Performance Readiness Assessment

For Determining the Appropriateness of Establishing Directives, Delegation and Performing Procedures beyond Principal Expectations of Practice[1]

INSTRUCTION TEMPLATE

Title/Procedure:	Name of directive, delegated act or practice
Applicable Authorizing Mechanism:	☐ **Delegation** ☐ **Medical Directive** ☐ **Direct Order** ☐ **Unnecessary** Check the type of authorizing mechanism being used to authorize performance of the procedure. If there is no requirement for an order or delegation to perform the procedure, check unnecessary.
Authorizing Profession:	Identify authorizing profession
Implementing Profession:	Identify implementing profession
Patient(s):	Identify recipient patients
Disposition:	☐ **Approved** ☐ **Being forwarded for Approval** ☐ **Not Approved** Identify the outcome of the performance readiness assessment: ▪ 'Approved': Directive, delegation or practice is approved and ready for activation. ▪ 'Being forwarded for Approval': Directive, delegation or practice is being forwarded to the appropriate authorities for approval (applies in larger corporate settings). 'Not Approved': Directive, delegation or practice is not appropriate but may be filed and referred to if the practice is re-considered in the future.
Date:	

Sponsors *(This Section For Use in Large Multi-professional Settings*)

Use this section to identify the representative sponsors leading the assessment when a number of individuals are affected.

Representative(s) of Authorizing Profession:	Name, position & signature
Representatives(s) of Implementing Profession:	Name, position & signature
Administrative Representative(s):	Name, position & signature

[1] This tool may be used to determine the appropriateness of establishing a directive and a delegation. As well, it may be used to evaluate performance of a procedure that does not require a directive or delegation but is beyond principal expectations of practice for the proposed implementer(s).

Have all applicable stakeholders been consulted: *(See Section 11 for list)* ☐ **Yes** ☐ **No**

For the assessment to be approved, applicable stakeholders identified in Section 11 must be consulted.

Is a completed Medical Directive or Delegation template attached*:* ☐ **Yes** ☐ **No** ☐ **N/A**

For approval of a medical directive, the written directive must be attached.

Is a completed Performance Readiness Plan attached*:* ☐ **Yes** ☐ **No** ☐ **N/A**

Complete and attach a Performance Readiness Plan when more indepth education is required. When education needs are less extensive, use Section 8 instead.

Assessment Parameters

The assessment parameters identify the necessary conditions for a proper directive, delegation or practice beyond principal expectations. Some parameters may not always apply in some practice settings. The degree of detail used to respond to the parameters depends on the circumstances in the situation. Providing a description or rationale in the comments section is recommended when approvers are not familiar with the proposed practices, information in the responses guides practice, or when an account of decisionmaking is desirable, If the responses indicate that relevant stakeholders are satisfied the proposed implementers will be able to perform the procedure and manage the outcomes in the patient's best interests then the directive, delegation or practice may be appropriate.

1. **Reason and Specific Benefits of the Directive or Delegation:**

1.1. Does establishing the directive or delegation address patients' best interests? ☐ **Yes** ☐ **No** ☐ **Unsure**

Comments:

Considerations:

Directives, delegation or practices beyond principal expectations may only be established to address patient interests and are only acceptable when the resulting care is always the same or better that it would be without the directive, delegation or practice. It is not acceptable to establish a directive, delegation or practice to advance professional self-interest, including pecuniary interest.

2. **Authorizer:**

Does the authorizer**:**

2.1. Have the scope, authority from their college, competencies and privileges (where applicable) to authorize performance? ☐ **Yes** ☐ **No** ☐ **Unsure**

2.2. Have an established or anticipated professional relationship with the patient? ☐ **Yes** ☐ **No** ☐ **Unsure**

2.3. Agree the directive applies to all his or her patients who meet the conditions? ☐ **Yes** ☐ **No** ☐ **Unsure**

2.4. Have the ability to provide ongoing supervision directly, or are other provisions for appropriate supervision in place? ☐ **Yes** ☐ **No** ☐ **Unsure**

Comments:

Considerations:

- **2.1 - Affirm Scope, Authority and Competence.**

- Authorizers may only authorize acts that they are authorized and competent to perform themselves. Colleges may have guidelines governing the use of directives and delegation. Refer to the relevant college guidelines as necessary.

- **2.2 – Affirm Professional Relationship.**
  - **Ordering Authorizers:** A professional relationship – established or anticipated - is usually required to authorize performance of procedures. There may be some instances where the relationship is established directly after a procedure is implemented (e.g. in an emergency room where the staff implement directives before a physician has seen a patient). There may be extremely limited circumstances where there is no relationship, but rigorous quality assurance provisions and high predictability assure safety (e.g. directives for inoculation under the Medical Officer of Health). Consult the relevant college with questions or for further guidance.
  - **Non-Ordering Authorizers:** In some instances, non-ordering authorizers may delegate a procedure for later performance pursuant to an order. For example, RTs may delegate oxygen administration to physiotherapists on condition of a physician's order; or nurse educators in a long-term care setting may delegate application of simple, well established dressings to unregulated care providers on condition of a physician's order plus assignment by a charge nurse. In these cases, no relationship needs to exist between the delegator and patient, however the delegator would be expected to have relevant knowledge of potential recipient patients and circumstances. **Note:** Performance of procedures delegated in this way may not take place until an order is in place, along with any applicable setting-specific authorization (e.g. assignment).
- **2.3 - Exceptions Compromise Safety and Thus Contraindicate a Delegation or Directive.**
  - Exceptions to a directive or delegation introduce a margin for error. If implementers cannot always reliably manage exceptions, the use of a delegation or directive is contraindicated. Exceptions may be manageable in smaller teams where consistent implementers and authorizers can readily and reliably identify them. They would be unacceptable in larger teams, particularly those with 24 hour mandates and multiple implementers.
- **2.4 - Ongoing Supervision Required.**
  - Ongoing supervision is essential to authorizing performance of any procedure. An authorizer must be satisfied that if they cannot provide direct supervision, another appropriately authorized and competent person can. The degree of supervision may vary depending on the patient's condition and needs, the nature of the procedure, the competencies and expertise of the implementers and the circumstances in the situation.

3. **Implementer:**

Does the implementer:

3.1. Have the scope and authority from their own college (where applicable) to perform the procedure(s) ☐ **Yes** ☐ **No** ☐ **Unsure**

3.2. Have the baseline competencies to perform the proposed procedure(s) and manage the outcomes given the:

3.2.1. predictability of the patient's condition and needs,

3.2.2. predictability of the procedure and its outcomes, and

3.2.3. circumstances in the situation including resources and safeguards (such as established standards of practice, written materials, back-up and supervision), and opportunities to attain and maintain competence? ☐ **Yes** ☐ **No** ☐ **Unsure**

Comments:

Considerations:

- **3.1 - Affirm Scope and Authority.**
  - Colleges may have guidelines governing what may be delegated and accepted in delegation. Refer to the relevant College for guidance as required.
- **3.2 - Affirm Baseline Competencies.**
  - In order to perform procedures beyond principal expectations safely and effectively, implementers must have baseline competencies upon which to acquire the additional competencies necessary to implement a directive, delegation or procedure.
- **3.2.1 – 3.2.3:**
  - **Appropriateness is Contingent upon Defined Standards of Care that are Well-known to Authorizers and Implementers.** Parameters 3.1.1-3.1.3 address the condition of predictability, through defined standards of care with well-known outcomes that enable implementers to safely and effectively implement a directive, delegation or a procedure

beyond principal expectations of practice. Resources and support, such as written guidelines and an appropriate level of supervision further enable implementers to safely and effectively perform such procedures.

- **What is Predictable and Well-known in One Setting for One Set of Authorizers and Implementers May be Different in Another.** For example, advanced cardiac procedures may be well known in a specialized cardiac setting, but not in a community care setting, and may be well known to advanced practice staff, but not to general practice staff. Thus, appropriateness must be determined on a case by case basis.
- **Appropriateness is Contingent upon the Ability to Maintain Competence.** If there are inadequate opportunities to maintain competence, or of the costs of maintaining competence outweigh the benefits, a directive, delegation or practice beyond principal expectations should not be used. Opportunities to maintain competence include those available through day-to-day practice, or through educational opportunities available at appropriate intervals (e.g. mock drills, learning labs, self-directed readings, supervised practice).

4. **Consent:**

4.1. Can informed consent be properly obtained? ☐ **Yes** ☐ **No** ☐ **Unsure**

Comments:

Considerations:

- **Informed Consent is Compulsory**. Questions to consider in completing this section: How will informed consent for the procedure be obtained? Can the person speaking with the patient provide all of the necessary information? If an authorizer is unable to obtain consent, and the person speaking with the patient is not able to fully explain the risks, benefits and alternatives of the procedure, then the medical directive, delegation or practice is contraindicated.
- **Provide Guidance Regarding How to Obtain Consent.** Identifying how consent will be obtained is essential. Use this section and the consent section in the Medical Directive and/or Delegation Template or Delegation Template to identify relevant information. The templates guide practice at the point of care, and would generally be the appropriate place to identify how to obtain consent in more detail.

5. **Review and Quality Monitoring Processes:**

5.1. Is there a process in place to ensure a regular review of the directive or delegation? ☐ **Yes** ☐ **No** ☐ **Unsure**

5.2. Is there a process in place to address questions or concerns arising from the directive or delegation? ☐ **Yes** ☐ **No** ☐ **Unsure**

Comments:

Considerations:

- **5.1 - Routine Review and Evaluation is Essential.**
  - Identifying how the directive or delegation will be reviewed and updated on an ongoing basis, for example at what intervals, using what indicators and by whom, is essential. Methods and indicators may include assessment of patients, best practice reviews, chart audits, a user focus group; re-certification processes or annual performance reviews of implementers.
- **5.2 - Identifying Avenues to Address Emergent Issues and Questions is Essential.**
  - Creating a process to address emergent issues and questions, particularly in the event of unexpected or untoward outcomes arising out of the directive or delegation, including who to contact and how to review a directive or delegation on an ad-hoc basis is essential.
- **5.1-2 - Coordinate with the Directive and/or Delegation Template or Delegation Template.**
  - The Directive &/or Delegation Templates also address Review and Quality Monitoring Processes to guide practice at the point of care. Include relevant information in the template.

If appropriate quality monitoring mechanisms cannot be established, the directive, delegation or practice is contraindicated.

6. **Practice Setting Feasibility**

6.1. Are the necessary human and material resources available to support the practice? ☐ **Yes** ☐ **No** ☐ **Unsure**

6.2. Is the practice sustainable? (For example can new staff readily adopt the practice? If intensive resources are required to support the practice over the longer-term, is this feasible?) ☐ **Yes** ☐ **No** ☐ **Unsure**

6.3. Does the practice broadly support effective health care delivery? (For example, if implementers are responsible for implementing the directive or delegation or performing the proposed procedure, will other services only they can provide be disrupted? Will other team members or care delivery systems be negatively impacted? Can these effects be offset?) ☐ **Yes** ☐ **No** ☐ **Unsure**

6.4. Can any billing, cost or liability considerations be appropriately managed? ☐ **Yes** ☐ **No** ☐ **Unsure**

6.5. Are there any other situation-specific factors to consider? ☐ **Yes** ☐ **No** ☐ **Unsure**

Comments:

Considerations:

- **6.1 - Having the Necessary Resources is Essential.**
  - This includes resources necessary to establish a practice, as well as to sustain it. For example if training time or space is not available, or equipment cannot be maintained, or if the costs of the resources – material and human - over the long run exceed the benefits, particularly if the services can be provided in another way, a directive or delegation may be contraindicated.
- **6.2 - Sustainability is a Priority.**
  - If a practice is not sustainable, for example not all eligible staff can maintain competence, or new staff members are unable to readily adopt the practice, then it may not be appropriate to establish a directive or delegation.
- **6.3 - Patient Interests Guide Evolution and Deployment of Health Human Resources.**
  - As professionals evolve in their roles and services they provide, consideration needs to be given to the impact of that evolution on broader care delivery systems. If evolving roles and services interfere with or cause discontinuation of another service that only the proposed implementer can provide, or compromises another team member's role and services, and this effect cannot be appropriately offset, the directive or delegation is contraindicated.
- **6.4 - Billing, Cost and Liability Considerations Must Be Addressed.**
  - The OHIP Schedule of Benefits has particular provisions for when physicians and authorizers may bill for the performance of procedures that others are performing. Physician authorizers are referred to the Schedule of Benefits, and to the OHA and Provider Services Branch at OHIP for guidance. In hospitals, consideration may also be given to cost implications arising out of base budgeting arrangements. Liability matters such as appropriate insurance coverage of authorizers and implementers may be a consideration. If cost, billing and liability implications cannot be appropriately addressed, the directive or delegation may not be feasible.

7. **Risk/Benefit Analysis:**

7.1. Do the benefits of proceeding by way of the directive, delegation or practice outweigh the risks? ☐ **Yes** ☐ **No** ☐ **Unsure**

Comments:

Considerations:

- **Conduct the Risk/Benefit Analysis in Light of Patient Interests and Circumstances in the Situation.** Where risks to patients exist, determine if they have been adequately offset given the provisions identified throughout this assessment. If not, then the directive, delegation or practice is contraindicated.
- **Higher Risks May Be Acceptable.** Where an authorizer is not able to perform the procedure (e.g. remote settings), and the risk of not performing it outweighs the risk of performing it, it may in patient best interests to proceed by way of a directive, delegation or practice, despite the risk.

8. **Education and Performance Readiness Plan:**

8.1. Is there a plan for enabling implementers to attain the necessary competencies and achieve performance readiness? (Identify a basic plan here, or where the plan is more involved, refer to the Performance Readiness Plan.) ☐ **Yes** ☐ **No** ☐ **Unsure**

Comments:

Considerations:

- **The Degree of Detail for the Plan Depends on Circumstances.** An education plan may range from a review of written materials (e.g. of a written directive or protocol) to successful completion of a continuing education course. Where competence acquisition needs are more extensive, the plan may be more comprehensive (for example it may involve establishing a curriculum including theoretical, practical and supervised practice components). Where the plan is straightforward, it can be identified here. Where it needs to be more extensive, the Performance Readiness Plan may be used. Documentation of the plan is recommended.
- **Forms May Be Used to Indicate Implementer Performance Readiness.** In some circumstances, especially in larger, more complex settings, it may be useful to document achievement of performance readiness. See the Implementer Performance Readiness Forms - Individual and Group for options.

If education is indicated but not possible, then the directive, delegation or practice is contraindicated.

9. **Communication Plan:**

9.1. Is there a plan for informing stakeholders and for activating the directive, delegation or practice? ☐ **Yes** ☐ **No** ☐ **Unsure**

Comments:

Considerations:

Establishing a communication and activation plan during the performance readiness assessment phase facilitates effective implementation. The plan should include information that any stakeholder needs to know to support safe and effective care and identification of which stakeholders will be informed by whom and how. It should also take into consideration the timing of approval, activation and communication to ensure coordination.

10. **References to Support Practice:**

10.1. Are there references to support practice? (References may be listed here or attached) ☐ **Yes** ☐ **No** ☐ **Unsure**

Comments:

Considerations:

In addition to best practice sources, references may include information obtained from relevant Colleges and from comparator organizations to determine generally accepted standards of practice.

11. **Those Consulted for Input:**

11.1. Have all affected stakeholders been consulted? List those consulted in the table below. ☐ **Yes** ☐ **No** ☐ **Unsure**

Comments:

Considerations:

- **Table for Use in Larger, Corporate Settings.** The table is set up to guide and obtain input in larger, corporate settings such as hospitals or nursing homes where multiple authorizers, implementers, administrators and administrative groups have accountabilities for the proposed practice. In less complex settings, the number of affected stakeholders would be reduced and in small team settings, use of the table may be unnecessary.
- **Table May Be Adapted for Use as an Approval Form.** The table may be adapted to serve as an approval form by including signatures of stakeholders and the date when they indicate agreement.

Stakeholders Consulted	**Names/Positions**	**Agree?**

1. Authorizers [2]		☐ **Yes** ☐ **No**
2. Implementers: • Implementer(s) or representatives, • Co-implementers (if applicable) [3] • Educators (if applicable) [4]		☐ **Yes** ☐ **No**
3. Administrators [5]		☐ **Yes** ☐ **No**
4. Professional Leaders of: • Authorizers; • Implementers; &, • Co-implementers (if applicable)		☐ **Yes** ☐ **No**
5. Applicable profession-specific groups/committees of: • Authorizers • Implementers • Co-implementers (if applicable)		☐ **Yes** ☐ **No**
6. Program Committees		☐ **Yes** ☐ **No**
7. Corporate Committees [6]		☐ **Yes** ☐ **No**
8. Other Relevant Individuals or Committees		☐ **Yes** ☐ **No**

[2] If a medical directive is being used, relevant authorizers include all physicians or authorizers potentially responsible for patients who may receive the procedure pursuant to the directive. As well, authorizers potentially affected by a directive, for example physicians with admitting privileges consulting to an Emergency Department, physicians responsible for Laboratory Services, or radiologists and other authorizers who may be, or may become responsible for an episode of care to which the directive applies are also consulted. All physicians responsible for patients who may receive a procedure under authority of the directive must sign off on it.

[3] Co-implementers are those performing the procedure upon implementation of the directive by another. For example medical radiation technologists may take an x-ray in accordance with a requisition completed by a nurse under authority of a directive from a physician. Or, medical laboratory technologists may analyze blood specimens in accordance with a requisition completed by geneticist under authority of a directive from physician.

[4] Educators are implementers who are designated to teach the procedure to other implementers.

[5] Relevant administrators include managers, program or corporate directors and medical directors of affected staff and areas.

[6] Corporate Committees include those with a mandate for governing clinical practice such as Pharmacy and Therapeutics Committees (only of medication involved), Medical Advisory Committees and the like.