A Roadmap for Co-Creating Interprofessional Models of Care
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# TABLE OF CONTENTS

## PART 1: INTERPROFESSIONAL MODELS OF CARE: DEVELOPMENT & IMPLEMENTATION

### SECTION A: INTRODUCTION & BACKGROUND

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>TOOLKIT PURPOSE AND OVERVIEW</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Purpose of the Toolkit</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Toolkit at a Glance</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>THE AIR TEAM MODEL</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Why create an AIR Team?</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>AIR Team Setup and Operation</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>A Day in the Life of the AIR Team</td>
<td>8</td>
</tr>
</tbody>
</table>

## SECTION B: ORGANIZATIONAL READINESS & ENGAGEMENT

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>ORGANIZATIONAL READINESS</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>AIR Team Experience</td>
<td>13</td>
</tr>
<tr>
<td>4</td>
<td>ORGANIZATIONAL ENGAGEMENT</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>What is Organizational Engagement?</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Who should be engaged?</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>AIR Team Experience</td>
<td>17</td>
</tr>
</tbody>
</table>

## SECTION C: GUIDELINES FOR CO-CREATING INTERPROFESSIONAL MODELS OF CARE

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>OVERVIEW OF THE GUIDELINES</td>
<td>21</td>
</tr>
<tr>
<td>6</td>
<td>STEP 1-REFLECT INTRAPROFESSIONALLY</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>What is meant by Intraprofessional Reflection?</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>How is Intraprofessional Reflection accomplished?</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>AIR Team Experience</td>
<td>27</td>
</tr>
<tr>
<td>7</td>
<td>STEP 2-RE-STORY THE PROFESSIONAL NARRATIVE</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>What is meant by Re-Storying the Professional Narrative?</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>How is Re-Storying achieved?</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>AIR Team Experience</td>
<td>32</td>
</tr>
<tr>
<td>8</td>
<td>STEP 3-ESTABLISH A HARMONIZATION PHILOSOPHY</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>What is a Harmonization Philosophy?</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>How is a Harmonization Philosophy established?</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>AIR Team Experience</td>
<td>34</td>
</tr>
<tr>
<td>9</td>
<td>STEP 4-ANALYZE ACTIVITIES AND DEVELOP COMPETENCY FRAMEWORK</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>How are activities Analyzed and a Competency Framework created?</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>AIR Team Experience</td>
<td>38</td>
</tr>
<tr>
<td>10</td>
<td>STEP 5-ESTABLISH AUTHORIZING MECHANISMS</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>What are Authorizing Mechanisms?</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>How are Authorizing Mechanisms determined?</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>AIR Team Experience</td>
<td>48</td>
</tr>
<tr>
<td>11</td>
<td>STEP 6-EDUCATE</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>Educational Considerations</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>AIR Team Experience</td>
<td>50</td>
</tr>
</tbody>
</table>
PART 1

INTERPROFESSIONAL MODELS OF CARE:
DEVELOPMENT & IMPLEMENTATION
INTRODUCTION & BACKGROUND

In this Section:

Chapter 1
Toolkit Purpose and Overview

Chartar 2
The Assertive Interprofessional Respiratory (AIR) Team Model
CHAPTER 1
TOOLKIT PURPOSE AND OVERVIEW

Purpose of the Toolkit

Interprofessional practice, which occurs when different professions come together for the purpose of patient-centred healthcare delivery, is becoming increasingly embraced and endorsed by governments to improve patient access to care, delivery, and efficiency. However, according to Lahey & Currie (2005), interprofessional practice does not occur or persevere because it is mandated. “It happens where conditions exist or are created that are conducive to experimentation with new ways of collaborating and where providers (as well as administrators, patients, and families) decide to exploit those conditions. It is sustained because of institutionalization of the underlying enabling conditions but more importantly, because experience demonstrates the advantages of interprofessional practice for both patients and providers” (p. 205-206). There is no recipe to make interprofessionalism a reality in a system where differences exist both between professions and within professions, and where patients are unique with varying care complexities. It requires creativity, courage, passion, and perseverance.

St. Joseph’s Health Centre’s has completed several projects related to interprofessional practice and developing interprofessional core competencies with clinicians working on point-of-care teams (also known as unit-based councils) (King et al., 1999; Loch, 1993). Building upon this foundation, the project team involved in the development of this Toolkit endeavoured to pilot a model of care that would allow for some experimentation with traditional healthcare provider roles.

This Toolkit is a compilation of one Heath Centre’s experience with the implementation of an innovative interprofessional team model—the Assertive Interprofessional Respiratory (AIR) Team. More importantly, the Toolkit provides a framework which organizations and individuals can use to engage with one another in the co-creation of interprofessional models of care in their own organizations. It can be used to help move interprofessional practice from conceptualization to operationalization.
Throughout the duration of the AIR Team project, a concerted effort was made to share emergent learnings with others through conference presentations and site visits. The feedback from these venues was instrumental in shaping both the thinking around this project as well as the structure and layout of this Toolkit.

Sample Conference Poster

Enhancing Scope of Practice for a Respiratory Therapist Through the Development of an Assertive Interprofessional Respiratory (AIR) Team Model in the Emergency Department

Toolkit at a Glance

The Toolkit is divided into three (3) main parts:

**Part 1 Interprofessional Models of Care: Development & Implementation**, is comprised of four (4) Sections:

Within the first section, Introduction and Background, the AIR Team Model is introduced. The presentation of this model of care provides a context for the reader by bringing to life the proposed framework for how to successfully develop and implement interprofessional teams.

The second section Organizational Readiness & Engagement explores the readiness of an organization for change, and techniques to foster engagement amongst stakeholders.

The third section presents the Guidelines for Co-Creating Interprofessional Models of Care that showcases step-by-step instructions to enable model of care restructuring, scope optimization, and teamwork development. Each guideline begins with a theoretical overview that is applicable to any interprofessional team, regardless of professional background, clinical context or specific patient population. Each guideline is brought to life with an exemplar which illustrates the AIR Team’s experience.
The **fourth** section explores the process and impact of *co-creating a team vision*. Engaging in Team Visioning positively impacts both the cohesion and the energy of a team. Resources to guide teams through the visioning process are also provided.

Part 1 concludes with a list of **references** and **additional readings** for those who wish to learn more about the literature that helped inform the development of this Toolkit.

**Part 2 Resources** contains a number of tools and resources that are referred to throughout the Toolkit.

Tools provided include:
- Sample job posting, delegations, medical directives, and pre-printed order sets
- Team Visioning worksheets
- Data collection and evaluation tools

**Part 3 Evaluation** presents preliminary findings of implementing the AIR Team Model in St. Joseph’s Health Centre Emergency Department, Toronto.
CHAPTER 2
THE AIR TEAM MODEL

St. Joseph’s Health Centre’s Assertive Interprofessional Respiratory (AIR) Team was a team of professionals who provided enhanced respiratory care to patients in the Health Centre’s Emergency Department between March 9, 2009 and July 3, 2009. The interprofessional AIR Team Model began its development in October 2008, was staffed and piloted for a five-month period, and concluded its formal project evaluation phase at the end of September 2009.

The AIR Team concept originally emerged from dialogue between leaders of various professional disciplines at the Health Centre who identified an opportunity to optimize clinician scope of practice in a model of care that truly integrated interprofessional practice at the patient’s bedside. The aim was to assemble three healthcare providers—a Registered Respiratory Therapist (RRT), a Registered Pharmacist (RPh) and a Registered Nurse (RN) to work together in St. Joseph’s Health Centre’s Emergency Department to deliver enhanced care to patients with respiratory illness.

This pilot project was made possible through a generous grant received from HealthForceOntario’s Optimizing Use of Health Providers Competencies Fund (OUHPCF). While the AIR Team was deemed a success, the decision regarding the team’s future operation at the Health Centre will be determined at the conclusion of the formal project evaluation phase.

Why create an AIR Team?

Given the serious nature and prevalence of respiratory disease in patients today, clinical practice guidelines have been developed to direct optimal respiratory patient management. For example, the Registered Nurses’ Association of Ontario has developed best practice guidelines for adult asthma care (2004a; 2007a), asthma care in children (2004b; 2008a) and for the care of dyspnea in patients with chronic obstructive pulmonary disease (2005). Most recently, the Ontario Lung Association (2008) has been disseminating an Emergency Department Asthma Care Pathway (EDACP) to emergency departments throughout Ontario in order to improve the management of patients presenting with asthma exacerbations.
Despite the development and implementation of patient guidelines, there is strong evidence that a care gap between what is known and what is practiced still exists and there is often a failure to transfer new information to the emergency department setting. Mackey et al., (2007) have indicated that, despite the efforts to disseminate high-quality evidence for the care of respiratory diseases in the emergency department, a lag in uptake of this evidence can be demonstrated. As such, patients with respiratory conditions may not be receiving optimal care in emergency departments in Canada, and therefore researchers have suggested implementing specialty teams in the emergency department for patients presenting with respiratory symptoms (Fulde & Duffy, 2006). To support this function, Cowie et al., (2001) identified nurses, pharmacists and respiratory therapists as specialists in the management of respiratory patients, along with their physician colleagues.

**AIR Team Setup and Operation**

At the core of the AIR Team Model was a strong, collaborative and cohesive team which is consistent with an assertion made by Morey et al. (2002) that teams need to be formalized in order to realize the benefits of enhanced teamwork behaviours. Furthermore, to better address the pressures in the emergency department and be more responsive to patient needs, Fulde & Duffy (2006) recommend implementing a specific interprofessional team to address the complexity of high-risk patient subgroups, including patients with respiratory illness.

The AIR Team at St. Joseph’s Health Centre was put in place to maximize patient safety and care through interprofessional collaboration. Due to the extensive coordination and training required for the team, the same Registered Nurse, Registered Respiratory Therapist, and Registered Pharmacist worked together on a daily basis. Trained replacement staff were available to occasionally replace an absent team member when needed. To facilitate this backup support, a second Registered Nurse, Registered Respiratory Therapist, and Registered Pharmacist participated, along with the three AIR Team clinicians in a month of education and training. The AIR Team was phased into the emergency department to ensure that the team was implemented as safely as possible since all three clinicians were working in a new clinical context and gaining experience with competencies that may not have been within the principal expectations of practice (PEP) for their profession (Federation of Health Regulatory Colleges of Ontario, 2007).

The team served as the primary care providers for respiratory patients triaged to the Acute and Urgent Area of the emergency department. However, the AIR Team was also mobile in that they provided consults to patients in the Resuscitation Room, Paediatrics, Ambulatory, Fast Track, and Crisis Areas of the emergency department (refer to the emergency department map on the next page). In these areas, the emergency department nurse remained the primary caregiver, but collaboration with the AIR Team was central to the patients’ ongoing care and management.
The AIR Team was intentionally assigned primary responsibility for respiratory patients in a specific geographical area within the emergency department. This allowed for the full integration of a team model where all three professions collaboratively worked together towards a common patient goal. The team was not responsible for the full care of patients in all patient areas of the emergency department to decrease any risk of the clinicians working in individual silos that may have limited opportunities for communication and care coordination.

The AIR Team operated 8 hours per day, 5 days per week. In order to determine the team’s hours of operation, a report was originally generated using emergency department data for the same time period from the previous year (January to June 2008) to determine the time of day that the majority of patients with respiratory complaints presented to the emergency department. Although working 0800 to 1600 yielded...
the best results, the team’s hours of operation were amended to 0730 to 1530 to facilitate patient handover from the night shift. During off hours, emergency department patients received care from a primary nurse (registered nurse) who would give a direct report to the AIR Team clinician following the night shift which ended at 0730. This adjustment of the AIR Team’s hours of operation minimized disruption to the emergency department, and decreased the number of patient handovers required.

A Day in the Life of the AIR Team

At the start of their shift, the AIR Team clinicians would receive a report of all patients with a primary respiratory complaint who were in the Acute and Urgent areas of the emergency department. Together as a team, a thorough and comprehensive assessment of each patient’s clinical status was completed to ensure that all clinicians were equally knowledgeable about each patient’s clinical condition and plan of care for the day. Once each patient’s initial assessment was completed, the team clinicians would divide up any outstanding or urgently ordered interventions, as well as complete a best possible medication history to assist in identifying any acute medication-related issues.

The clinician’s profession was not the sole determinant of the division of work. Instead, consideration was given to ensuring that workload was evenly distributed. Consideration was also given to the individual clinician’s expertise for challenging clinical scenarios. For example, while each of the AIR Team clinicians was competent in initiating intravenous access, the Registered Nurse would be the AIR Team clinician called upon for more difficult cases. This parallels one of the Registered Nurses’ Association of Ontario’s (RNAO) Best Practice Guidelines for collaborative practice that states, “the contribution of each team member needs to be optimized. Professionals need to focus on working together in a complementary manner rather than competing with other team mates” (RNAO 2006a, p. 31). In some instances, it was necessary for a specific profession to perform the activity. An example of such a case was inserting a foley catheter; a skill that could only be performed by the Registered Nurse. Throughout the process, the AIR Team clinicians would collaborate and liaise with the patient’s primary physician based on the patient’s clinical condition.

In addition to caring for existing patients in the emergency department, any new patients that presented during the team’s hours of operation with a respiratory condition would be assigned the AIR Team as their primary caregiver. Once again, the entire team would participate in the initial work-up for a new patient and would initiate any required interventions either through the implementation of medical directives or by contacting the most responsible physician.

For all of their patients, the team remained the patient’s primary care provider during the team’s hours of operation. While the team was operating in the emergency department, break coverage was negotiated among team members, however, only one AIR Team clinician would be on break at any given time, ensuring that two clinicians were still
available to meet patient care needs. At the end of the shift at 1530, the team would provide a hand-off report to the registered nurse who would have otherwise been assigned to the patient if the AIR Team was not present in the department.

As previously discussed, the team also provided consultative and support services to patients and clinicians working in other areas of the emergency department. Any member of the clinical team could initiate the consults. The types of consults included requests for respiratory assessments, assistance with delivery of treatments ordered, assessment of care, and/or patient discharge education. It was only in these instances, that any one AIR Team clinician reviewed the assessment, medication history and patient progress with the primary nurse, physician, and patient/family to collaboratively develop the patient’s care plan. However, more often than not, at least two or all three clinicians would attend to a requested consult.

This unique and flexible patient-care delivery model allowed the AIR Team clinicians to have shared responsibilities and decision-making to ensure timely and appropriate delivery of care for each and every patient.

“Workload equilibrium depends on an appropriate patient/client care delivery system. Such a system reflects a coordinated interdisciplinary approach incorporating ongoing communication between health professionals and patients/clients, ever mindful of the personal preferences and unique needs of each individual patient/client and the individual and collective capacity” (RNAO 2007b, p. 27) of each team member.
CHAPTER 3
ORGANIZATIONAL READINESS

Assessing Organizational Readiness together with aligning a team of change leaders is one of the first steps for the successful implementation of a change in clinical practice. The primary responsibility for a team of change leaders is to catalyze insight and clear thinking in their team so they are able to lead their organization’s change efforts with greater skill and competency (Recklies Management Project, 2001). Change leaders also challenge assumptions and act as role models for innovation, recognize opportunities to question existing practice and the status quo, and encourage curiosity and imaginative reflection about clinical practice (RNAO, 2007d).

Before any change can occur within an organization or system, it is important to have a roadmap for how the change will be created. Initially, stakeholders should be identified (Change Leader’s Roadmap, 2008). When a team is working towards change within an organization, it may be met with resistance from various sources. Change leaders are in a unique position to be able to ascertain required, or desired, organizational directions for the future. This comes from listening to all perspectives and being aware of their own voice of judgement. It is about identifying the highest intention of the speaker which could involve concern around patient care, relationships with colleagues, or other competing initiatives. Scharmer (2008) described a heightened state of attention whereby change leaders operate in a future space of possibility requiring a shift of the mind, will, and heart, and this will facilitate a productive response and action bringing emergent change to light.

It is important to understand the environment within which the change initiative will work. This landscaping of the environment can be assessed by reflecting on a series of questions:

“Never doubt that a small group of thoughtful, committed citizens can change the world” (Scharmer, 2008, p. 57).
An inquiry roadmap may be developed based on the results of both personal and group reflections. This provides change leaders with a sense of direction to move the initiative forward.

Once the change leaders within the project team have reached a shared understanding of the initiative and stakeholders have been identified, the change process may commence.
AIR Team Experience

An organization’s philosophy and culture can have a profound impact on the degree of collaboration a team experiences. Having interprofessional practice embedded in St. Joseph’s Health Centre’s strategic plan, helped create a culture that was open to the implementation of the AIR Team project.

The Health Centre’s formal involvement with interprofessional collaboration began in January 2007 when a team of clinical leaders were selected to attend the Educating Health Professionals in Interprofessional Collaboration (ehpic) leadership course at the University of Toronto’s Office of Interprofessional Education. The course required the team to return to the organization and obtain a snapshot of the lived experiences of interprofessional practice. The team spent the following year developing a team coaching workshop that would serve to enhance interprofessional practice at the Health Centre. The workshop was rolled out with twenty-six (26) clinical teams within the organization.

To ensure engagement of the senior leadership team, an exclusive workshop was held. The positive response helped to sustain the momentum for interprofessional practice, resulting in it becoming part of the hospital’s strategic plan for 2008-2011. Subsequent initiatives included the implementation of an interprofessional orientation program and the introduction of a week dedicated to celebrating interprofessional education. In addition, a Manager of Interprofessional Education was recruited and Interprofessional Student Placements through the University of Toronto commenced with the Family Health Teams in March 2009. It was evident that St. Joseph’s Health Centre was well positioned as an institution to continue on an interprofessional collaborative journey.
CHAPTER 4
ORGANIZATIONAL ENGAGEMENT

What is Organizational Engagement?

While Organizational Readiness focuses on assessing the landscape to determine the degree of readiness for change, Organizational Engagement focuses on integrating key groups or individuals into the initiative through collaborative participation.

Collaborative participation begins when people ask questions such as, “who needs to be included in the decision-making process?” Another question may be “who needs to be involved to create the most coordinated and mutually inspiring results?” (Anderson et al., 2008, p. 36). During the organizational inquiry that seeks to answer some of these questions, system voices that will be impacted or who may be able to impact the initiative or project, should be identified. The settings where healthcare services are delivered are intricate and complex. As such, the process of engaging stakeholders will be multi-faceted and will likely occur in various stages that coincide with key milestones.

When engaging others in the change process, a frequently encountered response is that “the current system is fine so why is there an attempt to fix it”? Appreciative Inquiry involves shifting the focus from a problem-based method of fixing situations towards generative responses that address systemic root issues. This is integral in addressing concerns that may be raised within the organization when seeking to implement a new initiative (Scharmer, 2008). By asking these generative questions, the organization’s readiness for change may be enhanced (Adams, 2009). Examples of generative questions may include the following:

REFLECTIVE QUESTIONS
Organizational Engagement
1. How might this new idea make our work even better?
2. Imagine we implemented this in a way that worked—what would be different?
   What would be possible now?
3. What do you need to make this work best?
4. What small change could we make that would result in the most difference?
Generative questions are formed by building upon current strengths and lived experiences by taking a snapshot image of what is best right now, and what the work environment would look like if the team was operating at its best everyday. This approach to organizational change is grounded in the heliotropic hypothesis; where you shine the light is where growth will occur (Cooperrider, 1990).

**Who should be engaged?**

When undertaking the co-creation of an interprofessional model of care, there are several considerations in terms of who ought to be engaged in the process.

Senior Management and Senior Leader support is an important factor when introducing a change initiative. Before attempting to engage the senior team, consider reviewing the organization’s mission, vision, values, and strategic plan to determine where the proposed change fits with the direction of the organization. This helps to position the initiative in a manner that is congruent with where the organization is focussing its energies.

Considering the specific context or setting where the initiative or team will be implemented is essential in identifying who needs to be engaged in the process. The introduction of a new role or new model of care into an existing setting or department will undoubtedly necessitate changes to departmental processes. Changes will likely impact every member of the department-specific team. While engagement of department leadership and select clinicians is often considered early, one must also take into account other players that will interface with the newly co-created team or model. For example, how will clerical or administrative processes be impacted by the presence of the team? How will clinicians external to the department interface with the team?

Another key consideration involves whether the proposed model of care will necessitate changes to existing organizational or setting-specific policies, standards or procedures, or result in the generation of new ones. The model may also necessitate the amendment or introduction of authorizing mechanisms such as medical directives or delegations. This will often require an approval through various committees. What committees will need to approve the revisions? Who are the representatives on the committees? What information will need to be shared about the overall initiative ahead of time, in order to provide sufficient context for the committees to be able to consider any proposed changes to practice?

The literature on interprofessional practice includes an examination of liability risks involved with the delivery of care from multiple providers (Lahey & Currie, 2005; The Conference Board of Canada, 2007a, 2007b). Consultation and engagement with Risk Management and Patient Safety within the specific practice setting will be integral in ensuring that the model of care is implemented as safely as possible and that the organization is aware of any potential risks associated with the practice model. Considerations regarding clinician and organizational liability will be discussed in greater detail in *Chapter 12 Step #7: Ensure Coordination*. 
The RNAO’s (2002b) *Toolkit for the Implementation of Clinical Practice Guidelines* offers assistance to those seeking to identify, analyze and engage stakeholders. Beyond the process for identifying the key individuals or groups that will impact or be impacted by the implementation process, the RNAO’s toolkit offers an approach for triaging stakeholders. Of particular interest is categorizing stakeholders in terms of their level of influence, support, and resulting approaches for engagement (p. 32). One size does not fit all; change leaders would be remiss to not devote time and energy to this critical step in the change implementation process.

These considerations are certainly not exhaustive. The intent is to provide a starting point in terms of questions that the team can pose to increase the likelihood of the model of care being successfully integrated into the organization. The following AIR Team Experience describes some approaches that the AIR Team used at St. Joseph’s Health Centre to engage the organization.

**AIR Team Experience**

The objective of the AIR Team was one where each member of the team would actively participate in the full spectrum of patient care. To initially lay the foundation for the program, the recruitment process to hire three AIR Team clinicians began. Job postings and descriptions were created for each of the AIR Team roles. By putting an *all call* for applications, discussions ensued with curious professionals creating conversations around the project within the Health Centre. For example, since the project involved the creation of a new nursing position, the Ontario Nurses Association within the organization was consulted during the process. The job postings were limited to internal candidates in order to facilitate the transition into the role. Postings were available through Internal Job Boards, and were distributed electronically to all clinical areas currently employing any one of the three eligible professions. The hiring process certainly assisted in raising the profile of the project throughout the organization (refer to *Resource 1* for a sample of the Pharmacist Job Posting).

The interview process (refer to interview questions on next page) resulted in the introduction of clinicians from outside of the emergency department which positively impacted cross-unit or cross-department relationships.

Early in the development of the model, a concern arose about the team’s successful integration into the emergency department. Historically, specialty teams and practitioners have not been universally accepted as they can be perceived as *consultants* who complete an assessment and make recommendations for action, while implementation of the proposed plan of care is often deferred to other healthcare professionals within the current staffing complement. The intent of the AIR Team was to be fully integrated within St. Joseph’s Health Centre’s Emergency Department and for the clinicians to provide their expertise in the direct care of the patients.
The AIR Team’s visibility was essential to its cohesiveness with other members of the emergency department staff and physicians. Morey et al., (2002) assert that teamwork is enhanced through visual changes in the team environment. Specifically, the authors suggest that teams ought to be visually identified through armbands, identification tags, etc. When the AIR Team was first launched in the department, the impact of coordinated team jackets that identified the Registered Nurse, Registered Pharmacist and Registered Respiratory Therapist as members of the AIR Team was underestimated. However, similar to the findings of Morey et al., the jackets served to assist other Health Centre staff and physicians, and most importantly the patients in both identifying the AIR Team care providers and according to some informal reports, increased the degree of trust in the team by adding another element of legitimization.

The AIR Team clinicians played an integral role in providing information to the emergency department staff about the project prior to its launch which helped integrate them into the emergency department at an early stage. Select emergency department clinicians were provided more in-depth information about the project and were key in assisting. This helped to

**INTERVIEW QUESTIONS**

All candidates were interviewed using a standardized interview guide with questions weighted and rated on a five-point scale with responses ranging from Poor to Exceptional. Interview questions were as follows:

1. Please tell us about why you are interested in the AIR Team position?
2. What strengths would you bring to this project?
3. What do you think will be your greatest challenge in developing and working with the team? What would your strategies to overcome these challenges be?
4. Can you give us a specific example of when you have worked on an interprofessional team at St. Joseph’s Health Centre? Did you feel that your role on this team enabled you to work to your full scope of practice? Why or why not?
5. How would you handle a situation where you presented a patient with one of your AIR Team colleagues (such as, Registered Respiratory Therapist, Registered Nurse, Medical Doctor, Registered Pharmacist) and they disagreed with your assessment and planned interventions for the patient? How would you handle a situation where one of your AIR Team colleagues presented a patient and you disagreed with their assessment and planned interventions for the patient?
6. You called to go to the ambulatory area of the emergency room to teach a patient, who has just been prescribed a multi-dose inhaler (MDI), to teach him how to use the device. The gentleman speaks only Portuguese. What strategies would you use to show the procedure to the patient? How would you confirm understanding?
7. If you were to be chosen to participate in the AIR Team project, what supports will you need to help make the project a success?
8. Qualifications (Provide applicant with a copy of the posting for their respective profession and ask them to speak to the qualification section).
9. Please provide us with a specific example of a time when you demonstrated one of the values of the Health Centre.
10. Do you have any questions for us?
raise the profile of the team and to clarify or dispel any concerns that were raised when AIR Team clinicians were off shift.

The benefits of early physician engagement are well documented in the literature. The first contact with the Emergency Department Physician group at St. Joseph’s Health Centre took place during one of the group’s regularly scheduled meetings. The Registered Nurse and Registered Pharmacist from the project’s lead team as well as the AIR Team’s Registered Respiratory Therapist attended the meeting. During this meeting, the interprofessional care model was presented, and physicians were provided with an opportunity to seek clarification regarding clinical and process impacts of the team’s presence in the emergency department. A lesson learned from the AIR Team experience is that early engagement does not guarantee continued engagement. Frequently checking in about the comfort level of the physician group and addressing emerging concerns with the project are key to ensuring sustained support.

The Adult and Paediatric Clinical Working Groups included representation from Emergency Department Physicians, a Respirologist, Internist and Paediatrician. As well, by vetting a number of medical directives and delegations through committees with extensive physician representation, physicians who would not necessarily be interacting with the AIR Team became aware of the interprofessional model that was being proposed. This helped to engage the physician group in the project.
GUIDELINES FOR CO-CREATING INTERPROFESSIONAL MODELS OF CARE

In this Section:

Chapter 5
Overview of the Guidelines

Chapter 6
STEP 1: Reflect Intraprofessionally

Chapter 7
STEP 2: Re-Story the Professional Narrative

Chapter 8
STEP 3: Establish a Harmonization Philosophy

Chapter 9
STEP 4: Analyze Activities and Develop Competency Framework

Chapter 10
STEP 5: Establish Authorizing Mechanisms

Chapter 11
STEP 6: Educate

Chapter 12
STEP 7: Ensure Coordination

Chapter 13
STEP 8: Evaluate to Maintain System Responsiveness and Flexibility
CHAPTER 5
OVERVIEW OF THE GUIDELINES

The Guidelines for Co-Creating Interprofessional Models of Care involve eight key steps that are presented in chapters 6 to 13. Some of the steps presented were planned. Others emerged as the working group became more fully engaged in the process. While the guidelines were developed specifically for the AIR Team, they have broad applicability and could ultimately be utilized in the co-construction of any interprofessional model of care, regardless of context or patient population.

The eight-step process was created by the Competency Working Group based on extensive dialogue between a group of individuals who were dedicated to further enhancing interprofessional practice at the clinical point of care. The Competency Working Group was comprised so each of the professions involved had representation from three different levels. Pharmacy, Respiratory Therapy and Registered Nursing had representation from:

- a provincial or national association for the profession,
- a member of the leadership team representing the profession within St. Joseph’s Health Centre, and
- the clinicians who would be enacting the model and optimizing scopes of practice in the clinical setting.

The dialogue was facilitated by the Manager of Interprofessional Practice and an internal expert on regulatory issues who provided direction regarding the safe and legislatively sound transition of the model of care. An emergency department physician was consulted following regular meetings for input and to inform how medicine would interface with the newly created team within the clinical context. The regulatory colleges representing the three professions involved were consulted as required either via telephone or e-mail in order to ensure that decisions were appropriate and authorizing mechanisms were established accordingly.

These guidelines are intended to be applied within a specific team structure and clinical context. That is to say, the guidelines will not necessarily result in a fundamental change in the role of any given professional group across all areas of practice. For example, in the AIR Team Project, the role and competencies of the Registered Pharmacist in the emergency...
department were altered. However, the role and competencies of the same pharmacist may look different outside of the AIR Team context, even within the same healthcare setting. Any change in practice must be considered with the specific practice setting, patient population, and team members in mind.

Guidelines for Co-Creating Interprofessional Models of Care

During the *Intraprofessional Reflective Process*, individuals who will be engaging in the conversations to co-create the practice model must first reflect on their own practice through a role- or discipline-specific lens. During this process, extensive self-reflection enables participants to consider their own identity as professionals, the unique knowledge and skills they possess, the other roles they may be able or willing to undertake and the degree to which they are prepared to negotiate their own professional boundaries.

The next step involves the working group engaging to *Re-Story the Professional Narrative*. During this phase, the participants consider not only their own understanding of their profession and professional identity, but how each of the professions is perceived by colleagues both within and from other professions. How does the general population understand the role of the profession? What are some of the stereotypes or traditional roles of the professional group? What ought to be maintained as unique to the profession and what can be shared? What new roles or future practices can be envisioned for the profession?
The working group then needs to **Establish a Harmonization Philosophy**. Prior to delving deeper into discussions to negotiate roles and responsibilities in an interprofessional model of care, guiding principles are established. This is the harmonization philosophy and will serve as a contract for how participants engage with one another in dialogue. As such, the harmonization philosophy will be negotiated and co-created by the working group.

The **Activity Analysis and Competency Framework** begins with the development of an activity inventory specific to the practice setting and patient population. What possible competencies and skills are required for the tasks that may arise in the course of providing care to patients in this context? Once the list has been developed, working group members can begin to dialogue about the potential roles and responsibilities of each of the professions vis-a-vis the specific activities in the inventory.

Participants can begin the process necessary to **Establish Authorization Mechanisms**. This may include establishing formal delegation of controlled acts and development of medical directives. This also allows for the formal integration of evidence-based practices with the model of care.

**Education** involves knowledge translation and competence assessment through formal education, lecture, skill development in practice labs and in the clinical setting, group work activities, unit orientation, etc. This is crucial in order to ensure that new activities for a given professional are integrated into the clinician’s practice as safely as possible. It also provides an opportunity for team members to build confidence and competence with their clinical skills.

The working group must **Ensure Coordination** of care and this can be accomplished in various ways. Scope of Practice Simulations can be utilized to present the team with clinical scenarios to determine how they may respond as a team, or as an individual. A phased-in integration provides opportunity for clinicians to refine team dynamics in order to optimize efficiencies, patient safety and scopes of practice. These, along with other strategies assist in improving safety and mitigating liability risks.

Finally the working group must engage in continual **Evaluation to Maintain System Responsiveness and Flexibility**. This helps to ensure flexibility in the model of care in order to respond to evolving patient care needs and other changes within the clinical setting. Evaluation can be frequent and informal but should also include more comprehensive formal evaluations. Based on the results of formal and informal evaluations, the working group can return to guidelines as needed in order to renegotiate the model of care or the specific clinician roles embedded within it.
CHAPTER 6
STEP 1: REFLECT INTRAPROFESSIONALLY

What is meant by Intraprofessional Reflection?

The promotion of interprofessional approaches in the delivery of health services has long been touted as a worthy end to pursue, in the hope that it would have a positive impact on the quality of services that healthcare consumers receive (Irvine et. al., 2002). At the service delivery level, workers are expected to cooperate with each other, develop interprofessional teams, interprofessional client treatments plans, and integrate their services in order to enhance client care. However, it has been reported that despite a developing body of knowledge about interprofessional collaborative practice, transformation to teamwork in healthcare is slow as professionals continue to protect their turf or limit scopes of practice to respond to their own needs (Canadian Health Services Research Foundation, 2005). Understanding concerns about professional turf and looking after professional needs are defensive manoeuvres that may seem contrary to interprofessional collaboration. However, these tactics should also be seen as normal professional reactions to the push towards interprofessional integration in clinical settings. They may provide the affected professions with time to think through what the impending change may mean to them. If these professional tactics are considered normal, temporary and managed responses to change, clinical environments can be reframed within a given setting. As such, intraprofessional reflection is a necessary step towards effective interprofessional collaboration.

As a matter of fact, interprofessional collaborative practice does not preclude strong disciplinary socialization (Orchard, Curran & Kabene, 2005). Therefore, strong intraprophessional ties are necessary in order for professionals to negotiate their roles within their interprofessional teams. Mickan and Rodger (2005) suggest that interprofessional team members are required to be socially competent and willing to share information, negotiate decisions and solve problems. They add though, that to communicate well and build a sense
of commitment, individuals need a certain level of self-knowledge and confidence in their own professional role and skills.

Orchard, Curran and Kabene (2005) are probably the most explicit authors in supporting the intraprofessional reflective process. They identified role clarification as an enabler to interprofessional collaborative practice. Role clarification is based on a profession gaining an understanding of the role assumed by its members and their knowledge in exercising these roles. The authors state that health professions will need to discuss and acquire:

- a clear understanding of their own role and expertise
- confidence in their own abilities
- recognition of the boundaries of their own profession
- commitment to values and ethics of their own profession
- knowledge of their own professional practice standards

Orchard, Curran and Kabene conclude by saying that movement towards role clarification requires discussion around the previous constructs and in particular the beliefs and values that underlie the boundaries of each profession.

**How is Intraprofessional Reflection accomplished?**

As a profession needs to negotiate its role, so do the members within each respective profession. As the professional group discusses its professional view on roles and scopes of practice, members of that profession must also negotiate their personal or individual scopes of practice. The latter refers to those activities within the scope of the profession that each member believes they have the knowledge, skill and judgment to perform. Individual scope of practice is important to consider, even beyond that of the professional scope, because individual ownership of the profession is the basis for negotiations during interprofessional interactions (Kvšrnstrom, 2008).

In an effort to create new models of interprofessional care, a professional discipline must reflect on its current role in meeting patient needs. The profession should also identify some potential opportunities for role development. Restructuring clinical work so that it reflects interprofessional care requires individual practitioners to consider how they want to share accountability for patient care. This process has to be personally and professionally negotiated. Personal and professional self-awareness using reflective practice serves to strengthen professional roles (Pearson et al., 2005 as cited by RNAO, 2007c).

The following questions will assist intraprofessional teams and individual members of a particular discipline to reflect on their roles.
REFLECTIVE QUESTIONS
Intraprofessional Awareness

1. What is my profession’s traditional role with this type of patient?
2. What is my profession’s traditional role within this type of setting?
3. What does my profession have in terms of knowledge, skill and judgment that can be used to enhance care for this type of patient?
4. What other roles can my profession do?
5. What roles can my profession share with other disciplines that have similar knowledge, skills and judgment?
6. How much am I personally prepared to negotiate my professional boundaries?

AIR Team Experience

Engaging in an intraprofessional reflective process was a crucial first step in the AIR Team experience. This step was emergent as opposed to planned. Discussions with team members revealed that the individuals engaged in the process of negotiating roles had extensively reflected on their individual roles and scopes of practice. What was identified in the process is that this step cannot be glossed over or taken for granted. It is important to honour that each individual involved will have a different professional lens through which he/she will analyze, interpret, and contribute to the dialogue.

Other team members who may have been involved in the project at an earlier stage must appreciate that each person who becomes part of the process, requires dedicated time for reflection prior to any discussion regarding role negotiation. For example, in the process of writing the grant proposal, the profession-specific leads for Nursing, Respiratory Therapy, and Pharmacy each participated in this reflective process as an independent activity. When profession-specific representatives at the clinician-level and representatives from the various professional associations joined the process, they too needed to engage in this step before team conversation could take place.
CHAPTER 7
STEP 2: RE-STORE THE PROFESSIONAL NARRATIVE

What is meant by Re-Storying the Professional Narrative?

Interprofessional collaboration is about changing practice. More specifically, it is about changing the way healthcare professionals practice, and includes modifying what professionals actually do, and not just the way that different professionals work together. Much of what professionals do in healthcare is dictated by external elements. Though it would be logical to believe that those external elements would be limited to the regulatory frameworks and legislation that affects practice, or an employer’s ability to induce a redefinition of a profession’s scope of practice because of new demands and skill requirements in the workplace, the elements at play are socially constructed and insidious but nonetheless powerful. Many current practices in healthcare are based on professional stereotyping and historical tradition. These two elements have a powerful effect on shaping practice. They shape practice in ways that may not necessarily be advantageous to the advancement of interprofessional collaborative environments in healthcare. As a result, re-storying the narrative of a profession is a process through which members examine the historical traditions and stereotypes attached to their professional work. Through this re-examination, the profession is poised to deconstruct the myths surrounding its practice, and reinvent itself through challenging the status quo.

Professional groups must re-examine how they see themselves and other professions. Professional stereotyping is the belief that all members of a specific group share similar traits and are prone to behave in the same way. These stereotypes may be generated through how a particular profession views itself and how it is perceived by other occupations. Carpenter (1995) suggests that changing stereotypes is a two-sided process. All parties must participate and grapple with how they see themselves and how they see others. For example, he demonstrates the need to tackle professional stereotypes by advocating for a change in the nurse-doctor relationship. He states that it would not be sufficient for nurses and doctors to change their perceptions of nurses—but they must also both change their
perception of doctors. He adds that if nurses persist in stereotyping doctors as arrogant and uncaring, for example, then it would be difficult for either party to behave differently towards each other. Furthermore, he concludes that change in the relationship is more likely to happen if each group believes that the other has changed its stereotypes about itself; for example, if nurses believe that doctors perceive them as being more competent and more confident. Carpenter (1995) makes a strong case about the need for professions to review the positive and negative stereotypes that are held about each profession because whether it is believed, professional stereotyping can ultimately limit effective teamwork if left unchecked (Mickan & Rodger, 2000). Individual clinicians can assist in addressing these stereotypes by understanding their own role, scope of practice and responsibilities, as well as those of others. Clinicians can facilitate this understanding by looking for opportunities and assuming responsibility for sharing profession-specific perspectives in interprofessional forums in both informal and formal settings (RNAO, 2006a).

Healthcare professionals must question why they do what they do. As they move to embrace new roles for themselves within a changing healthcare environment, they must seriously and critically look at the origins of their current practices, in order to carve out new and exciting roles for themselves and others. For example, Aloma Gender (1992) suggests that historical tradition has a profound effect on nursing practice. She looked at the role of rehabilitation nurses and found that they were not included in providing sexual counselling to patients when it came to maintaining and promoting patient sexual health. Her rationale for the exclusion of nursing in this activity was primarily due to nurses not seeing themselves as having the ability to talk about sexuality with their patients. She claims that this insecurity comes from the fact that training for nurses began in military and religious orders. Nurses became synonymous with the virtues of purity, modesty, self-sacrifice and humility. The rigidity and discipline of the institutions in which they worked did not promote sexuality as a positive, dynamic and creative life force. She ends by saying though, that in order for rehabilitation nurses to be able to address issues around human sexuality, they need to overcome barriers such as cultural and professional stereotypes. As such, it can be said that practice is developed within a historical context. This must be a consideration when professions engage in telling their story and reshaping their practice.

Professions must break out of the moulds that have been established by traditions that are not grounded in any regulatory logic in order for them to exercise their potential. Professional stereotyping also extends itself to what could be considered typical work for a given profession. This is also largely dependent on historical tradition. Typical work is not about a profession’s ability to perform activities that are consistent with its specific knowledge, skill and judgment. Rather, it is based on a habitual, repetitive activity that is mostly generated through historical practice and that is performed by one profession to the point where that one profession is granted ownership of that activity—without contest or disapproval from other professions.
These activities are not controlled acts and therefore can be performed by anyone, but have been accepted by few. How these activities have been allocated to a specific profession depends more on its professional status, and the organizational clinical structure of its work as opposed to being within the specific domain of a particular professional discipline. For example, procedures traditionally performed as part of nursing care that are not controlled acts include giving an oral or topical medication or toileting. These are stereotypical nursing functions that do not require a nurse to do them, but have been directed toward nursing for decades. Today, some nurses will fight to the death before sharing these activities. On the other hand, other professional groups may fight against taking up these activities. However, as professions review their roles within a given context, it will become increasingly important for them to consider those activities that are an integral part of their work, those activities that are not, those activities that could be an integral part of their work, and those activities that could be an integral part of everybody’s work.

Ultimately the goal of re-storying the professional narrative is the acceptance of new boundaries within a health profession. These conversations will not be easy, and may be fraught with creative tension. Orchard, Curran and Kabene (2005) provide a description of the process for creating a culture for interprofessional collaboration:

> “During the process (role clarification) it is important that all participants accept that each member of the profession has both the right and ultimate responsibility to argue about the truth and usefulness of ideas within his or her professional domain. Allowing group members to share their frustrations and challenge each other for a change in practice fosters open dialogue that is respectful, but at the same time honest and open. It is from this base of understanding that new modes of practice can emerge” (p. 5).

**How is Re-Storying achieved?**

Re-storying the narrative of a profession involves recognizing that there has been an external reality that has evolved through history and stereotypical thinking that has influenced professional practice. Intraprofessional groups are expected to work together in solidarity through a process of dialogue, conscious-raising and critical reflection about their practice. The function of deconstruction, reconstruction and construction in this process is to challenge what they think they know about their own professional practice, where they think practice needs to go to be relevant with the present realities of collaborative healthcare, and how they can build a firm foundation for those changes to happen so that the changes are sustainable.

The following questions will assist intraprofessional teams and individual members of a particular discipline with re-storying the narrative of their profession.
AIR Team Experience

While the intraprofessional reflective process is more solitary, the thinking and conversations for re-storying the professional narrative can happen in uniprofessional and interprofessional teams. This allows for the sharing of different perspectives in terms of how others understand the professional group’s identity. These dialogues begin to open up the scope optimizing potential by bringing to light the assumptions that are made regarding a specific profession, and also provides members of that professional group the opportunity to highlight aspects of their profession that others may be unaware of.

One such example in the AIR Team experience involved learning that taking vital signs is a competency that pharmacists obtain as part of their pre-entry to practice training. This was a surprise to every non-pharmacist in the room as this is not a practice that is often observed in an acute care hospital setting. This realization initiated further discussion on the possibilities of expanding the pharmacist role by incorporating other hands on direct patient care activities that they may not traditionally perform, but have the knowledge to do so.

REFLECTIVE QUESTIONS
Re-Story the Professional Narrative

1. What is a (professional discipline)? Example nurse, doctor, physiotherapist, etc.
2. What are some stereotypes about our profession? Ones that we hold about ourselves? Ones that others hold about us?
3. How have these stereotypes affected the way we practice?
4. What are some traditional activities/practices or roles associated with our profession?
5. Do all of these functions require discipline-specific knowledge, skills and judgment, and therefore have to be carried out by a member of our profession?
6. What are we as a group prepared to let go?
7. Which activities, practices or roles do we need to keep?
8. What possible future practices could be supported by the knowledge, skills and judgment of our profession?
CHAPTER 8
STEP 3: ESTABLISH A HARMONIZATION PHILOSOPHY

What is a Harmonization Philosophy?

Once every team member has engaged in the intraprofessional reflective process and in preliminary dialogue to re-story the professional narrative, a harmonization philosophy is established. Harmonization does not eradicate professional difference; it looks towards enhancing and challenging the traditions of how individual professionals operate within the structure of an organization.

The principles of harmonization speak to the willingness of the practitioner to begin to consider the practice environment through an interprofessional lens and demonstrate openness to new possibilities. Professional identity is often defined by organizational policy or structure, scopes of practice, knowledge and skill base. The goal of harmonization is to attenuate the attachment to historical identity and to re-define the individual’s professional practice, within legal, medical and ethical boundaries. This speaks to the deconstruction, reconstruction and construction phases of building the foundation for collaborative care. The process of harmonization when understood as an overlapping of roles or role blurring, has also been reported in the literature as having facilitated work coordination, improved information quality, and a reduced medication errors (RNAO, 2006a).

“To improve outcomes, the contribution of each team member needs to be optimized. Professionals need to focus on working together in a complementary manner rather than competing with other team members” (RNAO, 2006a).
How is a Harmonization Philosophy established?

Prior to delving deeper into the discussions that serve to negotiate roles and responsibilities in an interprofessional model of care, some guiding principles, assumptions or ground rules ought to be established. This will serve as a contract for how participants engage with one another in dialogue. As such, this contract will be negotiated and co-created by the team.

**Assumption 1**
All professions involved have an equal voice and accountability for negotiation around scopes of practice. Equality is a precondition to good social relations.

**Assumption 2**
Each skill or competency will be considered in light of what the profession is currently doing, should be doing, or could be doing. When seeking to optimize scope of practice, a decision to restrict a particular activity will be articulated by answering the question “why not?”

**Assumption 3**
Decisions will be made with the prescribed provincial legislative structures that regulate healthcare professionals in mind. Activities that have been further restricted by the employer will be deconstructed. Authorizing mechanisms and organizational policy changes will be initiated as appropriate to ensure the safe, ethical, and legally sound implementation of the care model.

**Assumption 4**
Core competencies will be inclusive of both clinical and interprofessional competencies. A competency is more than knowledge. It includes the understanding of knowledge, clinical skills, interpersonal skills, problem solving, clinical judgment and technical skills (Verma et al., 2006). This definition will include collaborative skills, and the ability for clinicians to adapt and negotiate their skills, knowledge and roles to provide interprofessional patient care.

**Assumption 5**
Negotiation of roles will seek to challenge traditional professional stereotyping. Decisions will be made collaboratively after careful consideration of the foundational and potential knowledge and skill of the particular profession.

**Assumption 6**
Scopes of practice will be optimized for the purpose of enhancing patient-centred care; the intent is not to replace any one of the professions with the other. The outcome of optimizing competencies is improved communication, timely care delivery, ensuring that the appropriate resources are available, and enhancing patient safety. “To improve outcomes, the contribution of each team member needs to be optimized. Professionals need to focus on working together in a complementary manner rather than competing with other team members” (RNAO, 2006a).
CHAPTER 9

STEP 4: ANALYZE ACTIVITIES AND DEVELOP COMPETENCY FRAMEWORK

How are activities Analyzed and a Competency Framework created?

Successful teams recognize the professional and personal contributions of all members. They promote individual development and team interdependence. Teams that have a high degree of interdependence require a greater degree of team collaboration. By recognizing the benefits of working together, the team sees accountability as a collective responsibility (Canadian Health Services Research Foundation, 2006).

Establishing a Harmonization Philosophy is essential in setting the tone for the dialogues that will ensue in order to co-create a model of care and optimize healthcare providers’ scopes of practice. However, before any interprofessional team can begin to look at opportunities for optimizing both its professional scope and the patient care experience, it must first examine the traditional care path that the patient/client experiences.

The activity analysis begins by engaging stakeholders to develop an outline of every step and/or intervention that a patient may experience during his/her visit with the team. This process helps to develop an activity inventory with a list of competencies and skills required to care for the specified patient population. It is important to note that the inventory will be specific to the patient group, clinical area, and organization. Consider the individuals who ought to be present in order to ensure that the inventory and resulting analysis is as comprehensive as possible. Recommendations include but are not limited to:

- Direct care clinician representation (preferably those who will be directly involved in enacting the practice model) for each professional group
- Leadership representation for each professional group
- At least one individual who brings an interprofessional lens (preferably an individual whose professional background is not one of the professions involved in the team’s implementation)
- An expert in healthcare regulation such as the Regulated Health Professions Act (1991) and the Public Hospitals Act (1990), who is knowledgeable with organization-specific policies regarding the development and approval of authorizing mechanisms
- Clinical expert(s) from the specific setting within the organization where the practice model will be enacted, who are familiar with clinical and other processes for that area

For the individuals who are representing specific professions, it is important that they are well versed in their own professional standards and current educational and expected competencies for that profession in order to ensure that scope of practice can be fully optimized.

Before initiating the process of analyzing the activity inventory, the team should reflect on how it will consider matters of scope and team optimization. While competencies and skills serve to optimize the scope of practice for a given profession, sharing of tasks serves to improve efficiency and optimize the team in order to provide the best patient care.

*Scope and Team Optimization*

![Diagram](attachment:image.png)

（St. Joseph's Health Centre - Toronto, 2009）

Without taking time to acknowledge the importance of the team process, optimization of scopes of practice for individual professions cannot be realized.

*Scope optimization* is a process that focuses on utilizing the professional’s knowledge, skill, and judgement to its full potential. A detailed assessment of each profession’s scope of practice is scrutinized using a 3D Model of Analysis. This three-tiered model looks at both current and future practice opportunities and ensures there is appropriate support in place for practice emancipation to occur.
In **Level 1**, the inventory list compiles what a professional is *currently doing* within his/her present healthcare setting. For example, a Registered Nurse managing a chest tube in the emergency department would be considered a principal expectation of practice (PEP) for that profession.

**Level 2** in the model of analysis compares the inventory list with what a professional *should be doing*, but may not be currently practicing due to either organizational/professional history or current workforce structure/resources. For example, engaging a Registered Respiratory Therapist in the process of routine medication administration falls under this classification.

Under **Level 3**, a team compares the inventory list with what a profession *could be doing*. The hidden potential for individual professions is identified through this step. Through identifying competencies, both education and formal delegation may be required to ensure coordination and a seamless process between the professionals. When considering activities that fall under Level 3, it is important to reflect on whether the profession has the foundational knowledge for the activity, whether the added skill or knowledge can be acquired, and whether adequate opportunities exist within the practice setting for the clinician to gain and maintain competence in the activity or skill. For example, intravenous catheter insertion by the Registered Pharmacist requires formal delegation from a professional for whom this controlled act is authorized and would fall under this classification.

Both Level 2 and Level 3 require a formal education plan to ensure competencies are met and standards of care already established within organizations are followed.

Each item in the inventory is then analyzed for its relevance to the skills and competencies of each profession represented in the care model. As the group moves through the inventory, continue to reflect back on whether the activity is something that each profession is *currently* doing, *should* be doing, or *could* be doing.

Once the team has come to a consensus regarding the analysis of the activity inventory, the entire team or subgroup can restructure the inventory to begin to generate the competency framework. This largely involves the re-grouping of specific activities under broader competencies and then can be further subdivided into competency elements. Review of profession-specific and/or interprofessional standards of practice provide the team with descriptors in terms of assessing whether the clinician is successful in meeting the competencies.
AIR Team Experience

The invitations for participation on the AIR Team’s Competency Working Group were determined based on thoughtful consideration for those who needed to be at the table (refer to the Acknowledgements section at the beginning of the Toolkit for the group’s membership). Working group participants from provincial or national associations representing the three professions added richness to the conversation as well as knowledge of broader profession-specific considerations. Regulatory College Standards were also key in this process as were relevant competencies from the National Emergency Nurses Affiliation (NENA, 2008a; 2008b; 2008c) which specify a standard of care for patients in an emergency department.

The results of the Activity Inventory Analysis and resulting Competency Framework for the AIR Team are presented in Table 1 and Table 2. Again, it is important to stress that the results of these processes are specific to each individual clinician in this project and are not intended to be applicable to individuals or teams of clinicians working in other contexts.

Initiating an Intravenous

In order to bring the consensus process to life for the activities in the inventory, the examples of initiating an intravenous and arterial blood procurement are presented in the AIR Team Experience. Initiating an intravenous is a skill at St. Joseph’s Health Centre that has historically been restricted to nurses whereas arterial blood procurement has been restricted to respiratory therapists. Due to the extensive similarities between these two skills, and the profession’s established competency with these skills, the decision for nursing and respiratory therapy to share these skills was a natural one. The conversation regarding whether it would be appropriate for the Registered Pharmacist to engage in either of these skills was a more courageous one and the resulting decision was one that was negotiated. Ultimately delegating this skill to the Registered Pharmacist on the AIR Team was based on an understanding that pharmacy already had a strong foundational knowledge related to this skill.

At St. Joseph’s Health Centre, registered nurses are provided with education, skills training, and certification to initiate an intravenous upon hire to ensure that the organization-specific standard is adhered to. Many new graduates and some experienced nurses have never had an opportunity to attempt or become competent in this skill. As such, it was determined that the same training program would be appropriate to ensure that the Registered Pharmacist on the AIR Team would be able to perform this skill safely. In addition, consideration was also given to the opportunities for achieving and maintaining competence in the skill. As the vast majority of AIR Team patients would be receiving intravenous therapy and/or medications, there was adequate opportunity for the Registered Pharmacist to become more confident and competent in the skill. Having the AIR Team Registered Pharmacist at the table for these conversations was integral as she would be able to speak to her degree of readiness and willingness to enact this new skill.
**Arterial Blood Gas Procurement**

Arterial blood gas procurement, on the other hand, was not a skill that was delegated to pharmacy. Most of the considerations for arterial blood gas procurement were identical to those for intravenous initiation. However, there are scarce opportunities in the emergency department to practice this skill and gain competence and it was understood as a procedure that was also more invasive. As such, arterial blood gas procurement was restricted to the Registered Respiratory Therapist and Registered Nurse on the team.

Every item in the activity inventory was discussed in a similar manner, with some necessitating more in-depth and lengthier discussions than others. The results of these dialogues are presented in **Table 1: Activity Inventory Analysis**.

**Table 1: AIR Team Activity Inventory Analysis**

<table>
<thead>
<tr>
<th>Legend</th>
<th>Controlled Act</th>
<th>^ Notation</th>
<th>Yes, will carry out</th>
<th>X No, will not carry out</th>
<th>Additional Education Required, Includes Skills, Training and Practice</th>
<th>Formal Delegation Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arterial Blood Gas Procurement</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arterial Blood Gas Procurement, on the other hand, was not a skill that was delegated to pharmacy. Most of the considerations for arterial blood gas procurement were identical to those for intravenous initiation. However, there are scarce opportunities in the emergency department to practice this skill and gain competence and it was understood as a procedure that was also more invasive. As such, arterial blood gas procurement was restricted to the Registered Respiratory Therapist and Registered Nurse on the team. Every item in the activity inventory was discussed in a similar manner, with some necessitating more in-depth and lengthier discussions than others. The results of these dialogues are presented in <strong>Table 1: Activity Inventory Analysis</strong>.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Legend

- **Legend**
  - * Controlled Act
  - ^ Notation
  - ✓ Yes, will carry out
  - ✗ No, will not carry out
  - ☀ Additional Education Required, Includes Skills, Training and Practice
  - ☔ Formal Delegation Required

<table>
<thead>
<tr>
<th>Competency</th>
<th>Care Delivery Activities</th>
<th>Registered Respiratory Therapist</th>
<th>Registered Nurse</th>
<th>Registered Pharmacist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Reconciliation</td>
<td>✗</td>
<td>✓</td>
<td>☀</td>
<td>✓</td>
</tr>
<tr>
<td>PO Medications</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>*Medications via Inhalation</td>
<td>✓</td>
<td>✓</td>
<td>☀</td>
<td>✓</td>
</tr>
<tr>
<td>Transdermal Medications</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>☀</td>
</tr>
<tr>
<td>*Subcutaneous Medications</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>☀</td>
</tr>
<tr>
<td>*Intramuscular Medications</td>
<td>✗</td>
<td>✓</td>
<td>☀</td>
<td>✓</td>
</tr>
<tr>
<td>*Intravenous Medications</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>☀</td>
</tr>
<tr>
<td>*Central Venous Access Device Medications</td>
<td>✗</td>
<td>✓</td>
<td>☀</td>
<td>✓</td>
</tr>
<tr>
<td>*PR Medications</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>☀</td>
</tr>
<tr>
<td>Non-Pharmacologic Treatment Plan</td>
<td>Speech Therapy (Breathing Techniques)</td>
<td>✓</td>
<td>✓</td>
<td>☀</td>
</tr>
<tr>
<td></td>
<td>*Inserting an Intravenous</td>
<td>✓</td>
<td>✓</td>
<td>☀</td>
</tr>
<tr>
<td></td>
<td>*Initiating an Infusion (Intravenous)</td>
<td>✓</td>
<td>✓</td>
<td>☀</td>
</tr>
<tr>
<td></td>
<td>*Initiating an Infusion (PKC)</td>
<td>✓</td>
<td>✓</td>
<td>☀</td>
</tr>
<tr>
<td></td>
<td>*Initiating an Infusion (Central Lines)</td>
<td>✓</td>
<td>✓</td>
<td>☀</td>
</tr>
<tr>
<td></td>
<td>*Initiating an Infusion (Porta Caths)</td>
<td>✗</td>
<td>✓</td>
<td>☀</td>
</tr>
<tr>
<td></td>
<td>*Blood/Blood Product Administration</td>
<td>✓</td>
<td>✓</td>
<td>☀</td>
</tr>
<tr>
<td></td>
<td>*Administering Oxygen</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Oral Airway Insertion</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>*Nasal Airway Insertion</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>*Suctioning (^Oral Only, Not a Controlled Act)</td>
<td>✓</td>
<td>✓</td>
<td>☀</td>
</tr>
<tr>
<td></td>
<td>*Bag Mask Ventilation</td>
<td>✓</td>
<td>✓</td>
<td>☀</td>
</tr>
<tr>
<td></td>
<td>Chest Compressions (^Basic Life Support)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Managing Chest Tubes</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Application of Cervical Collars</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Spinal Stabilization and Immobilization</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>*Foley Catheter Insertion</td>
<td>✗</td>
<td>✓</td>
<td>☀</td>
</tr>
<tr>
<td></td>
<td>Assist with Cardioversion, Defibrillation</td>
<td>✓</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td></td>
<td>Assist with Central Line Insertion</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Assist with Activities of Daily Living</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Therapeutic Relationships</td>
<td>Enhance Interprofessional Practice Competencies (^Team Visioning &amp; Enablers)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Patient Education</td>
<td>Patient Education (^Certified Respiratory Education Prep Course &amp; Exam)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Documentation</td>
<td>Documentation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Transcribing Orders</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Receiving &amp; Giving Report (Handover)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Interprofessional Collaborative Practice</td>
<td>Enhance Interprofessional Practice Competencies (^Team Visioning &amp; Enablers)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Processes and Tasks</td>
<td>Decontamination</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Patient Assist to Change into Grown and Personal Belongings Inventory</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Infection Control Practices and ICP Notification Process</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
The process of developing and analyzing the activity inventory was an extensive process that involved having courageous conversations with colleagues. The process of moving from an activity inventory to a competency framework involved sorting the activities into patient care competencies. After re-organizing the list into broader competencies, the next step involved integrating relevant standards from each of the regulatory colleges representing Respiratory Therapy, Nursing, and Pharmacy into the framework (College of Nurses of Ontario, 2009a, 2009b, 2009c, 2009d, 2009e; College of Respiratory Therapists of Ontario, 2003; National Association of Pharmacy Regulatory Authorities, 2003; Ontario College of Pharmacists, 2003; RNAO, 2002a, 2006b). Refer to the Table 2 for the AIR Team’s Competency Framework.

This step was critical in order to ensure that the education plan and competency assessment met the requirements of the regulatory colleges in terms of how competence would be assessed. Again, it is important to note that the competency framework presented below is specific to the AIR Team in the context of St. Joseph’s Health Centre’s Emergency Department and is not endorsed as being applicable to teams working in other settings.

**Table 2: AIR Team Competency Framework**

<table>
<thead>
<tr>
<th>Legend</th>
<th>Registered Respiratory Therapist</th>
<th>Registered Nurse</th>
<th>Registered Pharmacist</th>
</tr>
</thead>
<tbody>
<tr>
<td>*</td>
<td>Advanced Skill Level for Registered Respiratory Therapist</td>
<td>*</td>
<td>Advanced Skill Level for Registered Nurse</td>
</tr>
<tr>
<td>^</td>
<td>Notation</td>
<td></td>
<td>Advanced Skill Level for Registered Pharmacist</td>
</tr>
</tbody>
</table>

**COMPETENCY: PATIENT ASSESSMENT** (includes completing the assessment, interpreting findings and involving other members of the AIR/interprofessional team as required)

<table>
<thead>
<tr>
<th>Element</th>
<th>Care Delivery Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Assessment</td>
<td>General Head to Toe Assessment</td>
</tr>
<tr>
<td>Focused Assessment of the *Airway, Respiratory System, Cardiac, and Neurological System</td>
<td>*</td>
</tr>
<tr>
<td>Complete Vital Signs (Heart Rate, Blood Pressure, Respiratory Rate, Pulse Oximetry, Temperature)</td>
<td>• • •</td>
</tr>
<tr>
<td>Pain Assessment</td>
<td>• • •</td>
</tr>
<tr>
<td>Complete Skin and Wound Assessment for Admitted Patients (including Braden Scale)</td>
<td>• • •</td>
</tr>
<tr>
<td>Patient History</td>
<td>Interview patient, caregivers and other healthcare providers to obtain:</td>
</tr>
<tr>
<td>- History of Present Illness</td>
<td>*</td>
</tr>
<tr>
<td>- Risk Factors or Triggers for Current Illness</td>
<td>• • •</td>
</tr>
<tr>
<td>- Lifestyle</td>
<td>*</td>
</tr>
<tr>
<td>- Co-morbidities</td>
<td>*</td>
</tr>
<tr>
<td>- Current Best Possible Medication History, Relevant Past Medications and Allergies</td>
<td>* • *</td>
</tr>
<tr>
<td>Performing and Interpreting Diagnostic Tests/Results</td>
<td>Peak Expiratory Flow Rate</td>
</tr>
<tr>
<td>Sputum Collection</td>
<td>*</td>
</tr>
<tr>
<td>Electrocardiogram</td>
<td>*</td>
</tr>
<tr>
<td>Cardiac Monitoring</td>
<td>*</td>
</tr>
<tr>
<td>Arterial Blood Gas Sampling (^Interpretation Only)</td>
<td>* •</td>
</tr>
<tr>
<td>Venipuncture</td>
<td>*</td>
</tr>
<tr>
<td>Capillary Blood Sampling</td>
<td>*</td>
</tr>
<tr>
<td>Non-Invasive Blood Collection (e.g., Intravenous Lock, Central Venous Access Devices)</td>
<td>* •</td>
</tr>
<tr>
<td>Urine Specimen Collection</td>
<td>*</td>
</tr>
<tr>
<td>Interpret Chest Radiography</td>
<td>*</td>
</tr>
<tr>
<td>Ongoing Patient Assessment and Monitoring</td>
<td>Routinely and accurately identify the type and degree of monitoring required by a patient according to current health status. Interpret data collected to determine success of pharmacologic and non-pharmacologic plan, the need to modify these plans and the need to consult alternate members of the healthcare team.</td>
</tr>
</tbody>
</table>
### COMPETENCY: PHARMACOLOGIC TREATMENT

<table>
<thead>
<tr>
<th>Element</th>
<th>Care Delivery Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of the Pharmacologic Treatment Plan:</td>
<td>Make recommendations for pharmacologic therapy based on:</td>
</tr>
</tbody>
</table>
| Effectively use patient information to identify the need to initiate new medication therapy or alter existing medications therapy | - Diagnosis
- Efficacy
- Urgency of Clinical Condition
- Patient Preference Including Compliance and Cost Issues
- Co-morbid Conditions (e.g., Cardiac Disease, Renal Dysfunction)
- Concomitant Medications
- Potential for Adverse Drug Effects
- Past History of Medication Allergies or Intolerances

Complete Medication Reconciliation

Medication Administration Process: | Administer medications via the following routes: |
| Includes verifying the appropriateness of the order, assessing current clinical condition, checking allergies and ensuring medication is still appropriate to administer, administering the medication, evaluating its effect, and managing outcomes | - Oral
- Inhalation
- Transdermal
- Subcutaneous
- Intravenous
- Central Venous Access Devices (PICC, Central Lines)
- Rectal

Prior to administering the medication, the clinician verifies: 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.

### COMPETENCY: NON-PHARMACOLOGIC TREATMENT

<table>
<thead>
<tr>
<th>Element</th>
<th>Care Delivery Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of the Non-Pharmacologic Treatment Plan:</td>
<td>Make recommendations for treatment based on:</td>
</tr>
</tbody>
</table>
| Effectively use patient information to identify the need to initiate new treatments or alter existing non-pharmacologic treatment plan | - Diagnosis
- Efficacy
- Urgency of Clinical Condition
- Patient Preference
- Co-morbid Conditions (e.g., Cardiac Disease, Renal Dysfunction)
- Concomitant Treatment
- Potential for Adverse Outcomes
- Past History related to specific interventions

Implementation of Non-Pharmacologic Treatment Plan: | Assist with Speech Therapy (Breathing Techniques)
- Establishing Intravenous Access for Administration of Intravenous Therapy
- Fluid Therapy via Intravenous and Central Venous Access Device (IV, PICC, Central Line)
- Blood Product Administration
- Oxygen Therapy (with or without humidity)
- Oropharyngeal Suctioning
- Nasopharyngeal Suctioning
- Body Positioning Techniques to Alleviate Work of Breathing
- Insert Orogastric or Nasogastric Tubes
- Maintain, Change or Remove (Decannulation) Tracheostomy Tubes († Maintain Only)
- Bag Mask Ventilation
- Foley Catheter Insertion
- Oral Airway Insertion
- Nasal Airway Insertion
- Chest Compressions
- Chest Tube Management
- Activities of Daily Living

Prior to plan implementation, the clinician assesses the appropriateness of the intervention and evaluates effectiveness in order to inform adjustments to the treatment plan.
### Legend

- **^** Advanced Skill Level for Registered Respiratory Therapist
- **&** Advanced Skill Level for Registered Nurse
- ***^** Advanced Skill Level for Registered Pharmacist

### COMPETENCY: THERAPEUTIC RELATIONSHIPS

<table>
<thead>
<tr>
<th>Element</th>
<th>Care Delivery Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic Communication: Use a wide range of effective communication strategies and interpersonal skills to appropriately establish, maintain, re-establish and conclude the patient relationship</td>
<td>In order to establish a supportive and caring relationship with the patient, clinicians: - Introduce themselves, their professional background and their role in the team • - Explain the process of care that the patient can anticipate in the specific clinical context and provides the patient with an opportunity to ask questions and/or express concerns • - Are thoughtful in their communication with the patient, including using techniques such as active listening, and accommodation of open- and closed-ended questions • - Consider patient’s age, education, preferred language for communication and any other barriers to communication and implement strategies to address these barriers such as use of non-verbal communication skills, interpreters, language line phones, etc. • - Assess whether communication style continues to meet the patient’s needs on an ongoing basis • Patients are treated with dignity and respect during each and every interaction, regardless of gender, age, race, religion, culture, etc. Clinicians demonstrate compassion in answering patient questions, discussing the patient’s clinical condition and providing the patient with an opportunity to share his/her fears and anxieties and express their beliefs and wishes • • •</td>
</tr>
<tr>
<td>Patient-Centred Care: Engage patient as a partner to establish therapeutic goals and negotiate the roles/responsibilities of clinician(s) in meeting those goals</td>
<td>Clinicians solicit patient wishes, values and preferences when establishing the goals and objectives for the plan of care • Clinicians facilitate patient participation in all decisions regarding his/her care. In situations where the patient and/or other members of the healthcare team are not in agreement regarding the recommended care plan, clinicians respect the patient’s choice and provide information to ensure that the decision is informed and that the expected outcomes of any decisions are understood • • •</td>
</tr>
</tbody>
</table>

### COMPETENCY: PATIENT EDUCATION

<table>
<thead>
<tr>
<th>Element</th>
<th>Care Delivery Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide information on disease prevention and health promotion. Develop patient-specific education plan to optimize management of underlying disease</td>
<td>Note: Each of the professionals represented on the team have a unique body of knowledge and as such, the expertise that each team member brings with respect to patient education reflects the specific topic where information is exchanged (e.g., incentive spirometry versus in-depth medication information). Although there are topic-specific variations in the depth of knowledge that the team members have, this section describes general competencies related to patient education that are shared among the three professions. All three professionals on the team participated in a four-day course that prepared them to write the certification exam in order to obtain the Certified Respiratory Educator (CRE) designation. - Routinely and accurately identify the amount and type of education desired/required by patients to optimize health • - Assist the patient and significant others to obtain knowledge about health, wellness/illness, prevention and treatment • - Communicate using effective and appropriate skills while respecting the patient’s personal, cultural, and educational differences • - Consider the impact of lifestyle factors on the health of individual patients • • •</td>
</tr>
</tbody>
</table>

### COMPETENCY: DOCUMENTATION

<table>
<thead>
<tr>
<th>Element</th>
<th>Care Delivery Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation presents an accurate, clear and comprehensive picture of the patient’s needs, clinician interventions, and patient outcomes</td>
<td>Consistently identify situations that require documentation to promote patient safety and/or meet legal requirements • Ensure documentation is a complete, clear and timely record of care • Document significant communication with others and observations related to the patient’s care • Document informed consent when a treatment or intervention authorized in legislation is initiated • Ensure the patient has an opportunity to add his/her own information to the health record as appropriate or if indicated (e.g., there is a difference of opinion regarding care) • Ensure that the individual who performed the action or observed the event completes the documentation (except when there is a designated recorder) • Maintain confidentiality of patient health information and facilitate the patient’s right to access the health record • Ensure that organizational- and departmental-specific documentation standards are met • • •</td>
</tr>
</tbody>
</table>
### COMPETENCY: INTERPROFESSIONAL COLLABORATIVE PRACTICE

<table>
<thead>
<tr>
<th>Element</th>
<th>Care Delivery Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trust and Respect</strong></td>
<td>Create an environment that is emotionally safe and secure to ensure all team members feel comfortable</td>
</tr>
<tr>
<td></td>
<td>Communicate freely with team members to readily give and receive constructive feedback</td>
</tr>
<tr>
<td></td>
<td>Willingly engage in team decision-making</td>
</tr>
<tr>
<td></td>
<td>Acknowledge team members’ skills and abilities</td>
</tr>
<tr>
<td></td>
<td>Talk openly about trust and respect with all team members</td>
</tr>
<tr>
<td><strong>Appreciating Differences and Conflict Resolution</strong></td>
<td>Discuss issues of conflict with individuals who are involved rather than with colleagues who are removed from the situation</td>
</tr>
<tr>
<td></td>
<td>Identify your own personal resolution style to offer perspective when differences of opinion arise</td>
</tr>
<tr>
<td></td>
<td>Have team members address the perceived conflict with the individual early in the resolution process</td>
</tr>
<tr>
<td><strong>Knowledge of Other Professional Roles</strong></td>
<td>Ask and field questions appropriately</td>
</tr>
<tr>
<td></td>
<td>Seek appropriate referrals from colleagues</td>
</tr>
<tr>
<td></td>
<td>Accept and/or celebrate diversity</td>
</tr>
<tr>
<td></td>
<td>Set collaborative and patient-centred goals</td>
</tr>
<tr>
<td></td>
<td>Call one another by name</td>
</tr>
<tr>
<td></td>
<td>Avoid using uni-professional jargon</td>
</tr>
<tr>
<td></td>
<td>Avoid defensiveness and territoriality around division of tasks/ roles</td>
</tr>
<tr>
<td></td>
<td>Acknowledge the contributions of colleagues</td>
</tr>
<tr>
<td><strong>Shared Decision Making</strong></td>
<td>Appreciate each other’s contributions to patient/client outcomes</td>
</tr>
<tr>
<td></td>
<td>Be engaged and invested to the outcomes of decisions made</td>
</tr>
<tr>
<td></td>
<td>Provide leadership that is informal, functional, empowering, participative and consultative</td>
</tr>
<tr>
<td></td>
<td>Talk openly in the team about how patient/client care decisions are made, who should participate, and why</td>
</tr>
<tr>
<td><strong>Willingness to Share Power</strong></td>
<td>Include appropriate team members and patients in treatment discussions</td>
</tr>
<tr>
<td></td>
<td>Share knowledge with each other as a means of divulgating guarded knowledge</td>
</tr>
<tr>
<td></td>
<td>Create safe spaces where everyone feels welcome</td>
</tr>
<tr>
<td></td>
<td>Be open to having constructive and courageous conversations with team members</td>
</tr>
<tr>
<td></td>
<td>Talk about power with team: power is recognized by team members when inequality, privilege, and power differentials are discussed</td>
</tr>
</tbody>
</table>

**Legend**

* Advanced Skill Level for Registered Respiratory Therapist  
^ Notation  
* Advanced Skill Level for Registered Nurse  
* Advanced Skill Level for Registered Pharmacist
CHAPTER 10
STEP 5: ESTABLISH AUTHORIZING MECHANISMS

What are Authorizing Mechanisms?

The activity inventory analysis and competency framework development process facilitate consideration of where and how clinicians can optimize their scope of practice. Activities are examined in relation to required foundational knowledge, technical skill, and the ability to establish and maintain clinician competency. In some cases activities that result in scope optimization require the delegation of a controlled act. Lahey and Currie (2005) state that there “is a widespread consensus that structures for professional regulation, especially legislatively defined scopes of practice, are a barrier to a more integrated healthcare system in general and to interprofessional practice in particular” (p. 200). The controlled acts model in Ontario and other provinces does provide some flexibility through delegation to optimize scope and promote interprofessional practice and collaboration.

As a means of remedying tensions that may arise when professional groups demonstrate a tendency to be protective of their scopes, Lahey and Currie (2005) suggest that, just as interprofessional practice is seen as central to healthcare system reform, the regulatory bodies must have a mandate to facilitate interprofessional practice and must be held accountable to report on the degree to which they have adopted measures to embrace and move this agenda forward. The Federation of Health Regulatory Colleges of Ontario’s (2007) Guide on the Use of Orders, Directives and Delegation for Regulated Health Professionals in Ontario is certainly written with the aim of moving interprofessional practice forward. The establishment of authorizing mechanisms is a means of enhancing patient care, improving patient access and flow, and facilitating interprofessional practice. While this step stands alone as one of the guidelines, the thought processes and conversations informing the need for the establishment of authorizing mechanisms actually occurs as early as Step 1, (refer to the Decision-Making Framework on the next page). This Chapter provides an overview of medical directives and delegations.
For a more comprehensive review, the Toolkit authors recommend the Federation of Health Regulatory Colleges of Ontario’s (2007) *Interprofessional Guide* available at: [http://www.mdguide.regulatedhealthprofessions.on.ca](http://www.mdguide.regulatedhealthprofessions.on.ca), as well as visiting each regulatory college’s specific website.

**Delegation** is a process through which an individual or group of individuals authorized to perform a controlled act under the *Regulated Health Professions Act*, delegate authority to perform that act to a regulated or unregulated individual or group of individuals who are not authorized to perform that controlled act in the legislation. When delegation has occurred, the implementer is able to perform procedures that extend beyond his/her principal expectations of practice (Federation of Health Regulatory Colleges of Ontario, 2007). During the activity inventory analysis process, it is important for the individuals engaging in the decision-making process to be familiar with their own scope of practice and controlled acts, as well as those of the other professions represented in the practice model. This allows the team to identify when delegation may be required and to ensure that the decision to delegate the controlled act is a sound one.

A *medical directive* is an order authorized by an individual(s) with legislative ordering authority. They differ from a direct order in that they are written in advance and enable the implementer to determine whether the medical directive ought to be enacted based on an assessment of whether the particular patient meets the criteria established within the directive. In some situations, the implementer both determines whether the medical directive ought to be enacted, and also performs the procedure. In other situations, one implementer may be responsible for determining that the medical directive ought to be enacted but another implementer is responsible for performing the procedure.

In the first example, a Registered Respiratory Therapist may make the determination based on the criteria set out in a medical directive that a patient requires arterial blood gases, and then proceeds to obtain the arterial blood sample. In the latter example, a Registered Nurse may determine that a patient meets the criteria for an extremity X-ray but a Medical Radiation Technologist co-implements the directive by performing the procedure.

**Decision-Making Framework for Performing Any Procedure**

![Decision-Making Framework for Performing Any Procedure](image)

*Precondition 1: Assure performance readiness - competence to authorize & perform procedure & manage outcomes given circumstances in situation

- Procedure Beyond Principal Expectations of Practice
- Initial Performance Readiness Established?

  - Yes
  - No

  **Precondition 2: Assure applicable legislative and setting-specific authority is in place as necessary**

  - Performance Readiness Affirmed
  - Performance Readiness Unaffirmed

  **Precondition 3: Assure clinical appropriateness of procedure**

  - Yes
  - No

*Authorize and Perform Procedure and Manage Outcomes*

*Templates available to assist with establishing performance readiness—see Performance Readiness Assessment and Performance Readiness Plan forms and instructions*

**Legislative authority includes orders, directives and delegation. Setting-specific authority includes assignments, role description, privileges and the like. Templates available to assist with establishing directives and delegation—see Medical Directive and/or Delegation, Delegation and Supporting Document forms and instructions*

(Taken from Federation of Health Regulatory Colleges of Ontario (2007) *Interprofessional Guide* available at: [http://www.mdguide.regulatedhealthprofessions.on.ca](http://www.mdguide.regulatedhealthprofessions.on.ca)).
How are Authorizing Mechanisms determined?

In any clinical context, strong consideration must be given to whether or not it is appropriate to establish a medical directive or formal delegation. To justify establishing the medical directive or delegation, it must improve patient care and/or patient safety. It must serve the best interests of the patient, and not the interests of the profession, whether the profession is the authorizer or the implementer.

Some questions to consider when determining whether to establish authorizing mechanisms include:

**REFLECTIVE QUESTIONS**

**Authorizing Mechanisms**

1. Does establishing the authorizing mechanism improve patient safety or enhance patient care?
2. Does establishing the authorizing mechanism improve patient access to care?
3. Does establishing the authorizing mechanism expose the patient to increased risk?
4. Does the implementer have the foundational knowledge in order to implement the medical directive or to accept the delegation and manage the outcomes?
5. What additional education or training would be required in order to facilitate the safe implementation of the medical directive or delegation?

For example, defibrillation falls under the category of a controlled act that is not authorized to nursing. However, many organizations have delegated this controlled act to nurses working in critical care environments as well as critical care response teams. This is based on improved clinical outcomes for patients who have a shorter time to defibrillation following the onset of ventricular fibrillation and pulseless ventricular tachycardia. Nurses working in critical care settings have the knowledge, skill, and judgment to accept this delegation and have the clinical opportunities to gain and maintain competence in this skill.
AIR Team Experience

The AIR Team project necessitated the development of several formal delegations and medical directives to enable the team to operate within the regulatory framework.

Delegations that were developed are included in Resource 2 and include:
- Inserting an Instrument, Hand or Finger Beyond the Anal Verge
- Performing a Procedure Below the Dermis
- Administering a Substance by Injection or Inhalation

Several medical directives were also developed or amended in order to facilitate team implementation. Some examples* of the directives can be found in Resource 3. Medical directives included:
- Initiation, Titration and Discontinuation of Oxygen Therapy for Adult Patients (including Discharge Instructions)*
- Initiation of Nicotine Replacement Therapy for Patients in the Emergency Department*
- Cardio-Respiratory Medical Interventions in the Emergency Department*
- Initiation in Point-of-Care Capillary Blood Sugar Testing
- Venous Blood Sampling when a Critical Value is Obtained Through Point-of-Care Blood Glucose Monitoring
- Radial and Femoral Artery Blood Procurement

The AIR Team project also provided an opportunity to standardize care through the development of pre-printed order sets for select respiratory populations. Order sets were specific to the emergency department and are available in Resource 4. The pre-printed orders were developed by integrating evidence such as the Registered Nurses’ Association of Ontario’s Best Practice Guidelines specifically related to respiratory health (RNAO, 2004a; 2004b; 2005; 2007a; 2008a) and the Canadian Thoracic Society’s recommendations for management of chronic obstructive pulmonary disease (O’Donnell et al., 2007).

Pre-Printed Order Sets developed include:
- Emergency Department Adult Asthma Orders
- Emergency Department Chronic Obstructive Pulmonary Disease Orders
- Emergency Department Paediatric Asthma Orders
- Emergency Department Paediatric Croup Orders

St. Joseph’s Health Centre also collaborated with The Ontario Lung Association which was in the process of rolling out the Emergency Department Asthma Care Pathway (2008) throughout Ontario. The order sets and discharge instructions were adapted into an organization-specific template with some content revisions based on feedback from the Health Centre’s approving bodies, for example, Pharmacy and Therapeutics and the Medical Advisory Committee. As a result of the modifications, the Ontario Lung Association was unable to specifically endorse the use of the order sets and discharge instructions; however, the revised documents were felt to be a better fit for the Health Centre.
CHAPTER 11
STEP 6: EDUCATE

Educational Considerations

The analysis of an activity inventory, development of a competency framework and establishment of authorizing mechanisms provides the team with a foundation upon which to formulate an education plan.

When analyzing the activity inventory, team members engage in conversations regarding the need for additional education in order to ensure that each member of the team is able to carry out the activity based on a common standard of care. The team should also consider what other topics are necessary in order for the clinicians to function in the specific clinical context. For example, this can include information on department-specific processes and information systems.

When developing an education plan, it is important to identify the strengths of individual clinicians and engage them by providing opportunities to share their expertise with the team. Educational strategies and training sessions should be devised based on identified skills and competencies. Examples of such strategies include:

- lectures or presentations
- completion of checklists
- small group learning activities
- web-based or independent learning
- hands-on skill development modules

(RNAO, 2008b).

The use of varied strategies will not only hold the interest of the team members, but will also address differing learning styles within the team. The team must also consider who will be responsible for facilitating the education modules and how ongoing skills training and maintenance of competencies will be addressed, particularly for activities that may not be part of a specific profession’s principal expectations of practice.
AIR Team Experience

The education plan for the AIR Team project was developed to allow the AIR Team clinicians or project leaders the opportunity to teach and facilitate the core competencies traditionally associated with their own profession. The education plan captured the essence of interprofessional collaboration, as each AIR Team clinician had an opportunity to learn with, from and about one another. For example, pharmacy was responsible for the education module related to completing a best possible medication history and medication reconciliation.

Throughout the interactive modules, participants from different professional backgrounds were able to share and learn from each other’s unique clinical experiences. For example, although respiratory therapy was primarily responsible for the education module related to the use of medication delivery devices for inhalation treatments, all three professions had expertise in this specific skill and so teaching and learning was ultimately co-facilitated by respiratory therapy, nursing and pharmacy.

The AIR Team clinicians came from diverse clinical backgrounds and it was important for them to acquire the same specialized respiratory knowledge and skills. To help ensure this, AIR Team clinicians were required to obtain a Certified Respiratory Educator (CRE) designation. AIR Team clinicians enrolled in the CRE preparatory course offered by the Ontario Pharmacist’s Association. The course utilized a number of teaching strategies such as didactic sessions, device workshops, interactions with standardized patients and case scenarios. This helped to simulate the complexity of real-life clinical situations and provided an opportunity for the team to solve issues together. In order to prepare for the written exam, dedicated time was provided for the team members to study together and learn from each other’s clinical experience.

Clinicians were provided with observation time in respiratory-related outpatient clinics. This provided an opportunity to work with clinicians from various professional backgrounds who were providing specialized care for this patient population. As the team would be working in the emergency department, it increased awareness regarding outpatient follow-up care.

Education for AIR Team clinicians included an independent review of the RNAO’s Best Practice Guidelines related to adult and paediatric asthma as well as chronic obstructive pulmonary disease (RNAO, 2004a; 2004b; 2005; 2007a; 2008a). AIR Team clinicians integrated the practice guidelines into their own practice, however, a full implementation of the guidelines in the emergency department did not occur as this was beyond the scope of the AIR Team project.
CHAPTER 12
STEP 7: ENSURE COORDINATION

What is meant by Ensuring Coordination?

Members of interprofessional teams must understand their individual responsibilities and roles within the team, as well as those of their fellow team members in order to collaborate effectively for the provision of patient care. Interprofessional collaboration can be undermined by professional boundaries, a lack of understanding of one another's roles and poor communication (Barker, 2005; Reeves et al., 2009).

Current literature suggests that interprofessional education, defined as an educational, training, teaching or learning session in which two or more healthcare professionals learn interactively, does enhance care and collaboration amongst healthcare professionals (Reeves et al., 2009). Learning from and about one another gives healthcare professionals a greater knowledge of the similarities and uniqueness of each profession allowing for a greater understanding of roles and responsibilities and generation of trust (Barr, 1998). Integration of interprofessional education as a strategy to ensure coordination of the team can take many forms. It can be informal group study time, workshops, jointly attending external education and case study discussions.

How is Coordination undertaken?

When creating a practice model that includes significant alteration in scope-of-practice application, it is essential to include the clinicians who will be enacting the model. This not only ensures that they have an opportunity to contribute to the development of the model, but that they have a complete understanding of their roles on the team and the roles of each team member. In teams where it is not possible to include every clinician in the development of the model, representatives for the profession-specific clinical group should be engaged in the process, ensuring also that they share information with colleagues and obtain feedback regarding proposed practice changes.
Scope-of-practice simulations provide an opportunity to test and refine the model of care before implementing it into practice. Interprofessional practice simulations can be effective as a teaching strategy to enhance the ability of a team of healthcare professionals to jointly problem solve (Rodehorst 2005). In academic settings, case simulations:

- highlight differences and similarities between different healthcare professions,
- increase understanding and respect for the roles of different professions,
- clarify individual professional role in context of team,
- provide a sense of community within the team (i.e., limit hierarchy) (Rodehorst, 2005).

A phased-in implementation can be utilized to ensure that team members have an opportunity to slowly integrate new learnings into their practice and improve team coordination over time. For teams that are being integrated within larger teams, this also provides an opportunity for other clinicians interacting with the team to orient to the new model of care.

Approaches to ensure coordination of care also serve to address concerns around the risk for clinician and organizational liability. Liability concerns have often been cited by healthcare professionals as a barrier to interprofessional models of care. The concerns stem from a belief that there is a “possibility that these practices will lead to increased exposure to liability risks, and fears that they may be held accountable for the negligent acts of their colleagues” (The Conference Board of Canada, 2007, p. i). Below is a brief overview of liability issues in interprofessional care.

### Liability Issues in Interprofessional Care

The Conference Board of Canada (2007) conducted a review of legal principles and court decisions, as well as a literature review related to liability issues in interprofessional care models. The information presented below is a summary of The Conference Board of Canada’s (2007) *Liability Risks in Interdisciplinary Care: Thinking Outside the Box*. Recommendations included a need for healthcare organizations to ensure their clinicians practice according to a professional standard of care, implement policies to guide interprofessional care, and have in place, both organizationally and at the clinician level, appropriate malpractice liability insurance. They also recommend that clinicians must understand their own regulated scope of practice as well as the scopes of practice for the other professionals that they interact with on their team. Clinicians must be aware of policies that confirm scopes of practice, and roles and responsibilities for the individual practitioner as well as those of the team, particularly when roles may overlap.
Another liability concern in collaborative patient care involves the uncertainty of whether it is necessary for the clinician to disclose his/her professional background when providing care, and whether by not doing so implies a failure to obtain informed consent. While this specific issue has not been addressed by the Canadian court system, liability has been found where a patient provided consent to one practitioner, but another—possibly a less skilled practitioner, carried out the procedure or treatment. While hospitals have created written consent forms to cover situations where a team of individuals will be participating in the plan of care, it has been suggested that this approach can be adopted in cases where verbal (or non-verbal) consent is obtained by explaining the care model to the patient upon their initial visit so that they are aware that they will be receiving team-based care.

Clinicians are increasing their scopes of practice to perform activities that were traditionally carried out by another group. Questions have arisen as to the professional standard of care that the clinicians will be held up against—that of their own profession or that of the profession who was historically responsible for performing the activity in situations regarding liability. Experts suggest that historically, the courts have assessed professional standards on an individual basis and that the clinician has been, and will continue to be, held up against the standards of their peer group. There have been situations where clinicians have been held to a uniform standard, however, only in situations where the clinicians from different backgrounds share a common knowledge base.

What is crucial when considering overlapping scopes of practice is that the different professionals involved in providing team-based care understand and agree upon their individual and collective roles and responsibilities. Case law has demonstrated “the importance of engaging the health professions in a frank dialogue to determine the agreed-upon roles their members play, particularly in new healthcare delivery models” (Conference Board of Canada, 2007, p. 13).

The Conference Board of Canada (2007) also discusses risks that are associated with delegating a role or responsibility inappropriately. Inappropriate delegation occurs when “a healthcare professional has primary responsibility for given tasks, but relies on another professional who does not have the necessary knowledge or skill to properly carry them out” (Conference Board of Canada, 2007, p. 15).

In order to mitigate the risk associated with collaborative models of care, the Conference Board of Canada suggests that:

- The team follows policies that clearly articulate the shared understanding of the roles. All team members know, support and practice these policies.
- Team members have strong communication practices [including documentation] in dealing with each other and with patients/clients and their families.
- Team members consistently inform patients/clients as to the roles that all health professionals will have in their care.
- Team members ensure that patients/clients give informed consent to the proposed treatments.

While collaborative care models do increase the risk of joint and several liability, and vicarious liability (The Conference Board of Canada, 2007), this would be the case in any model, whether uniprofessional or interprofessional, where more than one individual is responsible for providing patient care. Certainly in an acute care hospital setting, there are very few examples where only one practitioner is responsible for patient care delivery from beginning to end.

Organizations have a responsibility to ensure that policies that support or guide interprofessional teams are in place, and that performance is consistent with stipulations in the policy. Direct (clinician) versus vicarious (organization) liability occurs when the organization has a policy in place, but did not ensure that clinicians were following it. An organization would be held directly liable if the policy or guideline was not in place and it would have been necessary in preventing harm. The duty of healthcare organizations vis-a-vis patients is to:

- select competent staff and monitor their continued competence,
- provide proper instruction and supervision,
- provide proper facilities and equipment,
- establish systems necessary for the safe operation of the healthcare organization

(The Conference Board of Canada, 2007, p. 44).

Case law has demonstrated that individual clinician competency, system issues and other work factors, as opposed to working in interprofessional teams, is the main influence on liability risk.

“A central premise behind the promotion of interprofessional practice is that the operational reality must change, that it is lack of collaboration among providers that is causing injury to patients; a move to collaborative care, if implemented, will be made because it is clinically appropriate and will lead to better patient care” (Lahey and Currie, 2005, p. 209).
AIR Team Experience

Interprofessional education was a cornerstone to establishing and ensuring coordination with the AIR Team. Education opportunities always involved all three professions. For example, preparation time for the Certified Respiratory Educator (CRE) exam was scheduled so that the three clinicians on the team studied together and had an opportunity to utilize each of their areas of expertise during preparation for the exam. All clinicians were present throughout the orientation program and this created opportunities for the professions with more expertise in a particular area to take part in teaching other team members.

Including each clinician in the development of the care model, enhanced understanding of roles and increased knowledge of the other professions on the team. As discussed in earlier steps, development of the care model involved exploration of the foundational knowledge of all three professions resulting in an enhanced knowledge of individual professions. It also clearly established individual and shared roles within the team.

The AIR Team was introduced to the emergency department using a phased-in implementation process. This provided extensive opportunities for the team to refine the dynamics of the care model and the clinical context in order to optimize efficiencies, patient safety and scopes of practice.

The first stage of the phased-in implementation had each member of the team partnered with a registered nurse within the emergency department. This allowed for a greater familiarity with emergency department procedure, introduced the team and the planned scope optimization for each profession to the emergency department staff, and allowed the AIR Team clinicians opportunities to further practice new skills (e.g., Registered Nurse taking arterial blood gases, Registered Pharmacist performing venipuncture, Registered Respiratory Therapist taking a best possible medication history).

The second stage had the entire team partnered with an emergency department registered nurse to give the team further opportunities to refine the model of care before going live and to give the emergency department staff additional time to observe and understand the altered roles of the individual professions on the AIR Team (e.g., Registered Respiratory Therapist, Registered Pharmacist administering medication and inserting an intravenous).

Extensive education on the role of the AIR Team within the emergency department was undertaken during the implementation process. This was to ensure that the emergency department staff understood how the AIR Team would fit into the day-to-day functioning of the emergency department. Informal team huddles, posters, flyers, e-mails, hospital newsletters and hospital educational rounds were utilized to communicate and educate the emergency department staff on the new team.
CHAPTER 13

STEP 8: EVALUATE TO MAINTAIN SYSTEM RESPONSIVENESS AND FLEXIBILITY

What is meant by System Responsiveness and Flexibility?

Frequent evaluations of the newly developed model of care are essential to ensure the model of care is flexible and responsive to changes in patient care needs and changes in the clinical practice setting. Evaluation should include frequent, informal team huddles as well as less frequent, but more rigorous formal evaluations.

How is the Evaluation conducted?

Team huddles need only involve the members of the interprofessional team functioning in the new care model plus whoever is directly supervising the team. Team huddles can be done informally with very little preparation. Frequent huddles help to identify what does and what does not work well and allow the team to adapt more rapidly to patient care needs and the clinical environment. These informal meetings provide support to team members who may be working in a significantly altered role and allow the team to celebrate individual and team victories on a regular basis. Any major issues with respect to scopes of practice or patient care should trigger a formal evaluation.

Formal evaluations provide an opportunity to bring in all partners and stakeholders who were a part of the development of the new care model. They also provide an opportunity to review any preliminary outcome data being collected to determine if pre-identified patient care and scope optimization goals are being met. Any major issues or concerns may require re-engagement in the steps used in developing the interprofessional model of care.
Adequate check-ins also prevent and/or identify process drift. Process drift is when the team informally responds to internal team or external clinical practice setting feedback, and changes its process/care model. It is most likely to happen when there are gaps in the care model that have not been formally identified and/or addressed or when the new team is at a stressful or busy time causing team members to revert back to their traditional roles.

AIR Team Experience

An example of an issue that arose early during the daily huddles for the AIR Team related to the practice of the Registered Pharmacist. As she was engaging in several new activities that were not part of her principal expectations of practice, the implementation phase began with eagerness on the part of all team members to learn and refine new skills in the practice setting. Examples of such skills for pharmacy included intravenous insertion, venipuncture, and obtaining an electrocardiogram. Following the initial excitement that came from scope and team optimization through the integration of new skills into practice, the AIR Team Registered Pharmacist raised a concern. When the patient assignment was manageable, all clinicians were able to engage in new activities but were still able to partake in activities that required their profession-specific expertise. During parts of the day when the patient assignment became more hectic, the all hands on deck approach resulted in the Registered Pharmacist having limited opportunities to engage in activities that comprised the core of pharmacy practice, such as reviewing and reconciling the patient’s medications or providing thorough medication-related discharge teaching. While this issue did not necessitate a formal change in the practice model, all AIR Team clinicians were aware of the concerns—and going forward, activities during hectic parts of the day were allocated in a manner that honoured each clinician’s profession-specific expertise.
TEAM VISIONING

In this Section:
Chapter 14
Team Visioning
CHAPTER 14
TEAM VISIONING

This Chapter on co-creating a shared team vision is written for healthcare professionals who have accepted the responsibility of creating an interprofessional healthcare team. In order to maximize worker potential, organizations must integrate programs that focus on teamwork, common values and diversity. These programs of work help team members reach their full potential in order to contribute to a healthy work environment. Opportunity to participate in decision-making also leads to improved job satisfaction and organizational commitment (RNAO, 2007c). Working with teams to establish a team vision is one approach to strengthening teams and contributing to a positive work setting. The information in this Chapter covers the who, what, when, where, and why of team visioning, including helpful tips if the team gets stuck and recommendations for how to proceed once the team vision, that inspires and engages all team members, has been successfully created.

It is recommended that teams consider team visioning at the time when team members are engaged in education, orientation, and coordination of care activities. For the purpose of this Toolkit, team visioning is recommended to occur between Chapter 11: Educate and Chapter 12: Ensure Coordination.

What is a team?

In the literature, there are a myriad of definitions of team or group, depending on the perspective of the authors. For the purpose of this Toolkit, teams rather than groups are referred to and use a comprehensive definition adopted from the management literature as follows:

“A team is a collection of individuals who are interdependent in their tasks, who share responsibility for outcomes, who see themselves and who are seen by others as an intact social entity embedded in one or more larger social systems, and who manage their relationships across organizational boundaries” (Cohen & Bailey, 1997, p 241).

It is anticipated that this definition of team applies to the majority of interprofessional teams in healthcare and therefore applies to this Toolkit’s audience.
What is a team vision?

A team vision is a picture of what a team seeks to create and achieve in the future. It can be expressed as a visual image or in a sentence or two as a team vision statement. Although it represents a future state, it is expressed orally and in writing in the present as if it were already happening.

For example, the AIR Team vision statement was as follows:

A team vision represents a state of being, not a state of doing. It is not a list of objectives the team desires to achieve. In order to avoid the trap of focusing too early and too specifically on what the team wants to achieve, it is recommended that the team vision statement begins with the sentence: “We are”… The team vision should represent a stretch from what currently exists. It should be expressed in broad terms. Teams do not need to worry about how they are going to realize their team vision. This step comes next, as the team develops action steps to enable its vision.

A team vision is distinct from a mission. A mission statement is more commonly associated with an organization as a whole, and not a single team within an organization. A mission represents the fundamental reason for the organization’s existence. To clarify the difference, “[one] will likely not ever get to the ultimate mission/purpose of the organization but will achieve many visions along the way” (Senge, 1994).

What is a shared, co-created team vision?

It is of paramount importance that the team vision is shared and co-created. In other words, the team vision has meaning and value to all team members (shared), and every member of the team has had an opportunity to contribute (co-created). Whether all members choose to contribute to the team vision or not it is their prerogative and must be respected.

What type of team should consider a shared, co-created team vision?

There are many different types of teams operating in organizations. In business, the literature often refers to work, parallel, project, and management teams. (Cohen & Bailey, 1997). In healthcare, examples include interprofessional, intraprofessional, unit, point-of-care, cross-agency, and population health teams. It is the project team’s assertion that any team that meets the definition in this Toolkit can derive substantial benefit from a team visioning process.
St. Joseph’s Health Centre has been successful in facilitating team visioning for the Senior Leadership team (interprofessional, comprised of the CEO, Vice Presidents, Directors, Chiefs and members of the Board of Directors), Nursing Practice Council (intraprofessional), and all twenty-six (26) Point-of-Care teams (interprofessional teams making tactical decisions impacting patient care).

Why should a co-created shared team vision be considered?

The team visioning process increases team cohesion, and team cohesion is positively related to team performance and effectiveness (Cohen & Bailey, 1997). There are many models and approaches in the literature for team building and creating positive change, and they include visioning as a critical step toward success (Cooperrider & Whitney, 1999; Crowell, 2000). A team vision provides context and clarity for the work, and upgrades the work to a higher purpose. It mobilizes the team’s energy. Teams are more energized, inspired, and committed when their vision is shared and co-created. In contrast, teams are much less energized, inspired and committed without a vision or when their vision is provided for them as in, for example, a top-down management approach.

Team visioning is also effective for those teams who perhaps proclaim externally that they “have a great team” and “everyone gets along” however, within the team, work doesn’t get accomplished without a great deal of internal conflict and wasted energy. Neuhauser (1988) termed this “phony teamwork”. The process of engaging team members and valuing their ideas and contributions toward the creation of a meaningful team vision eliminates the need for false civility in teams.

When should co-creating a shared team vision be considered?

Teams must have had the opportunity to get to know each other and appreciate and value each other’s differences BEFORE engaging in team visioning. In the theory of Appreciative Inquiry, this is referred to as the Discovery Phase. In small group theory, this occurs during the Forming Stage. In a general sense, this phase refers to a process of initiation of team members to their team. This is a very important part of team development as it builds trust and respect, it increases members’ comfort levels with each other, and it increases inclusion, a sense of belonging to the team, and team cohesion. Attempting team visioning without first building the foundation of the team is like trying to run before learning to walk.

With respect to this Toolkit, team members will have been engaged in initiation activities from the time of recruitment, throughout the process of following the guidelines, and during the creation of the interprofessional model of care (refer to Section C of this Toolkit).
Once the team has participated in some form of initiation, it is never too late for team visioning. Team visioning can be successful and equally meaningful for teams regardless of whether they are newly formed teams, teams that have worked together for decades, or anywhere in between. Team visioning is an excellent on-boarding strategy when bringing a new member(s) into an existing team.

**Who should facilitate the team visioning process?**

Ideally, the individual(s) conducting the team visioning should be a trained team coach/facilitator with previous team visioning experience. However, such skills and experience are not always widely available in healthcare organizations. One option is to hire a consultant(s) to assist in the team visioning process. Consultants with credentials as coaches, with experience facilitating team visioning for interprofessional teams working in healthcare, and with a background in Appreciative Inquiry may be the best fit for this kind of coaching exercise. (For additional information on team coaching or team visioning, refer to the Health Centre’s contact information at the front of this Toolkit).

The project team recommends where possible that facilitators or team coaches work in pairs, and that each represent a different profession. For team coaches, this model offers support, an extra individual to assist with observation of team process, and shared workload. For the teams, this models interprofessional collaboration, and teams benefit from the experience of two team coaches instead of one.

Ideally, it is recommended that the facilitators/team coaches be external to the team. The potential exists for dual team coach/team members to exert the influence of the team coach role to steer the team toward a team vision that serves his/her professional roles, and not necessarily a vision with meaning for all team members. For dual team coach/team members who stay detached from the process, the result may be a team vision with which they themselves are not engaged. In either case, the team vision could not be said to be truly shared and co-created when a team member is also a team coach.
What do facilitators/team coaches need to consider before beginning team visioning?

Participation of all team members is critical in order for the team vision to be shared and co-created. Some questions to ask include:

**REFLECTIVE QUESTIONS**

**Team Visioning**

1. **Are all team members present? If not, why not?**
2. **Are there creative ways to involve team members who are unable to be physically present during the team visioning process?**
3. **If the decision is made to proceed without all team members, how will the team involve absent members in the team vision?**
4. **How will the team vision be communicated to the broader workplace environment and to the team stakeholders?**

Dedicated space and time for the team visioning process is imperative. It is strongly recommended and preferred that team members are replaced if necessary during the team visioning process in order to avoid team members from being interrupted and/or leaving the process in the middle. If this is not possible, then the team should discuss at the outset how it will handle interruptions—will it continue, or wait until the team member returns?

In conducting team visioning, team coaches are advised to be committed to the process but not the outcome. In other words, team coaches are there to facilitate the process, but not to do the work for the team. In the formulation of its vision statement, if the team gets stuck (as often occurs), team coaches should avoid giving their ideas or making suggestions. Instead, team coaches should be skilled in using questions as a way to get teams to shift and get unstuck. Ultimately, if the team coach does not find the vision created particularly inspiring, that does not matter. If the team vision is shared, co-created, and the team is engaged, energized and inspired, that is all that counts!
How is a shared team vision co-created?
What is the process?

Using Appreciative Inquiry (AI) as the model for team visioning, is strongly recommended. AI is an approach to engage people in change. This approach taps the potential of human beings to make them more adaptive and more effective. It is based on the possibility of a more desirable future, co-created through everyone’s participation. It is based on solid, proven principles for unleashing people’s creativity and knowledge toward creating a collective sense of common purpose or shared vision (Cooperrider & Whitney, 1999).

AI involves asking appreciative questions about a topic of choice relevant to the team members to help them create stories. These stories are then used to create new, more compelling images of the team’s future. The future becomes visible through ideals interwoven with actual experiences of the team (Cooperrider & Whitney, 1999).

How is a team vision created using Appreciative Inquiry?

The process to create a team vision using the Appreciative Inquiry theory is illustrated in the following diagram beginning with Discovery, then Dream, Design and Destiny.

Refer to Resource 5 for a step-by-step example of Team Visioning with handouts that can be adapted to suit particular workplace environments (St. Joseph’s Health Centre, 2009).

(Adapted from Cooperrider & Whitney, 1999).
What if the team gets stuck while creating the team vision statement?

It is quite common for teams to get stuck when creating a team vision statement. Teams want a comprehensive statement(s) that is really meaningful, and the team members have so many ideas and values they want to incorporate. What often happens is that teams start to focus on word-smithing: grammar, sentence structure, and moving words around. For some team members who are not interested in these details, the energy for creating the team vision statement begins to wane.

If this occurs, take a break. Team coaches could ask for a volunteer or two from the team to work with them to try to create a couple of different team vision statements. These vision statements can then be presented to the team after the break for feedback.

When is the team vision statement exercise complete?

Once the team has a vision statement, it is important for team coaches to evaluate and observe the energy for vision within the team. For example, team coaches can ask the team members to close their eyes while the vision is read aloud and look for non-verbal cues that show the team is engaged and inspired. If it is not obvious from observation of body language, use a specific visual cue by asking the team members to indicate their level of engagement with the team vision in one of three ways:

- **Thumbs up** (really engaged and inspired),
- **Thumbs sideways** (the vision statement still needs some work but the member can live with it),
- **Thumbs down** (unacceptable; member is not engaged or inspired).

Try to achieve the unanimous thumbs up! However, the vision statement is finished when all votes are either thumbs up or sideways, but not down.
After Co-Creating a Shared Team Vision—Next Steps

Always follow the team visioning process by asking team members to develop a few action steps that will propel the team toward enabling the vision they just created. Don’t wait to do this or the momentum that has been generated through the process of creating the team vision may be lost. Take a break if necessary (it takes a lot of mental and emotional energy to create a team vision), but before terminating the session, have the team create a few actions that will move it in the direction of its vision. The goal is to generate a few quick wins in order to continue and sustain the momentum. Actions that are easy to implement and are likely to have the biggest impact, are the best choice for action steps.

When should the team vision statement be revisited?

The team vision is not static. It needs to be adapted in order to continue to be meaningful for team members. It is important to revisit the team vision when particular aspects of a team or team environment have changed. For example, revisit the team vision if there has been a change in:

- membership; existing team members have left the team and/or new members have joined the team,
- the purpose of the team or in its strategic direction,
- the leadership of the team,
- factors/conditions affecting team dynamics.

Ideally however, teams are encouraged to revisit their vision every six (6) months even if the team members and environment have not changed.
REFERENCES


ADDITIONAL READINGS


PART 1


PART 2

RESOURCES

1. Sample Job Posting
2. Delegations
3. Medical Directives
4. Pre-Printed Order Sets
5. Team Vision Worksheets
6. Intervention Response Time Data Collection Tool
7. Perceived Knowledge of Respiratory Care Survey
8. Respiratory Device Pocket Card
9. Interprofessional Collaborative Practice Survey
PART 2
SAMPLE JOB POSTING

Internal Posting (Professional/Technical) Classification: Registered Staff Pharmacist Full-Time Temporary (until June 30, 2009) 
Vacancy Number #: 2008-597 Location: Interprofessional Practice, AIR Team Salary: $39.701 to $46.950 per hour

Position Description: The Registered Staff Pharmacist – AIR Team reports to the Manager, Interprofessional Practice. During this research pilot project, three healthcare providers, a Registered Respiratory Therapist (RRT), Registered Pharmacist (RPh) and a Registered Nurse (RN), will form an Assertive Interprofessional Respiratory (AIR) Team to provide enhanced care to patients with respiratory illness in the emergency department. Each provider will have the opportunity to maximize his/her scope of practice and enhance his/her knowledge and skills. This flexible patient-care delivery model will allow the team members to have shared responsibilities and decision-making to ensure timely and appropriate delivery of care. In addition to clinical responsibilities, the successful candidate will complete a Certified Asthma/Respiratory Educator preparation course (Oct. 2 to 5, 2008) and Certification Exam (Nov. 2008), as well as other specified educational requirements between Oct. 2008 and Jan. 2009. During this phase, the successful candidate will continue to work in his/her primary area of employment. The clinical (or intervention) phase will involve 6 months of clinical work, full-time, beginning in Jan. 2009.

Primary Responsibilities:
- Provision of comprehensive quality patient care including initiation of medication reconciliation for respiratory patients in the emergency department with the AIR Team Respiratory Therapist and Registered Nurse
- Provide consultations upon request for respiratory patients in the ambulatory/fast track, paediatric and crisis areas of the emergency department
- Work in close collaboration with all members of the interprofessional team, including the emergency department physician and all clinical and non-clinical staff within the department
- Act as an education resource to the interprofessional team
- Data collection related to AIR team outcomes and implementation of evidence-based practices and best practice guidelines in collaboration with the interprofessional team
- Participate in program planning and development

Qualifications:
- Graduation from a recognized pharmacy degree program
- Licensure with the Ontario College of Pharmacists
- Hospital pharmacy residency an asset
- Previous hospital experience in direct patient care in a team environment required
- Knowledge in provision of pharmaceutical care (PC) an asset
- Excellent interpersonal, communication and organizational skills
- Demonstrated commitment to education and research. Experience with research activities an asset.
- Experience using Groupwise, word processing and spreadsheet computer software (preferably Windows 2000, Word, Excel) an asset
- Good attendance record

Posted: September 22, 2008
In order to be considered for the above transfer, applications must be received in the Human Resources Department on or before September 29, 2008. *Please indicate Vacancy Number on all application forms.

Equal Opportunity Employer
## Delegations

**Delegation: Performing a Procedure Below the Dermis**

<table>
<thead>
<tr>
<th>Contact Person:</th>
<th>___________________</th>
<th>_______</th>
<th>_____________________</th>
<th>Approved: <strong>/</strong>/__</th>
<th>Reviewed: <strong>/</strong>/__</th>
<th>Revised: <strong>/</strong>/__</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delegated Controlled Act?</td>
<td>Yes X No ___</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authorized to:</td>
<td>AIR Team Pharmacist</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Delegator:</td>
<td>AIR Team Registered Nurse</td>
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</tbody>
</table>
| Description of Procedure: | - The AIR Team Pharmacist is working as part of an interprofessional team with the AIR Team Respiratory Therapist and the AIR Team Registered Nurse when a medical directive is in place or an order is received:  
  - Inserting an intravenous catheter  
  - Performing venipuncture  
  - Obtaining a capillary blood glucose sample  
- The AIR Team pharmacist will obtain patient/substitute decision-maker consent before performing the procedure  
- Documentation will be completed in accordance with the College of Pharmacists Documentation Standards, St. Joseph’s Health Centre Documentation Standard of Care, IV Cannulation/Saline Lock Insertion Standard of Care, and the Venipuncture Standard of Care. Designation for documentation purposes will be specified as AIR Team Pharmacist | | | | | |
| Education and Ongoing Competence Requirements for Authorized Individuals: | - The Education plan for the AIR Team Pharmacist will include formal education on the Medication Administration Standard of Care, Safety of Medication Orders Standard of Care, Transcription and Verification of Medication Orders Standard of Care, IV Cannulation/Saline Lock Insertion Standard of Care, PICC Line Standard of Care, Central Venous Access Device Standard of Care and Oxygen Therapy Standard of Care. The AIR Team Pharmacist will have met the education and certification requirements specified in the above Standards of Care, will have an opportunity to practice the skills in a skills lab environment, and will be re-certified biannually to maintain competence. | | | | | |
| Clinical Conditions Required: | Patient’s clinical status requires intravenous access, venous blood sampling or capillary blood sampling for treatment or diagnostic purposes | | | | | |
| Situational Circumstances Required: | Patient is registered in the Emergency Department | Medical Directive is enacted or Order for treatment is received | | | | |
| Contraindications: | Patient/Substitute Decision-Maker does not consent to procedure | Other contraindications as per the IV Cannulation and/or Venipuncture Standard of Care | | | | |
| Approved by: | Nursing Practice Council  
- Interprofessional Practice Council  
- Pharmacy and Therapeutics | Respiratory Therapy Department  
- Pharmacy Staff Department | | | | |
| Author(s) and Title(s): | | | | | | |
| Next Review Date (2 yrs): | | | | | | |
| References and Resources: | Regulated Health Professions Act, 1991.  
**Delegation: Inserting an Instrument, Hand or Finger Beyond the Anal Verge**

<table>
<thead>
<tr>
<th>Contact Person:</th>
<th>______________________</th>
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<th>______________________</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(name)</td>
<td>(ext. #)</td>
<td>(area of experience)</td>
<td>Approved: <strong>/</strong>/__</td>
<td></td>
</tr>
<tr>
<td>Delegated Controlled Act?</td>
<td>Yes</td>
<td>X</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Authorized to:</td>
<td>AIR Team Pharmacist; AIR Team Respiratory Therapist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delegator:</td>
<td>AIR Team Registered Nurse</td>
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</table>

**Description of Procedure:**
- The AIR Team Pharmacist, and AIR Team Respiratory Therapist are working with the AIR Team Registered Nurse as part of an interprofessional team.
- The AIR Team Pharmacist and AIR Team Respiratory Therapist will be delegated the following act from the AIR Team Registered Nurse when a medical directive is in place or an order is received:
  - Inserting an Instrument, Hand or Finger Beyond the Anal Verge
  - Administering a suppository per rectum
  - Obtaining a rectal temperature
  - Obtaining rectal swabs for specimen collection
- The AIR Team Pharmacist and AIR Team Respiratory Therapist will obtain patient/Substitute Decision-Maker consent prior to any intervention.
- If the AIR Team Pharmacist or AIR Team Respiratory Therapist is not able to independently manage the outcomes of providing the treatment, the AIR Team Pharmacist/Respiratory Therapist will ensure that the other AIR team clinician(s) are informed of treatments administered to ensure that potential adverse outcomes/side effects can be anticipated and managed by the interprofessional team. Communication between team members will occur throughout their scheduled shift(s).
- Documentation will be completed in accordance with the College of Pharmacists Documentation Standards, College of Respiratory Therapists Documentation Standards, St. Joseph’s Health Centre Documentation Standard of Care, Medication Administration Standard of Care, Safety of Medication Orders Standard of Care and Transcription and Verification of Medication Orders Standard of Care. Designation for documentation purposes will be specified as AIR Team Pharmacist or AIR Team Respiratory Therapist.

**Education and Ongoing Competence Requirements for Authorized Individuals:**
- The Education plan for the AIR Team Pharmacist and AIR Team Respiratory Therapist will include an opportunity to practice the above-stated delegated act(s) in a skills lab environment. The delegates will be observed performing the skills under supervision by the AIR Team Registered Nurse or delegate to assess competence prior to performing the skills independently. Formal education on the Medication Administration Standard of Care, Safety of Medication Orders Standard of Care, and the Transcription and Verification of Medication Orders Standard of Care will be provided.

**Clinical Conditions Required:**
- Patient’s clinical status requires a procedure necessitating performing of the above-stated controlled act.

**Situational Circumstances Required:**
- Patient is registered in the Emergency Department
- Medical Directive is enacted or Order for treatment is received

**Contraindications:**
- Nursing/Substitute Decision-Maker does not consent to procedure
- Other contraindications as per the above stated Standards of Care

**Approved by:**
- Nursing Practice Council
- Interprofessional Practice Council
- Pharmacy and Therapeutics
- Respiratory Therapy Department
- Pharmacy Department

**Author(s) and Title(s):**

**Next Review Date (2 yrs):**

**References and Resources:**
- Decisions about Procedures and Authority, College of Nurses Standard of Practice, 2006.
Delegation: Administering a Substance By Injection or Inhalation

Contact Person: __________________     _______   ____________________________
(name)                                  (ext. #)                                   (area of experience)
Approved: __/__/__  Reviewed: __/__/__  Revised: __/__/__
(dd/mm/yy)

Delegated Controlled Act?  Yes  X  No __
Authorized to: AIR Team Pharmacist
Delegator: AIR Team Registered Nurse and AIR Team Respiratory Therapist

Description of Procedure:
- The AIR Team Pharmacist is working as part of an interprofessional team with the AIR Team Respiratory Therapist and
  the AIR Team Registered Nurse
- The AIR Team Pharmacist will be delegated the following act from the AIR Team Registered Nurse or AIR Team
  Respiratory Therapist when a medical directive is in place or an order is received:
  - Administering a substance by injection or inhalation
  - Administering fluids and medications via the intravenous route (Delegator: AIR Team RN)
  - Administering fluids and medications via a central venous access device (PICC and Central Line only)
    (Delegator: AIR Team RN)
  - Administering fluids or medications via the subcutaneous route (Delegator: AIR Team RN)
  - Administering fluids or medications via inhalation (Delegator: AIR Team RT and/or AIR Team RN)
  - Administering oxygen therapy via inhalation (Delegator: AIR Team RT)
- The AIR Team Pharmacist will obtain patient/substitute decision-maker consent before administering the fluid or
  medication (includes oxygen)
- If the AIR Team Pharmacist is not able to independently manage the outcomes of providing the treatment, the AIR
  Team Pharmacist will ensure that the other AIR team members are informed of treatments administered to ensure that
  potential adverse outcomes/side effects can be anticipated and managed by the interprofessional team. Communication
  between team members will occur throughout their scheduled shift(s)
- Documentation will be completed in accordance with the College of Pharmacists Documentation Standards, St. Joseph's
  Health Centre Documentation Standard of Care, Medication Administration Standard of Care, Safety of Medication
  Orders Standard of Care, Transcription and Verification of Medication Orders Standard of Care, IV Cannulation/Saline
  Lock Insertion Standard of Care, PICC Line Standard of Care, Central Venous Access Device Standard of Care and Oxygen
  Therapy Standard of Care. Designation for documentation purposes will be specified as AIR Team Pharmacist

Education and Ongoing Competence Requirements for Authorized Individuals:
The Education plan for the AIR Team Pharmacist will include formal education on the Medication Administration Standard
of Care, Safety of Medication Orders Standard of Care, Transcription and Verification of Medication Orders Standard of Care,
IV Cannulation/Saline Lock Insertion Standard of Care, PICC Line Standard of Care, Central Venous Access Device Standard of Care
and Oxygen Therapy Standard of Care. The AIR Team Pharmacist will have met the education and certification
requirements specified in the above Standards of Care, will have an opportunity to practice the skills in a skills lab
environment, and will be re-certified biannually to maintain competence.

Clinical Conditions Required: Patient’s clinical status requires the administration of a substance via injection or inhalation

Situational Circumstances Required:
- Patient is registered in the Emergency Department
- Medical Directive is enacted or Order for treatment is received
- Patient/Substitute Decision-Maker does not consent to procedure
- Other contraindications as per the above stated Standards of Care

Approved by:
- Nursing Practice Council
- Interprofessional Practice Council
- Pharmacy and Therapeutics
- Respiratory Therapy Department
- Pharmacy Staff Department

Author(s) and Title(s):

Next Review Date (2 yrs):

References and Resources:
- Decisions about Procedures and Authority, College of Nurses Standard of Practice, 2006.
MEDICAL DIRECTIVES

Directive: Initiation, Titration and Discontinuation of Oxygen Therapy for Adult Patients

Contact Person
- Professional Practice Leader, Nursing (ext 3239)
- Charge Therapist, Respiratory Services (ext 4556)
- Professional Practice Leader, Occupational Therapy (ext 4382)
- Professional Practice Leader, Physiotherapy (ext 3853)
- Respiratory Therapy Services (ext 6693)
- Clinical Coordinator, Pharmacy (ext 3941)

Delegated Controlled Act? Yes X No ___

Authorized to
AIR Team Pharmacist

Delegator
AIR Team Registered Nurse

Delegated Controlled Act? Yes for OT/PT/RPh No for RPN/RRT/AA

Authorized to
- Registered Respiratory Therapists (RRT)
- Anesthesia Assistants (AA)
- Registered Nurses (RN)
- Registered Practical Nurses (RPN)
- Occupational Therapists (OT)
- Physiotherapists (PT)
- AIR (Assertive Interprofessional Respiratory)
- Team Registered Pharmacist (RPh)

Description of Procedure
- The patient is assessed as per the Standard of Care for a specific unit/area/profession and on an as needed basis depending on the patient’s clinical presentation
- Oxygen saturation (SpO2) is measured via pulse oximetry
- Oxygen (O2) will be initiated if the patient’s SpO2 is less than 90% OR less than minimum acceptable SpO2 ordered by a physician AND/OR if the patient meets any of the clinical conditions listed on the next page
- If O2 is initiated and no SpO2 parameters are ordered, the most responsible physician (MRP) must be contacted and SpO2 parameter orders must be obtained
- O2 is initiated and titrated according to the table below
- Refer to the Oxygen Standard of Care for the Adult Patient for weaning and discontinuation of O2

<table>
<thead>
<tr>
<th>RPN /RPh</th>
<th>RN</th>
<th>RRT/AA</th>
<th>PT</th>
<th>OT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiate and titrate O2 up to 4 Litres per minute (Lpm)</td>
<td>Initiate and titrate O2 up to 6 Lpm OR Fraction of inspired O2 (FiO2) 0.40</td>
<td>Initiate and titrate O2 up to 6 Lpm OR FiO2 0.40</td>
<td>Initiate and titrate O2 up to 6 Lpm during treatment</td>
<td>Initiate and titrate O2 up to 4 Lpm during treatment</td>
</tr>
<tr>
<td>Must immediately discuss changes in patient’s condition with RN/RRT</td>
<td>Must discuss changes in patient’s condition with RN</td>
<td>Must follow up and weaning to be done in collaboration with RN</td>
<td>Must discuss changes in patient’s condition with RN</td>
<td></td>
</tr>
<tr>
<td>If the patient’s SpO2 remains less than 90% or as ordered, the RRT must be paged</td>
<td>Follow up and weaning to be done in collaboration with RN</td>
<td>Follow up and weaning to be done by RN</td>
<td>Follow up and weaning to be done by RN</td>
<td></td>
</tr>
</tbody>
</table>

FiO2 ≤ 0.40

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 Directive: Initiation, Titration and Discontinuation of Oxygen Therapy for Adult Patients (continued)

### Description of Procedure (continued)

<table>
<thead>
<tr>
<th>RPN/RPh</th>
<th>RN</th>
<th>RRT/AA</th>
<th>PT</th>
<th>OT</th>
</tr>
</thead>
<tbody>
<tr>
<td>FiO2 ≤ 0.40</td>
<td>Not applicable</td>
<td>Page RRT</td>
<td>Initiate and titrate O2 up to FiO2 1.0</td>
<td>May pre-oxygenate at FiO2 1.0, if suctioning is being performed</td>
</tr>
</tbody>
</table>

- The patient will be placed on the minimum amount of O2 required to keep SpO2 greater than or equal to 90% OR the minimum amount of SpO2 prescribed by the Most Responsible Physician (MRP)
- Assessment of O2 will be ongoing and titrated down in order to achieve the end goal of weaning the patient back to room air OR to baseline SpO2
- The MRP will be notified if significant changes in O2 levels occur

### Situational Circumstances Required

- The use of humidity must be considered for all patients with tracheostomies and/or if higher flows of oxygen is required (e.g., greater than or equal to 4 Lpm on nasal prongs, or FiO2 greater than or equal to 0.50)
- In some patients the initiation of oxygen will result in respiratory depression. These are patients who may suffer from Chronic Obstructive Pulmonary Disease, Obstructive Sleep Apnea, or Obesity Hypoventilation Syndrome. If this is suspected, O2 must be discontinued, and immediately page RRT, Rapid Evaluation and Acute Care Team (REACT) or the MRP. It may be necessary to obtain new SpO2 orders.

### Clinical Conditions Required

- Supplemental oxygen may be considered if one or more of the following clinical conditions are met:
  a) Hypoxia defined as SpO2 less than 90% OR less prescribed SpO2 parameters
  b) Possible cardiac or neurological ischemia
  c) Symptoms related to acute myocardial infarction
  d) Symptoms related to acute cerebral vascular accident (CVA)
  e) Low hemoglobin (Less than 80 g/L)
  f) Any acute event

### Contraindications

- No specific contraindications to oxygen therapy exist when indications are judged to be present

### Education and Ongoing Competence Requirements for Authorized Individuals

- The Education plan for the AIR Team pharmacist will include formal education on the Medication Administration Standard of Care, Safety of Medication Orders Standard of Care, Transcription and Verification of Medication Orders Standard of Care, IV Cannulation/Saline Lock Insertion Standard of Care, PICC Line Standard of Care, Central Venous Access Device Standard of Care and Oxygen Therapy Standard of Care. The AIR Team Pharmacist will have met the education and certification requirements specified in the above SOCs, will have an opportunity to practice the skills in a skills lab environment, and will be re-certified biannually to maintain competence.

### Approved by

- Medical Director, Respiratory Therapy
- Chair Pharmacy and Therapeutics
- Chair Medical Quality of Care Committee
- Chair Medical Advisory Committee
- All Departmental Chiefs
- Chief of Medicine
- Chief of Anaesthesia
- Chief of Emergency Medicine
- Chief of Obstetrics & Gynecology
- Chief of Surgery
- Chief of Paediatrics
- Chief of Family Medicine
- Chief of Psychiatry
- Chief of Diagnostic Imaging
- Chief of Laboratory Medicine

### Author(s) and Title(s)

Next Review Date: (2 yrs)

### References and Resources

- Centre for Disease Control (2003). Guidelines for preventing healthcare associated pneumonia. MMWR Recommendations and Reports.
- Pierson, David, MD FAARC. Clinical practice guidelines for chronic obstructive pulmonary disease: A review and comparison of current resources. Respir Care, March 2006 Vol 51 No 3.
**Directive: Initiation of Nicotine Replacement Therapy (NRT) for Patients (18 Years or older) in the Emergency Department**

<table>
<thead>
<tr>
<th>Delegated Controlled Act?</th>
<th>Yes</th>
<th>No</th>
<th>X</th>
</tr>
</thead>
</table>

**Authorized to**
- Registered Nurses working in the Emergency Department (ED)
- Registered Practical Nurses working in the Emergency Department caring for patients assessed as CTAS 4 and 5.
- AIR (Assertive Interprofessional Respiratory) Team Registered Nurse (RN) working in the ED
- AIR Team Registered Respiratory Therapist (RT)
- AIR Team Registered Pharmacist (RPh)

**Description of Procedure**
Medical interventions initiated by the Emergency Department nurse or AIR Team RN, RRT, and RPh for patients presenting to the Emergency Department with nicotine dependency.
- All patients triaged to the Crisis Area will be informed of the Health Centre’s smoke free policy and will be screened for nicotine dependency. Patients triaged to the main department will be screened as needed. Patients will be asked about their smoking status including number of cigarettes per day and the number of years they have been smoking.
- Patients will be informed that Nicotine Replacement Therapy (NRT) is offered at the Health Centre. Verbal consent for Nicotine Replacement Therapy will be obtained and documented on the patient chart (e.g., Patient screened for dependency. Patient consents to the Nicotine Patch). If the patient does not consent to Nicotine Replacement Therapy, this will be documented on the chart. Criteria for Determining Dose:
  - Patients who smoke 10 cigarettes per day or more, do not have a history of cardiovascular disease, and weigh more than 45 kg will be offered the Nicotine Patch 21 mg OD.
  - Patients who smoke less than 10 cigarettes per day and will be offered the Nicotine Patch 14mg OD.
  - Patients who smoke 10 cigarettes per day or more, but have a history of cardiovascular disease, or weigh less than 45 kg will be offered the Nicotine Patch 14mg OD.
  - Patients who are receiving greater than 600 mg/day of cimetidine will be offered the next lower patch size (e.g., a patient who smokes more than 10 cigarettes per day, has no history of cardiovascular disease and weighs more than 45 kg would receive a 14 mg Nicotine Patch instead of a 21 mg patch if they are receiving more than 600 mg of cimetidine daily).
  - Patients who do not consent to the Nicotine Patch may be offered the Nicotine Gum 4mg q1h prn x 2 (is not dependent on number of cigarettes smoked daily).
  - Patients who consent to the Nicotine Patch may be offered Nicotine Gum 2 mg q1h prn x 2 for breakthrough cravings in addition to applying the patch in the above specified strength.
- The Most Responsible Physician will be alerted to the initiation of NRT for patients receiving clozapine
- Patients initiating Nicotine Replacement Therapy must be advised to completely stop smoking while using NRT. If the patient wishes to resume smoking, use of the Nicotine Patch and/or Nicotine Gum must be discontinued.
- Documentation on the doctor’s order form or the E.R. chart will indicate that the medical directive was enacted.
- Blood pressure, heart rate and respiratory rate will be reassessed after initiation of NRT.

**Clinical Conditions Required**
- Nicotine Dependency

**Situational Circumstances Required**
- Patient must be a registered patient of the Emergency Department
- Patient must be 18 years of age or older
- Assigned nurse completes post-triage assessment

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### Directive: Initiation of Nicotine Replacement Therapy (NRT) for Patients (18 Years or older) in the Emergency Department (continued)

**Contraindications**
- Patient refuses treatment
- Patient is hypersensitive to nicotine or the patch
- Patient has recent Myocardial Infarct, life-threatening arrhythmias, or severe or worsening angina pectoris
- Patient has recent cerebrovascular accident
- Patient has generalized skin disorder (contraindication for Nicotine Patch)
- Patient has active temporomandibular joint disease (contraindication for Nicotine Gum)
- Patient is pregnant
- Patient is breastfeeding
- Patient is unable to chew gum and/or is unwilling to learn the proper technique (Gum must be absorbed across the buccal mucosa, it must not be swallowed)
- Refer to the Compendium of Pharmaceuticals and Specialties (CPS) for complete monograph

**Education and Ongoing Competence Requirements for Authorized Individuals**
- In service specific to medical directive

**Approved by**
- Director/Chief of Service
- Authorizing Emergency Physicians
- Chair, Pharmacy and Therapeutics
- Chair, Medical Quality of Care Committee
- Chair, Medical Advisory Committee

**Author(s) and Title(s)**
### Directive: Cardio-Respiratory Medical Interventions in the Emergency Department (ED)

**Contact Person:**
(name, position, extension number, area of expertise)

**Delegated Controlled Act?**
Yes [X] No ___

(IV insertion/fluid administration, Venipuncture and Oxygen administration for AIR Team RPh)

**Authorized to**
- ED Registered Nurses (RNs)
- ED Registered Practical Nurses (RPNs) working within the ED RPN scope of practice
- AIR (Assertive Interprofessional Respiratory) Team Registered Nurse
- AIR Team Registered Respiratory Therapist (RRT)
- AIR Team Registered Pharmacist (RPh)

**Description of Procedure**
Medical interventions initiated by ED nurse, and AIR Team RN, AIR Team RRT, and AIR Team RPh for patients presenting to the ED with Cardio/Respiratory problems:
- Initiate cardiac monitoring
- Obtain baseline blood pressure, heart rate, respiratory rate, temperature and oxygen saturation by pulse oximetry [SpO2]
- Obtain 12 lead ECG [Emergency Physician (EP) must review]
- Obtain CARDIAC lab profile
- TOX lab profile should be added if the patient exhibits any of the following: unexplained confusion, bizarre behaviour, suspicion or history of any substance abuse
- Obtain relevant drug levels (e.g., digoxin, theophylline)
- Obtain peak flow if history of asthma and if patient able to tolerate
- Insert luer lock [saline lock] – insert 3 saline locks as per thrombolytic protocol as needed
- Commence 0.9% saline at 25mL/hour as per Adult Intravenous (I.V.) Cannulation, Saline Lock Insertion and I.V. Therapy Standard of Care
- Commence oxygen as per Oxygen Standard of Care
- Obtain urine for analysis using Clinitek urinalysis machine

**Clinical Conditions Required**
- Chest pain and/or shortness of breath which may, or may not, be associated with diaphoresis, dizziness, loss of consciousness or changes in level of consciousness
- Slow/rapid/irregular heart rate
- Syncopal episode
- Pitting oedema — extremities +/- shortness of breath
- Chest congestion +/- productive cough
- History/family history of cardiac and/or respiratory disease
- Electrical injury
- Allergic reaction
### Directive: Cardio/Respiratory Medical Interventions in the Emergency Department (ED) (continued)

| Situational Circumstances Required | Patient must be in the Emergency Department  
|                                  | Patient is assigned to a nurse/AIR Team clinician after the post Triage assessment is completed |
| Contraindications                | Patient refuses treatment (ED physician must be informed) |
| Education and Ongoing Competence Requirements for Authorized Individuals | Completion of ED orientation – cardio respiratory component  
|                                  | In-service specific to medical directive  
|                                  | Education plan for AIR Team pharmacist will include formal education on the IV Cannulation/Saline Lock Insertion Standard of Care (SOC), Venipuncture SOC, and Oxygen Therapy SOC by the ER Education Coordinator or Delegate. The AIR Team Pharmacist will have met the education and certification requirements specified in the above SOCs, will have an opportunity to practice the skills in a skills lab environment, and will be re-certified biannually to maintain competence. |
| Approved by                      | Director/Chief of Service  
|                                  | Authorizing Emergency Physicians  
|                                  | Chair, Medical Quality of Care Committee  
|                                  | Chair, Medical Advisory Committee |
# PRE-PRINTED ORDER SETS

## EMERGENCY DEPARTMENT
### ADULT ASTHMA ORDERS (16 Years Old or Greater)

|------------|------------|------------|------------|------------|------------|------------|------------|------------|

**PRE-PRINTED ORDERS**

- **Fax or Send Copy to Pharmacy**: INITIAL
- **Page 1/2**

**Transcribed By**: (sign, designation, date & time)

**Verified By**: (sign, designation, date & time)

### Initial Orders

<table>
<thead>
<tr>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>Auscultate chest and obtain baseline vitals (T/HR/RR/BP/SpO₂/pain scale)</td>
</tr>
<tr>
<td>✔️</td>
<td>HR, RR, SpO₂ at least q2h and prn. BP and temperature q4h.</td>
</tr>
<tr>
<td>✔️</td>
<td>Implement Oxygen Medical Directive (RT-03) <strong>OR</strong> Achieve minimum SpO₂ of 95% or greater (in pregnancy).</td>
</tr>
<tr>
<td>✔️</td>
<td>Baseline Peak Expiratory Flow Rate (PEFR).</td>
</tr>
<tr>
<td>✔️</td>
<td>If core temperature is greater than 38°C, administer Acetaminophen 650 mg PO q4h pm.</td>
</tr>
<tr>
<td>✔️</td>
<td>Salbutamol 5 mg and Ipratropium 0.5 mg by nebulizer mask q 20 minutes x 3. If total medication volume is less than 3mL, add 0.9% NaCl to achieve a total maximum liquid volume of 5 mL (administer with oxygen).</td>
</tr>
<tr>
<td>✔️</td>
<td>If patient is afebrile and an infection is not suspected, nebulized treatments may be administered via portable oxygen tank in communal area</td>
</tr>
<tr>
<td>✔️</td>
<td>Auscultate chest and obtain HR, RR, SpO₂ and PEFR after third nebulized treatment. Document findings.</td>
</tr>
<tr>
<td>✔️</td>
<td>Prednisone 50 mg PO x 1 NOW <strong>OR</strong> Methylprednisolone 80 mg IV x 1 NOW in 50mL of D5W or 0.9% NaCl if there is concern about the reliability of the oral route.</td>
</tr>
</tbody>
</table>

### In addition to systemic corticosteroids, consider inhaled corticosteroids

<table>
<thead>
<tr>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>Cardiac Monitoring</td>
</tr>
<tr>
<td>✔️</td>
<td>IV Saline Lock</td>
</tr>
<tr>
<td>✔️</td>
<td>Other:</td>
</tr>
<tr>
<td>✔️</td>
<td>Other:</td>
</tr>
</tbody>
</table>

**Date:** Time: Signature: Print Name

### Continuation / Reassessment Orders

<table>
<thead>
<tr>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>Salbutamol 5 mg in 2mL 0.9% NaCl by nebulizer mask q2h x__ doses (administer with oxygen), then reassess</td>
</tr>
<tr>
<td>✔️</td>
<td>Cardiac Monitoring</td>
</tr>
<tr>
<td>✔️</td>
<td>Chest X-ray <strong>PA and Lateral</strong> <strong>Portable</strong></td>
</tr>
<tr>
<td>✔️</td>
<td>ECG</td>
</tr>
<tr>
<td>✔️</td>
<td>Routine Blood Work</td>
</tr>
<tr>
<td>✔️</td>
<td>Blood Culture x__</td>
</tr>
<tr>
<td>✔️</td>
<td>Arterial Blood Gases</td>
</tr>
<tr>
<td>✔️</td>
<td>Venous Blood Gases</td>
</tr>
</tbody>
</table>

**Date** | **Time** | **Signature** | **Print Name**

© St. Joseph’s Health Centre, Toronto, ON
EMERGENCY DEPARTMENT
ADULT ASTHMA ORDERS (16 Years Old or Greater)

☑ FAX OR SEND COPY TO PHARMACY INITIAL______

TRANScribed by (sign, designation, date & time):

VERIFIED BY (sign, designation, date & time):

For Severe And Potentially Fatal Asthma

If documenting completion only on order sheet, include initials, designation and date/time

<table>
<thead>
<tr>
<th>IV at __________ mL/h</th>
<th>DONE</th>
<th>SMO</th>
<th>MAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methylprednisolone __________ mg IV (40-125 mg) x 1 NOW OR Hydrocortisone __________ mg (250-500 mg) IV x 1 NOW (in severe circumstances)</td>
<td></td>
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</tr>
<tr>
<td>Salbutamol 5 mg by nebulizer mask (back to back). If total medication volume is less than 3mL, add 0.9% NaCl to achieve a total maximum liquid volume of 5 mL (administer with oxygen).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ipratropium bromide 0.5 mg by nebulizer mask (back to back). If total medication volume is less than 3mL, add 0.9% NaCl to achieve a total maximum liquid volume of 5 mL (administer with oxygen).</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Magnesium Sulphate __________ g IV x 1 NOW (usually 2 g in 100 mL D5W over 20 minutes).</td>
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<td>Other:</td>
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<td>Other:</td>
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<td>Other:</td>
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<td>Other:</td>
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<td>Other:</td>
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<tr>
<td>Other:</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Date: Time: Signature: Print Name

Referral / Discharge / Miscellaneous Orders

Consult Medicine
Consult CDU
Discharge home and follow-up with own Family Physician
Follow-up appointment in Adult Asthma Clinic ☐ New Referral
Provide Asthma Discharge Plan
Inhaler instruction prior to discharge by ER RN, ER Pharmacist, or RT
Other:
Other:
Other:
Other:

DATE TIME SIGNATURE PRINT NAME

#875-SJNet-ED PPD JUNE 2009
Emergency Department
Adult Asthma (16 years and over) Patient Discharge Instructions

Discharge Peak Flow: ___________ L/min

Provide Patient With Prescription (As Required) And Complete Section Below:

1. **Reliever Medication:** ______________________
   - **Device/Spacer:** ______________________
   - Instructed/assessed device/spacer technique. Initials ___________

2. **Controller Medication:** ______________________
   - **Device/Spacer:** ______________________
   - Instructed/assessed device/spacer technique. Initials ___________

3. **Prednisone:** _______mg, once a day for _____ days
   - Take the pill in the morning, with food, until the prescription is finished. Initials ___________

4. **Additional Medication(s):**
   - Take: _________________________________________________________________________
   - Take: _________________________________________________________________________
   - Continue with the other medication you were taking at home unless advised otherwise.

If patient does not have a drug plan, refer to Social Work (if available) or the Trillium Program (applications available at the local pharmacy). Initials ___________

**MD/Nurse/RT/Pharmacist To Complete Section Below:**

**Patient Follow-up Instructions:**
- Call your: [ ] Family Doctor* ________________________ to book an appointment within 7 days or ASAP.
- Call your: [ ] Specialist ________________________ to book an appointment within 2 to 4 weeks.
- Call your: [ ] Your local Asthma Education Centre (416-530-6043)
- Call your: [ ] Asthma Society 1-866-787-4050
- Call your: [ ] Other ________________________ If you have any further questions about your asthma.

*If patient does not have a family physician, provide patient with “Family Physicians Accepting New Patients List”.

**Return to the Emergency Department immediately if any of the following occur:**
- Your symptoms worsen
- Your reliever is lasting 2 hours or less
- You are unable to talk in sentences without taking a breath
- You have blueness around your lips and nails
- You are unsure or frightened by your asthma

**DATE** | **TIME** | **SIGNATURE** | **PRINT NAME AND DESIGNATION**
---|---|---|---

**REMEMBER... Asthma can be LIFE THREATENING, especially IF NOT TREATED**

#2880-ED JUNE 2009 Original-Patient Chart Copy-To Patient Modified from OLA ED Asthma Pathway (Dec 2008)
Emergency Department
Adult Asthma (16 years and over) Patient Discharge Instructions

**QUICK FACTS ABOUT ASTHMA...**

**What is Asthma?**

- Asthma affects the airways (bronchi) in your lungs
- Three main things happen in your airways when you have asthma
  - The lining of your airways swell and make more mucous
  - The airways become sensitive or twitchy to triggers
  - The muscles that wrap around your airways tighten
- These changes make your airways narrow and cause the symptoms of asthma
- Symptoms of asthma can include:
  - Wheezing
  - Chest tightness
  - Shortness of breath
  - Coughing
- You may have one or a combination of any of these symptoms

**Asthma Triggers:**

Examples of asthma triggers include: smoking, lung infections/colds, allergies (such as animals, dust mites, pollens and moulds), strong odours, air pollution, exercise, high humidity, stress and cold air.

- Not everyone with asthma has the same triggers
- It is important to know what triggers your asthma
- Avoiding things that trigger your asthma can reduce the amount of medication needed to control your asthma and can reduce your asthma symptoms.

**Asthma Medications:**

There are three major categories of medications used to treat asthma:

1. **Relievers**
   - Relax the muscles that tighten around the airways
   - Used to treat asthma symptoms; provide relief within minutes
   - Are taken on an as needed basis when you are well

2. **Controllers**
   - Used to treat airway inflammation (swelling) and mucous
   - Control asthma symptoms and prevent asthma from flaring
   - Need to be taken regularly even when you start to feel well

3. **Prednisone** (white pill)
   - Used to treat severe airway inflammation (swelling) and mucous

**Your Asthma Is In Control If:**

- You have symptoms (cough, wheeze, chest tightness or shortness of breath) less than 4 days per week
- You use your reliever medication less than 4 times per week (not including prior to exercise)
- You are not waking at night or early in the morning with symptoms

Provide patient with SJHC or Lung Association booklet on asthma

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>SIGNATURE</th>
<th>PRINT NAME AND DESIGNATION</th>
</tr>
</thead>
</table>

**REMEMBER...** Asthma can be **LIFE THREATENING**, especially **IF NOT TREATED**

**IF YOU HAVE QUESTIONS ABOUT ASTHMA CALL:**

The Lung Association - Asthma Action Helpline
1-800-668-7682 (toll-free) or visit online: [http://www.on.lung.ca](http://www.on.lung.ca)
### INITIAL ORDERS

<table>
<thead>
<tr>
<th>Description</th>
<th>DONE</th>
<th>SMO</th>
<th>MAR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medication Orders (Excluding Antibiotics)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auscultate chest and obtain complete vital signs (T/HR/RR/BP/SpO2/sat/pain scale)</td>
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<tr>
<td>O2 to keep SpO2 between ______% and ______%</td>
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</tr>
<tr>
<td>Salbutamol 4 puffs and Ipratropium bromide 4 puffs by MDI with spacer device q 20 minutes x 3. OR Salbutamol 5 mg and Ipratropium bromide 0.5 mg by nebulizer mask q 20 minutes x 3. If total medication volume is less than 3mL, add 0.9% NaCl to achieve a total maximum liquid volume of 5 mL. Administer with compressed air and continue to administer O2 as required to maintain SpO2 specified above.</td>
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<tr>
<td>Salbutamol 5 mg by nebulizer mask q1h x _____ doses (administer as above).</td>
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</tr>
<tr>
<td>Ipratropium bromide _____ mg (0.25 – 0.5 mg) by nebulizer mask q6h x ______ doses (administer as above).</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>PrednisONE 50 mg PO x 1 NOW OR Methylprednisolone 80 mg IV x 1 NOW in 50mL of DSW or 0.9% NaCl if there is concern about the reliability of the oral route.</td>
<td></td>
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<tr>
<td>Salbutamol 2 puffs by MDI with spacer device q2h x 2, then q4h x 2.</td>
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<tr>
<td>If core temperature is greater than 38ºC, administer Acetaminophen 650 mg PO q4h pm.</td>
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</table>

### Iv Orders

<table>
<thead>
<tr>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>IV saline lock</td>
<td></td>
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<tr>
<td>IV ____________________ at ________ mL/h</td>
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<tr>
<td>Others:</td>
<td></td>
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<tr>
<td>Others:</td>
<td></td>
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</tr>
</tbody>
</table>

#2881-SJ Net ED COPD July 2009
Antibiotic Orders

If documenting completion only on order sheet, include initials, designation and date/time

<table>
<thead>
<tr>
<th>Antibiotic Orders for Purulent Acute Exacerbations of COPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choose a class of antibiotic that the patient has not been exposed to within the past 3 months.</td>
</tr>
<tr>
<td>CefTRIAXone 1 g IV q24h OR</td>
</tr>
<tr>
<td>Azithromycin 500 mg IV q 24h OR</td>
</tr>
<tr>
<td>Azithromycin 500 mg PO on Day 1 THEN 250 mg PO q24h x 4 days OR</td>
</tr>
<tr>
<td>Moxifloxacin 400 mg IV q24h OR</td>
</tr>
<tr>
<td>Moxifloxacin 400 mg PO q24h OR</td>
</tr>
<tr>
<td>Amoxicillin 500 mg/Clavulanate 125 mg (Clavulin®) 1 tablet PO q8h</td>
</tr>
<tr>
<td>Other:</td>
</tr>
</tbody>
</table>

Laboratory And Diagnostics

- Cardiac Monitoring
- Chest X-ray  □ PA and Lateral  □ Portable
- ECG
- Routine Blood Work
- Blood Culture x
- Blood Gases  □ Arterial  □ Venous
- Sputum C&S (If temperature rises to greater than 38°C, patient has been on antibiotics in the preceding 3 months or has had more than 3 exacerbations within the past year or recent hospitalization or has been on steroids).
- Peak Expiratory Flow Rate (PEFR)

Referral / Discharge Orders

- Consult  □ Medicine  □ CDU
- Discharge home
- Outpatient Referral to Chest Clinic
- Referral to Dr.  □ private office
- Referral to Smoking Cessation Program (i.e. SJ HC Quit for Life)
- Inhaler instruction prior to discharge by ED RN, ED Pharmacist or RT
- Assess patient for influenza vaccination status. If patient has not received annual vaccination, inform patient that vaccination is strongly recommended to prevent acute exacerbation of COPD.

Discharge home with 5-10 day prescription for steroids. Consider antibiotics for discharge if patient has 2 or more of the following: purulent sputum, elevated WBC, or fever greater than 38°C. Choose a class of antibiotic that the patient has not been exposed to within the past 3 months.

DATE  TIME  SIGNATURE  PRINT NAME

#2881-5 J Ne ED PPO COPD JULY 2009
### Initial Orders

<table>
<thead>
<tr>
<th>Action</th>
<th>Initials</th>
<th>Designation</th>
<th>Date/Time</th>
<th>Done</th>
<th>SMO</th>
<th>MAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain patient weight _______ kg</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Ausculate chest and obtain complete vital signs (T/P/R/BP/SpO2/pain scale)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Initiate Medical Directive for the Administration of Antipyretic Medication for Paediatric Patients in the Emergency Department (ER 10) as appropriate</td>
<td></td>
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<tr>
<td>Oxygen to keep SpO2 greater than 92%. Notify MRP if child requires increasing O₂ to maintain SpO2 greater than 92%.</td>
<td></td>
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</tr>
<tr>
<td>Patients less than 16 kg: Salbutamol 2.5 mg and Ipratropium 0.5 mg in 2mL 0.9% NaCl by nebulizer mask q 20 minutes x 3 (administer with oxygen)</td>
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<tr>
<td>Patients 16kg or greater: Salbutamol 5 mg and Ipratropium 0.5 mg in 2mL 0.9% NaCl by nebulizer mask q 20 minutes x 3 (administer with oxygen)</td>
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</tr>
<tr>
<td>If patient is afebrile and an infection is not suspected, nebulized treatments may be administered via portable oxygen tank in communal area</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Auscultate chest, obtain respiratory rate and SpO₂ after third nebulized treatment (if applicable)</td>
<td></td>
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<tr>
<td>PrednisoLONE ________ mg PO (1-2 mg/kg; max dose/24 hours is 60 mg)</td>
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<tr>
<td>PrednisONE ________ mg PO (1-2 mg/kg; max dose/24 hours is 60 mg)</td>
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<tr>
<td>Dexamethasone ________ mg PO (0.3 mg/kg/24 hours; max of 20 mg/dose)</td>
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<tr>
<td>IV Saline Lock</td>
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<tr>
<td>Methylprednisolone ________ mg IV q6h (2-4mg/kg/24 hours; max 1g/dose)</td>
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<tr>
<td>Hydrocortisone ________ mg IV q_____ h (4-6 mg/kg/dose, q 4-6 h)</td>
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</tr>
</tbody>
</table>

**DATE** | **TIME** | **SIGNATURE** | **PRINT NAME**
## EMERGENCY DEPARTMENT

### PAEDIATRIC ASTHMA ORDERS  PAGE 2 of 2

**FAX OR SEND COPY TO PHARMACY**  INITIAL______

<table>
<thead>
<tr>
<th>TRANScribed BY (sign, designation, date &amp; time):</th>
<th>VERIFIED BY (sign, designation, date &amp; time):</th>
</tr>
</thead>
</table>

### CONTINUATION / REASSESSMENT ORDERS

<table>
<thead>
<tr>
<th></th>
<th>DONE</th>
<th>SMO</th>
<th>MAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeat Prednisolone __________ mg PO</td>
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<td></td>
</tr>
<tr>
<td>Repeat Prednisone __________ mg PO</td>
<td></td>
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</tr>
<tr>
<td>Salbutamol __________ mg in 2mL 0.9% NaCl by nebulizer mask q___h x ___ doses, then reassess (administer with oxygen)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salbutamol __________ mg in 2 mL 0.9% NaCl by nebulizer mask q___h prn (administer with oxygen)</td>
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<td></td>
</tr>
<tr>
<td>Chest X-ray</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Routine Blood Work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Culture x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasopharyngeal viral swab for virus culture, influenza A&amp;B, Parainfluenza 1,2,3, RSV</td>
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<tr>
<td>Venous Blood Gases</td>
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<tr>
<td>Other:</td>
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<tr>
<td>Other:</td>
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<td>Other:</td>
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<tr>
<td>Other:</td>
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<th>DATE</th>
<th>TIME</th>
<th>SIGNATURE</th>
<th>PRINT NAME</th>
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</thead>
</table>

### REFERRAL / DISCHARGE ORDERS

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Page paediatrics on-call to Dr.______________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to CDU</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Discharge home and follow-up with own Family Physician/Paediatrician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up appointment in Paediatric Asthma Clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up in Just for Kids Clinic</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>MDI instruction prior to discharge by ER RN, ER Pharmacist or RT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dexamethasone __________ mg PO to ER MD to provide as take home dose (0.3 mg/kg/24 hours; max of 20 mg/dose)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other:</td>
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<tr>
<td>Other:</td>
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<td>Other:</td>
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<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>SIGNATURE</th>
<th>PRINT NAME</th>
</tr>
</thead>
</table>
EMERGENCY DEPARTMENT  
PAEDIATRIC CROUP ORDERS  

□ FAX OR SEND COPY TO PHARMACY  INITIAL____

TRANSCRIBED BY (sign, designation, date & time):
VERIFIED BY (sign, designation, date & time):

Initial Orders
If documenting completion only on order sheet, include initials, designation and date/time

DONE  SMO  MAR

☑ Obtain patient weight ________ kg
☑ Auscultate chest and obtain complete vital signs (HR, RR, BP, SpO2, sat, pain scale)
☑ Initiate Medical Directive for the Administration of Antipyretic Medication for Paediatric Patients in the Emergency Department (ER 10) as appropriate
☑ Oxygen to keep SpO2 greater than 92%. Notify MRP if child requires increasing O2 to maintain SpO2 greater than 92%

☐ Administer cool humidified air. Apply a large volume nebulizer to a 1000 mL bottle of sterile water for inhalation. Turn dial on regulator counter-clockwise until resistance met. Attach blue corrugated tubing and administer with compressed air via mask or blow-by

☐ EPinephrine 1:1000 (1mg/mL) ________ mg by nebulizer mask (0.5mg/kg if less than 10 kg). For doses under 3 mg, add 2 mL of 0.9% NaCl in nebulizer and administer with oxygen.

OR

☐ EPinephrine 1:1000 (1mg/mL) 5mg by nebulizer mask (if greater than 10 kg). Administer with oxygen.

☑ Monitor SpO2 and heart rate during EPinephrine administration. If heart rate is greater than or equal to 200, stop treatment and notify MD.

☑ Auscultate chest, obtain SpO2 and respiratory rate after nebulized treatment (if applicable)

☐ Dexamethasone _________mg PO (1 mg/kg/24 hours; max of 20 mg/dose). Mix IV formulation of Dexamethasone with a maximum of 5 mL fruit juice and administer orally.

☐ Dexamethasone _________mg IV (0.6 mg/kg/24 hours; max of 20 mg/dose)

☐ IV Saline Lock

☐ Other:

☐ Other:

☐ Other:

☐ Other:

☐ Other:

☐ Other:

DATE  TIME  SIGNATURE  PRINT NAME

#2883 SJ Net-ED-POO--JULY-2009
Continuation / Reassessment Orders
If documenting completion only on order sheet, include initials, designation and date/time

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
<th>Done</th>
<th>SMO</th>
<th>MAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Epinephrine 1:1000 (1mg/mL) ______mg q1h prn to a max of _____ doses by nebulizer mask (0.5mg/kg if less than 10 kg). For doses under 3 mg, add 2 mL of 0.9% NaCl in nebulizer and administer with oxygen. OR Epinephrine 1:1000 (1mg/mL) 5mg q1h prn to a max of _____ doses by nebulizer mask (if greater than 10 kg). Administer with oxygen.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Chest X-ray</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Routine Blood Work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Blood Culture x __________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Nasopharyngeal viral swab for virus culture, influenza A&amp;B, Parainfluenza 1,2,3, RSV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Venous Blood Gases</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Page paediatrics on-call to Dr. ____________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Referral to CDU</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Other:</td>
<td></td>
<td></td>
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</tbody>
</table>

Other:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Signature</th>
<th>Print Name</th>
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</thead>
</table>

Discharge Orders / Other

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Referral to CDU</td>
</tr>
<tr>
<td>2</td>
<td>Discharge home with discharge instruction sheet and follow-up with own Family Physician/Paediatrician</td>
</tr>
</tbody>
</table>

Other:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Signature</th>
<th>Print Name</th>
</tr>
</thead>
</table>
TEAM VISION WORKSHEETS

**Step #1: Creating a Vision–Pair Interviews**

**PAIR INTERVIEWS**

- Find a partner to work with
- Choose an ‘A’ and a ‘B’
  - ‘A’ will be the interviewer. He/she will ask the questions in the interview guide
  - ‘B’ will be the interviewee. Answer in full detail

** After 10 minutes, change roles and repeat

**INTERVIEW GUIDELINES**

- Read the “Interview Guide” exactly as it is written
- Expand on each question–get curious
- Ask your partner additional questions if you wish

** Watch the time (take the full 10 minutes)
Interview Guide

Question 1: Tell me about your beginnings in healthcare. What first attracted you to this work? What initial experiences reinforced your commitment to this field?

Answer:

Question 2: We’ve all had our ups and downs in our work in healthcare, but there are moments when we feel alive, vibrant and inspired by our work. Think about a positive moment on a team you were on. Tell the story. Describe it in detail. What was happening? What made this a highlight for you?

Answer:

Question 3: When your healthcare team was functioning and collaborating at a high level, what ways of working together (supports, process, structures, etc.) supported the team to function at its best? What made it possible?

Answer:

Question 4: When you think about the future, imagine you had 3 wishes that would make a difference for our patients/clients and ourselves as healthcare providers. What would you wish for and why?

Answer:
## Interview Debriefing

Sit with your partner in a table group. Share one or two compelling stories that came out of your interview.

What do these stories teach us about our team’s current strengths?

**Answer:**

---

What hopes and wishes do you have for the team in the future?

**Answer:**

---

Choose your top 3 themes for each question. Be prepared to share your thoughts.

**Answer:**

---
Imagining Success

Imagine it is one year from now and you have achieved all the results you wanted and more on your team. You are feeling extremely proud of your accomplishments. The impact you are having on patients and the work environment have exceeded anything you could have hoped for.

Write a short article that covers:

- Your accomplishments over the past year that have made the most difference.
- How are patients and families describing the care they are receiving?
- How are staff describing what it’s like to work here today?
- What new relationships, practices, processes or interactions are happening now that are making the most difference for you and your patients/clients?

(be creative and just begin writing–try not to edit–go with your gut!)

Article:
**Imagining Success Debriefing**

Go around the table and read your Imagining Success Articles

- Listen carefully to the responses and take note of what interests or inspires you most—jot down words or phrases that resonate with you.
- Ask everyone to share what they jotted down—listen for what you all agree on or have energy for.
- Create a summary of what your team would like to create and achieve in the future.

Be bold and create statements that would really inspire you and your peers and colleagues:

- Create up to 3 bold statements *(e.g., We will be THE centre of excellence for…)*.
- Create a creative illustration of the sentiment you want to express.
- Present your bold statements.

**Bold statements:**
Team Vision

Record your team vision here.

Team vision:
## Intervention Response Time Data Collection Tool

**J number:** J

**Date:** 

**Patient Arrival Date:** 

**Patient Arrival Time:** 

**Number of hours of AIR team intervention:** 

**Patient Status at 0730:** O ER ○ Admitted ○ CDU  

**Time of Initial Assessment:** 

**If admitted during shift, what time was the patient admitted?** 

### Treatments via Inhalation

<table>
<thead>
<tr>
<th>Time ordered</th>
<th>Time first treatment administered</th>
<th>Time second treatment administered</th>
<th>Time third treatment administered</th>
</tr>
</thead>
</table>

### Chest X-Ray

**Time order written or medical directive initiated:** 

### Best Possible Medication History

**Time Completed:** 

### PRN Medication

- **Antipyretic**  
  - Time ordered:   
  - Time first dose administered:   
  - Total number of doses during shift: 

- **Analgesic**  
  - Time ordered:   
  - Time first dose administered:   
  - Total number of doses during shift: 

- **Antiemetic**  
  - Time ordered:   
  - Time first dose administered:   
  - Total number of doses during shift: 

- **Anxiolytic**  
  - Time ordered:   
  - Time first dose administered:   
  - Total number of doses during shift: 

### Arterial Blood Gases

**Time ordered:** 

**Time completed:** 

### Intravenous or PO Steroids

**Time ordered:** 

**Time administered:** 

### Antibiotics

**Time ordered:** 

**Time administered:** 

### Bronchodilator

**Time ordered:** 

**Time first dose administered:** 

**Total number of doses during shift:** 

### Antiemetic

**Time ordered:** 

**Time first dose administered:** 

**Total number of doses during shift:** 

### Anxiolytic

**Time ordered:** 

**Time first dose administered:** 

**Total number of doses during shift:**
## PERCEIVED KNOWLEDGE OF RESPIRATORY CARE SURVEY

**Instructions:**
This survey consists of 15 statements that are aimed at having you reflect on your knowledge base regarding the care of respiratory patients. Your responses will help us better understand how clinicians perceive their own knowledge as it pertains to caring for patients with respiratory illness.

Based upon your professional background and lived experiences, how would you rate your knowledge in relation to the standards of your professional discipline*?

Please circle your response.

*Refer to next side for definitions of the terms used in this Survey

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am knowledgeable about the risk factors that contribute to respiratory illness.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. I am knowledgeable about the triggers that contribute to asthma/COPD exacerbations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I am knowledgeable about best practices related to providing care for patients with respiratory illness.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I am knowledgeable about Ministry of Health initiatives aimed at optimizing care for respiratory patients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I am knowledgeable in recognizing the presence of physical signs and symptoms of respiratory distress.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I am knowledgeable in interpreting diagnostic results related to respiratory illness (e.g., laboratory, arterial blood gases, and chest x-ray results).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I am knowledgeable about the anatomical and physiological differences between adult and paediatric respiratory systems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I am knowledgeable about the differences in pharmacological interventions between adult and paediatric patients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I am knowledgeable about various medication delivery devices available to respiratory patients (how to use them and how to educate others on their use).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I am knowledgeable about the use of steroids to treat acute and chronic respiratory conditions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. I am knowledgeable about the various antibiotics used in the treatment of respiratory infections.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. I am knowledgeable about the use of oxygen in the treatment of respiratory illness (e.g., titration and oxygen delivery devices).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. I am knowledgeable in effective strategies to relay information to patients about their treatment plan.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. I am knowledgeable in assessment of patient comprehension of their treatment plan.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. I am knowledgeable about community resources available to provide follow-up care to patients with respiratory illness following discharge.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Definitions:
The definitions provided below will assist you in responding to the statements in the Perceived Knowledge of Respiratory Care Survey.

Novice (1)
- No experience or limited experience in the specific clinical situation that is being encountered
- Rules/concrete steps are required in order to perform
- Limited experience in a particular context results in rules being applied universally

Advanced Beginner (2)
- Previous experience in the clinical situation allows limited, but acceptable skill level
- Beginning to connect foundational knowledge with identification of patient clinical needs
- Principles that guide actions begin to be formulated and are based on experience

Competent (3)
- Have experience with the same or similar situations for 2 to 3 years
- Do not have the speed and flexibility of a proficient clinician but have a feeling of mastery and an ability to cope and manage various clinical situations

Proficient (4)
- Able to see the entire clinical picture
- Draw on previous experience and knowledge to determine if the patient is following an expected clinical course and can pick up on nuances in terms of changes in the patient’s clinical status

Expert (5)
- Extensive clinical experience
- Do not rely only on an organized systematic analysis of a clinical situation but incorporate an intuitive ability to identify a problem
- Performance is fluid, flexible, and highly proficient
- Still may rely on analytic problem solving in a situation that has not been previously encountered or when the clinical course is not what was expected

A Metered-Dose Inhaler, called an MDI for short, is a pressurized inhaler that delivers medication by using a propellant spray.

1. Shake the inhaler well before use (3 or 4 shakes).
2. Remove the cap.
3. Breathe out, away from the inhaler.
4. Bring the inhaler to your mouth. Place it in your mouth between your teeth and close your mouth around it.
5. Start to breathe in slowly and press the top of the inhaler once and keep breathing in slowly until a full breath has been taken.
6. Remove the inhaler from your mouth, and hold your breath for about 10 seconds, then breathe out.
7. If you need a second puff, wait 30 seconds, shake your inhaler again, and repeat steps 3 to 6.

Respiratory medications are separated into two classes: controllers and relievers.

<table>
<thead>
<tr>
<th>Mechanism of action</th>
<th>Controllers</th>
<th>Relievers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease inflammation</td>
<td>Should be taken daily even if without symptoms</td>
<td>Immediate bronchodilator relief Not to be used as monotherapy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Examples</th>
<th>Controllers</th>
<th>Relievers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budesonide (Pulmicort), Fluticasone (Flovent), Beclometasone (Ovar), Ciclesonide (Alvesco)</td>
<td>Salbutamol (Ventolin), Fomoterol (Budrow), Terbutaline (Bricanyl), Ipratropium bromide (Atrovent), Tiotropium bromide (Spiriva)</td>
<td></td>
</tr>
</tbody>
</table>

Combination medications:
- Symbicort contains budesonide and fomoterol
- Advair contains fluticasone and salmeterol
If the window indicator turns red, there are approximately 20 doses left. If you drop your turbuhaler or breathe into it after its dose has been loaded, you may cause the dose to be lost. If either of these things happens, reload the device before using it.

**How to Use a Turbuhaler**

A Turbuhaler is a dry-powder inhaler that features either a dose counter or a window indicator.

1. Unscrew and take off the cap. Hold the inhaler upright.
2. Slide the lever away from you as far as it will go to get the medication ready.
3. Breathe out away from the device.
4. Place the mouthpiece gently in your mouth and close your lips around it. Breathe in forcefully and deeply through your mouth.
5. Remove the turbuhaler from your mouth and hold your breath for about ten seconds, then breathe out.

If you drop your discus or breathe into it after its dose has been loaded, the dose may be lost. If either of these things happens, reload the device before using it.

**How to Use a Diskus**

A Diskus is a dry-powder inhaler that features a built-in counter, so that you always know how many doses you have left in it.

1. To open, place your thumb on the thumb grip and push until it "clicks" into place.
2. Slide the lever away from you as far as it will go to get the medication ready.
3. Breathe out away from the device.
4. Place the mouthpiece gently in your mouth and close your lips around it. Breathe in deeply until you have taken a full breath.
5. Remove the diskus from your mouth and hold your breath for about ten seconds, then breathe out.

1. Open the dust cap of the HandiHaler by pressing the green piercing button. Pull the dust cap upwards and then the mouthpiece. Carefully peel back the aluminum foil of the blister card until the capsule is fully visible.
2. Insert the capsule in the center chamber. It does not matter which end of the capsule is placed. Close the mouthpiece firmly until you hear a click. Press the green piercing button. This makes holes in the capsule and allows the medicine to be released. Breathe out completely. Raise the HandiHaler device to your mouth and close your lips tightly around the mouthpiece.
3. Breathe in slowly and deeply. You should hear or feel the capsule vibrate. Hold your breath as long as is comfortable while removing the HandiHaler from your mouth.
4. After you have finished, open the mouthpiece and tip out the used capsule and discard. Close the mouthpiece and dust cap.

If the window indicator turns red, there are approximately 20 doses left. If you drop your turbuhaler or breathe into it after its dose has been loaded, you may cause the dose to be lost. If either of these things happens, reload the device before using it.

Capsules should always be stored in the sealed blisters and only removed immediately before use because they are light sensitive. Do not store capsules in the device.
How to Use a Peak Flow Meter

A Peak Flow Meter measures how fast people can blow air out of their lungs. It is a useful tool to measure airway obstruction. Measuring peak flow regularly can help recognize changes in airflow, and can help catch exacerbations before they get out of control.

1. Move indicator to the base (to zero).
2. Stand or sit up tall.
3. Take a deep breath.
4. Put mouthpiece in your mouth.
5. Blow as hard and quickly as possible into the mouthpiece.
6. Repeat 2 more times.
7. Record the highest of your three readings.

References:
# INTERPROFESSIONAL COLLABORATIVE PRACTICE SURVEY

**Instructions:**
This survey consists of 18 statements that are aimed at having you reflect on your experience with interprofessional collaboration. The results of this survey will help us better understand how clinicians experience interprofessional collaboration in their practice environment.

For the purpose of this survey, please reflect on your experiences within the last month. If a strong example comes to mind when you answer the questions, please reference the question number and provide the example in the comments section, being sure not to include information that can be traced back to yourself or a particular team member. Please circle your response.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Almost always</th>
<th>Most of the time</th>
<th>Less than ½ the time</th>
<th>Almost never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  My colleagues from other disciplines treat me with respect.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2  I work with my team to make decisions based on consensus.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3  I accept ownership for resolving conflict with team members.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4  When I have a disagreement with a colleague, I ask questions in order to understand his/her perspective.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5  I take time to explain my role to colleagues.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6  Leadership is shared in team meetings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7  When two team members can both perform a task, we make a decision about it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8  I am consistent in sharing client information.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9  I willingly engage in shared decision-making.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10 The team talks together about our professional similarities and differences.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11 I trust decisions made by the interprofessional team.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12 Administrative duties that support the team, such as minute taking, are shared.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13 I acknowledge my team members’ qualities and skills regularly.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14 I involve patients in their treatment plans.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15 When deciding on treatment plans, I consult with colleagues from other disciplines.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16 I am comfortable receiving feedback from team members.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17 The team includes everyone who supports patient care in my area including clinicians, team members who provide administrative support, housekeeping and portering.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18 I feel included in my healthcare team.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**Comments:**
PART 3

Evaluation

In this Part:

Evaluation Overview
Findings
PART 3
EVALUATION OVERVIEW & FINDINGS

Overview

This Chapter presents various data collection tools that were developed, modified or implemented for the purpose of evaluating the effectiveness of the AIR Team model. At the time of Toolkit publication, the project team was able to provide a select number of preliminary results. A comprehensive Report on AIR Team Outcomes is expected to be available fall 2009.

The evaluation process for the AIR Team was multi-faceted and included assessment of the team’s impact on:
- Response time for key clinical interventions
- Patient experience of care
- Perception of knowledge related to respiratory care for the AIR Team clinicians
- Perception of knowledge related to respiratory care for the emergency department registered nurses
- Interprofessional collaborative core competencies for the AIR Team clinicians

Electronically captured results that are presented in this Chapter were obtained through data extractions from the Emergency Department Information System (EDIS), a tracking system that is utilized in a number of emergency departments.

Data collection for purposes of this Evaluation took place during the AIR Team Implementation Phase from March 9, 2009 to July 3, 2009 following approval from the Health Centre’s Research Ethics Board. During this time, the AIR Team was the primary care team for a total of 290 patients, with a mean age of 70.9 years (baseline=71.5). Throughout the Evaluation this group is also referred to as the AIR Team patients.

For comparison purposes, the baseline group includes patients who presented to the emergency department with a respiratory complaint and who were triaged to the Acute or Urgent Area one year earlier between March 9, 2008 and July 3, 2008 (n=698). Throughout the Evaluation this baseline group is also referred to as patients receiving standard care.
The admission rate for AIR Team patients was 76.9% compared to 68.5% for the baseline group which shows an increase of almost 10% in patients presenting with respiratory complaints from 2008 to 2009. The increase in AIR Team patients may be due to an improved recognition of patients requiring admission by the AIR Team. The high admission rate for both the AIR Team and baseline groups can be attributed to a triage process, where patients who are less ill and who are likely to be discharged home are triaged directly to the Ambulatory Area of the emergency department.

The high admission rate limited the opportunities for the AIR Team to have a significant impact on the number of referrals for outpatient follow-up care. Of the patients who were discharged home, 26.9% received an appointment or referral for outpatient follow-up. AIR Team interviews revealed that patients who did not receive formal follow-up referrals already had a scheduled appointment with their family physician, specialist, or outpatient clinic prior to their emergency department visit. Referrals to the Chest Clinic specifically increased from 1.8% in the baseline group to 11.9% in the AIR Team group of the patients who were discharged home from the emergency department.

A preliminary analysis of length of stay (LOS) data revealed that AIR Team patients had a shorter LOS in both the admitted and non-admitted groups. AIR Team patients who were admitted to the Health Centre had a LOS that was 226 minutes shorter on average than the baseline group. This result was statistically significant (n=221; p=0.001). The reduction in LOS for admitted patients ranged from 93 minutes to 360 minutes when compared to the baseline group. Additionally, the LOS for non-admitted AIR Team patients was 11 minutes shorter on average than the baseline group.

The AIR Team also manually recorded consultations provided during the intervention period. A total of 54 patient consults were provided, primarily in the Ambulatory and Paediatric Areas of the emergency department. Anecdotal data suggests that the actual number of consults exceeded this statistic.

AIR Team consults were requested for the following reasons:

- Patient Assessment
- Pharmacological Treatment Recommendation
- Patient Education
- Oxygen Titration
- Best Possible Medication History/Medication Reconciliation
- Outpatient Clinic Referral
- Medication Administration
- Arterial Blood Gas Procurement
- Airway Insertion and Suctioning
Evaluation Tools and Preliminary Results

Intervention Response Time Data Collection Tool

One approach to evaluating both quality of care for the patient and system-level outcomes regarding wait times, was to assess the response times for various clinical interventions. In order to facilitate the data collection process, a data collection tool was created by the Evaluation Working Group. The AIR Team clinicians utilized the Intervention Response Time Data Collection Tool (refer to Resource 6) during their regular hours of operation for new patients that were triaged to them (n=70). The tool was not completed for patients that arrived outside of the AIR Team’s regular hours, as the interventions captured by the tool were primarily relevant for patients who were still in the early phase of their emergency department stay. The tool captured the time the intervention was ordered and the time the treatment was initiated as well as the particular treatment or diagnostic test that was ordered. An analysis of the AIR Team’s impact on wait times for key clinical interventions will be available in the Report on AIR Team Outcomes.

Patient Experience of Care Surveys

Administering Patient Experience of Care surveys are an effective method of measuring various dimensions of the patient experience from the moment a patient enters the emergency department until the patient leaves. Analyzing the responses to these surveys can help the organization identify opportunities for practice improvement and assess whether the current status of health services are meeting patient needs or expectations. Feedback can be solicited from patients in a variety of ways: phone surveys, written surveys, or personal interviews. Written surveys are most commonly utilized, as they tend to be more cost-effective and are relatively easy to implement. Other advantages to written surveys include:

- they allow patients to take their time and think about responses,
- they allow patients to be more candid due to anonymity,
- they improve standardization of information.

While the option exists for an organization to develop its own unique survey tool, utilizing a tool that has been validated provides greater reliability of results.

Patient Experience of Care data specific to St. Joseph’s Health Centre’s Emergency Department has been collected since October 2002 using the National Research Corporation (NRC) Picker Survey. In order to compare the AIR Team patient experience to patients who received standard emergency department care, the project team opted to utilize the NRC Picker Survey. The survey would also provide the historical data set for comparison to the AIR Team data. Some modifications to the survey were necessary in order to ensure the questions were relevant to the AIR Team patient population. For example, the standard NRC Picker Survey poses a series of nurse-specific questions to the patient, as it is assumed that it is a nurse who will be providing the majority of direct patient care. For the AIR Team patients that were surveyed, the language was modified to reflect care received from your care team, as opposed to your nurse.
Patients who received care from the team were asked to participate in the survey. Surveys were provided with an envelope, and sealed envelopes were placed in a locked collection box. Patients were asked to complete the survey prior to being discharged from the emergency department (either to their home or an inpatient unit). It is important to note that patients would not receive further care within the emergency department at the time that the survey was provided to them.

Survey results for the AIR Team were compared to the NRC Picker historical data set collected a year earlier from April to June 2008. The surveys for the baseline group were randomly mailed to patients who had recently used the health service. The results provided in the following table are presented as positive scores, as defined by NRC Picker.

Table 3: Patient Experience of Care Survey Findings

<table>
<thead>
<tr>
<th>Questions asked</th>
<th>AIR Team (%)</th>
<th>Pre-Surveys (%)</th>
<th>Difference (%)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Arrival at the Emergency Department</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you had to wait to be seen, did someone from the Emergency Department</td>
<td>71.4</td>
<td>21.4</td>
<td>↑50</td>
<td>0.011</td>
</tr>
<tr>
<td>explain the reason for the delay?</td>
<td>n=7</td>
<td>n=28</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Your Care Team</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When you had important questions to ask a member of the team, did you get</td>
<td>88.5</td>
<td>56.5</td>
<td>↑32</td>
<td>0.004</td>
</tr>
<tr>
<td>answers you could understand?</td>
<td>n=26</td>
<td>n=62</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you had anxieties or fears about your condition or treatment, did a member</td>
<td>85</td>
<td>33.3</td>
<td>↑51.7</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>of the team discuss them with you?</td>
<td>n=20</td>
<td>n=51</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you have confidence and trust in the team treating you?</td>
<td>92.3</td>
<td>66.7</td>
<td>↑25.6</td>
<td>0.011</td>
</tr>
<tr>
<td></td>
<td>n=26</td>
<td>n=72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the team members talk in front of you as if you weren’t there?</td>
<td>80</td>
<td>78.6</td>
<td>↑1.4</td>
<td>0.880</td>
</tr>
<tr>
<td></td>
<td>n=25</td>
<td>n=70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How would you rate the courtesy of your care team?</td>
<td>100</td>
<td>89.7</td>
<td>↑10.3</td>
<td>0.089</td>
</tr>
<tr>
<td></td>
<td>n=26</td>
<td>n=68</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How would you rate the availability of your care team?</td>
<td>92</td>
<td>61.8</td>
<td>↑30.2</td>
<td>0.008</td>
</tr>
<tr>
<td></td>
<td>n=25</td>
<td>n=34</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Getting Tests</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you got any tests (e.g., blood, urine, X-rays), did someone explain why</td>
<td>84.6</td>
<td>48.1</td>
<td>↑36.5</td>
<td>0.005</td>
</tr>
<tr>
<td>you needed these tests in a way that you could understand?</td>
<td>n=26</td>
<td>n=27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did someone explain the results of these tests in a way you could understand?</td>
<td>80</td>
<td>55.6</td>
<td>↑24.4</td>
<td>0.060</td>
</tr>
<tr>
<td></td>
<td>n=25</td>
<td>n=27</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pain</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you were in pain, did you think that the Emergency Department staff did</td>
<td>80</td>
<td>41.7</td>
<td>↑38.3</td>
<td>0.019</td>
</tr>
<tr>
<td>everything they could to help you control your pain?</td>
<td>n=15</td>
<td>n=24</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Overall, AIR Team patients rated their experience of care for every question in the survey higher than patients receiving standard care. In response to the question regarding an overall rating of care for their emergency department visit, patient scores increased from 80.4% to 91.3% with the AIR Team.

Opportunities for continued improvement for both AIR Team and standard care patients were identified in the data, specifically regarding information provided to patients on discharge for follow-up care/treatment:

- Information on danger signals for a patient to watch for regarding his/her illness (AIR Team = 57.1% compared to 35.3% for patients receiving standard care)
- Information on who to call if a patient needs help or has more questions after leaving the emergency department (AIR Team = 66.7% versus 38.9% for patients receiving standard care)

**Perceived Knowledge of Respiratory Care Surveys**

An anticipated outcome of the AIR Team project was an increase in baseline perceived knowledge for the AIR Team clinicians regarding the provision or respiratory care. A 15-item tool was developed by the project team, which asked AIR Team clinicians to assess their own knowledge regarding several aspects of caring for patients with respiratory illness. The clinicians were asked to rate themselves on a 5-point scale. Survey responses indicate that the AIR Team clinicians had an increased level of perceived knowledge after the pilot period.
Benner’s (1984) *novice to expert* scale was utilized to describe the various ratings of this self evaluation tool. Benner’s scale was originally used as a scale to rate nursing competence but an environmental scan and small-scale literature review revealed that other professions had also embraced this model as a scale to evaluate the progression of professional competence. Administering the survey to clinicians from various professional backgrounds and clinical settings throughout the health centre helped refine the tool by clarifying ambiguous questions prior to administering it to the AIR Team clinicians.

Prior to attending the Certified Respiratory Educator preparatory course, (the first component of the AIR Team Education Plan), the AIR Team clinicians were asked to complete the **Perceived Knowledge of Respiratory Care Survey** (refer to *Resource 7*). Similarly, prior to the implementation of the AIR Team in the emergency department, emergency department Registered Nurses (ED RNs) were also asked to complete the survey. The intention of having the ED RNs complete the survey was to determine whether the AIR Team’s presence in the department resulted in knowledge transfer that would impact the ED RNs’ perception of their own knowledge regarding the care of respiratory patients.

At the end of the AIR Team implementation phase, AIR Team clinicians and ED RNs completed the same survey. The AIR Team clinicians rated their perceived knowledge higher in the post-survey for all 15 statements. For the AIR Team clinicians, the greatest percentage increase in the mean score was seen for the following statements:

- I am knowledgeable about community resources available to provide follow-up care to patients with respiratory illness following discharge: †46.7%
- I am knowledgeable about Ministry of Health initiatives aimed at optimizing care for respiratory patients: †40.0%
- I am knowledgeable about the risk factors that contribute to respiratory illness: †33.3%
- I am knowledgeable about the triggers that contribute to asthma/COPD exacerbations: †33.3%
- I am knowledgeable about the differences in pharmacological interventions between adult and paediatric patients: †33.3%
- I am knowledgeable about various medication delivery devices available to respiratory patients (how to use them and how to educate others on their use): †33.3%
- I am knowledgeable about the various antibiotics used in the treatment of respiratory infections: †33.3%
- I am knowledgeable in effective strategies to relay information to patients about their treatment plan: †33.3%

In the pre-survey, there were no occurrences where all the AIR Team clinicians rated themselves as *Expert* (5 out of 5). In the post-survey, each of the AIR Team clinicians rated themselves as *Expert* (5 out of 5) for the following statements:
I am knowledgeable about the risk factors that contribute to respiratory illness
I am knowledgeable about the triggers that contribute to asthma/COPD exacerbations
I am knowledgeable in recognizing the presence of physical signs and symptoms of respiratory distress
I am knowledgeable about various medication delivery devices available to respiratory patients (how to use them and how to educate others on their use)
I am knowledgeable about the use of steroids to treat acute and chronic respiratory conditions

The ED RNs rated their perceived knowledge higher in the post-survey for 14 of the 15 statements. The only statement that was rated lower in the post implementation survey was the ED RNs’ rating of their level of knowledge regarding Ministry of Health initiatives aimed at optimizing care for respiratory patients (decreased by 0.6%). For the ED RNs, the greatest percentage increase in the mean score was seen for the following statements:

- I am knowledgeable about various medication delivery devices available to respiratory patients (how to use them and how to educate others on their use): 18.8%
- I am knowledgeable in effective strategies to relay information to patients about their treatment plan: 17.7%
- I am knowledgeable in assessment of patient comprehension of his/her treatment plan: 17.6%
- I am knowledgeable about community resources available to provide follow-up care to patients with respiratory illness following discharge: 16.8%
- I am knowledgeable about the use of steroids to treat acute and chronic respiratory conditions: 16.6%

Often emergency department staff and physicians would specifically seek the AIR Team’s expertise in either nursing, respiratory therapy or pharmacy to answer profession-specific questions regarding the general care of patients. Similarly, emergency department staff and physicians called upon the AIR Team to answer respiratory-specific questions. The AIR Team clinicians noted a trend regarding questions that would repeatedly arise. The clinicians took the initiative to develop a Respiratory Device Pocket Card (refer to Resource 8) that they provided to the emergency department staff during small group in-services facilitated by the AIR Team clinicians. The increase in perceived knowledge for the ED RNs can likely be attributed to these formal and informal interactions between the AIR Team clinicians and the ED RNs.

**Interprofessional Collaborative Practice Surveys**

Another anticipated outcome of the AIR Team project was an increased competency in interprofessional collaboration. The competencies for interprofessional collaboration were presented in detail in the Competency Framework Table in Chapter 9.

The Health Centre had previously endeavoured to enhance interprofessional practice through team coaching for each of the organization’s point-of-care teams. An Interprofessional Collaborative Practice Survey (refer to Resource 9) was developed during the project (St. Joseph’s Health Centre, 2009) and was also utilized in the AIR Team project to determine if there was a change in how AIR Team clinicians experienced and
enacted interprofessional collaboration. This non-standardized tool included 18 statements, each of which related to one of the five core competencies for interprofessional collaboration. AIR Team clinicians were asked to rate each statement on a 4-point scale, with responses ranging from *almost always* (1) to *almost never* (4). The AIR Team clinicians completed the survey when they were first hired into their AIR Team roles. The same survey was administered at the end of the implementation phase of the project.

The categorization of statements according to interprofessional collaborative core competencies are presented in the following table:

**Table 4: Categorization of Interprofessional Collaborative Practice Statements by Core Competency**

<table>
<thead>
<tr>
<th>Core Competency</th>
<th>Trust and Respect</th>
<th>Appreciating Differences and Conflict Resolution</th>
<th>Knowledge of Other Professional Roles</th>
<th>Shared Decision-Making</th>
<th>Willingness to Share Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>My colleagues from other disciplines treat me with respect.</td>
<td>I accept ownership for resolving conflict with team members.</td>
<td>I take time to explain my role to colleagues.</td>
<td>When two team members can both perform a task, we make a decision about it.</td>
<td>I work with my team to make decisions based on consensus.</td>
<td></td>
</tr>
<tr>
<td>I trust decisions made by the interprofessional team.</td>
<td>When I have a disagreement with a colleague, I ask questions in order to understand his/her perspective.</td>
<td>I acknowledge my team members' qualities and skills regularly.</td>
<td>I willingly engage in shared decision-making.</td>
<td>Leadership is shared in team meetings.</td>
<td></td>
</tr>
<tr>
<td>I am comfortable receiving feedback from team members.</td>
<td>The team talks together about professional similarities and differences.</td>
<td>When deciding on treatment plans, I consult with colleagues from other disciplines.</td>
<td>I involve patients in their treatment plans.</td>
<td>I am consistent in sharing client information.</td>
<td></td>
</tr>
<tr>
<td>I feel included on my healthcare team.</td>
<td>The team includes everyone who supports patient care in my area including clinicians, team members who provide administrative support, housekeeping and portering.</td>
<td>The team includes everyone who supports patient care in my area including clinicians, team members who provide administrative support, housekeeping and portering.</td>
<td>Administrative duties that support the team, such as minute-taking, are shared.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In order to determine whether participation in the AIR Team project had an impact on interprofessional collaborative core competencies, the mean scores from the pre-intervention survey were compared to the mean scores from the post-intervention survey. The results were as follows:

- Knowledge of Other Professional Roles: ↑27.8%
- Shared Decision-Making: ↑22.9%
- Willingness to Share Power: ↑20.8%
- Appreciating Differences and Conflict Resolution: ↑19.4%
- Trust and Respect: ↑18.8%
In the pre-survey, there were no occurrences when all the AIR Team clinicians rated any of the statements as almost always (1). In the post-survey, each of the AIR Team clinicians rated every statement in the Trust and Respect category as occurring almost always (1). The AIR Team clinicians also rated the following statements as occurring almost always (1):

- I accept ownership for resolving conflict with team members
- When I have a disagreement with a colleague, I ask questions in order to understand his/her perspective
- I acknowledge my team members’ qualities and skills regularly
- When deciding on treatment plans, I consult with colleagues from other disciplines
- When two team members can both perform a task, we make a decision about it
- I willingly engage in shared decision-making
- The team includes everyone who supports patient care in my area including clinicians, team members who provide administrative support, housekeeping and portering
- I work with my team to make decisions based on consensus