Bill 90 and the therapeutic nursing plan

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The therapeutic nursing plan will soon become mandatory in all of Quebec's health institutions. It is a result of the changes legislated by Bill 90. Even though Bill 90 came into effect on January 20, 2003 and is thus several years old, it is useful to go over its major features in order to understand its impact on nursing care and the implementation of the therapeutic nursing plan (TNP).

Fields of practice as defined by Bill 90

Physicians	Nurses	Nursing assistants
Evaluate and diagnose all deficiencies in human health , prevent and treat illness in order to maintain or restore health.	**Assess the state of health of a person, determine and assure the carrying out of a nursing care and treatment plan, provide nursing and medical care and treatment in order to maintain or restore health and prevent illness, and provide palliative care.**	**Participate in the assessment of a person's state of health and the carrying out of a care plan, provide nursing and medical care and treatment to maintain or restore health and prevent illness, and provide palliative care.**

Bill 90

The enactment of Bill 90 several years ago brought about important changes in the health professions which impact on the routine practice of nursing in Quebec. Bill 90, modifying the Professional Code and other legislative dispositions as regards the health sector was ratified on June 14, 2002.[1]

Activities reserved to nurses (1)

- **Assessing the physical and mental condition of a symptomatic person;**
- **Providing clinical monitoring of the condition of persons whose state of health is problematic, including monitoring and adjusting the therapeutic nursing plan;.**
- **Initiating diagnostic and therapeutic measures, according to a prescription;**
- **Initiating diagnostic measures for the purposes of a screening operation under the Public Health Act (2001, chapter 60).**
- **Performing invasive examinations and diagnostic tests, according to a prescription;**
- **Providing and adjusting medical treatment, according to a prescription;.**
- **Determining the treatment plan for wounds and alterations of the skin and teguments and providing the required care and treatment;**

The above comparative table defines the scope of practice for the medical and nursing professions as well as for nursing assistants.

Dr Yves Lamontagne, president of the Collège des médecins, stated that the principle behind the legislation was to enable us to enter the XXI century. Medicine, as well as the ensemble of the health care delivery system that we offer has evolved considerably over the last 30 years. Bill 90

acknowledges this reality[2]. These changes became necessary because the Professional Code, which up until then governed professions in Quebec, no longer corresponded to the reality in the domain of health care.

Activities reserved to nurses (2)

- **Applying invasives techniques;**
- **Participating in pregnancy care, deliveries and postpartum care;**
- **Providing nursing follow-up for persons with complex health problems;**
- **Administering and adjusting prescribed medications or other prescribed substances;**
- **Performing vaccinations as part of a vaccination operation under the Public Health Act (2001, chapter 60).**
- **Mixing substances to complete the preparation of a medication, according to a prescription;**
- **Making decisions as to the use of restraint measures.**

Bill 90 defines and differentiates between the specific or shared competencies of eleven professions in the field of health care as practiced in Quebec and encourages their members to collaborate. For each of these professions, the Act describes a determined field of exercise. Certain professional activities, according to determined criteria, are reserved for each one with the intent being the protection of the public. The act also defines the competencies and knowledge required to exercise such activities as well as the risks incurred if they are not exercised by qualified persons.[3]

Activities reserved to nursing assistants (1)

- **Participate in the assessment of a person's state of health and the carrying out of a care plan, provide nursing and medical care and treatment to maintain or restore health and prevent illness, and provide palliative care.**
- **Take specimens according to a prescription.**
- **Introduce an instrument or a finger, according to a prescription, beyond the nasal vestibule, labia majora, urinary meatus, anal margin or into an artificial opening in the human body.**
- **Providing a training certificate has been issued, introduce an instrument, according to a prescription, into a peripheral vein in order to take a specimen.**
- **Providing for the care and treatment of wounds and alterations of the skin and teguments, according to a prescription or the nursing plan.**

First of all, we should clarify that the new legislation in no way narrows the field of practice of the various professional orders, nor does it take away any act which was reserved for the various professions. On the contrary, in certain cases, the field of practice is enlarged and other reserved acts are added.[4] Above all, it clarifies certain grey areas in the domain of reserved acts. For comparison, the tables show the acts reserved for nurses and nursing assistants.

Several professional associations in the field of health care were affected by this legislation: physicians, pharmacists, nurses, radiologists, dieticians, speech and hearing therapists, physiotherapists, ergotherapists, nursing assistants, medical technologists and respiratory therapists.

Effects on the nursing profession

Major elements concerning the nursing profession can be found in this legislation. They are concerned primarily with the treatment of alterations of the skin and teguments as well as the care of the feet, domains henceforth reserved to nurses.

Activities reserved to nursing assistants (2)

- **Apply invasive measures for the maintenance of therapeutic equipment.**
- **Provide care and treatment for wounds and alterations of the skin and teguments, according to a prescription or a nursing plan.**
- **Administer, other than by intravenous, medication or other prescribed substances.**
- **Participate in vaccinations as part of a vaccination operation under the Public Health Act (2001, chapter 60)**
- **Observe the state of consciousness of a person and monitor neurological signs.**
- **Mix substances to complete the preparation of a medication, according to a prescription.**

In this section of the legislation, the role of the nurse is considered mainly from the perspective of assessment and preventive measures which imply certain risk factors, the local treatment of wounds, and alterations of the skin and teguments. An interdisciplinary approach is recommended depending on the type, severity and evolution of the wound as well as close collaboration with the treating physician.

Other authorisations

Specifically and under certains conditions, nurses are authorised to:

- **Prescribe diagnostic examinations;**
- **Use diagnostic techniques that are invasive or entail risks of injury;**
- **Prescribe medication and other substances;**
- **Prescribe medical treatment ;**
- **Use techniques or apply medical treatments that are invasive or entail risk of injury .**

Source: http://www.opq.gouv.qc.ca/fileadmin/docs/PDF/Tableau-Champs-pratique.pdf

Thus, as far as wound care is concerned, Bill 90 attributes to nurses the responsibility for:

"Determining the treatment plan for wounds and alterations of the skin and teguments as well as providing for their care and treatment".[5] Thus, the nurse can now determine the treatment plan related to wounds and alterations of the skin and teguments without an individual or collective prescription. This confers greater autonomy on the nurse.[6] This article of Bill 90 allows the nurse, among other things, to determine a nursing directive in the TNP and the documentation of the wound treatment plan in a specific tool accompanying the therapeutic nursing plan (TNP).

Certain changes ratified by Bill 90 confirm what was already a reality, but without a doubt it gives nurses greater decisional power and more latitude to use their own judgment. A few terms are modified, others disappear: delegated medical act, standing prescription, authorized act, on site or remote monitoring. Other terms appear. They are:

Individual prescription

A prescription given by a physician to an authorized person. It designates an individual whose state has been previously evaluated. It can also be a pre-printed prescription.

Collective prescription

Enables an authorized professional to exercise certain activities without having to obtain an individual prescription from a physician. It implies that the person concerned does not need to have been previously seen by a physician.

Medical protocol

A description of procedures, methods, limits or norms applicable to a particular condition in an establishment. An individual or collective prescription can refer to a protocol depending on the situation.

Nursing care standard

The standard which concerns the way in which care is dispensed and under which circumstances. It can be a medical or nursing standard. For example: all patients in long-term care are offered an annual influenza vaccination without a medical prescription.[7]

Some terms which should not be confused

In order to understand the components and application of the therapeutic nursing plan, one must distinguish between the terms used and their acronyms.

WP: work plan destined for orderlies

TNP: therapeutic nursing plan

IIP: interdisciplinary intervention plan

NCTP: nursing care and treatment plan

CP: clinical pathway

PN: progress note

The therapeutic nursing plan

The therapeutic nursing plan is a separate documentation tool enabling us to rapidly identify and keep a paper trail of the crucial decisions taken by caregivers for their patients. It specifically touches on 3 of the 14 activities legally attributed to nurses by Bill 90 mentioned in the previous pages.[8] These activities are: "assessing the physical and mental condition of a symptomatic person", "providing clinical monitoring of the condition of persons whose state of health is problematic, including monitoring and adjusting the therapeutic nursing plan" and finally, "providing nursing follow-up for persons with complex health problems".

The therapeutic nursing plan

The therapeutic nursing plan is an application of Bill 90 and defines the scope of nursing practice (art. 36). It includes three activities reserved to nurses:

- **Assessing the physical and mental condition of a symptomatic person;**
- **Providing clinical monitoring of the condition of persons, whose state of health is problematic, including monitoring and adjusting the therapeutic nursing plan;**
- **Providing nursing follow-up for persons with complex health problems.**

The ensuing obligations

The introduction of the therapeutic nursing plan requires that nurses fully assume their role and exercise leadership in the health team. The therapeutic nursing plan requires nurses to develop competency with respect to the clinical examination in order to evaluate the physical and mental condition of the patient, to exercise effective clinical monitoring of their state and carry out the required nursing follow-up. The provisions of the TNP, including the scope of practice of the other health professionals, require nurses to distinguish their own field of competency from those of the auxiliary personnel. Since care must be carried out under the supervision of nurses, certain obligations are created requiring health centers to review the organisation of work and rethink it in terms of their specific vocations.

For their part, teachers must prepare students so that when they enter the workplace, they will be skilled in carrying out the physical exam and prepared to fill out the TNP. Consequently, and despite the difficulties that they might encounter in integrating the workplace and their inexperience in mastering all the functions inherent to the nursing profession, young graduates must rise to the task of coordinating the health team in providing care. They must be capable of expressing the nursing directives in order to orient the work of nursing assistants and other team members, thus fulfilling the requirements of the TNP.[9]

The client's priority problem or need

The therapeutic nursing plan highlights the importance of the nurses' evaluation of the condition of the patient. The TNP establishes a progressive clinical profile of the state of the patient and centers on their ***priority problem or need.*** The exhaustive gathering of facts correlates more with the nursing care and treatment plan (NCTP). However, since the therapeutic nursing plan is progressive, it must also reflect the changes which have an incidence on the clinical follow-up. Thus, new nursing directives will appear as the state of the patient evolves.

The criteria of priorities for the choice of the problem or need to be treated are the following:

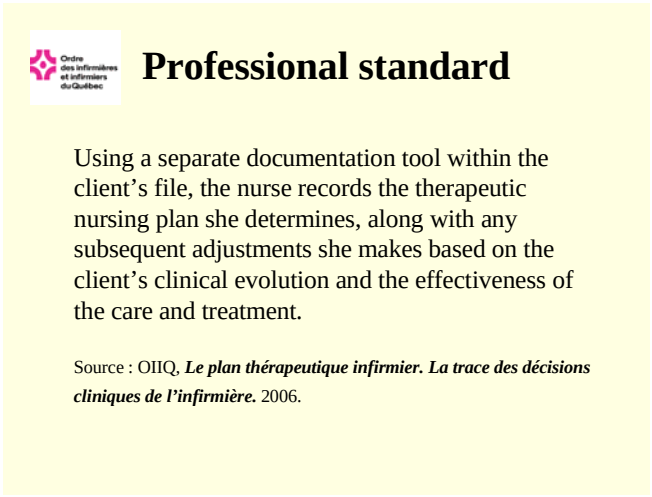
- Requires a particular clinical follow-up;
- Has an incidence on the client's clinical follow-up;
- Presents a significant change in their state.[10]

Differences and similarities between the TNP and the nursing care and treatment plan (NCTP)

- **TNP :** concerns solely the priority problem or need.
- Gives directives in relationship to the primary problem or need and not to all the problems of the client.
- It indicates who does what and how.
- It must be documented in the progress notes (PN).
- It is a professional requirement (Bill 90).
- It is progressive, in relationship to the changes in the state of the patient, but cannot be erased in order to be modified.
- It does not use a particular phraseology.
- It is conserved in the patient's file.
- It includes a specific obligatory plan for the care of wounds..
- It must be individualised.
- It is obligatory for all patients whose state requires follow-up.
- It gives greater visibility to nursing care.

- **NCTP :** can concern several problems or needs of the patient.
- It includes larger orientations concerning other needs or problems.
- The actions are generally carried out by the nurse and do not indicate if others should carry them out.
- The actions performed must be documented in the file progress notes (PN).
- It must be done but is often omitted.
- It is written according to a specific vocabulary (the nursing diagnostic is often used).
- It is written in pencil and erased for modifications.
- It is not conserved in the patient's file.
- It does not include any particular plan for the care of wounds.
- It can be standardised.
- It is not required in long-term, community health care or home care.
- It gives little professional visibility to the nurse.

The professional standard behind the TNP



Professional standard

Using a separate documentation tool within the client's file, the nurse records the therapeutic nursing plan she determines, along with any subsequent adjustments she makes based on the client's clinical evolution and the effectiveness of the care and treatment.

Source : OIIQ, ***Le plan thérapeutique infirmier. La trace des décisions cliniques de l'infirmière.*** 2006.

The professional standard which underlies the obligation of the TNP and gives it an official character is this : "Given the importance of the therapeutic nursing plan, for the security of the patient and for the quality of care, the Ordre des infirmières et infirmiers du Québec has decided to make its documentation obligatory as of April 1st, 2009". The table on the left presents the professional standard on which this obligation is based. All the members of OIIQ, whether they work in hospitals or clinics, administration, research or education must know and respect this standard.[11]

The implementation of the TNP

As with any major change, the therapeutic nursing plan will take time before it becomes common practice but gradually, nurses can make it theirs. According to the OIIQ, its implementation should be made progressively over three years: start-up the 1st year, implementation the 2nd , and consolidation the 3rd .

The objectives of the plan, spread over three years, aim to create optimal conditions for its implementation, reach the various clientele concerned and assure the necessary support. It is up to the nurses who desire to do so, to request that the TNP be integrated in the computer system that they use in clinical practice.[12]

What stays the same and what changes in our work habits

The therapeutic nursing plan introduces important changes in our work habits and it is appropriate to ask ourselves how nurses will situate themselves in relation to this novelty? Some believe that it will bring important changes to our practice, while others already see the therapeutic nursing plan as an additional burden in a profession which is already overburdened. What should one think?

What remains

The therapeutic nursing plan introduces important changes in our work habits but many elements remain unchanged. First of all, one should note that the nurse's evaluation, which is at the core of the TNP is based on the gathering of information, the clinical examination, the history of the patient, the medical diagnoses and the results of tests and

diagnostic exams.[13] The nurse's judgment must also take into account the values and preferences of the client and his family.[14] The gathering of data must be carried out according to the standard conceptual model whose elements are already familiar and remain unchanged.[15]

Progress notes (PN)

The therapeutic nursing plan includes a progress note (PN) complementary to the history which forms an integral part of the client's file.[16] The TNP does not eliminate the progress notes in the file, since this legal document maintains its importance in providing a sequential and chronological report of the evolution of the state of the patient and what is being done to help them. The notes to the file also reflect the effectiveness of the interventions proposed by the nurse. One must now find the priority problem or need which was recorded in the section "***assessment findings***" in the first part of the TNP form, as well as the nurse's clinical directives which can be found under "***clinical follow-up***" in the TNP with its related information.[17]

The treatment plan for wounds must be indicated in the TNP. It must also be found in the particular treatment plan and be mentioned in the progress notes (PN).[18] The preventive or educative actions in the nursing care and treatment plan (NCTP), which should not be confused with the orderlies work plan (WP), do not belong to the therapeutic nursing plan (TNP). The reason for this is that they are not solely concerned with the priority problem

Differences and similarities between the progress notes and the directives of the clinical follow-up

- **PN:** sequential, chronological, progressive description of all that happens on the clinical level : arrival, departure , signs and symptoms, changes in the condition of the patient, relocation to another service (eg: radiology), care given and the results, treatments, interventions, professional visits, etc.
- The date and the hour are entered in chronological order for the start of interventions.
- The nurse responsible for the patient signs her notes only at the end of her work shift.
- The progress notes are a legal obligation and fall under the Nursing Code of Ethics (art.14).
- They assure the continuity of care and the legal protection of the patient and the caregiver.
- They reflect the quality and the effectiveness of care.
- The progress notes are an essential component of the patient's file.

- **DCF:** progressive record of the nurse's directives concerning the priority problem or need.
- They indicate what should be done, by whom and in what manner.
- The directives are progressive in accordance with the changes in the condition of the patient and the effectiveness of the treatment.
- The date and hour are indicated for the start and finish of the interventions.
- Each annotation is initialed and the TNP is signed (in correspondence with the initials) with the mention of the program or service to which the nurse belongs.
- The directives are a legal obligation (Bill 90) and as with all professional records are governed by the Nurses Code of Ethics (art.14).
- They are a reflection of the quality and effectiveness of the care given.
- The directives of the clinical follow-up are a part of the TNP and an essential part of the patient's file. (Bill 90).

and can apply to more than one problem of the client.[19] Thus, for the time being, certain elements such as the gathering of information, the clinical examination, the progress notes (PN) as well as the nursing care and treatment plan (NCTP) remain unchanged.

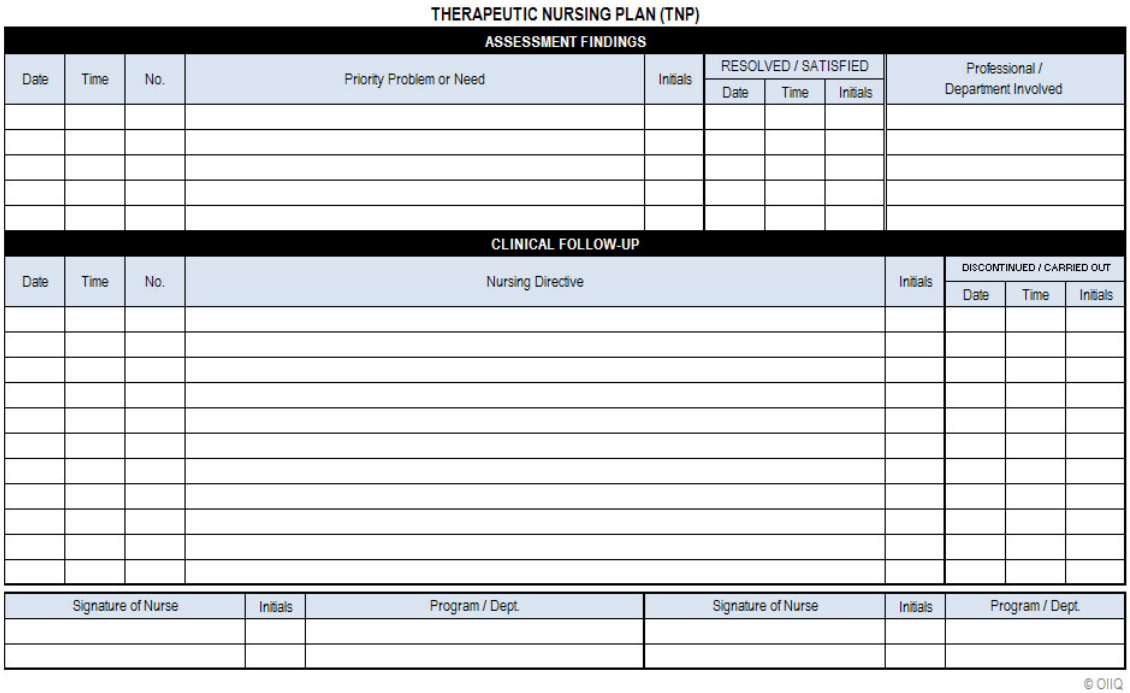
The form for the TNP

The form for the TNP has three sections.

The top section

The first section of the form is used for recording the priority problems or needs, which are the result of the nurse's evaluation or the report of a professional evaluation. This record must be precise and succinct, and include the date and hour of the evaluation, numbered in chronological order, and initialled by the nurse who entered the record, the date and hour of the resolution of the problem or the satisfaction of the need, as well as the initials of the nurse who observed this. According to the circumstances, the type of professional or service involved in the situation must also be inscribed, for example, a physiotherapist or a multidisciplinary team.

Thus, all the observed problems or needs are not found in this section of the TNP, only the priority ones. Standard interventions are consigned in other clinical tools.[20]



THERAPEUTIC NURSING PLAN (TNP)

ASSESSMENT FINDINGS								
Date	Time	No.	Priority Problem or Need	Initials	RESOLVED / SATISFIED			Professional / Department Involved
					Date	Time	Initials	

CLINICAL FOLLOW-UP							
Date	Time	No.	Nursing Directive	Initials	DISCONTINUED / CARRIED OUT		
					Date	Time	Initials

Signature of Nurse	Initials	Program / Dept.	Signature of Nurse	Initials	Program / Dept.

The second section

The second section of the TNP includes the nurse's directives for the clinical follow-up. A nursing directive contains instructions concerning an intervention.[21] Each directive must include the date and the hour of the annotation, as well as the number of the priority problem or need to which it refers chronologically. These directives orient the follow-up. They must include the initials of the nurse who entered them, the date and hour that they were carried out or stopped, as well as the initials of the nurse who made the observation.

The criteria for determining if a directive should be inscribed in the TNP are based on the objective of the directive. They can either clarify an intervention, establish a strategy or define a condition for its realisation. Thus each directive should answer the following questions:

- the aim of the directive (why)
- the object of the directive (what is it about?)
- the subject of the directive (to whom is it addressed?)

The third section

The third section concerns the signatures corresponding to the initials found in the first and second sections and the mention of the service or program concerned.

Particular treatment plan for the treatment of wounds and skin alterations

If a particular skin problem occurs, a specific plan must be elaborated. This plan can appear in a specific documentation tool apart from the file or be mentioned in the progress notes (PN).[22]

Standard follow-up

The clinical follow-up can be either standard or specific. The standard follow-up is one in which there are no complications. In this case, the reason for the hospitalisation, long-term care, community health care or home care constitutes a ***minimal inscription*** in the standard therapeutic nursing plan, in the place of the priority problem or need.[23] It is important to note this.

Treatment plan for wounds and alterations of the skin

- **Plan #** 1
- **Beginning** : April 4, 2009 3h00
- **End** :
- **Site :** left heel
- **Treatment :** clean the heel with NaCl 0,9% and dry.
  Apply a transparent dressing.
- **Signature :**
- **Signature :**

Source : OIIQ. À la découverte du PTI : http://www.oiiq.org/infirmieres/plan/formation/index.html p. 52

Moreover, the medical diagnosis does not appear in this note unless it has an incidence on the clinical follow-up of the patient and if it requires directives for the nurse's own interventions or for those of the assistants and auxiliary personnel. Thus it should not be systematically included.[24] In any case, the standard follow-up should follow the evaluation of the patient by a nurse. Moreover, the minimal information which constitutes the reason for the hospitalisation, long-term care, home care or community health care should proceed from this evaluation. It is this information which defines the clinical profile which is the object of the standard follow-up.

Specific follow-up

The specific or exceptional follow-up concerns the interventions necessitated by the client's health situation or by an atypical evolution of their state of health. For example, postoperative nausea is frequent and does not need specific follow-up unless persistent. It should, however, be included in the progress notes (PN) in the file.

Adjustments to the TNP

The therapeutic nursing plan is determined and readjusted only by the nurse, according to her evaluation. Thus, according to the evolution of the situation and her observations, the nurse must adjust the TNP. She must, for example, either define a new priority problem or need, or add to the nursing directives the interventions required by the state of health of the patient. For example: "Place the client at the nursing station for supervision during supper" (Directive to the orderlies work plan). The adjustments can thus concern changes regarding the progress of either a priority problem or need or the nurse's directives only. Moreover, any adjustment to the TNP must be justified in the progress notes (PN) in the client's file.[26]

Bill 90 and the advent of the therapeutic nursing plan (TNP) initiate a profound change in our profession and represent much more than just filling out the form correctly.

The responsibilities associated with the TNP

The responsibilities of the nurse associated with the TNP can apply throughout the entire duration of the follow-up of the patient's illness.

- The nurse's responsibilities can begin at the very start of the period of care, that is, on admission. The nurse must then, if possible, consult any prior TNP's in order to better understand the situation, the priority needs and problems of the client, the follow-up and the effectiveness, or not, of the treatments.

- During the care period, that is, while the client is hospitalized or under community health care or home care.

- At the end of the care period when they are discharged or transferred. At that moment, the nurse must transmit the required instructions for the care of the client, in the respect of the rules of the establishment where she works.

Various considerations

Various situations can occur which raise questions. The following statements may shed some light.

The TNP is, in its very essence, individual and consequently cannot be standardised as can certain care plans. It must thus be written up for each patient whose state requires follow-up whether they are in a hospital, in long-term care, community health care or at home

The nurse must complete a therapeutic nursing plan for each patient under her care, even for outpatient surgery, if the client must be hospitalised or if a clinical follow-up is required. The same applies to services such as intensive care where all the work is done according to protocols. Even there, a TNP must be completed. [27]

The client has access to his TNP, as he has to his medical file. He must however, respect the access procedure in place at the establishment where he is cared for.[28]

The TNP is established according to the composition of the core team and is not modified if it changes temporarily, for example if a team member is absent. The nurse must however, take into account those who are present in order to assure the clinical follow-up and to optimally organize the work of the team. [29]

When stating the directives, the nurse must respect the standards of the health care in place in the establishment and must coordinate the work of the team in order to assure the realization of the nursing follow-up.

Some special situations

Other situations can occur and pose problems. It is important to know how to solve them.

Only a nurse can draw up the TNP and nursing assistants must apply the directives which apply to them and for which they are responsible. If ever a nursing assistant refuses to apply the directives ordered by a nurse, they can be directed to their professional association, the OIIAQ, which is responsible for informing its members concerning the TNP.[30]

The administration of a PRN medical substance must also be included in the nurse's directive in the TNP if the situation of the client requires it.[31]

When a nursing directive is omitted, one must justify its non-application in the progress notes (PN). If this omission is not justified and it caused or may have caused prejudice to the client, one must fill out an accident-incident report form as in all other cases of omissions.[32]

The advantages of the TNP and possible concerns

The TNP is certainly a step forward towards greater professional visibility and recognition of the work of the nursing profession. It enables us to keep a paper trail of the important decisions taken by nurses and their results. It places the activities of nursing care on the same level as those of other professionals in the multidisciplinary team. It also highlights the leadership role of the nurse in the health care team. These are surely major advantages.

Obstacles

Obstacles which must be faced

- **Work overload.**
- **Nurses' perceptions of themselves.**
- **The capacity of leadership of nurses.**
- **The persistence of our work habits :**
  - **Difficulty in delegating;**
  - **Difficulty in working in multidisciplinary teams.**
- **The conservation of our professional tools.**
- **Writing difficulties.**
- **The lack of adaptability to change.**

But as with all change, there are obstacles and risks which must be taken into consideration. First of all, novelty is frightening and is always met with antagonism. Since the notion of the TNP has been around for a while now and its implementation will take place over three years, there is a good chance that misgivings will diminish relatively rapidly. After all, it is now a legal obligation!

However, where it hurts most, is that the TNP is seen by many as extra work in a profession already exhausted by excessive workloads and overtime. This is an important obstacle and will probably require readjusting the organisation of work in some health care centres. Unfortunately, the TNP will be mandatory in April 2009 and these changes have not yet been envisioned. We'll have to see.

Questions relative to the nurses' role

The advent of the TNP also raises other questions, which are neither pessimistic nor negative, and we must face them head on. Its implementation presupposes that the nurse play a more assertive role in the multidisciplinary team and above all, that she assume

leadership in the health care team. We can ask ourselves how many nurses will dare to express their knowledge, clinical judgment and leadership capacities?

Unfortunately, in the past, we have too often trained nurses to be submissive and follow orders rather than lead. Consequently, the attitude of leadership will probably be difficult for some nurses to develop, especially the younger arrivals in the workplace. Many will probably do well but others will have greater difficulty. The need to train our students to be more affirmative should also make our teachers think about how to orient nursing training to best respond to this.

The TNP also presupposes that we question certain work habits and leave to others some of the activities or tasks that we have done since time immemorial and which represent a powerful symbol of our profession. We must realise that the time when all that concerned the patient was necessarily done by the nurse is over. From now on, we must learn to delegate certain tasks: by taking control of the ensemble of healthcare interventions via the directives of the clinical follow-up of the TNP, the nurse must indicate who should do what and how, whether it be for example the nursing assistant, the family and social assistant or the orderly.

Let us make clear that this change should enable us to better assume our role vis-à-vis the patient and in the health care team. Above all, we must hope that this delegation of tasks will enable nurses to consecrate more time to interventions other than those of a strictly medical nature thus enabling them to reconnect with the essence of care giving.

- **Change may at times be a road full of pitfalls or of happy surprises.**
- **We must step forward with determination, taking into account what we have to gain and what we risk losing on the way.**
- **Our actions then will be determined by the logic of laws but also by the logic of the heart.**

Questions concerning our professional tools

The above are not the only questions raised by the implementation of the TNP. One of the foreseeable difficulties concerns the survival of some of our professional tools.

The nursing care and treatment plan (NCTP)

The therapeutic nursing plan does not necessarily call into question the necessity of a nursing care and treatment plan (NCTP). The latter, whose approach aims at prevention and the well-being of the person, constitutes a solid base for our actions. This larger vision of the state of the patient with its changes over time, on his family and his surroundings, remain necessary even in the presence of the TNP.

However, in the information transmitted by the OIIQ, as regards the TNP and how it will dovetail with the other professional tools, one must admit that the NCTP is threatened despite the fact that it is "inscribed in the field of exercise of the nurse". Since its presentation is variable, "it is more likely to disappear since it is often not filled out and generally not consigned in the client's file".[33]

Henceforth will we be putting out fires or will we be capable of thinking for the long term and planning our actions?

The information from the OIIQ also mentions that the NCTP was not made mandatory because overburdened nurses found its application too demanding. We can then ask ourselves that with the addition of the TNP to their other tasks, whether the nursing care and treatment plan will last long. Does one not say "the spirit is willing but the flesh is weak"? And when it comes to saving work, beautiful principles rapidly lose their value.

When this tool will have disappeared, will nurses look beyond the priority need or problem of the patient? Will they still be interested in anticipating and planning for the long term and not working solely in the "here and now"? Once they will become used to the "minimal note" which is that of the medical diagnosis, the reason for the hospitalisation, the long-term care or community health care, how will they succeed in becoming interested in a more holistic way in the condition of the patient where problems of another, more complex nature, intervene? For how much longer will nurses be able to remain thoughtful professionals capable of thinking in terms of care, analysing their practice and readjusting it to the needs of the patient, such as the NCTP allowed us?

The priority problem or need is very important, but it is only the point of the iceberg. When the care plan has disappeared, will we still be interested by this less apparent mass of difficulties that the person experiences such as anxiety, sorrow, fear, solitude, feelings of being abandoned? Will we be able to conserve these preoccupations which have been at the core of of nursing care since the dawn of time and which give it its richness and humanism?

Progress notes (PN)

The therapeutic nursing plan (TNP) does not eliminate the progress notes (PN) either. On the contrary, for the moment it remains the place where we document what is recorded in the TNP. Effectively, in the information from the OIIQ concerning the TNP, one reads that it is in itself a progress note complementary to the narrative progress notes. It doesn't replace them since they contain the justification for the clinical decisions grouped together in the TNP. Moreover, the TNP is in a way a chronological marker or table of contents which enables us to easily access the information contained in the progress notes and to know the clinical follow-up carried out by the nurse.[34]

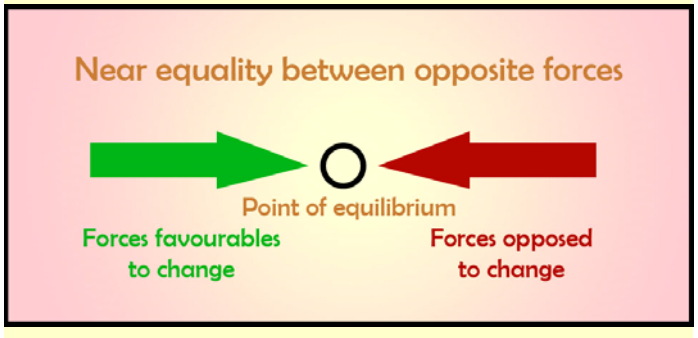
But since the "TNP is in itself a progress note", it would appear that the two documents duplicate each other. We will see which direction nurses will prefer? Is there not a risk that over time, having minimized the importance of the progress notes in the client's file, we will only take into account the formal obligations of the TNP? It is then logical to ask what will happen when the concern for efficiency, the tendency to rationalise tasks and the natural human penchant towards minimum effort will take the forefront. It remains to be seen.

The difficulties of writing

Another difficulty which we must anticipate in the writing up of the TNP is the fact that there is no terminology or specific vocabulary recommended for its composition. Nurses certainly appreciate the possibility of freely expressing themselves but one must worry that the difficulties associated with writing, which are commonplace in our society, may be reflected in the writing up of the TNP. The important thing is that all those concerned can understand what the nurse has written. Consequently, we must think about the subject of writing. The proposition of a list of terms which are clear would certainly be a help. The TNP should also have fixed rules of writing such as precision, conciseness, veracity, pertinence, correct grammar and spelling.

The TNP, as all other components of the health care file, reflects on the competency of the nurse who writes it. But it is also a window on the quality of care and on the expertise of the entire nursing profession. To be specific, the comment of Watson is particularly pertinent. "It is easy to think that the person who does not write their notes in a professional manner shows the same lack of professionalism in the care that they give" (Watson, 2003 in Y. Brassard). [35]

Change



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Bill 90 and the advent of the TNP in our nursing world sets in motion a profound professional change which goes beyond correctly filling out a form destined to this effect. It modifies our work habits and our professional tools and above all, it prompts another definition of our role in the health care team. However, the most important change is probably on the level of our own perception of ourselves as health professionals, of nurses as leaders and active participants in a multidisciplinary team.

Resistance to change is normal and to be expected. A major change often raises a force of resistance equal to its importance. We must thus anticipate, for a while, opposition to the TNP. But positive forces, the motor forces which underlie it are important, maybe more so than the counter forces of resistance.[36] Thus with time, with professional support and by remaining vigilant concerning the risks inherent to this novelty, it will finally become a part of our nursing standards.

Conclusion

One should not be a prophet of doom. The questions raised by the TNP and the difficulties which can flow from a too restrictive application will perhaps not even appear. But in order to avoid them, we must first of all anticipate them and think about them, in order to use this new tool in the best possible manner for the patient and for the future of our profession.

Change is a life force and immobility has a tendency to turn us to the past. In Aurore, Nietzsche wrote: "The serpent who doesn't succeed in changing his skin is destined to die". For us it is not so dramatic, but we must not deny that the implementation of the TNP will carry with it certain disruptions which with time and care will become a manifestation of our professional vitality.

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