Care Directives

The Nova Scotia College of Respiratory Therapists recognizes that the model for delivery healthcare is evolving and changing. In Nova Scotia healthcare practitioners are being called upon to practice to their full scope of practice so as to accommodate collaborative care models. It is imperative that safe, compassionate, and ethical care is provided by competent caregivers.

Respiratory Therapists have the educational background, skills, and experience to adapt and change and take on new roles within the healthcare team. This document is a framework to guide RTs through a process of development and approval of new roles when it will benefit the delivery of patient care.

What is a Care Directive:

A **Care Directive** (CD) is a written order from a regulated health professional who has the legislated authority to prescribe (such as a physician, nurse practitioner, midwife) for one or a series of medical procedures, treatments, and/or interventions that may be performed by Respiratory Therapists (RT's) for a range of clients/patients who meet specific criteria.

Care Directives also include:

- An assessment process used by respiratory therapists to decide whether to implement the care directive
- Required resources for performing CD (example: agency policy)
- Specific monitoring parameters
- Emergency care measures

Care Directives are always written, intended for the care of specific groups of patients for an extended period of time.

An example would be an RT deciding to and administering a medicated aerosol to an asthmatic patient in the Emergency department based on protocols

Some components of a care directive may be within the scope of practice of RT
e.g. Administration of a medication

While other components may require additional training and skill
e.g. ordering Chest X-Ray or insertion of an indwelling catheter for arterial blood sampling

How are Care Directives Utilized:

Care Directives are developed to facilitate the provision of safe, timely and appropriate patient care. They enable respiratory therapists to implement patient interventions efficiently and effectively in a collaborative care environment.

Principles that ensure safe, effective, timely and ethical patient care guide the decision-making process for the determination of appropriate care directives.

Development of specific care directives are to comply with existing legislation, rules and regulations as set out by the Nova Scotia College of Respiratory Therapists (NSCRT); they are not to contravene existing laws or acceptable standards for medical or RT practice.

Identification of the specific intervention to be ordered by a care directive; identification of the context under which the care directive can be implemented; and the competency requirements to perform a care directive are to be determined collaboratively between physicians, respiratory therapists, and the healthcare agency. Agency policies should be in place to support the implementation of a care directive.

All physicians in a department are to be in agreement with the decision to authorize a care directive for use by respiratory therapists. The Physician Chief of the department or service is responsible for obtaining and recording the agreements.

Care Directives may be piloted in specific practice settings and for pre-determined time periods prior to final approval and distribution, allowing for opportunity to evaluate effectiveness, and to evaluate inconsistencies and challenges with implementation.

Care Directives are to be reviewed at least every three years and more often if required by change in legislation, practice, etc.

GUIDING PRINCIPLES:

The decision to develop care directives in specific practice environments is guided by determining the most appropriate health discipline and giving careful assessment to:

1. **Client/patient needs**

    a. **Client/patient state of health and health issues**
        - Stable, unstable, critical, life threatening
    b. **Level of care**
        - Simple, complex, multiple interventions, invasive/non-invasive instrumentation
    c. **Risks and benefits**
    d. **Outcomes**

- Predictable, unpredictable, possible complications

2. **Context of Practice**

   a. **Client/patient population**
      - Age, gender, diagnostic groupings
   b. **Type of care**
      - primary, preventive, secondary, tertiary, rehabilitation, palliative
   c. **Complexity of interventions**
      - multiple, invasive, non-invasive
   d. **Frequency of intervention**
      - Performed hourly, daily, weekly, monthly
   e. **Service delivery model**
      - Primary care, multidisciplinary approach
   f. **Staffing**
      - Level of competence of RT, staff mix, number of students, availability of physicians

3. **Practitioner Competence**

Access to continuing education programs and clinical experiences are prerequisites to acquiring and maintaining competence, and an individual's competence to perform a specific task or function must be determined by their knowledge, skill and judgement relative to the task or function.

Care Directives are:

- approved for use by Respiratory Therapists in pre-determined environments; and
- developed in collaboration between the Physicians and Respiratory Therapists; and
- implemented only after the appropriate development and approval process and only in the specifically identified environments and applicable to identified patient populations.

The ultimate accountability for safe, competent, ethical care rests with individual practitioners; who are accountable to acquire and maintain competence and to recognize the limits of their practice.

While the parameters and clinical guidelines for care directives should be established by Respiratory Therapists and medicine, physicians maintain accountability for overall patient outcomes, including their decisions related to a care directive.
(e.g. decision to write a CD)

Respiratory Therapists make the ultimate decision as to when it is appropriate to implement a particular care directive utilizing the assessment of patient needs and determining that all specified criteria have been met as set forth in the care directive.

Professional Responsibilities:

New Care Directive

Physician/Respiratory Therapist

1. Identify the need for the development of a care directive that will result in improved efficiencies and outcomes of patient care.

2. Discuss the proposed care directive with the Physician Chief of the department, Health Service Director, and Director of Professional Practice or a Professional Practice Leader (PPL) to assess the appropriateness of developing the care directive.

3. In assessing the appropriateness, consider:
   - Patient needs
   - Context of Practice
   - Practitioner Competence

Education:

Educational learning modules with competency checklists may assist in the development of required competencies and maintenance of competence along with the utilization of various competency assessment techniques.

Frequency of reassessment of competence is based upon how often a care directive is implemented, the complexity of the medical directive, the impact on patient safety and the context of practice.

Approval:

Healthcare agencies meet their obligations to the public by establishing appropriate formalized decision making processes that promote shared accountability for the development, approval, implementation and evaluation of care directives and associated educational programs that support positive patient outcomes.

New Care Directives are approved through:

Physician Chief of the department or service; and
Health Services Director; and
Director of Professional Practice Development; and
Medical Advisory Committee (MAC) (or its equivalent)

Each Care Directive is to clearly articulate the following:

- description of the intervention
- specific conditions that are to be met
- specific circumstances that are to exist
- contraindications for implementing the care directive
- educational requirements and competency assessment of the RT implementing the care directive
- the expectations for physician availability to the health discipline implementing the care directive.

Revised Care Directives requiring non-substantive changes are approved by:

Physician Chief of the department of service, and
Health Services Director.
MAC is notified of the approval

DEFINITIONS

Agency

Facility or organization through which health services are provided or offered

Competent

Ability to integrate and apply the knowledge, skills and judgment required to practice safely and ethically in a designated role and practice setting.

Medical Advisory Committee

Acts in an advisory capacity to an agency's board and CEO in matters concerning the medical care of patients.

Care Directives

A written order from a regulated healthcare professional who has the legislated prescribing authority, for one or a series of medical procedures, treatments, and/or interventions (e.g. an algorithm) that may be performed by RT's) for a range of clients/patients who meet specified criteria.

Care Directives are always written, intended for the care of a group or population of clients/patients, and effective for an extended period of time.

Example: ordering of explicit diagnostic tests (e.g. blood work, x-rays) or administration of specific treatments (e.g. medicated Aerosol prior to the physician assessing the patient or providing a direct order.

Physician Availability

Normally indicates that the most appropriate physician is physically available in the practice environment.

Note: Practice environment refers to the clinical unit/area.

However, if not physically available (e.g. emergency department of a
rural facility), a physician is to be immediately available by phone, and physically available within 15 minutes.

Note - Most appropriate physician is that physician that has the expertise for the patient population, or the practice setting.

Example - The most appropriate physician for a medical directive in the Emergency Department is an Emergency Room Physician.

The most appropriate physician for a medical directive being implemented in the Eye Care Center is an Ophthalmologist.

Substantive Change

Those changes that have major or practical importance, and would include (but are not limited to) situations where the:

- care directive is being applied to a different health discipline
- care directive is being applied to a different practice area where the most appropriate physician supports are not as readily available
- scope of the care directive has expanded

References:

1. **Guidelines for Delegated Medical Functions and Medical Directives, CRNNS, CPSNS, 2003**

2. **Interprofessional Medical Directive Policy, Capital Health District Authority, CDHA, 2011**