The Professionals at the HPHA are committed to provide safe, quality patient care through interprofessional collaborative team work.
HPHA

Interprofessional Practice Model

September, 2010
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I. BACKGROUND

Over the last two decades there has been a growing provincial, national and international recognition of the need to revise the traditional care delivery models in all sectors of the health care system. Increasing patient acuity and complexity have resulted in increased demands on healthcare resources. These realities, combined with increased fiscal pressures demand changes that will realize improvements in the efficiency of care provision, that is patient/family-centered and is based on a model of interprofessional collaboration between all health care providers.

In his address to the Economic Club in February, 2004, Health Minister Smitherman commented that “our vision is of a system where all providers speak to one another in the same language, where there are no longer impenetrable and artificial walls between stakeholders and services: a system driven by the needs of patients, not providers.” (1)

In October of 2009 in his report “For Patient’s Sake” for the Minister of Health in Saskatchewan, Royal Commissioner Tony Dagnone stated that “spending and quality are not necessarily linked, which means that simply spending more money is not the solution. The solutions are to be found in a better integrated network of services, populated by providers who are enabled to use all of their skills and training, who provide care in accordance with evidence-based best practices, and who interact effectively with the patient and with each other.” (2)

The Interprofessional Steering Committee of HealthForce Ontario published a landmark document in July 2007 entitled “Interprofessional Care: A Blueprint for Action in Ontario”, which clearly defines the vision and direction for integrating interprofessional care (IPC) into Ontario’s Health Care system (3). This document defines interprofessional care as:

“the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings”.

In addition to defining the vision and direction of IPC, the document also noted that IPC will assist healthcare providers to manage increasing workloads more effectively, reduce wait-times for patients and improve patient outcomes (3),

The final report of the Interprofessional Care Strategic Implementation Committee was published on the HealthForce Ontario website in July, 2010, and includes implementation recommendations, guidelines and resources for healthcare organizations across the spectrum of care, LHIN’s, educational facilities and the government (33). Also included is an Interprofessional Care Charter, including patient expectations and commitments required of caregivers and leaders (see Figure 1.0), as well as a resource kit that includes educational materials and evaluation tools.
ADVANCING COMPETENCE IN INTERPROFESSIONAL CARE:
A CHARTER ON EXPECTATION AND COMMITMENTS

Patient Expectation
As a patient in Ontario, I expect my health care to be provided by various health caregivers who respect me and the health care choices I make. My caregivers seek to know my health experience and are prepared to work with me across settings to combine their knowledge and skills to meet my health goals.

IPC Blueprint
Interprofessional care (IPC) is the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings.

Caregiver Commitments
As a health caregiver in Ontario, in supporting the IPC vision,

1. I will seek to know the experience of those I care for, respect and strive to understand their needs, and work with them to develop their care plans that acknowledge their choices,
2. I will understand my role and understand the role and expertise of other health caregivers,
3. I will inform those who are caring for patients with me about the care I am providing with them,
4. I will ask questions, communicate to be understood, seek input and listen respectfully to generate options for care,
5. I will be aware of how my own behaviour and attitudes impact interprofessional care and how I actively foster a culture of collaboration, and
6. I will acknowledge that there are limits to what I know and will continue to learn from others so that care can be better integrated and led by the best possible ideas.

Leader Commitments
To meet patient expectation(s) and enable caregiver commitments in Ontario, as health system leaders,

1. We will align our language, processes, structures and resources to foster an IPC culture,
2. We will create opportunities to collaborate within and across sectors to integrate IPC into practice, education, policy, and research,
3. We will measure and evaluate our IPC initiatives to know what is being achieved, and
4. We will continuously improve IPC in the health care system by identifying, promoting and implementing practices that make a difference to patient care.

http://www.healthforceontario.ca/upload/en/whatishfo/ipcproject/ccwg%20resource%20guideline%20nov%202010-final%202010_.pdf

- 2 -
The final report provides a concise and compelling statement of the rationale for IPC:

“The need for interprofessional care resides in understanding that:

- Trend data indicates that Ontario faces a significant reduction in its health human resources workforce by 2010.
- Unless new ways of practicing health care are introduced, Ontario will face a significant shortage of health care workers and Ontarians will risk receiving sub-optimal care.
- The education system needs to prepare current and future providers to work in multi-disciplinary, collaborative, team-based models.
- Interprofessional care can help improve patient care while increasing provider satisfaction within a respectful and collaborative environment.” (33)

The Huron Perth Healthcare Alliance (HPHA) developed a Strategic Plan in 2008 with four corporate priorities:

1. Quality Patient Care: to provide safe, high quality patient care
2. Patient Access: To enable the effective and timely provision of patient care
3. Workplace Health: To create a preferred place to work, volunteer and provide care
4. Fiscal Health: To manage fiscal resources to meet and sustain operational and capital priorities

The strategic priority “Quality Patient Care” includes a corporate goal to “develop a professional practice model where healthcare professionals work to their full scope of practice”. As a result, the Nursing Practice Council reviewed the current Nursing Philosophy, Professional Practice Model and Care Delivery Models and recognized that they were outdated and did not represent nor support the current College of Nurses of Ontario’s (CNO) practice standards. It was agreed to embark on a renewal process to support this corporate goal.

Three working groups were established to discuss (i) the current philosophy and professional practice model, (ii) the current care delivery models and (iii) scope of practice of Registered Nurses (RNs) and Registered Practical Nurses (RPNs). These working groups also did a review of the literature related to best practice within these topics.

**Outcomes of Working Groups:**

(i) Current Philosophy and Professional Practice Model

Several disciplines were represented in the philosophy and professional practice model group and they reviewed the value of philosophy statements. A literature search revealed that interprofessional practice models improved patient outcomes and quality of work life (3-9). This group developed an Interprofessional Philosophy Statement that defines practice expectations for all regulated health professionals (RHPs) and unregulated health care providers at the HPHA:
“The Professionals of the HPHA are committed to provide safe, quality patient care through interprofessional collaborative teamwork.”

They also drafted an Interprofessional Practice Model (IPPM) that formed the basis for the model upon which this document is based.

(ii) Care Delivery Model

The Care Delivery Model group researched various care delivery models. The goal was to adopt a model that would support regulated care providers practicing to their full scope within a patient-centered care environment. The Autonomous Collaborative Care Model (4), although focused on nursing, could be adapted to meet these expectations for all regulated and unregulated care providers and would fit within the culture of the HPHA.

(iii) RN/RPN Scope of Practice

The Scope of Practice group analyzed the current CNO practice standards for RNs and RPNs (10,11), and found that nurses at the HPHA could practice to their full scope. For example, an analysis of the acuity level and care needs of patients within Maternal Child, Day Surgery, Emergency and Telemetry revealed that the care needs of some patients are within the scope of practice of RPNs. There was agreement to further investigate the inclusion RPNs in these departments.

In April 2009, the Nursing Practice Council, in collaboration with other regulated professionals, presented a draft Interprofessional Practice Model and a new care delivery model - the “Autonomous Collaborative Care Model” (4). The IPPM promotes all regulated professionals to work within their full scope of practice, in accordance with the parameters and requirements of the clinical area, and enhances professional practice expectations. The Autonomous Collaborative Care Model supports a patient-centered environment where the practice expectations for RHPs identified within the IPPM are operationalized. There was a positive response to the presentation and agreement that all regulated professionals at the HPHA practice to their full scope, and to utilize RPNs in CCU, Day Surgery, Maternal Child and Emergency. The elevation of practice of all regulated professionals will have a tremendous positive impact on the provision of patient care within the Alliance.

In October 2009 a series of workshops and consultations on interprofessional care (IPC) were held with the Chief Nursing and Professional Practice Officer of the Niagara Health System (NHS), and included representatives of all healthcare disciplines and leadership in the HPHA. Learning from the NHS experience was very helpful in guiding this work at the HPHA and determining the steps required to develop and implement an IPC model of care.

A Corporate Lead for Professional Practice was hired in March of 2010, to work with leadership, staff and physicians in the development and implementation of an interprofessional practice model for the HPHA. The first initiative was to establish an
Interprofessional Practice Council (IPPC), consisting of representatives of all regulated healthcare professions. The IPPC held its first meeting in April, 2010, and the early work of the IPPC included completion of the HPHA Interprofessional Practice Model (Figure 2.0), which serves as the framework for the revised model of care. The IPPC also approved the philosophy statement for the model:

“The Professionals of the HPHA are committed to provide safe, quality patient care through interprofessional collaborative teamwork.”

The IPPC developed a statement of goals for an IPPM (see Table 1.0), which will assist in guiding and shaping the work of the IPPC as well as all other interprofessional practice initiatives. At the centre of the model is Patient/Family-Centred Care, surrounded by interlocking circles which each represent the various healthcare providers (regulated and unregulated) of the HPHA. The interlocking of the circles is symbolic of the integrated, interprofessional collaborative care provided to patients and families. The four larger circles represent the key components of the IPPM: Interprofessional Collaborative Practice, Evidence Informed Practice, Professional Development and Role Clarity/Scope of Practice. These circles also overlap, depicting their interdependency and synergy, and provide the tools and vehicles necessary to realize truly interprofessional collaborative care. The outer ring which surrounds the model includes the various organizational and environmental supports that are required to implement and sustain the IPPM. These supports include Change Management Strategies, Transformational Leaders, Resource Allocation, Continuous Quality Improvement, Participatory Leadership, Quality Work Environment and Community Stakeholders.
Figure 2.0 – HPHA Interprofessional Practice Model

HPHA Interprofessional Practice Model

Philosophy Statement:
The Professionals of the HPHA are committed to providing safe, quality patient care through interprofessional collaborative teamwork.

Change Management
Resource Allocation

Continual Quality Improvement
Participatory Leadership
Transformational Leaders

Community Stakeholders
External Work Environment

Role Clarity/Ecology of Practice
• Mutual understanding of goals and scope
• Understanding role and scope of roles
• Understanding of each other’s models
• Collaborative Care Models

Interprofessional Practice Council
Unit Action Councils
Interdisciplinary care plans and documentation

"Bullet" Rounds

Evidence Informed Practice
• Best Practices
• College Standards
• Patient Safety
• Critical Thinking
• Quality improvement initiatives
• Research

Legend
Centre Circle – Focus of Care
Small Circles – Healthcare Providers
Middle Circles (6) – Key Components
Outer Circle – Supportive Factors

May 2010
Table 1.0

Guiding Principles of HPHA Interprofessional Practice Model

1. The “right care at the right time in the right place” for each patient.

2. Patients and families experience seamless, safe and effective care throughout their experience in the HPHA.

3. Interprofessional Care (IPC) is an inherent and essential component of the patient care experience in the HPHA.

4. All healthcare professionals (HCP’s) are considered equal and valued members of patient care teams.

5. The skills and scope of practice of all HCP’s are utilized to their fullest extent.

6. HPHA provides a stimulating, rewarding work environment, with a culture that fosters continuous growth and development for all HCP’s.

7. All levels of leadership and staff of the HPHA have accountability for IPC.

8. IPC is incorporated into the education of all of the students and staff of the HPHA.

9. All IPC initiatives and projects will be evaluated with respect to relevant outcomes (e.g. patient outcomes, staff evaluations, workload, fiscal impact, etc.).

The remainder of this document will describe the components of the Interprofessional Practice Model (Figure 2.0), and the evidence supporting their inclusion in the model.
II. HPHa INTERPROFESSIONAL PRACTICE MODEL

Philosophy Statement:

The professionals of the HPHA are committed to provide safe, quality patient care through interprofessional collaborative teamwork.

Model Framework

The Interprofessional Practice Model (IPPM) is designed to support patient/family-centered care, to elevate the practice expectations of the regulated and unregulated care providers at the HPHA, and identify attributes that support healthy work environments and excellent patient outcomes.

A) Patient and Family-Centered Care

Patient and Family-Centered Care is the central element of the HPHA IPPM; in fact, it is central to everything that we do. Patient-centered care is a critical component of healthcare and can be described as an approach to care that consciously adopts the patient’s perspective.

Orchard defines patient/client/family-centred collaborative care as a “partnership between a team of health providers and a patient where the patient retains control over his/her care and is provided access to the knowledge and skills of team members to arrive at a realistic team-shared plan of care and access to the resources to achieve the plan”.

Patient-centred care means that the patient/client (and their family, if applicable) is at the centre of their own health care. It involves listening to patients and families and actively engaging them as a member of the healthcare team when making care decisions. When the patient is at the centre, the healthcare system revolves around their needs rather than the needs of healthcare providers, fiscal pressures or space allocation. Patient-centred care means that patients are working with their healthcare providers to determine health goals and treatment plans that are realistic and achievable.

Patient-centred care is not a new concept. Researchers from the University of Western Ontario published the “Patient-Centred Clinical Method” in 1986, which included many of the key principles espoused in current models of patient/family/person-centred care. It seeks an integrated understanding of the whole person – their emotional needs and life issues as well as their medical concerns. Although this particular method culminates in enhancing the patient-physician relationship, the method is applicable to the relationships between all healthcare providers and their patients. (see figure 3.0)
More recently, the term “Person-Centred Care” or “People-Centred Health” is being used to describe this concept, as it reflects a shift from a primary focus on the treatment of disease to a focus on the promotion/achievement of health for the person as a whole. This represents a significant paradigm shift, from the traditional “patriarchal” medical model, to one in which the patient assumes responsibility for the management of their healthcare. The four key principles of people-centred health, as defined by the Canadian Association for People-Centred Health (CAPCH) (17) are:

1. **Responsibility** – People are responsible for their health and wellness. This principle is comprised of three key elements:
   - **Ownership** – People own the realities and determinants of their personal health and wellness and their need for health care services.
   - **Empowerment** - People empower themselves and can be further empowered by health care professionals to manage their health and wellness.
   - **Commitment** – People strive to improve their health and wellness.

2. **Autonomy** – People make their own decisions affecting their health and wellness. This principle is comprised of three key elements:
   - **Individuality** – People’s individuality and definitions of health care quality are respected.
· **Authority** – People have the authority to manage any or all aspects of their health and wellness and to delegate that authority to someone else.

· **Choice** – People have the right to know and choose among all available options on how best to manage their health and wellness.

3. **Informed Health Management** – People have the information needed to manage and make informed decisions about their health and wellness. This principle has three key elements:
   · **Personal Health Information** – People own their personal health information. This is defined as personal health records and information about alternative treatment options.
   · **Access** – People have access to their personal health information at all times. This information is clear and understandable.
   · **Privacy** – People’s health information is private. They have the right to share it with whomsoever they choose.

4. **Partnership** – People partner with healthcare providers to ensure the best possible outcomes. This principle has one very important element:
   · **Support** – People receive the support they require to take responsibility and ownership of their personal health, to access their information and to take decisions concerning the options available to them. Health care professionals collaborate with one another to provide the best possible health care and wellness options and services to the people they serve.

   (reference #17)

Engaging clients as integral members of the healthcare team is paramount in interprofessional collaborative practice. When clients are actively engaged in managing their own health, they become part of the decision-making team, rather than passive recipients of health care. Respecting and supporting clients’ diversity and informed decisions and choices are inherent in client engagement.

A person-centred model of practice also involves engaging the population served by an organization in decision-making around the services provided. The International Association for Public Participation (IAP2) has developed a methodology for including public participation in organizational decision making, based on seven core values (see Table 2.0). Capital Health, a large multi-site academic healthcare organization in Nova Scotia, Canada has recently transformed their organization to a “People-Centred Care” model of care, and utilized the IAP2 methodology to accomplish a strategic direction of citizen engagement and accountability (18). They have reached their goal of patient involvement in 100% of their committees, and offer coaching sessions for patients on how to be effective members of their committees.

**Table 2.0** - IAP2 Core Values of Public Participation

1) Public participation is based on the belief that those who are affected by a decision have a right to be involved in the decision-making process.

2) Public participation includes the promise that the public’s contribution will influence the decision.
3) Public participation promotes sustainable decisions by recognizing and communicating the needs and interests of all participants, including decision makers.
4) Public participation seeks out and facilitates the involvement of those potentially affected by or interested in a decision.
5) Public participation seeks input from participants in designing how they participate.
6) Public participation provides participants with the information they need to participate in a meaningful way.
7) Public participation communicates to participants how their input affected the decision.

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The HPHA Interprofessional Practice Model promotes the active engagement of patients and families in the management of their healthcare, and the active involvement of our patients and the communities that we serve in our committees and decision-making processes.

B) HPHA Healthcare Providers

Our patients are supported by 14 categories of care providers within the Alliance, represented in the model by the overlapping circles surrounding Patient and Family-Centred Care. This team of regulated and unregulated care providers (UCP’s) is committed to working collaboratively in the provision of excellent patient care within their scope of practice. The regulated care professions (RHPs) included in the model are: Occupational Therapy (OT), Speech and Language Pathology (SLP), Social Work (SW), Pharmacy (PHARM), Physiotherapy (PT), Respiratory Therapy (RT), Medical Laboratory Technology (MLT), Medical Radiation Technology (MRT), Dietetics (RD), Medicine (MD), Nursing (RNs and RPNs) and Midwifery (RMW). These overlapping circles of care providers represent the linking of relationships essential for collaborative practice where integrated assessments and care plans based on the patient’s goals result in positive patient outcomes.

C) Key Components of Interprofessional Practice Model

1. **Interprofessional Collaborative Practice**

In “Interprofessional Care: A Blueprint for Action”, interprofessional care is defined as “the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings” (3). In February 2010, the Canadian Interprofessional Healthcare Collaborative (CIHC) published “A National Interprofessional Competency Framework”, which describes the competencies required for effective interprofessional collaboration (19). In this document, interprofessional collaboration is defined as “the process of developing and maintaining effective interprofessional working relationships with learners, practitioners, patients/clients/ families and communities to enable optimal health outcomes. Elements of collaboration include respect, trust, shared decision making, and partnerships”.

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The domains and background considerations in the CIHC model that influence the application of the competency framework in a wide variety of situations in all healthcare settings are depicted in Figure 4.0. The four central domains—role clarification, team functioning, interprofessional conflict resolution and collaborative leadership are surrounded by two domains that support the others: interprofessional communication and patient/client/family/community-centred care. The under-laying highlighted areas represent three background considerations that influence the application of the framework in different situations: Contextual Issues, Quality Improvement and Complexity (simple to complex). Most of the elements of this model are included in the HPHA IPPM, in a format that reflects the care environment of the Alliance.

In 1997, D’Amour provided an early, simplistic definition of interprofessional collaboration, which speaks to the essence of IPC:

“Collaboration in healthcare teams is the process by which interdependent professionals are structuring a collective action towards patients’ care needs” (20).

In an interprofessional model of care, the client is more likely to be a part of that team, and the team reaches consensus about intervention goals. This differs from a multidisciplinary model of care, in that professionals from different disciplines function independently, in parallel to one another (21).

Combining the elements of interprofessional care with patient-centred care, Health Canada states that collaborative patient-centered practice is designed to enhance patient-, family-, and community-centred goals and values, provide mechanisms for continuous communication among health care providers, optimize staff participation in clinical decision making (within and across disciplines), and foster respect for the contributions of all providers (8). There is growing consensus that interprofessional collaborative patient-centered practice will realize the following outcomes:

- improved population health / patient care;
- improved access to health care;
- improved recruitment and retention of health care providers;
- improved patient safety and communication among health care providers;
- more efficient and effective employment of health human resources;
- improved satisfaction among patients and health care providers.

(3,5,6,8,9,13,14,16,22,33)
Figure 4.0 - The National Competency Framework (CIHC)
(reference # 19)
As the literature on IPC has been growing exponentially and deepening our understanding of the concepts, D’Amour and Oandasan (22) coined the term “interprofessionality” to expand upon these concepts. They define interprofessionality as “the development of a cohesive practice between professionals from different disciplines. It is the process by which professionals reflect on and develop ways of practicing that provides an integrated and cohesive answer to the needs of the client/family/population.” D’Amour and Oandasan further state that interprofessionality requires a paradigm shift, since interprofessional practice has unique characteristics in terms of values, codes of conduct, and ways of working, which need to be elucidated. The care provided to the patient and the patient’s willingness to participate are key factors in this approach. Interprofessionality also concerns the practice environment and the processes that support cohesive collaborative practice, as depicted in Figure 5.0. Therefore, interprofessionality requires continuous and effective interaction between professionals and managers, in order to understand the appropriate environmental conditions for the development of interprofessionality.

**Figure 5.0 - Collaborative Practice: Processes and Outcomes**

(Reference # 22)
The HPHA IPPM currently includes 4 key structural/organizational components to support and foster interprofessional collaborative practice:

➤ **Interprofessional Practice Council**

- Includes representatives from each regulated health profession employed in the HPHA
- Provides support and guidance that focuses on interprofessional evidence-based practices, research, patient and staff safety initiatives and patient centered care.
- Promotes and enhances interdisciplinary collaboration in practice, quality, education, research, patient safety and quality practice settings across all professions and programs with internal and external partners.
- Identifies, develops and promotes opportunities and initiatives that operationalize the integration of interprofessional collaborative practice at a unit/departmental level; including but not limited to interdisciplinary patient assessments and clinical documentation.
- Promotes a quality practice environment that empowers healthcare professionals to utilize evidence-based knowledge, skills and judgments to the full extent of their defined scope of practice.
- Identifies the need for, and supports the development, implementation and evaluation of best practices, policies and procedures, standards of practice, competencies, clinical practices guidelines, regulatory and legislative requirements in collaboration with the various Clinical Programs.
- Reports to the Corporate Lead, Professional Practice, who reports to the Chief Nursing Executive, who reports the work of the council to the Senior Leadership Team.

➤ **Unit Action Councils**

Unit Action Councils (UACs) will be formed for each patient care unit/program at all 4 sites of the HPHA. Collaborative practice on patient care units achieves optimal results when all staff (regulated and unregulated) who provide care to patients on that unit are involved in planning, problem solving, decision making and goal setting (4,23). Golanowski et al (23) stated that shared governance is a “vehicle to improve patient outcomes by engaging knowledgeable, front-line staff in shared decision-making, to improve patient care delivery”. Two key principles are:

1. The primary point of decision-making in clinical care is at the point of service (POS), where patients and care providers meet
2. Effective organizations are structured from the POS outward, so that all structures, activities and support systems have patient care as their primary focus (23).

The four important elements/characteristics of UACs are:

1. Accountability (authority, autonomy and control)
2. Partnership (clear, non-competitive, interdependent relationships with a focus on outcomes)
3. Ownership (invested in the council; can speak to personal contribution to the purpose and outcomes)
4. Equity (integration of all members contributions to outcomes; no outcome is due to or sustainable through the actions of one member) (23).

UACs provide a forum for all staff and leaders of a patient care unit to address patient care/process issues specific to their unit, through collaborative shared-decision making that is focused on patient- and family-centered care. Their primary goal is to create effective and efficient interdisciplinary POS decision-making processes, to achieve improved access to services and patient outcomes. Research has demonstrated the following outcomes/benefits of UACs: improved patient care, increased staff morale and job satisfaction, and operational efficiencies resulting in cost savings (7,23-26). All of these factors support the attributes of a quality work environment.

The principles of “Shared Governance”/Participatory Leadership are utilized in the development and management of the UACs (7,23-27). Membership of the council is determined by the staff on the unit, who vote for their colleagues to represent them. The elected representatives determine the leader for the group, and make all decisions by consensus. Program Directors/Managers of the unit will not lead the meetings of the UACs, however, they are there to provide support, mentorship and guidance as appropriate.

The Corporate Lead, Professional Practice guides and supports the development and implementation of the UACs for each patient care unit/area, utilizing the “Unit Action Implementation Guide”. The UACs are guided by ‘Terms of Reference’ in making decisions that determine the functioning of the UAC as well as decisions that affect the process of care on the unit. UACs report to the HPHA Corporate Lead, Professional Practice, who reports to the Senior Leadership Team through the Chief Nursing Executive. This reporting structure helps to ensure that the work of the UACs in the various patient care units is complementary and in alignment with the organization’s vision/mission and strategic goals.

Members of the UACs work with leadership to define behavioral expectations and unit norms. The principles of the “Juice” program and “Pull Conversations”¹ are employed and reinforced, enabling respectful, open and productive discussions. Staff members have opportunities for professional development in identifying areas for improvement and learning processes in their respective departments/units to address them. Topics for discussion could include, but are not limited to, process efficiencies to improve patient/family-centred care, role clarity/shared skill sets, change of shift/transfer of accountability, patient satisfaction, interdepartmental processes, unit cleanliness and quality of work life.

Outcomes are evaluated for all UACs and tracked centrally for the HPHA by the Corporate Lead, Professional Practice.

Interdisciplinary Care Plans and Documentation

One of the most significant challenges to interprofessional care is communication, and the absence of well-coordinated and integrated communication systems leads to medication errors and other adverse events, delays in treatment, duplication of work, wasted resources and frustration for the patient/family and healthcare providers alike (3,5-7,20,28). The American Joint Commission reported in 2006 that almost 70% of patient adverse events cite the lack of collaboration and communication between providers as a main cause of the error (29). Accreditation agencies, such as Accreditation Canada (41) now have accreditation standards and guidelines in place that include interdisciplinary care and team management. The American Joint Commission has collaborative practice guidelines in place for healthcare organizations and requires their implementation for Accreditation. Organizations are also graded on interdisciplinary practice plans (5). Tools and structures to improve interprofessional communication include the development of interdisciplinary assessment forms that are documented on the patient’s health record, and interdisciplinary care plans that are based on the patient’s/family’s goals for their care and treatment/management.

The Electronic Health Record (EHR) system utilized by the HPHA is Meditech, and current documentation by healthcare professionals is “siloed” and fragmented, as is typical of most current EHRs. The HPHA Electronic Documentation Steering Committee will work with the IPPC to revise assessment and documentation forms within Meditech. This enables interprofessional assessments and care plan documentation, which are readily accessible to all staff providing care for the patient.

“Bullet Rounds”

Interdisciplinary patient rounds are not new in acute care settings; however, the usual frequency is once per week. With the average length of stay (LOS) between four and five days in most acute care areas, the likelihood of these meetings resulting in timely discussions and collaborative decision-making for the majority of patients is low. Patient access to services has been a major concern in Ontario hospitals in recent years. Problematic access to acute care beds results in reduced patient access to health services, cancelled surgeries, delayed treatments and decreased ability to transfer patients to the healthcare setting most appropriate to meet their needs. One of the recommendations included in the Centre for Healthcare Quality Improvement (CHQI) “Flo Collaborative” strategy is to conduct quick morning discharge rounds on inpatient medical units with members of the interdisciplinary team, to discuss patients’ estimated discharge dates and medical readiness for discharge (30). Daily interdisciplinary rounds enable discharge planning to begin on admission, with timely identification of patient needs for interventions by appropriate healthcare disciplines, and early joint planning with families and community support agencies such as Community Care Access Centres (CCAC). Daily interdisciplinary rounds have been shown to result in better patient outcomes, decreased length of stay (LOS), less service duplication, reduced hospital costs and improved patient education (5,20,31,32).

“Bullet rounds” began at the HPHA in 2010, starting in inpatient Medicine/Palliative Care and Critical Care units at the Stratford General Hospital site and in Medicine at St. Marys Memorial Hospital site, with plans to implement throughout the Alliance.
2.0 Role Clarity/Scope of Practice

- Mutual Understanding of Each Profession’s Role and Scope

Another frequently cited challenge to interprofessional practice in healthcare teams is a lack of role clarity and understanding of each other’s professions (5, 6, 8, 9, 16, 19, 20-23, 28, 31, 33). This is an understandable consequence of our traditional educational system for healthcare professionals, in which uni-disciplinary education has been the norm; yet graduates enter the workplace in healthcare settings with an expectation that they will work in conjunction with many different healthcare professionals. Interprofessional education is now being incorporated into the curriculum of all healthcare disciplines, at a rate that exceeds the implementation of interprofessional care models in most healthcare organizations (33). Healthcare organizations that have implemented and embrace an interprofessional practice model are seen by new graduates as preferred employers, where they are able to practice to the full extent of their profession’s scope of practice. The lack of mutual understanding of each other’s professions needs to be addressed early in the implementation of the IPPM, as it undermines the trust and respect between disciplines that are essential for IPC teams. The HPHA IPPC identified the lack of understanding of each other’s disciplines as a challenge to IPC, so have initiated education sessions to address this challenge during IPPC meetings. This information will be disseminated and made available to all staff and physicians of the Alliance.

- Understanding of Shared Skill Sets

With greater mutual understanding amongst disciplines comes an understanding and appreciation for scopes of practice for each profession, as well as an understanding of shared skill sets amongst various disciplines. With the passing of Bill 179 (“An Act to amend various Acts related to regulated health professions and certain other Acts”) in Dec. 2009 by the Ministry of Health and Long-Term Care (MOHLTC) (34), amendments were made to various Acts related to regulated healthcare professionals, including amendments to enhance the scopes of practice of such professions as dietetics, medical radiation technology, midwifery, nursing, optometry, pharmacy, physiotherapy, respiratory therapy and social work. The various colleges that regulate these professions are in the process of developing regulations and procedures for implementation of these enhancements to their scope of practice. The HPHA likewise will review current care plans and clinical processes of care delivery, to ensure that all professions at the HPHA are able to practice to the full extent of their scope of practice.

- Collaborative Care Model

The HPHA Collaborative Care Model is based on the concepts of the nursing-focused “Autonomous Collaborative Care Model” (4), and operationalizes the concept of patient and family-centred interprofessional collaborative care. It expands upon the principle of differentiated nursing practice that focuses on the division of tasks required to meet patient
care needs, to include *all members of the interdisciplinary team*, emphasizing the need for collaboration in order to maximize effectiveness (4). With respect to nursing, the HPHA Collaborative Care Model is based on the premise that patient care assignments are related to the scope of practice and experience level of each category of nurse. The RN is assigned to the most complex, unpredictable and high risk patients as defined by the College of Nurses of Ontario (10,11). The RPN provides care to patients with predictable outcomes and less risk. The assignment clearly delineates the person who is ultimately accountable for the planning, delivery and evaluation of nursing care for each patient. It is essential that the assigned nurse is competent to provide all of the care, and/or collaborates with another care provider(s) to ensure that all care needs of the patient/family are met. Care providers work collaboratively, yet are accountable for the care they provide, making decisions autonomously within their scope of practice.

**Principles of HPHA Collaborative Care Model:**

- **Autonomy:** Regulated Healthcare Professionals (RHPs) are given the freedom to act on their knowledge and to make independent clinical decisions within their scope of practice, in the best interest of the patient/family. The degree of autonomy is affected by the complexity of the patient. All RHPs are expected to work to their full scope of practice, in accordance with the parameters and requirements of the clinical area.

- **Collaboration:** All RHPs will collaborate with patients, families and other members of the interprofessional team for the patient’s benefit. Shared planning, decision-making, problem solving and goal setting are the responsibility of all members of the healthcare team.

- **Accountability:** All RHPs are expected to work to their full scope of practice and take full accountability for their knowledge, skills, judgment and for the care they plan and deliver to their assigned patient(s) as well as for the outcomes of the care delivered.

- **Patient/Family-Centred Care:** (refer to page 9)

- **RN/RPN Assignments:** (see Appendix “A”)

- **Resource Utilization:** This model supports the concept of assigning the right care provider at the right time for the right patient/family while optimizing the number of direct care providers at the bedside. Consideration is given to patient preferences over care-provider routines. There is an emphasis on reduction in duplication of care and questions as a result of a limited number of care providers interacting with patient/family, and improved interprofessional collaborative care. High quality, cost-effective care is a result of healthcare professionals practicing to their full scope of practice at the right time with the right patient.

- **Continuity:** This is made possible through a patient-centred approach to managing care needs of the patient/family. All reasonable attempts are made to have the same
Caregiver assigned to the same patient(s), wherever possible. Communication of information between all health care providers is a fundamental component of patient care. The information shared between health care providers who are changing shifts, transferring patients from unit to unit or to another site, helps plan patient care, identifies safety concerns and facilitates continuity of care. The information imparted during this exchange is fundamental to the professional activities that follow, and consequently to the care the patient receives.

- **Standards of Practice:** All RHPs will practice in accordance with the standards of practice of their respective colleges, and in accordance with the legislative acts which govern their professions. These standards of practice will be reflected in unit policies and procedures.

- **Core Competencies:** Competencies refer to the knowledge, skills, judgment and attributes of a RHP to practise safely and ethically in a designated role and setting. Each department/unit shall develop and update the practice expectations of the RHPs working on that unit. Theses core competencies will provide the basis for staff selection, orientation process, staff quality assessment (performance appraisal process), all using the Benner model (see Appendix 1) as the underlying framework.

- **Unit Norms:** The development and implementation of Unit Action Councils will assist in the identification and communication of accepted formal and informal rules that govern interactions between care providers.

- **Discharge Planning:** Early and thorough discharge planning is the shared responsibility of all healthcare providers caring for the patient. Excellent documentation and care planning with a strong focus on continuity are essential in order to communicate these plans across the continuum of care.

**Underlying Assumptions of the HPHA Collaborative Care Model:**

- With respect to nursing, the RN/RPN relationship is one of collaboration, not supervision.

- This model contemplates an adequate number of support personnel (Housekeepers, Unit Clerks, etc.) to allow nurses and other RHPs to focus on the processes of care specific to their professions and minimize involvement in non-RHP tasks (e.g. delivering meals, collecting garbage, changing linen bags, transcribing physicians’ orders, etc.).

- All RHPs are accountable to document their plan of care, the care provided and the outcomes of that care.

- Effective communication of information between health care providers is a fundamental and essential component of patient care, and a professional practice
expectation of all of the respective colleges. The manner in which all exchanges occur is respectful and reflects active listening and engagement of the parties.

3.0 Professional Development

The HPHA is committed to the professional development of all of their staff. Resources include library resources at each of the four HPHA sites, shared library services and a variety of e-learning resources that are available through the “My Alliance” website. In addition, performance appraisals with a focus on professional growth and development are conducted on a regular basis.

The key elements/supports for staff professional development included in the HPHA IPPM are:

- Reflective Practice: Quality Assurance (QA) programs; self evaluation and peer feedback
- Personal Accountability: adherence to College QA programs
- Continuous Learning: learning activities beyond basic practice standards
- Mentoring/Coaching: relationships established for supportive growth
- Professional Associations: opportunities for professional growth and networking

4.0 Evidence Informed Practice

The provision of quality patient care relies on each healthcare professional maintaining an up-to-date knowledge of “best practices” in their profession, as defined by their colleges, professional associations and current peer-reviewed literature. As regulated healthcare professionals, it is their responsibility to maintain a current knowledge base and competencies required in the provision of care to their patients. The key elements of evidence informed practice in the HPHA are:

- Best Practices: all practice and care supported by current evidence
- Patient Safety: paramount in daily practice; attention to avoiding, managing and correcting unsafe acts and conditions in the organization. The HPHA Patient safety rounds are an opportunity to bring together multidisciplinary staff in an open, trusting forum to discuss actual or potential safety concerns in their area. They also act as a means for bring forth safety concerns to the management and senior management level, creating a direct channel for communication of these issues.
- Critical Thinking: skilled expertise in assessment of presenting signs and symptoms followed by appropriate action
- Quality Improvement Initiatives: evaluation of care processes as related to outcomes
- Research: scientific enquiry into factors affecting practice and patient care
The HPHA supports these practice expectations through an organizational commitment to professional development and continuing education.

D) Supportive Factors

1. Change Management

Despite the compelling evidence that an interprofessional practice model of care will bring significant benefits to patients, healthcare providers, healthcare organizations and the system as a whole, the changes required will be challenging to implement and require a well-planned transition management strategy. The current processes for care provision in our hospitals are deeply rooted, and both leaders, physicians and staff need to share the vision and conviction to the model, as well as acknowledge the need to change. In order for the transitions to be successful, a significant cultural shift is required in values and beliefs with respect to team functioning and relationships. At a 2010 Ontario Hospital Association conference on patient-centred care, Adalsteinne Brown (Assistant Deputy Minister – Health System Strategy Division, MOHLTC) while addressing the challenges inherent in implementing changes in health care, stated that “culture eats strategy for lunch” (36). For change management strategies to be successful and sustainable, the required cultural and value shifts need to be addressed successfully, in addition to a well-planned implementation strategy for process and organizational changes.

In the book “Switch: How to Change Things When Change is Hard” (37), the authors provide a model for implementing difficult changes that consists on three main components:

- **Direct the “Rider”, which is the rational side of people, by**
  - Pointing out and investigating the bright spots; what is working well already
  - Script the critical moves – break-down the bigger picture into smaller pictures that focus on specific behaviours
  - Point to the destination – everyone needs to know the direction of change, where you are going and why it is worth it.

- **Motivate the “Elephant”, which is the emotional side of people, by**
  - Find the feeling – knowing something is not enough to cause change; emotions need to be identified that will motivate people
  - Shrink the change – breakdown the change into smaller changes; don’t “spook the elephant”
  - Grow your people – cultivate a sense of identity and instill the growth mindset

- **Shape the path towards the changes desired by**
  - Tweaking the environment – change the situation to encourage the behaviour change
  - Build habits – look for ways to encourage habits, since when behaviour is habitual, it does not “tax” the “rider”
“Rally the herd – behaviour is contagious, so help the desired behaviour spread

Therefore, in addition to providing a rationale filled with compelling evidence of the benefits of IPC, methods of engaging staff and leaders emotionally in this vision are employed, so that there is a shared sense of ownership in the model and the changes required. Educational strategies are important in achieving this paradigm shift, including focus groups, staff forums and e-learning resources such as IPC Team Development Modules that provide consistent education to all staff, physicians and students of the HPHA. Formal and informal networking opportunities are arranged with staff and leaders, and an Interprofessional Practice Newsletter produced by the Interprofessional Practice Council is posted on the hospital website, ensuring availability to all staff.

Strategies to ensure sustainability of the changes are of equal importance to the implementation strategies themselves. The Institute for Healthcare Improvement produced a framework for successful and sustainable strategic improvement initiatives (see Figure 6.0)(38).

The framework cites three factors for sustainability:

- **Performance management**
  - Monitor all key metrics at unit level, including benefits in addition to improved patient care, such as process efficiencies, reduced wastage
  - Monitor 1-2 key outcome metrics that are regularly shared with staff, senior leadership and the board
  - Perform regular audits at the unit level to monitor compliance

- **Organizational infrastructure**
  - Decision support systems and ongoing measurement
  - Quality improvement training for all staff; initial orientation and regular “refreshers”
  - Forums for open discussion

- **Accountability**
  - Job descriptions
  - Performance reviews
  - Process “owners” identified at all levels of the organization
Another important factor for sustainability is ensuring that the initiative is aligned with the organization’s strategic directions; otherwise there is a risk of a lack of infrastructure support. The Interprofessional Practice Model is aligned with the “quality” corporate priority of the HPHA, which was one of the initial drivers for this work. It is also aligned with the “Workplace Health” corporate priority (refer to page 4).

It should be noted that sustainability is not static; there is constant movement and therefore a constant need for evaluation. The implementation of the IPPM is an ongoing journey, not a final destination. Changes are well planned and phased-in utilizing the various change management strategies noted.

2. **Resource Allocation**

The HPHA has committed resources in the creation of the position of Corporate Lead, Professional Practice, who is responsible for working with leadership, staff and physicians in the development and implementation of the IPPM. Resources will also be required for educational initiatives to support the implementation of the model, such as in-house educational sessions and e-learning tutorials.

3. **Continuous Quality Improvement**

A learning organization is one in which staff and associates continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are
nurtured, where collective aspiration is set free, and where people are continually learning how to learn together. This type of an organization provides opportunities for staff at all levels to be involved in developing department processes and quality improvement initiatives. Staff has opportunities to participate in hospital-based committees and to participate in interprofessional practice initiatives. Monitoring of patient outcomes and operational performance indicators will also be included in evaluations of the impact of changes implemented as part of the IPPM.

4. Participatory Leadership

Participatory Leadership provides a structure where regulated and unregulated care providers are empowered to make decisions about their work environments and can participate in decisions regarding the delivery of patient care. It promotes the growth of interdisciplinary relationships reflecting a level of clinical interaction that advances the work of the profession and clearly impacts good patient care.

Unit Action Councils are comprised of “unit staff” who are guided by ‘Terms of Reference’ in making decisions that affect their unit. Staff has opportunities for professional development in identifying opportunities for improvement, and learning processes in their respective departments/units to address them. Topics for discussion could include but are not limited to unit cleanliness, change of shift hand-offs, patient satisfaction, interdepartmental processes, and quality of work life. A “Unit Action Implementation Guide” assists the leaders and staff of units in the development and implementation of their own Unit Action Council.

5. Transformational Leaders

Transformational Leadership is an adaptive form of leadership which enables leaders to empower those around them to generate creative solutions to complex problems during periods of change and transition (39). The four characteristics of Transformational Leaders are: 1) Charisma, or idealized influence; 2) Inspirational motivation; 3) Intellectual stimulation, and 4) Individualized consideration (40). Transformational leaders motivate others to do more than they thought possible. They set more challenging expectations and typically achieve higher performance. Transformational leadership is an interactive relationship based on trust that positively impacts both the leader and the follower; it is a mutual responsibility of both the leader and the follower. As leadership transforms, the purpose of the leader and follower become focused, creating unity, wholeness, and collective purpose. Successful implementation of the IPPM in the HPHA relies upon transformational leadership, at all levels of hospital leadership.

6. Quality Work Environment

The HPHA is committed to ensure all staff work within a quality work environment (QWE) and gain quality of work life (QWL), as reflected in the corporate priority “Workplace Health”. Research reveals that a QWE and QWL are directly linked to quality patient outcomes (3,7,9,33).
Attributes of a QWE:
Efficient unit processes
Empowerment for decision making
Transformational leader (see above)
Safe work environment
Healthy staff with reduced sick time
Reduction in staff turnover
Opportunities for professional development

All staff has received training on the program “Juice”\(^2\), which provides the knowledge, skills and tools for staff to engage in respectful, open and productive discussions about difficult and contentious issues. “Juice” identifies five drivers of employee engagement:

1) “I Fit”, leads to a sense of belonging
2) “I’m Clear” leads to a feeling of security
3) “I’m Supported” leads to a state of freedom
4) “I’m Valued” leads to a feeling of significance
5) “I’m Inspired” leads to a sense of purpose

Utilization of the skills and “pull conversation” techniques learned in the “Juice” program is critical in the successful implementation of all components of the IPPM.

7. Community Stakeholders

In the development and implementation of the IPPM, inclusion of all community stakeholders who are involved in the spectrum of care for patients of the HPHA is important to the success of the model. Figure 7.0 depicts the spectrum of care that needs to be included in any interprofessional care model (33).

Community stakeholders for the HPHA include the CCAC that cares for our patients in the community, long-term care homes, tertiary care centres such as London Health Sciences Centre and St. Joseph’s Healthcare, the Southwest LHIN, and all other regional healthcare providers from both the public and private sectors. Successful planning for revisions to care processes that involve these stakeholders requires open and meaningful communication with these partners in patient care. Nurturing and strengthening these relationships will be pivotal in achieving truly seamless care for our patients and families.

III. SUMMARY

The purpose of this document is to provide the rationale and evidence that supports the HPHA Interprofessional Practice Model, and to provide some suggestions, direction and details with respect to the requirements for successful implementation of the model. It is not meant to represent an end-point, but rather a starting point on a journey that all leaders, physicians and staff of the HPHA have a voice in shaping. Specific details for the various components of the plan will evolve through discussions and working groups including all relevant stakeholders as this journey progresses. The alignment of this model with the HPHA Corporate Priorities, the MOHLTC directions for interprofessional care and national initiatives to promote interprofessional, person-centred care creates strong incentives and motivation to move forward. The success of the model will ultimately rest with the attainment of a shared vision for interprofessional practice within the HPHA, and a shared sense of ownership for this revised model of practice.
IV. REFERENCES

1) Smitherman, George, Right Honorable Minister of Health and Long-Term Care, Province of Ontario, Address to Economic Club, Toronto, Ontario, Feb. 2004.

2) Dagnone, T. Patient First Review Commissioners Report to Saskatchewan Minister of Health, October 2009.


18) Power C, (June 17, 2010) “People-Centred Care: Redefining Patient-Centred Care”. Presentation to Ontario Hospital Association conference “Redefining patient-Centred Care: What Does it Really Mean?”.


34) Legislative Assembly of Ontario, Bill 179 (Chapter 26, Statutes of Ontario, 2009)


V. APPENDIX “A”

RN and RPN Assignments

RN and RPN assignments are related to the scope of practice and experience level of each category of nurse, as identified in Benner’s Stages of Clinical Competencies (see below). The RN is assigned to the most complex, unpredictable and high-risk patients. The RPN provides care to patients with predictable outcomes and less risk. Each unit will develop “Patient Assignment Guidelines”, utilizing the College of Nurses’ three-factor framework: the patient; the nurse and the environment (10,11).

Benner’s Stages of Clinical Competence: Novice to Expert

The HPHA acknowledges Patricia Benner’s stages of clinical competence as the model professionals will use to measure their stages of professional development within their clinical practice. Proficiency in a particular role is a progressive process and is a function of time, influences, coaching, mentoring, leadership, continuous lifelong learning, reflective practice and feedback.

There was agreement amongst the interdisciplinary group that this model would be suitable for all regulated and unregulated care providers. Departments will develop clinical competencies/practice expectations for all categories of care providers within the department. Care providers will be evaluated based on Benner’s stages of clinical competence.

Benner’s model, based on interviews with nurses, describes the development of a healthcare provider’s clinical practice in a staged manner from novice to advanced beginner to competent to proficient and to achieving the status of expert. Progression through the continuum is dynamic and changes in the profession, standards, legislation, environment or position can result in a regression, albeit potentially short-lived. There are five stages in the continuum from novice to expert:

**Novice:**
Beginners have had no experience of the situations in which they are expected to perform. Novices are taught rules to help them perform. The rules are context-free and independent of specific cases; hence the rules tend to be applied universally. The rule-governed behavior typical of the novice is extremely limited and inflexible. As such, novices have no "life experience" in the application of rules. "Just tell me what I need to do and I'll do it."

**Advanced beginner:**
Advanced beginners are those who can demonstrate marginally acceptable performance, and who have coped with enough real situations to note, or to have pointed out to them by a mentor, the recurring meaningful situational components. These components require prior experience in actual situations for recognition. Principles to guide actions begin to be formulated. The principles are based on experience.
Competent:
Competence, typified by the providers who has been on the job in the same or similar situations two or three years, develops when they begin to see his or her actions in terms of long-range goals or plans of which he or she is consciously aware. For the competent provider, a plan establishes a perspective, and the plan is based on considerable conscious, abstract, analytic contemplation of the problem. The conscious, deliberate planning that is characteristic of this skill level helps achieve efficiency and organization. The competent provider lacks the speed and flexibility of the proficient provider but does have a feeling of mastery and the ability to cope with and manage the many contingencies of clinical practice. The competent person does not yet have enough experience to recognize a situation in terms of an overall picture or in terms of which aspects are most salient, most important.

Proficient:
The proficient provider perceives situations as whole rather than in terms of separate parts or aspects, and performance is guided by maxims. Proficient providers understand a situation as a whole because they perceive its meaning in terms of long-term goals. The proficient provider learns from experience what typical events to expect in a given situation and how plans need to be modified in response to these events. The proficient provider can now recognize when the expected normal picture does not materialize. This holistic understanding improves the proficient provider's decision making; it becomes less labored because the provider now has a perspective on which of the many existing attributes and aspects in the present situation are the important ones. The proficient provider uses maxims as guides which reflect what would appear to the competent or novice provider as unintelligible nuances of the situation; they can mean one thing at one time and quite another thing later. Once one has a deep understanding of the situation overall, however, the maxim provides direction as to what must be taken into account. Maxims reflect nuances of the situation.

Expert:
The expert performer no longer relies on an analytic principle (rule, guideline, maxim) to connect her or his understanding of the situation to an appropriate action. The expert provider, with an enormous background of experience, now has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions. The expert operates from a deep understanding of the total situation. The chess master, for instance, when asked why he or she made a particularly masterful move, will just say: "Because it felt right; it looked good." The provider is no longer aware of features and rules; his/her performance becomes fluid and flexible and highly proficient. This is not to say that the expert never uses analytic tools. Highly skilled analytic ability is necessary for those situations with which the provider has had no previous experience. Analytic tools are also necessary for those times when the expert gets a wrong grasp of the situation and then finds that events and behaviors are not occurring as expected when alternative perspectives are not available to the clinician, the only way out of a wrong grasp of the problem is by using analytic problem solving.