# JOINT STATEMENT ON RN CLINICAL PROTOCOLS BETWEEN THE COLLEGE OF PHYSICIANS AND SURGEONS OF SASKATCHEWAN (CPSS) AND THE SASKATCHEWAN REGISTERED NURSES' ASSOCIATION (SRNA)

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## PURPOSE

Physicians and registered nurses (RN)s have worked in collaborative practice for over a century to provide quality care to the people of Saskatchewan. Collaborative practice:

> Involves the continuous interaction of two or more professionals or disciplines, organized into a common effort to solve or explore common issues, with the best possible participation of the patient. Collaborative practice is designed to promote the active participation of each discipline in patient care. It enhances patient and family-centred goals and values, provides mechanisms for continuous communication among caregivers, optimizes staff participation in clinical decision-making within and across disciplines, and fosters respect for disciplinary contributions of all professionals (University of Toronto et al, 2004, p.28).

Each professional has specific roles and responsibilities for client care that arise from their legislated scope of practice. There are client care situations (e.g. management of anaphylaxis) in particular settings (e.g. public health) where activities within the scope of practice for physicians and RNs overlap. It is essential for the provision of safe client care, that when professional practices overlap there is collaboration, good communication, and clarity of roles and responsibilities. This joint statement provides a framework for collaboration between physicians, RNs, and employers when client care requires a RN to implement a RN clinical protocol. It has been incorporated into the *Standards for RN Specialty Practices* (SRNA, 2015).

## RN CLINICAL PROTOCOL

A RN Clinical Protocol outlines a series of registered nursing activities that are implemented in pre-determined situations to provide highly specialized client care. It allows a RN to work collaboratively with a physician(s) on an agreed upon practice for the clinical management of a client care situation where their scopes of practice overlap. It also allows RNs to contribute to timely, quality and efficient client care and provide a standardized process for the safe implementation of client care.

**Principles**

1. The activities within a RN Clinical Protocol must be within the scope of practice of the general practice RN. It does not:
    1) allow a RN in general practice (excluding the RN with additional authorized practice) to independently diagnosis a medical condition, disease or disorder, prescribe or dispense medications, order tests and treatments; or
    2) apply to an activity that requires physician delegation to a RN. A RN who is unsure whether an activity requires a physician delegation should consult with a clinical RN educator and/or with a SRNA Practice Advisor.
2. It provides the authority for a RN who has obtained the specialized competencies and proficiency to implement care:
    1) Independently, without a client specific order, in either:
        a. an Emergency Health situation; or
        b. a Health Service/Program.
    2) For an Advanced RN Intervention with a client specific order.
3. It must be contained in a written document which outlines a series steps for the implementation of specific client care.
    1) The steps for care will provide greater detail and direction than a guideline.
    2) The content within the document must contain information as outlined in the *Standards for RN Specialty Practices* (SRNA, 2015).
    3) Is made accessible in a nursing manual or a computer file.
4. To avoid confusion with other health care professionals who also utilize a clinical protocol (e.g. paramedics), a documented RN Clinical Protocol must be expressed as a "RN Clinical Protocol".
5. Wherever it is feasible, employers throughout Saskatchewan are encouraged to work collaboratively to standardize the use of RN Clinical Protocols across employment settings. The standardization of these documents are beneficial for: delivering consistent client care; mitigating error and increasing safe client care; allowing for the portability of competencies between employment settings; providing health care cost-savings; and enhancing quality improvement initiatives.

## RESPONSIBLITIES FOR RN CLINICAL PROTOCOLS

A RN Clinical Protocol is an agreed upon document that has shared responsibilities between a physician, the individual RN, and an employer.

A physician is responsible for:

1. Providing the medical diagnosis, treatment, prescribing and monitoring of the client's health and/or their disease or disorder.
2. Participating in the development and written agreement (with signature) for the policy and a RN Clinical Protocol that will be used in a client care situation. A medical representative (e.g. medical health officer, chair of a medical advisory

committee, department head) may approve the documents on behalf of a group of physicians.

3. Assuming the ongoing medical management of the client's care and provides client specific orders once he/she has been notified by a RN that a RN Clinical Protocol was implemented.

The individual RN meets the following standards:

1. Ensuring his/her practice is consistent with legislation, SRNA bylaws, the scope and standards of practice, and any pertinent SRNA documents including the most current version of the following:
    1) SRNA *Standards and Foundation Competencies for the Practice of Registered Nurses*;
    2) Canadian Nurses Association, *Code of Ethics for Registered Nurses;*
    3) *Standards for RN Specialty Practices;* and
    4) The *Joint Statement on RN Clinical Protocols between the College of Physicians and Surgeons of Saskatchewan (CPSS) and the Saskatchewan Registered Nurses' Association (SRNA)*,(SRNA, 2015).
2. Acting in a professional manner, being accountable for his/her own practice, and maintaining conduct, competence (knowledge, skill and judgment) and proficiency in all aspects of his/her nursing practice, including the competence required to conduct a RN Clinical Protocol.
3. Obtaining and maintaining the appropriate specialized competencies, proficiency, and education for any specialty practice he/she must perform.
4. Being aware of his/her competence and not performing any RN Clinical Protocol until he/she has obtained the appropriate education and received certification or approval to perform it from a qualified educator.
5. Adhering to the employer policy for a RN Clinical Protocol.
6. Identifying the appropriate situation when a RN Clinical Protocol can be implemented either independently without a client specific order, or will require a client specific order from a prescriber. The three situations for RN Clinical Protocols include:
    1) the immediate management of a Health Condition in an Emergency without a client specific order.
    2) the provision of care in a Health Service/Program without a client specific order.
    3) the implementation of an Advanced RN Intervention with a client specific order.
7. Being responsible and accountable to implement a RN Clinical Protocol by:
    1) adhering to the written protocol.
    2) completing an assessment of the client (e.g. health history and presenting state of health).

3) using clinical judgment to determine:
   (a) a nursing diagnosis derived from the assessment;
   (b) the available options for the client's care needs;
   (c) the risks and benefits of each option (e.g. the client's care warrants the implementation of a RN Clinical Protocol, the consequences to the client if the RN Clinical Protocol is not implemented); and
   (d) the ability to manage both intentional and unintentional outcomes until client specific orders are obtained.
4) obtaining written consent, when required, for an Advanced RN Intervention (e.g. external temporary cardiac pacing; CPAP/BiPAP ventilation; insertion of a PICC device, etc.).
5) communicating with a physician in a timely manner to obtain client specific orders when:
   (a) the client's health condition is stabilized;
   (b) the RN Clinical Protocol identifies that a physician must be contacted;
   (c) he/she does not have the competence to manage the intentional and/or unintentional care outcome(s);
   (d) the RN Clinical Protocol does not specify the client's health condition and their presenting signs and symptoms;
   (e) there is an acute change in the client's situation once the RN Clinical Protocol is initiated;
   (f) the laboratory findings, client assessment, or other data is inconsistent with information in the RN Clinical Protocol; or
   (g) other circumstances occur which are not listed.
6) documenting on the client's health record the:
   (a) name of the RN Clinical Protocol;
   (b) time it was provided;
   (c) client care that was provided;
   (d) client's response to the care;
   (e) time when the physician was contacted and client specific orders were received;
   (f) education provided to the client and his/her family; and
   (g) other information as appropriate.

The employer is responsible for:

1. Providing essential resources (e.g. personnel, equipment) that enable a RN to safely perform a RN Clinical Protocol and to meet the requirements of all SRNA standards and scope of practice documents, including the most current version of the following:

1) SRNA *Standards and Foundation Competencies for the Practice of Registered Nurses*;
2) the Canadian Nurses Association*, Code of Ethics for Registered Nurses;*
3) *Standards for RN Specialty Practices* including the *Joint Statement on RN Clinical Protocols between the College of Physicians and Surgeons of Saskatchewan (CPSS) and the Saskatchewan Registered Nurses' Association (SRNA),* (SRNA, 2015).

2. Ensuring policies, RN Clinical Protocols, and job descriptions support a RN's practice. A job description cannot expand the legislated scope of RN practice as interpreted by the SRNA.
3. Working with physicians, RNs and other care providers to identify potential RN Clinical Protocols and providing the organization's written approval in policy for their use.
4. Ensuring when it is applicable, that consent requirements for an Advanced RN Intervention is included within a RN Clinical Protocol (e.g. external temporary cardiac pacing; CPAP/BiPAP ventilation; insertion of a PICC device, etc.)
5. Ensuring a RN who is performing a RN Clinical Protocol receives the appropriate education to attain the specialized competency(ies) and proficiency and provides opportunities for a RN to maintain his/her competence.
6. Maintaining a current record of the RNs who are approved to perform a RN Clinical Protocol in a practice setting.

## SITUATIONS FOR A RN CLINICAL PROTOCOL

There are three situations where a RN Clinical Protocol would be implemented. They include:

- a Health Condition in an Emergency;
- a Health Service/Program; and
- an Advanced RN Intervention.

### A Health Condition in an Emergency

A RN Clinical Protocol is required when a RN must provide care independently without a client specific order to manage a client's health condition in an emergency situation and a physician is not immediately available to provide client specific orders.

### Criteria

1. Emergency care situations are described as sudden, unexpected and unpredictable, where a client is critically ill and has significant care needs, and the activities that are implemented in the RN Clinical Protocol will prevent serious health deterioration and/or complications for the client.

2. The RN Clinical Protocol for an emergency must be pre-determined and have an established document.
    - Note: For a life-threatening event, where there is no established RN Clinical Protocol, it is the ethical obligation of any RN to provide the best care possible, given the circumstances and his/her level of competence.
3. A health condition has distinct signs and symptoms of an underlying medical disease or disorder that with a RN's intervention can be improved or resolved until the client is medically managed by a physician, RN(NP), or other authorized prescribers. A RN is professionally accountable for the outcomes achieved through the intervention.
4. A "physician is not immediately available", is interpreted to mean that a physician is not accessible to provide timely client specific orders for a client.
5. Examples include but are not limited to: the management of anaphylaxis, life threatening cardiac arrhythmias that require defibrillation, and/or emergency cardiac medications, hypoglycemia and post-partum hemorrhage.

**A Health Service/Program**

A RN Clinical Protocol is required when a RN in a defined clinical role provides care independently, without a client specific order for individuals who are in an established Health Service/Program. The RN will assist a primary care provider to:

1) manage a client's diagnosed disease or disorder (e.g. insulin adjustment for gestational diabetes).
2) identify any diseases or disorders with unrecognized or pre-symptomatic signs or symptoms in a client (e.g. colorectal cancer screening program).
3) implement an Advanced RN Intervention to deliver client care for the purpose of disease prevention, health promotion, health maintenance, and/or rehabilitation (e.g. pap smear for health maintenance).

**Criteria**

1. To obtain the specialized competencies and implement the responsibilities for a defined clinical role, a RN is required to obtain specialized education that is appropriate to the role.
    1) The specialized competencies are obtained from an expert health care organization education or certification course, through a specialty certification, e.g. Canadian Nurses Association (CNA) Certification, or by other evidence-informed methods. For example, a Diabetes RN Educator could obtain certification with the Canadian Diabetes Educator Certification Board or another expert developed certification course; an employee health RN could obtain CNA certification in Occupational Health Nursing or another expert developed course; and a RN navigator

could obtain CNA certification in oncology nursing or another expert developed course.

2) When specialized education does not exist, a RN is responsible to obtain the education from an employer provided course that adheres to the education criteria as outlined in the *Standards for RN Specialty Practices* (SRNA, 2015).

2. An established Health Service/Program will have a specific focus with clients referred to it by a primary care provider, through public screening/prevention programs, employment policies, or other methods.

1) A physician must be designated to oversee the Health Service/Program. He/she is responsible for determining and approving the medical directive and working with the employer and RNs in the development and approval of a RN Clinical Protocol.

- A medical directive must be included in a RN Clinical Protocol when a RN is required to carry out specific activities on behalf of a primary care provider [e.g. physician, RN(NP)] that require a prescriber's order. For example, a RN is required to have an order to perform activities including but not limited to: ordering medical diagnostic tests, carrying out an Advanced RN Intervention, providing a client with his/her test results or a provisional medical diagnosis, or making referrals to specialists or a specialty clinic. A medical directive must adhere to the criteria outlined in the *Standards for RN Specialty Practices* (SRNA, 2015)**.**

2) The RN works as part of a collaborative team including but not limited to: the physician who is responsible for the Health Service/Program, physician specialists, the client's primary care provider [e.g. physician, RN(NP)], and others.

3) In most Health Service/Programs, a RN will perform care for a client who is healthy and stable and/or has been diagnosed with a pre-existing disease or disorder.

- In public screening programs, a client entering the Health Service/Program is assumed to be healthy and stable until he/she is diagnosed with a medical disease/disorder by a primary care provider.
- Each client must have a primary care provider [e.g. physician, RN(NP)] designated as most responsible for his/her care.

3. Appropriate communication must be established to ensure clear roles and responsibilities are understood between each care provider.

(a) A RN is responsible to:

- ensure the client and his/her primary care provider receives the client's health information (e.g. test results) in a timely manner.

- inform the primary care provider in a timely manner when a client's health status changes.
- inform a client he/she must consult with their own primary care provider for his/her ongoing medical care. The client's primary care provider [e.g. physician, RN(NP)] is responsible to follow-up with the client for his/her ongoing care needs.
- seek direction from the physician overseeing the Health Service/Program when a client does not have a designated primary care provider.

(b) The physician overseeing the Health Service/Program or the client's primary care provider is responsible to inform a client with a formal diagnosis of a medical condition, disease or disorder.

4. A RN in a defined clinical role may include but is not limited to a: RN navigator, diabetes RN educator, sexual assault RN examiner, employer health RN, and a RN enterostomal therapist.

**Advanced RN Interventions**

A RN Clinical Protocol is required for an Advanced RN Intervention that could pose a high risk of harm to a client if it is not carried out safely and competently. This activity is complex in its knowledge requirement and application, may require the performance of complex technical skills or minor invasive actions, and could have an increased potential for the occurrence of an unintentional outcome that must be managed appropriately and safely.

**Criteria**

1. A client specific order must be provided by a physician, RN(NP), or other prescribers prior to the implementation of an Advanced RN Intervention.
2. Only a RN who has attained the specialized competencies from an appropriate education, and is approved by his/her employer in a policy, may carry out an Advanced RN Intervention.
3. An Advanced RN Intervention is determined by conducting a practice assessment, and when required, consulting with a SRNA Practice Advisor.
4. Examples include but are not limited to: inserting a peripherally inserted central catheter (PICC), performing cardioversion, adjusting pacemakers or setting and/or adjusting implanted cardiac devices, or performing pelvic exams or pap tests.

## CRITERIA FOR RN CLINICAL PROTOCOLS

**1. Assessment**

The initial step is an assessment to determine if the proposed activity is appropriate to RN practice and will require a RN Clinical Protocol. The assessment includes a review of

evidence-informed research, the recommendations of an expert health care organization, experts within the employer organization, and other sources. An assessment tool for determining whether a RN Clinical Protocol is appropriate to RN practice is provided in the *Standards for RN Specialty Practices* (SRNA, 2015)**.**

- The professionals to include in a review for a RN Clinical Protocol are: physicians, RNs (e.g. point of care, administrators, managers, RN(NP)s, clinical nurse educators), employers, risk managers, and other health care providers as required (e.g. emergency medical services personnel, pharmacists, respiratory technicians).

**2. Policy**

All RN Clinical Protocols will require the support of a written employer policy.

- Policies for a RN Clinical Protocol must be agreed to and signed by a physician (or a representative for a group of physicians) and an employer.
- Policies must be reviewed on a regular basis according to best practice recommendations, every 2 to 3 years or sooner if there are changes to the practice. Revisions to RN Clinical Protocols must be approved by the appropriate authority within the organization.

**3. Documents**

The following are requirements for a RN Clinical Protocol**:**

1) When available, a document must be adopted when it meets the criteria for a RN Clinical Protocol and is developed by an expert health care organization or a formal educational institution. When this resource is not available, one must be developed collaboratively by RNs, physicians, employers, and other health care experts within the employer organization. For example: the Heart and Stroke Foundation of Canada is a recognized health care organization with expertise in setting standards of care for advanced cardiac life support (ACLS) and for developing documents (e.g. algorithms) for emergency cardiac situations.
2) Documents (e.g. algorithms, clinical pathways) that will be used as a RN Clinical Protocol must be enhanced to include the required information (e.g. etiology, intended and unintended outcomes) as outlined in this document.
3) A RN Clinical Protocol must be reviewed on a regular basis to ensure best practices and the current standards are met. The frequency of a review should come from the recommendation of an expert health care organization, best-practices, or be conducted every 2-3 years or sooner if the practice changes.
4) The flow chart in the *Standards for RN Specialty Practices* (SRNA, 2015) can be used for the development of a RN Clinical Protocol.
5) The content and format for a RN Clinical Protocol includes:
    a) Title: The name of the health condition or the Advanced RN Intervention.
    b) High alert precautions in red box: This information (e.g. specific signs and symptoms, test results) directs the RN to immediately contact a physician.

c) RN Clinical Protocol statement: The following statement provides information on the role of the document and it is recommended that it is included on each RN Clinical Protocol.

> "A RN Clinical Protocol outlines a series of registered nursing actions that are implemented in pre-determined situations to provide specialized client care in Saskatchewan. A RN who implements a RN Clinical Protocol must meet the criteria as outlined in the *Standards for RN Specialty Practices* (SRNA, 2015). This RN Clinical Protocol contains evidenced-informed practice that is used in conjunction with an individual RN's critical thinking and clinical judgment to determine when it is appropriate for it to be implemented according to the client's health care situation."

d) Definition: A description of the health condition or the Advanced RN Intervention. This may include:
- when to initiate the care for the health condition or the Advanced RN Intervention (e.g. specific signs and symptoms are exhibited by the client).
- whether a client specific order is required or is not required.
- any key definition of words or concepts.

e) Etiology: A description of the type of clients who experience the health condition or require the Advanced RN Intervention. A list of the causal factors attributed to the health condition or the Advanced RN Intervention could also be listed.

f) Objective: A summary of the signs and symptoms a client will typically exhibit with the health condition or when the Advanced RN Intervention is required.

g) Assessment: The health assessment, any tests or other actions that are required.

h) Nursing diagnosis and therapeutic actions:
- An example of a nursing diagnosis for the health condition requiring defibrillation may include: *Inadequate cardiac output for tissue/organ perfusion due to the cardiac arrhythmia.*
- An example of a nursing diagnosis for an Advanced RN Intervention for cardiac care may include: *Decreased cardiac output related to inadequate ventricular filling associated with rapid tachycardia*.
- Therapeutic actions including any pharmacologic and/or non-pharmacologic interventions.
- When required, the consent requirements for an Advanced RN Intervention.

i) Intended and unintended outcomes: Information on the management of the intended and unintended outcomes of the intervention(s), and any special precautions that must be monitored.

j) Communication: The time when a physician is contacted to report on the client's status and provides client specific orders. This may include orders:
- for care until the physician can attend to the client in-person; or
- the client is transported to another facility.

k) Education: The information to provide to the client and his/her family.
- Include any handouts or specific education materials.

l) Documentation: The information that must be recorded on the client's chart and care plan. The RN's responsibilities for the documentation in a chart for a RN Clinical Protocol are found in the *Standards for RN Specialty Practices,* (SRNA, 2015).

m) References: A list of evidence-informed research (e.g. SRNA practice documents, articles, texts, resources) that were used to develop the document.

n) Other content can be added as deemed necessary.

**4. Competencies and Education**

The expectations for obtaining the specialized competencies and the appropriate education for a RN Clinical Protocol are found in the *Standards for RN Clinical Protocols,* (SRNA, 2015).

**5. Resources**

The setting or location where a specialty practice will be implemented must contain the appropriate resources including:

- appropriate type and sufficient number of health care personnel and diagnostic/medical equipment (e.g. laboratory and x-ray services).
- access at all times to a physician or a RN(NP). When a physician or RN(NP) is not available, the employer must provide contingency plans for client care (e.g. referrals to an alternate care provider, the facility where clients are to be sent/transported).
- appropriate coverage for client care responsibilities if a RN must leave their assigned work area to provide care and/or assist another care provider.
- access at all times to a RN manager or RN with clinical nursing decision making authority. Non-RN managers can only provide direction to RNs for matters that are non-nursing related.

## RESOURCES

The SRNA is available to provide consultation on the RN scope of practice (e.g. questions on the activities RNs can implement, RN clinical protocols that can be used in a particular setting). Physicians, RNs and employers can contact the Saskatchewan Registered Nurses' Association, Practice Advisors at practiceadvice@srna.org; Toll free: 1-800-667-9945; Regina: 306-359-4200.

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