Positioning Nursing Within a Reformed Health Care System

By Kathleen M. MacMillan, RN, MA, MSc

This article will discuss the many changes in the Ontario health care system and the role that nurses can play in making the change effective, in ensuring that stated goals are met and that the health of the citizens of Ontario is improved and not compromised during the change process.

In his address to the Canadian Club in February, 1996, Ontario's Health Minister Jim Wilson outlined his vision for the future. Let me precis it for you. Consider his key messages and their relevance for nursing.

Firstly, Mr. Wilson summarized how our health care system has evolved to date: largely haphazardly, with a focus on construction of hospitals and on the care of the ill. Open ended payment systems encouraged and rewarded spending without accountability for outcomes.

Patient programs are still largely uncoordinated with expensive duplication and overlap among hospitals. This means that tax dollars are going to support large bureaucracies that could be spent on actual patient care and health promotion and illness prevention activities.

In Ontario, in the last five years, 6,700 hospital beds have been removed from the system without the closure of a single building - even though this number of beds is equivalent to 33 mid-sized hospitals.

(The former Ontario premier Bob Rae has been heard to comment that we have an "edifice" complex.)

We have been unwilling to go that extra step and so hospitals have been unable to realize the savings that we should have in administration and overhead costs. This is stealing funds from direct patient care.

Mr. Wilson says the only way to fix the health care system is to totally restructure it. The government is prepared to listen to health care providers on the front lines - to give them the tools to restructure the system so that we can provide more effective and appropriate health care.

The health care vision outlined consists of two main pillars: 1) patient focus, and 2) accountability. The former is the goal and the latter is how we reach that goal. The government is committed to maintaining funding at the same level (the existing 17.4 billion dollar health care budget), while focusing on patient needs and increasing accountability for the delivery of services designed to meet those needs.

Optimal care is described by Mr. Wilson as resting on three key principles:

l) Match the dollars to the patients - programs that deliver services directly to the patient in the setting that best serves their needs.

2) When you save dollars, you reinvest them in the patient, and

3) Unfettered access to the health care system - meaning primary care reform.

In his address, Mr. Wilson states that the barometer of success should not be if all health interests are satisfied but if the outcomes are improved, through a more accountable health care system.

We need to link funding with accountability and emphasize improved patient outcomes.

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Government's vision

Now, what does this mean for nurses? As described, it is a vision which is congruent with the nursing vision. How do we make this vision a reality?

Our health care system doesn't need more money. Nurses have been saying this for years. Existing monies need to be reallocated. The recent Ontario Nurses Association membership survey data supports this. Ninety-four respondents said that the system needs to be reformed - so nurses support restructuring in principle.

For OR nurses, like other nurses, change is familiar. Over the past two decades, we have seen surgical techniques evolve so that trauma and blood loss are minimized. This has led to shorter hospital stays, simpler wound care and reduced complications, partially why we need fewer hospitals.

A lot of the better outcomes are related to the presence of registered nurses who are extremely knowledgeable about perioperative care. Nurses who prepare patients so that their anxiety is alleviated, nurses who observe the patient and assist during induction of anesthesia, during surgery and in the immediate postoperative period. Skilled Registered Nurses who engage in assessment, treatment, discharge planning, rehabilitation and planning for long term care needs. Registered nurses who are vital ingredients of quality assurance and accountability.

Nurses could play an even larger role in the health care system, one that could contribute to cost-effectiveness as well as quality.

Most of these contributions are invisible to the consumer. The average surgical patient has no concept of the important role of registered nurses in providing safe perioperative care and improving patient outcomes.

I will talk about some suggested nursing activities to improve this state of affairs in four categories:

Achieving a high quality nurse provider, Ensuring that appropriate nursing interventions are used, Ensuring that nurses practice to the extent of their scope of practice, and social activism and advocacy.

1. Achieving a high quality "provider"

Firstly, we need a better quality of provider and a different kind of nurse. For years, we have been producing nurses to staff hospitals, based on concepts of hospital care in the 1960s and 70s. We have been producing nurses who worked on clients and not with them. Now we need nurses with skills in autonomous decision making, community development, advocacy, case management and crisis management. We need nurses for whom the client is the patient, the family and the community; nurses for whom the client is the decision maker and the nurse aids and supports the process.

"...OR Nurses have a reputation for being insular and for caring only about what happens inside the OR . This must change ..."

Why should OR nurses care about what happens in the community? Well, for example, if your community does not have adequate resources for home care following discharge, hospital stays will be longer, or there will be re-admissions, and this will reduce OR bookings.

OR Nurses have a reputation for being insular and for caring only about what happens inside the OR suite. This must change if you are to play a role in a different health care system.

Achieving a different kind of nurse involves three things: education (both basic and continuing), leadership, and what I will term "fertilizing and weeding the garden".

Education for registered nurses is on the brink of major change world wide. In Canada, five provinces are now committed to Baccalaureate education for preparation of Registered Nurses. Others are examining the issue carefully. *(continued on page 22)...*

Shown at the English Pub Night: L to R: Sharon Wilson, Port Perry Community Hosp., Pat Drysdale, Bowmanville Hosp., Joanne Drury, Oshawa General, Fran Fawcett, Whitby General, Peri Sturgeon, Whitby General Hosp. and Maggie Skaliks, DON,Surgery/CSR, Cobourg District Hosp.

Photo left: ORNAC President Vija Hay shown at the Past President's cabaret table with Martin Rosenbaum, (right) of the newly formed Sherwood-Davis&Geck, and an unidentified gentleman (left) behind the streamers.

▼ Cheers to the ORNAO entertainment committee on English Pub Night/Comedy Cabaret-Top Drawer! Great Dinner as well ! Party goers included **(Photo below)** L to R: Brian Bonnell of MDT Canada(Chairman of the ORNAO Exhibitors Advisory Committee), Janet Young-Laurin and Kathy Marshall, both of Royal Victoria Hospital,Barrie, Ont.

▼ **Photo Below:** The Andrew Sisters sing and dance for ORNAO delegates. John Flower, an exhibitor with Southmedic Inc. (right) is also a member of the Kingston-based "Music Hall" Comedy Cabaret group.

ORNAO 1996 Conference Planning Committee

Front row L to R:(standing),Helen Friend. Seated - Lynda Wilson, Secretary Treasurer, Sharon Ball, President, and Judi Tyndall, Immediate Past President and Conference Chairperson. **Back Row**: (L to R) Alaine Young, Janet MacCullouch, Wanda Collins, Janice O'Neill, Mindy Shinoff, Janet Rinaldi, Beth Stone, Audrey Macdonald and Susan Smith.

ORNAO Celebrate 15th Anniversary

Five ORNAO Past Presidents returned to celebrate the 15th Anniversary, May 5 to 8, 1996 in Toronto during 4th Provincial Conference of the organization. **Photo Right,** (L to R) Carole Starr, Peterborough, Hilda Gatchell, Oshawa, Ann Hayes, Hamilton, Vija Hay, Ottawa and Carol McDougall, South Carolina. ORNAO Past Presidents and terms of office were:

1st President - Ann Hayes (1982-84)
2nd President - Val Sherriff (1984-86)
3rd President - Carole Starr (1986-88)
4th President - Carol McDougall (1988-90)
5th President - Hilda Gatchell (1990-92)
6th President - Vija Hay (1992-94)
7th President - Judi Tyndall (1994-96)

At the head table a red rose (as always) marked a place for the late Val Sherriff, who served as ORNAO president as well as president at the national level.

Photo below**: Lynda Wilson**,(left) is the '96 winner of the $3000 Johnson&Johnson Drake Thompson Writing Award. (See # 4, page 9). Presenting is Dave Patterson of J&J, who recently transferred to California. **Sharon Ball**, new ORNAO president, also chairs ORNAC Awards Committee. See more Awards information on page 7.

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In Ontario, a new health care system will require a different kind of nurse to the one which we have been preparing. Future nurses will require different knowledge and skills to play a role in a community-based health care system. This has implications both for basic education and for continuing education. The College of Nurses of Ontario's Quality Assurance Program, mandated by the *Regulated Health Professions Act*, will also increase demand for continuing education. The nature and quality of that education can be influenced by nurses.

I would suggest that nurses want different courses than those which have been offered to date. They want courses that are academically and clinically sound and which build on prior knowledge. They want education which supports career progression and is broadly recognized. Diploma prepared nurses want courses that articulate with degree studies.

Educational facilities respond to pressure from consumers. Nurses must be prepared to state what they want and to refuse to take those courses that do not meet current needs. I do not believe that courses which focus on technical skills alone are going to meet your needs in the future. Nursing practice cannot remain a-contextual and a-political if it wants to survive and thrive.

Leadership in nursing is essential to positioning nursing for a reformed health care system. We no longer need managers for professional nurses. We need transformational leadership to foster professional practice through the development of professional practice environments. This means flattening hierarchies and treating clinical nurses as true colleagues, (after all, we are a practise discipline, so we must value practice). Functioning within relationships which are mentoring and supportive and abandoning the patriarchal models most of us currently practise within is a vital component.

When I speak of alternate organizational structures, I am not endorsing any particular models. Many have only served to retrench traditional hierarchies and have not delivered on the promised emancipation for nurses. Organizational structural change alone, without an underlying philosophical change, will not achieve professional equality.

"... Those nurses who require supervision are practising below the standard. This is simply not acceptable...."

Some will say that there are nurses who require supervision and so this would not work. I say, if you want to bring about change, you do not focus on the lowest common denominator. Your leadership strategies should be targeted to elevate the mean level of practice. For too long, we have developed agency policies for the lowest common denominator. It is time to stop. Those nurses who require supervision are practising below the standard. This is simply not acceptable.

"...Some of us have been working for twenty years - but we have had one year of experience twenty times..."

Now for fertilizing and weeding. I strongly believe that the level of practice of many nurses has been stunted by the environment in which they practice, and that much can be done to improve practice with different management techniques and organizational structures. It is time, however, that we made up our minds whether we are a profession (with accountability to the public) or a support group (with accountability to ourselves). We have a small number of colleagues among us who do not meet the current standards of practice and are unlikely to meet the new demands that our system will impose on us. Some of us have been working for twenty years - but we have had one year of experience twenty times. At the same time, we have exceptional nurses who are either unemployed or underemployed. Part of nursing leadership is to create an environment that puts pressure on those nurses who are holding us back and rewards those who are prepared to push the envelope. We cannot afford to continue to support nurses who will not, or cannot, grow and change and worse, to restrict those nurses who want a more professional practise by maintaining structures designed to meet the needs of lower functioning nurses. Continuing to do so hurts our profession and denies our clients the benefit of excellent nursing care.

Jean Gunn, a noted nurse leader of the 1930's once said that every patient deserves the best possible nurse, and not just some cheap substitute. If we are willing to tolerate substandard nurses, it is hard to argue against the use of unregulated workers. The actual difference in the quality of care provided by a registered nurse and that provided by a cheap substitute ought to be crystal clear.

We have good data on the cost-effectiveness of care provided by registered nurses in acute care. If you want access to this information, contact the Registered Nurses Association of Ontario (RNAO) for their reference list and annotated bibliography on unregulated workers. Every nurse should be familiar with this literature - it is your best defence against substitution.

The information is based on agency-wide outcomes. Those hospitals in the US which have at least 85% registered nurses, and those with the best educated nurses, have the lowest mortality rates, the lowest morbidity rates, the shortest lengths of stay and the lowest rates of readmission. This is cost-effectiveness with a capital "C".

2. Ensuring that appropriate nursing interventions are used

Next, appropriate interventions can only be provided with utilization of research and empowerment of nurses to use research findings. Access to research findings is critical for nurses. The government's emphasis on outcomes and accountability are going to make this essential for nursing. We can no longer provide care based on habit, routine, or outdated agency policies which restrict nursing autonomy. This indicates that all nurses must have some exposure to critical review of research literature. This is a current standard of practice in Ontario and most nurses cannot meet it.

How many OR nurses work in agencies that continue to prepare operative sites by shaving the skin? Often the evening prior to surgery? Research findings that indicate that this is a dangerous practice dates from the 1930s and particularly compelling research designed to confirm this was conducted in the 1970s, yet practice has remained unchanged in many institutions. What has prevented these research findings from being implemented more broadly?

The Province Wide Nursing Project, a one million dollar nursing project funded by the Ministry of Health and now commencing in the province of Ontario, is designed to facilitate access to research information for practising nurses. It is also designed to aid nurses in breaking down some of the traditional barriers to professional practice and to integrating services across the agency-community spectrum. There are three collaborating centres which are consortia of acute care, long term care and community agencies. The centres are located in the Ottawa, Cornwall and London areas.

Hopefully, in the near future, primary nurses in acute care facilities will talk directly with primary nurses in the community and there will be more congruence between methods and supplies used to provide care across the system. Accountability for nursing outcomes will be achieved by using the latest research information and evaluating the impact on patients, the system and other care providers.

3. Ensuring that nurses practice to the extent of their scope of practice

My remarks related to scope of practice are in reference to the recent passage of the Controlled Acts for Nursing, which were published recently. These were originally tied to the Controlled Acts for Nurse Practitioners, and this legislation was held up with the change of government. I am pleased to report, that after a two year plus wait, registered nurses will now be able to initiate their controlled acts.

Our next steps must be to ensure that all nurses are given the tools and the support to practice to their full extent.

Nurses now must consider how this legislation can work for them and for the people which they serve.

The province wide Nursing Project will also examine the scopes of practice of both RNs and RPNs to ensure that we are making use of the knowledge and skills of both types of nurses.

Once again, this will require leadership on the part of nurse managers and educators. I strongly suggest that we begin to move away from models that cause nursing practice to vary considerably from one employer to the next and that we look at a more global approach. This is enabling legislation and the possibilities for increasing nursing autonomy and decision making are considerable. For example, marrying the controlled acts for nursing with medical protocols can create situations in which nurses can make decisions within certain parameters - making *decision making* at the nurse-patient interface more appropriate and timely.

This applies, for example to oxygen administration, to advanced cardiac life support in emergencies, to wound care, and to the role of registered nurses as first assistants in the OR.

The possibilities only expand if we place nurse practitioners in the picture. The Health Professions Regulatory Advisory Council report on the Nurse Practitioner has been received by the Ontario Ministry of Health and is currently being reviewed. It should be released shortly.

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Now some nurses say to me, "Do you think that nurses want that kind of responsibility?" and I say yes, if they are real nurses. Nurses have always been responsible and accountable. For those who do not want to be responsible for a broader, more autonomous practice, there is always the solution of weeding.

4. Social activism and advocacy.

Finally, we need to consider advocacy and social activism as a legitimate role for nurses. Clearly, the code of ethics of the CNA and the CNO standards of practice tell us that, if the system is not fostering professional practice and quality patient outcomes, we must act to change it.

This is a nursing responsibility, if we are to have a health care system that is responsive to the needs of the people which we serve. Unfortunately, nurses have been socialized to believe that professionalism is not compatible with social activism. This is patently untrue and has done a disservice to the profession and to our clients.

Who is the primary nursing customer? It is the client - not the employer, not the health care system and not the physician, although we must work collaboratively and productively within those frameworks.

If we truly believe in the determinants of health, we know that factors such as housing, nutrition, education, social support, freedom from violence and socio-economic status contribute as much, and possibly more, to health than just the health care system. This is where nurses could play a significant role in promoting a parallel vision. Nothing is more powerful than a client and a nurse working together to achieve change.

We need to form partnerships with people so that they know what nurses actually do, so that our health care system is restructured in a manner that is most likely to deliver the quality, and cost-effectiveness, that we are all in search of. We must be accountable for this as much as for our clinical practice and we can make politicians accountable for delivering on their vision of the future.

All of the right messages are there. Restructuring of the health care system is long overdue. The messages are congruent with what nurses have been saying for some time. The ability to make the stated messages reality rests at least partially with nurses.

Reforming the health care system is not just a matter of closing hospitals or of recreating community services. These are important but not sufficient changes.

We need a paradigm shift and that includes a shift in how we think about nursing practice and how we function within that system.

Truly professional nursing practice needs a paradigm shift in management, in education, in a focus on outcomes as well as on process, and a new sense of accountability and responsibility that is based on a clear duty to clients. We can only demand a high quality health care system if we are prepared to provide high quality nursing.

If we remember what we are here for, and if we make the provision of quality health care a priority, we will be preparing ourselves for the future and we will be providing the right advice to policy makers. After all, the presence of this much chaos and uncertainty must provide unique opportunities where traditional approaches have led to stagnation. Nursing must not let these opportunities pass them by. ■