

# HPRAC

A Report to the Minister of  
Health and Long-Term Care  
on the Review of the Scope  
of Practice for Registered  
Nurses in the Extended Class  
(Nurse Practitioners)



**March 2008**

Submitted by the  
**Health Professions Regulatory Advisory Council (HPRAC)**





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March 31, 2008

The Honourable George Smitherman  
Minister of Health and Long-Term Care  
10<sup>th</sup> Floor, Hepburn Block  
80 Grosvenor Street  
Toronto, ON M7A 2C4

Dear Minister:

The Health Professions Regulatory Advisory Council is pleased to submit to you its report on the scope of practice for nurse practitioners in Ontario, as requested in your letter of June 28, 2007. HPRAC has found your request timely, absorbing and very illuminating. In this project, the Council saw many opportunities, at both the regulatory and clinical levels, for nurse practitioners to significantly improve the way we help people manage their health care, while receiving safe, professional services when they are needed. We also identified obstacles that must be overcome.

We believe that a broader scope for nurse practitioners will increase the availability and efficiency of patient care and lead to better and more comprehensive, coordinated services. Our recommendations make it possible for the optimal skills and knowledge of nurse practitioners to be exercised with patients in all areas of the province, without legislative or regulatory constraints. The recommendations will also advance the teamwork of professionals from many disciplines, a major advantage for someone receiving care.

HPRAC is recommending a fundamental change in the regulatory approach, one that honours the public interest principles of the *Regulated Health Professions Act, 1991*. It imposes a high standard of care on the College of Nurses, demands professional collaboration, expands the role of nurse practitioners, and places the patient firmly at the centre of all health services.

We want to acknowledge the contributions of hundreds of people who, either individually or through their organizations, provided information, analysis and

judgment about the challenging questions for which we sought answers. Their role in the development of this report was immense.

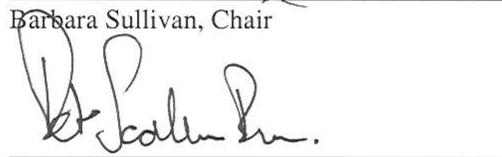
We encourage you to consider these important initiatives. We believe they will raise to a new level the degree of collaboration among professionals and the delivery of patient-centred care for all Ontarians.

Yours truly,



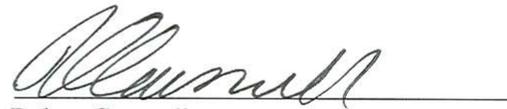
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Barbara Sullivan, Chair



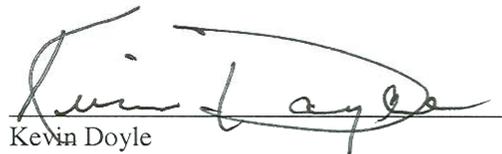
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Peter Sadlier-Brown, Vice-Chair



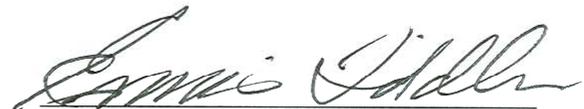
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Robert Carswell



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Kevin Doyle



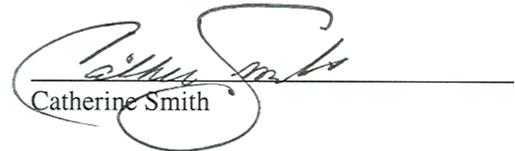
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## **Executive Summary**

### **Scope of Practice for Nurse Practitioners**

### **Recommendations to the Minister**

- In June 2007, the Minister of Health and Long-Term Care, The Honourable George Smitherman, asked the Health Professions Regulatory Advisory Council (HPRAC) to “undertake a review of the scope of practice for registered nurses in the extended class under the *Nursing Act, 1991* and include in the review the proposals made by the Council of the College of Nurses of Ontario with respect to controlled acts and the practice of registered nurses in the extended class.”
- The Minister’s letter called these issues “important matters” that support the government’s commitment to ensure that the health profession regulatory system keeps pace with the health care needs of Ontarians.
- Today’s health care system faces unprecedented challenges. The population it serves is growing, aging, and becoming more urbanized and more diverse – creating new and more complex needs. The Internet has empowered consumers to become more informed participants in their own care. Advanced technologies permit earlier diagnosis and more effective treatment. Clinical practices are evolving rapidly, and many services previously delivered in institutions can now be provided in the community.
- These trends combine to put a new focus on health human resources. It is imperative to educate, recruit and retain professionals with the needed competencies; to enable professionals to practice to the full extent of their capabilities; and to improve teamwork and collaboration in delivering patient-centred care.
- It is within the context of the broader challenges facing the health care system that HPRAC has undertaken its response to the Minister’s request for advice regarding the scope of practice of nurses in the extended class. Building on its 2006 report, *Regulation of Health Professions in Ontario: New Directions*, HPRAC has considered this question from the point of view of shaping the delivery of health care in the 21<sup>st</sup> century.

### **Background**

- Registered nurses in the extended class under Ontario’s *Nursing Act, 1991* are also known as nurse practitioners (NPs). NPs have additional knowledge and skills that build on the broad health science education of registered nurses in the general class (RNs). Their training equips them to independently perform some of the diagnostic and treatment functions that lie within the purview of physicians.
- Education programs in the 1970s prepared registered nurses for “extended” responsibilities and, since that time, nurse practitioners have worked in Ontario in a

variety of settings. In the early years, the role was not widely implemented due to the absence of legislative recognition and government funding.

- In 1998, Ontario became the first province in Canada to enshrine the NP role in legislation. NPs were authorized to perform a series of controlled acts beyond those done by registered nurses in the general class – such as prescribing specific medications, ordering certain x-rays and diagnostic tests, and suturing wounds. (Controlled acts are health care activities that carry a substantial risk of harm if performed by unqualified personnel.)
- Over the past decade, the provincial government has invested in education and provided funding to implement the NP role, and further legislative and regulatory changes have been made to support its evolution. For example, amendments to regulations under the *Public Hospitals Act* and long-term care legislation have enhanced the NP role in hospital outpatient and emergency departments and in long-term care homes.
- NPs today work mainly in primary care settings, such as community clinics, Family Health Teams, long-term care homes and physician offices. Many practice in remote communities with limited access to health care services. Ontario currently has about 800 primary care NPs. About 300 nurses with NP training also work in acute care, mainly in hospitals in highly specialized areas such as cardiac or neonatal care.
- Due to changes in technology, clinical practices and population needs over the past decade, NPs now contend that their legislated scope is too restrictive. The drugs NPs can prescribe, the laboratory and other diagnostic tests they can order, and the procedures they can perform, are listed mainly in regulations. These lists have become dated, but changing them is a complex, time-consuming process. The result is that NPs may be unable to order the latest drugs or tests for their patients or offer the best evidence-based care.
- A partial solution has been the use of medical directives by which physicians authorize NPs in advance to perform specific acts under specific conditions for specific patient populations. But this remedy has brought other problems. Medical directives are complex documents that usually require considerable time to draft. In a hospital setting or group practice, more than one physician is involved and all must concur. If one physician leaves a group practice, or clinical needs or best practices change, the process must be repeated. Much time is consumed that could be spent on patient care.
- Where there are no directives in place, NPs report they are constantly having to “chase” physicians to obtain permission to do things they are capable of doing – and their physician partners find the interruptions just as frustrating. In other cases, the NP simply sends the patient to a physician, delaying treatment.

## **The CNO Proposal**

- NPs contend that their training and experience enables them to do much more for their patients than their current scope of practice allow. They are convinced that the health care system and the patients it serves would benefit from making the most of their capabilities.
- To meet this challenge, the College of Nurses of Ontario (CNO) developed proposals in 2006 to significantly expand the scope of practice for NPs, while placing restrictions on controlled acts in practice standards to be developed by the CNO, rather than in government regulations.
- The proposed enlarged scope of practice includes additional controlled acts such as setting and casting fractures, ordering a wider range of tests and applying forms of energy for treatment purposes. The CNO practice standard, which is binding on NPs, would establish limitations and conditions for the performance of these acts. For example, NPs would be barred from setting certain types of fracture.
- It should be noted that even though a profession as a whole has access to specific controlled acts, individuals within the profession can perform only those acts they have training and experience to carry out safely.

## **Research and Consultations**

- In response to the Minister's referral, HPRAC included the CNO's proposals in an overall review of the scope of practice for NPs. An extensive process of research and consultation was undertaken – including a review of published literature, a review of NP regulation in other jurisdictions, interviews with experts, a call for written submissions, and a series of public meetings and stakeholder roundtables in six Ontario communities.

## **What HPRAC Learned**

- The NP role has been exhaustively researched. Several randomized controlled trials as well as a host of descriptive studies point in the same direction, finding virtually no evidence of harm resulting from NP practice.
- NPs play a role in health care in many countries. HPRAC scanned the regulatory regime across Canada, in many U.S. states and in the U.K. and New Zealand. A close look at three jurisdictions considered leaders in NP regulation – British Columbia, Nova Scotia and Oregon – revealed that most of the changes proposed to NPs' scope of practice by the CNO have already been implemented there.
- The CNO did not seek, nor did anyone propose, granting NPs unconditional access to controlled acts. One of the underlying problems has been reliance on regulations to set limitations on the exercise of those acts. As HPRAC has observed previously,

the regulation-making process has not been timely enough to keep up with changing conditions.

- From NPs themselves, HPRAC heard that the proposed revisions to their scope of practice reflect what many of them are already doing competently under medical directives.
- The majority of participants in the consultations were nursing organizations and individual nurses, who expressed overwhelming support for the CNO's proposals.
- Many other health professionals and their organizations also took part in the consultations. Some of these stakeholders expressed full or partial support for the CNO's position. However, a number of issues were raised, largely based on doubts about NPs' competence to perform additional controlled acts independently. Questions were posed as to whether NPs had the technical skills to perform the acts sought, as well as the clinical judgment to decide when these acts should be performed.
- HPRAC found that Ontario's NP education programs for both primary care and acute care NPs are well established and well respected. A national consensus on core competencies for NPs has been created by the Canadian Nurse Practitioner Initiative (CNPI). Educators in the Ontario programs confirm that the curriculum is designed to produce graduates who possess the CNPI competencies. Emphasis is placed on such areas as clinical thinking, diagnostic reasoning and health assessment.
- New versions of the NP education programs are to be introduced in the fall of 2008, and educators indicate that the content will include all requirements for the expanded NP role as proposed by the CNO. Indeed, the existing programs cover almost all of the necessary content and have for some time.
- The CNO has approved a national examination based on the CNPI competencies as the qualifying exam for registration as a primary health care NP in Ontario. U.S.-based examinations will be adapted for use as qualifying exams for acute care NPs until Canadian exams are in place. During their careers, most if not all, NPs take advantage of continuing education opportunities, but participation is voluntary.
- Some stakeholders were concerned that the CNO's current quality assurance program is not designed for an expanded scope of practice. The CNO is working on an improved quality assurance program, including a practice review every three years.

## HPRAC's Conclusions

- **Having considered the research results and consultation input, HPRAC has concluded that expansion of the NP scope of practice and changes to the regulatory system are in the public interest.**
- It is clear that the performance of the health care system can be improved by increasing the capacity of NPs to contribute to patient-centred care. A wider role for NPs will make the most of their training and experience, help to meet health human resources challenges, reduce the need for paper-intensive medical directives, foster continuity of care, promote interprofessional collaboration and increase access to services.
- To expand the NP role while ensuring protection of the public and providing flexibility for the future, HPRAC is recommending a fundamental change in regulatory approach.
- HPRAC proposes to couple a wider scope of practice for NPs with appropriate standards, limitations and conditions to be established by the CNO for the performance of controlled acts. This new, enabling regulatory framework will replace the current approach that constrains NP practice through restrictive provisions built into the laws and regulations that make controlled acts available to NPs.
- HPRAC has carefully considered the issues raised by some stakeholders about expansion of the NP scope of practice. On balance, HPRAC has concluded that these concerns do not undermine the case for a new approach grounded in an enabling regulatory framework. HPRAC acknowledges that, in order to arrive at this conclusion, an element of trust is required: trust in the basic principles of self-regulation under the *Regulated Health Professions Act, 1991* and trust in the ability of the regulatory college – the CNO – to protect the public interest.
- The new regulatory approach means that the scope of practice for NPs will adapt in a timely way to current needs and gaps in services as well as future requirements. Increased flexibility will occur in tandem with a more forceful and active role for the CNO as a dynamic regulator.
- The CNO will be called on to more vigorously regulate the profession to protect the public from the risk of harm and will be equipped with new tools and levers to address issues of continuing competence and quality assurance. As well, to encourage interprofessional collaboration, HPRAC recommends that the CNO be required to involve other professions in the development of standards, limitations and conditions for the NP scope of practice. All in all, HPRAC is confident that the new regulatory framework embodies a measured approach, with the appropriate checks and balances to protect the public.

- HPRAC suggests that the legislative changes necessary to implement the new regulatory framework take effect on June 4, 2009 – the expected proclamation date for parts of the *Health System Improvements Act, 2007* affecting regulated professions.
- A transition period will be required until the new model for regulating NPs in Ontario is up and running. During this time the CNO must put in place the necessary programs and policies and establish detailed standards, limitations and conditions through interprofessional consultation. Ontario's NP education programs are already being updated, a process that will ensure the content supports the expanded scope.
- HPRAC expects this new regulatory approach to have wider impact, given the emergence of advanced practice in several other health professions. Other regulatory colleges may find these concepts relevant.
- HPRAC views the enabling regulatory framework for NPs as the next stage in the development of professional self-regulation in Ontario. It will be up to all those who are committed to the principles of self-regulation to make this new model work.
- **For HPRAC's recommendations to implement this new direction, see page 64.**

## **Review of the Scope of Practice of Extended Class Nurses (Nurse Practitioners)**

### **The Minister's Question**

In June 2007, the Minister of Health and Long-Term Care, The Honourable George Smitherman, asked the Health Professions Regulatory Advisory Council (HPRAC) to:

undertake a review of the scope of practice for registered nurses in the extended class under the *Nursing Act, 1991* and include in the review the proposals made by the Council of the College of Nurses of Ontario with respect to controlled acts and the practice of registered nurses in the extended class.

This request was one of a series of eight items referred by the Minister to HPRAC in the letter. The Minister requested HPRAC to provide advice on the nursing question by March 31, 2008.

The Minister's letter called these issues "important matters" that support the government's commitment to ensure that the health profession regulatory system keeps pace with the health care needs of Ontarians.

### **HPRAC'S Central Response**

HPRAC has considered the Minister's request in the context of the broad challenges facing the health care system – such as a growing and aging population, a society that is becoming more urbanized and more diverse, health consumers empowered by the Internet, new medical technologies, changing clinical practices, the shift from institutional to community care – and the imperative that health human resources respond to these trends. Building on its 2006 report, *Regulation of Health Professions in Ontario: New Directions*, HPRAC has approached the Minister's request from the point of view of shaping the delivery of health care in the 21<sup>st</sup> century.

HPRAC has concluded that the overall performance of the health care system can be improved by increasing the capacity of nurse practitioners to contribute to patient-centred care. A wider role for nurse practitioners will increase access to services, foster continuity of care, promote interprofessional collaboration and help meet health human resource challenges.

To expand the nurse practitioner role while ensuring protection of the public and providing flexibility for the future, HPRAC is recommending a fundamental change in regulatory approach, within the construct of the *Regulated Health Professions Act, 1991*. HPRAC proposes to couple a broader scope of practice for nurse practitioners with appropriate standards, limitations and conditions to be established by the College

of Nurses of Ontario, on the recommendation of an interprofessional standards committee.

This new direction imposes a high standard of care on the regulatory college. It demands interprofessional collaboration and in the end, it protects the public interest.

## **Background on Extended Class Nurses**

Registered nurses in the extended class (RN-ECs) under Ontario's *Nursing Act, 1991* are also known as nurse practitioners (NPs) and these terms are used interchangeably in this report.

NPs are advanced practice nurses with additional knowledge and skills that build on the broad, generalist health science education of registered nurses in the general class (RNs). NPs have additional qualifications beyond those of RNs, such as at least two years of recent, safe nursing experience plus graduation from an approved NP education program. Their training equips them to perform some of the diagnostic and treatment functions that traditionally lie within the purview of physicians. NPs work primarily in the area of overlap between nursing and medicine.

A common definition of nurse practitioner was adopted by the Canadian Nurse Practitioner Initiative (CNPI), led by the Canadian Nurses Association, with funding from Health Canada. A two-year project, the CNPI consulted with representatives of nursing and other health care professional organizations, regulators, educators, employers, unions and federal, provincial and territorial officials on ways to integrate nurse practitioners more fully within Canada's health system.

The CNPI definition is as follows:

Nurse practitioners are registered nurses with additional educational preparation and experience who possess and demonstrate the competencies to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform specific procedures within their legislated scope of practice.<sup>1</sup>

While physician shortages may have been one reason for introducing this role, nurse practitioners do not see themselves as physician replacements.<sup>2</sup> NPs' practice is grounded in nursing knowledge and expertise. Like all nurses, NPs take a holistic approach to care, addressing not only symptoms but also the patient's emotional response, facilitating connections with community resources and putting an emphasis on health promotion and social determinants of health (the "bio-psycho-social"). NPs

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<sup>1</sup> College of Nurses of Ontario, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class, August 2007.

<sup>2</sup> Nurse Practitioners' Association of Ontario, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class, November 2007.

address the experience of health or illness for the patient, within the context of family and community.<sup>3</sup>

### **Legislative History**

Education programs in the 1970s prepared registered nurses for additional or “extended” responsibilities and since that time nurse practitioners have worked in Ontario in a variety of settings. In the early years, the role was not widely implemented due to the absence of legislative recognition and government funding. It was not until 1998 that nurse practitioners were formally enshrined in legislation through the *Expanded Nursing Services for Patients Act*, which set out a scope of practice for NPs or members of the “extended class” of nurses and protected the title of Registered Nurse (Extended Class). Ontario was the first province in Canada, followed quickly by Alberta, to proclaim legislation of this kind. Since then, the provincial government has invested in education and provided funding to support the implementation of the role.

Over the past decade, further legislative and regulatory changes have been made to support implementation and evolution of the role. Examples include amendments to regulations under the *Public Hospitals Act* and various long-term care legislation that have enabled the NP role in hospital outpatient and emergency departments and in long-term care homes, respectively.

Under the 1998 legislation, the regulated “extended class nursing” role in Ontario was limited to primary care. For years, however, some RNs with a master’s degree in nursing and specialized training have worked in acute care settings, mostly in hospitals or academic health science centres in southern Ontario. Their role emerged because of a shortage of medical residents. Currently, clinical nurse specialists and acute care nurse practitioners - as they have been known - work in highly specialized areas under medical orders or directives that allow them to perform complex tasks. They are found in such fields as cardiovascular surgery, oncology, psychiatry, gerontology and obstetrics and in subspecialties including neonatal intensive care and paediatric oncology. Some acute care NPs also work in the community – for example, some of them support technologically dependent children at home or staff freestanding dialysis clinics. Because the 1998 legislation recognized only the primary care extended class nurse, all nurses who practiced in specialty areas as nurse practitioners were registered by the College of Nurses as Registered Nurses in the general class.

Changes to the *Nursing Act* regulations in August 2007 introduced three new specialty areas for nurse practitioners. These enable nurse practitioners working in acute care settings to register in the extended class, provided they pass an examination in one of three specialties: NP-Pediatrics, NP-Adult or NP-Anaesthesia.

In addition to the three acute care specialties, a new title for the primary health care specialty – Nurse Practitioner – Primary Health Care (NP-PHC) – was also established. Nurses who were registered in the extended class when the changes took effect have

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<sup>3</sup> Pamela Pogue, President, NPAO, at Toronto public meeting, November 20, 2007.

automatically been issued a primary care specialty certificate. The regulatory changes also protect the titles of nurse practitioners in the four specialty areas.

As of November 2007, there were 814 NPs with the NP-PHC certificate and about 300 NPs who are expected to qualify for a certificate in one of the acute care specialties once they take the examinations.<sup>4</sup> NPs with one specialty certificate may be issued one or more additional specialty certificates if they meet all of the applicable requirements.<sup>5</sup> Ontario accounts for just over half of NPs registered in Canada, based on 2006 statistics.<sup>6</sup>

Across Ontario, nurse practitioners currently work in various settings – including hospitals, mental health and social service agencies, community care access centres, long-term care homes, correctional facilities, Family Health Teams and solo physician offices. Many practice in remote areas where there is limited access to health care services.

## **What Is a Scope of Practice?**

The Minister's request for advice on extended class nurses has led to HPRAC's first scope of practice review since the *Regulated Health Professions Act, 1991 (RHPA)* was introduced. HPRAC expects similar reviews to follow, given the pace of change in health care and the resulting need to maximize human resources. The Council has attempted to take an approach to this review that will also be applicable to other professions in the coming years.

As the Health Council of Canada has observed, the scope of a profession cannot be encompassed entirely in one document.<sup>7</sup>

In Ontario, the legislative framework includes the *Regulated Health Professions Act (RHPA)* and a series of profession-specific Acts. The *RHPA* contains provisions with respect to the duties and powers of the Minister, the role of HPRAC, a list of controlled acts and other prohibitions. It also includes a procedural code governing the operation of regulatory colleges.

Each profession-specific Act includes a scope of practice statement. The scope of practice statement in the *Nursing Act, 1991* says:

The practice of nursing is the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive,

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<sup>4</sup> Nurse Practitioners' Association of Ontario, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class, November 2007.

<sup>5</sup> Ontario Regulation 275/94 s.11.2 (5) under the *Nursing Act, 1991*.

<sup>6</sup> Canadian Institute for Health Information (CIHI), *Workforce Trends of Registered Nurses in Canada, 2006*, p. 55.

<sup>7</sup> Health Council of Canada, *A Review of Scopes of Practice of Health Professions in Canada: A Balancing Act*, November 2005, p. 7.

preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function.<sup>8</sup>

This statement covers not only NPs but applies to the entire profession of nursing. It embraces registered practical nurses (RPNs) and registered nurses (RNs) as well as NPs – all of whom are regulated by the College of Nurses of Ontario (CNO).<sup>9</sup> In contrast, in British Columbia, three colleges regulate the practice of nursing.

The statutory scope of practice statement is only the beginning. Each profession-specific act also indicates any controlled acts the profession is authorized to perform (if any), the title or titles restricted to members of the profession and other provisions. As noted above, the *Nursing Act, 1991* gives NPs access to specific controlled acts and provides for title protection.

When HPRAC reviews a professional scope of practice, it analyzes the scope of practice statement and the controlled acts authorized to the profession. Additionally, HPRAC examines the implications of the harm clause contained in the *RHPA*, which prohibits everyone except health professionals acting within their scope of practice from treating or giving advice with respect to health where serious physical harm may result.<sup>10</sup> As well, HPRAC considers regulations developed under the profession-specific act (in this case, the regulations under the *Nursing Act, 1991*) and other legislation that may affect the profession (where nursing is concerned, the *Healing Arts Radiation Protection Act*, the *Laboratory and Specimen Collection Centre Licensing Act*, the *Hospital Insurance Act* and the *Public Hospitals Act*, among others).

Also examined are the standards of practice, guidelines, policies and by-laws developed by the regulatory college. The CNO has established a practice standard, *Registered Nurses in the Extended Class*, requiring NPs to “know and practice in accordance with the standards relevant to their practice area” and sets out other detailed requirements.<sup>11</sup> While not obliged to do so, the CNO may seek input from other health professions in developing standards for nursing practice. A regulation under the *Nursing Act* makes it an act of professional misconduct for a NP to “contraven[e] a standard of practice of the profession or [fail] to meet the standard of practice of the profession”.<sup>12</sup> Another regulation requires NPs to comply with the CNO’s practice standard respecting consultation with members of other health professions before communicating a diagnosis.<sup>13</sup>

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<sup>8</sup> *Nursing Act, 1991*, s. 3.

<sup>9</sup> There are two classes of nurses under the Act (s. 8) – registered practical nurses and registered nurses. NPs are RNs with an extended certificate. Under the Ontario Regulation 275/94 s. 11.4(1) under the *Nursing Act, 1991*, NPs are entitled to use the title RN Extended Class, which is somewhat confusing since NPs are part of the RN class and not a separate class on their own.

<sup>10</sup> s. 30. Effective June 4, 2009 or on an earlier day to be established by proclamation, this section will be amended by striking out “physical” and substituting “bodily”. See *Health System Improvements Act, 2007*, S.O. 2007, c. 10, Sched. M, ss. 6 and 75 (1).

<sup>11</sup> College of Nurses of Ontario Practice Standard, *Registered Nurses in the Extended Class* (2005), Pub. No. 41038, p.3.

<sup>12</sup> Professional Misconduct Regulation, O.Reg. 799.93 (the “Professional Misconduct Regulation”), s.1 para.1.

<sup>13</sup> Ontario Regulation 275/94 s.20 under the *Nursing Act, 1991*.

All these elements, combined, determine the profession's scope of practice. HPRAC has considered the full range in conducting its review of the scope of practice of registered nurses in the extended class.

### **Individual Scope of Practice vs. Professional Scope of Practice**

In addition to the scope of practice for a profession, the term “scope of practice” is employed by regulatory agencies to define the procedures, actions and processes that a specific registered individual may perform. This individual scope of practice is based on, among other things, the registrant's education, clinical experience and demonstrated competency. While a professional scope of practice describes the full scope of activity open to the profession as a whole, an individual scope of practice describes the scope of activity within which individual practitioners may conduct their practice.<sup>14</sup> The individual scope of practice generally represents a subset of the larger professional scope of practice.

It is apparent that it is a complicated exercise to delineate NPs' scope of practice, whether professional or individual. This complexity is one of the challenges facing NPs and the professionals with whom they work.

### **How HPRAC Reviews a Profession's Scope of Practice**

Anticipating the need for scope of practice reviews, HPRAC carefully considered the processes to be used and issued a document on this subject in spring 2007.

In developing its advice to the Minister, HPRAC attempts to ensure that its processes are thorough, timely and efficient and reflect principles of fairness, transparency, efficiency and evidence-based decision making. HPRAC undertakes research to secure evidence for its conclusions, drawing on organizations and individuals with expertise in the matters under consideration, both in Ontario and elsewhere. The Council tailors its consultation process to the individual matters under consideration. Given the wide interest in, and the significant implications of, the nursing question, HPRAC conducted an extensive program of research and consultation.

HPRAC has developed a series of criteria to be used in assessing proposals to change a profession's scope of practice. These criteria are as follows<sup>15</sup>:

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<sup>14</sup> HPRAC, *Review of a Professional Scope of Practice under the Regulated Health Professions Act* (May 2007), pp.2-3.

<sup>15</sup> HPRAC, *Review of a Professional Scope of Practice under the Regulated Health Professions Act* (May 2007), pp. 8-9.

### *1. Relevance to the Profession*

The profession should demonstrate that the requested change in scope of practice is rationally related to the practice of the profession and to the qualifications and competencies of members of the profession. It should describe whether the proposed change to the scope of practice provides recognition and authority for existing competencies, or seeks to expand the scope of the practice of the profession.

### *2. Risk of Harm*

If the proposed change in scope of practice presents an increased risk of harm to the public, the profession should demonstrate how it intends to mitigate that risk, and how the training and competencies of members provide assurance that patients or clients will be cared for within evidence-based best practices.

### *3. Relevance to the Health Care System and Relationship to other Professions*

The profession should demonstrate that a change in the scope of practice is consistent with evolution in the health care delivery system, and particularly with changing dynamics among health professionals who work in integrated, team-based and collaborative care models.

### *4. Sufficiency of Supervision and Need for Autonomy*

The profession should demonstrate that a change in the scope of practice is the most appropriate, effective and efficient means to provide clinical and patient care services, that delegation or supervisory structures currently available are inadequate, and that the authority for independent or autonomous professional activity is required in the provision of patient care.

### *5. Body of Knowledge*

The profession should show that there is a systematic body of knowledge within the profession to perform the activities being requested and that this change in role is broadly accepted within the profession.

### *6. Education and Accreditation*

Members of the profession should demonstrate that they have, or will have, the knowledge, training, skills and experience necessary to carry out the duties and responsibilities involved in the proposed change in scope of practice. In addition, the profession should demonstrate that the education programs are appropriately accredited by an approved accreditation body.

### *7. Leadership's Ability to Favour the Public Interest*

The profession's leadership should show that it will distinguish between the public interest and the profession's self-interest and will favour the public interest at all times.

### *8. Profession's Support and Willingness to Comply with Regulation*

The profession should demonstrate that it supports the proposed change in scope of practice and that compliance with regulatory requirements is likely among its members.

### *9. Economic Impact*

The profession should demonstrate an understanding and appreciation of the economic impact of the proposed change in scope of practice for the profession, the public and the health care system.

### *10. Public Need*

The profession should demonstrate that a significant public need would be met through the proposed change in scope of practice.

## **HPRAC's Approach to Formulating Its Advice**

In considering how to approach the Minister's request for advice, HPRAC examined the question carefully and noted that the Minister specifically asked HPRAC to include the CNO's proposals in its review of the scope of practice for registered nurses in the extended class, implying that examining the CNO proposals should be one of many dimensions of the overall review. The CNO's submission served as a starting point for HPRAC's work, which was also influenced by a review of literature on the NP role, a review of how other jurisdictions have regulated this role, and what HPRAC heard through extensive consultations.

## **Relationship to Other Requests from the Minister**

The Minister's letter of June 28, 2007 includes eight separate referrals to HPRAC. Two of the other items touch upon the review of the scope of practice of NPs.

The Minister has also asked HPRAC to:

examine the authority given to non-physician health professions to prescribe and/or use drugs in the course of their practice under the *Regulated Health Professions Act, 1991 (RHPA)* and the health profession acts. I ask that the Council provide advice specific to

each of these professions respecting whether lists, categories or classes of drugs should be prescribed by regulation for the profession, or whether restrictions on prescribing of drugs should be placed in regulation under the respective health profession Act.

In the *New Directions* report, HPRAC said it believes that further examination of the individual listing of drugs in regulations for non-physician health professions who are authorized to prescribe is warranted.<sup>16</sup> The *New Directions* report also commented that regulations that specify drugs by class, with suitable practice guidelines as instituted in other jurisdictions, is a preferable approach to the listing of individual drugs.<sup>17</sup> Along these lines, the *Health System Improvements Act, 2007* provides for categories of drugs to be designated in regulations under the *Nursing Act, 1991*. Nursing is one of several professions with the authority to prescribe or use drugs in the course of practice.

Although the prescribing, dispensing, selling and compounding of drugs was a key area raised in the CNO submission and by practitioners, the Council has decided to consider these issues in addressing the Minister's request concerning the prescribing and use of drugs by non-physician professionals. HPRAC has determined that a substantive response is necessary because of the complexity of the issues, and the implications for patient safety.

During the consultative process, many questions were raised, and diverse comments were received. The questions posed are not simple. For example: should NPs be able to dispense drugs and under what authority, that is, autonomously or under delegation? What specific changes would be required in complementary legislation, such as the *Drug and Pharmacies Regulation Act*? Should NPs be authorized to prescribe narcotics as a category of drugs? What, if any, requirements should be established for the safe storage of drugs that might be dispensed by NPs? HPRAC is scheduled to begin work on the Minister's question regarding the prescribing and use of drugs by non-physicians in April 2008. These questions, along with others, will be scrupulously explored in that process.

While this report will not make recommendations on this subject, it will offer some initial observations, consider broader policy issues and recap what was heard in the consultations.

A further request in the Minister's June 2007 letter concerns interprofessional collaboration. The Minister asked HPRAC to:

recommend mechanisms to facilitate and support interprofessional collaboration between health Colleges beginning with the development of standards of practice and professional practice guidelines where regulated health professions share the same or similar controlled acts, acknowledging that individual health

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<sup>16</sup> HPRAC, *Regulation of Health Professions in Ontario: New Directions* (April 2006), p. 90.

<sup>17</sup> HPRAC, *Regulation of Health Professions in Ontario: New Directions* (April 2006), p. 90.

Colleges independently govern their professions and establish the competencies for their profession.

In responding to this request, HPRAC is seeking ways to enable colleges to work together by removing legal and other barriers that impede them from collaborating. One purpose of collaboration among colleges is to encourage interprofessional care by their respective members at the clinical level.

In the consultations, HPRAC was repeatedly urged to take into account the impact on interprofessional care and collaboration among colleges when considering recommendations for changes to the scope of practice of NPs. HPRAC has kept this imperative firmly in mind throughout the course of its deliberations.

## **Research and Consultation Process**

The analysis undertaken to assess the NP scope of practice was informed by a comprehensive review of the literature and an examination of how other jurisdictions regulate NPs. HPRAC posted a literature review and a jurisdictional review on its website, together with the CNO submission and appendices, giving interested parties in-depth background information on the issues.

A wide-ranging consultation process took place from September through December 2007. A variety of formats were employed, including written submissions, public meetings, invitational roundtables and key informant interviews with groups and individuals.

Interested individuals and organizations were encouraged to comment on the CNO submission in writing. More than 125 written submissions were received by the November 15, 2007 closing date; these were posted on the HPRAC website.

Public meetings were held in Ottawa, London, Hamilton, Thunder Bay, Sudbury and Toronto, giving interested parties the opportunity to make presentations in person and to participate in discussions. Patients and their families took part in these sessions, along with professionals and associations. Roundtables in Ottawa, London, Hamilton, Thunder Bay and Sudbury brought together local health care providers, administrators and educators, while two roundtables in Toronto involved representatives of regulatory bodies, professional associations, educational programs, hospitals and the community care sector. Key informants who were interviewed included nursing educators, insurers and providers of professional liability coverage, experts in NP practice and regulators from other jurisdictions including the U.K., Oregon, British Columbia and Nova Scotia.

In all, more than 300 individuals and organizations participated in the consultation process by filing written submissions, speaking at public meetings and participating in roundtables or in interviews. While the majority of participants were from the nursing

field, there was a broad mix of other health care providers as well, including other professionals, facilities and institutions, and community care providers.

The generous contribution of time and effort by those consulted enabled HPRAC to draw on a broad base of expertise, opinion and experience in developing its analysis and recommendations.

## **Environmental Scan: An Evolving Health Care System**

The Minister's request prompted HPRAC to consider the role that NPs can and should play in the health care system of today and tomorrow. To assess that role, HPRAC began by examining the demands on the health care system and how nurse practitioners can help meet them.

### **Changing Technology and Clinical Practice**

We live in a time of fast-paced change in health care delivery. The advent of digital communications has exerted a wide-ranging influence on everything from health records to telemedicine. The Internet has empowered consumers with unprecedented access to information to maintain health and become knowledgeable participants in their own care. New technologies such as magnetic resonance imaging (MRI) permit earlier and more reliable diagnosis.

At the same time, less invasive surgeries, more day surgery, more ambulatory care and the substitution of drug therapies for surgery have had a profound impact on clinical practice. Innovations in pharmacology have revolutionized treatment of diseases such as HIV/AIDS, cancer, mental illness and cardiac care. As a result, health services that were previously provided in hospitals can now be delivered in the community or provided as out-patient services. As patients move between settings – for example, from hospitals to their own homes or long-term care facilities – continuity of care is a priority to keep the focus on patient needs. These rapid advances in clinical and pharmaceutical practice place enormous demands on professionals to keep pace – demands that must be met by developing new competencies.

### **Factors Driving Change**

Demographic change has profound implications for health needs and the health care system created to meet them. Ontario's population is growing, aging and becoming more urbanized and more diverse.<sup>18</sup>

The population is expected to increase by 3.1 million people by 2025, with growth coming primarily from immigration and concentrated largely in the Greater Toronto Area. While the GTA's population is expected to grow by 33 per cent, central, eastern

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<sup>18</sup> See Ontario Ministry of Finance, *Toward 2025: Assessing Ontario's Long-Term Outlook* and Statistics Canada, *Census Data*, 2001.

and southwestern regions will likely record slower increases and both northeastern and northwestern Ontario will probably experience population declines. According to the 2001 census, nearly a quarter of Ontario's population speaks one of more than 100 languages other than English.

The share of seniors in the Ontario population is forecast to rise sharply from 12.9 per cent in 2005 to 19.4 per cent in 2025 as the baby boom generation enters the senior years and life expectancies continue to rise. The expanding senior population points to a higher incidence of chronic diseases, greater need to care for patients with multiple complex conditions and more emphasis on resources to help seniors remain in their own homes.

As Ontario's population ages, so do its health care professionals. Nineteen per cent of practicing physicians are over age 60, and 11 per cent are over 65. As an Ontario Medical Association study has reported, while the province's population is aging and growing and needing more care, the physician workforce is shrinking.<sup>19</sup> In addition, more than one third of all physicians responding to the National Physician Survey (2007) indicated that they plan to scale back on their hours of practice, compounding the overall shortage of medical services.

Demographic stresses also affect the nursing profession, though less dramatically. Based on 2007 membership statistics<sup>20</sup>, the CNO reports that one quarter of RNs in the general class are 55 years or over and 11 per cent are 60 or over. Fourteen per cent of RN(EC)s is 55 or over and 4 per cent are 60 or over.

### **Interprofessional Care**

These demographic trends combine to put a new focus on health human resources. Experimentation and innovation in their use, development and management is essential.

In May 2006, the Ministry of Health and Long-Term Care announced the creation of HealthForceOntario<sup>21</sup> – a multi-year strategy to give Ontario the right number and mix of health care providers. It includes initiatives to help predict Ontario's health human resource requirements; develop new provider roles to meet changing needs; work closely with the education system to develop people with the right knowledge, skills and attitudes; and recruit and retain health professionals by competing effectively with other jurisdictions.

A key priority in HealthForceOntario is to place more emphasis on interprofessional, collaborative care to make better use of vital health human resources. In July 2007, the Interprofessional Care Steering Committee appointed by the Ministry submitted a report, *Interprofessional Care: A Blueprint for Action in Ontario*. It defines

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<sup>19</sup> Ontario Medical Association, Doctors: Physician Resource Crisis Continues to Deepen in Ontario, November 21, 2005 (<http://www.oma.org/Media/News/pr051121.asp>).

<sup>20</sup> College of Nurses of Ontario, Membership Statistics Report 2007, pp. 8, 24.

<sup>21</sup> HealthForceOntario, May 3, 2006 (<http://www.healthforceontario.ca/WhatIsHFO.aspx>).

interprofessional care as “the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings.”<sup>22</sup>

As the report observes, “The health care system is gradually being transformed to ensure that the patient is at the centre, delivery is timely, care is safe, continuity is maintained and access is guaranteed. Improved collaboration and teamwork are expected to help caregivers manage increasing workloads, reduce wait times and reduce the likelihood of adverse reactions to care.”<sup>23</sup> The report calls for the incorporation of interprofessional care into existing legislation, systems and infrastructure and notes that recent initiatives such as Family Health Teams, wait-times management and Local Health Integration Networks (LHINs) all depend on interprofessional collaboration.

### **Encouraging Innovation**

HPRAC contends the health professions regulatory environment should encourage and support innovation in professional delivery of health care in Ontario. Facilitating interprofessional care through the regulation of health professions is essential. It is also vital for professionals to have the flexibility to provide patient care to the fullest extent of their qualifications and training, and the capacity to respond effectively to changes in technologies and to new methodologies.

From a national perspective, HPRAC notes that interest in exploring the role of NPs in a reformed health care system has become a common theme in discussions about health care strategy. Over the past decade, numerous federal and provincial reports on health human resources and health care reform have called for the expansion of the role to further such objectives as improved access to care and the development of interprofessional teams.

It is within the context of the broader challenges facing the health care system that HPRAC has undertaken its response to the Minister’s request for advice regarding the scope of practice of nurses in the extended class. Building on its 2006 Report, *Regulation of Health Professions in Ontario: New Directions*, HPRAC has considered the Minister’s question from the point of view of shaping the delivery of health care in the 21<sup>st</sup> century.

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<sup>22</sup> *Interprofessional Care: A Blueprint for Action in Ontario*, p. 7.

<sup>23</sup> *Interprofessional Care: A Blueprint for Action in Ontario*, p.11.

## Considerations Guiding HPRAC'S Analysis

At the outset, HPRAC adopted a series of considerations to frame its review of the scope of practice of nurse practitioners. They include:

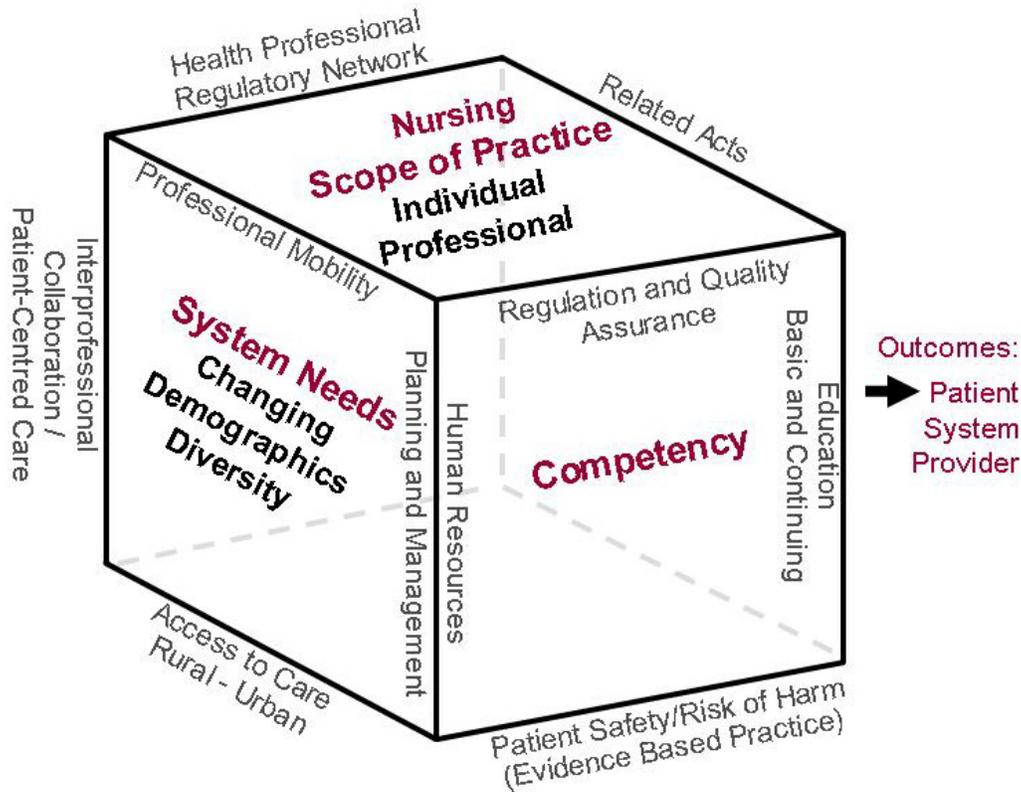
1. Recommendations to change the scope of practice for nurse practitioners must be in the best interest of the public and protect the public from risk of harm. They must also satisfy HPRAC's other criteria for reviewing scopes of practice.
2. The Minister's request for advice provides an opportunity to review and make recommendations on the legislative and regulatory framework underlying the scope of practice for nurse practitioners with a focus on:
  - Removing longstanding barriers,
  - Supporting effective utilization of NPs across the care continuum,
  - Enabling interprofessional care, and
  - Weighing the relevance to other professions of proposed changes.
3. The CNO submission is a starting point to review the scope of practice for NPs. Recommendations and decisions on this issue should be further informed by system needs, evidenced-based research, experience in other jurisdictions and advice from experts and interested individuals and organizations.
4. The review of the scope of practice for NPs must include consideration of health human resource challenges and the need to:
  - Reduce barriers to continuity of care,
  - Improve access to patient-centred care, and
  - Clarify roles.
5. The diversity of NP practice demands a regulatory framework that will provide the College of Nurses of Ontario with the authority, flexibility and tools to regulate the NP role effectively.

Building on these considerations, HPRAC identified three core themes as the basis for categorizing findings that would arise from the research and consultations. These themes, which framed HPRAC's deliberations, were:

- System needs,
- NP scope of practice, and
- NP competency.

These topics were incorporated into a diagram (Figure 1) that was shared with participants at public meetings and expert roundtables.

**Figure 1. Framework of Analysis, Review of the Scope of Practice of Nurse Practitioners**



### **Nurse Practitioners' Current Scope of Practice**

Controlled acts are health care activities that carry a substantial risk of harm if performed by unqualified personnel. Under the *Nursing Act, 1991*, registered nurses (RNs) can perform three controlled acts when ordered by another health professional that is authorized to perform them. These acts are: performing a procedure on tissue below the dermis or the surface of a mucous membrane, administering a substance by injection or inhalation, or putting an instrument, hand or finger beyond a body orifice or artificial opening in the body. RNs can also initiate procedures involving these acts, that is, perform them without an order, in circumstances permitted by the regulations.

A nurse practitioner (NP) is a registered nurse with an extended certificate of registration. In 1998, the *Nursing Act* was amended to allow registered nurses in the extended class (RN-ECs) to perform three additional controlled acts that RNs are not permitted to perform.

The *Nursing Act* grants NPs the authority to independently perform the three controlled acts authorized to RNs, along with the three additional controlled acts: communicating a diagnosis, ordering the application of a form of energy designated by regulation (the regulation designates diagnostic ultrasound of the abdomen, pelvis and breast) and

prescribing a drug designated by regulation. The Act also empowers nurse practitioners to independently administer by injection or inhalation a drug they have prescribed. As well, the regulations under the *Nursing Act* were amended to authorize NPs to autonomously perform a wider range of procedures than those performed by RNs – for example, suturing a wound.

In tandem with granting new controlled acts to NPs, the *Healing Arts Radiation Protection Act* was amended to allow nurse practitioners to order x-rays of the chest, ribs, arms, the wrists, hands, legs or ankle and to order mammograms. And the regulations under the *Laboratory and Specimen Collection Centre Licensing Act* were amended to permit nurse practitioners to order specific laboratory tests.

As a general rule, NPs can order RNs or registered practical nurses (RPN) to perform any controlled act the NP is authorized to perform. Important exceptions are procedures permitted to NPs under the regulations rather than the Act.<sup>24</sup>

### **Barriers to NP Practice**

The 1998 legislation that shaped the current role of nurse practitioners also sowed the seeds of the issues that have led to the Minister's current request to HPRAC. While NPs received access to additional functions through the 1998 statutory changes, substantial restrictions applied.

For example, communication of a diagnosis is permitted only under certain conditions, which in practice means that a physician often must be consulted first. A list-based approach was adopted to define the NP's authority to prescribe medications and order laboratory and diagnostic tests. The lists of individual drugs and tests authorized are established in regulations, and changing regulations is a cumbersome and time-consuming process. As new medications become preferred to older ones, and as new tests supersede older ones, the regulatory process has not kept pace. NPs often find themselves restricted to outmoded or limited options and their patients prevented from having access to the latest, evidence-based or appropriate care.

Moreover, with changing technologies and evolving population health needs, NPs have found they need access to additional controlled acts to serve their patients effectively. While their education and training has kept up with changing times, NPs find that the regulatory framework has not.

The reality, however, is that through medical directives, many NPs are overcoming some regulatory barriers to practise to the full extent of their capabilities. A medical directive is a delegation by a physician to a NP of the authority to perform acts outside the NPs' regulated scope of practice.<sup>25</sup> Medical directives are in effect orders given in

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<sup>24</sup> This is because s. 5.1 of the *Nursing Act* permits RNs and RPNs to follow the NPs' orders only in relation to controlled acts authorized by that section of the Act.

<sup>25</sup> The authority to delegate the performance of a controlled act is contained in the *Regulated Health Professions Act, 1991*, s. 27. (1).

advance that enable a nurse to perform specific procedures under specific conditions without a direct assessment by the physician.<sup>26</sup> They are used in circumstances where instructions related to care and medical treatment can be applied to a defined patient population, and are relevant to more than one patient. The medical directive contains the delegation and authority for health care providers to carry out the recommended treatments when patients are deemed to have met the established criteria.

Medical directives, however, generate a host of other problems. They are cumbersome documents and can take hours, weeks or years to write and be approved. When the directing physician leaves a group practice, the process must be repeated. In the hospital setting, numerous physicians may be involved in preparing and authorizing a medical directive, and all must concur, requiring time-consuming discussions, and subsequent approval by the hospital Medical Advisory Committee. In remote areas, where NPs face a wide variety of cases, all situations must be captured in directives and this is a difficult task. Medical directives are also believed by many to blur accountability for performance of procedures between the physician and the nurse.<sup>27</sup>

HPRAC heard frequently that if there is not a medical directive in place, inefficiencies and interruptions can ensue. NPs must repeatedly seek permission from a physician to carry out fairly routine services, such as ordering a refill of a prescribed drug. NPs told HPRAC that this often leads to such physician responses as: “Can’t you do that?” and “You know the patient better than I do.” Much time, of both NPs and physicians, which could be better spent on patient care, is wasted.

## **What the College of Nurses Proposed**

Initially, HPRAC requested that the College of Nurses of Ontario (CNO) respond to a detailed questionnaire on the changes it proposed in the scope of practice for nurses in the extended class. In reply, the CNO filed a submission on August 24, 2007.

The CNO is calling for fundamental changes in the scope of practice and regulatory regime for NPs. The recommendations are intended to keep pace with NPs’ current practice and respond to the varied contexts where NPs now work, enabled by medical delegation and directives. The CNO submission is based on four key proposals:

1. Amend the *Nursing Act, 1991*, to remove limitations on controlled acts currently authorized to NPs, including:
  - communicating a diagnosis,
  - prescribing drugs designated by regulations,
  - ordering the application of a form of energy prescribed by regulations,
  - administering a substance by injection or inhalation,

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<sup>26</sup> Federation of Health Regulatory Colleges cited in CNO Sub., p. 5.

<sup>27</sup> College of Nurses of Ontario, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class, August 2007; Nurse Practitioners' Association of Ontario, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class, November 2007.

- performing a procedure on tissue below the dermis or the surface of a mucous membrane, and
- putting an instrument, hand or finger beyond certain body openings.

2. Amend the *Nursing Act, 1991* to give NPs access to three additional controlled acts:

- setting or casting a fracture of bone or a dislocation of a joint,
- dispensing, selling, or compounding a drug, and
- applying a form of energy prescribed by regulations.

3. Amend the regulations under the *Nursing Act* and other legislation and regulations to remove constraints that prevent NPs from working to the full extent of their capabilities.

For example, CNO's proposed regulations under the *Nursing Act* would enable NPs to perform cardiac pacemaker adjustments, cardioversion, defibrillation, electrocoagulation, fulguration and transcutaneous cardiac pacing, as well as applying low frequency diagnostic ultrasound. NPs would also be permitted to order these procedures, as well as electromyography, nerve conduction studies and magnetic resonance imaging – plus diagnostic ultrasound, which can now be ordered on a limited basis. NPs now often perform these tasks under medical directives.

Other examples of changes to remove barriers include amendments to the *Healing Arts Radiation Protection Act* to confer broad authority on NPs to order x-rays and CT scans, and amendments to Regulation 965 under the *Public Hospitals Act* to expand NPs' role in admitting and treating inpatients.

4. Make the College of Nurses responsible for setting conditions or limitations on the RN(EC) scope of practice through its Practice Standard, rather than including these in legislation or regulation. If conditions are moved to the Practice Standard, a NP not meeting them would face a professional misconduct review.<sup>28</sup>

Some examples put forward by the CNO of limitations that would be imposed on the exercise of controlled acts by NPs through the practice standards include: NPs would be prohibited from setting or casting a fracture of an elbow, hip, pelvis or femur; they could perform fulguration or electrocoagulation only in consultation with a physician; and they could sell drugs only where there are client access barriers.<sup>29</sup>

In response to HPRAC's questionnaire, the CNO also offered comments on the economic impact of its proposal, identifying some potential cost increases and savings. For example, improved access to NP services could lead to higher utilization, while savings could occur if physicians no longer have to repeat assessments already performed by NPs. Regulatory costs, for example, for quality assurance, could also rise.

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<sup>28</sup> College of Nurses of Ontario, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class, August 2007.

<sup>29</sup> Idem.

HPRAC recognizes that an array of economic factors are in play and are hard to quantify without knowing the details of implementation, such as how many NPs will ultimately work in the system and where they will be placed. HPRAC did not, therefore, undertake an in-depth economic impact study of the CNO proposal.

The CNO sets out its position in this way:

Since 1998 there have been no changes to RN(EC)s' access to controlled acts, despite changes in practice realities (e.g., frequent changes in evidence supporting best practice), advances in technology (e.g., introduction of automatic external defibrillators), health system developments (e.g., health human resource shortages, especially in remote and rural communities, and a public insistence on more timely access to health care services), and population health needs (e.g., aging population).

Although the regulatory framework has remained stagnant, the education sector has responded to the above factors and RN(EC)s are graduating with the competencies to meet the needs of their clients and respond to health system developments. Currently, RN(EC)s relies heavily on authorizing mechanisms, such as delegation and medical directives.... (W)hile delegation and medical directives serve a purpose, they should not be necessary where the performance of an act or procedure is a common part of the profession's practice and is a core competency developed in education and maintained through practice.<sup>30</sup>

## **Current Competency Requirements for NPs**

Previous sections of this report have presented background on NPs' current scope of practice in the context of the evolving needs of the health care system. HPRAC has compiled background on educational and other requirements that NPs must meet to demonstrate their competence to practice. It is NPs' competencies that form the basis for potential expansion of the NP role in health care.

### **Core Competencies**

The core competencies of NPs have been identified through a consensus process conducted by the Canadian Nurse Practitioner Initiative (CNPI).<sup>31</sup> The process developed the Canadian Nurse Practitioner Core Competency Framework. The CNPI defines "competency" as: "The integrated knowledge, skills, judgment and attributes

<sup>30</sup> College of Nurses of Ontario, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class, August 2007.

<sup>31</sup> Canadian Nurse Practitioners Initiative, *Nurse Practitioners: The Time is Now* ([http://www.cnpi.ca/about\\_the\\_cnpi/np\\_final/index.asp?lang=e&](http://www.cnpi.ca/about_the_cnpi/np_final/index.asp?lang=e&)).

required of a nurse practitioner to practice safely and ethically in a designated role and setting.”

The framework sets out four broad competencies that are shared by all NPs:

- Health Assessment & Diagnosis,
- Health Care Management & Therapeutic Intervention,
- Health Promotion & Prevention of Illness, Injury and Complications, and
- Professional Role and Responsibility.

Each NP working in his or her day-to-day practice – or individual scope – demonstrates competence through activities specific to the nature of the practice. These activities are outlined in more detail under each broad competency in the CNPI document.

### **Educational Preparation**

Through research and consultation, HPRAC has confirmed that Ontario’s NP education programs are designed to produce graduates who possess the four broad CNPI competencies within their respective specialty areas. This conclusion is based on input from nursing educators and on an examination of the content of Ontario’s three NP programs: the NP-Primary Health Care (NP-PHC) Program offered by the Council of Ontario University Programs in Nursing (COUPN), the acute care NP program at the University of Toronto, and the Advanced Neonatal Nursing graduate diploma at McMaster University in Hamilton.

The NP-PHC Program – offered through COUPN, a consortium of 10 universities – prepares all Ontario primary care nurse practitioners. In existence for more than a decade, it underwent an external review in 2007 by the U.S.-based National Organization of Nurse Practitioner Faculties. This was part of preparation for the move from its current status as a postgraduate certificate program to a Master of Nursing program that will be launched in fall 2008. It was also reviewed in 1998 by a team led by Dr. Alba DiCenso.<sup>32</sup>

In the University of Toronto’s Master of Nursing – Acute Care NP program, all students must complete 10 required courses and two elective courses, as well as three periods of concentrated practice<sup>33</sup>. All but two courses are common to both adult and paediatric streams. Graduates of the program are prepared to provide care to adult or paediatric patients but not both. The program has received Ontario Council on Graduate Studies (OCGS) approval.

The Advanced Neonatal Nursing graduate diploma program at McMaster focuses on the knowledge required to care for sick newborns. At least two years of neonatal

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<sup>32</sup> Di Censo. Evaluation of the Nurse Practitioner Initiative: Progress Report. McMaster University, 1998.

<sup>33</sup> University of Toronto, Faculty of Nursing Master of Nursing Overview, accessed December 30, 2007. ([http://www.nursing.utoronto.ca/students/Graduate\\_Students/mnstudents/NursePractitioner2006.htm](http://www.nursing.utoronto.ca/students/Graduate_Students/mnstudents/NursePractitioner2006.htm) accessed Dec. 30, 2007).

nursing experience, plus completion of at least three quarters of the McMaster Master of Science program in nursing, are required to qualify for admission to this specialized program. The diploma requirements are in addition to those for the nursing M.Sc. degree. Neonatal NPs told HPRAC they are not competent to provide care to the broader paediatric population and they restrict their practice to care of the sick neonate. A significant portion of graduates of this program have been successful in writing the U.S. neonatal NP examination.

### **Accreditation**

Generally speaking, an accreditation is a standard for determining whether an educational program produces graduates who meet the required competencies for a regulated scope of practice. None of the NP programs in Ontario has undergone an external review for accreditation purposes and no accreditation program currently exists in Canada. However, the review and approval of the University of Toronto program by the Ontario Council on Graduate Studies is considered equivalent to accreditation. The Canadian Association of Schools of Nursing – the national accrediting body for undergraduate nursing programs – is currently considering a national accreditation system for NP programs.

### **Entry to Practise**

To become registered in the extended class (as nurse practitioners) in Ontario, registered nurses must meet the following key requirements<sup>34</sup>:

- demonstrate at least two years of safe nursing experience over the past five years – including one year in an advanced nursing practice role (one that requires use of advanced knowledge and decision-making skills in assessment, diagnosis and health care management),
- have graduated from an approved NP education program,
- have passed a regulatory exam, and
- be registered, or eligible for registration, as a registered nurse (RN).

The Council of the CNO has adopted the Canadian Nurse Practitioner Core Competency Framework to guide the approval of NP education programs and regulatory exams for entry into the extended class.

### **Requirements for Specialties**

NPs enter practice at the specialty level. The specialties agreed upon by the CNPI are: family/all ages, adult and paediatric. These correspond to Ontario's NP-Primary Health Care, NP-Adult and NP-Paediatrics, respectively.<sup>35</sup>

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<sup>34</sup> College of Nurses of Ontario, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class, August 2007.

<sup>35</sup> Canadian Nurse Practitioner Initiative Future NP Regulatory Approach Forum Summary Notes, January 2006. ([http://www.cnpi.ca/documents/pdf/tech-report/section2/05\\_LegReg\\_AppendixD.pdf](http://www.cnpi.ca/documents/pdf/tech-report/section2/05_LegReg_AppendixD.pdf)).

The NP-PHC requires broad general competencies to meet the needs of the individual, family and community in the primary care setting. NP-PHCs work collaboratively with primary care family physicians as well as other health professionals. In this setting, the focus is on health promotion and illness and injury prevention for the well client, as well as episodic care for minor illness and management of chronic disease. Clients can vary from infants to the elderly.

A NP-PHC is not restricted to family practice and may focus on a specific population or client group – such as NPs who provide primary care to residents of a long-term care home or to an aboriginal community. In these examples, additional knowledge in geriatrics or aboriginal health issues would be obtained through continuing education and experience.

In the acute care setting, the NP is providing care to patients who are acutely ill or have complex chronic illness with complications. The NP works as part of a team of providers including a physician specialist or team of specialists. The level of specialization, educational preparation and entry to practice requirements for the role of an acute care NP (NP-Adult or NP-Paediatrics) are based on the patients' developmental stage. The physiology, manifestations of illness, collection of information, interpretation of test results, possible diagnoses, potential complications and treatment options vary significantly according to developmental stage.

### Examinations

Through its testing service, the Canadian Nurses Association conducts national NP examinations for primary care (family/all ages). The CNO has adopted this examination as the standard for entry-to-practice for Ontario NP-PHCs. There has been an Ontario entry-to-practice exam for NPs in primary care since the NP program began and all current registrants have successfully passed this examination. Currently, there are no provincial or national examinations for NPs working in acute care practices. The CNO proposes to use the American examinations during the transition and work is underway to “Canadianize” the content of these exams. It is expected that these examinations will be in place by fall 2008.

Movement from one specialty NP category to another requires additional graduate education and experience. For example, if a NP-Paediatrics wanted to move into adult practice, she or he would have to obtain the requisite education and clinical experience in adult acute care and pass the examination for NP-Adult.

## Continuing Competence and Quality Assurance

The CNO's quality assurance (QA) program for NPs consists of three elements: reflective practice; practice review; and the CNO's practice-setting consultation initiative.<sup>36</sup>

All CNO registrants – registered practical nurses (RPNs), registered nurses (RNs) and NPs – are required to participate in the Reflective Practice Program, which involves a five-step process. Each year, nurses are required to:

- Complete a self-assessment of their practice,
- Obtain feedback from a peer of their choice,
- Evaluate the results of the previous year's learning plan,
- Develop a learning plan for the current year, and
- Implement the learning plan.

In addition, all NPs are required by the regulations to undergo a practice review at the end of their first three years or first 1800 hours of practice as NPs (whichever occurs first). The aim is to ensure they are competent for the NP role.

As well, an individual NP may also be required to undergo a practice review either on a random basis or because the CNO's Quality Assurance Committee "has reasonable grounds" to question his or her knowledge, skills or judgment.<sup>37</sup> This provision is the same for RNs and RPNs.

The CNO's Practice Setting Consultation Program is a survey developed and conducted by the CNO. It is used to identify the attributes of practice settings that will help nurses (NPs, RNs and RPNs) meet their standards of practice and promote quality nursing care.<sup>38</sup>

## Continuing Education

Unlike physicians, NPs are not currently required to report continuing education (CE) hours or units. CE for NP-PHCs is offered online by the COUPN consortium. Five courses, developed with funding from the provincial government, are available according to enrolment demand – one providing regular updates on pharmacology. While these courses are not mandatory, enrolment is high. There are no comparable formal CE programs for acute care NPs. The NPAO annual conference and meeting includes an educational component that attracts almost 100 per cent member participation of both primary care and acute care NPs. Other learning opportunities

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<sup>36</sup> Additional information pertaining to the CNO's QA approach is provided by the following CNO Fact Sheets: *Quality Assurance - Quality Assurance Program*; *Quality Assurance - Reflective Practice*; and *Quality Assurance - Practice Review*. All available on the CNO's website: [www.cno.org](http://www.cno.org).

<sup>37</sup> *Nursing Act, 1991*, Ontario Regulation 275/94, s.26 (1).

<sup>38</sup> College of Nurses of Ontario, "Is My Workplace a Quality Practice Setting?" *Communique/ September 2001*, pp.8-9.

include medical CE and other health discipline CE programs, in which NPs regularly participate.

### Professional Liability Insurance

Unlike some other professions in Ontario, or requirements for NPs in some other provinces, the CNO does not require Ontario NPs to hold professional liability insurance, although it has the power to do so under the *RHPA*.<sup>39</sup> Many NPs have professional liability insurance through their employers or through the Canadian Nurses Protective Society (CNPS) as a result of membership in the Nurse Practitioners' Association of Ontario (NPAO).<sup>40</sup> The NPAO is a specialty interest group of the voluntary Registered Nurses Association of Ontario (RNAO), which provides the relationship with the CNPS. Nurse practitioners voluntarily join the RNAO and the NPAO.

## **What HPRAC Learned from Research**

Having considered background information on the NP scope of practice, NP competencies and current trends in the health care system, HPRAC undertook a focused research program. This included a review of published literature on NPs and a look at regulatory approaches in other jurisdictions.

### **Literature Review**

A substantial body of literature has been produced on NPs, covering their role, scope of practice, education, training and credentialing. Also probed are their acceptance, efficacy and impact on patient care, interprofessional collaboration and the health system overall. A search using the phrase “nurse practitioner” on PubMed, a database maintained by the U.S. National Library of Medicine, yields over 12,000 citations from academic and research papers in virtually every type of clinical setting.

In Canada, significant work on the NP role has been undertaken at both national and provincial levels. In 2006, major papers were released as part of the Canadian Nurse Practitioner Initiative (CNPI).<sup>41</sup> In Ontario, recent and proposed reforms to the NP role have emerged from the IBM/McMaster study<sup>42</sup> of primary health care NPs and

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<sup>39</sup> *Regulated Health Professions Act, 1991*, Section 94(1) (y) of the Health Professions Procedural Code under the RHPA.

<sup>40</sup> All NPAO members are members of the RNAO. All RNAO members registered with the CNO as NPs are automatically provided \$5M occurrence-based professional liability coverage through the Canadian Nurse Protective Society (“CNPS”). Additional coverage is available from Nurse Insurers and CNPS Plus: NPs can purchase additional coverage of either \$2M or \$5M to a maximum of \$10M occurrence-based professional liability coverage. The CNPS coverage is excess coverage, meaning that it will respond only if the NP is otherwise uncovered (for example, through an employer), as in the case of a NP in independent practice.

<sup>41</sup> Canadian Nurses Association, *Nurse Practitioners: The Time is Now*. Final Report of the CNPI. Ottawa, 2006.

<sup>42</sup> IBM Consulting, Report on the Integration of Primary Health Care Nurse Practitioners into the Province of Ontario, January 2005.

associated task teams at the Ministry of Health and Long-Term Care. The literature review has been posted on HPRAC's website and key findings are summarized below.

### System Needs

Historically, NP roles evolved to address gaps in health services. For example, early NP funding initiatives in Ontario focused on placing RN(EC) positions in rural, remote and underserved communities, and the decline in resident availability for neonatal intensive care units led to the introduction of neonatal NPs.<sup>43</sup>

A large body of research confirms the roles played by NPs in a range of care settings and across the care continuum. Several studies have examined the role of NPs in settings with shortages of services or service delays – such as primary care, geriatric care, care for chronic diseases (e.g., diabetes or heart failure) and service in rural and remote areas or for marginalized populations.

The CNPI confirmed that NPs provide one answer to meeting current and future needs regarding health human resources and skill shortages. Both in Canada and other countries, the NP role has been introduced to complement and improve access to health services, not simply as a replacement or substitute for physicians or other providers.

### NP Scope of Practice

There is little in the Canadian literature on scope of practice issues.<sup>44</sup> However, the literature confirms that role ambiguity and lack of understanding of the NP function, by the public and health care providers, are perceived as significant barriers to effective implementation of the role.

The scope of practice and competencies for NPs differs from those for physicians. Medicine and nursing have separate scopes of practice in some areas as well as overlapping scopes in others. The general class registered nurse (RN) practices within the overlap in an interdependent way for controlled acts (e.g., carrying out medical orders for specific patients or following medical directives for groups of patients). The NP carries out some of these overlapping functions independently and some interdependently (by physician order for individual patients or by medical directive for groups of patients).

The scope of practice for the medical profession is broad. Within the profession's scope, each physician has an individual scope of practice defined by his or her competency. For example, all physicians have the legal authority to prescribe any approved drug but physicians limit their prescribing to their individual area of knowledge and practice.

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<sup>43</sup> College of Nurses of Ontario, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class, August 2007.

<sup>44</sup> IBM Consulting, Report on the Integration of Primary Health Care Nurse Practitioners into the Province of Ontario, January 2005.

The controlled acts for both medicine and nursing represent a small component of the entire scope of practice for the respective professions. Physicians have authority to perform all but one of the controlled acts enumerated in the *RHPA*.

The core role of the NP is distinguished by autonomous extended practice involving the application of high-level clinical knowledge, enhanced by autonomy and legislated privileges. This role is characterized by a nursing model of practice.<sup>45</sup> However, the capability of NPs may be diminished by controlling protocols.<sup>46</sup>

The boundary between nursing and medicine is an area of interest in the literature: this is exactly the area traversed by the NP role. The potential for greater flexibility clearly exists. As one article argues, to suggest that certain tasks must forever be performed only by physicians is unduly rigid and a recipe for a cumbersome and costly health system that leaves significant consumer needs unmet.<sup>47</sup>

The scope of practice for NPs varies among Canadian jurisdictions and among other countries. In addition, roles differ between types of NPs (e.g., primary health care NPs and acute care NPs) and in response to practice setting, geography and access to care challenges. Under medical delegation or directives, NPs working in specialized fields carry out procedures normally limited to physicians. For example, NPs in neonatal intensive care units perform activities normally done by neonatologists. Primary care NPs may function as the attending provider in a long-term care setting, with expertise in the care of cognitively impaired, frail elderly patients, with many co-morbid conditions.

### NP Competency

Most studies of the impact of NPs on patients, providers and the system have been descriptive, observational studies with samples too small to measure clinical effect. According to two Canadian authors,<sup>48</sup> new health care provider roles can be likened to the introduction of new therapies and should be evaluated in similar ways to evaluate their safety, effectiveness and economic efficiency. This assertion argues for the use of randomized controlled trials (RCTs) to evaluate the NP role. Studies to date do not cover all of the potential areas of NP practice and have used a variety of data and methods, making it challenging to apply standard analytical techniques to give the data more combined power. Approximately a dozen RCTs have compared NPs with standard physician care, making NPs the most extensively researched health care provider role.

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<sup>45</sup> Gardner et al, 2004 in Carryer et al. 2007.

<sup>46</sup> Carryer, J., Gardner G., Dunn, S., Gardner A. (2007). The capability of nurse practitioners may be diminished by controlling protocols. *Australian Health Review*, 31:1, 108-115.

<sup>47</sup> Idem.

<sup>48</sup> Bryant-Lukosius and Dicenso (2004) Bryant-Lukosius, D., DiCenso, A. (2004). A framework for the introduction and evaluation of advanced practice nursing roles. *Journal of Advanced Nursing*, 48(5):530-540.

RCT studies that have been conducted show a strong directional agreement with the observational studies. The overall findings, mainly from research comparing NP and physician care, can be summarized as follows:

- NPs provide substitutive care to patients that achieve equivalent outcomes to that provided by physicians on most measures; that is, there is no difference.
- Patients express greater satisfaction with NP care because NPs spend more time with patients and have strong communication skills.
- Patients who receive care from NPs demonstrate greater compliance with medication and treatment regimens.
- Some groups of NP patients have reported improvement in self-perceived quality of life.
- In practices with NPs, physicians have been able to expand their patient roster and care for more patients.
- Collaboration between NPs and physicians enhances patient care.
- There is scant, if any, evidence of harm despite the degree of scrutiny that NP practice has undergone.

Most of the evidence concerns the NP role in primary care. Acute care NP practice is less well researched, with the exception of the neonatal NP.

A publication by the Canadian Health Services Research Foundation reviews literature from the U.S., U.K. and Canada and concludes that NPs can provide care that is safe, effective and comparable to physicians in a wide range of situations and circumstances.<sup>49</sup> In particular, the literature reviewed emphasizes: the contribution NPs can make to resolving key health care delivery issues (e.g., access, wait times, system efficiency and effectiveness and costs); and the insufficient or minimal planning that has been undertaken for the education, employment and deployment of NPs internationally and in Canada.

### **Jurisdictional Review**

To put Ontario's approach in perspective, HPRAC undertook an extensive review of how other jurisdictions in Canada and internationally regulate nurse practitioners. (The jurisdictional review and related materials are posted on the HPRAC website, [www.hprac.org](http://www.hprac.org).)

#### Canada

In Canada, 12 of the 13 provinces and territories (all but the Yukon) have established regulatory regimes for NPs within the profession of nursing. The jurisdictional review provides summaries of the regulatory approach to NPs in all Canadian provinces and territories, with a focus on the following points for each:

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<sup>49</sup> Canadian Health Services Research Foundation (2002). *Myth: Seeing a nurse practitioner instead of a doctor is second-class care. Mythbusters.*

- What is the regulatory body?
- What key legislation establishes the regulatory framework, including both statutes and regulations, as relevant?
- Does the regulatory framework recognize and regulate NPs?
- What classes does the regulatory framework establish?
- How does the regulatory framework define nursing practice?
- What is the general approach to defining NPs scope of practice?
- What constitutes authorized practice by NPs, focusing only on authorized practices NPs may initiate beyond what they would otherwise be permitted as RNs?
- What entry-to-practice requirements are established, as set out in legislation?
- What specialty designations, if any, are available to NPs?
- What title protection, if any, is extended to NPs?
- What continuing competence requirements are set out in the legislation?
- Is mandatory insurance a requirement for NPs?
- Are any legislative reforms anticipated that would significantly alter the regulatory framework for NPs?

### Selected International Jurisdictions

A further component of the jurisdictional review covers two countries where nursing regulation is national in scope: New Zealand, where a regulatory framework for NPs has been established; and Britain, which has no regulatory framework for NPs but has established a regulatory process to extend prescribing authority to registered nurses and certain other non-physicians. The review addresses the same points as set out above for Canadian provinces and territories.

### Selected U.S. Jurisdictions

Nurse Practitioners have been practicing in the United States since 1965<sup>50</sup> and numbered nearly 140,000 as of 2006.<sup>51</sup> NPs are regulated at the state level by Boards of Nursing, and are licensed to practice in every state as well as the District of Columbia.<sup>52</sup> State legislatures have enacted laws governing nurse practitioner definition, scope of practice, prescribing authority and requirements for physician collaboration.<sup>53</sup>

The U.S. component of the jurisdictional review does not encompass every state but covers a selection of jurisdictions where the regulatory framework for NPs allows a greater degree of autonomy than does Ontario. It includes the following:

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<sup>50</sup> American Academy of Nurse Practitioners, Frequently Asked Questions (<http://npfinder.com/faq.pdf>).

<sup>51</sup> The Pearson Report: "A National Overview of Nurse Practitioner Legislation and Healthcare Issues", The American Journal for Nurse Practitioners, Vol. 11, No. 2, February 2007, Page 14.

<sup>52</sup> American Academy of Nurse Practitioners, Frequently Asked Questions (<http://npfinder.com/faq.pdf>).

<sup>53</sup> Buppert, Carolyn. Nurse Practitioner's Business Practice and Legal Guide, Third Edition, Jones and Bartlett Publishers, 2008, Page 123.

- Summaries of the regulatory approach to NPs in three states (Colorado, Michigan and Oregon) focusing on the same points as set out above for Canadian provinces and territories,
- A chart summarizing the regulation of NPs in 26 U.S. states, 11 of which do not impose mandatory requirements in legislation for physician involvement in NP practice, and 12 of which do impose such requirements, and
- An overview of the regulation of NPs and of core competencies for NPs in the U.S.

For the purposes of its analysis and recommendations HPRAC has focused on three jurisdictions viewed as leaders in NP regulation: British Columbia, Nova Scotia and Oregon. Figure 2 provides a comparison of access to controlled acts authorized to NPs in these jurisdictions as a basis for comparison to the changes proposed in the CNO's submission. As the chart indicates, these three leading jurisdictions have already adopted most of the changes proposed by the CNO.

**Figure 2: Controlled Acts in Other Jurisdictions**

Controlled act sought by CNO	British Columbia	Nova Scotia	Oregon
Communicating a diagnosis	Y	Y	Y
Forms of energy – ordering <ul style="list-style-type: none"> <li>• Electricity</li> <li>• MRI</li> <li>• Diagnostic ultrasound</li> </ul>	Y <sup>54</sup> N Y	Y Y Y	Y Y Y
Forms of energy – applying <ul style="list-style-type: none"> <li>• Electricity</li> <li>• Diagnostic ultrasound</li> </ul>	Y L <sup>55</sup>	Y Y	Y Y
Procedures <ul style="list-style-type: none"> <li>• Tissue below dermis / mucous membrane Instrument, hand or finger beyond certain body openings</li> </ul>	Y Y	Y Y	Y Y
Setting and casting – fracture / Dislocation	L <sup>56</sup>	Y	Y
Drugs <ul style="list-style-type: none"> <li>• Prescribing</li> <li>• Dispensing</li> <li>• Selling</li> <li>• Compounding</li> </ul>	Y Y N Y	Y <sup>57</sup> N N N	Y L L N
Administering a substance, injection or inhalation <ul style="list-style-type: none"> <li>• Drugs</li> <li>• Other</li> </ul>	Y Y	Y Y	Y Y
Ordering diagnostic tests (other than forms of energy)	Y	Y	Y

Y = Applicable legislation (statute or regulations) authorizes NPs to initiate the act on essentially the same terms as sought by CNO.

L = Applicable legislation (statute or regulations) authorizes NPs to initiate the act, but on a limited basis in comparison with the terms sought by CNO.

N = Applicable legislation (statute or regulations) does not authorize NPs to initiate the act sought by CNO. Note: An open legislative framework as established by applicable statute and/or regulation does not preclude the imposition of related standards, limitations or conditions by the regulatory body or, as is the case in Nova Scotia, in the collaborative practice agreement which each NP is required to have in place.<sup>58</sup>

<sup>54</sup> Legislative change is currently underway in British Columbia to eliminate ambiguity in NPs' ability to order and apply electricity.

<sup>55</sup> Unlimited access to the application of ultrasound is being sought by the College of Registered Nurses of British Columbia.

<sup>56</sup> NPs in British Columbia are authorized to set or cast a closed simple fracture of a bone, or reduce a dislocation of a joint.

<sup>57</sup> See HPRAC (2007). Scope of Practice for Registered Nurses in the Extended Class (Nurse Practitioners): A Jurisdictional Review. Nova Scotia has recently passed revised legislation to govern nursing practice including the regulation of NPs. This new act (the *Registered Nurses Act*, S.N.S. 2006, c.21 received Royal Assent on November 23, 2006) is anticipated to come into effect on or about April 2008. This legislation will no longer restrict NP prescribing to an approved list of drugs, consistent with the authority sought by CNO.

<sup>58</sup> Nova Scotia's current legislation requires each NP to establish a collaborative practice agreement subject to prior review and approval by the College of Registered Nurses of Nova Scotia. When the new legislation comes into effect (see preceding footnote) NPs will continue to establish collaborative practice agreements subject to prior review. Approval by the College will no longer be required.

## Perspectives from the Consultations

Overall, HPRAC found the consultations to be informative and extremely valuable in building its understanding of the issues and eliciting ideas on possible strategies to address them. Differing perspectives emerged on the further evolution of the NP role, falling between two opposing views:

- NPs in Ontario are already doing most of what the CNO proposes but currently perform these tasks under delegated authority from physicians through medical directives. NPs have demonstrated that they are competent to perform these controlled acts safely and effectively, and it is time to remove barriers to NP practice.
- The envelope is being pushed too far, too fast. Before granting additional controlled acts, it is necessary to be satisfied that NPs are competent to perform them safely and effectively and that the public interest case for allowing them to do so is compelling.

The CNO's proposals received strong endorsement from nursing organizations. As the Registered Nurses' Association of Ontario commented in its submission<sup>59</sup>:

RNAO urges HPRAC to accept CNO's recommendations in their entirety to remove legislative barriers and enable RN(EC)s to practice to their full scope, reflective of their education, competencies, and experience. This is critical at a time when access to health services is challenged by limited human resources and when public safety must be maintained...

RNAO fully supports CNO's proposal to place conditions necessary to protect the public in practice standards rather than in legislation. Monitoring through a regulatory body rather than through the courts will be more consistent with self-regulation, and more appropriate and accessible for monitoring compliance.

The Nurse Practitioners' Association of Ontario (NPAO) in its submission remarked<sup>60</sup>:

NPAO enthusiastically supports the recommendations to expand scope of practice as outlined in CNO's submission. NPAO agrees with CNO's view that "legislative evolution of the nurse practitioner role in Ontario has failed to keep pace with practice realities, health system developments, technological advancements and population health needs." We also believe that the time has come to make the

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<sup>59</sup> Registered Nurses' Association of Ontario, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class, November 2007.

<sup>60</sup> Nurse Practitioners' Association of Ontario, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class, November 2007.

appropriate adjustments to legislation impacting nurse practitioner practice in order to increase access to safe and appropriate care from nurse practitioners thereby better meeting the health care needs of the public ... This referral to HPRAC presents an opportunity to build on the knowledge and experience of the first decade of the regulated nurse practitioner role to enable the role to meet the future health care needs of Ontarians.

While the majority of representations were made by the nursing community in support of the CNO's position, HPRAC also heard from a number of other health professionals and their organizations. Many of these stakeholders expressed varying degrees of support for the CNO submission, but a number of significant issues were raised. These concerns were largely based on doubts or a lack of understanding about NPs' competence to initiate the additional controlled acts. They also frequently reflected confusion over what the CNO was actually requesting.

Key points emerging from the consultations are summarized below under the three headings: System Needs, NP Scope of Practice, and NP Competency.

### **System Needs**

Many participants in the consultation process remarked that it is essential to make better use not only of NPs, but also of other health care professionals. The system overall is facing a health human resources challenge of enormous magnitude and everyone's talents and skills must be fully tapped. As a participant at the Toronto roundtable put it, "There is plenty of work to go around."

Overwhelmingly, participants described the current barriers to NP practice as having a significant impact on access to care and, in particular, on the continuity of care. They described:

- unnecessary wait times for patients due to duplication of effort by NPs and physicians,
- unnecessary transfers to hospital emergency departments because the patient's needs exceed the NP's current scope of practice,
- drug lists that prevented NPs from prescribing the most current drugs – the most frequently cited irritant by NPs and pharmacists alike,
- time needed for patient care that was spent producing and chasing paper and "working around" barriers,
- detailed medical directives that absorbed many hours of work and were often outdated almost as soon as approved, and
- practices that changed when the collaborating physician changed, due to concerns about medical directives.

Over and over, examples were given to show how the current framework for regulation of NPs is not working and requires significant reform if the health care system is to function more efficiently and effectively. Many voices emphasized the importance of

interprofessional, patient-centred, collaborative care to respond to an evolving health care system and increasingly complex patient needs.

### Access to Care

Participants confirmed that access to health care is being challenged by demographic changes such as an aging population – and the resulting shift toward chronic disease management and more complex cases – and cultural diversity. Access issues persist in rural and remote parts of the province, largely due to health human resource shortages. Several rural and remote communities said they needed someone to provide primary care, given the lack of physicians. Under the authority of Health Canada policy, some remote aboriginal communities have general class RNs providing care that exceeds the current scope of practice for extended class nurses in Ontario.

The Espanola and Area Family Health Team, which believes the proposed changes will improve timely access to patient care, wrote:

Our community is one of the many in Northern Ontario which have faced ongoing crises in health care with up to 30% of the citizens without a family physician at any given time. Currently we have two very high functioning Nurse Practitioners who are working to their full scope of practice....The bottom line is that if the NP can order diagnostic tests, make diagnoses and prescribe a wider range of treatment options for patients with whom they are very familiar, more patients will be seen and better overall health will be the result.<sup>61</sup>

It was emphasized that many NPs play an important role in helping to bridge experiences between more and less acuity of illness, and to bridge the gap between hospital and community. From a patient and health system perspective, the ability to create these linkages fosters two crucial goals: strengthening continuity of care and maintaining the individual's functional independence in the community.

Many of those consulted spoke of the increasing need to make better use of NPs in acute care settings, particularly within hospitals. They also observed that “administrative red tape” prevents professionals from practicing to their full scope and impedes collaboration with other members of the team.

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<sup>61</sup> Espanola and Area Family Health Team, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class, November 2007.

### **WHAT HPRAC HEARD...ABOUT ACCESS TO CARE**

**“Coming out of the north, where physicians were more comfortable working with an outpost nurse, and into the city, where there has been a lot of resistance to our role, I've found really difficult. I couldn't provide the full type of care to the patients, especially in under-serviced areas where you don't have a consistent physician. In some communities [near the city], patients would be without physicians for a long while and I was very limited in what I could do.”**

– Ursula Danner, Nurse Practitioner in geriatric care at St. Joseph's Hospital, Thunder Bay, formerly Primary Care Nurse Practitioner, Mary Berglund Community Health Centre, Ignace

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**“We have had one physician, two nurse practitioners, a social worker, clinical pharmacist, chiropodist, dietitian, registered nurse, registered practical nurse and clerical support in our team. Our one physician has had a tremendously large practice. Our nurse practitioners must see fairly independently their group of patients. They consult with our physician. He is in charge of a rest home, nursing home, has hospital privileges, and he is a medical director of a Community Care Access Centre. This is the reality of a rural practice. So every time a nurse practitioner has to treat a hypertensive patient or order very basic diagnostic tests such as an x-ray or lab work, you can understand logistically that current rules do not lend themselves to good efficient practice.”**

– Judy White, Administrator for the Tilbury District Family Health Team

### Long-Term Care and Home Care

NPs in long-term care settings spoke of older, frailer and more cognitively impaired residents who were receiving complex continuing care. Patients' lives were disrupted by unnecessary transfers to hospital for episodic care. Moreover, it was noted that even a couple of hours on a gurney in hospital can cause pressure ulcers among these vulnerable patients. NPs practicing in long-term care emphatically sought broader access to prescribing and to ordering diagnostic tests to meet the needs of their clients. One NP described her role as “the attending” for a number of LTC facilities.<sup>62</sup>

As the Ontario Long-Term Care Association commented in supporting the CNO's proposal to extend the NP scope of practice: “These changes will help to address the growing need for timely and safe treatment of residents in LTC homes and enhance the existing potential for reduced hospitalizations and avoidable transfers to emergency departments.”<sup>63</sup>

Similar issues arose with home care. Again, participants described clients who had to be taken to the emergency room when their care needs were beyond the NP's current

<sup>62</sup> Dona Ree, Nurse Practitioner in Long-Term Care Facilities in Thunder Bay Regional Health Sciences Centre at Thunder Bay public meeting, November 13, 2007.

<sup>63</sup> Ontario Long-Term Care Association, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class, November 2007.

scope. Sometimes all that was needed was simple renewal of prescriptions that were not on the NP list. Many home care clients face difficult mobility problems during these transfers.

### **WHAT HPRAC HEARD...ABOUT LONG-TERM CARE**

**“In March 1999, the Ministry of Health and Long-Term Care announced a pilot project to introduce nurse practitioners into long-term care homes. While there were only 17 positions, over 75 long-term care homes and community partners were served through this initiative.**

**In the past seven years, the experience in long-term care homes, corroborated by a growing body of research, has continued to demonstrate significant positive impact of nurse practitioners on the primary care of residents in long-term care homes as well as their impact on maintaining physician satisfaction and, most importantly, resident and family satisfaction. In fact, the success of nurse practitioners has prompted many multiple home operators, including municipal homes, to hire additional nurse practitioners over and above the Ministry-funded positions.**

**Nurse practitioners in long-term care homes have also demonstrated their potential to reduce avoidable transfers to emergency or admission to hospital and assist physician retention.**

**Physicians are typically only present in homes several days a week or in some cases several days a month ... nurse practitioners, on the other hand, are in the home daily, interacting not only with residents but with family and long-term care home staff, and are, in some cases, on first call.”**

– Nancy Cooper, Director of Policy and Professional Development, Ontario Long-Term Care Association

### Supporting Continuity of Care

It was frequently stressed that the scope of practice must support the fluid movement of NPs across care sectors to provide patients with continuity of care.

Participants in the consultations told of cases where NPs were serving outpatients in hospital clinics but were unable to follow the patient once admitted to hospital. Palliative care patients living at home lost the connection with their caregiver when admitted to an inpatient palliative care unit. Specialist NPs following paediatric patients who are technologically dependent in the home are unable to provide support once the child is admitted to hospital for an acute episode, even though the NP knows the child and family better than anyone else. The reverse is also true – specialist NPs working with technologically dependent children in hospital are unable to provide support once the children go home because their medical directives do not extend beyond the walls of the hospital.

The nature of a nursing model of practice is one of continuity of care and caregiver support. It is not normally episodic and context dependent. NPs want to continue to be part of the team wherever the client is receiving care. They say their scope of practice should support this kind of flexibility and interprofessional care as part of a patient-centred system.

### **WHAT HPRAC HEARD...ABOUT CONTINUITY OF CARE**

**“Removing barriers in existing legislation has huge implications for my practice. This will allow me the flexibility to fully enact my scope of practice across the settings from inpatient to outpatient thereby, I believe, decreasing inefficiencies of system issues and increasing timely access to care.”**

– Rose-Frances Clause, Advance Practice Nurse for children to sustain life at home at Hamilton Health Sciences

### Supporting Collaborative Practice

It was widely agreed that changes to NPs’ scope of practice should support the growing emphasis on interprofessional care. The College of Physicians and Surgeons of Ontario (CPSO) endorsed an expanded scope of practice for NPs, but only within a collaborative model. As the CPSO commented:

The CPSO is concerned that the proposed changes may result in parallel primary care delivery, rather than truly collaborative practice by nurses and physicians. In its submission, the CNO emphasizes that the changes will enhance, not impede, collaborative care. Our support for the proposed changes is contingent upon this being the case, as we do not think parallel practice patterns would be of benefit to Ontario’s patients.

The success of collaborative care for *any* health care professional, including physicians, is dependent on achieving the correct balance of independent activity and consultation with experts for the benefit of patients. To this end, we hope the CPSO and CNO will continue to work together to promote collaborative care by physicians and nurses.<sup>64</sup>

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<sup>64</sup> College of Physicians and Surgeons of Ontario, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class, November 2007.

## **WHAT HPRAC HEARD...ABOUT INTERPROFESSIONAL CARE**

**“The system is messy and not likely to get less messy. The points of interaction among health professionals are points of complexity.... The system must make changes to support this kind of collaboration so that it is synchronous with the changing needs or the most frustrated people in this will be the patients.”**

– Marian McGee, BNSc., MPH, DrPH (Doctor of Public Health)

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**“We endorse the view that the nurse practitioner’s practice must be in the context of very strong collaborative interdisciplinary healthcare practice. This we see as fundamental to success.**

**The expanded RN(EC) scope of practice reflects the current practice environment, the educational preparation of nurse practitioners, and the required competencies. The proposed changes speak to very diverse practice settings. Within the practice settings we represent, we recognize that there are some differences between our environment and what might be the environment in northern Ontario. The changes need to address that complexity and diversity. The proposed changes will streamline and bring some efficiency to the practice of nurse practitioners that will be very important in the hospital sector.”**

– Winnie Doyle, Vice President, Clinical Services and Chief Nursing Executive, St. Joseph's Health Care Hamilton, in a joint public hearing presentation with Hamilton Health Sciences

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**“Physicians in collaborative settings are aware of each of the other team members' skill and competency, which often makes the consultative process redundant and inefficient. Physicians are not being utilized to their full scope of practice with time spent on consultative processes for matters such as prescription renewals for stable patients. Formal and informal quality assessment processes by team members in a collaborative setting act as a check and balance in providing quality patient care. In a truly collaborative practice, team members are all able to consult freely with each other when they encounter a problem they are unable to solve alone.”**

– Dr. Laura Muldoon, Somerset West Community Health Centre, Ottawa

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**“Working in a team approach with physicians and other allied health professionals just demonstrates the kind of care that can be provided. Certainly there is overlap in professional services. But nurse practitioners are not physicians or are not physician replacements... that is not really the purpose of the College's proposal. The nurse practitioners have learned to complement the medical model quite well and in collaboration with our partners.”**

– Aaron Medd, Primary Care Nurse Practitioner at NorWest Community Health Centre, Thunder Bay

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**“The term interprofessional education across the university setting is a hot topic. The Lawrence S. Bloomberg Faculty of Nursing at U of T is engaged in that on every level across the university. We call upon and develop relationships across the disciplines and continue to nurture those relationships. The Faculty of Nursing and our group has been able to engage all kinds of providers across all of the various disciplines recognizing that there are health conditions that cross disciplines.”**

– Krista Keilty, Director of the Nurse Practitioner Acute Care Program at the University of Toronto and Advance Practice Nurse at the Hospital for Sick Children

### Problems with Medical Directives

During the consultations, HPRAC heard much about the significant limitations arising from use of medical directives as a way to authorize specific procedures. Time taken to develop the documents was one factor, as noted above. This approach also imposes constraints on the regulator. When a NP performs a controlled act outside the NP scope of practice under delegation from a physician, the CNO cannot establish standards of practice for this activity. The CNO and others argued that the public interest and patient safety are better served when a controlled act is carried out under the direct regulation of the college of the individual who is performing the act.

### **WHAT HPRAC HEARD...ABOUT MEDICAL DELEGATION AND DIRECTIVES**

**“In the community and in a primary care setting there would be no way to cover every issue with medical directives. It would be absolutely impossible. We believe there is no substitute for critical analysis of each unique situation. The client base in the community is not limited to one type of patient.”**

– Leanne Crump, Primary Care Nurse Practitioner at the Peterborough Family Health Team

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**“No, you cannot provide care as well with a medical directive. Especially with drugs and tests. We develop these documents (the directives), and they are huge documents. There is a lot of support behind them. We send them through many people to have signatures put on them and then they go to the Medical Advisory Committee for approval. That may be a two-year process. So in that two-year period I have been technically practising outside that medical directive because I have been prescribing those drugs or ordering those tests. We need to remove the document to remove the risk that we are putting ourselves at by not practicing within our scope or what we have been delegated, or been asked or supported in our hospital to do.”**

– Tina Hurlock-Chorostecki, Acute Care Nurse Practitioner at London Health Sciences Centre

## NP-Anaesthesia

In its 2006 *New Directions* report, HRAC noted that nurse anaesthetists “with their additional skills, could work in collaboration with physicians and other professionals such as dentists, or could support the work of family health teams, hospital surgical programs, and care provided in community health centres”, and proposed that a new role “should be explored, along with competencies and entry-to-practice requirements, educational programs, and issues relating to supervision, delegation, self-initiation and medical orders”.<sup>65</sup>

Unlike other NP specialties, where educational programs and practice realities preceded legislative recognition, the NP-Anaesthesia role has been created through the 2007 amendments to the regulations<sup>66</sup> under the *Nursing Act* before educational programs have been devised and before the role has actually been defined in practice. This new role does not fit with the CNPI specialty categories and was not part of the CNPI initiative.

During the consultations, it was generally acknowledged that looming human resource issues in anaesthesia care will require alternatives to the provision of all services by physicians. However, Ontario educators and regulators told HPRAC that they are not fully cognizant of the intended scope of practice for the NP-Anaesthesia. In developing the role, Ontario can build on substantial international experience with non-physician anaesthesia care.

HPRAC understands that initial steps on curriculum development have now been taken at the University of Toronto.<sup>67</sup> It is expected that the first cohort of NP-Anaesthesia students will begin the program in May 2008. Four to six post-masters degree positions will be available, with a designated anaesthesiologist preceptor and setting support. The curriculum, being developed with the involvement of the Faculty of Medicine, the Faculty of Nursing and the Michener Institute, will include some of the features of the anaesthesia assistant course now being offered at the Michener Institute, including pharmacology, monitoring, equipment, and pain management across settings, principles of anaesthesia, plus 600 hours of supervised clinical work. The curriculum design anticipates that NPs will work in a collaborative practice model. Prospective students will likely have experience working in intensive care, emergency or pain management.<sup>68</sup>

## *International Background*

Two historical models of anaesthesia care have developed in the western world. In the United States, intra-operative anaesthesia evolved as a nursing specialty after 1909 and

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<sup>65</sup> HPRAC, *Regulation of Health Professions in Ontario: New Directions* (April 2006), p. 78.

<sup>66</sup> O. Reg. 502/07, s. 2.

<sup>67</sup> Information presented at Ontario Hospital Association Conference, February 11, 2008 by Pamela Hubley, Consultant in Nurse Practitioner Programs at University of Toronto.

<sup>68</sup> Updates can be obtained at University of Toronto nursing website, [http://www.nursing.utoronto.ca/students/Graduate\\_Students/npdiploma/np\\_reg.htm](http://www.nursing.utoronto.ca/students/Graduate_Students/npdiploma/np_reg.htm).

medicine moved into this field relatively late in the 1930s. In Britain, anaesthesia evolved as a medical specialty and this is the historical root of Canadian medical and nursing practice.

Certified Registered Nurse Anaesthetists (CRNAs) are a prominent feature of American health care and they deliver approximately 60 per cent of all operative anaesthetics, including those for critical surgical procedures such as coronary artery bypass surgery. This role is not in place to date in any Canadian jurisdiction. While most CRNAs in the U.S. are autonomous practitioners, others work in anaesthesia care teams under the supervision of anaesthetists. Some states regulate them as NPs.

There is a significant variance in the U.S. in the authority of NP-anaesthetists to work independently. Despite the numbers of qualified CRNAs, many NP-anaesthetists must work under physician supervision depending on the regulatory models in various states or rules imposed by individual hospitals. In many hospitals, while NP-As have the technical skills to do epidurals, inductions, intubations, line placements, catheters etc., the physician anaesthesiologist bears the liability and responsibility for the NP-As performance.

In the U.S., role conflict between CRNAs and medical anaesthetists is considerable, at least at the organizational level, if not at the point of practice.<sup>69</sup> A recent publication<sup>70</sup> described a systematic review of the literature comparing the effectiveness and safety of care provided by CRNAs and physician anaesthetists. While the four studies that were examined in detail all had some methodological limitations, the review authors found no conclusive evidence that the anaesthesia provider makes any difference to patient outcome. An article frequently cited by anaesthetists as evidence that anaesthesia care teams are the safest model of care<sup>71</sup> was not included in this review because it is not original research but an interpretation of previously published papers.<sup>72</sup> In fact, purely anaesthesia-related adverse events are difficult to define for research purposes and are relatively rare. Hence, a randomized controlled trial may be almost impossible to conduct with a large enough sample to reliably measure the clinical effect of different anaesthesia providers.<sup>73</sup>

### **NP Scope of Practice**

In discussing changes to the scope of practice, participants stressed that no one was suggesting that NPs should do anything for which they were not properly educated and trained. If NPs were to take on additional functions, appropriate standards for public

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<sup>69</sup> Kane M., Smith A.F., 2004. An American tale: professional conflicts in anaesthesia in the United States: implications for the United Kingdom. *Anaesthesia*, 59, 793-802.

<sup>70</sup> Smith A.F., Kane M., Milne R, (2004). Comparative effectiveness and safety of physician and nurse anaesthetists: a narrative systematic review. *British Journal of Anaesthesia* 93 (4) 540-545.

<sup>71</sup> Abenstein, J.P., Warner, M.A., (1996). Anesthesia providers, patient outcomes and costs. *Anesthesia & Analgesia*, 82:1273-1283.

<sup>72</sup> Smith, S.F., Kane, M., Milne, R. (2004). Comparative effectiveness and safety of physician and nurse anaesthetists: a narrative systematic review. *British Journal of Anaesthesia*; 93:540 – 545.

<sup>73</sup> Idem.

protection would have to be put in place. This view was shared by both NPs and other health professionals.

### Communicating a Diagnosis

In public hearings and roundtables, few concerns were expressed about changing the current limitations on communicating a diagnosis. NPs told of interrupting appointments to get a physician's consent to convey a diagnosis that was evident from results of a test or from a consultation report. This was most particularly the case with respect to chronic conditions such as diabetes, where the NP had often been involved in patient management over a period of time.

NPs also reported cases where they were unable to independently communicate a differential diagnosis to explain to patients why they were being referred for a mammogram (for a palpated breast lump that might be malignant) or for a surgical consultation about a biopsy (after positive results from a mammogram). Communicating the differential diagnosis – that is, the possible causes of symptoms or test results – is seen to be vital in these cases to ensure that the patient follows up promptly with additional screening tests or consultations.

NPs in all parts of the province confirmed they would continue to consult with physicians as needed and would communicate a diagnosis only when there was sufficient clinical evidence to support the diagnosis.

A submission from the Ontario Medical Association (OMA) supported the current prescribed requirement respecting consultation with members of other health professions. The OMA argues that “nurses with advanced training in a particular area will still have less expertise than physicians in the equivalent specialty field (and in this instance “specialty field” is intended to include FPs and RN(EC)s in primary care)”.

The Ontario College of Family Physicians (OCFP) in its written submission also recommended maintaining the existing constraints on this controlled act for NPs. The OCFP expressed the opinion that the NP role is relatively new in family practice and more research is required. The OCFP states<sup>74</sup>:

The CNO has not established an adequate rationale for requesting the removal of current requirements regarding the prescribed standards of practice respecting consultation with other healthcare professionals. Regardless of the settings, RN(EC)s have less training and less knowledge and skills than their collaborating physicians. Specialists in family medicine, working in primary care settings, provide RN(EC)s with important guidance and advice. Their greater knowledge and skills often results in care

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<sup>74</sup> Ontario College of Family Physicians, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class, January 2008.

delivered in the practice, thereby avoiding inappropriate, unnecessary and costly referrals.

The *Nursing Act, 1991* requires NPs to consult with other appropriate health professionals before communicating a diagnosis. The current CNO Practice Standard for NPs states that a consultation is<sup>75</sup>:

an explicit request by a RN(EC) for a specific physician to become involved in the care of the client for which the RN(EC) has primary responsibility at the time of the request. Consultation happens when the nurse reaches the limit of the RN(EC) scope of practice, beyond which she/he cannot provide care independently and additional information and/or assistance is required from a professional with a more extensive knowledge base related to the specific client situation.

The Practice Standard also outlines explicit requirements for consultation and collaboration including detailed clinical and procedural expectations. Procedural expectations focus on communication between the RN(EC) and physician, documentation of the request and ensuring the physician has access to the client's health record.

The CNO council has adopted the *Canadian Nurse Practitioner Core Competency Framework*. This framework states that when performing health assessment and diagnosis, “the NP initiates timely, effective consultation, collaboration and/or referral to physicians, other health-care professionals and social service providers, as appropriate, to assess and diagnose client health/illness status.” It also requires that “when fulfilling their professional role and responsibility, the NP demonstrates an understanding of scopes of practice, formally requesting consultation and referring clients to physicians or other members of the health-care team at any point in the care process when the client's condition is assessed as beyond the nurse practitioner scope of practice, or the individual nurse practitioner's competence”.

### Ordering and Applying Forms of Energy

NPs made presentations that described problems with the current restrictions on ordering and applying forms of energy. It was noted that a NP does not have legal authority to defibrillate a patient, although new technology has made this so safe that members of the general public are encouraged to do so in an emergency in a public place. NPs working in cardiology units described the need to reset cardiac pacemakers. NPs working in oncology said it was necessary to order follow-up CTs and MRIs as part of ongoing monitoring of cancer patients. NPs in the emergency room cannot order x-rays of the shoulder, which means a patient needing a shoulder examination must wait for a physician's order.

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<sup>75</sup> College of Nurses of Ontario. Practice Standard: Registered Nurses in the Extended Class. 2005.

Similar barriers to care were recounted in community settings. NPs can order ultrasounds of the abdomen, pelvis and breast – but not the thyroid. As a result, HPRAC heard from a NP about a patient who was ultimately diagnosed with thyroid cancer and waited an extra two weeks for a physician to order the scan. Another NP reported that her inability to order a bone density test caused problems almost every day – she educates patients about osteoporosis and screens for risk factors, but is unable to order the key diagnostic test. A NP had to send a patient to a doctor to obtain an order for an echocardiogram, delaying the test that showed a serious heart defect.

In long-term care settings, NPs sought the authority to order and apply Doppler technology to assess residual urine in the bladder or to check for vein thrombosis. They also wanted to be able to order additional x-rays beyond the extremities to assess patients for pneumonia, heart failure, fractures of the hip and other conditions. The aim is to avoid unnecessary transfers to the emergency room for cognitively impaired or otherwise frail patients.

A number of participants noted that the CNO document was not entirely clear on what was being requested with regard to forms of energy. For example, the Ontario Society of Diagnostic Medical Sonographers (who represents a currently unregulated group and is the subject of one of the referrals in the Minister’s June 28, 2007 letter) was concerned about the application of high-frequency ultrasound waves – a concern that arose from lack of clarity in the CNO submission.

The Ontario Association of Medical Radiation Technologists (OAMRT), the College of Medical Radiation Technologists of Ontario and the Ontario Association of Radiology Managers (OARM) expressed doubts about NPs’ knowledge of the cumulative risk of exposure to x-rays and the importance of limiting life-time exposure. As the OAMRT submission commented, “Prescribing ionizing radiation and potentially harmful other medical radiations is a serious patient safety issue with potential long-term adverse effects.” While in principle supporting the CNO proposal to expand the NP scope of practice, the OARM also raised a number of issues involving the ordering and application of energy with respect to both magnetic resonance imaging and diagnostic ultrasound.

### Setting and Casting Fractures

During the consultations, it became apparent that the CNO submission did not clearly describe the intended limitations on its request to add setting or casting a fracture of a bone or a dislocation of a joint to the controlled acts NPs can perform, although details were included in an appendix.

NPs in rural practices described cases where patients had to be referred to an emergency room for the reduction and splinting of a simple finger dislocation or the casting of a simple non-displaced fracture. A simple, non-displaced fracture is one where a crack or break in a bone is not close to vital structures (such as a growth plate in a child) or to nerves or blood vessels; the bone is still in alignment and all sensation

and circulation in the limb is normal. In this case, a cast is required to support the limb during the normal healing process.

In a written submission, the Orthopaedic Section of the OMA criticized this proposed expansion to the NPs' scope of practice, citing NPs' insufficient knowledge and clinical experience. The OCFP and the OMA shared this view.

#### Prescribing, Dispensing, Selling, Compounding Drugs

Participants from the nursing community strongly supported an expansion of NP scope of practice in the area of prescribing drugs – particularly to do away with the regulation that contains a list of individual drugs that a NP is authorized to prescribe.

NPs told of how restrictions on prescribing kept them from providing the best care. One NP recalled how she had to send four patients with poison ivy to the emergency room where they waited six hours to get a prescription. NPs can counsel and educate patients with HIV – but must send them to a physician for a prescription for certain medications. For diabetes, NPs cannot change a patient's drug therapy, even though they are monitoring the patient and are experts in the disease. If NPs had been able to prescribe these various drugs, HPRAC was told, patients could have started treatment sooner.

The Ontario College of Pharmacists (OCP) and the CPSO clearly articulated their support for abolishing the list-based system. Individual pharmacists expressed frustration about the list of drugs and the time that it took to check whether or not a particular drug was “on the list”.

NPs also sought the authority to provide samples of medications to patients, which is categorized as dispensing.

The OCP – as well as some individual pharmacists – expressed concern about the proposal to allow NPs to dispense, compound and sell drugs, noting that these aspects of pharmacists' practice are strictly controlled by detailed legislative requirements. They said that the same rules should apply to all providers performing these functions.

A pressing matter identified by many NPs was their inability to order a prescription refill for a patient if the drug was not on the list of those that they are authorized to prescribe. Indeed, physicians also expressed frustration that a qualified NP, having appropriately assessed a patient, could not independently order a repeat prescription, and had to rely on the physician to do so. No matter what the practice setting or geographic location, the limitation on the NP authority was seen as inefficient and often as a barrier to good patient care, particularly if a physician was not readily at hand when the prescription was required.

### Administering a Substance

The ordering and administration of medication by inhalation is related to the NP-Anaesthesia role, but not exclusively so. NPs also have to order inhaled medications to treat chronic obstructive lung disease and asthma.

The new NP-Anaesthesia role sparked many questions during the consultations, including:

- Is the NP-Anaesthesia an autonomous practitioner or an assistant to the physician anaesthetist? If it is not an autonomous role, is it a poor fit with NP regulation?
- Is the role intended to involve more than intra-operative care? Would it extend to pre-operative assessment, post-operative care, provision of obstetrical anaesthesia and pain management?

Concerns about the proposed NP-Anaesthesia role were raised in the OMA's written submission and in one of the Toronto roundtables where respiratory therapists (RTs) participated. The OMA supports the role only if the NP-Anaesthesia works as part of an anesthesia care team (ACT) under the supervision of anesthesiologists. The OMA submission did agree NPs should be able to initiate life-saving Advanced Cardiac Life Support (ACLS) algorithms while waiting for a physician response.<sup>76</sup> RTs opposed introduction of the new NP-Anaesthesia role.

The OMA Section on Anesthesiology also objected to an autonomous NP role in anaesthesia. Its written submission did not specifically critique the proposed NP-Anaesthesia role though it did advocate strongly for the ACT model, which is currently being pilot tested in various sites across the province. The group called for evaluation of this model. It also suggested that there may be a role for non-physician providers in pre-operative assessment and in pain management but further work was needed to clarify the specific roles and functions. NPs suggested that this role could assist in the management of chronic pain.

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<sup>76</sup> Ontario Medical Association, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class, October 2007.

## **WHAT HPRAC HEARD...ABOUT NPS' SCOPE OF PRACTICE**

**“My consultative physician comes to the facility maybe once or twice a month... Because of the energy regulations, nurse practitioners are limited to basically the long bone in the arms and the chest x-ray. My patients have very extensive osteoporosis, osteopenia, and they come in with back pain, hip pain, and they fall. At present, it will be an emergency visit if they fall and require some form of x-ray. If I had the authority I could arrange to have the x-ray done and most of the time if the x-ray is negative it will prevent a hospital transfer ... We should be able to order venous and arterial Dopplers especially when the risk of deep vein thrombosis is a potential. Echocardiograms: I've had people coming in to the long-term care facility who have no physician. Picking up a murmur or something similar, and being able to do some investigative work prior to sending them to a specialist would be helpful to the patient.”**

– Dona Ree, Nurse Practitioner in Long-Term Care Facilities in Thunder Bay Regional Health Sciences Centre

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**“The needs of patients are more complex and there is an important role for nurse practitioners in supporting timely access to care, early onset symptom management, and comprehensive treatment. Still, patients will always need physician involvement and collaboration to address their needs fully. The current controlled acts do not allow patient-centred care where the nurse practitioner can order a treatment but cannot communicate the diagnosis. Delegation is confusing for all professions, and there is confusion with the role and purpose of medical directives.”**

– Karen Perkin, St. Joseph's Health Care London

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**“In the current system, there are interruptions and inefficiencies experienced by providers and patients due to the lack of authority to provide services within nursing practice. Nursing regulations are not in tune with the increasing pace of technology and best practice. An example is the restrictive and unwieldy process to authorize drugs and tests for NPs. Updating the list under the best circumstances takes 16 months to approve. As an example, I don't have the authority to prescribe a contraceptive patch, but I could prescribe every other kind of birth control. This causes delays in care and access. It is confusing to patients regarding their level of care when the nurse practitioner can prescribe or order a treatment in almost any form, other than the one the patient needs or requests, or when I have to make a request or interrupt another professional to provide the prescription.”**

– Willi Kirenko, Past President, Nurse Practitioners' Association of Ontario

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**“When I write that NP-Paediatrics examination to be eligible in the extended class, I still won’t have the prescriptive authority to provide care to my full scope (in the hospital). None of our drugs are on the approved list, so that means I would still need to continue to practise via medical directives in an in-patient setting under the *Public Hospitals Act*.”**

– Lisa Pearlman, Advanced Practice Nurse in paediatric acquired brain injury at the London Health Sciences Centre

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**“If a physician has ordered a medication that is not on our list to renew, it becomes a hazard for the patient who may have to wait a considerable time to see a physician. Spending time tracking down physicians for medication repeats for drugs not on the list means after-hours and lunchtimes devoted to this pursuit. Managing chronic disease is challenging. Although we can order the tests, encourage patients to manage their conditions and report in for medication adjustment such as diabetes, we are unable to make the necessary adjustments as recommended in the best practice guidelines.”**

– Bonny Johnson, Whitewater Bromley Community Health Centre Satellite, Beachburg

### **NP Competency**

A key question in the consultation process was whether NPs have the education and training to support the proposed changes in scope of practice. While many of the issues set out below were raised during public meetings and stakeholder roundtables, detailed discussion took place during a key informant meeting with educators from both the primary and acute care NP programs in Ontario.

It was noted that NPs are supervising medical students in many settings and participating in medical education. This struck some as ironic, given the limitations on NPs’ scope of practice compared to that of physicians.

#### Entry to Practice

NPs assert that their educational preparation equips them to practice beyond their present legal scope. They conveyed a strong message that Ontario’s NP educational programs contain all of the elements required to meet the core competencies needed for the expanded scope proposed by the CNO. They also indicated that they are already performing the controlled acts in their current practice, and are trained to do so.

The CNO stresses that its proposed changes to the NP scope of practice are in keeping with the Canadian Nurse Practitioner Core Competency Framework developed by the CNPI as part of a national consensus. The CNO assesses the curricula of NP education programs based on whether they teach the necessary competencies (typically through a combination of academic and clinical learning). Program approval is based on this assessment.

### *Primary Health Care Program*

Ontario's Primary Health Care Nurse Practitioner Program is offered through a consortium of 10 universities – the Council of Ontario University Programs in Nursing (COUPN). According to the CNO, “The program teaches the necessary critical thinking and problem solving associated with the expanded controlled acts ...”<sup>77</sup>

The program is evolving from a post-graduate certificate program to a master's program that is to be launched in fall 2008. Educators involved in the program stated that, while NPs are taught theoretical content, clinical practice in some skills in the expanded scope – such as setting and casting of fractures – is not a requirement because these areas are not included in the current scope. They said that for NPs certain activities might require a continuing education course to gain competency – for example, ordering x-rays specific to the type of practice, or setting and casting a fracture. Overall, educators are confident the COUPN master's program will contain all of the learning requirements to meet the competencies requested by the CNO.

### *Acute Care Program*

Those NPs who currently work in acute care stated that the core competencies for this kind of practice are identical to those outlined by the CNPI for the NP-PHC, and are the same for comparable specialist NP roles in the U.S. They are currently working exclusively under medical directives as they were not covered by the original NP legislation. They point out that almost nothing in the existing lists of drugs and diagnostic tests is relevant to their practice needs.

The University of Toronto NP Master's program is currently undergoing some changes. Graduates of this program are eligible to register with the CNO as either a NP-Adult or a NP-Paediatrics. The new version of the program will be ready in fall 2008.

In discussions with faculty, it became clear that the program seeks to produce graduates who are competent in critical thinking, diagnostic reasoning, health assessment, evidence-based practice, pathophysiology and therapeutics and can then focus after graduation on a specialized area of practice. Course content has an adult stream and a paediatric stream. Graduates can acquire additional specialized clinical skills following graduation. In many cases this includes institution-based learning and short courses based on the specific needs of the practice.

### *Neonatal Program*

Neonatal NPs are educated at McMaster University. The first specialized NP program in Ontario, it has been extensively evaluated. The neonatal NP carries out many of the invasive procedures that would normally be done by a neonatal resident or neonatologist, in addition to managing the care of pre-term and very sick infants. The

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<sup>77</sup> College of Nurses of Ontario, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class, August 2007.

curriculum content includes highly specialized clinical knowledge and most, if not all, applicants are already experienced neonatal intensive care unit (NICU) nurses. Many of the graduates of the McMaster program have successfully written the U.S. entry-to-practice examinations and maintain their standing by adhering to the quality assurance program in the U.S. As well, U.S. nurses have taken the McMaster program and graduates have been registered to practice in the U.S.

The role of the neonatal NP represents a specialized practice that does not fit neatly into the four categories established under recent changes to Ontario's nursing regulations. Graduates of the program indicate they do not have the broad competencies required for the NP-Paediatrics category.

#### *NP-Anaesthesia*

Ontario currently has no program for the NP-Anaesthesia category, although plans are progressing at the University of Toronto Faculty of Nursing in collaboration with the Faculty of Medicine. While the role's definition and how it will fit into the system are not yet clear, there is ample material from other jurisdictions, especially the U.S., to draw on.

#### Continuing Competence and Quality Assurance

It appears a trend toward interprofessional continuing education (CE) has emerged. The roundtable in Thunder Bay included representation from the Northern Ontario Medical School and the Nursing School from Lakehead University. During this meeting, plans were made to collaborate with the nursing faculty at Lakehead University to co-develop CE programs. Queen's University has re-named its medical CE programming "professional CE" and NPs are active participants and presenters in these activities. McMaster offers post-graduate, problem-based interdisciplinary learning tutorials and NPs take part in these.

Institution-based CE forms the basis for much of the specialized education for acute care NPs. The accreditation of these programs offered in non-academic settings is an issue, as is the fact that they are not portable. The NPAO has suggested developing a CE system to address these concerns.

HPRAC heard substantial support for strengthening the CNO's quality assurance (QA) program. The CPSO, which is generally supportive of the proposed expanded scope for NPs, has raised this as an issue. The NPAO agrees and so do educators of NPs.

The CNO is planning changes to its current QA program that will include a combination of:

- self-assessment,
- peer assessment, and
- practice assessment on a three-year cycle.

The current proposed date for implementation of the new QA program for all registrants (NPs, RNs and RPNs) is 2010. The CNO has indicated that timing could be moved forward for NPs to coincide with amendments to legislation regarding an expanded scope of practice. As part of its proposed changes to quality assurance, the CNO is seeking a regulation amendment to expand the scope of mandatory NP practice reviews.

Ontario does not currently have a provincial drug information system, so the CNO cannot proactively monitor NPs' prescribing patterns. Other professional regulatory colleges in Ontario whose members are authorized to prescribe drugs face the same problem. Representatives of other jurisdictions – such as British Columbia – spoke of the value of drug information systems in triggering practice reviews. HPRAC will more fully consider this aspect in its report on non-physician prescribing, and examine Ontario's developing e-health record initiatives in this regard.

### **WHAT HPRAC HEARD...ABOUT QUALITY ASSURANCE**

**“Distance education offered by COUPN is available, and is usually used for people in the North and experienced nurses who want to keep up-to-date. A funding problem for the program is that it is on a demand basis, so the number of programs and courses offered depends on demand.”**

– Pat Topp, Ontario Primary Care Nurse Practitioner Program

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**“The current Reflective Practice requirement of the CNO is an annual expectation and is well put together. As we add more specialties to Nurse Practitioner practice, one consideration for QA might be a peer review process undertaken with another experienced Nurse Practitioner, preferably in the same specialty.”**

**Review of a Nurse Practitioner's continuing education activities upon registration renewal would be reasonable.”**

– Jennifer Fournier, Sudbury District Nurse Practitioner Clinic

### *Professional Liability Insurance*

During its consultative process, HPRAC hosted a meeting with representatives of the insurance sector, and reviewed a number of current documents to determine whether professional liability protection is a barrier to collaborative care provided by multidisciplinary teams in general, or to an expanded scope of practice for NPs, in particular.

A joint statement issued by the Canadian Medical Protective Association (CMPA) and the Canadian Nurses Protective Society (CNPS) in 2005 stated:

Collaborative practice inevitably reinforces the need for health care professionals to ensure they individually have adequate personal professional liability protection and that the other health care professionals with whom they work collaboratively are also adequately protected so that neither is held financially responsible for the acts or omissions of another.<sup>78</sup>

In the event of legal action against them, professionals, both individually and as part of a team, are accountable for their practice and bear liability risks, along with employers and other members of the team. In Ontario today, most nurse practitioners are employed, either through hospitals, long-term care facilities or primary care organizations such as Family Health Teams, Family Health Groups, home care agencies and community health centres.

While most organizations appear to have appropriate liability protection, it remains unclear to HPRAC whether all of the existing and emerging organizations have adequate coverage. Insurers told HPRAC that this is a matter of serious concern to them, and should be to NPs and their patients as well. HPRAC has also heard that as the NP role changes, and more independent practices materialize and new practice models develop, the attention to liability protection for the individual NP becomes a matter of increasing interest and importance. The evolution of care settings, corporate organization and NP scope of practice could present serious liability protection gaps if they are not addressed directly.

While risks in medical negligence and malpractice actions are somewhat different to those for nurse practitioners, an increased risk may be posed as the scope of practice for NPs is enhanced. In Ontario, a minimum level of professional liability protection is mandatory for physicians<sup>79</sup>, either through CMPA or another insurance provider; under the CMPA, protection is unlimited. The Healthcare Insurance Reciprocal of Canada (HIROC), a non-profit corporation, provides coverage for most hospitals and facilities in the \$25 million range.

Insurers, along with other key informants and references in the literature, also emphasize the importance of clear accountability within collaborative care teams. It is vital to ensure that the roles and functions of all team members are clearly understood by other team members and by the patient.<sup>80</sup>

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<sup>78</sup> *CMPA/CNPS Joint Statement on Liability Protection for Nurse Practitioners and Physicians in Collaborative Practice* (March 2005).

<sup>79</sup> See s. 50.2 of CPSO By-Law #30 and s. 2 of O. Reg. 865/93 issued under the *Medicine Act*.

<sup>80</sup> For further discussion of this issue, see, for example: CMPA, *Collaborative Care: A Medical Liability Perspective* (2006).

## **WHAT HPRAC HEARD...ABOUT PROFESSIONAL LIABILITY**

**“Why should my professional liability be subsumed by another group of healthcare professionals? Why does it not rest with me as a healthcare professional within my scope of practice and within the acts that govern my scope of practice?”**

– J. Rob Mackenzie, Nurse Practitioner in a geriatric rehabilitation unit in London

### **Other Issues**

In addition to this feedback, HPRAC received comments about some issues that should be brought to the Minister’s attention.

#### Remote and Rural Communities

In the roundtables and public hearings, particularly in northern Ontario, and in several written submissions, concerns were raised about the challenges facing RNs in remote and rural communities who are working beyond their scope of practice because of a shortage of physicians and NPs. The RNs affected are generally employed by the federal government or First Nations bands.

HPRAC learned that the College of Registered Nurses of British Columbia (CRNBC) is introducing the concept of certified practice by registered nurses to address these challenging circumstances. Some nursing activities have been identified as certified practices, which mean they can be carried out by registered nurses who have completed an education course approved by the CRNBC. For remote nursing practice, these activities involve independently diagnosing a minor acute disease and treating it with a prescription medication, suturing wounds independently and performing reproductive health activities such as providing birth control pills and the patch. Certified practices do not include the act of prescribing. Any prescription medications that RNs administer or dispense are provided by their employer. Existing practitioners who already have the required competencies will not be obliged to take a course. However, they will be required to successfully complete the course exit evaluation and obtain a letter from their employer confirming their competency.

A transition period for implementing the certified practices model is scheduled to run until the end of 2008. In the meantime, RNs who are currently carrying out certified practices as part of their employment can continue to do so.

British Columbia is implementing this model because of concern there is no consistency in RNs’ educational preparation for these activities. Moreover, this approach makes both the college and the public aware of who these nurses are and what services they are providing.<sup>81</sup>

<sup>81</sup> Nurses (Registered) and Nurse Practitioners Regulation, B.C. Reg. 233/2005, O.C. 476/2005, College of Registered Nurses of British Columbia, and Bylaws, Section 4.16, p.13. Griffiths H, Introducing Certified Practices, NursingBC, Apr. 2007, pp. 18-21. CRNBC-Certified Practices fact sheets, Dec. /07, Jan. /08.

During HPRAC's consultations, access to basic primary health care services was cited repeatedly as an issue in remote and rural communities. The B.C. model could offer a solution for improving access to primary health care services provided by registered nurses while minimizing the risk of harm to the public. For people who live in or around James Bay, for instance, this could be an important step forward.

Adopting this model could also help avoid unintended consequences from expansion of the scope of practice for NPs. There is a risk that access to services could be restricted – particularly in remote aboriginal communities, where health services are under local control and not under the direction of Health Canada.

### Physician Schedule of Benefits

Several issues were frequently raised involving the Physician Schedule of Benefits and Fees under the *Health Insurance Act*.

One was the referral of patients to specialists. This is a result of the way family physicians and specialists are compensated in the OHIP system, which contains financial incentives and disincentives that impede nurses from referring patients directly to specialists. Both NPs and family physicians object to the time spent on physician approval of referrals recommended by NPs. They concur that NPs are competent to make these referrals directly in most cases.

Another consideration regarding the fee schedule is the impact of the fee-for-service (FFS) model on the integration of the NP role in service delivery. It is seen to be difficult to add a NP to a medical practice when physicians are reimbursed on an FFS basis: the NP becomes an operating cost, rather than an essential part of a team practice.

As new models of primary care delivery (including Family Health Teams, Family Health Groups, Primary Care Networks and other models) emerged over the past decade, incentive payments were introduced to encourage physicians to change practice patterns and to include screening and health promotion activities such as smoking cessation programs, influenza vaccinations and other immunizations. Further incentives reward physicians for activities such as home visits and coverage of hospital emergency departments. In various models, much of the work done by a team member, most particularly the NP, is seen to remunerate the physician or team of physicians, rather than the entire team. An argument can be made that the incentives provide revenue that ensures that a team can exist. Nonetheless, new models in Australia and Britain are being developed to provide incentives for the team,<sup>82</sup> rather than individual members of the team.

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<sup>82</sup> Oandasan, I, Baker, G.R., Barker, K. et al. (2006). *Teamwork in Healthcare: promoting effective teamwork in healthcare in Canada. Policy Synthesis and Recommendations*. Canadian Health Services Research Foundation.

## Hospital Admissions and Discharges

The *Public Hospitals Act* presents limitations to NPs that cause unnecessary delays and costs to the health care system. Currently, even if the NP is the most responsible care provider, the regulations under the Act prohibit the NP from discharging a patient from a hospital. As a result, patients often have to remain in hospital while they wait for a physician to approve the discharge. This sometimes leads to additional overnight or even weekend hospital stays. In order to address these issues, amendments to the regulations under the *Public Hospitals Act* will be required.

In a similar vein, NPs are constrained by *Public Hospitals Act* regulations from admitting a patient to a hospital. On the other hand, physicians, midwives and in certain circumstances dentists, can order hospital admission if they believe “it is clinically necessary that the person be admitted.”<sup>83</sup> NPs are not able to make an informed judgment about the clinical necessity of admitting a patient despite their skills, knowledge and observation of the patient.

## **The Case for Change**

Having considered the research findings and consultation input, HPRAC has concluded that expansion of the NP scope of practice and changes to the regulatory system is in the public interest. These changes will respond to demands for increased patient access to appropriate care, improved continuity of care, and greater clarity in the role of professionals.

The proposed scope of practice revisions largely reflects the activity of many NPs under medical directives. Eliminating, or at the least sharply reducing, the need for these directives will enable NPs to serve their patients better and ensure that their skills, as well as those of their physician and other partners, are used efficiently. Where NPs currently work without medical directives, situations described to HPRAC were replete with examples of how patient care was undermined by restrictions that constrained NPs from doing what they are entirely capable of doing, or forced them to interrupt their practice to obtain physician approval for various tasks. In fact, HPRAC heard that the necessary route of seeking authority to provide services tended to impede, rather than promote, interprofessional collaboration.

It is clear that overall performance of the health care system can be improved by increasing the capacity of NPs to contribute to patient-centred care. A wider role for NPs will make the most of their training and experience, help to meet health human

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<sup>83</sup> See s. 11(1) of Regulation 965 under the *Public Hospitals Act*. Regarding dentists, the regulation states that a person can be admitted to hospital

“(b) on the order or under the authority of an oral and maxillofacial surgeon who is a member of the dental staff;

(b.1) if the person is being admitted for treatment by a dentist who is a member of the dental staff other than an oral and maxillofacial surgeon, on the joint order of the dentist and a physician who is a member of the medical staff; or”

resources challenges, foster continuity of care, promote interprofessional collaboration and increase access to services.

A major matter of concern for HPRAC was whether the proposed expansion of the NP scope of practice can be undertaken while maintaining patient safety, and the influence of educational programs on this prerequisite. Ontario's current NP education programs are recognized as having a high quality and providing NPs with the training required for the current NP-PHC role. The neonatal education programs already meet or exceed international standards. Other developing acute care NP educational programs are expected to meet exacting standards for existing and proposed acute care roles. Even in the neophyte specialty of NP-Anaesthesia, where educators, professionals from several disciplines, and providers are collaborating – on a relatively urgent basis – on the development of a specialized curriculum, HPRAC was impressed with the commitment and exactitude of those involved.

HPRAC was also reassured by the findings of the literature and jurisdictional reviews. Randomized controlled trials on the NP role, along with observational studies, provide virtually no evidence of patient harm arising from NP practice. A close look at three leading jurisdictions in NP regulation shows that the kinds of changes the CNO is seeking have already been implemented elsewhere.

Having concluded that a significant expansion of the NP scope of practice is justified, the question for HPRAC became how best to achieve this. The CNO did not seek, nor did anyone propose, granting NPs unfettered access to the relevant controlled acts. One of the underlying problems is that, in the past, reliance has been placed on legislation and regulations to set limitations on the exercise of controlled acts. As HPRAC has observed previously<sup>84</sup>, the regulation-making process is cumbersome and has not proven able to deliver timely changes in requirements to keep up with evolving technologies, clinical practices and population needs. The process of developing and passing legislation is even more unwieldy. A more flexible way must be found to balance access to controlled acts with safeguards to protect the public from the risk of harm.

## **Toward an Enabling Regulatory Framework**

**HPRAC is proposing a fundamental change in Ontario's approach to the regulation of health professionals, within the *RHPA* construct. It couples an expanded professional scope of practice that is confirmed in both statute and regulation, with appropriate standards, limitations and conditions established and enforced by the regulatory college for the performance of controlled acts and the conduct of the profession. It imposes a high standard of duty and care on the regulatory college. It demands interprofessional collaboration. And in the end, it protects the public interest.**

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<sup>84</sup> HPRAC, *Regulation of Health Professions in Ontario: New Directions* (April 2006), pp.62-71.

An enabling regulatory framework would replace the current approach that constrains NP practice mainly through restrictive provisions built into the laws and regulations that make controlled acts available to NPs. The revised framework will permit NPs to maximize their contribution to health care delivery based on their competencies and within their professional and individual scope of practice. It will also enhance the role of the CNO to more actively regulate the NPs and protect the public.

Fundamental to this framework is the commitment of the College to place the necessary, stringent conditions on its members respecting the College's standards of practice, and action by government to remove specific directions to the profession from the statute and regulations under the statute. It also reflects HPRAC's previous concerns about the ability of the regulation-making process to be current with state-of-the-art practice, and its inability to be timely with respect to regulatory change approvals.

HPRAC recognizes that many if not most of the participants in the consultations were nurses, NPs and nurse educators, who expressed broad support for the proposals in the CNO submission. HPRAC also considered the views of other important stakeholders as summarized in the section *Perspectives from the Consultations*. Some of these participants expressed full or partial support for the CNO's submission, while others raised concerns about the proposed enhancements to the NP scope of practice. All of the comments, concerns and suggestions compiled during the review were weighed in developing the recommendations in this report.

On balance, HPRAC has concluded that the concerns raised do not undermine the case for a new approach, grounded in the creation of an enabling regulatory framework. However, HPRAC acknowledges that, in order to arrive at this conclusion, an element of trust is required: trust in the basic principles of self-regulation under the *RHPA* and trust in the ability of the regulatory college – the CNO – to protect the public interest.

The regulatory framework HPRAC proposes rests on the foundation of health professions regulation as set out in the *RHPA*: the self-governance of professions. As HPRAC has previously observed:

Self-regulation in Ontario's health professions is a partnership in which government confers certain rights and responsibilities to a profession that has the demonstrated capabilities to administer them. The underlying premise is that self-regulation preserves the public interest in several ways: it enlists practitioners in setting enforceable standards for the professions, relies on their expertise to develop measures to protect the public on the verge of technological or other advancements affecting the profession, delegates governing bodies to resolve complaints, and addresses other matters related to a member's inability or conduct.<sup>85</sup>

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<sup>85</sup> HPRAC, *Regulation of Health Professions in Ontario: New Directions* (April 2006), p.62.

The new approach is also founded on two other core elements of the *RHPA* – the system of controlled acts and overlapping rather than exclusive scopes of practice.

While the *RHPA* was a momentous step forward in regulating health professions when it was enacted in 1991, so much so that other jurisdictions are still trying to emulate the model, it was designed to be “living legislation”. HPRAC considers that the regulatory framework must continue to evolve to meet the changing needs of the 21<sup>st</sup> century. HPRAC’s approach therefore builds on the principles of the *RHPA*. It recommends ways to make the regulatory framework more flexible and adaptable, while strengthening the accountability of the regulatory college and its members.

The proposed enabling regulatory framework will:

- establish a broad professional scope of practice for NPs under the *Nursing Act* and regulations, and
- place responsibility for setting appropriate and rigorous standards, limitations and conditions on practice, which could necessarily be changed over time, with the CNO.

The approach provides for the evolution of NP practice over time – consistent with “changes in practice environments, advances in technology and other emerging issues” – through standards, limitations and conditions adopted by the CNO without recourse to changes in legislation or regulations. This is in line with recent amendments to the *RHPA* that make it an object of the regulatory colleges to respond to these trends.<sup>86</sup>

Increased flexibility is balanced with an enhanced role for the CNO to more actively and rigorously regulate the profession in the public interest and ensure appropriate accountability measures to protect the public from the risk of harm. Under this model, the CNO will be equipped with new tools and levers to address issues of continuing competence and quality assurance. As well, to encourage interprofessional collaboration, the framework requires the CNO to involve other professions in the development of standards, limitations and conditions for the NP scope of practice.

HPRAC is confident that this option delivers a measured approach with the appropriate checks and balances to protect the public.

The new balanced approach means the scope of practice for NPs will adapt in a timely way to current needs and gaps in services as well as future requirements and NPs’ competencies. It mandates a more forceful and active role for the CNO as a dynamic regulator of the nursing profession. It makes the regulation of NPs simpler, clearer and more transparent. And it brings Ontario’s legislative framework for NP practice into line, or in the forefront, of other leading jurisdictions in Canada and the United States.

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<sup>86</sup> See clause 10 of the new objects for health regulatory colleges under the *Regulated Health Professions Act*, to take effect on June 4, 2009: “To develop, establish, and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues.”

A transition period will be required before the new model for regulating NPs in Ontario is up and running. During this time the CNO must put in place the necessary programs and policies and establish detailed standards, limitations and conditions through interprofessional consultation. Ontario educational institutions are already updating their NP training programs, a process that will ensure that curriculum content supports the core competencies necessary to meet the CNO's registration requirements.

HPRAC proposes a five-year review of the new regulatory framework and its implementation to ensure that this approach is effective in serving the public interest through safe and effective NP practice.

HPRAC contemplates that this new approach will have wider significance, given the emergence of advanced practice in several health professions. It provides for a new way of doing business that other regulatory colleges may find relevant.

HPRAC sees the enabling regulatory framework for NPs as the next stage in the development of professional self-regulation in Ontario, and one that will not be unique to the profession of nursing. It will be up to all those who are committed to the principles of self-regulation to make this new model work.

## **Recommendations and Implementation Proposals**

### **Simplicity and Clarity in Regulation**

- 1. Recommendation: Consider rewriting Ontario Regulation 275/94 under the *Nursing Act, 1991*, and substituting a revised version to make it clearer and easier to follow.**

Throughout HPRAC's consideration of this request from the Minister, many individuals and organizations spoke of the lack of clarity and apparent confusion in the CNO's proposals for statutory and regulation changes. To HPRAC, this was not surprising, since HPRAC members had been attempting to find a logical thread through the legislation and regulations governing nurses in Ontario. Over the years a perplexing array of additions, deletions and alterations have built up, with the result that the regulatory framework has become almost incomprehensible to nurses, members of other professions and the public.

In presenting its case for change, the CNO had to explain numerous inconsistencies. To take just one example, the word "class" is used in two distinct and different ways. In one circumstance it describes professional designations, such as whether a member is a registered nurse or a registered practical nurse; in another, it describes types of registration groupings, such as whether a registrant is qualified for general, temporary or special assignment membership. The confusion is increased by reference in the regulations to nurse practitioners as registered nurses in the "extended class", implying they form a third class of nurses, although the Act says there are only two classes –

RNs and RPNs. To an external observer, these are apples and oranges, but difficult to understand when they are part of provincial law. While Newfoundland and Labrador adopted the title nurse practitioner in 2001 and Alberta in 2002, Ontario continued with the awkward designation “Registered Nurse in the Extended Class” until 2007, when new legislation recognized the nurse practitioner title, a term that is used in the literature, in health care facilities and on the street.

Further, the regulations set out a bewildering set of registration requirements, where one cannot readily ascertain the pertinent rules for registered nurses, registered practical nurses or nurse practitioners.

HPRAC maintains that the law should be plain to all parties. As the health care system puts more emphasis on interprofessional care, it is especially important for scope of practice and other regulatory provisions to be readily understood, not only by the professionals regulated but by other professionals with whom they collaborate. In this case, the law is not clear. HPRAC recommends that the Minister consider withdrawing completely Ontario Regulation 275/94, and replacing it with a revised version that provides clarity to any and all who read it.

**2. Recommendation: Amend the *Nursing Act, 1991* to list all controlled acts NPs are authorized to perform.**

Currently, some controlled acts authorized to NPs are set out in the *Nursing Act, 1991* while others are set out in regulations under the Act (O.Reg. 275/94 – General). This amendment will make it possible for NPs, other health professionals or members of the public, to readily determine the full ambit of controlled acts authorized to nurses by referring to the *Nursing Act*. As a result, the simplicity, clarity and transparency of NP regulation will improve. Regulations under the Act may prescribe specific conditions for the controlled acts, such as forms of energy NPs are authorized to order and apply.

This change will also clarify the ability of NPs to order a RN or RPN to perform the controlled acts authorized to NPs. NPs currently cannot delegate the performance of a controlled act authorized only by the regulations.

**To implement Recommendation 2, the following legislative changes are proposed:**

[1.] That the words “certain registered nurses” in the title preceding section 5.1 of the *Nursing Act, 1991* be deleted and replaced with the words “nurse practitioners”.

[2.] That section 5.1 (1) of the *Nursing Act, 1991* be repealed and the following substituted:

5.1 (1) In the course of engaging in the practice of nursing, a member who is a nurse practitioner in accordance with the regulations is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following acts:

1. Communicating a diagnosis identifying a disease or disorder as the cause of a person's symptoms.
2. Performing a procedure on tissue below the dermis or below the surface of a mucous membrane.
3. Applying or ordering the application of a form of energy prescribed by regulations under this Act.
4. Prescribing a drug prescribed by regulations under this Act.
5. Administering, by injection or inhalation, a drug that the member may prescribe under paragraph 4.
6. Putting an instrument, hand or finger,
  - i. beyond the external ear canal,
  - ii. beyond the point in the nasal passages where they normally narrow,
  - iii. beyond the larynx,
  - iv. beyond the opening of the urethra,
  - v. beyond the labia majora,
  - vi. beyond the anal verge, or
  - vii. into an artificial opening into the body.
7. Setting or casting a fracture of a bone or a dislocation of a joint.

Note: On a day to be named by proclamation of the Lieutenant Governor, section 5.1 is amended by the Statutes of Ontario, 2007, chapter 10, Schedule R, section 16 by adding the following paragraph:

8. Treating, by means of psychotherapy technique delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgment, insight, behaviour, communication or social functioning.

## **Titles**

- 3. Recommendation: Standardize terminology about nurse practitioners in all laws and regulations by eliminating the use of the terms “registered nurse (extended certificate)”, “registered nurse (extended class)” and “registered nurse in the extended class” in favour of the term “nurse practitioner”.**

HPRAC has previously endorsed the title “nurse practitioner” as the recognized designation for a RN with an extended certificate.<sup>87</sup> While s. 11(1) of the *Nursing Act* has been amended to protect the title of “nurse practitioner”, continued use of the terms “registered nurse (extended certificate)”, “extended class nurses” and “registered nurse

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<sup>87</sup> HPRAC, *Regulation of Health Professions in Ontario: New Directions* (April 2006), pp.60-61.

(extended class)” in the Act and regulations makes this legislation unnecessarily difficult to understand. Changes to the use of these terms in other legislation that impacts nurse practitioners should similarly be made. In its implementation proposals for this recommendation, HPRAC has initially identified certain changes to regulations and statutes to advance clarity. Substantive changes that address NP scope of practice are addressed in further recommendations.

**To implement Recommendation 3, numerous changes to statutes and regulations as currently worded are proposed:**

[3.] That the words “certain registered nurses” in the title preceding section 5.1 of the *Nursing Act, 1991* be deleted and replaced with the words “nurse practitioners”.

[4.] That the definition of “registered nurse in the extended class” in section 0.1 of Part I of Ontario Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

“nurse practitioner” means a member who holds a certificate of registration as a nurse practitioner;

[5.] That section 3 of Ontario Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

**3.** (1) A person may apply for a certificate of registration as a registered nurse, registered practical nurse or nurse practitioner by completing an application form supplied by the Executive Director and submitting it along with the required application fee.

(2) Upon receipt of the required registration fee, the Executive Director shall issue a certificate of registration to a person,

(a) if the Executive Director proposes to register the person under clause 15 (1) (a) of the Health Professions Procedural Code; or

(b) if authorized or directed by a panel of the Registration Committee to issue the certificate to the person. O. Reg. 39/98, s. 3; O. Reg. 158/00, s. 1 (3).

[6.] That the title preceding section 8.3 of Ontario Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

**MUTUAL RECOGNITION FOR NURSE PRACTITIONERS**

[7.] That subsection 8.3 (1) and of Ontario Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

**8.3** (1) Subject to subsections (3) and (5), an applicant who meets all of the following requirements shall have met the requirements for a certificate of registration as a nurse practitioner:

1. The applicant must have been registered to practise nursing in another province or territory in Canada with a certificate or licence considered by the Registration Committee to be one which was equivalent to a nurse practitioner.

2. The applicant must satisfy either the Executive Director or the Registration Committee that the applicant previously practised one of the nurse practitioner

specialties recognized by this Regulation, in another province or territory in Canada.

3. If any of the nursing programs which the applicant completed in order to be permitted to practise one of the nurse practitioner specialties recognized by this Regulation were not university programs, the applicant must have successfully completed any additional education and training determined by the Registration Committee.

4. The applicant must have successfully completed the examinations for that nurse practitioner specialty referred to in subparagraph 3 i of subsection 11.1 (1).

5. The applicant must provide written confirmation from the regulatory body for nursing in each province or territory in Canada in which the applicant practised during the five years prior to the date of application verifying that the applicant, while registered, met that regulatory body's continuing competence or quality assurance requirements.

6. The applicant,

i. in the opinion of the Executive Director or the Registration Committee, as the case may be, must have no additional need for education or experience based on evidence of safe nursing practice in a nurse practitioner specialty recognized by this Regulation during the preceding year, or

ii. must have successfully completed any additional education requirements determined by the Registration Committee.

7. The applicant must meet the requirements of section 5. O. Reg. 502/07, s. 1.

[8.] That the title preceding section 11.1 of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

CERTIFICATES OF REGISTRATION FOR NURSE PRACTITIONERS

[9.] That the first paragraph of subsection 11.1 (1) of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

**11.1** (1) the following are non-exemptible registration requirements for a certificate of registration as a nurse practitioner:

[10.] That subclause 11.1 (1) 1., iii of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

iii. must hold or have held a certificate of registration as a nurse practitioner in another jurisdiction which the Registration Committee is satisfied is equivalent to a certificate of registration as a nurse practitioner.

[11.] That subsection 11.1 (2) of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

2. The applicant,

i. must have graduated from an Ontario university program for preparing nurse practitioners for a specialty which program was, at the time the applicant graduated, approved by Council,

- ii. must have graduated from a university program in another province or territory in Canada or one of the United States of America for preparing nurse practitioners for a specialty program which was, at the time the applicant graduated, approved by Council,
- iii. must have graduated from a university nursing program that the Registration Committee is satisfied was, at the time the applicant graduated, equivalent to a current Ontario university program referred to in subparagraph i, or
- iv. subject to subsection (4), must have graduated from a nursing program other than one referred to in subparagraphs i, ii or iii and satisfied the Registration Committee that he or she has obtained additional nursing education, training or experience that, together with the education provided by the nursing program from which he or she graduated, is equivalent to the education currently provided to a graduate of an Ontario university program referred to in subparagraph i.

[12.] That subparagraphs 11.1 (1) 3., 11.1 (2), 11.1 (3) of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

- 3. At the time of successfully completing all other requirements for registration as nurse practitioner or at the time of application, whichever is later, the applicant must,
    - i. successfully complete,
      - A. whatever examinations are approved by Council for that specialty for which the applicant had successfully completed the program referred to in paragraph 2, or
      - B. whatever examinations are set by or administered by the College for that specialty for which the applicant had successfully completed the program referred to in paragraph 2, and
    - ii. satisfy the Registration Committee that, during the past five years,
      - A. he or she has practised nursing for at least two years,
      - B. his or her nursing practice was performed safely, and
      - C. for at least one of those years, he or she practised in a nursing role that required him or her to use advanced knowledge and decision-making skills in assessment, diagnosis and health care management. O. Reg. 502/07, s. 2.
- (2) An applicant who graduated from an Ontario university program for preparing nurse practitioners that was, at the time the applicant graduated, approved by the Council of Ontario University Programs in Nursing and by the Senate or Governing Council of the University that offered the program, is deemed to have met the requirement of subparagraph 2 i of subsection (1).
- (3) The following are additional registration requirements for a certificate of registration as a nurse practitioner:
- 1. The applicant is able to demonstrate the ability to speak and write either English or French with reasonable fluency.

2. The applicant is a Canadian citizen or a permanent resident of Canada or authorized under the *Immigration and Refugee Protection Act* (Canada) to engage in the practice of nursing.

3. An applicant who graduated from a program referred to in subparagraph ii, iii or iv of paragraph 2 of subsection (1) must, if the program was located outside Ontario, show proof of registration, or eligibility for registration, as the equivalent of a nurse practitioner, in the jurisdiction in which the program was located.

[13.] That subsections 11.2 (1), (2) and (3) of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

**11.2** (1) There shall be the non-acute care nurse practitioner specialty of Primary Health Care.

(2) There shall be following acute care nurse practitioner specialties:

1. Paediatrics
2. Adult
3. Anaesthesia
4. Neonatal

(3) An applicant being issued a certificate of registration as a nurse practitioner shall also be issued a specialty certificate for that specialty for which the applicant successfully completed the examinations referred to in subparagraph i of paragraph 3 of subsection 11.1 (1).

[14.] That subsections 11.3 (1), (2) and (3) of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

**11.3** (1) Where a member's certificate of registration as a nurse practitioner is suspended or revoked, any specialty certificate issued to the member is automatically suspended or revoked until the suspension or the revocation is lifted or removed.

(2) Where a former member's certificate of registration as a nurse practitioner is reinstated, any specialty certificate the former member held at the time of the suspension or revocation shall also be reinstated unless otherwise directed by the committee that determined that the reinstatement should take place.

(3) Where a member holding a certificate of registration as a nurse practitioner resigns that certificate, any specialty certificate issued to the member is automatically revoked.

[15.] That subsections 11.4 (1) of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

**11.4** (1) Subject to subsections (2), (3), (4) and (5), a member holding a certificate of registration as a nurse practitioner shall use the title "Nurse Practitioner" or the abbreviation "NP" when practising in that role.

[16.] That subsections 11.4 (6) of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

(6) Except as permitted by the Act or this Regulation, no other title, designation, variation or abbreviation shall be used by a member holding a certificate of registration as a nurse practitioner.

[17.] That the first paragraph of subsection 11.5 (1) of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

**11.5** (1) A person who meets the following requirements is entitled to attempt the examinations that must be successfully completed as a requirement for the issuance of a certificate of registration as a nurse practitioner.

[18.] That subsection 11.5 (6) of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

6. The person must not have attempted on three previous occasions the examinations for a specialty which would, if successfully completed, have met the examination requirement for registration as a nurse practitioner.

[19.] That the first paragraph of section 17 of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

**17.** For the purpose of clause 5 (1) (a) of the Act, a nurse practitioner may perform any of the following procedures if he or she meets all of the conditions set out in subsection 15 (5):

[20.] That section 18 of Regulation 275/94 under the *Nursing Act, 1991* be amended by deleting the words “registered nurse in the extended class” and substituting the words “nurse practitioner”.

[21.] That section 1. (1) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the definition of “attending registered nurse in the extended class” and substituting the following:

“attending nurse practitioner” means a member of the nursing staff registered as a nurse practitioner who attends a patient in the hospital;

[22.] That section 1. (1) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the definition of “extended class nursing staff” and substituting the following:

“nurse practitioner staff” means those nurses who are registered as nurse practitioners in a hospital,  
 (a) who are employed by the hospital and are authorized to diagnose, prescribe for or treat out-patients in the hospital,  
 (b) who are not employed by the hospital and to whom the board has granted privileges to diagnose, prescribe for or treat out-patients in the hospital.

(Note: Substantive amendments to this section follow in a later recommendation.)

[23.] That section 1. (1) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the definition of “registered nurse in the extended class” and substituting the following:

“nurse practitioner” means a member of the College of Nurses of Ontario who is registered as a nurse practitioner under the *Nursing Act, 1991*.

- [24.] That paragraph 4. (1) (c) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner”.
- [25.] That clauses (i), (ii), (iii), (iv), (v), and (vii) of subsection 7. (2) (a) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner” wherever they occur.
- [26.] That paragraphs 7 (2) (a) and 7 (2) (b) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner” wherever they occur.
- [27.] That the definition of “nursing staff” in subsection 7.1 (2) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner” wherever they occur.
- [28.] That paragraph 11 (3) (a) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner”.
- [29.] That subsection 14 (2) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “registered nurse in the extended class” and substituting the words “nurse practitioner”.
- [30.] That subsection 18 (1) and 18 (3) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner” wherever they occur.
- [31.] That paragraph 19 (5) (a) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “registered nurses in the extended class” and substituting the words “nurse practitioners”.
- [32.] That paragraph 19 (5) (c) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner”.
- [33.] That paragraph 19 (5) (h) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner”.
- [34.] That subsection 22 (6) (a) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner”.
- [35.] That subsections 24 (1), 24 (2), 24 (3) (a), and 24 (3) (b) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “registered nurse in the extended class” wherever they occur, and substituting the words “nurse practitioner”.
- [36.] That Section 1 of the *Immunization of School Pupils Act* be amended by repealing the definition of "registered nurse in the extended class" and substituting the following:

"nurse practitioner" means a member of the College of Nurses of Ontario who is registered as a nurse practitioner under the *Nursing Act, 1991*.

[37.] That the definition of “registered nurse in the extended class” in Subsection 1 (1) of the *Health Protection and Promotion Act* be repealed and the following substituted:

"nurse practitioner" means a member of the College of Nurses of Ontario who is registered as a nurse practitioner under the *Nursing Act, 1991*.

[38.] That Section 26 of the *Health Protection and Promotion Act* be amended by deleting the words "or registered nurse in the extended class" after "physician", and substituting the words “or nurse practitioner”.

[39.] That Section 30 of the *Health Protection and Promotion Act* be amended by deleting the words "or registered nurse in the extended class" after "physician" and substituting the words “or nurse practitioner”.

[40.] That Subsections 34 (1) and 34 (2) of the *Health Protection and Promotion Act* be amended by deleting the words "registered nurse in the extended class" and substituting the words “nurse practitioner” wherever they occur.

[41.] That Subsection 34 (4) of the *Health Protection and Promotion Act* be amended by deleting the words "or registered nurse in the extended class" and substituting the words “or nurse practitioner”.

[42.] That Subsection 37 (1) of the *Health Protection and Promotion Act* be amended by deleting the words "or registered nurse in the extended class" after "physician" and substituting the words “or nurse practitioner”.

[43.] That Subsection 38 (2) of the *Health Protection and Promotion Act* be amended by deleting the words "or registered nurse in the extended class" after "physician" and substituting the words “or nurse practitioner”.

[44.] That Subsection 40 (1) of the *Health Protection and Promotion Act* be amended by deleting the words "or registered nurse in the extended class" after "physician" and substituting the words “or nurse practitioner”.

[45.] That the first paragraph of section 37.1 of R.R.O. of the *Vital Statistics Act* be amended by deleting the words "registered nurse who holds an extended certificate of registration under the *Nursing Act, 1991*" and substituting the words “nurse practitioner”.

[46.] That subclause 7.1 (2) (b) Ontario Regulation 107/96 under the *Regulated Health Professions Act, 1991* be repealed and the following substituted:

(b) a member of the College of Nurses of Ontario who is a nurse practitioner, with respect to ordering the application of soundwaves for diagnostic ultrasound, or

[47.] That clause 8. (1) (3) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by deleting the words “registered nurse in the extended class” and substituting the words “nurse practitioner”.

[48.] That clause 8. (1) (4) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by deleting the words “registered nurse in the extended class” and substituting the words “nurse practitioner”.

[49.] That clause 8. (1) (5) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by deleting the words “registered nurse in the extended class” and substituting the words “nurse practitioner”.

[50.] That clause 8 (1) (6.1) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by deleting the words “registered nurse in the extended class” and substituting the words “nurse practitioner”.

[51.] That clause 8 (1) (7.1) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by deleting the words “registered nurse in the extended class” and substituting the words “nurse practitioner”.

[52.] That subclause 22 (2) (b) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by deleting the words “registered nurse in the extended class” and substituting the words “nurse practitioner”.

### **Scope of Practice Statement**

#### **4. Recommendation: Make no changes to the scope of practice statement as set out in Section 3 of the *Nursing Act, 1991*.**

Section 3 of the *Nursing Act* currently defines the scope of practice for nursing, including the practice of NPs, RNs and RPNs, as follows:

The practice of nursing is the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function.

HPRAC carefully considered the statement to ensure that it appropriately describes the functions of all members of the College of Nurses. The Council notes that no changes were proposed by any proponent. HPRAC has concluded that the current definition is broad enough to encompass the full range of nursing activities in Ontario, including that of NPs.

### **Specialty Certification and Categories of Specialty**

#### **5. Recommendation: Maintain the current requirement in the regulations for NPs to have a specialty certificate and also continue the current specialty categories.**

##### Primary Health Care and Acute Care (Paediatrics and Adult) Specialties

Current regulations under the *Nursing Act* require each NP to be issued both an extended certificate of registration and a specialty certificate for one of the following four specialties:<sup>88</sup>

<sup>88</sup> Ontario Regulation 275/94 ss.11.2 (1)-(3) under the *Nursing Act, 1991*.

- the non-acute specialty of Primary Health Care; or
- the acute care specialties of: Paediatrics; Adult; or Anaesthesia.

NPs with one specialty certificate may be issued one or more additional specialty certificates, if they meet all of the applicable requirements.<sup>89</sup> These provisions protect the public by allowing the CNO to establish entry to practice requirements for NPs that are specific to the area of specialty in which they will practice.

The categories are consistent with recommendations by the CNPI that reflect a national consensus within the nursing profession. They are also the basis of current efforts by the CNA to establish corresponding national licensing examinations. HPRAC agrees with the conceptual approach behind these categories, which focuses on the patient population independent of practice setting. This approach allows NPs, in particular acute care NPs, the flexibility to respond to patient needs both in and out of the hospital setting, facilitating continuity of care. These categories were recently introduced (by amendment to the General Regulation 275/94 effective August 27, 2007<sup>90</sup>) and there is no compelling reason to change them.

#### Acute Care – Anaesthesia

However, with respect to the NP-Anaesthesia category, HPRAC advises the Minister to defer implementation until work has been completed to define the role, identify the required competencies and develop and deliver an educational program.

HPRAC considered whether the current acute care specialty of NP-Anaesthesia should be removed from the regulation. It was not a category recommended by the CNPI, was not included in the CNO's submission and was raised by only a few participants in the consultations.

Although the NP-Anaesthesia is a new role in Ontario – indeed in Canada – nurses are providing anaesthesia care in more than 100 countries. This new specialty was established in Ontario by regulation in August 2007 but details on its scope and nature are still unclear to many.

As this category was not contemplated by the CNPI, no core competencies have been identified. The CNO has acknowledged that more work must be done to develop the entry-to-practice requirements for this role. Educators advise that programs to prepare NPs for this specialty are in their infancy. The stakeholders who did address the issue were concerned about the lack of clarity as to the nature and extent of the new role and the availability of education programs to prepare individuals to perform it.

HPRAC has concluded that because of the highly technical and specialized nature of the NP-Anaesthesia role, and the particular didactic and clinical training required, it

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<sup>89</sup> Ontario Regulation 275/94 s.11.2 (5) under the *Nursing Act, 1991*.

<sup>90</sup> O.Reg. 502/07, amending the Ontario Regulation 275/94 under the *Nursing Act, 1991*.

should remain a separate acute care specialty under the regulation. As a result, specific entry-to-practice requirements will be required to practice as a NP-Anaesthesia. Nurses play a major role in anaesthesia care in many other countries and HPRAC is convinced that this role can work in Ontario if developed properly. However, HPRAC recommends that this specialty not be part of the initial implementation of the new regulatory framework. The CNO should undertake additional preparatory work, in consultation with other relevant professions and educators, and make recommendations to the Minister to clarify the role and ensure its successful introduction.

While there may be some nurses residing in Canada who hold credentials as Certified Registered Nurse Anaesthetists from the United States, none are currently practicing autonomously in any Canadian jurisdiction, nor may they legally use the Nurse Practitioner-Anaesthesia title in Ontario at this time. Therefore the impact of delaying the implementation of this specialty would be minimal.

**6. Recommendation: Add a new acute care specialty of “Neonatal” (NP-Neonatal).**

Acute Care – Neonatology

Neonatal NPs are well established in Ontario: for example, McMaster University has had a world renowned program for over 20 years.

HPRAC is persuaded that a new specialty category is warranted, as the NP-Paediatrics category is not appropriate for neonatal NPs. Neonates represent “a specific population with entirely different patho-physiological disease processes and needs in comparison to [those] of the young infant and child.”<sup>91</sup> It would not make sense to expect someone trained as a neonatal NP to function safely and effectively in a paediatric setting – or conversely, to expect someone trained as a paediatric NP to perform the neonatal NP role.

While recognizing that the CNPI did not recommend neonatology as a separate category of NP specialty, HPRAC believes that the addition of this new category is consistent with the life-time continuum reflected by the other categories. It represents an earlier, distinct phase of development – the foetal and neonatal period.

**To implement Recommendation 6, the following changes in the regulation are proposed:**

[53.] That Ontario regulation 275/94 under the *Nursing Act, 1991* be amended by adding the following subparagraph to subsection (2) of section 11.2:

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<sup>91</sup> Written submission of Dr. Bosco A. Paes, Division Head of Neonatology and Clinical Director of Neonatal Intensive Care, McMaster Children’s Hospital, to Ms. Jenna Hofbauer, CNO dated August 1, 2007 (copied to Barbara Sullivan, Chair, HPRAC).

4. Neonatal  
(See also recommendation 13)

### **Title Protection**

#### **7. Recommendation: Extend title protection to the proposed new specialty, “NP-Neonatal”**

The regulations under the *Nursing Act* allow NPs to use titles corresponding to the four categories of specialty certificate.<sup>92</sup> From a public protection vantage point, this helps to ensure that NPs who hold themselves out as specialty NPs do in fact hold the credentials required for that designation. HPRAC recommends extending to the proposed new specialty of NP-Neonatal the same level of title protection as now applies to the existing specialties.

#### **To implement Recommendation 7, the following changes to the regulation are proposed:**

[54.] That Ontario regulation 275/94 under the *Nursing Act, 1991* be amended by adding the following subparagraph to subsection (2) of section 11.4:

(5.1) A member holding a Neonatal specialty certificate may use the title “Nurse Practitioner — Neonatal” or the abbreviation “NP — Neonatal”, when practising in that role.

### **Individual Scope of Practice**

#### **8. Recommendation: Amend the *Nursing Act, 1991* to allow nurse practitioners to deliver only health care services within the specialty for which they hold a specialty certificate and within that specialty, only those health care services for which they are academically prepared and for which competency has been established and maintained, and make nurse practitioners responsible under the law for identifying the limits of their educational preparation and competencies, and for resolving situations beyond their expertise by consulting with, or referring patients to, other health care providers.**

#### Practice within Specialty Certificate

The current regulatory framework does not expressly require NPs to practice only within the specialty or specialties for which they hold certificates, or within the sphere of activities for which they have adequate educational preparation.<sup>93</sup>

<sup>92</sup> Ontario Regulation 275/94 ss.11.4 (1)-(5) under the *Nursing Act, 1991*.

<sup>93</sup> By comparison, by O.Reg. 865/93 under the *Medicine Act, 1991*, physicians: (1) must be certified by either the Royal College of Physicians and Surgeons of Canada or by the College of Family Physicians of Canada (s.3 (1) paragraph 4); and (2) it is a term, condition and limitation of a physician’s certificate of registration that he or she, “practice only in the areas of medicine in which the holder is educated and experienced” (s.2 (5)).

HPRAC recommends an amendment to the *Nursing Act* to make it explicit that a NP who holds a specialty certificate in one category cannot practice as a NP in a different specialty without the corresponding certification. The proposed change is consistent with the concept of specialty certificates and the underlying rationale that they protect the public by allowing the CNO to establish entry-to-practice requirements tailored to the areas of specialty in which NPs will practice. This amendment to the Act will resolve an ambiguity that arises from the current regulations. NPs are not allowed to refer to themselves as specialists in any of the four categories without the corresponding specialty certificate. But it is unclear whether NPs can practice in a specialty area without certification as long as they do not refer to themselves as specialists.

This legislative change would achieve the intent of a provision in the CNO's proposed *Practice Standard: Performance of Controlled Acts by Nurse Practitioners*,<sup>94</sup> to the effect that: "When performing a controlled act, a Nurse Practitioner must practice within the limits of knowledge and experience of the specialty for which the Nurse Practitioner holds a specialty certificate." The CNO proposed that this Practice Standard be incorporated by reference into the General Regulation under the Act, giving it the force of law.<sup>95</sup> HPRAC's recommendation is that this requirement be incorporated directly into the *Nursing Act, 1991* for greater clarity.

#### Practice within Educational Preparation and Competencies

The areas of specialty are quite broad. Once a NP has received a specialty certificate, the question arises as to what activities may be undertaken within that specialty area. The issue here is the individual scope of practice within which the NP works on a day-to-day basis. This issue arises whether or not the area of practice may be characterized as a distinct sub-specialty such as oncology or cardiology.

HPRAC's objective is to protect the public interest in access to safe and effective health care delivered by NPs. The recommended provisions will make it clear that NPs must restrict their practice to those health care services for which they are prepared academically, and have maintained competence.

Throughout the consultations, those supporting the CNO's proposal for a more permissive legislative framework argued that NPs could be relied upon to confine their individual practices to the sphere of activities supported by their educational preparation and competencies. The CNO's existing Practice Standard, *Registered Nurses in the Extended Class*, similarly requires NPs to "know and practice in accordance with the standards relevant to their practice area".<sup>96</sup>

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<sup>94</sup> College of Nurses of Ontario, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class Appendix C, August 2007.

<sup>95</sup> College of Nurses of Ontario, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class Appendix B, August 2007.

<sup>96</sup> CNO Practice Standard, *Registered Nurses in the Extended Class* (2005), Pub. No. 41038, p.3; by regulation issued under the *Nursing Act*, it is an act of professional misconduct for a NP to, "contraven[e] a standard of practice

The current statutory framework established for NPs in the state of Oregon includes these provisions. The Oregon State Board of Nursing has found these requirements to be essential tools, both for communicating to NPs that they must confine their practices to areas where they have the educational preparation and competencies to provide safe and effective care, and for taking disciplinary action against those who fail to do so.<sup>97</sup> HPRAC has concluded that inserting comparable provisions in the *Nursing Act* will establish boundaries for a NP's individual scope of practice appropriate to protecting the public interest – and do so with more clarity, permanence and prominence than the current or proposed CNO Practice Standards. At the same time, the recommended provisions are broad enough to allow NPs to expand their individual scopes of practice over time while remaining within their specialty. They are also broad enough to permit the CNO to establish detailed standards, limitations and conditions for NP practice as necessary.

### Enforcing Boundaries of Individual Scope of Practice

These recommendations on Individual Scope of Practice place responsibility squarely with the CNO to enforce practice boundaries at the specialty level. The CNO must impose appropriate entry-to-practice requirements for each of the specialty categories and refuse specialty certification to applicants who fail to meet those requirements.

The question remains, however, how to enforce the boundaries of individual scope of practice within these specialty categories. That is, once NPs are registered, what will ensure that they practise within the boundaries of their educational preparation and competencies?

These recommendations communicate clearly and prominently – in the *Nursing Act* itself – that NPs must confine their practices to the areas where they have educational preparation and competencies, and that there are mechanisms to support the effectiveness of the recommended changes.

First and foremost is self-regulation by NPs themselves to control their own individual practice boundaries, consistent with the self-regulatory model that guides the profession.

The practice setting provides a further layer of reassurance. The places where NPs work generally have established policies and procedures to ensure that NPs possess the necessary qualifications to undertake the tasks they are employed or otherwise engaged to perform. If a NP is involved in highly intrusive procedures, these activities will

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of the profession or [fail] to meet the standard of practice of the profession”: Professional Misconduct Regulation, s.1 para.1.

<sup>97</sup> Oregon's provisions [Oregon State Administrative Rules, Division 50, Nurse Practitioner Scope of Practice, 851-050-0005(8)] are as follows: “The nurse practitioner will only provide health care services within the nurse practitioner’s scope of practice for which he/she is educationally prepared and for which competency has been established and maintained. Educational preparation includes academic coursework, workshops or seminars, provided both theory and clinical experience are included. The nurse practitioner is responsible for recognizing limits of knowledge and experience and for resolving situations beyond his/her nurse practitioner expertise by consulting with or referring clients to other health care providers.”

generally be carried out in the hospital setting, where the credentialing of health care providers, including NPs, is undertaken with care reflecting the risk of harm to patients. In or out of the hospital setting, health care teams may choose to establish collaborative practice agreements, or similar tools, to ensure clarity regarding roles, responsibilities and accountability measures.

Other mechanisms rest with the College of Nurses itself. The CNO has established quality assurance requirements, currently being revised, that NPs must respect. It also has statutory responsibilities to hold complaints, discipline and incapacity proceedings where necessary. Appropriate action must be taken in response to patient complaints or other information that a NP is failing to practice in accordance with relevant standards and other expectations.

**To implement Recommendation 8, the following changes to the Act are proposed:**

[55.] That the *Nursing Act, 1991* be amended by adding the following section:

**Individual scope of practice for nurse practitioners**

5.2 (1) A nurse practitioner shall provide health care services as a nurse practitioner:

- (a) only within the specialty for which he or she holds a specialty certificate; and
- (b) within that specialty, only those health care services for which he or she is educationally prepared and for which competency has been established and maintained.

(2) “Educational preparation” within the meaning of subsection (1) (b) includes academic coursework, workshops or seminars, provided both theory and clinical experience are included.

(3) A nurse practitioner is responsible for identifying the limits of his or her educational preparation and competencies, and for resolving situations beyond his or her expertise by consulting with or referring patients to other health care professionals.

**Standards, Limitations and Conditions on NP Practice**

9. **Recommendation: Amend the *Nursing Act, 1991* to require nurse practitioners to comply with all standards, limitations and conditions established by the College of Nurses of Ontario for the performance of controlled acts, as set out in the CNO publication to be entitled, *Practice Standards, Limitations and Conditions: Performance of Controlled Acts by Nurse Practitioners*, as that publication is published and amended by the CNO from time to time.**

The current framework imposes restrictions upon NP practice mainly through prescriptive requirements built into the legislation and regulations granting access to controlled acts to NPs. With regard to one controlled act – communicating a diagnosis – NPs are required by the regulations to comply with the CNO’s practice standard respecting consultation with members of other health professions.<sup>98</sup>

The CNO has coupled its proposal to grant NPs broader access to certain controlled acts with the proviso that, in the performance of those controlled acts, NPs will be required to adhere to standards of practice developed by the CNO. As contemplated by the CNO:

- The proposed *Practice Standard: Performance of Controlled Acts by Nurse Practitioners*,<sup>99</sup> as published by the CNO (as of a specified date) would be prescribed as a standard of practice for the profession.
- The CNO would ensure that the document is circulated to NPs and available to the public upon request.
- Each NP who performs controlled acts must comply with the standards set out in that document.<sup>100</sup>

The content of the CNO’s proposed *Practice Standard: Performance of Controlled Acts by Nurse Practitioners* is not confined to “standards” of practice; it also seeks to establish “limitations” and “conditions” for NP practice. The phrase “limitations and conditions” is defined in the document as, “Criteria that a Nurse Practitioner must adhere to when performing controlled acts.”<sup>101</sup> However, a distinction can be drawn between the plain meanings of the two terms: a “limit” or “limitation” establishes a boundary between what can and cannot be done in the performance of a controlled act, while a “condition” refers to a requirement that must be met before a controlled act may be performed.

HPRAC endorses the CNO’s proposal that the performance of controlled acts by NPs should be subject to standards, limitations and conditions that the College will establish. However, HPRAC would add the stipulation that these standards, limitations and conditions must be the product of a statutory committee of the college with interdisciplinary membership.

This concept is consistent with British Columbia’s approach to NP regulation that establishes a broad, enabling legislative framework for NP practice, but then scales back what is permitted through comprehensive standards, limits and conditions established by the College of Nurses of British Columbia. In some cases, the standards, limits and conditions even prohibit the performance of acts otherwise permitted by the

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<sup>98</sup> Ontario Regulation 275/94 s.20 under the *Nursing Act, 1991*.

<sup>99</sup> College of Nurses of Ontario, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class Appendix C, August 2007.

<sup>100</sup> College of Nurses of Ontario, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class Appendix B, August 2007.

<sup>101</sup> CNO proposed *Practice Standard: Performance of Controlled Acts by Nurse Practitioners*.

legislative framework.<sup>102</sup> During HPRAC’s consultations, British Columbia was often cited as a pacesetter in NP regulation. Nova Scotia has adopted a regulatory approach similar to British Columbia’s and other provinces are considering doing so.

This approach is not entirely new to Ontario. The Health Professions Procedural Code under the *RHPA* contemplates the possibility that standards, limitations and conditions could be established for a class of professionals (such as NPs). In s. 95(1), the Code authorizes the council of a college to make regulations (subject to prior review by the Minister and approval by the Lieutenant Governor in Council):

- (a) prescribing classes of certificates of registration and imposing terms, conditions and limitations on the certificates of registration of a class, and
- (n) prescribing the standards of practice of the profession and prohibiting members from acting beyond the scope of practice of the profession in the course of practising the profession.

This authority is in addition to the power of a college to impose standards, limitations and conditions on individuals as a result of decisions made through registration, discipline or incapacity proceedings.<sup>103</sup>

Consistent with the recommendations to simplify regulation by placing related provisions together, HPRAC recommends including the CNO’s mandate to establish these standards, limitations and conditions in Section 5.1 of the *Nursing Act, 1991*, where controlled acts are listed, rather than in the regulations.

**To implement Recommendation 9, the following changes to the *Nursing Act, 1991* are proposed:**

[56.] That the *Nursing Act, 1991* be amended by adding the following subsections to section 5.1:

- (3) A nurse practitioner shall comply with all standards, limitations and conditions established by the College for the performance of controlled acts by nurse practitioners.
- (4) For the purposes of subsection (2), the standards, limitations and conditions shall be those set out in the publication of the College entitled, “*Practice Standards, Limitations and Conditions: Performance of Controlled Acts by Nurse Practitioners*”, as that publication is published and amended by the College from time to time.

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<sup>102</sup> *Health Professions Act*, R.S.B.C. 1996, c.183, as amended, and the Nurses (Registered) and Nurse Practitioners Regulation, B.C. Reg.233/2005, s.6, 11(1) and (3). By way of example, see Appendices B.C. – 30, 31 and 32 to the jurisdictional review.

<sup>103</sup> See, for example, Health Professions Procedural Code, ss.19 (6), 23(2), 51(2) and 69(1).

(5) The College shall establish the standards, limitations and conditions referred to in subsections (2) and (3) on the recommendation of the Nurse Practitioners Standards Committee as prescribed.

### **Interprofessional Development of Standards, Limitations and Conditions for NP Practice**

- 10. Recommendation: Amend the *Nursing Act, 1991* and regulations to provide for interprofessional involvement in the development of standards, limitations and conditions for nurse practitioner practice, and amend the regulations to provide for the composition of the Nurse Practitioner Standards Committee and the duties of the committee.**

Because the NP scope of practice overlaps with that of other professions, and with the growing emphasis on interprofessional care, HPRAC is proposing a statutorily mandated interprofessional committee for the development of standards, limitations and conditions for NP practice. This will provide an ongoing forum to discuss the standards that should be in place to reflect and require best practices.

The current regulatory framework does not oblige the CNO to involve individuals from other relevant professions – such as medicine or pharmacy – in the development of NP practice standards. The CNO indicates that in practice it does engage in such consultations, although HPRAC heard reservations about the CNO consultative process. However, it is crucial that expert advice from key stakeholders is actively solicited. Wide, proactive consultation is clearly required in a collaborative health care environment.

The creation of a statutory committee with mandatory interprofessional membership is in line with the approach adopted by British Columbia and Nova Scotia. It is consistent with recently introduced provisions in the *RHPA* making it an object of the health profession colleges to promote interprofessional collaboration, and anticipates future developments in interprofessional care.

Where interprofessional committees exist, the question arises as to whether members serve as individuals or as representatives of their respective regulatory colleges.

In Nova Scotia the *Registered Nurses Act* requires equal representation on what are called the Diagnostics and Therapeutics Committee and the Diagnostics and Therapeutics Appeal Committee from each of:

- the College of Registered Nurses of Nova Scotia,
- the College of Physicians and Surgeons of Nova Scotia, and
- the Nova Scotia Pharmaceutical Society.

A quorum of the committee includes at least one member from each of the three disciplines of nursing, medicine and pharmacy.<sup>104</sup> The governing body (or council) of the Registered Nurses of Nova Scotia appoints the members of the committee and there is no representation from Nova Scotia's Ministry of Health.

In British Columbia, by contrast, it is the College of Registered Nurses of British Columbia that determines the composition of the Nurse Practitioners Standards Committee. Creation of this committee is required by regulation,<sup>105</sup> but the authority to specify its composition and responsibilities lies with the college.<sup>106</sup>

The committee includes one family physician and one specialist physician approved by the College of Physicians and Surgeons of British Columbia, and one pharmacist, approved by the College of Pharmacists of British Columbia. The committee also includes: seven RNs and/or NPs, at least one of whom is a nurse educator from a NP education program; one appointee from the board governing the College of Registered Nurses of British Columbia; and one person nominated by the British Columbia Ministry of Health Services.<sup>107</sup> There is no prescribed formula for quorum.

In the model HPRAC proposes, the committee members from other professions would serve as individual experts and not as representatives of their respective professional colleges, but would be nominated by the colleges.

HPRAC acknowledges that legislating interprofessional collaboration presents inherent difficulties. Successful collaboration depends on a constructive give-and-take that is hard to mandate.

Nevertheless, HPRAC contends that the proposed model strikes a reasonable balance that requires the CNO to develop standards, limitations and conditions with ongoing input from individuals with relevant expertise, while at the same time not giving any one participant veto power over the process. The self-regulatory role of the CNO is respected by placing final responsibility for making appointments to the Nurse Practitioners Standards Committee with the college.

Participants in HPRAC's consultations stressed that additional expert input from a range of health professionals is necessary before the CNO finalizes its proposed

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<sup>104</sup> *Registered Nurses Act*, S.N.S. 2001, c.10, as amended, s.53 and 54. N.S. has recently passed revised legislation to govern nursing practice including the regulation of NPs. This new act (the *Registered Nurses Act*, S.N.S. 2006, c.21 received Royal Assent on November 23, 2006) is anticipated to come into effect on or about April 2008. It calls for the governing body (Council) of the College of Registered Nurses of Nova Scotia to establish both a Nurse Practitioner Committee and an Interdisciplinary NP Practice Review Committee. The composition of both committees is to be prescribed by regulation; those regulations are currently unavailable for review.

<sup>105</sup> *Nurses (Registered) and Nurse Practitioners Regulation*, B.C. Reg.233/2005, s.11 (1) and (3); issued under B.C.'s *Health Professions Act*, R.S.B.C. 1996, and c.183, as amended.

<sup>106</sup> B.C.'s *Health Professions Act*, s.19 (1) (t) empowers the Board of the B.C. Nurses' College to create the committee; College by-laws specify its composition and responsibilities.

<sup>107</sup> *Health Professions Act*, R.S.B.C. 1996, c.183, as amended, s.19 (1) (t); B.C. Nurses College Board by-laws, s.1.24.

standards, limits and conditions for NP practice.<sup>108</sup> In HPRAC's view, this work must be done through the Nurse Practitioners Standards Committee, with the membership and mandate set out below, before the recommendations in the next section of this report to expand the NP scope of practice take effect.

When developing these standards, limitations and conditions, the CNO should give careful consideration to similar frameworks established by other Canadian jurisdictions – in particular, those established by the College of Registered Nurses of British Columbia.

**To implement Recommendation 10, the following changes to the statute and regulations are proposed:**

[57.] That the *Nursing Act, 1991* be amended by repealing paragraph 14. (1) (e) and substituting the following paragraph:

(e) prescribing the composition and mandate of the Nurse Practitioners Standards Committee

[58.] That the *Nursing Act, 1991* be amended by repealing subsections 14 (2) and 14 (3).

[59.] That the *Nursing Act, 1991* be amended by adding a new section as follows:

14.1 The Council may make by-laws respecting the standards, limitations and conditions established by the College to govern the performance of controlled acts by nurse practitioners on recommendation of the Nurse Practitioners Standards Committee.

[60.] That Ontario regulation 275/94 under the *Nursing Act, 1991* be amended by repealing Section 20 and substituting the following:

20. (1) For the purposes of subsection 5.1 (4) of the Act, the Nurse Practitioners Standards Committee shall be composed of the following members appointed by Council:

- (a) Six registered nurses and/or nurse practitioners, at least one of whom is a nurse educator from a nurse practitioner education program; and one of whom is a member of the Council;
- (b) One person who is not or has not been a) a member of a College as defined in the *Regulated Health Professions Act, 1991* or b) a member of a Council as defined in the *Regulated Health Professions Act, 1991*;
- (c) Two members of the College of Physicians and Surgeons of Ontario, one of whom shall be a family physician and one of whom shall practise in a specialty of medicine, approved by the College of Physicians and Surgeons of Ontario;
- (d) One member of the Ontario College of Pharmacists, approved by the Ontario College of Pharmacists; and

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<sup>108</sup> For example: Ontario Orthopaedic Association, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class, November 2007.

- (2) The Nurse Practitioners Standards Committee shall develop, establish and maintain standards, limitations and conditions for nurse practitioners including, but not limited to, the performance of controlled acts by nurse practitioners and shall assume any further duties assigned to it by Council.
- (3) The Nurse Practitioners Standards Committee may consult, as it considers necessary or appropriate, with members of one or more health professional colleges or other individuals who have expertise relevant to a particular area of practice or on any other matter considered by the Committee.

### **Expanded Access to Controlled Acts**

#### **11. Recommendation: Amend the *Nursing Act, 1991* to include all of the controlled acts authorized to nurse practitioners, and amend the General Regulation to designate the specific forms of energy NPs will be able to order and apply.**

HPRAC recommends that broad access to the controlled acts be granted where reasonable justification exists for access to these acts by some NPs within the profession. The proposed new regulatory framework will provide the CNO with the tools to ensure that the actual performance of these controlled acts will take place only where consistent with safe and effective practice and when performed by qualified professionals. One of the most valuable of these tools will be the development of standards, limitations and conditions based on mandatory interprofessional consultation.

The controlled acts recommended, and identified in Recommendation 2, are:

1. Communicating a diagnosis identifying a disease or disorder as the cause of a person's symptoms.
2. Performing a procedure on tissue below the dermis or below the surface of a mucous membrane.
3. Applying or ordering the application of a form of energy prescribed by regulations under this Act.
4. Prescribing a drug prescribed by regulations under this Act.
5. Administering, by injection or inhalation, a drug that the member may prescribe under paragraph 4.

6. Putting an instrument, hand or finger,
  - i. beyond the external ear canal,
  - ii. beyond the point in the nasal passages where they normally narrow,
  - iii. beyond the larynx,
  - iv. beyond the opening of the urethra,
  - v. beyond the labia majora,
  - vi. beyond the anal verge, or
  - vii. into an artificial opening into the body.
7. Setting or casting a fracture of a bone or a dislocation of a joint.

Note: On a day to be named by proclamation of the Lieutenant Governor, section 5.1 is amended by the Statutes of Ontario, 2007, chapter 10, Schedule R, section 16 by adding the following paragraph:

8. Treating, by means of psychotherapy technique delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgment, insight, behaviour, communication or social functioning.

Concerns about granting NPs access to expanded controlled acts were raised by some stakeholders during the consultation process. Areas of particular concern included the following:

- Application of forms of energy,
- Dispensing, compounding and selling of drugs,
- Setting and casting fractures,
- Administering by inhalation or injection with respect to the role of a NP-Anaesthesia.

In responding to these concerns, HPRAC reviewed how other professions with access to these controlled acts are regulated; the balance between access to procedures and risk of harm; and current and proposed quality assurance measures by the CNO.

The granting of statutory authority for controlled acts gives a clear mandate to the CNO to develop detailed standards, limitations and conditions regarding the substance of the controlled acts performed by NPs, rather than simply addressing the process of delegation. It is important that the CNO undertake a complete review of its proposed standards, limitations and conditions for controlled acts through the multidisciplinary Nurse Practitioners Standards Committee.

Except where otherwise noted, HPRAC has concluded that expanded access to controlled acts should be authorized to NPs as requested by the CNO. HPRAC is satisfied that the proposed regulatory changes – including the standards, limitations and

conditions to be developed to guide NP practice – will provide the necessary safeguards on the performance of these acts.

### Communicating a Diagnosis

Both the OCFP and the OMA advocated no change to the current restrictive wording on NP access to the controlled act of communicating a diagnosis. Other participants in the consultations expressed very little concern about this issue.

NPs described numerous clinical situations where the need to consult a physician caused problems that adversely affected patient relations and care. For example, NPs who had a relationship with a patient and, upon receiving test results that confirmed diabetes, had to arrange for a physician – whom the patient did not know – to convey the diagnosis.

Other professions that are authorized to perform this act include: podiatry, chiroprody, dentistry, medicine, naturopathy, optometry, psychology and traditional Chinese medicine. The wording for other professions refers to “subject to terms, conditions and limitations.”

In Appendix C to its submission, the CNO included a revised Practice Standard (approved by the CNO Council in December 2006) intended to accompany an expanded scope of practice for NPs. It provides for the following limitations and conditions on communicating a diagnosis identifying a disease or disorder as the cause of a person’s symptoms:

- Before communicating a diagnosis, a Nurse Practitioner shall have:
  - established a nurse-client relationship;
  - performed an advanced comprehensive or focused health assessment including a physical examination;
  - ordered appropriate laboratory and/or diagnostic imaging tests and/or other tests guided by best practice evidence, safety and cost-effectiveness;
  - reviewed, interpreted and documented the test results; and
  - formulated the differential diagnosis (es) and identified potential treatment options.
- When a Nurse Practitioner diagnoses a condition beyond the Nurse Practitioner’s expertise to manage, the Nurse Practitioner shall contact an appropriate health care provider for consultation and/or initiate a referral within 72 hours of communicating a diagnosis.

HPRAC has carefully examined the checks, balances and safeguards that the CNO proposes to impose in tandem with a removal of the current limitations on the controlled act of communicating a diagnosis, and agrees that legislative restrictions on

the performance of this controlled act by NPs should be removed. Any limitations or conditions necessary can be included in the CNO practice standard.

Applying or Ordering the Application of a Form of Energy Prescribed by the Regulations

*Applying Forms of Energy*

HPRAC reviewed this proposal from the perspective of both ordering and applying forms of energy and in light of the specific requests made by the CNO to reflect current practice as well as system needs. Significant concerns were raised by stakeholders, such as the Ontario Association of Medical Radiation Technologists, the Ontario Medical Association and the Ontario College of Family Physicians. Adding this controlled act to the scope for NPs was supported by the College of Physicians and Surgeons of Ontario.

Three other health professions are authorized to perform this controlled act – dentistry, medicine and optometry. For all three, access is broad – compared with the current narrow provisions for NPs. For dentistry, for example, the provision reads:

In the course of engaging in the practice of dentistry, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following: Applying or ordering the application of a prescribed form of energy.

Similar wording is used for medicine and optometry except that optometry is limited to applying energy, and ordering is not authorized.

Overall, HPRAC has concluded that access to these controlled acts should be granted as requested by the CNO. HPRAC is confident that the proposed changes in regulations – subject to the standards, limitations and conditions to be developed to guide NP practice – will provide the necessary controls on the performance of these acts.

In Appendix C of its submission to HPRAC, the CNO provided details on the forms of energy it requests authorization for NPs to apply and proposes limitations. In the consultations, NPs reported clinical situations where bedside technology could be used to improve the assessment, management or monitoring of disease. Many of these examples involve acute care NPs practicing in a team environment and reflect current practice under medical delegation. A brief sketch of the relevant technologies follows:

1. Electricity for
  - i. Cardiac pacemaker therapy – the amendment will enable an acute care NP to adjust the rhythm on an established, implanted pacemaker. The NP works in collaboration with a cardiologist.
  - ii. Cardioversion – is used to treat an abnormal heart rhythm that is affecting cardiac output. It is generally performed in the hospital setting where the NP works in collaboration with a physician.

- iii. Defibrillation – restores heart rhythm in a life-threatening situation in any setting. The NP may work independently or as part of a resuscitation team; some technology is designed for use by the lay public.
  - iv. Electrocoagulation – is the application of energy to seal a blood vessel to control bleeding. It will be applied only in consultation with a physician.
  - v. Fulguration – is the use of electricity to treat lesions. It will be applied only in consultation with a physician.
  - vi. Transcutaneous cardiac pacing – is the application of a temporary, external pacemaker where the heart rhythm is not adequate. It is requested for the NP-Anaesthesia only.
2. The CNO’s request to apply ultrasound involves low-frequency soundwaves only – for example, to assess a patient’s inability to fully empty the urinary bladder, or to check for blocked vessels in the leg. This is done through bedside technology.

Appendix C of the CNO submission states that it is intended that a NP “shall not operate a high-frequency diagnostic ultrasound machine; or perform ultrasonography”. This should allay concerns by sonographers that the purpose of requesting this controlled act was to allow NPs to become substitute providers of their services. HPRAC maintains that the CNO should make these distinctions clear in its *Practice Standards, Limitations and Conditions: Performance of Controlled Acts by Nurse Practitioners* and any related documents and instructions to the profession.

The CNO also proposes that NPs perform electrocoagulation and fulguration only in consultation with a physician. Transcutaneous cardiac pacing is requested for the NP-Anaesthesia only.

#### *Ordering Forms of Energy*

The CNO requested expansion of NPs’ ability to order other health professionals to apply forms of energy for purposes of diagnosis or treatment. The specific forms of energy NPs seek to order are the same as those they seek authorization to apply, with the addition of the following to the list:

- Electricity for
  - electromyography – a diagnostic test to assess the function of muscles
  - nerve conduction studies – to test for hearing loss
- Electromagnetism for MRI.

Some clinical situations where the need to order a form of energy could arise include the use of ultrasound to examine heart function in critically ill patients, and MRI to establish neurological complications in the cardiac surgery patient. The information from these tests guides appropriate responses by acute care NPs working in hospital settings and can lead to appropriate referrals to other health professionals. Enabling NPs to order these tests, according to parameters established in standards, limitations and conditions, means patients can be diagnosed more quickly and have issues

managed sooner, leading to a shorter length of stay in the intensive care unit. Another example would be the monitoring by an acute care NP of a chronic condition that requires re-assessment using MRI, such as the cancer patient whose tumour status is being observed.

It should be noted that expansion of the controlled act of “communicating a diagnosis” is dependent on the NP’s ability to order appropriate diagnostic tests.

HPRAC is satisfied that many NPs, working within their individual scope of practice, have adequate educational preparation for this expanded role. Others may need to add to their training and competencies. HPRAC reviewed the current and proposed curriculum for the COUPN NP-PHC program and noted that the existing curriculum<sup>109</sup> includes learning objectives and content related to:

- identification of the need for radiographic and sonographic assessments;
- knowledge of indications and process for requesting an x-ray film, ultrasound and mammogram;
- recognition of normal and gross abnormal findings indicative of common health conditions seen in primary health care practice; and
- evaluation and incorporation of findings of the radiologist into the therapeutic plan of care.

Learning objectives are established for knowledge of radiation safety including the ability to: describe basic fundamentals of essential radiation physics; describe basic principles of radiobiological protection; and identify key features of legislation and guidelines governing use of medical radiation technology.

The curriculum includes an objective to demonstrate an understanding of the standards of practice respecting the ordering of x-ray, ultrasound and mammography including the ability to describe the standards respecting the ordering of x-ray and ultrasound; justify the reasons for ordering specific x-rays and ultrasound; and justify the reasons for referral.

*Performing a procedure on tissue below the dermis*

This controlled act is authorized to the following professions: chiroprody, podiatry, traditional Chinese medicine, dental hygiene, dentistry, medical laboratory technology, medical radiation technology, medicine, midwifery, naturopathy, nursing, and respiratory therapy. Some professions have specific wording outlining “additional requirements”.

The CNO’s request involves removal of restrictions in the legislation and regulations on the performance of this controlled act by NPs. Any necessary constraints would be imposed through standards, limitations and conditions adopted by the CNO. For

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<sup>109</sup> Proposed Graduate Primary Health Care Nurse Practitioner Program Module Content, Council of Ontario Universities Programs of Nursing (COUPN), 2006.

example, the CNO's proposed practice standard includes as a requirement to consult with a physician before suturing wounds in certain situations.<sup>110</sup> HPRAC supports this approach.

#### Putting an instrument, hand or finger...

In practice, a NP must be able to conduct a comprehensive physical examination and this may require palpation or insertion of instruments in any of these body openings, beyond what the general class RN may initiate. Examples of interventions that may be needed include:

- removal of foreign objects from body openings (a raisin in the nostril or the ear of the small child) or removal of impacted ear wax,
- intubating a patient for the purposes of managing the airway in a cardiac or respiratory arrest,
- changing a tracheotomy tube for a patient with an artificial airway,
- investigating a problem with a stoma for a person with an ostomy, or
- re-insertion of a dislodged feeding tube where children are being fed by a tube inserted through the abdomen into the stomach.

The specific area of practice will determine exactly what the NP is required to do and what competencies are required to carry out the task.

Again, the CNO's request involves removal of restrictions in the legislation and regulations and placing any constraints on the performance of this controlled act in the CNO's practice standards, limitations and conditions. For example, the CNO has proposed the following limitation: "No NP other than a Nurse Practitioner-Anaesthesia or a Nurse Practitioner with advanced specialized knowledge, skill and judgment in this area shall secure and manage the airway of a client during a surgical procedure." Again, HPRAC supports this approach.

#### Setting or casting a fracture of a bone or a dislocation of a joint

Setting and casting did not emerge as a key issue for NPs in the consultation process. However, some cases were mentioned where a simple finger dislocation or a simple, non-displaced fracture had to be referred to an emergency department.

Significant concerns were raised about adding this controlled act for NPs by the OMA, the OMA Section on Orthopaedics and the OCFP on grounds of NP skills and training. Educators also indicated that NPs might need additional education to develop competence in this controlled act and that its performance would be specific to certain practice settings.

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<sup>110</sup> College of Nurses of Ontario, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class, Appendix C, August 2007.

The CNO and other interveners described current practice where not only NPs but also RNs and RPNs routinely set and cast fractures under medical delegation as orthopaedic assistants or technicians, indicating that some members of the nursing profession have the competency to do certain procedures. For some CNO members, most particularly those in remote and rural areas, the ability to independently carry out these procedures is essential to patient well-being. The CNO currently has no mandate to set standards and regulate this controlled act where it is performed by nurses. In B.C., the standards, limitations and conditions established for NPs require certification by the College of Registered Nurses on an individual basis for those NPs who seek to set or cast a closed simple fracture of a bone or reduce a dislocation.<sup>111</sup>

The CNO has proposed the following limitations and conditions for NPs' performance of this act<sup>112</sup>:

A Nurse Practitioner shall not:

- set or cast a fracture that is open, displaces a growth plate/epiphysis, extends into a joint, is a pathologic fracture, or is a fracture of an elbow, hip, pelvis or femur;
- set or cast a fracture or dislocation where there is reason to believe that blood vessels, ligaments, nerves or muscles are damaged or;
- reduce a displaced fracture without physician consultation.

Before setting or casting a fracture of a bone or a dislocation of a joint, a Nurse Practitioner shall:

- perform and document the findings of an advanced focused health assessment and physical examination and;
- order and document the findings of diagnostic tests.

HPRAC recommends further development of the competencies required for NPs to perform this controlled act. This should be done by the proposed interprofessional Nurse Practitioners Standards Committee with expert advice as required from the appropriate professionals, including physicians with expertise in orthopaedics.

#### Prescribing, dispensing, selling or compounding a drug

HPRAC will consider the controlled act of “prescribing, dispensing, selling or compounding a drug” by NPs as part of the Minister’s referral regarding non-physician prescribers.

Although this is clearly a key area for reform, HPRAC is convinced that it is important to have a consistent approach among relevant health professionals, such as physicians, pharmacists, dentists, midwives and others who have the authority to prescribe or use

<sup>111</sup> College of Registered Nurses of British Columbia, *Scope of Practice for Nurse Practitioners (Family)*, 2007, p.10, Appendix B.C.-30 to the Jurisdictional Review.

<sup>112</sup> College of Nurses of Ontario, Submission to HPRAC respecting the scope of practice for registered nurses in the extended class, Appendix C, August 2007.

drugs in the course of their practice. The proposed limitations and conditions outlined by the CNO in their submission to HPRAC will be considered in this review.

*Prescribing Drugs*

During consultations, HPRAC heard ample evidence that the current system based on lists of approved, individually specified drugs in the regulations is cumbersome and slow to respond to changes in practice, new drug products and new knowledge. This conclusion was also reflected in HPRAC's *New Directions* report to the Minister of April 2006. Several pharmacists and physicians supported the CNO request to remove restrictions on prescribing and to provide broader access to this controlled act for NPs.

Of particular importance in considering this request is the specialized nature of NP practice in both primary and acute care, where specific drugs are efficacious and efficient for specific conditions, settings and patient populations. To maintain a comprehensive and current list of specific drugs that would serve all types of NP practice is not feasible. HPRAC welcomes changes to the regulation that will allow the drugs authorized to NPs to be prescribed by category, rather than individual drug.

HPRAC will consider the controlled act of prescribing drugs by NPs as part of the Minister's request for advice relating to prescribing and use of drugs by non-physicians. Its review will also include discussions relating to the potential role and value of a provincial drug information system in monitoring prescribing patterns and supporting quality assurance for all professionals with prescribing authority, both physician and non-physician.

*Dispensing, compounding and selling drugs*

To a large extent, this CNO request deals with limited, but current problems in NP practice, and largely affects NP practices in remote areas. For example, providing patients with manufacturer's samples of medications to tide them over until the pharmacy opens is technically "dispensing". Adding water to a bottle of dried amoxicillin powder and labeling the bottle to give it to parents of a child with a middle ear infection is technically "compounding and dispensing" – but clinically appropriate when it is late evening and the nearest pharmacy is 150 miles away. Providing a poor student with the new HPV vaccine at a discounted price is technically "selling".

Pharmacists told HPRAC that all practitioners should abide by the same rules with regard to these functions.

HPRAC will consider the controlled acts of dispensing, compounding, and selling of drugs by NPs as part of the Minister's request for advice relating to prescribing and use of drugs by non-physicians.

Administering a substance by injection or inhalation

A change to this controlled act will largely involve the authority of NP-Anaesthesia, but could also be significant to a primary care nurse practitioner who is providing care to an asthma patient, or a patient with emphysema without access to a respiratory therapist. Since it relates to the prescribing and use of drugs, it will be addressed as part of the Minister's request for advice regarding non-physician prescribers. Proposed limitations and conditions provided by the CNO to HPRAC in their submission will be included in the review.

**To implement Recommendation 11, the following changes to the regulations are proposed:**

[61.] That Ontario regulation 275/94 under the *Nursing Act, 1991* be amended by repealing Section 17.

[62.] That Ontario regulation 275/94 under the *Nursing Act, 1991* be amended by repealing Section 18 and substituting the following:

18. (1) For the purposes of paragraph 2 of subsection 5.1 (1) of the Act, a nurse practitioner may apply the following forms of energy:

1. Electricity for,
  - i. cardiac pacemaker therapy,
  - ii. cardioversion,
  - iii. defibrillation,
  - iv. electrocoagulation,
  - v. fulguration,
  - vi. transcutaneous cardiac pacing.

2. Soundwaves for diagnostic ultrasound.

(2) For the purposes of paragraph 2 of subsection 5.1 (1) of the Act, a nurse practitioner may order the following forms of energy:

1. Electricity for,
  - i. cardiac pacemaker therapy,
  - ii. cardioversion,
  - iii. defibrillation,
  - iv. electrocoagulation,
  - v. electromyography,
  - vi. fulguration,
  - vii. nerve conduction studies, or
  - viii. transcutaneous cardiac pacing.

2. Electromagnetism for magnetic resonance imaging.

3. Soundwaves for diagnostic ultrasound.

[63.] That section 1 of Ontario Regulation 107/96 under the *Regulated Health Professions Act, 1991* be amended by adding the following:

- 6.1 A member of the College of Nurses of Ontario who is registered as a nurse practitioner is exempt from subsection 27 (1) of the Act for the purpose of applying electricity for cardiac pacemaker therapy, cardioversion, defibrillation, electrocoagulation, electromyography, fulguration, nerve conduction studies, transcutaneous cardiac pacing, or soundwaves for diagnostic ultrasound.

[64.] That subclause 7.1 (2) (b) Ontario Regulation 107/96 under the *Regulated Health Professions Act, 1991* be repealed and the following substituted:

- (b) a member of the College of Nurses of Ontario who is a nurse practitioner, with respect to ordering the application of soundwaves for diagnostic ultrasound, or

## **Registration Requirements**

### **12. Recommendation: The following registration requirements for nurse practitioners should be mandatory:**

- **Registered Nurse with minimum two years general practice,**
- **Minimum standard education (Masters/ graduate degree in nursing with specialty NP stream),**
- **Minimum clinical hours/practicum,**
- **Successful completion of national entrance examination for NP-PHC specialty,**
- **During transition, successful completion of adapted American exams for NP-Adult and NP-Paediatric specialties,**
- **Successful completion of the American Neonatal NPs exam for the NP-Neonatal specialty, and**
- **A one-year, formal supervised practice by either a NP or a physician post-certification.**

**Further, the development of a Canadian certification exam for acute care NP specialties (NP-Adult, NP-Paediatric, NP-Neonatal, NP-Anaesthesia) and the development of a national program accreditation framework should be an immediate priority.**

The Canadian Nurses Association Testing Service conducts the national examinations for the NP-PHC. As noted earlier, the CNO has agreed to adopt these as the standard for entry to practice for Ontario NPs. At this time, there are no provincial or national examinations for NPs working in acute care specialty practice. The CNO has started work to adapt the U.S. entrance examinations for the NP-Adult and the NP-Paediatrics to reflect the Canadian context. These modified exams will be used during transition.

The CNO has approved existing NP programs – as reviewed by the Ontario Council on Graduate Studies in the case of the University of Toronto program and the National Organization of Nurse Practitioner Faculties in the case of the COUPN program - as

drafted for fall 2008 implementation. HPRAC has no immediate changes to propose to the theoretical content. However, depending on what changes to the NP scope of practice are ultimately made under legislation, it may be necessary to augment clinical practice to ensure competence in selected areas. HPRAC also notes that work to develop an educational program for the new NP-Anaesthesia specialty is underway at the University of Toronto.

While recognizing that U.S.-based exams must be used during the transition period, HPRAC recommends the development of Canadian national certification examinations for acute care NP specialties (i.e., NP-Adult, NP-Paediatric, NP-Neonatal and NP-Anaesthesia) as soon as possible. Critical factors, including differences in the International System of Units vs. American measurement systems, must be integrated.

In terms of additional entry requirements, HPRAC recommends one year of formal supervised practice by a NP or a physician (not both) following initial NP certification. This is a response to comments made during the consultations that many new graduates of NP programs have the minimum two years of clinical experience as a RN and need more opportunity to develop critical thinking and clinical judgment skills in a NP practice setting.

As noted above, a national accreditation system for NP education programs is currently under active discussion by the Canadian Association of Schools of Nursing. HPRAC endorses these efforts.

In response to changes to the controlled acts authorized to NPs, the CNO will be required to make appropriate adjustments to the competencies required and educators will be required to amend curricula accordingly.

### **Quality Assurance and Continuing Competence**

**13. Recommendation: The CNO should expedite development and implementation of a new, enhanced quality assurance program, and introduce a mandatory continuing education program. The continuing education program should include:**

- **Minimum hours,**
- **CNO approval of continuing education programs (clinical and theoretical) for purposes of quality assurance, and**
- **Standards for continuing education programming to meet specific competencies as required.**

The CPSO expressed concern about the capacity of the CNO to provide appropriate oversight of an expanded scope of practice for NPs, given the CNO's current quality assurance (QA) provisions. This concern was shared by some NPs, by key informants and by educators.

HPRAC itself is emphatic that the CNO must develop and implement significant and more exacting requirements for its quality assurance, continuing quality improvement, and continuing competency programs, and that these should be in place at the earliest opportunity. While HPRAC is aware that the CNO is currently revising its QA program and proposes more rigour for the regulation of NPs, including periodic practice reviews (every three years), it is HPRAC's view that the College should expedite work on the new program to support implementation of any increased authority and accountability of NPs. This is essential to ensure the confidence not only of the public, but of other professionals who will work with NPs in their specialties.

### Mandatory Continuing Education

In the consultations, HPRAC heard that NPs are regularly participating in a number of continuing education opportunities, some with a nursing focus and some in medical areas. Participation is not mandatory and there is no requirement to report continuing education (CE) hours or units. The OCFP has a well developed program for accrediting, approving and recording CE participation for family physicians. This might be a sound model to follow, and is recommended to the CNO.

HPRAC recommends that the CNO introduce a mandatory continuing education program with both theoretical and clinical components and minimum units or hours. According to changes to the NP scope of practice, NPs should be required to complete additional continuing education to ensure competence in specific areas, for example, setting and casting a fracture. Continuing education standards should be established to meet these specific needs.

Some CE programming is not linked to educational programs but is offered by institutions, professional associations or other non-academic settings to support specialized clinical settings. This kind of CE is not portable and may contribute to professional mobility issues. It would help if the CNO were to recognize, evaluate and endorse such CE offerings to support quality assurance.

### Quality Assurance

- 14. Recommendation: Amend the General Regulation to provide that, in carrying out a practice review, the assessor shall ensure that the member has conducted, and conducts his or her practice consistent with requirements of the *Nursing Act*, regulations issued under the Act, and all relevant standards, limitations and conditions.**

The CNO has presented a proposal for an amendment to its general regulation to the Minister to broaden the scope of mandatory NP practice reviews. Specifically, the CNO has proposed to amend clause 27(2) (b) of Ontario regulation 275/94 under the *Nursing Act, 1991* to provide that, in carrying out an assessment – that is, a practice review – the assessor shall ensure that the member has conducted, and conducts, his or her practice consistent with requirements of the *Nursing Act*, regulations issued under the Act, and

all relevant standards, limitations and conditions. HPRAC supports an expanded QA mandate for the CNO, including review of NPs' adherence to the relevant standards, limitations and conditions, and recommends that this amendment to the regulation proceed.

**To implement Recommendation 14, the following changes to the regulations are proposed:**

[65.] That Ontario regulation 275/94 under the *Nursing Act, 1991* be amended by revoking subsection 27 and substituting the following:

- 27.** (1) Every member who is issued a certificate of registration as a nurse practitioner shall, at the end of his or her first three years or first 1800 hours of practice as a nurse practitioner, whichever occurs first, undergo an assessment of his or her knowledge, skills and judgment to ensure that the member is competent to practise as a nurse practitioner.
- (2) In carrying out an assessment under this section, the assessor shall,
- (a) ensure that the member has conducted, and conducts, his or her practice consistent with requirements of the *Nursing Act*, regulations issued under the Act, and all relevant standards, limitations and conditions,
  - (b) ensure that the member has established an appropriate network for consultation with members of other health professions,
  - (c) ensure that the member has complied with the consultation indicators required in the standards of practice published by the College and provided to the members,
  - (d) review the evaluation prepared by the member, in the form provided by the College, of his or her first 1800 hours of practice or first three years of practice, as the case may be.

### **Mandatory Professional Liability Insurance**

#### **15. Recommendation: Amend the General Regulation under the *Nursing Act, 1991* to require NPs to have professional liability protection adequate to the risks presented by their practice<sup>113</sup>**

HPRAC recommends mandatory liability insurance protection for NPs to ensure that a patient who has suffered harm as the result of negligent conduct or malpractice by a NP will have access to compensation commensurate with usual civil law principles. Such a patient could be deprived of this compensation if the nurse practitioner were uninsured or underinsured, no matter how the insurance is provided.

NPs in all provinces and territories with the exception of Ontario have professional liability protection on an individual basis, either automatically upon registration with

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<sup>113</sup> Health Professions Code, s.95 (1) para.34.

their respective regulatory bodies<sup>114</sup> or further to requirements imposed by those regulators.<sup>115</sup> In Ontario, professional liability protection for nurse practitioners is not mandated by the College. While liability risks are not an overwhelming barrier to collaborative or team-based practice, they could cause concern when nurse practitioners exercise an expanded scope of practice, including having the independent authority to perform controlled acts within a multidisciplinary environment or as autonomous providers. An appropriate level of professional liability protection will be necessary to manage these risks. It is recommended that the CNO give careful consideration to the quantum of coverage required in light of recent experience in Canada, and that its by-laws make explicit the evidence that is acceptable respecting liability protection.

**To implement Recommendation 15, the following changes to the regulations are proposed:**

[66] That Ontario regulation 275/94 under the *Nursing Act, 1991* be amended by adding the following paragraphs to subsection (1) of section 11.1:

5. The applicant must hold professional liability protection that extends to all areas of practice in compliance with by-laws established by Council.
6. It is a term, condition and limitation of a certificate of registration in the extended class that the certificate expires when the holder no longer has the professional liability protection required by subsection 11.1(1) paragraph 5.
7. If a member fails to provide to the College evidence that the member holds professional liability protection in compliance with the by-laws when the College requests it, the Registrar shall immediately give the member notice of intention to suspend the member and may suspend the member's certificate of registration for failure to provide the evidence 15 days after notice is given.

**Transitional Provisions**

*Registration*

**16. Recommendation: A transitional program for registering existing NP-PHC's and new NP candidates should be introduced with the following features:**

- a. **Existing RN-ECs who are currently registered with the CNO should be considered to have met the requirements for registration as NP-PHCs under the new system.**

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<sup>114</sup> NPs in all provinces and territories (other than Ontario, British Columbia and Quebec) are automatically provided \$5M occurrence-based professional liability coverage through the CNPS. This is the same coverage discussed above as available to NPs in Ontario through membership in the NPAO / RNAO.

<sup>115</sup> In B.C., for example, by-laws established by the B.C. College require that all NPs be insured against liability for negligence in the provision of services that constitute the practice of nursing in an amount of at least \$5 million per claim in a form satisfactory to the College: B.C. College By-laws, Part 8.

- b. NP candidates who seek registration in the acute care specialties before June 2009 should be required to pass an examination, and be provided an opportunity to have their credentials assessed for equivalency with new registration requirements.**
- c. NP candidates who seek registration in either the primary or acute care specialties after June 2009 should be required to pass an examination and to have one year of supervised practice following registration.**

HPRAC recommends that RN-EC's who are currently registered should qualify as NP-PHC registrants under the new system, that is, they should not have to requalify. Any new NP-PCH registrants should be required to pass an examination, and to have one year of supervised practice following registration. During the transition period, those applicants who have been practicing as acute care nurse practitioners should be required to pass an examination, and should be provided an opportunity to have their credentials assessed for equivalency with new registration requirements respecting the year of supervised practice. After June 2009, graduates would be required to pass the examination and have one year of supervised practice following registration as an acute care nurse practitioner. These recommendations are illustrated in the following chart:

<b>Status</b>	<b>Requirement – Examination</b>	<b>Requirement – Supervised Practice</b>
<b>Registered NP- PHC</b>	<b>No</b>	<b>No</b>
<b>NP-Adult, Paediatric, Anaesthesia, Neonatal</b>	<b>Yes</b>	<b>No</b>
<b>All NP specialties, post June 2009</b>	<b>Yes</b>	<b>Yes</b>

**17. Recommendation: Legislative and regulation changes to grant NPs expanded access to controlled acts should come into effect no later than June 4, 2009. By that date, the following must be in place:**

- CNO's standards, limitations and conditions as established on the recommendation of the Nurse Practitioners Standards Committee;**
- Revised entry-to-practice requirements; and**
- Changes to the quality assurance program.**

The necessary supports and safeguards must be in place before an expanded NP scope of practice can be implemented – including standards, limitations and conditions developed with interprofessional input; revised entry-to-practice requirements; and an enhanced quality assurance program.

HPRAC is confident that this work can be completed by June 2009. This is the date that the 2007 amendments to the *RHPA* are expected to be proclaimed, and work necessary to implement statutory changes for NPs can continue in tandem with other changes impacting the College. The development of standards, limitations and conditions with an interprofessional committee with the recommended make-up could begin

immediately, even if legislation has not yet passed and whether or not new or revised regulations have been approved.

### **Five-Year Review**

**18. Recommendation:** Amend the *Nursing Act, 1991* to require the Health Professions Regulatory Advisory Council to report to the Minister, within five years after the amendment of section 5.1 to grant additional authorized acts to nurse practitioners on the effectiveness of:

- section 5.1 and related amendments pertaining to nurse practitioners in the *Nursing Act, 1991*, and regulations issued under the Act to regulate nurse practitioners and to govern them in accordance with the Act, the Health Professions Procedural Code and the *Regulated Health Professions Act, 1991*; and
- the standards, limitations and conditions established by the College to govern the performance of controlled acts by nurse practitioners.

Given that the recommendations in this report are groundbreaking and may be relevant to other health professions, HPRAC recommends a five-year review of the proposed changes to the NP scope of practice and the corresponding regulatory framework. The review would evaluate how well the changes have succeeded in protecting the public interest in safe and effective NP practice – in effect, watching the watchdog.

**To implement Recommendation 18, the following changes to the *Nursing Act, 1991*, are proposed:**

[67.] That the *Nursing Act, 1991* be amended by adding the following section:

#### **Five-year report**

20. The Health Professions Regulatory Advisory Council shall report to the Minister, within five years after the amendment of section 5.1 of this *Act* to grant additional authorized acts to nurse practitioners as set out above, on the effectiveness of,

(a) section 5.1 and related amendments pertaining to nurse practitioners in this *Act* and regulations issued under this Act to regulate nurse practitioners and to govern them in accordance with this Act, the Health Professions Procedural Code and the *Regulated Health Professions Act, 1991*; and

(b) the standards, limitations and conditions established by the College to govern the performance of controlled acts by nurse practitioners.

## Complementary Amendments to Legislation and Regulations

### **19. HPRAC recommends that complementary amendments to other legislation and regulations be made.**

Numerous consequential amendments will be required to bring other statutes and regulations into line with an expanded scope of practice for NPs. For example, HPRAC proposes amendments to:

- the *Healing Arts Radiation Protection Act* to give NPs broad diagnostic authority to order x-rays and CT scans,
- Regulation 682 under the *Laboratory Specimen and Collection Centre Licensing Act* to give NPs broad diagnostic authority to order lab tests, and
- Regulation 965 under the *Public Hospitals Act* to give NPs various authorities regarding the treatment of inpatients.

#### **HPRAC therefore proposes:**

[68.] That subsection 1 (1) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the definition of “extended class nursing staff” and substituting the following:

- “nurse practitioner staff” means those nurse practitioners in a hospital,
- (a) who are employed by the hospital to whom the board has granted privileges of diagnosing, prescribing for or treating patients in the hospital, and
  - (b) who are not employed by the hospital and to whom the board has granted privileges to diagnose, prescribe for or treat out-patients in the hospital;

[69.] That subsection 7 (2.1) of RRO Regulation 965 under the *Public Hospitals Act* be revoked.

[70.] That subsection 11 (1) of RRO Regulation 965 under the *Public Hospitals Act* be amended by adding the following paragraph:

- (d) on the order or under the authority of a nurse practitioner who is a member of the nurse practitioner staff;

[71.] That subsection 11 (2) of RRO Regulation 965 under the *Public Hospitals Act* be amended by adding the words “nurse practitioner” after the word “dentist” wherever they occur.

[72.] That section 14 of RRO Regulation 965 under the *Public Hospitals Act* be deleted and replaced with the following:

14. (1) A physician, an oral and maxillofacial surgeon, a nurse practitioner or a midwife who knows or suspects that a person being admitted to the hospital on the physician’s, oral and maxillofacial surgeon’s, nurse practitioner’s or midwife’s order is or may become dangerous to himself or herself or to other persons, shall forthwith notify the administrator concerning the patient.

(2) An attending physician, attending dentist, attending midwife or attending nurse practitioner who knows or suspects that his or her patient is suffering from an infectious disease or condition shall forthwith notify the administrator and either an infection control officer or an infection control nurse about the patient.

[73.] That subsection 16 (1) of RRO Regulation 965 under the *Public Hospitals Act* be deleted and replaced with the following:

16. (1) if a patient is no longer in need of treatment in the hospital; one of the following persons shall make an order that the patient be discharged and communicate the order to the patient:

1. The attending physician, nurse practitioner or midwife or, if the attending dentist is an oral and maxillofacial surgeon, the attending dentist.
2. A member of the medical, dental, nurse practitioner or midwifery staff designated by a person referred to in paragraph 1.

[74.] That subsection 17 (1) and 17 (2) of RRO Regulation 965 under the *Public Hospitals Act* be amended by adding the words “or nurse practitioner” following the word “physician” wherever they occur.

[75.] That paragraph 19 (4) (a) of RRO Regulation 965 under the *Public Hospitals Act* be amended by adding the words “nurse practitioners” after the word “dentists”.

[76.] That paragraphs 19 (4) (c) and 19 (4) (h) of RRO Regulation 965 under the *Public Hospitals Act* be amended by adding the words “nurse practitioner” after the word “dental”.

[77.] That paragraphs 19 (4) (k) of RRO Regulation 965 under the *Public Hospitals Act* be amended by adding the words “nurse practitioner” after the word “dentist”.

[78.] That paragraph 19 (5) (a) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “registered nurses in the extended class” and substituting the words “nurse practitioners”.

[79.] That paragraph 19 (5) (c) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner”.

[80.] That paragraph 19 (5) (h) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner”.

[81.] That subsection 22 of RRO Regulation 965 under the *Public Hospitals Act* be amended by adding the following:

- (4) The Registrar of the College of Nurses of Ontario, the Council of the College of Nurses of Ontario or an investigator appointed by the Council of the College of Nurses of Ontario, after giving written notice to the administrator and the chair of the medical advisory committee, may for the purposes of investigating the care provided to a patient or out-patient of a hospital by a nurse practitioner,
- (a) inspect and receive information from medical records or from notes, charts and other material relating to patient care and reproduce and retain copies thereof; and

(b) interview hospital staff and medical and professional staff with respect to the admission, treatment, care, conduct, control and discharge of patients or any class of patients and the general management of the hospital insofar as it relates to the hospitalization of a patient or patients whose care and treatment are being investigated by the College.

(4.1) If the Registrar, the Council or an investigator appointed by the Council wishes to interview a member of the hospital staff, or medical or professional staff, the Registrar, the Council or the investigator, as the case requires, shall give written notice to the administrator of the subject matter of the interview and the identity, if known, of the persons to be interviewed.

(4.2) An administrator who receives written notice under subsection (5) shall forthwith give written notice to each person who may be interviewed of the subject matter of the interview and inform the person that the person may have legal counsel present at the interview.

[82.] That paragraph 25 (1) (b) of RRO Regulation 965 under the *Public Hospitals Act* be amended by adding the words “a member of the nurse practitioner staff” after the words “midwifery staff”.

[83.] That the following subsection be added to section 25 of RRO Regulation 965 under the *Public Hospitals Act*:

(9) Where a patient is admitted to a hospital by a nurse practitioner, the attending nurse practitioner shall, within seventy-two hours of admission or prior to discharge, if the patient is discharged within seventy-two hours of admission,

- (a) take a history of the patient;
- (b) give the patient a physical examination;
- (c) make a provisional assessment of the patient’s condition; and
- (d) records, dates and authenticates the history and reports of the findings of the physical examination and the provisional diagnosis of the patient.

[84.] That Form 1 of RRO Regulation 965 under the *Public Hospitals Act* be amended by adding the words “or nurse practitioner” after the word “physician”.

[85.] That subsection 6 (1) of the *Healing Arts Radiation Protection Act* be amended by adding a new clause as follows:

- (g) a person registered as a nurse practitioner under the *Nursing Act, 1991*.

[86.] That subsections 6 (2) and 6 (3) of the *Healing Arts Radiation Protection Act* be repealed.

[87.] That the definition of "specimen collection centre" in section 5 of the *Laboratory and Specimen Collection Centre Licensing Act* be repealed and the following substituted:

"specimen collection centre" means a place where specimens are taken or collected from the human body for examination to obtain information for diagnosis, prophylaxis or treatment, but does not include,

- (a) a place where a legally qualified medical practitioner is engaged in the practice of medicine or surgery,
- (b) a place where a legally qualified nurse practitioner is engaged in the practice of nursing, or
- (c) a laboratory that is established, operated or maintained under a licence under this Act;

[88.] That subclause 9 (1) (a) (iv) of R.R.O. 1990, Regulation 682 (Laboratories) under the *Laboratory and Specimen Collection Centre Licensing Act* be repealed and the following substituted:

- (iv) at the request of a legally qualified nurse practitioner.

[89.] That appendix C to R.R.O. 1990, Regulation 682 (Laboratories) under the *Laboratory and Specimen Collection Centre Licensing Act* be repealed.

[90.] That section 13 of R.R.O. 1990, Regulation 682 (Laboratories) under the *Laboratory and Specimen Collection Centre Licensing Act* be repealed and the following substituted:

Every legally qualified medical practitioner and every legally qualified nurse practitioner who performs laboratory tests for the exclusive purpose of diagnosing or treating his or her own patients in the course of his or her practice is exempted from the provisions of sections 5 to 17 of the Act and this Regulation.

[91.] That the definition of "statement of medical exemption" in section 1 of the *Immunization of School Pupils Act* be repealed and the following substituted:

"statement of medical exemption" means a statement in the prescribed form signed by a physician or a nurse practitioner stating that the prescribed program of immunization in relation to a designated disease or designated diseases,

- (a) may be detrimental to the health of the person named in the statement, or
- (b) is unnecessary in respect of the person named in the statement by reason of past infection or laboratory evidence of immunity.

[92.] That Subsection 3 (2) of the *Immunization of School Pupils Act* be repealed and the following substituted:

**Exception**

(2) Subsection (1) does not apply to the parent of a pupil in respect of the prescribed program of immunization in relation to a designated disease specified by a physician or a nurse practitioner in a statement of medical exemption filed with the proper medical officer of health and, where the physician or nurse practitioner has specified an effective time period, only during the effective time period.

[93.] That Subclause 12 (2) (b) (ii) of the *Immunization of School Pupils Act* be repealed and the following substituted:

- (ii) a statement of medical exemption in the prescribed form signed by a physician or a nurse practitioner stating that the prescribed program of immunization in relation to the

designated disease is unnecessary in respect of the pupil by reason of past infection or laboratory evidence of immunity.

[94.] That Form 1 of RRO 1990, Reg. 645 of the *Immunization of School Pupils Act* be amended by adding the words “or Nurse Practitioner’s” after the word “Physician’s”

[95.] That Subsection 34 (1) of the *Health Protection and Promotion Act* be repealed and the following substituted:

**Physician or nurse practitioner to report refusal or neglect of treatment**

(1) Every physician and every nurse practitioner shall report to the medical officer of health the name and residence address of any person who is under the care and treatment of the physician or the nurse practitioner in respect of a communicable disease and who refuses or neglects to continue the treatment in a manner and to a degree satisfactory to the physician or the nurse practitioner.

[96.] That the definition of “extended class nursing staff” in subsection 1 (1) R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be repealed and the following substituted:

“Nurse practitioner staff” means those nurse practitioners in a hospital, (a) who are employed by the hospital and are authorized to diagnose, prescribe for or treat in-patients or out-patients in the hospital, and

(b) who are not employed by the hospital and to whom the governing body or authority of the hospital has granted privileges to diagnose, prescribe for or treat out-patients in the hospital;

[97.] That subsection 7. (4) in subsection 1 (1) R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by adding the words “nurse practitioner” after the words “attending physician”.

[98.] That subsection 8. (1.1) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be repealed.

[99.] That subsection 8 (1.2) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be repealed.

[100.] That subsection 11 (1) (e) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be repealed and the following substituted:

(e) admitted as an in-patient or registered as an out-patient on the order or under the authority of a nurse practitioner.

[101.] That subsection 11 (2) (a) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by adding the words “or nurse practitioner” after the word “physician”.

[102.] That subsection 11 (2) (b) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by adding the words “or nurse practitioner” after the word “physician”.

[103.] That subclause 21 (2) (a) (i) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by adding the words “or nurse practitioner” after the word “physician”.

[104.] That subclause 21 (2) (b) (i) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by adding the words “or nurse practitioner” after the word “physician”.

[105.] That subclause 21 (2) (c) (i) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by adding the words “or nurse practitioner” after the word “physician”.

[106.] That subclause 21 (2) (d) (ii) be of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by adding the words “or nurse practitioner” after the word “physician”.

[107.] That subclause 22 (1) (a) (i) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by adding the words “or nurse practitioner” after the word “physician”.

[108.] That subclause 22 (1) (a) (ii) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be revoked.

## Summary of Recommendations

### Simplicity and Clarity in Regulation

1. **Recommendation:** Consider rewriting Ontario Regulation 275/94 under the *Nursing Act, 1991*, and substituting a revised version to make it clearer and easier to follow.
2. **Recommendation:** Amend the *Nursing Act, 1991* to list all controlled acts NPs are authorized to perform.
3. **Recommendation:** Standardize terminology about nurse practitioners in all laws and regulations by eliminating the use of the terms “registered nurse (extended certificate)”, “registered nurse (extended class)” and “registered nurse in the extended class” in favour of the term “nurse practitioner”.

### Scope of Practice Statement

4. **Recommendation:** Make no changes to the scope of practice statement as set out in Section 3 of the *Nursing Act, 1991*.

### Specialty Certification and Categories of Specialty

5. **Recommendation:** Maintain the current requirement in the regulations for NPs to have a specialty certificate and also continue the current specialty categories.
6. **Recommendation:** Add a new acute care specialty of “Neonatal” (NP-Neonatal).

### Title Protection

7. **Recommendation:** Extend title protection to the proposed new specialty, “NP- Neonatal”.

### Individual Scope of Practice

8. **Recommendation:** Amend the *Nursing Act, 1991* to allow nurse practitioners to deliver only health care services within the specialty for which they hold a specialty certificate and within that specialty, only those health care services for which they are educationally prepared and for which competency has been established and maintained, and make nurse practitioners responsible under the law for identifying the limits of their educational preparation and competencies, and for resolving situations beyond their expertise by consulting with, or referring patients to, other health care providers.

### **Standards, Limitations and Conditions on NP Practice**

9. **Recommendation:** Amend the *Nursing Act, 1991* to require nurse practitioners to comply with all standards, limitations and conditions established by the College of Nurses of Ontario for the performance of controlled acts, as set out in the CNO publication to be entitled, *Practice Standards, Limitations and Conditions: Performance of Controlled Acts by Nurse Practitioners*, as that publication is published and amended by the CNO from time to time.

### **Interprofessional Development of Standards, Limitations and Conditions for NP Practice**

10. **Recommendation:** Amend the *Nursing Act, 1991* and regulations to provide for interprofessional involvement in the development of standards, limitations and conditions for nurse practitioner practice, and amend the regulations to provide for the composition of the Nurse Practitioner Standards Committee and the duties of the committee.

### **Expanded Access to Controlled Acts**

11. **Recommendation:** Amend the *Nursing Act, 1991* to include all of the controlled acts authorized to nurse practitioners, and amend the General Regulation to designate the specific forms of energy NPs will be able to order and apply.

### **Registration Requirements**

12. **Recommendation:** The following registration requirements for nurse practitioners should be mandatory:
- Registered Nurse with minimum two years general practice,
  - Minimum standard education (i.e., Masters/ graduate degree in nursing with specialty NP stream),
  - Minimum clinical hours/practicum,
  - Successful completion of national entrance examination for NP-PHC specialty,
  - During transition, successful completion of adapted American exams for NP-Adult and NP-Paediatric specialties,
  - Successful completion of the American Neonatal NPs exam for the NP-Neonatal specialty, and
  - A one-year, formal supervised practice by either a NP or a physician post-certification.

Further, the development of a Canadian certification exam for acute care NP specialties (NP-Adult, NP-Paediatric, NP-Neonatal, NP-Anaesthesia)

and the development of a national program accreditation framework should be an immediate priority.

### **Quality Assurance and Continuing Competence**

13. **Recommendation:** The CNO should expedite development and implementation of a new, enhanced quality assurance program, and introduce a mandatory continuing education program. The continuing education program should include:
- Minimum hours,
  - CNO approval of continuing education programs (clinical and theoretical) for purposes of quality assurance, and
  - Standards for continuing education programming to meet specific competencies as required.
14. **Recommendation:** Amend clause 27(2)(b) of the General Regulation to provide that, in carrying out an assessment, that is, a practice review, the assessor shall ensure that the member has conducted, and conducts, his or her practice consistent with requirements of the *Nursing Act*, regulations issued under the Act, and all relevant standards, limitations and conditions.

### **Mandatory Professional Liability Insurance**

15. **Recommendation:** Amend the General Regulation under the *Nursing Act, 1991* to require NPs to have professional liability insurance adequate to the risks presented by their practice.<sup>116</sup>

### **Transitional Provisions**

16. **Recommendation:** A transitional program for registering existing NP-PHCs and new NP candidates should be introduced with the following features:
- Existing RN-EC's who are currently registered with the CNO should be considered to have met the requirements for registration as NP-PHCs under the new system.
  - NP candidates who seek registration in the acute care specialties before June 2009 should be required to pass an examination, and be provided an opportunity to have their credentials assessed for equivalency with new registration requirements.
  - NP candidates who seek registration in both the primary and acute care specialties after June 2009 should be required to pass an examination and to have one year of supervised practice following registration.

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<sup>116</sup> Health Professions Code, s.95 (1) para.34.

- 17. Recommendation:** Legislative and regulation changes to grant NPs expanded access to controlled acts should come into effect no later than June 4, 2009. By that date, the following must be in place:
- CNO's standards, limitations and conditions as established on the recommendation of the Nurse Practitioners Standards Committee,
  - Revised entry-to-practice requirements, and
  - Changes to the quality assurance program.

### **Five-Year Review**

- 18. Recommendation:** Amend the *Nursing Act, 1991* to require the Health Professions Regulatory Advisory Council to report to the Minister, within five years after the amendment of section 5.1 to grant additional authorized acts to nurse practitioners on the effectiveness of:

- section 5.1 and related amendments pertaining to nurse practitioners in the *Nursing Act, 1991*, and regulations issued under the Act to regulate nurse practitioners and to govern them in accordance with the Act, the Health Professions Procedural Code and the *Regulated Health Professions Act, 1991*; and
- the standards, limitations and conditions established by the College to govern the performance of controlled acts by nurse practitioners.

### **Complementary Amendments**

- 19. HPRAC recommends that complementary amendments to other legislation and regulations be made.**

## Summary of Implementation Proposals

### Simplicity and Clarity in Regulation

[1.] That the words “certain registered nurses” in the title preceding section 5.1 of the *Nursing Act, 1991* be deleted and replaced with the words “nurse practitioners”.

[2.] That section 5.1 (1) of the *Nursing Act, 1991* be repealed and the following substituted:

5.1 (1) In the course of engaging in the practice of nursing, a member who is a nurse practitioner in accordance with the regulations is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following acts:

1. Communicating a diagnosis identifying a disease or disorder as the cause of a person’s symptoms.
2. Performing a procedure on tissue below the dermis or below the surface of a mucous membrane.
3. Applying or ordering the application of a form of energy prescribed by regulations under this Act.
4. Prescribing a drug prescribed by regulations under this Act.
5. Administering, by injection or inhalation, a drug that the member may prescribe under paragraph 4.
6. Putting an instrument, hand or finger,
  - i. beyond the external ear canal,
  - ii. beyond the point in the nasal passages where they normally narrow,
  - iii. beyond the larynx,
  - iv. beyond the opening of the urethra,
  - v. beyond the labia majora,
  - vi. beyond the anal verge, or
  - vii. into an artificial opening into the body.
7. Setting or casting a fracture of a bone or a dislocation of a joint.

Note: On a day to be named by proclamation of the Lieutenant Governor, section 5.1 is amended by the Statutes of Ontario, 2007, chapter 10, Schedule R, section 16 by adding the following paragraph:

8. Treating, by means of psychotherapy technique delivered through a therapeutic relationship, an individual’s serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual’s judgment, insight, behaviour, communication or social functioning.

## **Titles**

[3.] That the words “certain registered nurses” in the title preceding section 5.1 of the *Nursing Act, 1991* be deleted and replaced with the words “nurse practitioners”.

[4.] That the definition of “registered nurse in the extended class” in section 0.1 of Part I of Ontario Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

“nurse practitioner” means a member who holds a certificate of registration as a nurse practitioner;

[5.] That section 3 of Ontario Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

**3.** (1) A person may apply for a certificate of registration as a registered nurse, registered practical nurse or nurse practitioner by completing an application form supplied by the Executive Director and submitting it along with the required application fee.

(2) Upon receipt of the required registration fee, the Executive Director shall issue a certificate of registration to a person,

(a) if the Executive Director proposes to register the person under clause 15 (1) (a) of the Health Professions Procedural Code; or

(b) if authorized or directed by a panel of the Registration Committee to issue the certificate to the person O. Reg. 39/98, s. 3; O. Reg. 158/00, s. 1 (3).

[6.] That the title preceding section 8.3 of Ontario Regulation 275/94 be revoked and the following substituted:

### MUTUAL RECOGNITION FOR NURSE PRACTITIONERS

[7.] That subsection 8.3 (1) and of Ontario Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

**8.3** (1) Subject to subsections (3) and (5), an applicant who meets all of the following requirements shall have met the requirements for a certificate of registration as a nurse practitioner:

1. The applicant must have been registered to practise nursing in another province or territory in Canada with a certificate or licence considered by the Registration Committee to be one which was equivalent to a nurse practitioner.

2. The applicant must satisfy either the Executive Director or the Registration Committee that the applicant previously practised one of the nurse practitioner specialties recognized by this Regulation, in another province or territory in Canada.

3. If any of the nursing programs which the applicant completed in order to be permitted to practise one of the nurse practitioner specialties recognized by this Regulation were not university programs, the applicant must have successfully completed any additional education and training determined by the Registration Committee.

4. The applicant must have successfully completed the examinations for that nurse practitioner specialty referred to in subparagraph 3 i of subsection 11.1 (1).

5. The applicant must provide written confirmation from the regulatory body for nursing in each province or territory in Canada in which the applicant practised during the five years prior to the date of application verifying that the applicant, while registered, met that regulatory body's continuing competence or quality assurance requirements.

6. The applicant,

i. in the opinion of the Executive Director or the Registration Committee, as the case may be, must have no additional need for education or experience based on evidence of safe nursing practice in a nurse practitioner specialty recognized by this Regulation during the preceding year, or

ii. must have successfully completed any additional education requirements determined by the Registration Committee.

7. The applicant must meet the requirements of section 5. O. Reg. 502/07, s. 1.

[8.] That the title preceding section 11.1 of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

CERTIFICATES OF REGISTRATION FOR NURSE PRACTITIONERS

[9.] That the first paragraph of subsection 11.1 (1) of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

11.1 (1) The following are non-exemptible registration requirements for a certificate of registration as a nurse practitioner:

[10.] That subclause 11.1 (1) 1. iii of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

iii. must hold or have held a certificate of registration as a nurse practitioner in another jurisdiction which the Registration Committee is satisfied is equivalent to a certificate of registration as a nurse practitioner.

[11.] That subsection 11.1 (2) of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

2. The applicant,

i. must have graduated from an Ontario university program for preparing nurse practitioners for a specialty which program was, at the time the applicant graduated, approved by Council,

ii. must have graduated from a university program in another province or territory in Canada or one of the United States of America for preparing nurse practitioners for a specialty program which was, at the time the applicant graduated, approved by Council,

iii. must have graduated from a university nursing program that the Registration Committee is satisfied was, at the time the applicant graduated,

equivalent to a current Ontario university program referred to in subparagraph i, or

iv. subject to subsection (4), must have graduated from a nursing program other than one referred to in subparagraphs i, ii or iii and satisfied the Registration Committee that he or she has obtained additional nursing education, training or experience that, together with the education provided by the nursing program from which he or she graduated, is equivalent to the education currently provided to a graduate of an Ontario university program referred to in subparagraph i.

[12.] That subsection 11.1 (1) 3., 11.1 (2), 11.1 (3) of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

3. At the time of successfully completing all other requirements for registration as nurse practitioner or at the time of application, whichever is later, the applicant must,
  - i. successfully complete,
    - A. whatever examinations are approved by Council for that specialty for which the applicant had successfully completed the program referred to in paragraph 2, or
    - B. whatever examinations are set by or administered by the College for that specialty for which the applicant had successfully completed the program referred to in paragraph 2, and
  - ii. satisfy the Registration Committee that, during the past five years,
    - A. he or she has practised nursing for at least two years,
    - B. his or her nursing practice was performed safely, and
    - C. for at least one of those years, he or she practised in a nursing role that required him or her to use advanced knowledge and decision-making skills in assessment, diagnosis and health care management. O. Reg. 502/07, s. 2.

(2) An applicant who graduated from an Ontario university program for preparing nurse practitioners that was, at the time the applicant graduated, approved by the Council of Ontario University Programs in Nursing and by the Senate or Governing Council of the University that offered the program, is deemed to have met the requirement of subparagraph 2 i of subsection (1).

(3) The following are additional registration requirements for a certificate of registration as a nurse practitioner:

1. The applicant is able to demonstrate the ability to speak and write either English or French with reasonable fluency.
2. The applicant is a Canadian citizen or a permanent resident of Canada or authorized under the *Immigration and Refugee Protection Act* (Canada) to engage in the practice of nursing.
3. An applicant who graduated from a program referred to in subparagraph ii, iii or iv of paragraph 2 of subsection (1) must, if the program was located outside Ontario, show proof of registration, or eligibility for registration, as the

equivalent of a nurse practitioner, in the jurisdiction in which the program was located.

4. The applicant must not have been refused registration in the nursing profession in another jurisdiction.

(4) An applicant who graduated from a program referred to in subparagraph iv of paragraph 2 of subsection (1) shall, if requested by the Registration Committee, undergo an assessment of his or her competence using a process approved by the Registration Committee so as to permit the Registration Committee to determine what additional nursing education, training or experience, if any, is required in order for the applicant to meet the requirements of that subparagraph.

(5) If an applicant for a certificate of registration as a nurse practitioner fails to successfully complete the examinations referred to in subparagraph i of paragraph 3 of subsection (1), the applicant must, as an additional non-exemptible registration requirement,

- i. if requested by the Registration Committee, undergo an assessment of his or her competence using a process approved by the Registration Committee, and
- ii. successfully complete such additional education and obtain such additional training and experience as the Registration Committee determines is necessary to enable the applicant to practise safely in a specialty recognized by this Regulation, before resubmitting to the examinations referred to in subparagraph i of paragraph 3 of subsection

[13.] That subsections 11.2 (1), (2) and (3) of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

**11.2** (1) There shall be the non-acute care nurse practitioner specialty of Primary Health Care.

(2) There shall be following acute care nurse practitioner specialties:

1. Paediatrics
2. Adult
3. Anaesthesia
4. Neonatal

(3) An applicant being issued a certificate of registration as a nurse practitioner shall also be issued a specialty certificate for that specialty for which the applicant successfully completed the examinations referred to in subparagraph i of paragraph 3 of subsection 11.1 (1).

[14.] That subsections 11.3 (1), (2) and (3) of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

**11.3** (1) Where a member's certificate of registration as a nurse practitioner is suspended or revoked, any specialty certificate issued to the member is automatically suspended or revoked until the suspension or the revocation is lifted or removed.

(2) Where a former member's certificate of registration as a nurse practitioner is reinstated, any specialty certificate the former member held at the time of the

suspension or revocation shall also be reinstated unless otherwise directed by the committee that determined that the reinstatement should take place.

(3) Where a member holding a certificate of registration as a nurse practitioner resigns that certificate, any specialty certificate issued to the member is automatically revoked.

[15.] That subsections 11.4 (1) of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

**11.4** (1) Subject to subsections (2), (3), (4) and (5), a member holding a certificate of registration as a nurse practitioner shall use the title “Nurse Practitioner” or the abbreviation “NP” when practising in that role.

[16.] That subsections 11.4 (6) of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

(6) Except as permitted by the Act or this Regulation, no other title, designation, variation or abbreviation shall be used by a member holding a certificate of registration as a nurse practitioner.

[17.] That the first paragraph of subsection 11.5 (1) of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

**11.5** (1) A person who meets the following requirements is entitled to attempt the examinations that must be successfully completed as a requirement for the issuance of a certificate of registration as a nurse practitioner:

[18.] That subsection 11.5 (6) of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

6. The person must not have attempted on three previous occasions the examinations for a specialty which would, if successfully completed, have met the examination requirement for registration as a nurse practitioner.

[19.] That the first paragraph of section 17 of Regulation 275/94 under the *Nursing Act, 1991* be revoked and the following substituted:

**17.** For the purpose of clause 5 (1) (a) of the Act, a nurse practitioner may perform any of the following procedures if he or she meets all of the conditions set out in subsection 15 (5).

[20.] That section 18 of Regulation 275/94 under the *Nursing Act, 1991* be amended by deleting the words “registered nurse in the extended class” and substituting the words “nurse practitioner”.

[21.] That section 1. (1) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the definition of “attending registered nurse in the extended class” and substituting the following:

“attending nurse practitioner” means a member of the nursing staff registered as a nurse practitioner who attends a patient in the hospital.

[22.] That section 1. (1) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the definition of “extended class nursing staff” and substituting the following:

“nurse practitioner staff” means those nurses who are registered as nurse practitioners in a hospital,

(a) who are employed by the hospital and are authorized to diagnose, prescribe for or treat out-patients in the hospital.

(b) who are not employed by the hospital and to whom the board has granted privileges to diagnose, prescribe for or treat out-patients in the hospital.

(Note: Substantive amendments to this section follow in a later recommendation.)

[23.] That section 1. (1) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the definition of “registered nurse in the extended class” and substituting the following:

“nurse practitioner” means a member of the College of Nurses of Ontario who is registered as a nurse practitioner under the *Nursing Act, 1991*.

[24.] That paragraph 4. (1) (c) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner”.

[25.] That clauses (i), (ii), (iii), (iv), (v), and (vii) of subsection 7. (2) (a) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner”.

[26.] That paragraphs 7 (2) (a) and 7 (2) (b) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner” wherever they occur.

[27.] That the definition of “nursing staff” in subsection 7.1 (2) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner” wherever they occur.

[28.] That paragraph 11 (3) (a) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner”.

[29.] That subsection 14 (2) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “registered nurse in the extended class” and substituting the words “nurse practitioner”.

[30.] That subsection 18 (1) and 18 (3) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner” wherever they occur.

[31.] That paragraph 19 (5) (a) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “registered nurses in the extended class” and substituting the words “nurse practitioners”.

[32.] That paragraph 19 (5) (c) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner”.

[33.] That paragraph 19 (5) (h) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner”.

[34.] That subsection 22 (6) (a) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner”.

[35.] That subsections 24 (1), 24 (2), 24 (3) (a), and 24 (3) (b) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “registered nurse in the extended class” wherever they occur and substituting the words “nurse practitioner”.

[36.] That Section 1 of the *Immunization of School Pupils Act* be amended by repealing the definition of "registered nurse in the extended class" and substituting the following:

"nurse practitioner" means a member of the College of Nurses of Ontario who is registered as a nurse practitioner under the *Nursing Act, 1991*.

[37.] That the definition of “registered nurse in the extended class” in Subsection 1 (1) of the *Health Protection and Promotion Act* be repealed and the following substituted:

"nurse practitioner" means a member of the College of Nurses of Ontario who is registered as a nurse practitioner under the *Nursing Act, 1991*.

[38.] That Section 26 of the *Health Protection and Promotion Act* be amended by deleting the words "or registered nurse in the extended class" after "physician", and substituting the words “or nurse practitioner”.

[39.] That Section 30 of the *Health Protection and Promotion Act* be amended by deleting the words "or registered nurse in the extended class" after "physician" and substituting the words “or nurse practitioner”.

[40.] That Subsections 34 (1) and 34 (2) of the *Health Protection and Promotion Act* be amended by deleting the words "registered nurse in the extended class" and substituting the words “nurse practitioner” wherever they occur.

[41.] That Subsection 34 (4) of the *Health Protection and Promotion Act* be amended by deleting the words "or registered nurse in the extended class" and substituting the words “or nurse practitioner”.

[42.] That Subsection 37 (1) of the *Health Protection and Promotion Act* be amended by deleting the words "or registered nurse in the extended class" after "physician" and substituting the words “or nurse practitioner”.

[43.] That Subsection 38 (2) of the *Health Protection and Promotion Act* be amended by deleting the words "or registered nurse in the extended class" after "physician" and substituting the words “or nurse practitioner”.

[44.] That Subsection 40 (1) of the *Health Protection and Promotion Act* be amended by deleting the words "or registered nurse in the extended class" after "physician" and substituting the words “or nurse practitioner”.

[45.] That the first paragraph of section 37.1 of R.R.O. of the *Vital Statistics Act* be amended by deleting the words "registered nurse who holds an extended certificate of registration under the *Nursing Act, 1991*" and substituting the words “nurse practitioner”.

[46.] That subclause 7.1 (2) (b) Ontario Regulation 107/96 under the *Regulated Health Professions Act, 1991* be repealed and the following substituted:

(b) a member of the College of Nurses of Ontario who is a nurse practitioner, with respect to ordering the application of soundwaves for diagnostic ultrasound, or

[47.] That clause 8. (1) (3) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by deleting the words “registered nurse in the extended class” and substituting the words “nurse practitioner”.

[48.] That clause 8. (1) (4) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by deleting the words “registered nurse in the extended class” and substituting the words “nurse practitioner”.

[49.] That clause 8. (1) (5) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by deleting the words “registered nurse in the extended class” and substituting the words “nurse practitioner”.

[50.] That clause 8 (1) (6.1) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by deleting the words “registered nurse in the extended class” and substituting the words “nurse practitioner”.

[51.] That clause 8 (1) (7.1) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by deleting the words “registered nurse in the extended class” and substituting the words “nurse practitioner”.

[52.] That subclause 22 (2) (b) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by deleting the words “registered nurse in the extended class” and substituting the words “nurse practitioner”.

### **Specialty Certification and Categories of Specialty**

[53.] That Ontario regulation 275/94 under the *Nursing Act, 1991* be amended by adding the following subparagraph to subsection (2) of section 11.2:

4. Neonatal

### **Title Protection**

[54.] That Ontario regulation 275/94 under the *Nursing Act, 1991* be amended by adding the following subparagraph to subsection (2) of section 11.4:

(5.1) A member holding a Neonatal specialty certificate may use the title “Nurse Practitioner — Neonatal” or the abbreviation “NP — Neonatal”, when practising in that role.

## **Individual Scope of Practice**

[55.] That the *Nursing Act, 1991* be amended by adding the following section:

### **Individual scope of practice for nurse practitioners**

5.2 (1) A nurse practitioner shall provide health care services as a nurse practitioner:

(a) only within the specialty for which he or she holds a specialty certificate; and

(b) within that specialty, only those health care services for which he or she is educationally prepared and for which competency has been established and maintained.

(2) “Educational preparation” within the meaning of subsection (1) (b) includes academic coursework, workshops or seminars, provided both theory and clinical experience are included.

(3) A nurse practitioner is responsible for identifying the limits of his or her educational preparation and competencies, and for resolving situations beyond his or her expertise by consulting with or referring patients to other health care professionals.

## **Standards, Limitations and Conditions on NP Practice**

[56.] That the *Nursing Act, 1991* be amended by adding the following subsections to section 5.1:

(3) A nurse practitioner shall comply with all standards, limitations and conditions established by the College for the performance of controlled acts by nurse practitioners.

(4) For the purposes of subsection (2), the standards, limitations and conditions shall be those set out in the publication of the College entitled, “*Practice Standards, Limitations and Conditions: Performance of Controlled Acts by Nurse Practitioners*”, as that publication is published and amended by the College from time to time.

(5) The College shall establish the standards, limitations and conditions referred to in subsections (2) and (3) on the recommendation of the Nurse Practitioners Standards Committee as prescribed.

[57.] That the *Nursing Act, 1991* be amended by repealing paragraph 14. (1) (e) and substituting the following paragraph:

(e) prescribing the composition and mandate of the Nurse Practitioners Standards Committee

[58.] That the *Nursing Act, 1991* be amended by repealing subsections 14 (2) and 14 (3).

[59.] That the *Nursing Act, 1991* be amended by adding a new section as follows:

14.1 The Council may make by-laws respecting the standards, limitations and conditions established by the College to govern the performance of controlled acts by nurse practitioners on recommendation of the Nurse Practitioners Standards Committee.

[60.] That Ontario regulation 275/94 under the *Nursing Act, 1991* be amended by repealing Section 20 and substituting the following:

20. (1) For the purposes of subsection 5.1 (4) of the Act, the Nurse Practitioners Standards Committee shall be composed of the following members appointed by Council:

(a) Six registered nurses and/or nurse practitioners, at least one of whom is a nurse educator from a nurse practitioner education program; and one of whom is a member of the Council;

(b) One person who is not or has not been a) a member of a College as defined in the *Regulated Health Professions Act, 1991*, or b) a member of a Council as defined in the *Regulated Health Professions Act, 1991*;

(c) Two members of the College of Physicians and Surgeons of Ontario, one of whom shall be a family physician and one of whom shall practise in a specialty of medicine, approved by the College of Physicians and Surgeons of Ontario;

(d) One member of the Ontario College of Pharmacists, approved by the Ontario College of Pharmacists; and

(4) The Nurse Practitioners Standards Committee shall develop, establish and maintain standards, limitations and conditions for nurse practitioners including, but not limited to, the performance of controlled acts by nurse practitioners and shall assume any further duties assigned to it by Council.

(5) The Nurse Practitioners Standards Committee may consult, as it considers necessary or appropriate, with members of one or more health professional colleges or other individuals who have expertise relevant to a particular area of practice or on any other matter considered by the Committee.

### **Expanded Access to Controlled Acts**

[61.] That Ontario regulation 275/94 under the *Nursing Act, 1991* be amended by repealing Section 17.

[62.] That Ontario regulation 275/94 under the *Nursing Act, 1991* be amended by repealing Section 18 and substituting the following:

18. (1) For the purposes of paragraph 2 of subsection 5.1 (1) of the Act, a nurse practitioner may apply the following forms of energy:

1. Electricity for,
  - i. cardiac pacemaker therapy,
  - ii. cardioversion,
  - iii. defibrillation,
  - iv. electrocoagulation,
  - v. fulguration,
  - vi. transcutaneous cardiac pacing.
2. Soundwaves for diagnostic ultrasound.

(2) For the purposes of paragraph 2 of subsection 5.1 (1) of the Act, a nurse practitioner may order the following forms of energy:

1. Electricity for,
  - i. cardiac pacemaker therapy,
  - ii. cardioversion,
  - iii. defibrillation,
  - iv. electrocoagulation,
  - v. electromyography,
  - vi. fulguration,
  - vii. nerve conduction studies, or
  - viii. transcutaneous cardiac pacing.
2. Electromagnetism for magnetic resonance imaging.
3. Soundwaves for diagnostic ultrasound.

[63.] That section 1 of Ontario Regulation 107/96 under the *Regulated Health Professions Act, 1991* be amended by adding the following:

- 6.1 A member of the College of Nurses of Ontario who is registered as a nurse practitioner is exempt from subsection 27 (1) of the Act for the purpose of applying electricity for cardiac pacemaker therapy, cardioversion, defibrillation, electrocoagulation, electromyography, fulguration, nerve conduction studies, transcutaneous cardiac pacing, or soundwaves for diagnostic ultrasound.

[64.] That subclause 7.1 (2) (b) Ontario Regulation 107/96 under the *Regulated Health Professions Act* be repealed and the following substituted:

- (b) a member of the College of Nurses of Ontario who is a nurse practitioner, with respect to ordering the application of soundwaves for diagnostic ultrasound, or

### **Quality Assurance**

[65.] That Ontario regulation 275/94 under the *Nursing Act, 1991* be amended by revoking subsection 27 (2) and substituting the following:

- 27.** (1) Every member who is issued a certificate of registration as a nurse practitioner shall, at the end of his or her first three years or first 1800 hours of practice as a registered nurse in the extended class, whichever occurs first, undergo

an assessment of his or her knowledge, skills and judgment to ensure that the member is competent to practise as a nurse practitioner.

- (2) In carrying out an assessment under this section, the assessor shall,
- (a) ensure that the member has conducted, and conducts, his or her practice consistent with requirements of the *Nursing Act*, regulations issued under the Act, and all relevant standards, limitations and conditions,
  - (b) ensure that the member has established an appropriate network for consultation with members of other health professions,
  - (c) ensure that the member has complied with the consultation indicators required in the standards of practice published by the College and provided to the members,
  - (d) review the evaluation prepared by the member, in the form provided by the College, of his or her first 1800 hours of practice or first three years of practice, as the case may be.

### **Liability Protection**

[66.] That Ontario regulation 275/94 under the *Nursing Act, 1991* be amended by adding the following paragraphs to subsection (1) of section 11.1:

- 5. The applicant must hold professional liability protection that extends to all areas of practice in compliance with by-laws established by Council.
- 6. It is a term, condition and limitation of a certificate of registration in the extended class that the certificate expires when the holder no longer has the professional liability protection required by subsection 11.1(1) paragraph 5.
- 7. If a member fails to provide to the College evidence that the member holds professional liability protection in compliance with the by-laws when the College requests it, the Registrar shall immediately give the member notice of intention to suspend the member and may suspend the member's certificate of registration for failure to provide the evidence 15 days after notice is given.

### **Transitional Provisions**

[67.] That the *Nursing Act, 1991* be amended by adding the following section:

#### **Five-year report**

20. The Health Professions Regulatory Advisory Council shall report to the Minister, within five years after the amendment of section 5.1 of this *Act* to grant additional authorized acts to nurse practitioners as set out above, on the effectiveness of,

- (a) section 5.1 and related amendments pertaining to nurse practitioners in this *Act* and regulations issued under this Act to regulate nurse

practitioners and to govern them in accordance with this Act, the Health Professions Procedural Code and the *Regulated Health Professions Act, 1991*; and

(b) the standards, limitations and conditions established by the College to govern the performance of controlled acts by nurse practitioners.

### **Complementary Amendments**

[68.] That subsection 1 (1) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the definition of “extended class nursing staff” and substituting the following:

“nurse practitioner staff” means those nurse practitioners in a hospital,  
 (a) who are employed by the hospital to whom the board has granted privileges of diagnosing, prescribing for or treating patients in the hospital, and  
 (b) who are not employed by the hospital and to whom the board has granted privileges to diagnose, prescribe for or treat out-patients in the hospital;

[69.] That subsection 7 (2.1) of RRO Regulation 965 under the *Public Hospitals Act* be revoked.

[70.] That subsection 11 (1) of RRO Regulation 965 under the *Public Hospitals Act* be amended by adding the following paragraph:

(d) on the order or under the authority of a nurse practitioner who is a member of the nurse practitioner staff;

[71.] That subsection 11 (2) of RRO Regulation 965 under the *Public Hospitals Act* be amended by adding the words “nurse practitioner” after the word “dentist” wherever they occur.

[72.] That section 14 of RRO Regulation 965 under the *Public Hospitals Act* be deleted and replaced with the following:

14. (1) A physician, an oral and maxillofacial surgeon, a nurse practitioner or a midwife who knows or suspects that a person being admitted to the hospital on the physician’s, oral and maxillofacial surgeon’s, nurse practitioner’s or midwife’s order is or may become dangerous to himself or herself or to other persons, shall forthwith notify the administrator concerning the patient.  
 (2) An attending physician, attending dentist, attending midwife or attending nurse practitioner who knows or suspects that his or her patient is suffering from an infectious disease or condition shall forthwith notify the administrator and either an infection control officer or an infection control nurse about the patient.

[73.] That subsection 16 (1) of RRO Regulation 965 under the *Public Hospitals Act* be deleted and replaced with the following:

16. (1) if a patient is no longer in need of treatment in the hospital; one of the following persons shall make an order that the patient be discharged and communicate the order to the patient:

1. The attending physician, nurse practitioner or midwife or, if the attending dentist is an oral and maxillofacial surgeon, the attending dentist.
2. A member of the medical, dental, nurse practitioner or midwifery staff designated by a person referred to in paragraph 1.

[74.] That subsection 17 (1) and 17 (2) of RRO Regulation 965 under the *Public Hospitals Act* be amended by adding the words “or nurse practitioner” following the word “physician” wherever they occur.

[75.] That paragraph 19 (4) (a) of RRO Regulation 965 under the *Public Hospitals Act* be amended by adding the words “nurse practitioners” after the word “dentists”.

[76.] That paragraphs 19 (4) (c) and 19 (4) (h) of RRO Regulation 965 under the *Public Hospitals Act* be amended by adding the words “nurse practitioner” after the word “dental”.

[77.] That paragraphs 19 (4) (k) of RRO Regulation 965 under the *Public Hospitals Act* be amended by adding the words “nurse practitioner” after the word “dentist”.

[78.] That paragraph 19 (5) (a) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “registered nurses in the extended class” and substituting the words “nurse practitioners”.

[79.] That paragraph 19 (5) (c) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner”.

[80.] That paragraph 19 (5) (h) of RRO Regulation 965 under the *Public Hospitals Act* be amended by deleting the words “extended class nursing” and substituting the words “nurse practitioner”.

[81.] That subsection 22 of RRO Regulation 965 under the *Public Hospitals Act* be amended by adding the following:

(4) The Registrar of the College of Nurses of Ontario, the Council of the College of Nurses of Ontario or an investigator appointed by the Council of the College of Nurses of Ontario, after giving written notice to the administrator and the chair of the medical advisory committee, may for the purposes of investigating the care provided to a patient or out-patient of a hospital by a nurse practitioner,

(a) inspect and receive information from medical records or from notes, charts and other material relating to patient care and reproduce and retain copies thereof; and

(b) interview hospital staff and medical and professional staff with respect to the admission, treatment, care, conduct, control and discharge of patients or any class of patients and the general management of the hospital insofar as it relates to the hospitalization of a patient or patients whose care and treatment are being investigated by the College.

(4.1) If the Registrar, the Council or an investigator appointed by the Council wishes to interview a member of the hospital staff, or medical or professional staff, the Registrar, the Council or the investigator, as the case requires, shall

give written notice to the administrator of the subject matter of the interview and the identity, if known, of the persons to be interviewed.

(4.2) An administrator who receives written notice under subsection (5) shall forthwith give written notice to each person who may be interviewed of the subject matter of the interview and inform the person that the person may have legal counsel present at the interview.

[82.] That paragraph 25 (1) (b) of RRO Regulation 965 under the *Public Hospitals Act* be amended by adding the words “a member of the nurse practitioner staff” after the words “midwifery staff”.

[83.] That the following subsection be added to section 25 of RRO Regulation 965 under the *Public Hospitals Act*:

(9) Where a patient is admitted to a hospital by a nurse practitioner, the attending nurse practitioner shall, within seventy-two hours of admission or prior to discharge, if the patient is discharged within seventy-two hours of admission,

- (a) take a history of the patient;
- (b) give the patient a physical examination;
- (c) make a provisional assessment of the patient’s condition; and
- (d) records, dates and authenticates the history and a report of the findings of the physical examination and the provisional diagnosis of the patient.

[84.] That Form 1 of RRO Regulation 965 under the *Public Hospitals Act* be amended by adding the words “or nurse practitioner” after the word “physician”.

[85.] That subsection 6 (1) of the *Healing Arts Radiation Protection Act* be amended by adding a new clause as follows:

- (g) a person registered as a nurse practitioner under the *Nursing Act, 1991*.

[86.] That subsections 6 (2) and 6 (3) of the *Healing Arts Radiation Protection Act* be repealed.

[87.] That the definition of "specimen collection centre" in section 5 of the *Laboratory and Specimen Collection Centre Licensing Act* be repealed and the following substituted:

"specimen collection centre" means a place where specimens are taken or collected from the human body for examination to obtain information for diagnosis, prophylaxis or treatment, but does not include,

- (a) a place where a legally qualified medical practitioner is engaged in the practice of medicine or surgery,
- (b) a place where a legally qualified nurse practitioner is engaged in the practice of nursing, or
- (c) a laboratory that is established, operated or maintained under a licence under this Act;

[88.] That subclause 9 (1) (a) (iv) of R.R.O. 1990, Regulation 682 (Laboratories) under the *Laboratory and Specimen Collection Centre Licensing Act* be repealed and the following substituted:

(iv) at the request of a legally qualified nurse practitioner.

[89.] That appendix C to R.R.O. 1990, Regulation 682 (Laboratories) under the *Laboratory and Specimen Collection Centre Licensing Act* be repealed.

[90.] That section 13 of R.R.O. 1990, Regulation 682 (Laboratories) under the *Laboratory and Specimen Collection Centre Licensing Act* be repealed and the following substituted:

Every legally qualified medical practitioner and every legally qualified nurse practitioner who performs laboratory tests for the exclusive purpose of diagnosing or treating his or her own patients in the course of his or her practice is exempted from the provisions of sections 5 to 17 of the Act and this Regulation.

[91.] That the definition of "statement of medical exemption" in section 1 of the *Immunization of School Pupils Act* be repealed and the following substituted:

"statement of medical exemption" means a statement in the prescribed form signed by a physician or a nurse practitioner stating that the prescribed program of immunization in relation to a designated disease or designated diseases,

(a) may be detrimental to the health of the person named in the statement, or

(b) is unnecessary in respect of the person named in the statement by reason of past infection or laboratory evidence of immunity.

[92.] That Subsection 3 (2) of the *Immunization of School Pupils Act* be repealed and the following substituted:

**Exception**

(2) Subsection (1) does not apply to the parent of a pupil in respect of the prescribed program of immunization in relation to a designated disease specified by a physician or a nurse practitioner in a statement of medical exemption filed with the proper medical officer of health and, where the physician or nurse practitioner has specified an effective time period, only during the effective time period.

[93.] That Subclause 12 (2) (b) (ii) of the *Immunization of School Pupils Act* be repealed and the following substituted:

(ii) a statement of medical exemption in the prescribed form signed by a physician or a nurse practitioner stating that the prescribed program of immunization in relation to the designated disease is unnecessary in respect of the pupil by reason of past infection or laboratory evidence of immunity.

[94.] That Form 1 of RRO 1990, Reg. 645 of the *Immunization of School Pupils Act* be amended by adding the words "or Nurse Practitioner's" after the word "Physician's".

[95.] That Subsection 34 (1) of the *Health Protection and Promotion Act* be repealed and the following substituted:

**Physician or nurse practitioner to report refusal or neglect of treatment**

(1) Every physician and every nurse practitioner shall report to the medical officer of health the name and residence address of any person who is under the care and treatment of the physician or the nurse practitioner in respect of a communicable disease and who refuses or neglects to continue the treatment in a manner and to a degree satisfactory to the physician or the nurse practitioner.

[96.] That the definition of “extended class nursing staff” in subsection 1 (1) R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be repealed and the following substituted:

“Nurse practitioner staff” means those nurse practitioners in a hospital, (a) who are employed by the hospital and are authorized to diagnose, prescribe for or treat in-patients or out-patients in the hospital, and

(b) who are not employed by the hospital and to whom the governing body or authority of the hospital has granted privileges to diagnose, prescribe for or treat out-patients in the hospital.

[97.] That subsection 7. (4) in subsection 1 (1) R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by adding the words “nurse practitioner” after the words “attending physician”.

[98.] That subsection 8. (1.1) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be repealed.

[99.] That subsection 8 (1.2) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be repealed.

[100.] That subsection 11 (1) (e) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be repealed and the following substituted:

(e) admitted as an in-patient or registered as an out-patient on the order or under the authority of a nurse practitioner.

[101.] That subsection 11 (2) (a) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by adding the words “or nurse practitioner” after the word “physician”.

[102.] That subsection 11 (2) (b) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by adding the words “or nurse practitioner” after the word “physician”.

[103.] That subclause 21 (2) (a) (i) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by adding the words “or nurse practitioner” after the word “physician”.

[104.] That subclause 21 (2) (b) (i) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by adding the words “or nurse practitioner” after the word “physician”.

[105.] That subclause 21 (2) (c) (i) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by adding the words “or nurse practitioner” after the word “physician”.

[106.] That subclause 21 (2) (d) (ii) be of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by adding the words “or nurse practitioner” after the word “physician”.

[107.] That subclause 22 (1) (a) (i) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be amended by adding the words “or nurse practitioner” after the word “physician”.

[108.] That subclause 22 (1) (a) (ii) of R.R.O. 1990, Regulation 552 under the *Health Insurance Act, 1990* be revoked.

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