SEIU NURSING DIVISION Healthcare

Quality Assurance Workbook 2013

HEART

For the second year, SEIU's Nursing Division is pleased to offer this Quality Assurance Workbook in recognition of the professional and compassionate care you provide every day – in hospitals, long-term care facilities, and the growing homecare sector.

Ontario's healthcare system is coming under increasing pressure because of a struggling economy and an aging population. Nursing is growing more stressful as a result. Inappropriate workload is taking a toll, as are the destabilizing effects of funding cutbacks and contracting out.

Our challenge as nurses and as a union is not simply to cope with change, but to shape it. SEIU is taking the challenge seriously. You'll see we have a new logo and website, even a new name - SEIU Healthcare. We are more committed than ever to making sure that your experiences and insights are heard by employers, the government, and the public. Your firsthand knowledge of care delivery must be respected and valued in order for change to be successful.

It's going to be an exciting year for SEIU Healthcare, and for the Nursing Division in particular. As 2013 progresses, we'll be undertaking a campaign that emphasizes the importance of employing all of Ontario's nursing professionals appropriately, in accordance with their full scope. It's a question of finding the right fit, so healthcare can be provided efficiently, but without losing the heart.

Heart is a strong word. It evokes warmth and compassion, courage and determination. No one represents those qualities more than nurses. As you use this Workbook to support your professional development, never lose sight of how much your work truly matters to those whose lives you touch.

Carol McDowell
Nursing Division President
SEIU Healthcare

INTRODUCTION

This is the second edition of our "Nursing Division – Quality Assurance Workbook" (SEIU, Rothwell, 2012). It is our hope that you found the first edition practical as you embarked upon your quality assurance journey for 2012! Continuing competence in our nursing profession is a critical issue for the public and our nursing profession. It is each and every nurse's responsibility to assure continuing competence in the best interest of quality, safe and ethical client care.

As nurses we are responsible and accountable for our own nursing practice. Nurses have a duty and obligation to comply with our codes of conduct, standards of practice and maintain our own nursing competence in the chosen field of their profession. We must engage in continuous lifelong learning so we are able to meet the current challenges that are presented each and every day in our nursing practice by the expansion of knowledge, evidence, changes in client demographics and health system enhancements and redesign.

Reflective practice is the key to maintaining our nursing competence! Reflective practice is a process that we continuously do each and every day when we enact nursing. Do you reflect on the clients you cared for? Do you think about what went well during that experience? Do you think of how you or your colleagues could have perhaps cared differently for a client and their family? This is reflective practice!

REFLECTIVE PRACTICE AND COMPETENCE

Reflective practice or self-assessment has gained popularity in nursing as a means to promote professional practice and assist nurses to maintain and improve their practice. For many nurses, self-assessment is acceptable as it is an independent way of improving one's own practice. It allows the individual nurse to consider his/her practice within the context of their own practice environment.

The College of Nurses of Ontario (2002) defines competence as "the nurse's ability to use his/her knowledge, skill, judgment, attitudes, values and beliefs to perform in a given role, situation or practice setting." Continuing competence ensures the nurse is able to perform in a complex and changing environment. It also increases the public's confidence in the nursing profession.

According to MacKay and Campbell (2001), defining competence can be challenging. Recognizing that this reference is somewhat dated, they did articulate that this can be described in a variety of ways both within and outside the profession of nursing. Many authors acknowledge that defining competence is difficult because of the complexity of the concept. However, there appears to be three (3) common threads amongst all definitions of competence:

1. Competence relates to the ability of a nurse to practice in a specific role;

2. Competence is influenced by the practice setting;

3. Competence is the integration of knowledge, skills, judgment, and abilities.

Standards of practice are "authoritative statements that describe the responsibilities for which practitioners are accountable; are used to protect the public, and monitor the quality of performance." (Campbell & Mackay, 2001). The College of Nurses of Ontario (2002) has clearly defined professional standards we as nurses must adhere to, one of which is competence. There are very specific indicators that we must ensure are embedded into our nursing practice.

SELF-REGULATION IMPORTANT – WHY IS IT IMPORTANT FOR ME TO UNDERSTAND AS A PROFESSIONAL NURSE?

As a professional nurse, understanding the concept of self-regulation is important because of its definition. Whether you are a novice, advanced beginner or expert nurse, you understand that protecting the public is at the core of your chosen profession.

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:

1) First, the consumer rights must be protected and promoted through the advocacy role of the nurse.

2) 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 to 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 entitled, "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.

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.

The Regulated Health Statute Law Amendment Act (Bill 179) received Royal Assent in 2009. The amendments introduced greater accountability and oversight mechanisms to the RHPA (gave more power to "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 a 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).

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.

QA Quality Assurance CHANGES FOR 2013! SO WHAT HAS CHANGED?

The College of Nurses has determined for this year that nurses will only need to identify two (2) learning goals and record them accordingly. Unlike previous years, the CNO determined which standard or guideline we needed to reflect upon in order to meet our QA requirements. Once you have identified your learning goals, you then need to link them to the most appropriate standard and/or guideline.

The College's QA (Quality Assurance) Program (2013) is based on the principle that lifelong learning is essential to continuing competence.

Nurses in every setting demonstrate their commitment to continually improving their nursing practice by engaging in practice reflection, and by setting and achieving learning goals.

Every nurse registered in the General or Extended classes is required by law to participate in QA. The College consulted with nurses across the province to develop its QA Program, which is designed to:

- support nurses in practicing according to the College's standards of practice
- help nurses develop the practice areas in which they have identified learning needs
- increase the public's confidence in the nursing profession.

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

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

Self-Assessment

Self-Assessment is a self-directed, two-part process that results in a Learning Plan. You are required to complete your Self-Assessment every year. Through the process of self-assessment, you identify your areas of strength, and learning needs. You are required to develop two learning goals each year. Once you have a learning goal, you choose the College practice document to which it relates. Each goal may be based on the same practice document or two different ones, whichever meets your learning needs.

There are two parts to the Self-Assessment component:

PART A: PRACTICE REFLECTION

By reflecting on your practice, you discover what your strengths and learning needs are. Getting peer input can help you identify strengths and learning needs that you missed or didn't think about, building on your own reflection. This will help you to continually improve your competence as a nurse.

When reflecting, consider how the following elements have an impact on your practice:

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 in your nursing practice may be an issue you have identified.

Changes in the practice environment: Changes that require additional knowledge, skill and judgment for a nurse to deliver safe 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 careers.

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.

You will use the results of your practice reflection –– your identified learning needs –– to develop learning goals and your Learning Plan.

If you use the Practice Reflection worksheet in myQA, (www.cno.org) then your learning needs are automatically transferred to your Learning Plan.

PART B: DEVELOPING AND MAINTAINING A LEARNING PLAN TO MEET YOUR LEARNING NEEDS

The results of Practice Reflection will form the basis of your Learning Plan.

Your Learning Plan is a record of the activities you did to help you maintain your competence as

a nurse.

You can use myQA to add your learning goals and learning activities to your plan. Remember, you have to choose the practice standard your goal relates to.

The College expects nurses to update their Learning Plan regularly and to keep it for two years.

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 (2013)
Component One – Self-Assessment

Self-Assessment is a self-directed, two-part process that results in a Learning Plan. You must participate in this component.

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.

Component Two - Practice Assessment

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.

Practice Reflection Worksheet (2013) – A SAMPLE

The following are key questions that you may consider when you reflect on your practice. The following illustrates an example of how you may document your reflective practice with the intent of developing the QA Program Learning Plan.

Describe an experience, event or change in your practice or practice setting that was significant to you.

1. Our organization implemented a workplace relations policy that addresses horizontal violence and work-place bullying. On my unit there is concern as to how one should approach colleagues when they are not team players. This has created conflict between some nurses.
2. I made a medication error by not administering the correct dosage. I was not aware of the eight (8) rights as the medication standard was revised from the College of Nurses.

Based on what you described above, what were your strengths and what were your areas of improvement?

1. I participated on the committee developing the workplace relations policy. I presented to my staff on the unit. However, I still have difficulty approaching colleagues when they do not support me or others.
2. Since my medication error, I have learned important principles of patient safety and to always practice using the eight (8) rights to medication safety. I need to learn more about the changes in safe medication practice.

What input have you received from your peers about your practice?

1. I am a team player and create a positive work environment.
2. I am a good coach and mentor for the PN students that practice on our unit during their practical.
3. I am patient centered and take good care of my clients.

Based on your own reflection and input you received, what are your learning needs?

1. I need to complete the Medication Learning module from the College of Nurses of Ontario (www.cno.org) to ensure I know all of my practice expectations to practice safely and competently.
2. I need to learn how to approach my colleagues in a professional manner when there is a disagreement or misunderstanding to avoid conflict.

Practice Reflection worksheet

Use this worksheet to reflect on your practice; you can use more than one if you need to. You do not have to submit this worksheet to the College if you are selected for Practice Assessment.

Describe an experience, event or change in your practice or practice setting that was significant to you.

What happened?

What was your role?

Based on what you described above, what were your strengths and what were your areas for improvement?

Areas for improvement will inform your learning needs.

What input have you received from your peers about your practice?

Consider asking: "Can you give me an example of what my learning needs might be?"

Consider any feedback you have received from clients.

Based on your own reflection and the input you received, what are your learning needs?

What do you need to learn to improve your practice?

Which elements relate to your learning needs?

- ☐ Advances in technology
- ☐ Changes in the practice environment
- ☐ Entry-to-practice competencies
- ☐ Interprofessional care

QUALITY ASSURANCE PROGRAM LEARNING PLAN (2013)

Collection of Personal Information

The College of Nurses of Ontario (the College) collects the information in the Learning Plan for Practice Assessment under the general authority of the RegulatedHealth Professions Act, 1991, S.O. 1991, c. 18, the Nursing Act, 1991, S.O. 1991, c. 32, and its regulations, and the College's bylaws. The College collects the information for the purpose of assessing your continuing competence 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.

Name	
Registration Number	QA Year
Class	Current Practice Setting
Client Population	

Learning Needs

What learning needs did I identify through Practice Reflection?

1. To complete the Medication Standard Learning module from CNO to ensure I practice safely and competently.
2. To learn more about conflict resolution by reading the Conflict Prevention and Management Guideline developed by CNO.

Learning Goal #1

What do I want to learn?

To complete the Medication Standard Learning module from CNO to ensure I practice safely and competently.

Which practice document does my goal relate to?

Medication Revised (2008).

Goal #1: Activities and Timeframes

How am I going to achieve my goal?

1. By March 31, I will complete the Medication Learning Module on line.
2. I will review two (2) articles related to safe medication practice by reading the Institute of Safe Medication (ISMP) updates.
3. By June 30, I will ask my manager and educator to provide our nurses with an update on the changes to the Medication Standard so that all my colleagues are aware of these changes to their practice.
4. On a quarterly basis, I will review the Standard from the College of Nurses of Ontario to ensure I am aware of changes to practice.
5. I will present to my colleagues at our staff meeting in June, the lessons I have learned.

Learning Goal #2

What do I want to learn?

To review current literature on conflict in the workplace and to review the Conflict Prevention and Management guideline from CNO.

Which practice document does my goal relate to?
Conflict Prevention and Management (2006).

Goal #2: Activities and Timeframes

How am I going to achieve my goal?

1. By May 31 I will review the Conflict Prevention and Management (2006) document from the CNO.
2. Discuss the new policy and procedure that the organization has developed at a staff meeting in March.
3. Read articles relevant to conflict in the workplace to help me with addressing issues with my colleagues.
4. Review the Registered Practical Nurses Association website for materials relevant to RPN practice relating to conflict in the workplace on a monthly basis.
5. Ask our educator to provide education on conflict resolution by September 30.

How do my learning goals support my commitment to continuing competency?

How does my learning relate to the competencies of my practice?
I am able to keep up to date and competent on safe medication practices and develop strategies on how to deal with workplace conflict. This will create a quality work environment for other nurses.

Evaluation of changes/outcomes to my practice

What did I learn? What impact has my Learning Plan had on my practice?
I have learned the importance through my error of ensuring I am aware of standard changes. The learning module helped me enhance my practice. I am much more confident with approaching colleagues when there is a practice issue.

QA PROGRAM LEARNING PLAN FORM

Collection of Personal Information

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Name	
Registration Number	QA Year
Class	Current Practice Setting
Client Population	

Learning Needs: What learning needs did I identify through Practice Reflection?

Haven't done Practice Reflection yet? Use the Practice Reflection worksheet to help you identify your strengths and learning needs.

Learning Goal #1: What do I want to learn? Which practice document does my goal relate to?

Need help creating a goal? Review the Developing SMART Learning Goals guide.

Your learning goal must be based on your current practice setting and one of the College's practice documents.

Goal #1: Activities and Timeframes: How am I going to achieve my goal?

Learning Goal #2 What do I want to learn? Which practice document does my goal relate to?

Need help creating a goal? Review the Developing SMART Learning Goals guide.

Your learning goal must be based on your current practice setting and one of the College's practice documents.

Goal #2: Activities and Timeframes How am I going to achieve my goal?

Learning Goal #3 What do I want to learn? Which practice document does my goal relate to?

Need help creating a goal? Review the Developing SMART Learning Goals guide.

Your learning goal must be based on your current practice setting and one of the College's practice documents.

Goal #3: Activities and Timeframes How am I going to achieve my goal?

How do my learning goals support my commitment to continuing competency?
How does my learning relate to the competencies of my practice?

Continue to maintain and update your Learning Plan throughout the year.

Evaluation of changes/outcomes to my practice

What did I learn? What impact has my Learning Plan had on my practice?

QA PROGRAM LEARNING PLAN FORM

Collection of Personal Information

The College of Nurses of Ontario (the College) collects the information in the Learning Plan for Practice Assessment under the general authority of the RegulatedHealth Professions Act, 1991, S.O. 1991, c. 18, the Nursing Act, 1991, S.O. 1991, c. 32, and its regulations, and the College's bylaws. The College collects the information for the purpose of assessing your continuing competence 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.

Name	
Registration Number	QA Year
Class	Current Practice Setting
Client Population	

Learning Needs: What learning needs did I identify through Practice Reflection?

1. Learn more about providing culturally sensitive care.

2. Learn about how social media can affect the nurse-client relationship.

3. Understand more about the increase in sexually transmitted diseases and strategies to address this concern

Haven't done Practice Reflection yet? Use the Practice Reflection worksheet to help you identify your strengths and learning needs.

Learning Goal #1: What do I want to learn? Which practice document does my goal relate to?

Culturally Sensitive Care practice guideline

As a NP working with a diverse client population, I want to identify resources to support staff in providing culturally sensitive care. I will achieve this goal by October 30.

Need help creating a goal? Review the Developing SMART Learning Goals guide. Your learning goal must be based on your current practice setting and one of the College's practice documents.

Goal #1: Activities and Timeframes: How am I going to achieve my goal?

1. By January 15, I will review the Culturally Sensitive Care practice guideline.
2. By April 1, I will complete a literature review on this topic using the CINAHL database in the workplace library.
3. By June 1, I will contact pastoral services to request a fall presentation for staff to include information about providing culturally sensitive care and client cultures we commonly encounter in practice.
4. By August, I will collaborate with the rest of the team to create a resource binder about providing culturally sensitive care for staff using relevant resources from the literature review and the organization.
5. By October 30, I will reflect on and document my own culture, values, beliefs and biases, and consider how this may affect my approach to client care.

Learning Goal #2 What do I want to learn? Which practice document does my goal relate to?

Therapeutic Nurse-Client Relationship practice standard

I want to develop an in-service session for nursing staff that identifies the risks associated with using social media, and the possible effect on the nurse-client relationship. I want to hold the session by the end of the fall.

Need help creating a goal? Review the Developing SMART Learning Goals guide.

Your learning goal must be based on your current practice setting and one of the College's practice documents.

Goal #2: Activities and Timeframes How am I going to achieve my goal?

1. *February: Review the Therapeutic Nurse-Client Relationship practice document and webcast.*
2. *May: Review workplace policies related to the use of social media.*
3. *July: Research and develop a glossary of various social media applications.*
4. *September: Complete a literature search on social media and nurse-client relationships, and identify the most relevant articles for review.*
5. *October: Develop and deliver an in-service presentation for nursing staff on the potential risks associated with using social media.*

Learning Goal #3 What do I want to learn? Which practice document does my goal relate to?

Nurse Practitioner practice standard

I want to participate in the development of strategies to address the increase of sexually transmitted diseases (STDs) among teenagers in my community. I want to begin implementation by the late fall.

Need help creating a goal? Review the Developing SMART Learning Goals guide.

Your learning goal must be based on your current practice setting and one of the College's practice documents.

Goal #3: Activities and Timeframes How am I going to achieve my goal?

1. *January: Set up focus groups with teenagers in the community to better understand the reason for the increase in STDs.*
2. *May: Conduct educational sessions at the local high schools on the risks of STDs.*
3. *July: Submit a proposal to run a sexual health clinic on weekends and evenings at the local community centre.*
4. *September: Meet with other members of the health care team to gain support to operate a full-time sexual health clinic.*

How do my learning goals support my commitment to continuing competency?
How does my learning relate to the competencies of my practice?

I am remaining competent by learning about culturally sensitive care and how social media can affect the nurse-client relationship. I am also learning about and developing strategies to decrease the number of STDs in my community. This new knowledge will contribute to quality nursing practice and increase the public's confidence in the profession.

Continue to maintain and update your Learning Plan throughout the year.

Evaluation of changes/outcomes to my practice
What did I learn? What impact has my Learning Plan had on my practice?

1. *The presentation by the community centre's Director has given many of the staff, including myself, the opportunity to reflect on our own cultures, values, beliefs and biases and how these can affect client care.*
2. *Staff have been referencing the Culturally Sensitive Care resource binder I helped develop. The Nurse Educator and I have received positive feedback. Staff have also added resources to it, such as the contact information for the organization's interpreter services.*
3. *I received positive feedback from my peers about my in-service presentation on social media.*
4. *I have a better understanding of how nurses use social media and the adverse affect this technology can have on the nurse-client relationship if used inappropriately.*
5. *I have begun to develop strategies with my colleagues and students to decrease the number of STDs. There has been an increase in clients coming into the clinic to be screened.*

PRACTICE STANDARD

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario
THE STANDARD OF CARE.

Medication, Revised 2008

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

THE STANDARD OF CARE.

VISION
Leading in regulatory excellence

MISSION
Regulating nursing in the public interest

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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 role, job description or area of practice.

— College of Nurses of Ontario

Introduction

Safe, effective and ethical medication practice is an important component of client care. As with any nursing procedure, administering, recommending and/or prescribing[1] a medication requires knowledge, technical skills and judgment. Nurses[2] need the competence to assess the appropriateness of a medication for a client, manage adverse reactions, understand issues related to consent and make ethical decisions about the use of medications. As well, client care environments need systems and structures that support and facilitate safe medication practice.

The College of Nurses of Ontario's (the College's) practice standards apply to all nurses regardless of their role or practice area. Nursing practice standards are expectations that contribute to public protection. They inform nurses of their accountabilities and the public of what to expect of nurses.

College practice standards, along with the *Regulated Health Professions Act, 1991* (RHPA) and *Nursing Act, 1991,* provides a framework for nursing practice.[3]

Medication, Revised 2008 replaces the 2003 *Medication* practice document and includes four standard statements with indicators that describe nurses' accountabilities for medication practice. Administering a medication is one component of a continual process that goes beyond the task of giving a medication to a client. Nurses must apply their knowledge about the client and the medication when assessing, planning, implementing and evaluating the process. The College advocates for the same nurse performing all administration steps to minimize the chance of error and clarify individual accountability. This document applies to prescription drugs as well as other substances, including over-the-counter medications and herbal preparations. The decision tree on page 14 can help nurses decide about medication administration and determine if administering a specific drug is within their individual nursing role.

Nursing education

As a result of differences in basic nursing education, the foundational knowledge of RNs and RPNs is different. Both categories study from the same body of nursing knowledge, which includes pharmacology. However, RNs study for a longer period of time, allowing for a greater depth and breadth of knowledge. Those who apply for College registration must meet basic RN and RPN competencies for medication administration. Nurse Practitioners (NPs) demonstrate additional competencies associated with their authority to prescribe a drug.[4] To determine the category of nurse most appropriate to administer a medication in a particular context, the needs of the client, the knowledge, skill and judgment of the nurse, and the features of the practice environment need to be reviewed.[5]

In practice, nurses may need to administer medications by routes and methods that were not included in the experiences of their basic educational program. While nurses will have learned the competencies associated with safe medication practices, they may need additional knowledge to competently assume these responsibilities. You can acquire such knowledge and skill in continuing education courses or in-service education. As well, you need to become familiar with the policies and procedures provided

[1] Nurse Practitioners have the additional authority to prescribe a drug.

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

[3] For more information on the legislation governing nursing practice, see Appendix A on page 17.

[4] For more information, refer to the College's *Nurse Practitioner* practice document at www.cno.org/docs.

[5] For more information, refer to the College's *Utilization of RNs and RPNs* practice document at www.cno.org/docs.

by an employer. Nurses are accountable for assessing their competencies and related skills in providing care related to medications. Even nurses who do not administer medications must still understand the actions (for example, purposes, risks and potential side effects) when caring for clients who receive medications as part of their treatment plan.

Standard Statements

There are four standard statements, each with accompanying indicators, that describe a nurse's accountabilities related to medication practice. The standard statements describe broad principles that guide nursing practice and are listed in a manner that reflects the steps of the nursing process. The standard statements have been organized for clarity; however, the process is not a linear progression. For example, it is expected that assessment will occur throughout all phases of medication administration and not solely as the first step in the process. The indicators are broad statements that nurses can apply to their particular practice environment.

1. Assessment

Nurses use their knowledge, skill and judgment in the assessment of the client, the medication and the practice supports prior to administering medication.

Indicators

The nurse meets the standard by:

a) accepting **authorizing mechanisms**[6] only from prescribers with ordering authority (for example, physicians, NPs, dentists, chiropodists and midwives);
b) accepting a medication order that is complete and includes the order date, client name, medication name, dose in units, route, frequency, purpose (for example, a research or PRN medication), and prescriber's name, signature and designation (the prescription label is the order);
c) accepting an outpatient or community order[7] for medication that includes all of the above information as well as the amount to be dispensed, the duration of therapy and the number of repeats or refills;
d) withholding the medication and following up with a prescriber in a timely manner in the event that a medication order is incomplete, unclear, inappropriate or misunderstood;[8]
e) requesting written orders when the prescriber is present, or only accepting electronic orders when there is a secure system in place (for example, via a secure fax or e-mail);
f) accepting a **verbal order** only in an emergency situation or when the prescriber cannot document her or his orders (for example, in the operating room or during a code);
g) recognizing that **telephone orders** should be limited to situations requiring direction for client care when the prescriber is not present;
h) ensuring that verbal and telephone orders are repeated in their entirety for accuracy;
i) documenting verbal and telephone orders as well as the prescriber's name and designation in the client's record (the nurse is not responsible for ensuring that such orders have been signed by the prescriber);[9]
j) assessing her or his own knowledge, skill and judgment to competently carry out medication administration, use medication equipment and intervene during an **adverse reaction**;

[6] Bolded words are defined in the glossary on page 9.

[7] Clients in the community may not be regularly assessed by a health care provider or have pharmaceutical supports in place to promote client safety. Limiting the amount of medication and the time the medication is available helps ensure that clients receive an appropriate course of therapy.

[8] For more information, refer to the College's *Disagreeing With the Plan of Care* practice document at www.cno.org/docs.

[9] For more information, refer to the College's *Documentation, Revised 2008* practice document at www.cno.org/docs.

[10] For more information, refer to the College's *Consent* practice document at www.cno.org/docs.

k) verifying that informed consent[10] has been obtained from the client or the client's substitute decision-maker;
l) assessing the appropriateness of the prescribed medication for the client by considering the:
   - client's age, weight, pathophysiology, laboratory results, vital signs, medication knowledge, and choice or preference,
   - expected benefits and potential risks/side effects, the possible interaction with other medications, and any foods that are contraindicated or decrease absorption,
   - client's allergies, sensitivities and previous adverse reactions, and
   - appropriate use of the medication as prescribed for the client in the particular situation (for example, a PRN medication);
m) ensuring and/or advocating for appropriate resources to monitor and intervene to manage potential adverse drug reactions (for example, having the prescriber on-site before administration);
n) performing all of the administration steps to minimize the chance of error and clarify individual accountability (for example, exercising judgment in deciding whether to involve other nurses in preparing the vaccine in a mass-immunizing campaign); and
o) identifying and advocating for systems and resources that support nurses in maintaining competency in medication practice.

2. Planning

Nurses are accountable for ensuring the accuracy, appropriateness and completeness of a client's plan of care in regards to medication order(s), and for communicating concerns about the treatment plan to other members of the health care team.

Indicators

The nurse meets the standard by:

a) transcribing medication orders as written, or validating the accuracy and completeness of the transcription when others have completed the transcribing;
b) scheduling dosing times for a medication, taking into consideration the effect of food intake on medication absorption, contraindications, required interventions before, during and after administration (for example, blood pressure), and client choice or preference;
c) refraining from accepting medication order information from those who do not have pharmacology knowledge (for example, a unit clerk);
d) communicating orders with individuals within the circle of care (for example, the health care team or client or, with consent, the family);
e) demonstrating clear, evidence-based rationale for decisions and taking appropriate steps[11] to resolve issues relating to medication administration; and
f) advocating for systems that provide a mechanism for resolution when there is disagreement among members of the health care team regarding a medication order.

[11] For more information, refer to the College's *Disagreeing With the Plan of Care* practice document at www.cno.org/docs.

3. Implementation

Nurses prepare and administer medication(s) to clients in a safe, effective and ethical manner.

Indicators

The nurse meets the standard by:

a) ensuring that the client receives appropriate education about the treatment plan and current medication;
b) ensuring that the client or the client's substitute decision-maker has given consent[12] to administer the medication;
c) preparing and administering the medication according to an evidence-based rationale;
d) obtaining a new supply of medication if there are concerns about how the medication has been maintained;
e) applying principles of infection prevention and control[13] when administering medication;
f) verifying:
   - the right client,
   - the right medication,
   - the right reason,
   - the right dose,
   - the right frequency,
   - the right route,
   - the right site, and
   - the right time;[14]
g) ensuring that the client receives appropriate monitoring during and after administering the medication, and intervening if necessary;
h) documenting, during and/or after medication administration, in the client's record according to documentation standards;[15] and
i) advocating for appropriate environmental supports to ensure clients receive safe, effective and ethical care.

4. Evaluation

Nurses evaluate client outcomes following medication administration and take appropriate steps for follow-up.

Indicators

The nurse meets the standard by:

a) recognizing client outcomes following medication administration, including effectiveness, side effects, signs of adverse reactions and/or drug interactions;
b) following up with the prescriber regarding any concerns or questions about the medication;
c) referring clients to the appropriate care provider for further assessment and follow-up when necessary (for example, when the underlying problem persists despite PRN medication);
d) documenting actions taken or advice given and client outcomes according to documentation standards;
e) documenting, when appropriate, if the client is capable of self-administering the medication, including the type of assistance the client requires, if any, and the ongoing nursing assessment of the client's capacity to continue self-administration; and
f) advocating for adequate resources and systems that facilitate safe, effective administration according to standards.

[12] For more information, refer to the College's *Consent* practice document at www.cno.org/docs.

[13] For more information, refer to the College's *Infection Prevention and Control* practice document at www.cno.org/docs.

[14] This is known as the rights of medication administration.

[15] For more information, refer to the College's *Documentation, Revised 2008* practice document at www.cno.org/docs.

Enhancing Client Safety

Nurses and employers have a shared responsibility to create safe practice environments. Quality practice settings include appropriate staff, medication systems (for example, delivery, administration, policies, procedures) and environments to facilitate safe, effective and ethical care. The following section provides information and resources to help nurses and employers work together to prevent and resolve medication issues.

Safe medication practices

To support safe medication practice, systems need to be in place to track, address and learn from any medication errors that occur in the practice environment.

Medication errors

A medication error is defined as any preventable event that may cause or lead to inappropriate medication use or client harm while the medication is in the control of the health care professional, client or consumer. Such events may be related to professional practice, health care products, procedures and systems, including prescribing; order communication; product labelling, packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring and use.[16]

Medication errors can be further classified into errors of commission (for example, giving the wrong medication) and errors of omission (for example, not administering an ordered medication), which can result in an adverse drug event resulting in harm, injury or death. Or, it could result in a "near miss." In this situation, an error does not reach the client, but had it, the client could have been harmed. (For example, a wrong dose is prescribed but is intercepted before administration.)

Preventing and reducing errors involves collaboration between the nurse, other health care professionals and the facility. Nurses can often identify and correct errors before they occur. Addressing individual accountability and using a systems-based approach to analyze errors ensures that errors are identified, and that staff participate in an interprofessional process that identifies root causes and results in corrective actions. When an error is made, the nurse must ensure the well-being of the client and limit the client's exposure to any potential harm. The plan of action will depend on the problem(s) identified. Some strategies to address problems are system modifications, in-service education, individual assistance and potential performance management.

Safe medication practice includes:

- advocating for setting-specific, accessible, current **medication information**, such as drug formularies;
- evaluating the need for a colleague to conduct an **independent double-check** on a prepared medication;
- meeting and being aware of the facility's expectations on independently double-checking preparations;
- advocating for written policies and supporting processes when the practice setting requires independently double-checking preparations;
- having knowledge of **high alert medications** for the practice setting (for example, chemotherapeutic agents);
- avoiding the use of error-prone abbreviations, dose designations and symbols, and advocating for a policy on the use of acceptable abbreviations;
- reporting all errors and near misses using formal practice-setting communication mechanisms;
- advocating for organizational systems and policies that promote continuity and safety of client medication administration during transfer of care and at transition points;
- ensuring that the client or the client's substitute decision-maker has the most complete and accurate list possible of all medications currently being taken;
- communicating to the client and appropriate

[16] (National Coordinating Council for Medication Error Reporting and Prevention, 2008)

caregivers the current list of medications during **transfer of accountability**;
- addressing system issues that contribute to medication errors;
- advocating for and/or participating in interdisciplinary error-reporting and root cause system analysis;
- advocating for facility policies and/or procedures regarding disclosure of adverse events; and
- following legislation and/or advocating for practice setting policies and procedures regarding the storage, counting, administration and disposal of medication.

Medication reconciliation

This process is intended to prevent medication errors when a client's care is transferred. Medication reconciliation assists in reducing the risk of preventable adverse events and is an important client safety initiative. The medication reconciliation process may involve all members of the health care team.

The process involves:
- creating the most complete, accurate list of all medications a client is currently taking and the time the last medication was given (for example, a best possible medication history);
- using this list when writing admission medication orders;
- comparing the list and the admission medication orders;
- identifying any discrepancies and, if any are found, bringing them to the attention of the prescriber and making appropriate changes to the orders;
- communicating the current list of medications to the client and appropriate caregivers;[17] and
- comparing the medication history to transfer/discharge orders to ensure that the client's medications are reconciled at transfer/discharge.[18]

Institute for Safe Medication Practices Canada

The Institute for Safe Medication Practices (ISMP) Canada is an independent, national, non-profit agency committed to the advancement of medication safety in all health care settings. It works collaboratively with the health care community; regulatory agencies and policy-makers; provincial, national and international client safety organizations; the pharmaceutical industry and the public. ISMP Canada is a resource for information on how to prevent errors and identify high alert medications. It also has a list of industry accepted abbreviations. For more information, contact ISMP Canada at:

Toll-free: 1 866 544-7672
E-mail: info@ismp-canada.org
Website: www.ismp-canada.org

Adverse drug reactions

A serious adverse drug reaction (ADR) is defined as a noxious and unintended response to a drug that occurs at any dose and requires in-patient or extended hospitalization; causes congenital malformation; results in persistent or significant disability/incapacity; is life-threatening or results in death.[19] A nurse who assesses a serious ADR should report it or advocate for reporting it to the Canada Vigilance Program:

Toll-free: 1 866 234-2345
Website:
www.hc-sc.gc.ca/dhp-mps/medeff/index_e.html

[17] (Institute for Safe Medication Practices Canada, 2006)

[18] (Safer Healthcare Now, 2007)

[19] (Health Canada, 2007)

Glossary

Adverse reaction. Undesirable physical reactions to health products, including drugs, medical devices and natural health products. Drugs include prescription and non-prescription pharmaceuticals; biologically derived products such as vaccines, serums and blood derived products; cells, tissues and organs; disinfectants and radiopharmaceuticals.[20]

Authorizing mechanism. An order, initiation, directive[21] or delegation. A means specified in legislation or described in a practice standard or guideline through which nurses obtain the authority to perform a procedure or make the decision to perform a procedure.[22]

High alert medications. Drugs that bear a heightened risk of causing significant client harm when they are used in error.[23]

Independent double-check. A process that ensures that a second practitioner conducts a verification, either in the presence or absence of the first practitioner. For example, a nurse may use this process to verify a dosage calculation. The most critical aspect is to ensure that the first health care provider does not communicate what he or she expects the second practitioner to find; this would reduce the visibility of a mistake.[24]

Medication information. Information about a specific drug such as indications, appropriate dose, precautions, contraindications, drug/food interactions, expected outcomes, potential adverse reactions, side effects and how to minimize and treat them, high alert medications, special consideration, storage and administration.

Telephone order. An order communicated via telephone by an authorizer who is not physically present to write the order. The person accepting the order must have knowledge of the client, including his or her health history and treatment plan. Ultimately, the person implementing the order is accountable for ensuring that the order is appropriate. Practice settings should establish procedures for timely sign-off by the authorizer of the telephone order.

Transfer of accountability. An interactive process of transferring client-specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity of care and the safety of the client.[25]

Verbal order. An order that is communicated by an authorizer who is present in the practice environment but is unable to document the order. Verbal orders must only be used in emergency situations or when the prescriber is unable to document the order, such as in the operating room.

[20] (Health Canada, 2007)

[21] For more information, refer to the College's *Directives* practice document at www.cno.org/docs.

[22] For more information, refer to the College's *Authorizing Mechanisms* practice document at www.cno.org/docs.

[23] (Institute for Safe Medication Practices Canada, 2008)

[24] (Institute for Safe Medication Practices Canada, 2008)

[25] (Patton, 2007)

Medication Terms

Allergy challenge testing. The administration of an allergen by oral, inhaled or other route in which a positive test is a significant allergic response (for example, anaphylactic shock). Unless delegated, nurses cannot perform allergy challenge testing.

Allergy testing and desensitizing injections. An allergy test is a prick/puncture procedure to determine allergies, if any. A positive test results in a wheal and area of erythema. A desensitizing injection is an intracutaneous injection to desensitize to an allergen. Because allergy testing and desensitizing injections carry a risk of adverse reactions, nurses must be able to recognize side effects, intervene in the event of complications (for example, difficulty breathing, rash or anaphylactic shock) and manage outcomes. If the nurse cannot manage adverse outcomes, a competent health care practitioner and appropriate environmental supports and medications must be readily available.

Controlled substance. Any type of drug that the federal government has categorized as having a higher-than-average potential for abuse or addiction. Such drugs are divided into categories based on their potential for abuse or addiction. Controlled substances range from illegal street drugs to prescription medications.[26]

The Office of Controlled Substances of Health Canada regulates the distribution of controlled substances in Canada, including those substances used by individuals and health care facilities for legitimate scientific or health reasons. The governing federal legislation includes the *Controlled Drugs and Substances Act*, the *Narcotic Control Regulations*, Part G (Controlled Drugs) of the *Food and Drug Regulations and Benzodiazepines and Other Targeted Substances Regulations*.

Under the legislation, all licensed health care facilities in Ontario, such as public hospitals, private hospitals and long-term care facilities as defined by the *Nursing Homes Act*, are required to maintain a count of controlled substances. Facilities that are not provincially licensed as defined by the *Homes for the Aged and Rest Homes Act* are not bound by the *Controlled Drugs and Substances Act* and related regulations.

Immunizing agent(s). A vaccine. The skill required to administer immunizing agents is the same as that for other injections. For more information, refer to the College's *Influenza Vaccinations* practice guideline.

Over-the-counter (OTC) medication without an order. Medications and preparations that do not require a prescription; for example, herbal therapies and acetaminophen. OTC medications are not part of the act of prescribing. In some situations, however, the nurse's role may include administering or recommending OTC medications to clients. Nurses are solely accountable for recommending OTC medications to clients and for any outcomes of those recommendations. Before recommending an OTC medication, nurses must have the knowledge, skill and judgment about the client's situation; the client's condition and medication profile; and the medication. Legislation or organizational policies may require an order from an authorized prescriber. For more information, refer to the College's *Complementary Therapies* practice document.

Placebo. A pharmacologically inert substance that has no physiological effect. Administering placebos to clients without their knowledge and informed consent is inappropriate and unacceptable.

Placebos may be administered:

- when prescribed with client consent because the client experiences a placebo effect; and/or
- as part of a double-blind research study in which the client has been informed, as part of the consent process, that he or she may receive a placebo.

[26] (Health Canada, 2008)

PRN medication(s). Medications that are prescribed and administered as needed. The order includes the frequency, such as Q4H, and the purpose (for example, sleep, pain or nausea). Nurses must have current knowledge of the use and action of PRNs, as well as the competence to assess the need for PRNs and whether to administer them to a client.

Range doses. Dosages, frequencies or routes that are prescribed in ranges (for example, Gravol 50–100 mg for nausea). Most medications are not prescribed in range doses; however, range doses are used in situations in which the need for the amount of a drug varies from day to day or within the same day. Range doses give nurses the flexibility to administer the dose that best suits the assessment of the client.

Self-administration. Administrating one's own medication. Clients may self-administer their medications at home and in some agencies to develop or maintain an optimal level of functioning and independence. Clients who self-administer may be completely independent, or may require some assistance, such as reminders, help opening containers or assistive devices (for example, dosettes), or help in filling assistive devices. Nurses must ensure that medications are securely stored.

When using investigational and emergency release medications (off label). When physicians prescribe these medications, the physician or pharmacist must give the nurse a drug monograph/information. Although the nurse is not accountable for any outcomes produced by the medications, the nurse is accountable for correctly administering the drug, and is required to intervene and possibly withhold medications if severe side effects occur. After administration, the nurse monitors the client for adverse side effects.

When using medication brought from home. In some settings, such as geriatric daycare centres and children's camps, clients bring their medications from home. Nurses may administer these medications if they are in their original dispensing containers (that is, not in an envelope or assistive device for self-administration). If the information provided by the client or the client's representative is different from that on the dispensing label, the nurse needs to use her or his judgment about the appropriateness of following the directions and follow up with the prescriber when required. The nurse should document the discrepancy and her or his rationale for following the chosen directions.

Additional Information

Administration of medication by an unregulated care provider (UCP)

Technological advances, shorter hospital stays, fiscal constraints and a general shift to community-based care have contributed to the increased use of UCPs to assist with or perform aspects of care, including medication administration, that were formerly provided by regulated care providers. Nurses may teach UCPs medication administration, including the process of administration and documentation, as required. Although administering by some routes is not a controlled act and doesn't require delegation, there is still a risk of harm when performing any procedure if it is not done competently. The nurse remains responsible for the:

- ongoing assessment of the client's needs;
- plan of care in conjunction with the health care team;
- evaluation of the client's health status; and
- effectiveness of the medication(s).

UCPs do not have the knowledge to provide this component of the plan of care. If the nurse decides it is appropriate for the UCP to administer medication(s), the nurse is accountable to ensure criteria are developed and communicated to the UCP that clearly define when the UCP needs to contact the nurse. The nurse must make provisions to ensure an ongoing assessment of the client's condition.[27]

Dispensing

Dispensing is a controlled act authorized, to various extents, to some health care professionals, including pharmacists, NPs, physicians and dentists. It involves the selection, preparation and transfer of one or more prescribed drug doses to a client or his or her representative for administration. Dispensing applies to prescription medications only, not to over-the-counter medications. Although repackaging is performed both with the delegation of dispensing and when delegation is not required, the difference lies in what medication you are repackaging.

Dispensing involves:

- receiving/reading the prescription;
- adjusting the order according to approved policy (for example, substitution), if appropriate;
- selecting the drug to dispense;
- checking the expiry date;
- reconstituting the product, if needed;
- repackaging the drug;
- labelling the product; and
- completing a final physical check to ensure the accuracy of the finished product.

RNs and RPNs do not have access to the controlled act of dispensing; however, some health care professionals (e.g., pharmacists, physicians) can delegate the act of dispensing to RNs and RPNs. NPs are not authorized to delegate dispensing.

Each practice setting must identify who is delegating the authority to dispense and the RNs and RPNs delegated with the authority, the delegation process, and client specific orders or directives for dispensing specific types of drugs.

Therefore, delegation is required for RNs and RPNs to perform any of the following activities:

- preparing/packaging leave of absence (LOA) or pass medication from a drug supply not previously dispensed to the client (for example, prescribed ward stock);
- filling a mechanical aid or alternative container from a ward stock or unit dose supply for client self-administration or for a UCP to administer;
- providing clients with several doses (from stock supply) for self-administration (for example, giving the client either the entire prescription or several doses in an emergency department, or providing oral contraceptives or antibiotics in a clinic to take home);
- repackaging large-volume ward stock into smaller containers for another alternate ward stock supply; and
- providing sample prescription drug packs.

[27] For more information, refer to the College's *Utilization of Unregulated Care Providers (UCPs), Working With Unregulated Care Providers* and *Authorizing Mechanisms* practice documents at www.cno.org/docs.

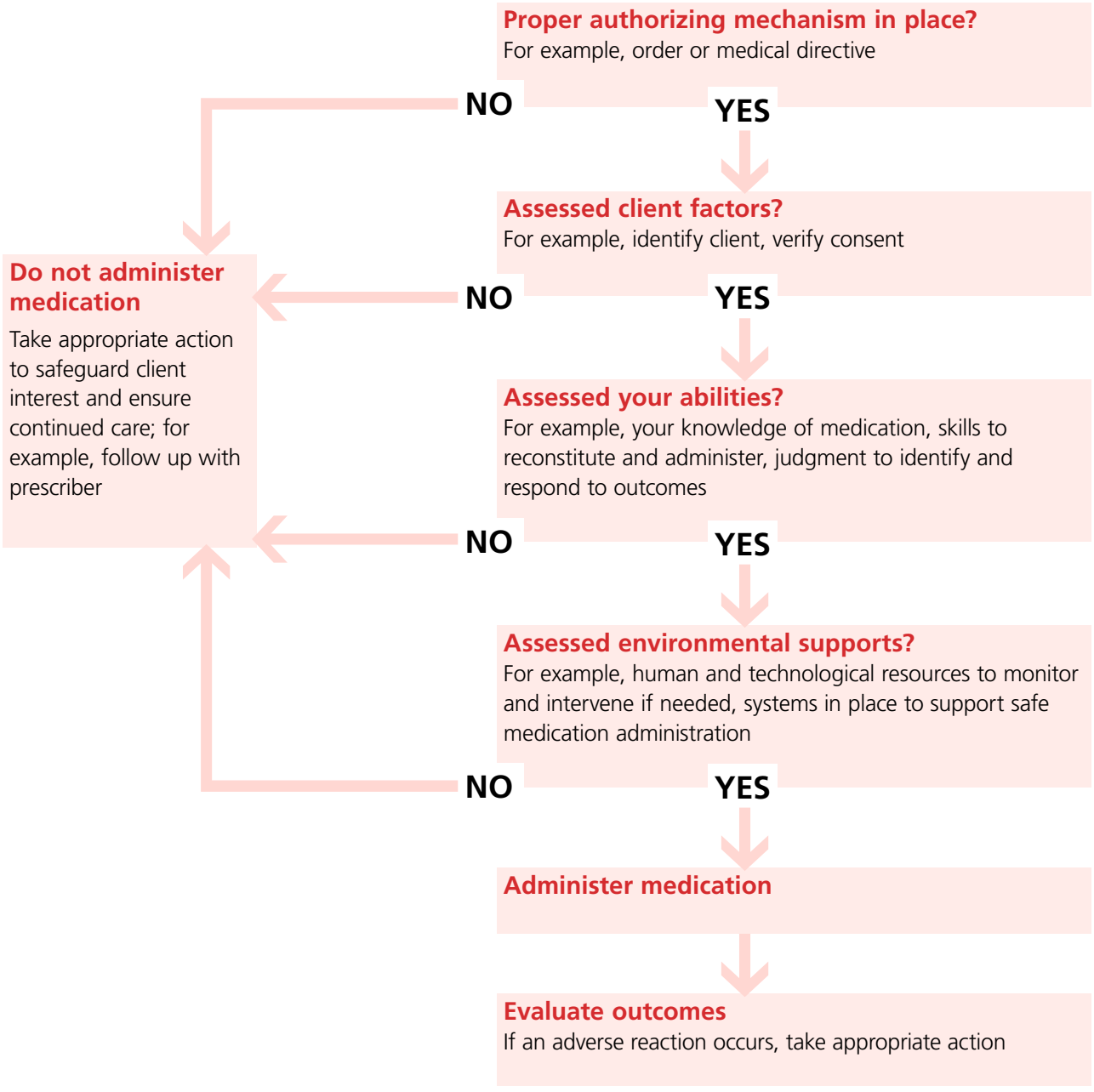
Conversely, nurses do not require delegation to repackage a drug. Because dispensed drugs come in blister packs, vials or unit dose packages labelled with the drug name, dose, frequency and the client's name, it is considered repackaging, not dispensing, to do the following:

- fill a mechanical aid or alternative container from the client's own blister pack or prescription bottle to facilitate self-administration or administration by a caregiver;
- repackage and label drugs from the client's own blister pack or vial for an LOA;
- give a client LOA medications prepared by a pharmacy; or
- give a client her/his blister pack or prescription bottle to take on an LOA.

For more information on delegation, refer to the College's *Decisions About Procedures and Authority, Revised 2006* practice standard and *Authorizing Mechanisms* practice guideline.

Decision Tree: Deciding About Medication Administration

Use this tool to help you determine whether or not to administer a medication. Be sure to consider all of the components of medication administration in this document.



Note: *Document during and/or after administering medication, according to documentation standards.*

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Appendix A: Legislation Governing Nursing Practice

The *Regulated Health Professions Act, 1991* (RHPA)[28] and *Nursing Act, 1991* set and guide the practice of nursing. Under these acts, nurses are given the authority to perform controlled acts and provide client care. The scope of practice statement for nursing is:

The practice of nursing is the promotion of health and the assessment of, the provision of, care for, and the treatment of, health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function.[29]

Controlled acts are defined as acts that could cause harm if performed by those who do not have the knowledge, skill and judgment to perform them. A regulated health professional is authorized to perform a portion or all of the specific controlled acts that are appropriate for his or her profession's scope of practice. Because some scopes of practice overlap, certain professionals are authorized to perform the same, or parts of the same, controlled acts.

Nurses are authorized to perform three controlled acts when ordered or permitted by regulations under the *Nursing Act*:

- performing a prescribed procedure below the dermis;
- administering a substance by injection or inhalation; and
- putting an instrument, hand or finger beyond a body orifice or artificial opening to the body.

NPs can perform the controlled acts authorized to all nurses as well as additional controlled acts.[30]

Although administering medications by some routes is not a controlled act (for example, orally or topically), there is a risk of harm in performing any procedure if it is not done competently. Performing controlled acts represents only a small portion of nursing practice. It is important to note that:

- controlled acts are not the only procedures that can cause harm;
- having the authority to perform a procedure does not automatically mean it is appropriate to do so; and
- each nurse is accountable for her or his decisions and actions.

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

[29] From the *Nursing Act, 1991*.

[30] For more information, refer to the College's *Nurse Practitioner* practice document at www.cno.org/docs.

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SEIU Healthcare has created the two (2) following self assessment tools for you to review your practice as it relates to the Medication (2008) and Conflict Prevention and Management (2006)

MEDICATIONS – SAFE NURSING PRACTICE

When I hear the words "patient safety" the first thing that comes to my mind is medication errors. We all know as nurses there are a whole host of factors we need to consider when we think of patient safety. As knowledge workers, we must continuously be assessing our nursing practice to ensure we provide competent, safe and ethical nursing care. As knowledgeable nurses we have a significant role to play when it pertains to medications and safe practice. We have the knowledge (indications, contraindications, dose, interactions, adverse effects, route and knowledge of how to administer medications safely), skill and judgment to assess the appropriateness for a particular patient.

Competent medication administration includes the following components:

1. Preparing the medication correctly
2. Ensuring the eight (8) rights
3. Monitoring the patient while administering the medication
4. Appropriately intervening as necessary
5. Evaluating the outcome of the medication on the patients health status
6. Documenting the process

Eight (8) Rights of Medication Administration

1. Right Client – Check the name on the order and the patient. Use two (2) identifiers. Ask the patient to identify herself/himself.
2. Right Medication – Check the medication label. Check the order.
3. Right Dose – Check the order. Confirm appropriateness of the route ordered. Confirm that the patient can take or receive the medication by the ordered route.
4. Right time – check the frequency of the ordered medication. Double-check that you are giving the ordered does at the correct time. Confirm when the last dose was given.
5. Right frequency – Check the order. Confirm when the last dose was given.
6. Right Site – Check the order. Confirm the route of administration.
7. Right Reason – Confirm the rationale for the prescribed medication. What is the patient's history? Why is he/she taking this medication?
8. Right Route – Check the order. Verify the route of administration.

Preparing and Administering Medications – Some Helpful Hints

A copy of the medication order should be used as a reference to check the correct dose three times:

- ✓ FIRST: When one identifies the vial/syringe/bottle/bag/powder/capsule/tablet the medication is in.
- ✓ SECONDLY: When one is preparing the medication, and
- ✓ THIRD: After one has completed the preparation process.

Checking the patient's identification number (on the ID band secured to the patient) and the name on the order is an imperative. Two (2) identifiers are essential for safe medication practice – ID band and name as stated by the patient or caregiver.

Double Checking Medications

Certain medications may require a double check, double sign and documentation when administered to a patient. It is important to know your practice setting's policy on this issue. When we perform a double check, we may be doing the following:

If a medication is being administered on an infusion pump, you want to ensure that it is the right drug for the right patient. Ensure the pump is set correctly at the start of the infusion for the ordered rate, all subsequent rate changes and at the change of shift or handover. Include this patient safety information during your transfer of accountability (TOA).

Essential Tips for Safe Medication Practice

- ✓ Know the medication
- ✓ Confirm patient information
- ✓ Double check orders and verify with other colleagues if uncertain
- ✓ Avoid abbreviations
- ✓ Use a leading zero before a decimal (eg. 0.5 mL)
- ✓ Minimize distractions when drawing up medications
- ✓ Communicate with patient and families.

STANDARD WORK – MEDICATION REVISED (CNO, 2008)

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

Standard Work	Completed	Incomplete
1. **Assessment:** Nurses use their knowledge, skill and judgment in the assessment of the client, the medication and the practice supports prior to administering medications.		
Accepting authorizing mechanisms only from prescribers with ordering authority (for example, Physicians, Nurse Practitioners, Midwives, Dentists and Chiropodists)		
Accepting a medication order that is complete and includes the order date, client name, medication name, dose in units, route, frequency, purpose (for example, a PRN medication), and the prescriber's name, signature and designation.		
Accepting an outpatient or community orders MUST consist of all the above information, as well as the amount to be dispensed, the duration of the therapy, and the number of repeats or refills		
Withholding the medication and following up with a prescriber in a timely manner in the event that a medication order is incomplete, unclear, inappropriate or misunderstood by the RPN (nurse)		
Requesting written orders when the prescriber is present, or only accepting electronic orders when there is a secure system in place (for example, by fax or secure email)		
Accepting a VERBAL ORDER only in an emergency situation or when the prescriber cannot document her or his orders (for example, in the operating room or during a cardiac arrest)		
Recognizing TELEPHONE ORDERS should be limited to situations requiring direction for client care when the prescriber is not present.		
Ensuring that both VERBAL AND TELEPHONE orders are repeated in their entirety for accuracy		
Documenting VERBAL AND TELEPHONE orders as well as the prescriber's name, and designation in the client's record (the nurse is NOT responsible for ensuring that such orders have been signed by the prescriber).		
Assessing his/her own knowledge, skill and judgment to completely carry out medication administration, use medication equipment and intervene during an ADVERSE REACTION.		
Verify that informed consent has been obtained from the client or the client's substitute decision maker		

Assessing the appropriateness of the prescribed medication for the client by considering the following a) client's age, weight, pathophysiology, laboratory results, vital signs, medication knowledge, and choice or preference b) expected benefits and potential risks/side effects, the possible interaction with other medications, and any foods that are contraindicated or decrease absorption c) client's allergies, sensitivities, and previous adverse reactions, d) appropriate use of the medication as prescribed for the client in the particular situation (for example, PRN medication).		
Ensuring or advocating for appropriate resources to monitor and intervene to manage potential adverse reactions (for example, having the prescriber present before administration)		
Performing all of the administration steps to minimize the chance of error and clarify individual accountability		
Identifying and advocating for systems and resources that support nurses in maintaining competency in medication practice.		
2. Planning: Nurses are accountable for ensuring the accuracy, appropriateness, and completeness of a client's plan of care in regards to medication orders, and for communicating concerns about the treatment plan to the other members of the health care team.		
Transcribing medication orders as written, or validating the accuracy and completeness of the transcription when others have completed the transcribing.		
Scheduling dosing times for a medication, taking into consideration the effect of food intake on medication absorption, contraindications, required interventions before, during and after administration (for example, BP) and the client choice or preference		
Refraining from accepting medication order information from those who do not have pharmacology knowledge (for example, a unit clerk)		
Communicating orders with individuals within the circle of care (for example, health care team, or client or with consent the family)		
Demonstrating clear, evidence-based rationale for decisions and taking appropriate steps to resolve issues relating to medication administration		
Advocating for systems that provide a mechanism for resolution when there is a disagreement among members of the health care team regarding the medication order.		
3. Implementation – Nurses prepare and administer medication(s) to clients in a safe, effective and ethical manner		
Ensuring that the client receives appropriate education about the treatment plan and current medication		
Ensuring that the client or the client's substitute decision-maker has given consent to administer the medication		
Preparing and administering the medication according to an evidence-based rationale		
Obtaining a new supply of medication if there are concerns about how the medication has been maintained		

Applying principles of infection prevention and control when preparing and administering medications		
Verifying: • the right client • the right medication • the right reason • the right route • the right dose • the right frequency • the right site • the right time		
Ensuring that the client receives appropriate monitoring during and/or after medication and intervening if necessary		
Documenting during and/or after medication administration, in the client's record according to documentation standards		
Advocating for appropriate environmental supports to ensure clients receive safe, effective and ethical care		
4. Evaluation –Nurses evaluate client outcomes following medication administration and take appropriate steps for follow-up		
Recognizing client outcomes following medication administration, including effectiveness, side effects, signs of adverse reactions and/or drug interactions		
Following up with the prescriber regarding any concerns or questions about the medication		
Referring clients to the appropriate care provider for further assessment and follow up when necessary		
Documenting actions taken or advice given and client outcomes according to documentation standards		
Documenting when appropriate, if the client is capable of self-administering the medication, the type of assistance the client requires, if any, and the ongoing nursing assessment of the client's capacity to continue selfadministration		
Advocating for adequate resources and systems that facilitate safe, effective administration according to standards.		

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

1. **Accountability.** One of the most important components of client care is safe, effective and ethical medication practice. As with any nursing procedure, administering, recommending and/or prescribing a medication requires an accountable nurse to have knowledge, technical skills and good nursing judgment. Nurses must continuously maintain their competence to assess the appropriateness of a medication for a client, manage adverse reactions, understand issues related to consent and make ethical decisions about the use of medications.
2. **Continuing Competence.** Improve your knowledge: by completing the CNO Medication 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 Medication Standards (2008).
3. **Ethics.** Protect yourself and your client by ensuring you continuously make effective ethical decisions about medication use.
4. **Knowledge.** Acquire the knowledge of CNO Medication Standards: instructional learning modules from CNO; appropriate plans of care and clear communication; practice setting policies and procedures. Review CNO Standard quarterly. Visit the Institute of Safe Medication Practice (ISMP) to maintain awareness of medication safety.
5. **Knowledge Application.** Apply the knowledge: identify opportunities for improvement in medication administration by supporting safe medication practices. Evaluate the need for a colleague to conduct an independent double-check on a prepared medication. Continuously seek opportunities to learn about new medications, their effects on client care and share your knowledge with your colleagues.
6. **Leadership.** Demonstrate nursing leadership: role model safe medication practices by advocating for setting specific accessible, current medication information, such as drug formularies. Share knowledge with other health care providers, coach and mentor colleagues if one identifies gaps in medication practice. Engage in committees to ensure medication practices reflect CNO standards, become a champion within your practice setting related to safe medication practices. Provide education/ health teaching to colleagues on issues related to safe medication practice and or provide current literature on medications. Report errors as they can enhance professional practice, enable changes to be made in your setting to avoid future errors, and promote a culture of patient safety.
7. **Relationships.** Maintain professional and/or therapeutic relationships with colleagues to support safe medication practice. Share your nursing knowledge, skill and judgment required by CNO's professional standards to prevent errors. Share your knowledge with colleagues including novice nurses, foster a supportive environment in applying the medication standard.

WITHOUT STANDARD WORK, IMPROVEMENT IS IMPOSSIBLE!!!

I am knowledgeable and aware of how my 7 Professional Nursing Standards apply to the CNO Medication Revised (2008) Standards

Signature: Date:

Developed by: Donna Rothwell, RN, BScN, MN Wharton Fellow, SEIU Healthcare February 2013

PRACTICE GUIDELINE

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario
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Conflict Prevention and Management

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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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Introduction

Nursing is a profession that is based on collaborative relationships with clients and colleagues. When two or more people view issues or situations from different perspectives, these relationships can be compromised by conflict. In this document, conflict refers to a power struggle in which a person intends to harass, neutralize, injure or eliminate a rival.[1]

Conflict is commonly perceived as being a negative issue. However, the experience of dealing with conflict can lead to positive outcomes for nurses,[2] their colleagues[3] and clients.[4] Conflict that is managed effectively by nurses can lead to personal and organizational growth. If conflict is not managed effectively, it can hinder a nurse's ability to provide quality client care[5] and escalate into violence and **abuse.**[6,7] Because of this, nurses need to be aware of the ways in which conflict can escalate and be prepared to prevent or manage it in the workplace.

While conflict is an inherent part of nursing,[8] the provision of professional services to clients does not include accepting abuse. In addition, conflict among colleagues can lead to antagonistic and passive-aggressive behaviours (such as **bullying** or **horizontal violence**) that compromise the **therapeutic nurse-client relationship**.[9] Nurses who effectively deal with conflict demonstrate respect for their clients, their colleagues and the profession.

Conflict that remains unresolved can have far-reaching effects that ultimately influence every aspect of client care.[10] To protect the public's right to quality nursing services, the College of Nurses of Ontario (the College) is committed to helping nurses recognize and manage conflict in the practice setting, and to prevent conflict from escalating into abuse.

The *Conflict Prevention and Management* practice guideline replaces the 2004 *Nurse Abuse* practice guideline, originally published as Abuse of Nurses in 2000. It is meant as an overview, not as a comprehensive conflict-management resource. This guideline outlines key factors associated with conflict with clients, colleagues and in the workplace, and offers strategies for preventing and managing conflict that has escalated. It also highlights the role of nurses in formal leadership positions, as well as the importance of the debriefing process in the prevention and management of conflict.

Nurse-Client Conflict

The therapeutic nurse-client relationship is the foundation for providing nursing services that contribute to the client's health and well-being. The role of the nurse in the therapeutic nurse-client relationship is to support the client in achieving the client's health goals. However, unresolved conflict can impede the attainment of these goals.

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[1] (Sportsman, 2005)

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

[3] In this document, the term *colleague* refers to the individuals nurses work with to deliver client care. These include nurses, physicians, managers, administrators and other members of the health care team.

[4] In this document, the term *client* refers to an individual, family, group or community.

[5] (Gerardi, 2004)

[6] (Freshwater, 2000; Kelly, 2006; Gerardi, 2004)

[7] Bolded words are defined in the glossary on page 11.

[8] (Thomas, 1976)

[9] Refer to the College's *Therapeutic Nurse-Client Relationship, Revised 2006* practice standard.

[10] (Diaz, 1991)

Key factors

It is possible to identify characteristics and situations that are associated with the evolution or escalation of conflict among nurses, clients and their families. Nurses who know how to recognize key factors associated with conflict may prevent its escalation and improve the delivery of care.

Conflict between a nurse and a client can escalate if a client is:

a) intoxicated or withdrawing from a substance-induced state;

b) being constrained (for example, not being permitted to smoke) or restrained (for example, with a physical or chemical restraint);

c) fatigued or overstimulated; and/or

d) tense, anxious, worried, confused, disoriented or afraid.

Conflict between a nurse and a client can escalate if a client has:

a) a history of aggressive or violent behaviour, or is acting aggressively or violently (for example, using profane language or assuming an intimidating physical stance);

b) a medical or psychiatric condition that causes impaired judgment or an altered cognitive status;

c) an active drug or alcohol dependency or addiction;

d) difficulty communicating (for example, has aphasia or a language barrier exists); and/or

e) ineffective coping skills or an inadequate support network.[11]

Conflict between a nurse and a client can escalate if a nurse:

a) judges, labels or misunderstands a client;

b) uses a threatening tone of voice or body language (for example, speaks loudly or stands too close);

c) has expectations based on incorrect perceptions of cultural or other differences;

d) does not listen to, understand or respect a client's values, opinions, needs and ethnocultural beliefs;[12]

e) does not listen to the concerns of the family and significant others, and/or act on those concerns when it is appropriate and consistent with the client's wishes;

f) does not provide sufficient health information to satisfy the client or the client's family; and/or

g) does not reflect on the impact of her/his behaviour and values on the client.

Prevention

One part of the therapeutic nurse-client relationship is providing **client-centred care**. Nurses can provide client-centred care by following the client's lead about information-giving and decision-making,[13] attempting to understand the meaning behind the client's behaviour and using proactive communication strategies that focus fully on the client. Nurses can employ client-centred care strategies to prevent behaviours that contribute to the escalation of conflict.

Nurses can:

a) continually seek to understand the client's health care needs and perspectives;

[11] (Leather, 2002)

[12] Refer to the College's *Therapeutic Nurse-Client Relationship, Revised 2006* practice standard and *Culturally Sensitive Care* practice guideline.

[13] (RNAO, 2003)

b) acknowledge the feelings behind the client's behaviour;

c) ask open-ended questions to establish the underlying meaning of the client's behaviour;

d) engage in active listening (for example, use verbal and nonverbal cues to acknowledge what is being said);

e) use open body language to display a calm, respectful and attentive attitude;

f) acknowledge the client's concerns about the health care system and his/her experiences as a client;

g) respect and address the client's wishes, concerns, values, priorities and point of view;[14]

h) anticipate conflict in situations in which it has previously existed and create a plan of care to prevent its escalation; and

i) reflect to understand how her/his behaviour and values may negatively affect the client.

Management

There are many different strategies for managing conflict that can be implemented by nurses before conflict escalates. Conflict-management strategies should be individually tailored to each client situation. Nurses need to use their professional judgment to determine which strategy is most appropriate for each client.

A nurse can:

a) implement a **critical incident** management plan;

b) remain calm and encourage the client to express his/her concerns;

c) avoid arguing, criticizing, defending or judging;

d) focus on the client's behaviour rather than the client personally;

e) involve the client, the client's family and the health care team members in assisting with the behaviour and developing solutions to prevent or manage it;

f) state that abusive language and behaviours are unacceptable, if the nurse believes this will not escalate the client's behaviour;

g) step away from the client, if necessary (for example, to regain composure or to set personal space boundaries);

h) leave the situation to develop a plan of care with the assistance of a colleague if the client intends to harm the nurse;[15] and

i) protect themselves and other clients in abusive situations by withdrawing services, if necessary (see the decision tree on page 11).

Conflict With Colleagues

Conflict among colleagues can have an indirect influence on the therapeutic nurse-client relationship. Poor relationships among members of the health care team negatively affect the delivery of care. For example, workplace bullying can erode a nurse's confidence and compromise her/his ability to foster therapeutic relationships with clients.[16]

Key factors

Power dynamics are inherent among colleagues. However, the misuse of this power can contribute to conflict among members of the health care team. By recognizing factors that can contribute to the misuse of power among colleagues, nurses can seek constructive and collaborative approaches to resolving differences.[17]

[14] (RNAO, 2003)

[15] (Davies, 2006)

[16] (Based on 2006 written feedback from Alix McGregor, RN, EdD)

[17] (College and Association of Registered Nurses of Alberta, 2003)

Conflict among colleagues can escalate if:

a) bullying or horizontal violence exists;

b) barriers to collaborative collegial behaviour encourage the marginalization of others[18] (for example, formation of identity groups based on culture or religion);

c) different practice perspectives are accentuated by factors such as age, length of service, generation gap, culture and education level;[19]

d) team members do not support each other in achieving work responsibilities or meeting learning needs;

e) colleagues are intentionally or unintentionally put into situations beyond their capabilities;[20]

f) new graduates and/or employees are not supported by experienced nurses[21] and/or systemic orientation practices;[22]

g) fear of reprisal impedes the reporting of conflict by staff; and/or

h) there is a lack of awareness about the need to anticipate and manage conflict.

Prevention

As members of the health care team, nurses must be able to work in cooperation with colleagues to deliver safe, effective and ethical client care. Unresolved conflict among colleagues may hinder communication, collaboration and teamwork, which negatively affects client care. In addition, nurses are less likely to be abused by clients if they do not tolerate abuse among colleagues.

Nurses can employ consistent strategies to help prevent conflict among colleagues from escalating.

Nurses can:

a) promote a respectful work environment by modelling professional behaviours;[23]

b) mentor, support and integrate new staff members into the practice setting;[24]

c) reflect on personal attitudes, motivators, values and beliefs that affect relationships with colleagues, identify personal areas in need of improvement and strive to alter their own behaviour in situations that have previously ended in conflict; and

d) recognize that personal stress may affect professional relationships and take steps to manage that stress.

Management

To function effectively as part of a team, nurses must establish positive collegial relationships. Positive collegial relationships result from good communication, mutual acceptance and understanding, use of persuasion rather than coercion, and a balance of reason and emotion when working with others.[25] The active management of conflict is an integral part of building positive collegial relationships. Colleagues who work together to manage conflict effectively will help to foster a work environment that produces positive outcomes for both nurses and clients.

[18] (Baltimore, 2006)

[19] (Farrell, 2001; Baltimore, 2006)

[20] (Baltimore, 2006)

[21] (Baltimore, 2006)

[22] (Boychuk Duchscher & Cowin, 2004)

[23] (World Health Organization, 2002)

[24] Refer to the College's *Supporting Learners* practice guideline.

[25] (Gerardi, 2004)

Nurses can:

a) address conflict directly rather than avoiding or postponing its resolution;[26]

b) focus on the behaviours that lead to the conflict rather than on the colleague personally;

c) validate assumptions through open dialogue with colleagues rather than acting on misperceptions or assumptions; and

d) collaborate with colleagues to identify the underlying cause of the conflict. In some situations, a neutral party (for example, a professional mediator) may be necessary.

Workplace Conflict

Employers and nurses are partners in the delivery of optimal health care; they share the responsibility for creating a healthy workplace for all members of the health care team. This responsibility involves ensuring that conflicts do not negatively affect client health outcomes or relationships among colleagues. A healthy workplace is an environment in which nurses can safely identify conflict and implement systems for its management.

Key factors

Many factors in the health care system can contribute to the escalation of conflict within nurses' practice settings.[27] A quality work environment is one that supports nurses in preventing and managing conflict in daily practice. This support includes the reduction or elimination of workplace factors that can lead to conflict.

Conflict can escalate if:

a) organizational policies or programs aimed at identifying, preventing and managing the incidence of conflict and abuse in the workplace do not incorporate and address prohibited grounds under the Ontario Human Rights Code, 1990, such as race, ethnicity or sexual orientation;

b) organizational policies are not communicated to staff or adhered to at all levels;

c) there is a lack of formal performance feedback mechanisms;

d) existing formal performance feedback mechanisms do not address how behaviours affect conflict;

e) the workplace culture promotes under-reporting of incidences of conflict;[28]

f) managers and administrators abuse or bully;

g) managers and administrators show favouritism to certain staff members and ignore their disruptive behaviour;

h) there is a lack of role clarity for staff;[29]

i) communication is negatively affected by working conditions (for example, heavy workload or fast work pace);

j) nurses and other health care professionals are working at peak stress times or under stressful conditions;

k) working conditions are poor (for example, lack of ventilation, too much noise, safety hazards);[30]

[26] (Kelly, 2006)

[27] (Di Martino, 2003)

[28] (Henderson, 2003; Marshall & Robson, 2005)

[29] (Jackson, Clare & Mannix, 2002)

[30] (Di Martino, 2002)

l) intense organizational change exists;[31] and/or

m) staff perceive job insecurity.

Prevention

The aim of establishing a quality work environment is to develop a culture in which nurses prevent conflict from escalating.[32] In a quality work environment, employers provide mechanisms that nurses can readily use to intervene in conflict before it escalates.

Employers can:

a) implement policies that do not tolerate abuse of any kind;[33]

b) ensure that policies against workplace conflict are also directed at combating any form of discrimination;[34]

c) ensure that managers model professionalism in preventing and managing conflict;

d) establish and uphold organizational values, vision and mission that acknowledge the health, safety and well-being of staff;

e) educate managers and staff in communication, as well as in conflict prevention and management;

f) support effective collaboration and communication among health care team members, especially between nurses and physicians[35] (for example, interprofessional rounds);

g) implement strategies to ease the impact of change and decrease stress among staff;

h) identify and address staffing needs as soon as possible, especially at peak times; and

i) ensure a comfortable and safe physical environment (for example, use safety mirrors, security guards, protective barriers, surveillance cameras and/or a system of alert when urgent help is needed).[36]

Management

Employers can promote quality practice settings in which nurses are encouraged to understand conflict and employ strategies to mitigate it. Employers can institute reporting systems to help nurses acknowledge when conflict has occurred. A fair and efficient reporting system encourages communication among staff members by helping nurses identify underlying causes of conflict. Open communication and understanding will promote an atmosphere of trust and respect within the health care team.

Employers can:

a) provide a system that promotes the reporting of incidences of workplace conflict, protects nurses from reprisal[37] and deals with reports fairly and efficiently;

b) routinely assess the incidence of workplace conflict and implement strategies for corrective action; and

c) institute clear policies and consequences for those who breach policies aimed at preventing conflict and abuse.

[31] (Henry & Ginn, 2002)

[32] (Royal College of Nurses, 2005)

[33] (International Council of Nurses, 1999; Canadian Practical Nurses Association, 1999)

[34] (World Health Organization, 2002)

[35] (O'Brien-Pallas, Hiroz, Cook & Mildon, 2005)

[36] (Di Martino, 2002)

[37] (World Health Organization, 2002; French & Morgan, 2002)

Role of Nurses in Formal Leadership Positions

All nurses have the potential to demonstrate leadership in their professional roles. However, nurses in formal leadership positions who make decisions in the workplace have particularly important roles to play in the resolution of conflict. Nurses in formal leadership positions are responsible for supporting nurses in effective conflict management. For example, nurse administrators should establish systems that facilitate the development of conflict-resolution skills for all members of the health care team.[38]

Preventing conflict among staff members

All nurses lead by example. When nurses in formal leadership positions actively promote behaviours that prevent the escalation of conflict, nurses see the value of conflict management first-hand.

Nurses in formal leadership positions can:

a) make conflict resolution a priority among all staff members;

b) empower staff members to resolve problems among colleagues;

c) provide nurses with greater autonomy by participating in decision-making and opportunities for professional development;[39]

d) foster positive relationships, trust and respect among staff members[40] and promote a work environment in which conflict-creating forms of behaviour (for example, exclusion or dysfunctional cliques) are not tolerated;[41]

e) recognize the factors that contribute to conflict and promptly intervene to diffuse conflict situations before they escalate;[42]

f) help staff members to develop conflict-management interventions;

g) recognize that change can precipitate conflict and implement management strategies that encourage positive attitudes toward change; and

h) seek learning opportunities to increase the comfort level of staff members in dealing with conflict resolution.

Managing conflict among staff members

Conflict that remains unacknowledged will not disappear. Nurses in formal leadership positions can promote conflict management among staff by establishing and using reporting processes that are fair and confidential. By actively resolving conflict among staff, nurses in leadership positions will help to establish equitable work environments for all members of the health care team.

Nurses in formal leadership positions can:

a) offer a confidential environment[43] for staff to report episodes of conflict without fear of retribution;

b) deal with reports promptly, fairly and confidentially; and

c) ensure that appropriate follow-up procedures are in place to support nurses who have been abused in the course of their practice.

Debriefing After a Critical Incident

Sometimes, despite a nurse's best efforts to identify risk factors for conflict and implement strategies to prevent it, conflict may escalate into a critical

[38] Refer to the College's *Professional Standards, Revised 2002* practice standard.

[39] (Daiski, 2004)

[40] (Registered Nurses Association of Ontario, 2006)

[41] (Royal College of Nurses, 2005)

[42] (Royal College of Nurses, 2005)

[43] (Porter-O'Grady, 2004)

incident. After a critical incident has taken place, it is important for the nurse involved to collaborate with the health care team to debrief about the situation. Debriefing allows nurses to reflect on and learn from what has occurred. This can provide insight into the conflict's contributing factors, as well as contribute to its future prevention and management.

Nurses can:

a) consult with those involved about the meaning of their experiences during the incident with the intent to heal themselves and the client and family;

b) review and reflect on responses and recommend future strategies based on team members' actions;

c) reflect on their own behaviour, which may have unintentionally affected the nurse-client relationship;

d) help the client understand how his/her behaviour negatively affected the therapeutic nurse-client relationship;

e) develop communication strategies with the client so the client can express his/her feelings appropriately;

f) use best-practice strategies to develop a care plan for dealing with the client's behaviour;[44] and

g) use **anticipatory planning** to develop a consistent approach of addressing the client's behaviour in the future.[45]

[44] (Davies, 2006)

[45] (Davies, 2006)

Glossary

Abuse
The misuse of power within a relationship. Abuse can be emotional, verbal, physical and/or sexual. Examples of abusive behaviours include intimidation, swearing, cultural slurs, hitting, pushing, inappropriate comments, inappropriate touching and sexual assault.

Anticipatory planning
Involving the client in making decisions based on the client's values, beliefs and wishes.[46]

Bullying
Any act or verbal comment that could isolate or have negative psychological effects on a person. Bullying usually involves repeated incidents or a pattern of behaviour that is intended to intimidate, offend, degrade or humiliate a particular person or group of people.[47]

Client-centred care
A client-centred approach to care focuses on the individual as a whole person, rather than solely on the delivery of services to the client. Client-centred care involves advocacy, empowerment and respect for the client's autonomy, voice, self-determination and participation in decision-making.[48]

Critical incident
Any sudden unexpected event that has an emotional impact that can overwhelm the usually effective coping skills of an individual or a group.[49]

Horizontal violence
Interpersonal conflict among colleagues that includes antagonistic behaviour such as gossiping, criticism, innuendo, scapegoating, undermining, intimidation, passive aggression, withholding information, insubordination, bullying, and verbal and physical aggression.[50]

Therapeutic nurse-client relationship
A professional relationship that is established and maintained by the nurse as the foundation for providing nursing services that contribute to the client's health and well-being. The relationship is based on trust, respect, empathy, professional intimacy and the appropriate use of the nurse's inherent power.

[46] (Davies, 2006)

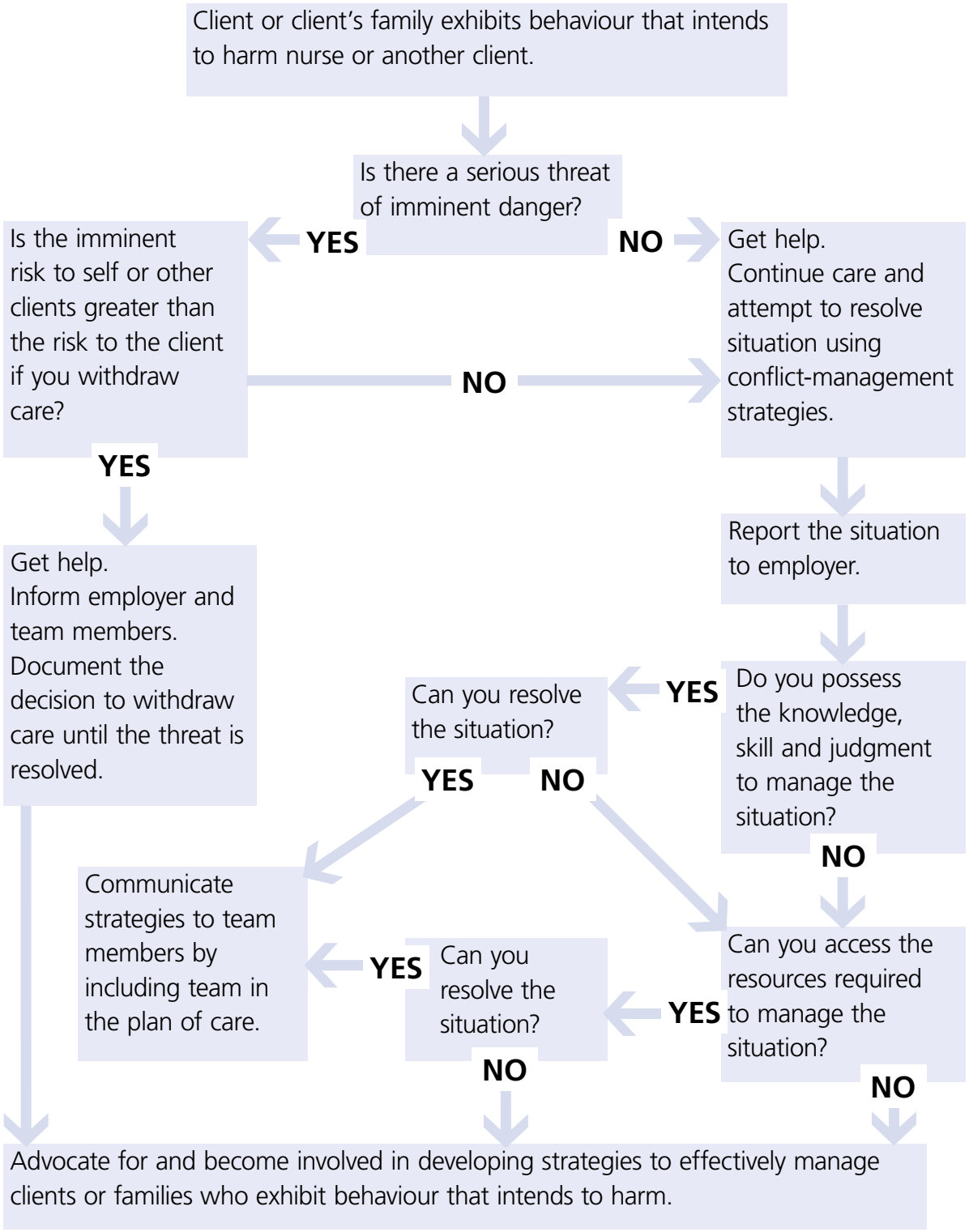
[47] (Klass, 2006)

[48] (RNAO, 2002)

[49] (Caine & Ter-Bagdasarian, 2003)

[50] (Baltimore, 2006)

Decision Tree: Withdrawal of Services



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CONFLICT PREVENTION AND MANAGEMENT

The nursing profession is one that is based on collaborative relationships with colleagues, patients and families. It requires individuals to work closely together with varying backgrounds or cultures. A therapeutic nurse-client relationship is the foundation of nursing care. It contributes to both the patient's well being and their health. Conflict can impede these collaborative relationships by not allowing the nurse to fully support the client in attaining his or her goals (CNO, 2006). Good communication skills or conflict resolution skills can decrease the risk of conflict.

Conflict is an inevitable component of our professional lives. Let's face it: health care settings are naturally stressful environments. Workplace stress can give rise to personal conflicts between colleagues – and when conflict escalates, no one wins.

The following are some typical sources of conflict in health care today:

- Limited time or resources, for example when staffing shortages lead to heavier workloads, longer shifts and overtime
- Differing goals, work styles, work ethics or perspectives which can make it a challenge to communicate or understand another colleagues point of view
- High-involvement work settings where collaboration is essential – like the operating room or in the emergency department
- Disparities in knowledge, experience or power, which are common in the health care hierarchy

The costs associated with conflict in health care are significant. Conflict has a negative effect on productivity. Clearly, when nurses are butting heads rather than working towards a common goal, they are less efficient, can compromise quality and safe patient/client care which leads to errors. However, conflict has other hidden costs as well.

According to Longo and Sherman (2007) not only does conflict affect nursing productivity but it also has a much larger emotional and physical impact.

Why is Conflict Important to Resolve?

In general, we as nurses tend to have difficulty in dealing with conflict in an open manner and avoiding conflict, harboring emotions that the conflict creates leading them to act out in covert ways. Nurses need to achieve effective team building skills within nursing groups in order to deliver quality and productivity required for good patient outcomes and the organizational structure. The decisions nurses make in team-managed environments are more superior to decisions made in a hierarchal environment in terms of both quality and cost effectiveness. It is an imperative for nurses to be able to manage and possess conflict management skills to be able to function successfully in the evolving health care system (CNA, 2006).

Nurses as Facilitators of Conflict Resolution

Nurses need to become more proactive and learn to effectively communicate with their peers, patient's, and patient families. Good communication skills are key to resolving his or her own conflicts or facilitate conflict resolution between other individuals. As a facilitator, the nurse must protect each person's self respect by focusing on the issue and the personality of the individual involved.

It is also important not to blame the participants for the problem. This can hinder open and complete discussions of the issue at hand. Encouraging discussion of both positive and negative feelings will increase the chances of both parties expressing their concerns. Fostering active listening and understanding enhances this as well.

Some Dos and Don’ts for Effective Communication Skills

Dos

- ✓ Do maintain eye contact
- ✓ Be aware of your body language and tone of your voice
- ✓ Do ask for clarification
- ✓ Do ask open-ended questions
- ✓ Paraphrase at the appropriate time
- ✓ Do listen
- ✓ Always speak respectfully

Don’ts

- Do not look down
- Do not mismatch your communication style
- Do not assume
- Do not interrupt
- Do not blame

STANDARD WORK – MEDICATION REVISED (CNO, 2008)

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

Standard Work	Completed	Incomplete
1. **Nurse-Client Conflict –** The therapeutic relationship is the foundation for providing nursing care that contribute to the overall health and well-being. Unresolved conflict can impede the attainment of the client's health goals.		
In many situations it is possible to identify characteristics and situations that are associated with the escalation of conflict amongst nurses, clients and their families. Nurses who know how to recognize key factors associated with conflict may prevent its escalation and improve the delivery of care and patient outcomes.		
Conflict between a nurse and client can escalate if the client is: a) intoxicated or withdrawing from a substance-induced state b) being constrained (ie., not able to smoke) or restrained (physical or chemical c) fatigued or overstimulated; and/or d) tense, anxious, worried, confused, disoriented or afraid		
Conflict between a nurse and client can escalate if a client has: a) a history of aggressive behaviour, or acts violently or aggressively (physical and verbal) b) a medical or psychiatric condition that causes impaired judgment c) an active drug or alcohol dependency or addiction d) difficulty communicating (ie., asphasia, or language barrier) e) ineffective coping skills or an inadequate support network.		
Conflict between a nurse and client can escalate if a nurse: a) judges, labels or misunderstands a client b) uses a threatening tone of voice or body language c) has expectations based on incorrect perceptions of cultural or other differences d) does not listen to, understand or respect a client's values, opinions, needs and ethnocultural beliefs e) does not listen to family issues or concerns f) does not reflect on the impact of her/his behaviours and values on the client.		
Prevention: One part of the therapeutic nurse client relationship is providing patient/client centered care. Nurses can achieve this by following the client's lead about information-giving and decision making, attempting to understand the meaning behind the client's behaviour and using proactive communication strategies that focus fully on the client.		

Nurses can: a) continually seek to understand the client's health care needs and perspectives b) acknowledge the feelings behind a client's behaviour c) ask open-ended questions d) engage in active listening e) use effective body language to display a calm, respectful and attentive attitude f) acknowledge the client's wishes, concerns values, priorities and point of view g) anticipate conflict in situations in which it has previously existed and create a plan of care to prevent its escalation h) reflect to understand how his/her behaviour and values negatively affect the client		
2. **Conflict with Colleagues –** conflict with colleagues has an indirect influence on the therapeutic nurse-client relationship. Poor relationships among members of the inter-professional health care team can negatively affect the delivery of care.		
Conflict amongst colleagues can escalate if: a) bullying or horizontal violence exists b) barriers to collaborative collegial behaviour encourage the marginalization of others c) different practice perspectives are accentuated by factors like age, years of seniority, generational diversity and gaps, culture and education levels d) team members do not support one another in achieving work responsibilities or meeting learning needs e) colleagues are put in situations intentionally or unintentionally beyond their competence or capabilities f) new graduates are not supported by experienced nurses g) fear of reprisal impedes the reporting of conflict by staff h) there is a lack of awareness about the need to anticipate and manage conflict		
Prevention: As members of the health care team, nurses must be able to work with colleagues to deliver safe, effective and ethical care. Unresolved conflict may hinder communication, collaboration, and teamwork, which negatively affects client care.		
The following strategies can be implemented to help prevent conflict: a) promote a respectful workplace environment by modelling professional behaviours b) mentor, support, and integrate new staff members into the practice setting c) reflect on person attitudes, motivators, values and beliefs that affect relationships with colleagues d) recognize personal stress may affect professional relationships and take appropriate steps to manage that stress		

3. **Workplace Conflict-** Employers and nurses are partners in the delivery of optimal health care, they share the responsibility for creating a healthy work environment for all members of the interprofessional health care team. This responsibility involves ensuring that conflict does NOT negatively affect client care outcomes or relationships among colleagues.		
Conflict can escalate if: a) organizational policies or programs aimed at identifying, preventing, and managing the incident of conflict and abuse in the workplace do not incorporate and address prohibited grounds under the Ontario Human Rights Code, 1990, such as race, ethnicity or sexual orientation b) organizational policies are not communicated to staff or adhered to at all levels of the organization c) there is a lack of formal performance feedback mechanisms d) existing formal feedback mechanisms do not address how behaviours affect conflict e) the workplace culture promotes under-reporting of incidences of conflict f) managers and administrators abuse or bully g) managers and administrators show favouritism to certain staff members and ignore disruptive behaviour h) there is a lack of role clarity for staff i) communication is negatively affected by working conditions (ie., heavy workloads) j) nurses and other interprofessional health care members are working at peak stress times or under stressful conditions k) working conditions are poor (ie., lack of ventilation, too much noise, safety hazards) l) intense organizational change exists m) staff perceive job insecurity		
Prevention: The aim of establishing a quality work environment is to develop a culture in which nurses prevent conflict from escalating.		
Employers can: a) implement policies that do not tolerate abuse of any kind b) ensure managers role model professionalism in preventing and managing conflict c) establish and uphold the organizations values, mission and vision d) educate all staff in conflict preventions and management e) implement strategies to ease the impact of change and decrease stress among staff f) identify and address staffing needs as soon as possible g) ensure a comfortable and safe physical environment (ie., security, surveillance cameras)		

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

1. **Accountability.** One of the most important components of client care is safe, effective and ethical nursing practice. As with any nursing intervention, a nurse must be able to manage conflict in the best interest of quality and safe client outcomes. Nurses are accountable to have knowledge, technical skills and good nursing judgment in preventing and managing conflict. Nurses must continuously reflect on their practice and maintain their competence to assess the appropriateness of conflict resolution with patients, patient families and/or colleagues.
2. **Continuing Competence.** Improve your knowledge: by reviewing the Conflict Prevention and Management (2009) guideline available on the CNO website: www.cno.org. Review as needed and annually 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 workplace relations, and conflict resolution
3. **Ethics.** Protect yourself and your client by ensuring you continuously make effective ethical decisions about client care and professional relationships. It is an imperative for nurses to be able to manage and possess conflict management skills to be able to function successfully in the evolving health care system (CNA, 2006).
4. **Knowledge.** Acquire the knowledge of CNO Conflict Prevention and Management, appropriate plans of care and clear communication; practice setting policies and procedures. Review CNO Standard quarterly. Visit the quality of worklife for nurses website to maintain awareness of quality work environments and conflict prevention.
5. **Knowledge Application.** Apply the knowledge: identify opportunities for improvement in conflict resolution by supporting clients and colleagues. Continuously seek opportunities to learn about new strategies to manage conflict to ensure quality, ethical and safe client care.
6. **Leadership.** Demonstrate nursing leadership: role model good communication skills and conflict resolution by advocating for setting specific accessible, current policies. Share knowledge with other health care providers, coach and mentor colleagues if one identifies gaps in medication practice. Engage in committees to ensure conflict management and prevention that reflect CNO standards, become a champion within your practice setting related to conflict resolution.
7. **Relationships.** Maintain professional and/or therapeutic relationships with colleagues to promote positive patient outcomes. Share your nursing knowledge, skill and judgment required by CNO's professional standards to avoid conflict. Share your knowledge with colleagues including novice nurses, foster a supportive environment in applying the conflict prevention and management guideline.

WITHOUT STANDARD WORK, IMPROVEMENT IS IMPOSSIBLE!!!

I am knowledgeable and aware of how my 7 Professional Nursing Standards apply to the Conflict Prevention and Management (2009) Guideline

Signature: Date:

Developed by: Donna Rothwell, RN, BScN, MN Wharton Fellow, SEIU Healthcare February 2013

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