

Health System & Workforce Optimization: Focus on Nursing



***Nova Scotia Association of Health Organizations
Nursing Leadership Conference
Dartmouth, Nova Scotia
April 18, 2008***

***Dr. Jeanne Besner, Director
Health Systems and Workforce Research Unit***



calgary health region



- ***Context / background***
 - ***“Workforce & Health System Optimization”***
- ***Why a focus on nursing role optimization?***
- ***Findings from Research***
 - ***Scope of Nursing Practice***
 - ***Nursing Job Redesign***
 - ***Interprofessional practice***
- ***Implications***
- ***What next?***



Commissions/reports on health care reform/nursing:

- ***Fyke Commission (Saskatchewan, 2001)***
 - *Focus on quality, accountability and sustainability*
 - *Avoid overlap, duplication & inefficiency in service delivery*
 - *Address morale issues among health care providers*
 - *Respect contributions of all staff*
 - *Reduce unnecessary and ineffective work*
 - *Produce better patient outcomes and improved job satisfaction*
- ***Mazankowski Report (Alberta, 2002)***
 - *Address sustainability of the Alberta Health Care System*
 - *Focus on health and wellbeing*
 - *Improve accountability (value for dollars spent)*
 - *Develop a patient oriented system*
- ***Canadian Nursing Advisory Committee (2002)***
 - *Maximize nursing scopes of practice*
 - *Create professional practice environments*
 - *“As nursing goes, so goes the rest of the system”*



- ***Romanow Commission (2002)***
 - *Improve timely access and enhance quality of care*
 - *Transform system from one in which providers work in silos to one in which they work collaboratively to deliver seamless, integrated care across the continuum*
 - *Change the scopes and patterns of practice of health care providers to reflect a growing emphasis on collaborative teams and networks of health providers*
- ***Kirby Report (2002)***
 - *Address the shortage of health professionals and find ways to increase individual and collective productivity*
 - *Enable the skills and competencies of providers to be utilized to the fullest and deliver health care services by the most appropriately qualified health professionals*



- ***2003 First Ministers Accord on Health Care Renewal***
 - *Timely access to high quality, effective, patient-centered health services*
 - *Improve continuity and coordination of care*
 - *Focus on population health*
 - *Ensure Canadians have access to needed health providers now and in future*

- ***2004 Plan to Strengthen Health Care***
 - *Ensure adequate supply and appropriate mix of health care providers*
 - *Address interdisciplinary training*
 - *Accelerate integration of internationally educated providers*



- ***Working to Full Scope of Practice***
 - ***Professional role is reflected in the knowledge base of the profession***
 - ***The knowledge & skills acquired through education***
 - ***Role defined at “entry to practice”***
 - ***Reflected in professional practice standards and codes of ethics***
 - ***Role enactment***
 - ***Application of knowledge and skills within parameters defined by legislation, experience, competence and contextual factors***

Why Start with Nursing?



calgary health region



- **30+ regulated occupations in health care**
 - **Largest group is nurses at over 40%**
 - RNs = 76%; LPNs = 22%; RPNs = 2%
 - **Calgary: RNs (89.5%) + RPNs (1.2%)+ LPNs (9.3%) in direct care = 42.6% total CHR workforce**
 - **Next largest group is physicians at 9%**
 - **We have relatively little data about the other 50%**
 - Source: CIHI, 2005, Health Council of Canada, 2005
- **“As nursing goes, so goes the rest of the system”**
 - Source: CNAC, 2005
- **“Biggest bang for the buck”**
 - **Nurses as gatekeepers may prevent optimized utilization of other professionals**
 - **All occupational health care groups target for ongoing research**
 - **Will adapt role effectiveness model to other regulated professions**

- ***More than an activity supporting medicine (International Council of Nurses, 1995)***
- ***Optimum health and wellbeing of individuals, families, groups, communities, populations (CNA, 2007)***
- ***Value added to health care delivery is entry to health, even through episodes of illness, crisis, and/or transition***
- ***Yardstick by which professional accountability is judged and privilege of self-regulation is granted***



Specialized body of knowledge

- ***Client viewed against background of culture, beliefs, values & environmental influences (i.e. determinants) on health and illness***
- ***Nursing assessment involves focus on relationship b/w determinants and actual health status***
- ***Synthesis and interpretation of data derived from assessment & determination of actions that reflect interplay among those factors is the essence of registered nursing practice***
- ***Interpreting significance of determinants requires knowledge of population & patient/family risk factors***
 - ***Also of consequence when making staffing decisions***

Optimal utilization of RN knowledge/skill

- ***Key clinical role functions of RNs***
 - ***Comprehensive assessment, planning, intervention & evaluation***
 - ***Biological, psychological, social, cultural, spiritual***
 - ***Identification of real/potential risks to patient/family***
 - ***Basis from which to identify teaching/support needs***
 - ***Leads to enhanced self-care capacity***
 - ***Determination of monitoring/surveillance needed to mitigate risks, prevent complications/injuries***
 - ***By whom, over what period of time, at what frequency & intensity***
 - ***Coordination of care, communication with & involvement of interprofessional team members across care continuum***
- ***Other role functions of RNs***
 - ***Identifying needed improvements to health system and profession when necessary to better serve patients and families***
 - ***Leadership***
 - ***Mentoring/teaching (colleagues, other professionals, students)***
 - ***Research (application of best evidence in practice)***

Findings from Scope of Practice Research



Actual versus Expected Role Functioning

- ***Enactment of role***
 - ***50% of RNs, 73% of RPNs and 20% of LPNs reported working to full scope***
 - ***Most managers and “specialized” nurses felt staff nurses were not working to full scope***
 - ***Influenced by employer policies, procedures, practices***
 - ***Limited by colleagues, other professionals***
- ***Role overlap exists within nursing***
 - ***Little differentiation in role of RNs, RPNs, LPNs***
 - ***Focus on task versus role performance has narrowed gap b/w RNs and LPNs in particular***
 - ***Insufficient attention to redefining role of RNs with introduction of more LPNs in late 1990s***

Actual / Expected Role (continued)



- ***Role overlap between nursing & other health professionals***
 - *E.g. social work, Occupational Therapy, etc.*
 - *No discussion of differences in education, knowledge base or expertise that account for how health professionals utilized*
 - *Power struggles within and between nurses and other professionals*
 - *Ineffective communication*
- ***Lack of recognition of what nurses do***
 - *Leads to underutilization, dissatisfaction, devaluing own and others' role*
 - *Professional documents, competency statements do not allow objective determination of similarities or differences in knowledge base of the three occupational groups*
- ***Lack of trust in others' capabilities***
 - *Leads to poor interprofessional relationships*
 - *Contributes to lack of professional autonomy*
 - *Leads to overlap and duplication of activities/tasks performed by nurses and other professionals*
 - *Adds to heavy workloads, inadequate time for team work and continuing education*



Data derived from role effectiveness research

- Aim was to improve utilization of RNs and others***
- Direct observation of nurses on 2 units (1 control)***
- Information recorded (using PDA) about role functions***
 - Type of activity (e.g. administering medications)***
 - Nature of interactions (e.g. family, physician)***
 - Mode of communication (telephone, face-to-face)***
 - Focus of conversation (e.g. patient teaching)***
 - Time in Travel***
 - Number and nature of interruptions***



RNs spend

- **~ 36% of time in direct care activities**
 - ***E.g. ADL/personal care (12.4%), biomedical assessment (6.5%); medication administration / treatments (10.2%), engagement (1.4%), mobilization (0.6%)***
 - ***Patient and family assessment /teaching /support (4.4%)***
- **~ 19% of time in charting, reviewing information**
- **~ 16% in care coordination**
- **~ 9% in indirect care**
 - ***E.g. administration (3.3%), hand washing (1%), reorganizing unit (4.6%)***
- **~12% “in flight” (i.e. travel)**
 - ***Interruptions often occur while ‘in flight’ and are primarily by nursing colleagues***
 - ***May be associated with higher risk of medical errors***



- ***General Medical Unit – profile of patients***
 - *Most have one or more “top ten” diseases (ICD-10 codes)*
 - *73% discharged to own home; < 1/3 referred to HC*
 - *Primarily elderly, chronic patient population*
 - *63% aged 65+*
- ***Insufficient staff expertise in gerontological assessment***
- ***Insufficient spent in identification of risk factors***
- ***Relatively little evidence of time spent in establishing therapeutic relationships, advocacy***
- ***Not much evidence of collaborative, interprofessional care***

So What?



- **1/3 of patients returned within 90 days of discharge**
 - *Median about 28 days*
 - *44% returned if diagnoses in top ten ICD-10 codes*
 - *35 % returned on more than one occasion within 90 days*
 - *62% readmitted via Emergency Department*
- **Key predictors of 90 day readmission**
 - *Lack of adequate support (social, financial, familial)*
 - *Premature discharge*
 - *Non-adherence with meds, follow-up instructions*
 - *Substance abuse, homelessness, events external to patient control*
 - *Limited control over dietary restrictions, activity*
 - *Delay in seeking Rx at first sign of recurring symptoms*
(Anthony et al, 2005)
- **Most of these predictors associated with comprehensive assessment**
 - *Suggests we could prevent some readmissions by focusing on improving assessment at the time of admission (i.e. by optimizing the utilization of RNs & other health professionals)*

So What? (continued)



- ***Patient data reveal:***
 - ***Patients' ability to navigate the system related to quality of their interactions with the system***
 - ***Ability to cope depends on extent to which health needs anticipated***
 - ***Providers must identify people at risk due to social isolation***
 - ***Self-care ability enhanced when providers engage patient/family in care planning***
 - ***Effective communication among team members is NB to optimal outcomes of care***
- ***This is often not what patients experience***

Source: Patient Journey Study, 2007



Strategies for Role Optimization (suggestions obtained through nursing and interprofessional research)

- ***Model new approaches (create examples in practice; demonstration sites)***
- ***Committed, effective leadership***
- ***Dispel myths related to “others” roles (i.e. clarify roles)***
- ***Include all members of the health care team (value & respect the contribution of all health care providers)***
- ***Create time and space for interprofessional learning***
- ***Manage competing priorities and commitments***
- ***Implement structural (i.e. service delivery models) and functional (i.e. role functioning) changes needed to promote excellence in clinical practice across professions and settings***



- ***Redesign of work (functional)***
 - ***Align education and practice with patient / population needs***
 - ***E.g. Gerontology, chronic diseases***
 - ***Optimal utilization of every member of the team***
 - ***Address role ambiguity, duplication & unnecessary overlap***
- ***Establish new models of service delivery based on population/patient health needs (structural)***
 - ***Focus on collaborative practice***
 - ***Consider the continuum of care***



Collaborative Practice

Collaborative practice is a patient and family centered process for communication and decision-making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client / patient care provided. It is designed to promote the active participation of several care providers. It enhances patient, family and community-centered goals and values, provides mechanisms for continuous communication among health care providers, optimizes client / family and staff (within and across disciplines) participation in clinical decision-making and fosters respect for the contributions of all members of the team.

Adapted from: (Way, Jones & Busing, Ontario College of Family Physicians, 2000).



- **Effectiveness & Efficiency: Existing Models**
 - **Total patient care / Primary Nursing** (often all RN staff)
 - Not cost effective, particularly during nursing shortages
 - Waste of skills and time performing work that others could do
 - When RNs/LPNs assigned work “in parallel” – leads to role confusion and tension
 - May result in inappropriate care assignments
 - **Functional care** (tasks assigned to specific worker)
 - Task focused, ritualistic, dependent on rules, policies, protocols, procedures
 - Decreases professional autonomy, narrows role of all providers
 - May lead to boredom and decrease in job satisfaction
 - Leads to fragmentation of care, increase in errors/omissions
 - Decreases attention to psychosocial, spiritual needs
 - Many examples in service delivery currently
 - E.g. Discharge Nurse, Resource Nurse, Nurse-in-charge, etc.



- **Effectiveness & Efficiency: Existing Models**
 - **Team Nursing** (usually led by a team leader)
 - **Group of workers with diverse levels of education, skills/abilities deliver care to a group of patients**
 - **Team leader rarely provides “hands-on” care**
 - **Assumes accountability and responsibility for outcomes of care**
 - **Supervises/observes and evaluates team members**
 - **Emerged in 1950s (nursing shortage; LPNs unregulated)**
 - **Ineffective when short-staffed because requires more personnel**
 - » **RNs leads the team, but provides no direct care**
 - **Case Management** (coordination of care delivery)
 - **Case manager may not have a role in direct care delivery**
 - **Can lead to duplication of service across care continuum**
 - **Case managers in various settings, but not integrated**
 - **Patient/family may have more than one Case Manager**
 - **May also narrow the “assessment, planning, evaluation” functions associated with other professional roles**



- **Hybrid of other care delivery models**
 - **Shared responsibility & accountability for delivery of care to a group of patients**
 - **Assignment of tasks/activities negotiated by team members, based on needs of patients and capabilities/experience of team members on shift by shift basis**
 - **All team members involved in care delivery**
 - RN does not “supervise” other providers
 - Optimized role for all interprofessional team members
 - May allow greater flexibility, continuity of care
 - **May lead to re-definition of existing positions**
 - E.g. Clinical nurse educators, CNS, NPs, discharge planners, etc.
- **Will require**
 - **(Re) education of workforce, culture/attitude shift**
 - **Time for reflection, learning together**
 - **Leadership support at all levels**
 - **Effective communication structures and clear role delineation**
 - **Experimentation with new staff to patient ratios**
 - **Rigorous evaluation to assess impact on outcomes and on HHR planning and management**



Patient/Population

- *Improved health outcomes (decreased morbidity/mortality)*
- *Improved access to & timeliness of health care services*
- *Improved self-care capability*
- *Improved quality, safety*
- *Increased satisfaction*

Provider

- *Improved quality of worklife*
 - *Decrease in turnover, absenteeism, injuries*
- *Improved retention and recruitment*
- *Improved interprofessional relationships*

System

- *Enhanced productivity*
- *Long-term sustainability*
 - *Decreased capacity pressures*
 - *Cost-effective service delivery*
- *Improved health human resource planning and management capability*



- ***“The definition of insanity is doing the same thing over and over again, but expecting a different result.”***

Albert Einstein

- ***Is our current way of doing things working for us?***
 - ***Overtime, turnover, absenteeism, shortages***
 - ***Wait times, capacity pressures, quality of care, sustainability***
 - ***The time and power to change that is now!***

Contact Information



calgary health region



Dr. Jeanne Besner

Director, HSWRU

10101 Southport Road SW

Calgary, Alberta T2W 3N2

Phone: (403) 943-0181

Jeanne.besner@calgaryhealthregion.ca

www.calgaryhealthregion.ca/hswru