Enabling Nurse Practitioners to Admit and Discharge: A Guide for Hospitals

September 2012
This guide was prepared for the ownership and use of the Ontario Hospital Association (OHA). It is a resource for hospitals that may be considering implementing the new nurse practitioner admit/discharge provisions made under Regulation 965 of the Public Hospitals Act.

The material within this guide is for general information only and should be adapted by each hospital to suit its circumstances. This guide reflects the interpretations and recommendations regarded as valid at the time that it was published based on available information. It is not intended as, nor should it be construed as, legal or professional advice or opinion.

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- The Nurse Practitioners’ Association of Ontario
- The Ontario Medical Association
- The Registered Nurses’ Association of Ontario
This guide was developed for hospital, physician and nursing leaders who wish to successfully implement the newest provisions under Regulation 965 of the Public Hospitals Act related to nurse practitioners having the authority to admit and discharge hospital in-patients. It builds on previous work done by the Registered Nurses’ Association of Ontario (RNAO) and the Nurse Practitioners’ Association of Ontario (NPAO) on this topic that resulted in the development of the RNAO/NPAO Nurse Practitioner Utilization Toolkit.

Though this guide focuses on the admission and discharge provisions made under Regulation 965, these are only two of several recent legislative amendments that have enabled nurse practitioners to do more within their scope of practice. This guide does not extensively discuss the other recent changes, such as those relating to the independent provision of treatment to patients. Such guidance may be developed at a later date as appropriate. Many of the principles outlined within this guide are applicable to hospitals as they consider the implementation of provisions regarding the scope of practice of nurse practitioners.

The combination of factors to be considered with respect to the implementation of the admission and discharge provisions will differ from organization to organization. There is no “one-size-fits-all” approach. It will therefore be up to the individual hospital to determine how best to enable nurse practitioners to admit and discharge patients, keeping in mind the needs and interests of their patients, their communities, their institutional policies and procedures, and the relevant clinical settings. When hospitals have decided on the implementation model most suited to their organization, the result should be an effective model of care that delivers a quality patient experience.

Specifically, this guide will:

- Outline the legislative basis that enables nurse practitioners to admit and discharge hospital patients;
- Highlight the organizational issues that will have to be addressed to ensure the successful implementation of the new admit and discharge provisions;
- Identify elements for the successful organizational rollout.

Chapter summaries are provided below:

**Understanding the Changing Role of the Nurse Practitioner:**
This section provides a high-level overview of the nurse practitioner role in Ontario.

**The Legislative Basis of a Nurse Practitioner’s Authority to Admit and Discharge:**
This section outlines the legislative provisions that enable nurse practitioners to admit and discharge patients.

**Organizational Considerations when Enabling Nurse Practitioners to Admit and Discharge:**
This section identifies several issues for hospitals to consider as they evaluate how best to implement the new provisions under Regulation 965. The topics discussed in this section include the importance of having a rationale for the implementation of the provisions; understanding the potential impact of implementation on the organization’s current model of care delivery; and the implications of a hospital’s decision to have nurse practitioners provide services as Employees rather than as Professional Staff.

**Elements of a Successful Implementation:**
This section provides checklists that hospitals may find helpful in ensuring successful implementation of the provisions under Regulation 965.
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1. UNDERSTANDING THE CHANGING ROLE OF THE NURSE PRACTITIONER

1.1 Background

Ontario’s health care system has continually sought ways to improve access to health care services and the overall quality of care provided. Whether it has been through the introduction of new provider roles or by optimizing the scopes of practice for regulated health care professionals, there has been an ongoing commitment to enable hospitals to continue to meet community needs and provide effective care.

New provisions made under Regulation 965 of the Public Hospitals Act have enabled nurses in the extended class to admit, treat and discharge hospital patients. This guide focuses primarily on the new provisions related to admission and discharge (with some discussion on treatment where appropriate) as they may apply to nurse practitioners who are already practicing in a hospital or in the community. This resource also outlines some of the issues hospital leadership should consider with respect to implementation.

1.2 Role Overview

Nurse practitioners work in a variety of rural and urban settings including family health teams, community health centres, nurse practitioner-led clinics, hospitals, rehabilitation facilities, long-term care facilities, schools, workplaces, and home health care agencies.

The four recognized specialty nurse practitioner categories in Ontario are:

- NP – Adult (400 members)
- NP – Paediatrics (175 members)
- NP – Primary Health Care – (1,499 members)
- NP – Anaesthesia (0 members)

As of June 1, 2012, over 2,000 nurse practitioners were registered with the College of Nurses of Ontario (CNO) in the three categories of Adult, Primary Health Care and Paediatrics. Although a fourth specialty certificate in Anaesthesia was permitted under Regulation 275/94 of the Nursing Act, regulations are still pending with respect to this nurse practitioner specialty. The CNO therefore does not currently register nurse practitioners in this category.1

1.3 The Nurse Practitioner Role

Subsection 1(1) of Regulation 965 made under the Public Hospitals Act defines “extended class nursing staff” as registered nurses in the extended class in a hospital who are:

a. Employed by the hospital and are authorized to diagnose, prescribe for, or treat patients in the hospital (Employee NPs); and,

b. Not employed by the hospital and to whom the board has granted privileges to diagnose, prescribe for, or treat patients in the hospital (Professional Staff NPs).

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1 See the College of Nurses of Ontario’s website at http://www.cno.org/what-is-cno/nursing-demographics/membership-totals-at-a-glance/ for more information.
This definition was most recently amended in 2011, changing any references of “out-patient” to “patient”. The effect of this change to the definition of “extended class nursing staff” has been that nurse practitioners, previously limited to providing certain services to out-patients only, have been enabled to practice independently within their scope on all patients – out-patients and in-patients. When taken together with recent amendments made to other legislation, including the Nursing Act, nurse practitioners can now provide the following services to all hospital patients:

- Order any laboratory test appropriate for client care (October 1/11);³
- Apply a prescribed form of energy (October 1/11);⁴
- Set or cast a fracture or dislocation of joint (October 1/11);⁵
- Dispense/sell/compound drugs (October 1/11);⁶
- Broadly prescribe drugs appropriate for client care within the scope of practice (October 1/11);⁷

- Provide client care orders to be implemented by registered nurses and registered practical nurses for procedures related to diagnosing and treating clients (e.g., venipuncture to obtain blood samples) (October 1/11);⁸
- Order services for which patients are insured (July 1/11);⁹
- Order diagnostics and treatments for hospital patients (July 1/11);¹⁰
- Complete and sign a medical certificate of death in certain circumstances (July 1/11).¹¹

All these amendments offer legislative recognition of the value of the nurse practitioner role in improving the quality, delivery, access and efficiency of patient care.

Of the approximately 2,000 nurse practitioners registered with the CNO, the majority generally practice as employees. The remaining nurse practitioners tend to be those who work in the community – perhaps in a nurse practitioner-led clinic, as part of a Family Health Team, in a long-term care setting or a community health centre. For this latter group of nurse practitioners, a hospital may consider granting the nurse practitioner privileges in the hospital (thereby making him/her part of the Professional Staff), since it may facilitate the continuity of patient care between the community and the hospital.

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² O Reg 216/11, s 2 struck out all previous references to “out-patient” in the definition of “extended class nursing staff” in Regulation 965 and replaced them with “patient”. Also, section 1 of the Public Hospitals Act defines “patient” as an in-patient or an out-patient.
³ RRO 1990, Reg 682. This regulation made under the under the Laboratory and Specimen Collection Centre Licensing Act deleted Appendix C, which had prescribed a limited number of tests that nurse practitioners could order.
⁴ Nursing Act, SO 1991, c 32, s 5.1(1). However, this authority still requires a regulation under the Regulated Health Professions Act to come into effect.
⁵ Nursing Act, SO 1991, c 32, s 5.1(1).
⁶ Nursing Act, SO 1991, c 32, s 5.1(1). See also O Reg 275/94, ss 16(1), 16(4). This authority is subject to certain conditions prescribed in the regulation.
⁷ Nursing Act, SO 1991, c 32, s 5.1(1). See also O Reg 275/94, s 17. However, nurse practitioners are not currently allowed to prescribe a controlled substance i.e., substances included in Schedules I, II, III, IV or V of the Controlled Drugs and Substances Act.
⁸ Nursing Act, SO 1991, c 32, s 9.
⁹ RRO 1990, Reg 552, s 7.
¹⁰ RRO 1990, Reg 965, ss 16, 24. This is subject to certain restrictions.
¹¹ RRO 1990, Reg 1094, s 35(3).
2. THE LEGISLATIVE BASIS OF A NURSE PRACTITIONER’S AUTHORITY TO ADMIT AND DISCHARGE

2.1 The Public Hospitals Act

Regulation 965 under the Public Hospitals Act grants nurse practitioners the authority to admit and discharge hospital patients.

Specifically, subsection 16(1) of the regulation states:

If a patient is no longer in need of treatment in the hospital, one of the following persons shall make an order that the patient be discharged and communicate the order to the patient:

1. The attending physician, registered nurse in the extended class or midwife or, if the attending dentist is an oral and maxillofacial surgeon, the attending dentist.

2. A member of the medical, extended class nursing, dental or midwifery staff designated by a person referred to in paragraph 1.

These amendments came into force on July 1, 2011.

This same regulation authorized nurse practitioners to admit patients, though the effective date of the authority was delayed until July 1, 2012. Clause 11(1)(a.1) of the regulation states:

No person shall be admitted to a hospital as a patient except…on the order or under the authority of a registered nurse in the extended class who is a member of the extended class nursing staff;

WHAT THIS MEANS FOR HOSPITALS

These amendments are enabling rather than mandatory. That means that on an individual basis, hospitals will have to work through what these new provisions might look like in their particular organizations. If a decision is made to move forward, the hospital should take steps to ensure successful implementation. This guide presents hospitals with considerations as they move through that process.
As discussed earlier, the provisions under Regulation 965 permitting nurse practitioners to admit and discharge are enabling rather than mandatory. The provisions offer hospitals an option to use existing resources within their organizations to serve the best interests of their patients and maximize patient care. However, there are several factors that hospitals will have to consider when evaluating the appropriateness of implementing these provisions.

As part of that assessment, the following may be considered:

- The organizational objectives that the newly enabled nurse practitioner role will meet;
- The changes that may have to be made to the organization’s model of care delivery; and
- The most appropriate practice arrangement for nurse practitioners (i.e., privileged vs. employees) to provide services to the hospital.

Each of these considerations will be discussed in more detail below.

### 3.1 Organizational Objectives

Hospitals that enable nurse practitioners to admit and discharge patients may want to align this function with a broader corporate objective or strategic direction. At the heart of any such corporate goal or strategic direction, will be the desire to serve the best interests of patients and maximize patient care. However, the specific initiatives undertaken to reach that goal may differ from organization to organization and could take into account other factors such as patient mix, patient flow, physician resources, staffing and clinical/program needs. For instance, if a hospital’s priority is to enhance patient flow through its emergency department, enabling nurse practitioners to admit and discharge may add valuable resources to its quality improvement efforts.

In determining whether to enable nurse practitioners to admit and discharge patients, hospitals should explore the following questions:

- What organizational objectives will nurse practitioners who admit and discharge meet?
- Where in my organization would nurse practitioners who can admit and discharge have the most impact on patient care? Does this align with the organization’s current priorities?
- Which nurse practitioners should admit or discharge? Should it be all nurse practitioners within the organization or just a particular group?

A key consideration for hospitals is that wherever newly enabled nurse practitioners are deployed within the organization, there should be a clear nexus between the new role and an identified organizational need. Establishing this link from the onset may also help hospitals in later engagement and communication with internal and external stakeholders.

### 3.2 Model of Care Delivery

Enabling nurse practitioners to admit and discharge can have a significant impact on a hospital’s model of care delivery. As hospital leaders determine what changes may need to be made to the way the organization delivers care, the following are some suggested guiding principles for the development of any revised delivery model:

- It should optimize patient care and meet patient needs.
- It should address any identified care gaps, specific issues or problems.
• It should facilitate inter-professional care and seamless patient care.

• It should be aligned with organizational priorities.

More specifically, hospitals should understand how enabling nurse practitioners to admit and discharge patients may affect:

• The ultimate accountability for the patient’s care; and,

• The care team’s roles and responsibilities.

3.2.1 Determining Accountability for Patient Care

In hospitals where nurse practitioners can admit and discharge patients, organizations should carefully think about where ultimate accountability for patient care will rest.

The Healthcare Insurance Reciprocal of Canada (HIROC) recommends that “…all patients who are admitted to hospital should have a physician/surgeon designated as the Most Responsible Physician”. In current practice, it is understood that the designation Most Responsible Physician (MRP) can be used interchangeably with Most Responsible Provider/Practitioner, and that the abbreviation “MRP” is inclusive of both. Though not defined by legislation or regulation, the term “MRP” has become accepted through practice to refer to the provider who has primary responsibility and accountability for the care of a patient within the hospital.

HIROC’s recommendation underscores the importance of having a single provider designated as the MRP to prevent the “dilution of responsibility that is inherent in the team approach to patient care”. According to HIROC, the MRP designation identifies to the patient, to the organization and to other care team members:

• The provider with training in the area of the patient’s diagnosis;

• The provider who is responsible for managing, overseeing, coordinating and directing the patient’s care;

• The provider to whom the results from diagnostic tests, consultations and other interventions are reported; and

• The provider who remains responsible for the patient’s care when not physically at the hospital (i.e., on-call) unless care has been transferred.

The decision about which provider will be a patient’s MRP is usually made as soon as possible upon the patient’s admission, and revisited where appropriate, until the patient is discharged.

This guide proposes two principles when designating an MRP:

1. The MRP role is most appropriately assumed by a single provider.

2. The MRP designation comes with particular responsibilities to the patient that must be fulfilled on admission, during his/her stay in the hospital and upon discharge, including when the provider is physically present at the hospital, as well as after hours.

An assessment of which provider is most suitable to be a particular patient’s MRP must take these responsibilities into account. When the provider admitting or discharging the patient is a nurse practitioner, this assessment should involve the nurse practitioner and the care team, together with the appropriate department head and practice lead.

The discussion with respect to MRP designation is especially important when determining accountability for the patient after hours. When the MRP is a physician who is not physically at the hospital, arrangements are made so that care of the patient is typically transferred to a physician colleague. Similarly, if the MRP is a nurse practitioner, it will be his/her responsibility to make arrangements for after hours care in collaboration with other members of the care team.

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13 Ibid.
14 Ibid.
For hospitals, the following considerations may be helpful for MRP designation discussions:

- Communicating the hospital’s transfer of care expectations, guidelines and requirements including the need for the MRP to continue to provide the care required by the patient until responsibility for the patient’s care has been transferred to another provider.

- Designing the hospital’s MRP policies within a clearly communicated and understood policy framework, especially with respect to:
  a. complex patient care situations; and,
  b. documentation of MRP changes in the patient’s record.

- Ensuring that laboratory or diagnostic results are communicated to the MRP on a timely basis.

### WHAT THIS MEANS FOR HOSPITALS

Despite having designated an MRP, the reality of patient care is that it will be shared with other members of a team. To ensure that patient care remains seamless and that accountability for care is clear, consider some of these important issues:

- The designation of an MRP as written in policy must correspond with what occurs in practice;
- Transfers of care must be clearly communicated and documented; and,
- When assuming or handing over care, providers should communicate clearly and comprehensively about the patient’s condition and the communication should be reflected in the patient’s chart.\(^\text{15}\)

### 3.2.2 Roles and Responsibilities – Inter-professional Care

Role clarity for all members of the care team facilitates seamless patient care. Additionally, having clearly stated roles and responsibilities ensures that the needs and expectations of the organization, the care team, and the patient have been considered. Where nurse practitioners are part of a team in which they will be admitting and/or discharging patients, the hospital leadership and the care team will have to work together to define the roles and responsibilities of the individual members. Hospitals, particularly human resources departments, may want to document these final decisions and review them on a regular basis.

#### USING A COLLABORATIVE PRACTICE AGREEMENT

A Collaborative Practice Agreement (CPA) is one way to document shared understanding and the agreement of all members of an inter-professional team respecting the roles of each team member and responsibilities within that group.\(^\text{15}\) These agreements can be used to facilitate discussions about roles and responsibilities for nurse practitioners to independently admit, discharge or treat patients.

CPAs can address the following issues:

- Scope and terms of exercise of the nurse practitioner admit and discharge authorities;
- Defining which patients the nurse practitioner can admit and/or discharge; and
- On admission, during hospitalization or at discharge, the “triggers” for nurse practitioner communication or consultation with physician(s).

It is recommended that CPAs be reviewed periodically to ensure that they remain current and consistent with evolving standards of practice, institutional policies and procedures, and legislative or regulatory changes.

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\(^{16}\) See the RNAO/NPAO Nurse Practitioner Utilization Toolkit for an example of a CPA.
3.3 Nurse Practitioners as Employees or Professional Staff

One of the other basic considerations for hospitals deciding whether to enable their nurse practitioners to admit and/or discharge patients, is how they will empower them to do so. The Public Hospitals Act contemplates only two ways in which nurse practitioners can be enabled to admit and discharge within a hospital. They can either be:

(a) **Employee NPs** – an employee of the hospital who is authorized to diagnose, prescribe for, and treat patients;

or,

(b) **Professional Staff NPs** – not an employee of the hospital, but to whom the hospital board of directors has granted privileges to diagnose, prescribe for and treat patients. For example, this could be a nurse practitioner employed by a Family Health Team or NP-Led Clinic who is seeking privileges to admit his/her patient to the hospital.

Unlike Employee NPs, Professional Staff NPs are independent contractors. In some circumstances, it may also be the case that in addition to duties set out in hospital by-laws for this category of nurse practitioner, there is a written contract with the hospital that formally documents the relationship between them. These contracts could include any promises or negotiations that were part of the recruitment process or more information about the specific roles and responsibilities of the parties.

Before proceeding to enable nurse practitioners to admit or discharge, hospitals should address the following:

- Provision of Services;
- Reporting Relationships;
- Oversight of the Quality of Care Provided; and,
- Insurance and Liability Issues.

3.3.1 Provision of Services

(a) **Employee NPs**

Employee NPs will typically be enabled to admit and/or discharge from a particular clinical area and within their scope of practice. Hospitals should consider the following procedural steps:

- Ensure that the employment file includes a job or role description that clearly outlines the nurse practitioner’s scope of practice including the authority to admit and/or discharge patients and the specific area(s) of the hospital where these can be exercised.

- Ensure that the employment contract is signed and retained.

- Ensure that where other documents, such as local unit, departmental or program guidelines, policies, procedures, rules, regulations or corporate guidelines, enable nurse practitioners to admit and/or discharge, a copy of the particular document is noted in the employment file.

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17 In this context, independent contractor only refers to the relationship of the nurse practitioner vis-à-vis the hospital (i.e., the Professional Staff NP is not an employee of the hospital). The use of the term here does not imply anything with respect to the billing of OHIP or any of the other ways that nurse practitioners may be remunerated.
(b) Professional Staff NPs

Hospitals that wish to enable nurse practitioners to admit and/or discharge as Professional Staff should consider the following procedural steps:

- Review the hospital’s Professional Staff by-laws\(^\text{18}\) and make amendments where necessary.

- Review the hospital’s credentialing and privileging policies and procedures and make amendments where necessary to enable nurse practitioners to admit and discharge patients.\(^\text{19}\)

- Follow the hospital’s procedure for credentialing the applicant (the OHA’s Professional Staff Credentialing Toolkit describes this process in more detail).

3.3.2 Reporting Relationships

(a) Employee NPs

Generally, an Employee NP may report to a variety of managers, such as a nursing manager, a nurse practitioner professional practice leader, a physician department chief, and/or a program director.

Hospitals should develop an appropriate reporting relationship structure that is reflective and responsive to the specific roles and responsibilities of the nurse practitioner in the organization.

(b) Professional Staff NPs

Professional Staff NPs will ordinarily be accountable and report to the Chief of the Department in which the nurse practitioner has been granted privileges.\(^\text{20}\) This accountability should be set out in the hospital’s Professional Staff by-laws.

3.3.3 Oversight of the Quality of Care Provided by Nurse Practitioners

Quality of care is a term that is undefined by legislation. For hospitals, ensuring that health care providers remain competent and deliver care in accordance with the standards outlined by their regulatory health college may be at least one aspect of assessing the delivery of quality care. As well, given that in Ontario, most health care providers are regulated, every health care professional can ensure that they are delivering quality care to patients by practicing within the scope of their knowledge, skill and judgment.

For all nurses, including both Employee and Professional Staff NPs, the CNO prescribes the standards against which their competence and hence, the quality of care provided, may be measured.

The CNO’s Practice Standard for nurse practitioners applies to all aspects of their practice and states that nurse practitioners are accountable for practicing within their legal scope of practice and their level of knowledge, skill and judgment.

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\(^\text{18}\) To the extent that Nurse Practitioners may constitute a distinct category of Professional Staff within a hospital, the hospital by-laws should be amended such that the rights attached to and the duties of this new category are set out.

\(^\text{19}\) See the OHA’s Professional Staff Credentialing Toolkit for more information.

\(^\text{20}\) Though the stated reporting relationship is probably consistent with current practice, s 4 of Regulation 965 requires that a hospital board pass by-laws that provide for the organization of Nurse Practitioners, among others. These by-laws may outline a different reporting relationship for Nurse Practitioners than the one noted above.
Lastly, hospitals have a responsibility to ensure that all health care providers working in their organizations are qualified to do the work they might be expected to perform. For nurse practitioners who can independently admit and discharge, this may mean providing a more focused delivery of hospital policies and procedures relating to admission and discharge. It may also mean ensuring training in some manner so as to satisfy any clinical leadership requirements within the hospital.

In addition, hospitals may wish to consider if these internal hospital requirements, together with CNO standards, are the appropriate basis for developing performance measures for nurse practitioners who admit and discharge in their organizations.

### 3.3.3.1 Admission, Discharge and Quality of Care

As with other providers who admit and discharge, nurse practitioners will be expected to perform several activities related to these responsibilities. In addition, some of these general responsibilities may also be applicable when a patient is being transferred to other areas of the hospital.

These activities are summarized in the chart below:

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>SPECIFIC RESPONSIBILITIES (LEGISLATED)</th>
<th>GENERAL RESPONSIBILITIES (RECOMMENDED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission</td>
<td>• Taking a patient history⁹²</td>
<td>• Medication reconciliation including best possible medication history⁹⁶</td>
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<td></td>
<td>• Giving a physical exam⁹³</td>
<td>• Documentation of admission history and assessment</td>
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<td></td>
<td>• Making a diagnosis⁹⁴ (may be provisional)</td>
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<td></td>
<td>• Writing admission orders⁹⁵ (can include orders for treatment)</td>
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</tr>
<tr>
<td>Discharge</td>
<td>• Assessing patient prior to discharge</td>
<td>• Medication reconciliation</td>
</tr>
<tr>
<td></td>
<td>• Communicating impending discharge to patient⁹⁶</td>
<td>• Arranging for follow-up appointment with family physician/nurse practitioner or appropriate hospital clinic</td>
</tr>
<tr>
<td></td>
<td>• Writing discharge orders⁹⁷</td>
<td>• Arranging for home care if necessary</td>
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<tr>
<td></td>
<td>• Documenting discharge summary⁹⁸</td>
<td>• Completing transfer orders to a rehabilitation or long-term care facility if required</td>
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⁹² See the OHA’s Professional Staff Credentialing Toolkit, page 25. It is accepted that hospitals owe a duty of care to their patients. That duty requires hospitals to provide competent clinical personnel.

⁹³ RRO 1990, Reg 965, s 25(3.2).

⁹⁴ Ibid.

⁹⁵ RRO 1990, Reg 965, s 11(2) states that a patient shall not be admitted unless it is clinically necessary. This seems to presume that a diagnosis, provisional or otherwise, has to be made. See also s 25(1) which states that an admitting note must set out the reason for admission.

⁹⁶ RRO 1990, Reg 965, s 25(1) requires the hospital’s board establish procedures such that an admitting note can be written and authenticated by a nurse practitioner and entered into the patient’s medical record.

⁹⁷ See the Institute for Safe Medication Practice’s website at http://www.ismp-canada.org/medrec/ for more information.

⁹⁸ RRO 1990, Reg 965, s 19(4)(m).

⁹⁹ RRO 1990, Reg 965, s 19(4)(h).
(a) **Employee NPs**

Ensuring that an Employee NP is meeting performance standards related to admission or discharge as specified in his/her employment file is one way of determining if he/she is delivering quality care. The employment file should identify the person(s) responsible for the ongoing assessment of the nurse practitioner’s performance and the timing of assessments. The Chief Nursing Executive is ultimately responsible for nursing services provided within the hospital and should be the person made aware of any performance issues.30

(b) **Professional Staff NPs**

For Professional Staff NPs, it is the Chief or Head of the Department in which the nurse practitioner has been privileged, that may have the general administrative oversight of the quality of care provided by the nurse practitioner. This is the person who will ultimately be responsible for investigating and responding to concerns about a Professional Staff NP’s performance. (See Chapter 8 of the OHA’s [Professional Staff Credentialing Toolkit](#) for more information.)

The oversight provided by the nurse practitioner’s Chief or Head of Department is part of a broader process of supervision of the hospital’s Professional Staff detailed in Regulation 965. Certain provisions of that regulation have made the hospital’s Medical Advisory Committee (MAC) accountable for ensuring the quality of care provided by all Professional Staff in the hospital, including nurse practitioners. Specifically, section 7 of the regulation requires the MAC to make recommendations to the board concerning:

- The dismissal, suspension or restrictions of hospital privileges of any member of the medical staff and, of any member of the dental, midwifery or *extended class nursing staff*, if there is such staff in the hospital.32

In other words, the MAC, acting on recommendations from the nurse practitioner’s Chief or Head of the Department and through the credentialing process, has the responsibility of making a considered and informed recommendation to the board regarding the Professional Staff NP’s privileges as it may reflect his/her ability to deliver quality care.

However, it should be noted that if a Professional Staff NP wanted to challenge a hospital board’s decision regarding his/her privileges, he/she would be entitled to a more limited process of appeal (extended to him/her through the hospital by-laws) than that outlined in the *Public Hospitals Act*. This is because the appeal provisions in the *Public Hospitals Act* apply only to medical staff. For example, a Professional Staff NP does not have the right to appeal to the Health Professions Appeal and Review Board (HPARB). (See the OHA’s [Professional Staff Credentialing Toolkit](#) for more information.) Where the MAC has determined that a Professional Staff NP’s privileges should be changed for reasons of professional misconduct, incompetence or incapacity, the hospital must report this information to the CNO.

More broadly, Regulation 965 requires the MAC to make recommendations on identified *systemic or recurring issues related to the quality of care* provided by Professional Staff NPs (among other Professional Staff) to the quality committee of the board established pursuant to the *Excellent Care for All Act (ECFAA)*.33 A member of the hospital’s MAC and the Chief Nursing Executive are *ex-officio* members of this committee.34

30 RRO 1990, Reg 965, s 18(3).
31 RRO 1990, Reg 965, s 7(2)(a)(ii).
32 RRO 1990, Reg 965, s 7(2)(a)(v).
33 RRO 1990, Reg 965, s 7(2)(a)(vi).
34 O Reg 445/10, s 3.
Together, these legislative provisions establish the MAC as a central part of the oversight of the performance and by inference, the quality of care, provided by Professional Staff NPs only—both on an individual level and at the systemic level. However, despite this currently established legal framework, hospitals should keep in mind that the quality of care delivered to patients by nurse practitioners (and indeed all health care professionals providing care within the organization), whether they are Employee or Professional Staff NPs, should be a priority for the entire leadership team within the organization. As such, hospitals are encouraged to review and adapt their current processes to build and facilitate the communication and collaboration between the MAC and the Chief Nursing Executive.

WHAT THIS MEANS FOR HOSPITALS

Oversight of the quality of care provided by all nurse practitioners within an organization should be a collaborative responsibility of a hospital’s clinical leadership. Therefore, hospitals are encouraged to build and/or reinforce practices and procedures that allow for ongoing communication between the Chief Nursing Executive and the MAC, and that are part of the broader organizational commitment to the delivery of quality care to patients.

3.3.4 Insurance and Liability

Insurance and liability are important considerations for hospitals as they determine the best way to enable nurse practitioners to admit or discharge, now that they will be doing so independently. When any health care provider assumes new independent responsibilities, there is a potential for increased risk. Therefore, hospitals are encouraged to have discussions with their insurers, informing them of the nurse practitioner expanded responsibilities and identifying related coverage issues. Additionally, hospitals should consider whether any internal practices, policies and procedures must be developed or revised to minimize liability and best support these new nurse practitioner responsibilities.

(a) Employee NPs

Where nurse practitioners are employees of a hospital, the doctrine of vicarious liability applies. Vicarious liability means that an employer can be held legally responsible for the negligent acts of its employees that occur within the scope and course of their employment. However, in the event that something adverse occurs within the hospital, this legal doctrine does not automatically imply that a hospital will be held liable. In fact, there are several factors that must be considered before hospital liability is found. Therefore, each event should be considered in context and examined on a case-by-case basis.

In Ontario, most hospitals have broad professional liability insurance coverage for the acts of their employees. Given that Employee NPs will now be admitting and discharging patients, hospitals may want to review their insurance coverage to ensure that it appropriately reflects these additional responsibilities.

(b) Professional Staff NPs

Professional Staff NPs are generally independent contractors and as such, the doctrine of vicarious liability will generally not apply. In these circumstances, the nurse practitioner is solely responsible for ensuring that he/she is adequately protected against professional practice liability. The department within the hospital that oversees the credentialing functions should ensure that nurse practitioner applicants provide evidence of insurance coverage or professional liability protection, in the same way that physicians, dentists and midwives are asked to provide evidence of their insurance coverage or professional liability protection.

35 RRO 1990, Reg 965, s 7(21).

There are two final points on liability that must be made. The first is that hospitals should be aware that while they may not be responsible for the negligence of a Professional Staff NP practicing within the organization, they are responsible for ensuring that nurse practitioners are reasonably qualified to do the work they might be expected to perform.  

Secondly, the *Regulated Health Professions Statute Law Amendment Act* has proposed changes to section 13.1 of Schedule 2 of the *Regulated Health Professions Act*. These provisions would require all regulated health professionals in Ontario to be personally insured against professional liability under a professional liability insurance policy or belong to a specified association that provides a member with personal protection against professional liability. These provisions have not yet been proclaimed. However, when they do come into force, hospitals may want to revisit their policies with respect to liability coverage and their nurse practitioners.

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37 See the OHA’s *Professional Staff Credentialing Toolkit*, page 25. It is accepted that hospitals owe a duty of care to their patients. That duty requires hospitals to provide competent clinical personnel. The same principle would apply to Professional Staff NPs.


39 See the *Regulated Health Professions Act*, SO 1991, C. 18, at 13.1(1). These provisions are not yet in force and will be proclaimed at some yet to be determined date. See also the corresponding proposed changes to the by-laws of the College of Nurses of Ontario at [http://www.cno.org/Global/pubs/mag/inserts%20fall%202010/PLP%20Proposed%20Bylaw%20changes%20final.pdf](http://www.cno.org/Global/pubs/mag/inserts%20fall%202010/PLP%20Proposed%20Bylaw%20changes%20final.pdf).
In addition to the specific issues highlighted in the previous sections, hospital leadership should also undertake an organizational environmental scan to identify broader issues of culture, resourcing and corporate strategic alignment that may need to be addressed prior to implementation. As stated previously, individual hospitals will determine how best to enable nurse practitioners to admit and discharge patients keeping in mind the needs and interests of their patients, their communities, their institutional policies and procedures, and the relevant clinical settings.

The following checklists may be helpful.

**4.1 Assessing Organizational Readiness**

✓ Is the organizational and clinical culture supportive of enabling nurse practitioners to admit and discharge?

✓ Have the staff and management, including clinicians and other departments and managers directly impacted by the nurse practitioner role, been identified?

✓ Do all the relevant staff understand the parameters within which nurse practitioners will be admitting and/or discharging?

✓ Does the organization have the financial and human resources to support any infrastructural changes that may be necessary to successfully enable nurse practitioners to admit and discharge patients?

**4.2 Establishing Supportive Infrastructure**

✓ Have organizational by-laws, policies and procedures been reviewed and amended, as necessary, to enable nurse practitioners to admit and discharge?

✓ Has the organizational model been reviewed and amended, as necessary, to clarify reporting relationships and oversight of nurse practitioners?

✓ Has the human resources infrastructure been reviewed and amended, as necessary, to evaluate the performance of Employee NPs who may be admitting and discharging?

✓ Has the MAC infrastructure been reviewed and amended, as necessary, to accommodate the appointment and performance review of Professional Staff NPs?

✓ Has the hospital’s information technology (IT) system been modified to accept admitting and discharging orders from nurse practitioners?

✓ Has the hospital’s IT system been modified to recognize and accept nurse practitioners as providers able to independently order treatment and diagnostics?

✓ Has the hospital’s IT system been modified to provide nurse practitioners with the results of lab tests and diagnostics where nurse practitioners have ordered them?

✓ Have medical directives been reviewed, amended or discarded, as necessary, recognizing the new roles for nurse practitioners, including being able to independently treat hospital patients?

✓ Have organizational policies that reference “physician” been updated to “provider” where appropriate?
✓ Has the organization put structures and processes in place to ensure ongoing communication among members of the inter-professional team?

4.3 Communicating with Stakeholders

✓ Has the organization communicated with internal and external stakeholders about the proposed changes and how it aligns with the hospital’s corporate priorities?

✓ Have stakeholders had a chance to participate in a process to provide input or feedback?

✓ Have all members of the inter-professional care team been apprised of the changes?

✓ Has the organization developed an internal and external communications and education strategy with respect to the proposed changes?

4.4 Monitoring and Evaluating Implementation

✓ Has the organization developed a mechanism to evaluate the impact of newly enabled nurse practitioners?
5. CONCLUSION

The provisions under Regulation 965 enabling nurse practitioners to admit and discharge patients present an opportunity for hospitals to enhance patient care and experience. Additionally, by being enabling rather than mandatory, hospitals have the latitude to implement the provisions in a way that best aligns with their corporate objectives. In some cases, these provisions may simply reinforce existing practice, while in others, these provisions may be the impetus for new ways of delivering care in the organization. The OHA is confident that the considerations presented within this guide will be helpful in framing discussions within hospitals as they evaluate their next steps.