College of Registered Nurses of Manitoba

Registered Nurse Responsibilities Related to Professional Practice Issues

The practice direction *Practice Expectations for RNs* requires RNs to identify and respond to professional practice issues that interfere with the ability to practise according to the practice expectations and *Code of Ethics for Registered Nurses* and which could have an injurious effect on the client or others. All RNs – direct care providers, managers, educators and researchers are expected to provide leadership in the identification and resolution of professional practice issues. The *Code of Ethics for Registered Nurses* requires registered nurses to contribute to safe and supportive work environments and seek constructive and collaborative approaches to resolve differences impacting on care.

What are the principles in managing professional practice issues?

- Validate the facts of the situation. The information you initially receive may reflect just one aspect or one side of an issue.
- Attempt to resolve the issue with the person directly involved. A collaborative approach may enable you to validate or correct your understanding of the events and issues in order to work directly with the person involved to resolve the issue.
- Be specific in defining the issue. Focus on the risk to safe, ethical care. The *Practice Expectations for RNs* are an excellent starting point for defining a practice issue. This publication includes a list of terms you may find helpful in defining the issue. You can consult with a one of the College's nursing practice consultants if you need to validate or explore the issue.
- Work to resolve the issue at the appropriate organizational level or with the appropriate members of the health-care team. Involve others only as necessary.
- Report the issue as required by legislation and facility policy.
- Keep notes of discussions and actions taken.

What should I do if the issue can't be resolved with the person directly involved?

- Present the issue to the next organizational level. Clearly state the issue. Refer to the *Practice Expectations for RNs* to articulate implications for professional practice and patient safety.
- Describe the factors, such as people, departments, resources, processes and policies, that impact on the issue. If you are a manager, you may be expected to conduct a root cause analysis.
- State whether the situation is recurrent, or is likely to recur.
- State your expectations for change and resolution of the issue.
- Indicate your commitment to helping to resolve the issue. Participate in resolving the issue by making suggestions and implementing constructive solutions. Identify resources which might be helpful to resolve this issue.

What should I do if the issue is still not resolved in a reasonable period of time?

- Put your concerns in writing. You may need to address your concerns about the practice issue to a higher level within your organization.
- Continue to communicate your concerns and work constructively for resolution of the issue.

Resources

- *The Regulated Health Professions Act*
- *Practice Expectations for RNs*
- *Code of Ethics for Registered Nurses*
- Canadian Patient Safety Dictionary

Definitions

Collaboration: Working together with one or members of the health care team who each make a unique contribution to achieving a common goal. Each individual contributes from within the limits of his or her scope of practice.

Professionalism: Includes the conduct, aims and qualities that characterize a professional person.

Health-Care Team: Includes intradisciplinary, interdisciplinary and intersectoral members participating in health-care services.

Latent Condition: The structural flaws in the system, or "resident pathogens", that predispose to adverse outcomes.

Unsafe situations: Events or processes that risk harm to clients. These include "near miss" incidents, errors and adverse events.

From the Canadian Patient Safety Dictionary (2003)

Adverse event: 1. An unexpected and undesired incident directly associated with the care or services provided to the patient; 2. an incident that occurs during the process of providing health care and results in patient injury or death; 3. an adverse outcome for a patient, including an injury or complication.

Cause: An antecedent set of actions, circumstances or conditions that produce an event, effect or phenomenon. A cause may be proximate or remote to the event, effect or phenomenon.

Critical Incident: An incident resulting in serious harm to the patient, or the significant risk thereof. Incidents are considered critical when there is an evident need for immediate investigation and response. The investigation is designed to identify contributing factors and response includes actions to reduce the likelihood of recurrence.

Hazard: A set of circumstances or a situation that could harm a person's interests, such as their health or welfare.

Incident: Includes events, processes, practices or outcomes that are noteworthy by virtue of the hazards they create for, or the harms they cause, patients.

Patient safety: the reduction and mitigation of unsafe acts within the health-care system, as well as through the use of best practices shown to lead to optimal patient outcomes.

Process: A course of action or sequence of steps, including what is done and how it is done. Examples of these interrelated activities within the health-care system include decision making, problem solving and communication.

Risk: The probability of danger, loss or injury within the health care system.

Root Cause Analysis: A systematic process of investigating a critical incident or an adverse outcome to determine the multiple, underlying contributing factors. The analysis focuses on identifying the latent conditions that underlie variation in performance and, if applicable, developing recommendations for improvements to decrease the likelihood of a similar incident in the future.

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