refusal of which has been determined to be harmful to the therapeutic relationship, only after considering:
   - that the gift was not solicited by the nurse,
   - that the client is mentally competent,
   - the client's intent and expectation in offering the gift (that is, will the client expect anything in return, or will the nurse feel a special obligation to that client over others?),
   - the appropriateness of the timing[20] (for example, on discharge versus Valentine's Day),
   - the potential for negative feelings on the part of other clients who may not be able to, or choose not to, give gifts, and
   - the monetary value and appropriateness of the gift; and

c) giving gifts to clients only as a group of nurses or from an agency/corporation after determining that:
   - the client is clear that the nurse does not expect a gift in return;
   - it does not change the dynamics of the therapeutic relationship; and
   - there is no potential for negative feelings on the part of other clients or toward other members of the health care team.

[20] (Walker & Clark, 1999)

4) Protecting the client from abuse

Nurses protect the client from harm by ensuring that abuse is prevented, or stopped and reported.

Indicators

The nurse meets the standard by:

a) intervening and reporting, when appropriate,[21] incidents of verbal and non-verbal behaviours that demonstrate disrespect for the client;
b) intervening and reporting behaviours toward a client that may be perceived by the client and/or others to be violent, threatening or intended by the nurse to inflict physical harm;
c) intervening and reporting a health care provider's behaviours or remarks toward a client that may reasonably be perceived by the nurse and/or others to be romantic, sexually suggestive, exploitive and/or sexually abusive;[22]
d) not entering a friendship, or a romantic, sexual or other personal relationship with a client when a therapeutic relationship exists;
e) ensuring that after the nurse-client relationship has been terminated and the nature of the relationship has been **psychotherapeutic** or for the provision of intense psychosocial counselling, the nurse:
   - must not engage in a personal friendship, romantic relationship or sexual relationship with the client or the client's significant other for one year following the termination of the therapeutic relationship, and
   - may, after one year, engage in a personal friendship, romantic relationship or sexual relationship with a client (or the client's significant other) only after deciding that such a relationship would not have a negative impact on the well-being of the client or other clients receiving care, and considering the client's likelihood of requiring ongoing care or readmission (if the client returns for further care at the facility, the nurse must declare to her/his manager the nature of the relationship and decline the assignment of the client);
f) being cautious about entering into a personal relationship, such as a friendship or romantic or sexual relationship, with a former client or a former client's significant other after the termination of a therapeutic relationship if:
   - it is determined that such a relationship would not have a negative impact on the future care of the client,
   - the relationship is not based on the trust and professional intimacy that was developed during the nurse-client relationship, and
   - the client is clear that the relationship is no longer therapeutic;
g) not engaging in behaviours toward a client that may be perceived by the client and/or others to be violent, threatening or intending to inflict physical harm;
h) not engaging in behaviours with a client or making remarks that may reasonably be perceived by other nurses and/or others to be romantic, sexually suggestive, exploitive and/or sexually abusive (for example, spending extra time together outside of the client's care plan);
i) not exhibiting physical, verbal and non-verbal behaviours toward a client that demonstrate disrespect for the client and/or are perceived by the client and/or others as abusive;
j) not neglecting a client by failing to meet or withholding his/her basic assessed needs;
k) not engaging in activities that could result in monetary, personal or other material benefit, gain or profit for the nurse (other than the appropriate

[21] There may be circumstances when a client does not offer his/her consent to share information regarding abuse with the police or other authorities; for example, spousal abuse.

[22] The *Regulated Health Professions Act, 1991* sets out provisions for the mandatory reporting of sexual abuse of a client by a regulated health care provider to the appropriate regulatory college.

renumeration for nursing care or services), the nurse's family and/or the nurse's friends, or result in monetary or personal loss for the client; and

l) not accepting the position of power of attorney for personal care or property[23] for anyone who is or has been a client, with the exception of those clients who are direct family members of the nurse. Should a person for whom the nurse has been named power of attorney become a client, the nurse must declare to the manager that she/he is the client's power of attorney and decline the client assignment.

[23] Property includes bank accounts and other financial matters.

How To Apply this Standard

Decision tree

Use this tool to work through a personal situation to determine whether a particular activity or behaviour is appropriate within the context of the nurse-client relationship. The decision tree should be used while considering all of the components of the nurse-client relationship and the behavioural expectations contained within this document. The tool may also be useful for self-reflection and peer input as part of the self-assessment process, and for guiding client care discussions in your practice setting.

Proposed behaviour

↓

Meets a clearly identified therapeutic need of the client, rather than a need of the nurse? For example, is it in the plan of care?

NO → Abstain from behaviour*

YES

↓

Is the behaviour consistent with the role of nurses in the setting?

NO → Abstain from behaviour*

YES

↓

Is this a behaviour you would want other people to know you had engaged in with a client?

NO → Abstain from behaviour*

YES

↓

Proceed with the behaviour and document it.

Exploratory questions

- Is the nurse doing something that the client needs to learn how to do for himself/herself?
- Can other resources be used to meet the need?
- Whose needs are being met?
- Will performing the activity cause confusion regarding the nurse's role?
- Is the employer aware that nurses are performing this activity?
- Does the employer have a policy regarding nurses performing this activity?
- Will the employer's insurance cover the nurse when performing this activity?

* Consult with the health care team, manager and/or College to determine how to best address the client's unmet needs.

Warning signs of crossing a boundary

There are a number of warning signs that indicate that a nurse may be crossing the boundaries of the nurse-client relationship.[24] Nurses need to reflect on the situation and seek assistance when one or more of the following warning signs are present:

- spending extra time with one client beyond his/her therapeutic needs;
- changing client assignments to give care to one client beyond the purpose of the primary nursing care delivery model;
- feeling other members of the team do not understand a specific client as well as you do;
- disclosing personal information to a specific client;
- dressing differently when seeing a specific client;
- frequently thinking about a client when away from work;
- feeling guarded or defensive when someone questions your interactions with a client;
- spending off-duty time with a client;
- ignoring agency policies when working with a client;
- keeping secrets with the client and apart from the health care team (for example, not documenting relevant discussions with the client in the health record);
- giving a client personal contact information unless it's required as part of the nursing role; and
- a client is willing to speak only with you and refuses to speak with other nurses.

When a colleague's behaviour crosses a boundary

If a nurse believes that a colleague is crossing a therapeutic boundary, the nurse needs to carefully assess the situation. Address with the colleague:

- what was observed;
- how that behaviour is perceived;
- the impact on the client; and
- the College's practice standards.

If the nurse is unable to speak with the colleague directly or the colleague does not recognize the problem, the next step is to speak to the colleague's supervisor. The nurse should put the concerns in writing and include the date, time, witnesses and some type of client identification, such as initials or a file number. If the situation is not resolved, further action is needed. This action should include informing the client of his/her rights and sending a letter describing the concerns to the next level or the highest level of authority in the agency, or reporting the matter to the College.

If a nurse witnesses another nurse or a member of the health care team abusing a client, the nurse must take action. College research indicates that when someone intervenes in an incident of abuse, the abuse stops. After intervening, a nurse must report any incident of unsafe practice or unethical conduct by a health care provider to the employer or other authority responsible for the health care provider. When an unregulated care provider abuses a client, the nurse must intervene to protect the client and notify the employer.

In all cases, the nurse must inform the client of his/her right to contact police and begin criminal proceedings.

Certain legislation requires further reporting of abuse. The *Regulated Health Professions Act, 1991* requires regulated health professionals to report the sexual abuse of a client by a regulated health professional to the appropriate college. The *Child and Family Services Act, 1990* requires reporting suspected child abuse to the Children's Aid Society.

[24] (Registered Nurses Association of British Columbia, et al., 1995)

Maintaining a Quality Practice Setting

As partners in care, employers and nurses share responsibility for creating an environment that supports quality practice. These strategies will help employers and nurses develop and maintain a quality practice setting that supports nurses in providing safe, effective and ethical care.

A quality practice setting will:

- promote reflective practice;
- support client-centred care;
- provide resources, including appropriate staffing, to support nurses in establishing therapeutic relationships;
- provide resources to support the provision of culturally sensitive care;
- promote positive collegial/interprofessional relations by role modelling and promoting an organizational culture of respect;
- recognize whether the setting is at increased risk for potential boundary violations and have policies in place on issues, such as accepting gifts from clients, to guide and support nurses in meeting College standards;
- support staff requesting a change of assignment due to stress or boundary issues;
- support staff activities that help relieve stress;
- have expert resources to assist nurses in situations in which establishing a therapeutic relationship is particularly challenging;
- have zero tolerance for abuse;
- debrief after critical incidents to provide support to staff and determine the cause, a possible solution and how to prevent a recurrence;
- have a known procedure for reporting abuse of clients and/or staff members;
- ensure reports of abuse are investigated and addressed;
- ensure that proactive visible leadership and clinical supervision is available to support nurses in developing therapeutic relationships and maintaining boundaries;
- endeavour to have consistent caregivers and continuity of care to promote the establishment of trust and comfort; and
- provide nurses with appropriate documentation forms and consultation methods to resolve ethical and boundary issues.

Suggested Reading

College of Nurses of Ontario. (2000). *Consent* practice guideline. Toronto: Author.

College of Nurses of Ontario. (1999). *Culturally Sensitive Care* practice guideline. Toronto: Author.

College of Nurses of Ontario. (1999). *Ethics* practice standard. Toronto: Author.

College of Nurses of Ontario. (1999). *Professional Misconduct* document. Toronto: Author.

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Sheets, V.R. (2001). Professional boundaries: Staying in the lines. *Dimensions of Critical Care Nursing*, *20*(5), 36-39.

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College of Nurses of Ontario. (2000). *Consent* practice guideline. Toronto: Author.

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Registered Nurses' Association of Ontario. (2002, July). Nursing best practice guideline: *Establishing Therapeutic Relationships*. Toronto: Author.

Sheets, V.R. (2001). Professional boundaries: Staying in the lines. *Dimensions of Critical Care Nursing*, *20*(5), 36-39.

Appendix A: Abusive Behaviours

Abuse can take many forms, including verbal and emotional, physical, neglect, sexual and financial. Examples of such abusive behaviours are listed below.

Verbal and emotional includes, but is not limited to:

- sarcasm;
- retaliation or revenge;
- intimidation, including threatening gestures/ actions;
- teasing or taunting;
- insensitivity to the client's preferences;
- swearing;
- cultural/racial slurs; and
- an inappropriate tone of voice, such as one expressing impatience.

Physical includes, but is not limited to:

- hitting;
- pushing;
- slapping;
- shaking;
- using force; and
- handling a client in a rough manner.

Neglect includes, but is not limited to:

- non-therapeutic confining or isolation;
- denying care;
- non-therapeutic denying of privileges;
- ignoring; and
- withholding:
  - clothing,
  - food,
  - fluid,
  - needed aids or equipment,
  - medication, and/or
  - communication.

Sexual includes, but is not limited to, consensual and non-consensual:

- sexually demeaning, seductive, suggestive, exploitative, derogatory or humiliating behaviour, comments or language toward a client;
- touching of a sexual nature or touching that may be perceived by the client or others to be sexual;
- sexual intercourse or other forms of sexual contact with a client;
- sexual relationships with a client's significant other; and
- non-physical sexual activity such as viewing pornographic websites with a client.

Financial includes, but is not limited to:

- borrowing money or property from a client;
- soliciting gifts from a client;
- withholding finances through trickery or theft;
- using influence, pressure or coercion to obtain the client's money or property;
- having financial trusteeship, power of attorney or guardianship;
- abusing a client's bank accounts and credit cards; and
- assisting with the financial affairs of a client without the health care team's knowledge.

Appendix B: Nursing a Family Member or Friend for Paid Employment

In some instances, nurses, especially those working in small communities, may be required to care for a family member, friend or acquaintance as part of their professional employment. These situations should be limited to circumstances in which there are no other care providers available. The client should be stabilized and, if possible, care transferred. If a nurse's sexual partner[25] is admitted to an agency where the nurse is providing care or services, the nurse must make every effort to ensure that alternative care arrangements are made. Until alternative arrangements are made, however, the nurse may provide care.

If it isn't possible to transfer care, a nurse must consider the following factors.

Input from the client. A client may feel uncomfortable receiving nursing services from someone with whom he/she has or had a personal relationship.

Self-awareness/reflection. Carefully reflect on whether you can maintain professionalism and objectivity in caring for the client, and whether your relationship interferes with meeting the client's needs. Also, ensure that providing care to a family member or friend will not interfere with the care of other clients, or with the dynamics of the health care team. Discuss the situation with your colleagues and employer before making a decision.

Maintaining boundaries. When providing nursing care for a family member, friend or acquaintance:

- be aware of the boundary between your professional and personal roles;
- clarify that boundary for the client;
- meet personal needs outside of the relationship; and
- develop and follow a plan of care.

Confidentiality. It is important not to disclose information about a client to other family members and/or friends without the client's consent, even after the nurse-client relationship has ended.

[25] If a nurse's sexual partner is also the nurse's client, the care could be considered sexual abuse and reported to the College, as outlined in the *Regulated Health Professions Act, 1991*.

STANDARD WORK FOR THE NURSE (RPN/RN) – THERAPEUTIC NURSE CLIENT RELATIONSHIP (CNO, 2006)

Standard work is a nurses' professional accountability to know their roles and their responsibilities as it applies to meeting the Therapeutic Nurse Client Relationship practice standard (2006) as espoused by the College of Nurses of Ontario (CNO). Each RPN/RN has standard work at every level when providing quality and safe patient/client centred care. By applying the College of Nurses of Ontario Therapeutic Nurse Client Relationship Standards (2006), the process of standard work becomes part of nurses' accountability and professional practice.

Standard Work	Completed	Incomplete
1. Components of the Nurse-Client Relationship – Five (5) components to the nurse-client relationship. Regardless of the context, length of interaction, and whether the RPN/RN is the primary or secondary care provider, these components are always present and integral to this therapeutic relationship		
Trust – this is an integral part of the therapeutic relationship as clients are vulnerable. It is important to keep promises.		
Respect – recognizes inherent dignity, worth & uniqueness of every individual		
Professional Intimacy – relates to physical tasks nurses perform ie., bathing, psychological, spiritual and social elements as well – all of these elements provide closeness to the client		
Empathy – expressing understanding, validating & reasoning with the health care experience		
Power – nurse client relationship is one of unequal power. Nurses have more power than the client & nurses need to understand the effect this has on the relationship. Nurses can influence plan of care, privileged information & advocating for patients – a misuse of power is considered abuse		
2. Therapeutic Communication – Nurse uses a wide range of communication strategies & interprofessional skills to appropriately establish, maintain, re-establish and terminate therapeutic nurse-client relationship.		
Introducing self to client by name and professional category/designation		
Addressing client by name and/or title that client prefers		
Listening to client & significant others with the intent to understand – giving client time, opportunity & ability to explain		
Informing client information will be shared with the health care team		
Being aware of your verbal/non-verbal communication & how client may interpret it		
Modifying your communication style to meet the needs of the client		
Helping client to find the best possible solution by assessing client's knowledge, beliefs and wishes		

Considering client preferences – providing information to promote client choice to make informed decisions		
Listening to, understanding & respecting client's values, opinions, needs & ethnocultural beliefs		
Recognizing that all behaviours have meaning		
Refraining from self-disclosure unless it meets a specific therapeutic client need –not the nurses' need		
Reflecting on interactions with clients & health care team		
Discussing throughout the relationship ongoing strategies for meeting client's care needs after termination of the therapeutic relationship		
3. Client Centered Care – Nurses work with the client to ensure that all professional behaviours and actions meet the therapeutic needs of the client		
Actively engaging the client as a partner in care – identifying client goals, wishes & preferences in plan of care		
Understanding client's abilities, limitations, & needs related to health condition & needs for nursing care		
Discussing expectations & identifying realistic ability to meet expectations		
Negotiating with client both nurses' & client's roles, family members in achieving goals in plan of care		
Recognizing client's well being is affected by nurses' ability to effectively establish & maintain relationship		
Acknowledging biases & feelings that have developed & how they could affect the relationship		
Reflecting on how stress can affect therapeutic relationship & managing this stress		
Demonstrating sensitivity & respect for client choices		
Acknowledging difficulty establishing a relationship with a client & requesting a transfer of care when relationship is not evolving therapeutically		
Committing to being available to the client for the duration of care		
Engaging with client in evaluating the nursing care & services the client is receiving		
4. Maintaining Boundaries – Nurses are responsible for effectively establishing and maintaining the limits or boundaries in the therapeutic nurse-client relationship		
Setting & maintaining boundaries with client & helping clients to understand when their requests are beyond the limits of the therapeutic relationship		
Developing & implementing a comprehensive plan of care with client & health care team to meet client needs		
Ensuring any approach or activity that could be perceived as boundary crossing is included in plan of care		

Recognizing that there may be an increased need for vigilance in maintaining professionalism & boundaries in certain practice settings like client's home		
Ensuring that the nurse does not interfere with the client's personal relationships		
Abstaining from disclosing personal information, unless it meets an articulated therapeutic need		
Continually clarifying his/her role in the therapeutic relationship especially if client is unclear of boundaries/limits		
Ensuring that co-existing relationships do not undermine the judgement & objectivity in the relationship		
Abstaining in engaging in financial transactions unrelated to the provision of care & services with client or client's family significant other		
Consulting with colleagues/manager when unclear about boundary crossing ie., self-disclosure, giving or receiving a gift		
Ensuring that nurse-client relationship & nursing strategies are developed for sole purpose of promoting health & well-being of client not the nurse		
Documenting client specific information in client's record regarding instances when it was necessary to consult with a colleague/manager about an uncertain situation		
Considering cultural values of the client in the context of maintaining boundaries including self-disclosure & gift giving		
Giving and Accepting Gifts		
Abstaining from receiving gifts unless in rare circumstances the refusal will harm the relationship		
Accepting a team gift or an individual gift if the refusal of which has been determined to be harmful to the therapeutic relationship only after considering the following: • the gift was not solicited by the nurse • the client is mentally competent • the client's intent & expectation in offering the gift – does client expect anything in return • the appropriateness of the timing ie., day of discharge • the potential negative feelings on the part of other clients who may not be able to or choose not to give gifts • monetary value of the gift		
Giving gifts to clients only as a group of nurses or from an agency: • the client is clear the nurse does not expect anything in return • it does not change the dynamics of the therapeutic relationship • there is no potential negative feelings on the part of the other clients or toward other members of the health care team		

5. Protecting the Client from abuse – Nurses protect the clients from harm by ensuring that abuse is revented, or stopped or reported		
Intervening & reporting when appropriate incidents of verbal & non-verbal behaviours that demonstrate disrespect for the client		
Intervening & reporting behaviours toward a client that may be perceived by the client and/or others to be violent, threatening or intended by the nurse to inflict physical harm		
Intervening & reporting a health care provider's behaviours or remarks that may be perceived by the nurse and/or others to be romantic, sexually suggestive, exploitative and/or sexually abusive		
Not entering a friendship or a romantic, sexual or other personal relationship with a client when a therapeutic relationship exists		
Ensuring that after the nurse-client relationship has been terminated & the nature of the relationship has been psychotherapeutic the nurse: • must not engage in a personal relationship with the client or the client's significant other for one year following the termination of the therapeutic relationship • may after one year engage in a personal friendship, romantic relationship or sexual relationship with a client (or client's significant other) only after deciding that the relationship will not have a negative impact on the well being of the client		
Being cautious about entering into a personal relationship such as a friendship or romantic or sexual relationship with a former client or a client's significant other after the termination of a therapeutic relationship • it is determined that such a relationship would not have a negative impact on the future care of the client • the relationship is not based on trust & professional intimacy that was developed during the nurse-client relationship • the client is clear that the relationship is no longer therapeutic		
Not engaging in behaviours toward a client that may be perceived by the client and/or others to be violent, threatening or intending to inflict physical harm		
Not engaging in behaviours with a client that may reasonably be perceived by other nurses and/or others to be romantic, sexually suggestive, exploitative and/or sexually abusive (for example, spending extra time together outside of the client's care plan)		
Not exhibiting physical, verbal and non-verbal behaviours toward a client that demonstrate disrespect for the client		
Not neglecting a client by failing to meet or withholding his/her basic assessed needs		
Not engaging in activities that could result in monetary, personal or other material benefit, gain or profit for the nurse		
Not accepting the position of power of attorney for personal care or property for anyone who has been a client with the exception of those clients who are direct family members of the nurse		

LINKING COLLEGE OF NURSES OF ONTARIO (CNO) SEVEN (7) PROFESSIONAL NURSING STANDARDS (2002) WITH THE CNO THERAPEUTIC NURSE CLIENT RELATIONSHIP STANDARD (2006)

1. **Accountability.** The core of nursing is the therapeutic nurse client relationship. The nurse is accountable in establishing and maintaining this key relationship by using their nursing knowledge, judgment and skills, as well as caring attitudes and behaviours.
2. **Continuing Competence.** Improve your knowledge: by completing the CNO Therapeutic Nurse Client Relationship Learning Modules www.cno.org , review as needed and yearly ; review your practice settings policies & procedures; stay abreast with updates from CNO by searching the CNO Website and reading the quarterly CNO Standard; attend in services when offered and be involved with your practice settings nursing practice meetings to advocate for policy changes reflecting CNO's Therapeutic Nurse Client Standards (2006).
3. **Ethics.** Protect yourself and your client by ensuring you maintain an ongoing therapeutic nurse client relationship and recognize when there is potential for boundaries to be crosses. Maintaining therapeutic relationships demonstrates nurses' commitment to providing safe, effective & ethical care by showing accountability for professional practice & the care the client receives, & transferring knowledge about client's well being.
4. **Knowledge.** Acquire the knowledge of CNO Therapeutic Nurse Client Relationship Standards: instructional learning modules from CNO; appropriate plans of care and clear communication; practice setting policies and procedures. Review CNO Standard
5. **Knowledge Application.** Apply the knowledge: identify warning signs of crossing a boundary by reflecting on the situation and seeking assistance when one or more of the following signs are present: spending extra time with a client, dressing differently, changing assignments, spending time with client while off duty, keeping secrets or giving a client personal contact information
6. **Leadership.** Demonstrate nursing leadership: role model therapeutic communication and behaviours; role model trust, respect, professional intimacy, empathy and power in the therapeutic nurse client relationship. Share knowledge with other health care providers, coach and mentor colleagues if one identifies gaps in the therapeutic nurse client relationship. Engage in committees to ensure therapeutic relationship practices reflect CNO standards, become a champion within your practice setting related to enacting therapeutic relationships at all times. Provide education/ health teaching to colleagues on issues related to therapeutic relationships and or provide current literature on client centered care as it relates to clear boundaries within the therapeutic nurse client relationship. Ensure orientation includes education related to therapeutic relationships and relevant policies and procedures. Provide adequate time and support for initiating, maintaining and terminating a therapeutic nurse client relationship.
7. **Relationships.** Maintain professional and/or therapeutic relationships: appropriately utilizing power, trust, intimacy, respect and empathy demonstrates that the RPN has within the therapeutic nurse client relationship the nursing knowledge, skill and judgment required by CNO's professional standards; share your knowledge with colleagues including novice nurses, foster a supportive environment in applying the therapeutic nurse client relationship standards.

WITHOUT STANDARD WORK, IMPROVEMENT IS IMPOSSIBLE!!!

I am knowledgeable and aware of how my 7 Professional Nursing Standards apply to the CNO Therapeutic Nurse Client Relationship (2006) Standards

Signature: Date:

Developed by: Donna Rothwell, RN, BScN, MN, SEIU Healthcare February 2012

PRACTICE STANDARD

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario

THE STANDARD OF CARE.

Documentation, Revised 2008

Table of Contents

COLLEGE OF NURSES OF ONTARIO
ORDRE DES INFIRMIÈRES ET INFIRMIERS DE L'ONTARIO

THE STANDARD OF CARE.

OUR MISSION is to protect the public's right to quality nursing services by providing leadership to the nursing profession in self-regulation.

OUR VISION is excellence in nursing practice everywhere in Ontario.

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College of Nurses of Ontario
101 Davenport Rd.
Toronto, ON M5R 3P1

www.cno.org

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Nursing standards are expectations that contribute to public protection. They inform nurses of their accountabilities and the public of what to expect of nurses. Standards apply to all nurses regardless of their roles, job description or areas of practice.

— College of Nurses of Ontario

Introduction

Nursing documentation is an important component of nursing practice and the interprofessional documentation that occurs within the client[1] health record. Documentation — whether paper, electronic, audio or visual — is used to monitor a client's progress and communicate with other care providers. It also reflects the nursing care that is provided to a client.

This practice standard explains the regulatory and legislative requirements for nursing documentation. To help nurses[2] understand and apply the standards to their individual practice, the content is divided into three standard statements that describe broad practice principles. Each statement is followed by corresponding indicators that outline a nurse's accountability when documenting and provide guidance on applying the standard statements to a particular practice environment.

To further support nurses in applying the standards, the document also includes appendices containing important supplementary information and a list of suggested readings. Appendix A provides strategies for nursing professionals — including nurses, researchers, educators and nurse employers — to support quality documentation practices in their work settings. Appendix B includes a sampling of provincial and federal legislation governing nursing documentation, and Appendix C references general resources on electronic documentation.

Why Document?

Nursing documentation:

- reflects the client's perspective, identifies the caregiver and promotes continuity of care by allowing other partners in care to access the information;
- communicates to all health care providers the plan of care,[3] the assessment, the interventions necessary based on the client's history and the effectiveness of those interventions;
- is an integral component of interprofessional documentation within the client record;
- demonstrates the nurse's commitment to providing safe, effective and ethical care by showing accountability for professional practice and the care the client receives, and transferring knowledge about the client's health history; and
- demonstrates that the nurse has applied within the therapeutic nurse-client relationship[4] the nursing knowledge, skill and judgment required by professional standards regulations.

Whether documenting for individual clients, or for groups or communities, the documentation should provide a clear picture of:

- the needs or goals of the client or group;
- the nurse's actions based on the needs assessment; and
- the outcomes and evaluation of those actions.

Data from documentation has many purposes:

- It can be used to evaluate professional practice as part of quality improvement processes.
- It can be used to determine the care and services a

[1] In this document, a client may be an individual, family, group or community.

[2] In this document, nurse refers to Registered Practical Nurse (RPN), Registered Nurse (RN) and Nurse Practitioner (NP).

[3] In this document, the term plan of care may refer to treatment plan, care plan, care map, service plan, case management, mental health assessment plan, resident assessment forms, or other terms organizations use.

[4] For more information, refer to the College's *Therapeutic Nurse-Client Relationship, Revised 2006* practice standard at **www.cno.org/publications**.

client required or that were provided.
- Nurses can review outcome information to reflect on their practice and identify knowledge gaps that can form the basis of learning plans.
- In nursing research, documentation is used to assess nursing interventions and evaluate client outcomes, identify care and documentation issues and advance evidence-based practice.

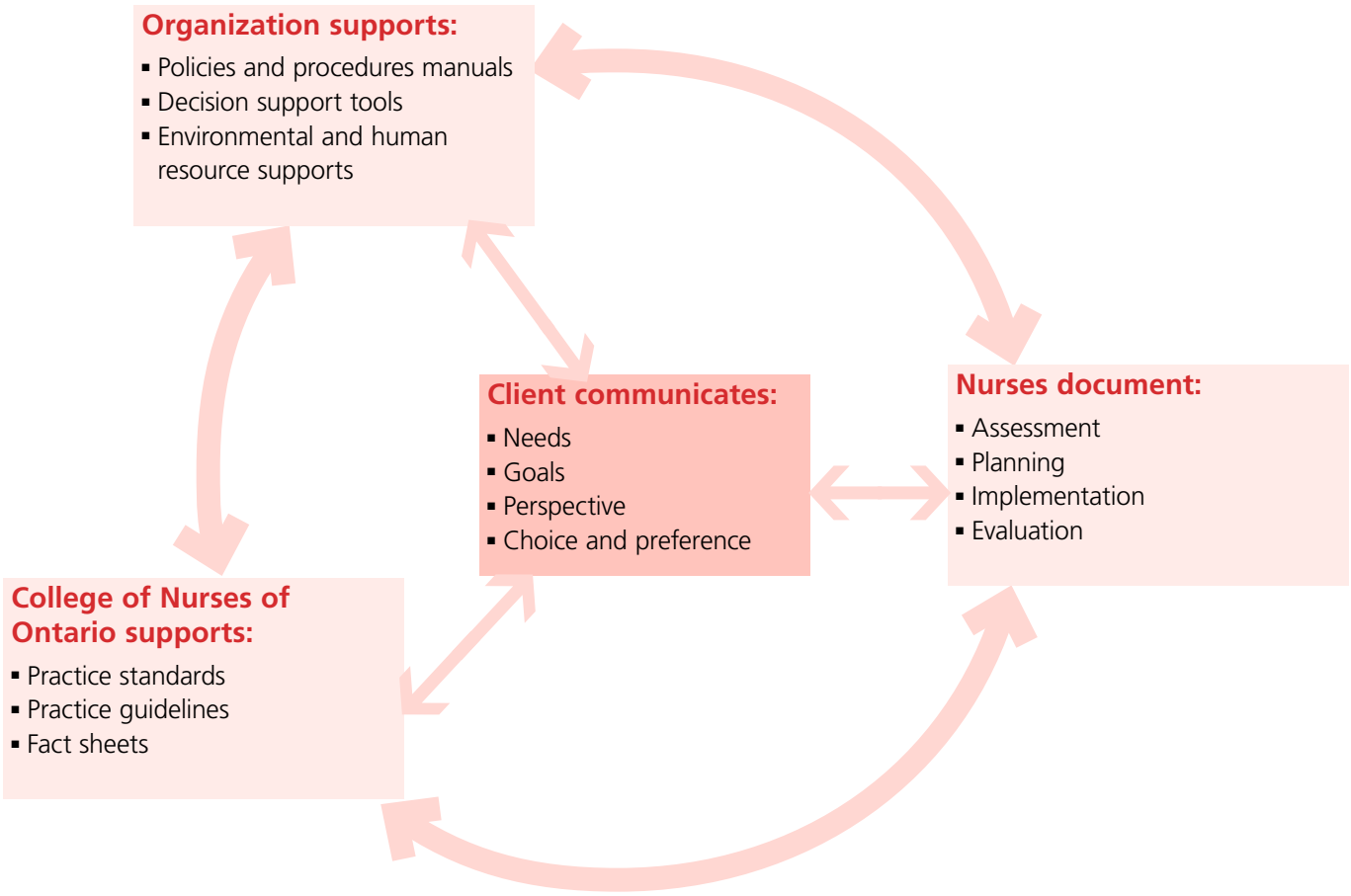
Nurses are required to make and keep records of their professional practice. As regulated health care professionals, nurses are accountable for ensuring that their documentation is accurate and meets the College's practice standards. Failing to keep records as required, falsifying a record, signing or issuing a document that the member knows includes a false or misleading statement, and giving information about a client without consent, all constitute professional misconduct under the *Nursing Act, 1991*. Nursing documentation may be accessed in College investigations and other legal proceedings.

The diagram on page 5 illustrates the inter-relationships supporting nurses in the provision of safe, effective and ethical care.

The Inter-relationships that support clients through documentation

This diagram illustrates how the nursing profession, the organizational environment and the self-regulatory framework within which nurses practise work together to support the client to obtain and/or maintain optimal functioning.

- The College's fact sheets, practice standards and guidelines support nurses in the provision of safe, ethical and effective care.
- Nursing organizations support nurses with policies, procedures and decision support tools.
- As self-regulated professionals, they are accountable to the practice standards that the College sets.



Results of above inter-relationships

Complete documentation that demonstrates:

- Communication
- Accountability
- Legislative requirements

Standard Statements and Indicators

Documentation, Revised 2008 includes three standard statements and corresponding indicators that describe a nurse's accountabilities when documenting.

- The standard statements describe broad principles that guide nursing practice.
- The indicators can help nurses apply the standard statements to their particular practice environment.

Communication

Nurses ensure that documentation presents an accurate, clear and comprehensive picture of the client's needs, the nurse's interventions and the client's outcomes.

Indicators

A nurse meets the standard by:

a) ensuring that documentation is a complete record of nursing care provided and reflects all aspects of the nursing process, including assessment, planning, intervention (independent and collaborative) and evaluation;
b) documenting both objective and subjective[5] data;
c) ensuring that the plan of care is clear, current, relevant and individualized to meet the client's needs and wishes;
d) minimizing duplication of information in the health record;
e) documenting significant communication with family members/significant others,[6] substitute decision-makers and other care providers;
f) ensuring that relevant client care information kept in temporary hard copy documents (such as kardex, shift reports or communication books) is captured in the permanent health record. For example, if the electronic system is unavailable, the nurse must ensure that information captured in temporary documents is entered in the electronic system when it becomes available again;
g) providing a full signature or initials, and professional designation (RPN, RPN[Temp], RN, RN[Temp] or NP) with all documentation;
h) providing full signature, initials and designation on a master list when initialling documentation;
i) ensuring that hand-written documentation is legible and completed in permanent ink;
j) using abbreviations and symbols appropriately by ensuring that each has a distinct interpretation and appears in a list with full explanations approved by the organization or practice setting;
k) documenting advice, care or services provided to an individual within a group, groups, communities or populations (for example, group education sessions);
l) documenting the nursing care provided when using information and telecommunication technologies[7] (for example, providing telephone advice);
m) documenting informed consent[8] when the nurse initiates[9] a treatment or intervention authorized in legislation; and
n) advocating for clear documentation policies and procedures that are consistent with the College's practice standards.

[5] Documentation should reflect a nurse's observations and should not include unfounded conclusions, value judgments or labelling.

[6] Significant other may include, but is not limited to, the person the client identifies as being the most important in his or her life. Examples include spouse, partner, parent, child, sibling or friend.

[7] For more information, refer to the College's *Telepractice* practice guideline at **www.cno.org/publications**.

[8] For more information, refer to the College's *Consent* practice guideline at **www.cno.org/publications**.

[9] For more information, refer to the College's *RHPA: Scope of Practice, Controlled Acts Model* reference document at **www.cno.org/publications**.

Accountability

Nurses are accountable for ensuring their documentation of client care is accurate, timely and complete.

Indicators

A nurse meets the standard by:

a) documenting in a timely manner and completing documentation during, or as soon as possible after, the care or event;
b) documenting the date and time that care was provided and when it was recorded;
c) documenting in chronological order;
d) indicating when an entry is late as defined by organizational policies;
e) documenting at the next available entry space, and not leaving empty lines for another person to add documentation (when using paper documentation forms). If there are empty lines, the nurse should draw a line from the end of the entry to the signature. When using an electronic system, the nurse should refrain from leaving a space in a free-flow text box;
f) correcting errors while ensuring that the original information remains visible/retrievable;
g) never deleting, altering or modifying anyone else's documentation;
h) enabling a client to add his or her information to the health record when there is a disagreement regarding care;[10]
i) documenting when information for a specific time frame has been lost or cannot be recalled;
j) indicating clearly when an entry is replacing lost information;
k) ensuring that documentation is completed by the individual who performed the action or observed the event, except when there is a designated recorder, who must sign and indicate the circumstances (for example, a code situation, or instances when an electronic system has technical difficulties and someone else enters the information when the system becomes available again);
l) clearly identifying the individual performing the assessment and/or intervention when documenting; and
m) advocating at the nurse's facility for clear documentation policies and procedures that are consistent with the College's standards.

[10] For more information, refer to the College's *Confidentiality and Privacy—Personal Health Information* practice guideline at **www.cno.org/publications**.

Security

Nurses safeguard client health information by maintaining confidentiality and acting in accordance with information retention and destruction policies and procedures that are consistent with the standard(s) and legislation.

Indicators

A nurse meets the standard by:

a) ensuring that relevant client care information is captured in a permanent record;
b) maintaining confidentiality of client health information,[11] including passwords or information required to access the client health record;
c) understanding and adhering to policies, standards and legislation related to confidentiality;
d) accessing only information for which the nurse has a professional need to provide care;
e) maintaining the confidentiality of other clients by using initials or codes when referring to another client in a client's health record (for example, using initials when quoting a client's roommate);
f) facilitating the rights of the client or substitute decision-maker to access, inspect and obtain a copy of the health record, unless there is a compelling reason not to do so (for example, if disclosure could result in a risk of serious harm to the treatment or recovery of an individual);[12]
g) obtaining informed consent from the client or substitute decision-maker to use and disclose information to others outside the circle of care;[13]
h) using a secure method such as a secure line for fax or e-mail to transmit client health information (for example, making sure the fax machine is not available to the public);
i) retaining health records for the period the organization's policy and legislation stipulates when required by the nurse's role (for example, in independent practice);
j) ensuring the secure and confidential destruction of temporary documents that are no longer in use; and
k) advocating for clear documentation policies and procedures that are consistent with the College's standards.

[11] For more information, refer to the Ontario Information and Privacy Commissioner's website at www.ipc.on.ca.

[12] For more information, refer to the Ontario Information and Privacy Commissioner's website at www.ipc.on.ca.

[13] For more information, refer to the College's *Confidentiality and Privacy—Personal Health Information* practice guideline at **www.cno.org/publications**.

Appendix A: Supporting Documentation Practices

All nurses — including employers who are nurses, researchers and educators — must demonstrate the knowledge, skill, judgment and attitude required of regulated health professionals. They must also reflect on their role in improving their practice settings, and advocate for quality nursing care practices.

Strategies that nurses in all roles can use to support documentation practices that meet the College's *Documentation, Revised 2008* practice standard include:

- facilitating nursing staff involvement in choosing, implementing and evaluating the documentation system as well as the policies and procedures and risk management systems related to documentation;
- providing access to appropriate, reliable and available documentation equipment, and to IT support;
- providing access to documentation equipment that meets ergonomic standards;
- ensuring policies are available and reflect the documentation standards to guide practice (for example, having explicit assessment norms and standards of care for charting by exception);
- ensuring that staff orientation includes documentation systems and relevant policies and procedures;
- ensuring that effective mechanisms are in place to help nurses apply the organization's documentation policies;
- supporting nurses' development of information and knowledge management competencies, and designing continual quality improvement activities related to effective documentation;
- developing performance management processes that provide opportunities to improve documentation;
- providing adequate time to document appropriately and review prior documentation;
- identifying and acknowledging nursing excellence in staff documentation;
- having an available and open management structure (for example, "management walkabouts" that focus on documentation issues or trends); and
- providing opportunities to explore or promote team building as it relates to documentation practices.

Appendix B: Nursing Documentation Legislation References

The following list contains a sampling of federal and provincial legislation that may affect nursing documentation. The legislation was in force at the time this document was published.

Federal Legislation

To obtain copies of current federal legislation, contact the Government of Canada Inquiry Centre at 1 800 O Canada (1 800 622-6232) or visit the Department of Justice website at www.laws.justice.gc.ca/en.

Access to Information Act, 1985

Personal Information Protection and Electronic Documents Act, 2000

Privacy Act, 1985

Provincial Legislation

To obtain copies of current Ontario legislation, contact Publications Ontario at 1 800 668-9938 or visit the Ontario Statutes and Regulations website at www.e-laws.gov.on.ca.

Charitable Institutions Act, 1990

Child and Family Services Act, 1990

Coroners Act, 1990

Freedom of Information and Protection of Privacy Act, 1990

Health Care Consent Act, 1996

Health Protection and Promotion Act, 1990

Homes for the Aged and Rest Homes Act, 1990

Mental Health Act, 1990

Municipal Freedom of Information and Protection of Privacy Act, 1990

Nursing Act, 1991

Nursing Homes Act, 1990

Occupational Health and Safety Act, 1990

Personal Health Information Protection Act, 2004

Public Hospitals Act, 1990

Quality of Care Information Protection Act, 2004

Regulated Health Professions Act, 1991

Appendix C: Electronic Documentation Resources

Below are some general resources related to electronic documentation.

Canada Health Infoway *Canada Health Infoway: Establishing Electronic Health Records for Canadians* www.infoway-inforoute.ca

Canadian Institute for Health Information *CIHI - Canadian Institute for Health Information* www.cihi.ca

E-Health Ontario www.ehealthontario.ca

Health Canada *Electronic Health Record* www.hc-sc.gc.ca

Registered Nurses Association of Ontario *Nursing and E-health Initiative* www.rnao.org

Suggested Reading List

Ammenwerth, E., Mansmann, U., Iller, C., & Eichstadter, R. (2003). Factors affecting and affected by user acceptance of computer-based nursing documentation: Results of a two-year study. *Journal of the American Medical Informatics Association*, *10*(1), 69-84.

Cheevakasemsook, A., Chapman, Y., Francis, K., & Davies, C. (2006). The study of nursing documentation complexities. *International Journal of Nursing Practice*, *12*(6), 366-374.

Hebert, M. (2000). A national education strategy to develop nursing informatics competencies. *Canadian Journal of Nursing Leadership*, *13*(2), 11-14.

Kossman, S.P., & Scheidenhelm, S.L. (2008). Nurses' perceptions of the impact of electronic health records on work and patient outcomes. *CIN: Computers, Informatics, Nursing*, *26*(2), 69-77.

Langowski, C. (2005). The times they are a changing: Effects of online nursing documentation systems. *Quality Management in Health Care*, *14*(2), 121-125.

Lee, T. (2006). Nurses' perceptions of their documentation experiences in a computerized nursing care planning system. *Journal of Clinical Nursing*, *15*(11), 1376-1382.

Nagle, L.M., & Catford, P. (2008). Toward a model of successful electronic health record adoption. *Electronic Healthcare*, *7*(1), 84-91.

Oroviogoicoechea, C., Elliott, B., & Watson, R. (2008). Review: Evaluating information systems in nursing. *Journal of Clinical Nursing*, *17*(5), 567-575.

Saletnik, L.A., Niedlinger, M.K., & Wilson, M. (2008). Nursing resource considerations for implementing an electronic documentation system. *AORN Journal*, *87*(3), 585-596.

STANDARD WORK FOR THE REGISTERED PRACTICAL NURSE (RPN/RN) DOCUMENTATION STANDARD (CNO, 2008)

Standard work is a nurses' professional accountability to know their roles and their responsibilities as it applies to meeting the Documentation Standards (2008) as espoused by the College of Nurses of Ontario (CNO). Each RPN/RN has standard work at every level when providing quality and safe patient/client centred care. By applying the College of Nurses of Ontario Documentation Standards (2008), the process of standard work becomes part of nurses' accountability and professional practice.

Standard Work	Completed	Incomplete
1. Communication – ensures documentation represents an accurate, clear & comprehensive picture of clients needs, nursing interventions and the client's outcomes.		
Ensures documentation is a complete record of nursing care provided including all aspects of the Nursing Process, assessment, planning, intervention (both independent & collaborative) and evaluation		
Documents both objective & subjective data – does NOT reflect unfounded conclusions, value judgments or labelling		
Ensures the plan of care is clear, current, relevant and reflects individualized clients needs &wishes		
Minimize the duplication of information in health record (ie., if documented on flow sheet no need to document elsewhere)		
Documenting significant communication with family members/significant others, substitute decision makers & other health care providers		
Ensures all relevant client care information kept in "temporary" hard copy documents (ie., kardex, communication books, shift reports) is captured in the permanent health record.		
Provides a full signature or initials, and professional designation (RPN/RN) with all documentation		
Provides a full signature, initials & professional designation (RPN/RN) on a master list when initialling documentation		
Use practice setting approved abbreviations and symbols		
Documents advice, care or services provided to an individual within a group, communities or groups		
Documents nursing care provided when using information & telecommunication like telephone advice		
Documents informed consent when the RPN initiates a treatment or intervention authorized in legislation		
Advocates for clear documentation policies in your practice setting reflecting CNO's Documentation Standards		

2. Accountability – Nurses are accountable for ensuring their documentation of client care is accurate, timely & complete		
Documents in a timely manner & completes documentation during or as soon as possible after care or event		
Documents date & time care was provided and time documentation was recorded		
Documents in a chronological order		
Documents late entries according to practice setting policies		
Documents in the next available space – do NOT leave empty lines – if empty lines draw a line across		
Correct errors while ensuring original information remains visible/retrievable		
Never delete/modify or alter anyone else's documentation		
Enabling a client to enter his/her information in health record if a disagreement regarding care occurs		
Documenting when information for a specific time frame has been lost or cannot be recalled		
Ensure documentation is completed by the individual who performed the action, observed the event EXCEPT when there is a designated recorder ie., code situation		
Clearly identify the individual performing the assessment and/or intervention when documenting		
3. Security – Nurses safeguard client health information by maintaining confidentiality & act in accordance with information retention and destruction policies & procedures		
Ensures all relevant client care information is documented in a permanent record		
Maintains confidentiality of client information including passwords needed to access client information		
Understands & adheres to policies, standards & legislation related to confidentiality		
Accesses only information nurse has a professional need to provide care		
Maintaining confidentiality of other clients by using initials when referring to another client in a health record		
Facilitate the rights of a client or substitute decision maker to access, inspect or obtain a copy of health record		
Obtaining informed consent from client/SDM to use or disclose information to others outside circle of care		
Using a secure method such as a secure fax line or email to transmit health information		
Retaining health records for the period your practice setting policies stipulate		
Ensuring secure & confidential destruction of temporary documents that are no longer in use		

LINKING COLLEGE OF NURSES OF ONTARIO (CNO) SEVEN (7) PROFESSIONAL NURSING STANDARDS (2002) WITH THE CNO DOCUMENTATION STANDARDS (2008)

1. **Accountability.** Provide and facilitate the best documentation based on client care provided: communicate an accurate , clear and comprehensive reflection of the client's needs, your nursing interventions & the clients outcomes based on your interventions; communicates to all health care providers the plan of care, the assessment, the interventions based on the client's history and the effectiveness of those outcomes. Nurses are required to make & keep records of their professional practice; nurses are accountable for ensuring their documentation is accurate & meets CNO's practice standards.
2. **Continuing Competence.** Improve your knowledge: by completing the CNO Documentation Learning Modules www.cno.org , review as needed and yearly ; review your practice settings policies & procedures; stay abreast with updates from CNO by searching the CNO Website and reading the quarterly CNO Standard; attend in services when offered and be involved with your practice settings nursing practice meetings to advocate for policy changes reflecting CNO's Documentation Standards (2006).
3. **Ethics.** Protect yourself and your client by ensuring you document in a timely manner. Nursing documentation demonstrates nurses' commitment to providing safe, effective & ethical care by showing accountability for professional practice & the care the client receives, & transferring knowledge about client's health history
4. **Knowledge.** Acquire the knowledge of CNO Documentation Standards: instructional learning modules from CNO; appropriate documentation tools & forms; practice setting policies and procedures (abbreviations). Review CNO Standard
5. **Knowledge Application.** Apply the knowledge: documenting in a timely, non-judgmental & factual manner, documenting chronologically, correcting errors accordingly, documentation is completed by the individual who performed the action or observed the event; documenting objective & subjective information
6. **Leadership.** Demonstrate nursing leadership: role model proper documentation principles; role model proper use documentation standards; share knowledge with other health care providers, coach and mentor colleagues if gaps in their documentation, active involvement in committees to ensure documentation standards reflect CNO standards, become a documentation champion within your practice setting. Provide education/ health teaching to colleagues on nursing documentation and or provide current literature on nursing documentation. Ensure orientation includes documentation systems and relevant policies and procedures. Provide adequate time and support for documentation.
7. **Relationships.** Maintain professional and/or therapeutic relationships: nursing documentation demonstrates that the RPN has within the therapeutic nurse client relationship the nursing knowledge, skill and judgment required by CNO's professional standards; share your knowledge with colleagues including novice nurses, foster a supportive environment in applying the documentation standards.

WITHOUT STANDARD WORK, IMPROVEMENT IS IMPOSSIBLE!!!

I am knowledgeable and aware of how my 7 Professional Nursing Standards apply to the CNO Documentation Standards

Signature: _____ Date: _____

Developed by: Donna Rothwell, RN, BScN, MN, SEIU Healthcare January 2012

QA Self-Assessment: Quality Assurance

A Guide To Developing Your Learning Goals and Learning Plan 2011

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario

THE STANDARD OF CARE.

Collection of Personal Information
The College of Nurses of Ontario (the College) collects the information in the Learning Goal page under the general authority of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, the *Nursing Act, 1991*, S.O. 1991, c. 32, and its regulations, and the College's by-laws. The College collects the information for the purpose of assessing your practice through its Quality Assurance Program. Appropriate measures are taken to safeguard the confidentiality of the personal information you provide and all documents become the property of the College.

If you have any questions about the collection, use and/or disclosure of this information contact the Manager of Information Management, College of Nurses of Ontario, 101 Davenport Rd., Toronto, ON M5R 3P1, 416 928-0900 or toll-free in Ontario 1 800 387-5526.

Self-Assessment: A Guide to Developing Your Learning Goals and Learning Plan 2011 Pub. No. 44005

Additional copies of this booklet may be obtained at **www.cno.org/qa**, or by contacting the College's Customer Service Centre at 416 928-0900 or toll-free in Ontario at 1 800 387-5526.

College of Nurses of Ontario
101 Davenport Rd.
Toronto ON M5R 3P1

www.cno.org

44005
DEC 2010
2010-114

Introduction

This guide can help you meet the requirements of Component 1: Self-Assessment of the College's Quality Assurance (QA) Program. It explains the steps required to develop your learning goals and complete a Learning Plan.

Start the Self-Assessment process by going to the online QA Program at **www.cno.org**. The online site is secure; all your information will remain confidential. The interactive program is fast and easy to use. There, you can document your Practice Reflection and create, save, edit and review your learning goals for your Learning Plan. You will also find QA Program resources, including a glossary and examples of how to document your learning goals.

Self-Assessment

Self-Assessment is a self-directed, two-part process that **results in a Learning Plan**. Each year, the College will select two practice documents to be the focus of the year's QA Program. You must use these two documents to complete your Self-Assessment.

The College practice standards for 2011 are:

- ***Infection Prevention and Control***
- ***Documentation, Revised 2008.***

Are you an NP? You must also review the *Nurse Practitioners* practice document.

During the Self-Assessment process, you will identify your learning needs in relation to the selected practice documents. You should also reflect on how the following elements apply to your nursing practice while completing your learning goals — the information can be used in your Practice Reflection:

- advances in technology
- changes in the practice environment
- entry-to-practice competencies
- interprofessional care.

There are two parts to the Self-Assessment component. Part A, Practice Reflection, involves thinking about your practice and obtaining peer input to determine your strengths and the areas you need to improve.

Part B involves developing learning goals and creating and maintaining a Learning Plan.

TIPS

- Your QA Program activities must address the selected practice documents. Members can use other College practice documents for their QA Program activities, but only in addition to the selected practice documents.
- Definitions are provided in the glossary on page 6.

Part A: Practice Reflection

Think about your practice and obtain peer input to help you determine your strengths and the areas you need to improve. Reflecting on your practice helps you to continually improve your competence as a nurse. Obtaining peer input improves your awareness of your practice.

You can document your Practice Reflection activities online at **www.cno.org**, using the interactive Practice Reflection form. Or, you can print a blank Practice Reflection form from the website and fill it out by hand.

The Practice Reflection process will help you identify your learning goals that are required for Part B, developing your Learning Plan.

TIP

- If you are selected for Component 2: Practice Assessment you may be asked to identify the resources you used to reflect on your practice, but the College will not review your Practice Reflection form. However, the College will review your Learning Plan.

The chart below suggests a process for reflecting on your practice.

Steps to completing Practice Reflection

Step #1

Identify the resources and activities you will use to reflect on your practice.

Resources may include:

- discussions with colleagues and supervisors
- College practice standards and guidelines, online learning modules, teleconferences and practice consultations
- workplace resources (for example, performance assessments)
- academic and/or continuing education courses such as conferences
- podcasts and webinars
- nursing journals and magazines.

Step #2

Identify the peer(s) who you will ask for input.

You may choose to ask:

- What do you think I do well?
- What can I improve?
- Can you give me an example of how I effectively apply the *Infection Prevention and Control* and the *Documentation, Revised 2008* practice documents? In what areas could I improve?

Are you an NP?

Ask for input from a peer familiar with the *Nurse Practitioners* practice document.

Step #3

When developing your learning goals, consider:

- Your strengths and the areas you need to improve.
  - How do they relate to the two selected practice documents?

Consider how the following elements affect your practice:

- advances in technology
- changes in the practice environment
- entry-to-practice competencies
- interprofessional care.

TIP

- Definitions for the elements can be found in the glossary on page 6.

Part B: Learning Plan

Once you have completed Part A, Practice Reflection, you're ready to develop your learning goals.

Your Learning Plan is evidence of your participation in the QA Program. It documents your learning goals, the activities you plan to reach these goals and the changes to your practice from implementing the goals. You are expected to update the learning goals in your Learning Plan throughout the year as you complete the activities you identified.

TIPS

- You must complete at least one learning goal for each practice document selected for the QA Program.

Are you an NP?
You need to create an additional learning goal for the *Nurse Practitioners* practice document.

You can complete your learning goals online using the interactive QA Program at **www.cno.org**. Your learning goals will be saved in your online Learning Plan Summary. You can easily access the Learning Plan Summary to review and update your goals and print any pages; the information will be saved automatically for two years.

If you want to fill out the Learning Plan by hand, then you can download and print blank forms at **www.cno.org/qa**. You will have to save the paper copy for two years.

You can incorporate information from professional development activities and workplace performance assessments into your learning goals.

Steps to completing the online learning goal page

Step #1

Choose one of the selected practice documents.
Select the practice document box (*Infection Prevention and Control* or *Documentation, Revised 2008*) that relates to your goal. If you have additional goals that relate to different practice documents, then identify them by picking the box marked "Other." Then, select the title of the document from the drop-down menu.

Step #2

Document your learning goal.
Use the "goal" section of the page to document your learning goal. Your goal should be SMART:

- specific to your learning needs
- measurable within your practice
- attainable within your practice and with your skills
- relevant to your role and responsibilities
- have a timeline and deadline.

Are you an NP?
You must also choose the *Nurse Practitioners* practice document as the basis for one of your goals.

Step #3

Document the activities and timeframe for completing the activities necessary to achieve your goal.
Activities are actions you plan to take to achieve your goal. For example, you could plan to complete an online educational session; read nursing journals; attend conferences, seminars or workshops; or work with a preceptor. Set realistic, time-limited target dates to complete your activities.

Step #4

Document the changes to your practice.
Continually update your learning goal by documenting the changes you made to your practice after completing activities or achieving your goal. Describe how these changes affect client care and/or nursing practice. The information in this section can form the basis for completing your Practice Reflection next year.

Step #5

Ensure the expected and actual goal completion dates are filled out.

Document when you plan to achieve your goal in "expected goal completion date." Document when you achieved your goal in "actual goal completion date." If you cannot complete a goal in the current practice year, then you can carry it over to the next year. However, document any achievements you make toward completing the goal on the learning goal page.

Step #6

Ensure you've considered how the following elements impact your practice:

- advances in technology
- changes in the practice environment
- entry-to-practice competencies
- interprofessional care.

Step #7

Review and edit your learning goal page if necessary.

Step #8

Go to the Learning Plan Summary link to review all your saved learning goals.

Your learning goals will be saved on the Summary page for two years. During that time, you can review and edit any of the goals.

TIPS ◆ For more information on creating SMART goals, review the College's *Developing SMART Learning Goals* guide at **www.cno.org**.

Glossary

Advances in technology: The introduction of new, innovative or different skills, processes or knowledge into a nurse's practice setting. For example, learning how to use a new electronic documentation system.

Changes in the practice environment: Changes that require additional knowledge, skill and judgment for a nurse to deliver safe, effective and ethical nursing care. For example, changes in the client population, nursing care delivery systems or legislation.

Entry-to-practice competencies: Expectations that all nurses must maintain throughout their career. The RN, RPN and NP competency statements are at **www.cno.org/qa**.

Interprofessional care: The provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings.

Peer: A member of the interprofessional team who understands your role as a nurse. A peer does not have to be in the same role as you.

Practice standards: For the purposes of the QA Program, the term *practice standard* refers to a College practice standard or practice guideline. A practice standard outlines the knowledge, skill and judgment necessary for safe practice, and includes accountabilities and responsibilities. Practice standards and guidelines are at **www.cno.org/publications**.

QUALITY ASSURANCE LEARNING PLAN – SAMPLE

Name: Sally Smith RPN Area of Nursing Practice: Direct Practice	CNO Registration # ABCD123 Position In Nursing: Surgical Nursing

Practice Document – Documentation Standard
Start Date – February 1
Completion Date – October 30

Goal	Activities to Achieve Goal	Evaluation of Changes to my nursing practice
In the next six months I want to be able to revise our inpatient surgical unit's documentation policy to reflect the CNO's Documentation (2008) standard.	Discuss current policy at our monthly staff meeting and/or unit council by April 30	Completing the learning module on documentation enabled me to understand more comprehensively the changes in nursing documentation and generated new knowledgerelated to nursing documentation
	Complete the CNO Documentation learning module on line at www.cno.org	Requesting a CNO Outreach Consultant is a new way to share knowledge as well as learning more about CNO.
	Contact CNO Outreach Consultant to arrange a teleconference/site visit to discuss documentation during Nurses Week in May	Creating a working group enabled others to be engaged in creating change is a meaningful way as well as learning more about our documentation standards
	By June 30, create a working group to include unit staff, educator, manager and a member from Nursing Council to review and revise current policy to reflect the changes in the CNO Documentation (2008) standard September 30 complete an initial draft of a revised documentation policy and seek approval at the monthly staff meeting. October 30 all staff will have received education on the revised documentation policy.	This gave me confidence in my ability to interpret and apply documentation standards and guidelines not only to my professional nursing practice but also in my practice setting

QUALITY ASSURANCE LEARNING PLAN – SAMPLE

Name: Billy Rubin RPN Area of Nursing Practice: Direct Practice	CNO Registration # 123 ABCD Position In Nursing: Long Term Care

Practice Document – Therapeutic Nurse Client Relationship Standard
Start Date – March 1
Completion Date – November 30

Goal	Activities to Achieve Goal	Evaluation of Changes to my nursing practice
In the next eight months I want to be able to identify ways to coach nursing students in our facility to maintain therapeutic relationships with our clients during their clinical and pregraduate experience.	To attend the CNO Teleconference in April on the Therapeutic Nurse Client Relationship Standard and encourage other students and colleagues to attend.	Attending the CNO teleconference and completing the learning module on documentation enabled me to understand more comprehensively the changes in the TNCR and generated new knowledge related to professional boundaries
	Complete the CNO Therapeutic Nurse Client Relationship (TNCR) learning module on line at www.cno.org by May 15	Developing key strategies enabled me to learn more about the TNCR standards.
	To develop some key strategies to maintain therapeutic nurse client boundaries and approve them at our staff meeting by the end of May.	This gave me confidence in my ability to interpret and apply TNCR standards and guidelines not only to my professional nursing practice but also in my practice setting. I have learned new strategies for my professional practice to ensure I maintain therapeutic boundaries with my clients.
	Provide education to all staff re: strategies in June.	
	Meet with the Nursing Faculty in June, my manger and colleagues to discuss what education has been provided to students and share ideas with faculty on strategies we have developed to ensure boundaries are maintained.	
	Therapeutic nurse client relationships with students are embedded in ongoing feedback during clinical and pre graduate as well as a standing agenda item at our monthly staff meetings	

QUALITY ASSURANCE LEARNING PLAN

Name: Area of Nursing Practice:	CNO Registration # Position In Nursing:

Practice Document – Start Date – Completion Date –

Goal	Activities to Achieve Goal	Evaluation of Changes to my nursing practice

COMPONENT TWO – PRACTICE REVIEW

Each year, the College randomly selects nurses to participate in Practice Assessment, which includes a review of the nurse's completed Learning Plan and other specified assessments (such as objective multiple-choice tests based on selected practice documents).

Members become eligible for Practice Assessment after two years of registration. Members of the General and Transitional Class will be randomly selected to participate in practice assessment; once selected, the member will be exempt for 10 years.

COMPONENT THREE – PEER ASSESSMENT

All nurses whom are randomly selected to participate in Component Two – Practice Review will have their Learning Plan and assessment results reviewed by a peer assessor. The College of Nurses of Ontario's Quality Assurance (QA) Committee then reviews the peer assessor's report and can recommend or direct the nurse to complete follow-up activities like completing learning modules on CNO's website.

Nurses who have successfully completed the process must continue to maintain and update their Learning Plan on an ongoing basis.

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College of Nurses of Ontario (2006). *Therapeutic Nurse Client Relationship.* Toronto: Author

College of Nurses of Ontario (2006) *Learning Module: Therapeutic Nurse Client Relationship.* Toronto: Author

College of Nurses of Ontario (2008). *Documentation.* Toronto: Author

College of Nurses of Ontario (2008). Learning Module: *Documentation.* Toronto: Author

The Regulated Health Statute Law Amendment Act (2009) (Bill 179)