Registered Nurse Prescribing Referral

Submission to the
Health Professions Regulatory Advisory Council
(HPRAC)

January 15, 2016
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Summary of RNAO Recommendations for HPRAC

1) The Minister of Health and Long-Term Care amend necessary legislation and regulations by the end of 2016 to authorize registered nurses (RN) to autonomously perform the following controlled acts as specified in the Regulated Health Professions Act:
   a. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual.
   b. Applying or ordering the application of a form of energy.
   c. Prescribing, selling and compounding a drug as defined in the Drug and Pharmacies Regulation Act.

2) RNs’ expanded scope of practice must be based on an enabling framework (independent prescribing as defined by HPRAC) and not restricted by lists, protocols or collaborative practice agreements.

3) The Ministry of Health and Long-Term Care, in collaboration with the Ministry of Training, Colleges and Universities and educators implement an expanded RN scope of practice through a phased-in approach. Beginning with current RNs in 2016 through a voluntary university-level continuing education course, followed by incorporation of the expanded scope into the baccalaureate nursing curriculum by 2020.

4) The College of Nurses of Ontario implement a communications system for both the public and other health providers to know which RNs are eligible to practice within an expanded scope (i.e. through the public registrar).

5) The Ministry of Health and Long-Term Care and the Registered Nurses’ Association of Ontario partner to disseminate a public education campaign to inform Ontarians and other health providers about the expanded scope of practice for RNs.

6) Health system planners and researchers develop an evaluation system to track progress on process and outcome indicators related to an expanded RN scope of practice.
RNAO response to HPRAC’s Registered Nurse Prescribing Referral

Background

The Registered Nurses’ Association of Ontario (RNAO) is the professional association representing registered nurses (RN), nurse practitioners (NP) and nursing students in all settings and roles across Ontario. For over 90 years RNAO has advocated for opportunities to improve the health of Ontarians by addressing health and health-care imperatives, including optimizing the use of health professions. For example, RNAO was the catalyst behind the proclamation of NP legislation, the baccalaureate entry to practice requirement for RNs, implementation of NP-led clinics, and the funding of NP positions in long-term care. We have actively participated in many HPRAC consultations dating back to 1998. For example, RNAO has developed submissions on the regulation of chiropody and podiatry in Ontario,\(^1,2\) the regulation of paramedics under the Regulation Health Professions Act (RHPA),\(^3,4\) the regulation of physician assistants under the RHPA,\(^5\) the use of the “Doctor Title” in Traditional Chinese Medicine,\(^6\) the scope of practice of NPs,\(^7,8\) interdisciplinary collaboration among Health Colleges and Regulated Health Professionals,\(^9,10\) non-physician prescribing and administration of drugs,\(^11\) and the five year review of the RHPA.\(^12\)

Many organizations across the province have identified areas where the health system needs to improve, including reducing wait times,\(^13\) eliminating fragmentation and breaking down geographical discrepancies in service,\(^14,15,16\) improving afterhours access to service in primary care,\(^17,18\) and minimizing rates of hospitalization and emergency room visits for ambulatory care sensitive conditions.\(^19,20\) In December 2015, the Ministry of Health and Long-Term Care released a discussion paper with plans to address the structural issues that affect these areas listed above. The objectives cited in the paper include reducing inequities in access to care, integrating the health system and standardizing care delivery.\(^21\) Implementing RN prescribing through an enabling framework (independent prescribing as defined by HPRAC) is an opportunity to achieve these health system goals. In other jurisdictions where RNs practise to an independent expanded scope, clients have same day or next day appointments in primary care,\(^22\) increased continuity of care and caregiver,\(^23,24\) improved chronic disease management (i.e. refilling prescriptions),\(^25\) increased access to care for vulnerable populations (i.e. homeless clients with communicable illnesses)\(^26\) and timely access to care for those living in rural or remote areas.\(^27,28,29\)

Full utilization of health human (HHR) resources is essential if we want to improve the health system. An optimized HHR workforce will fuel the Ministry of Health and Long-Term Care’s goals to provide integrated and locally responsive health services, timely access to primary care, and continuity of care between sectors.

We appreciate the opportunity to offer feedback on a proposal to expand the scope of practice of the RN to include the authority to prescribe. RNAO has been urging an expanded RN scope of practice for many years. In 2012, RNAO released the
recommendations of the provincial Primary Care Nurse Taskforce on optimizing the full utilization of primary care nurses to strengthen patient outcomes and generate health system effectiveness in *Primary Solutions for Primary Care*. The taskforce included: Canadian Family Practice Nurses Association (CFPNA), Canadian Nurses Association (CNA), Ontario Medical Association (OMA), George Brown College, Association of Ontario Health Centres (AOHC), Association of Family Health Teams of Ontario (AFTHO), Ontario College of Family Physicians (OCFP), Ontario Nurses’ Association (ONA), Registered Practical Nurses Association (RPNAO), Nurse Practitioners’ Association of Ontario (NPAO), Ontario Family Practice Nurses (OFPN), and Community Health Nurses’ Initiatives Group (CHNIG). The taskforce determined the time had come to authorize an expanded scope for RNs in Ontario, including prescribing, the ability to order diagnostic testing and the authority to communicate a diagnosis, given the strong evidence on the benefits internationally.

In 2012, the nations’ Premiers and Territorial Leaders, recommended through the Council of the Federation’s working group on Health Care Innovation to enable all members of the interdisciplinary team to practise to their maximum scope of practice.

Also in 2012, the Drummond Commission, which conducted a full review of public services, recommended enabling health professionals to practise to their full scope with RNs assuming full responsibility for certain aspects of care delivery, shifting responsibilities from physicians to RNs to optimize human resource capacity while lowering costs, and enabling RNs to provide follow-up care to increase continuity of care and access.

In 2014, the Canadian Academy of Health Sciences suggested modernizing the healthcare environments so RNs could deliver more care without the need for an order, thereby, decreasing the reliance on physicians, increasing the role of RNs and NPs in primary care (i.e. nurse led clinics that provide low complexity primary care), implementing RN-led telemedicine, and enabling RNs to provide follow-up care that will ultimately decrease the number of unnecessary emergency room visits.

In 2015, the provincial Rural, Remote and Northern Area Provincial Nursing Task Force, re-confirmed the need to expand the RN scope to meet health needs in rural, remote and northern regions. Also in 2015, the Ontario Long Term Care Association advocated for more skilled and knowledgeable staff that could respond to resident needs in a timely manner.

In recognition of RNs’ capacity, Premier Kathleen Wynne first committed to expanding the RN scope of practice to include prescribing at RNAO’s 88th Annual General Meeting in 2013. Supportive public opinion was reflected in an editorial in the Toronto Star. In 2014, the Liberal government made RN prescribing a commitment of its re-election platform, and at RNAO's Queen’s Park Day in 2015, Minister Hoskins re-confirmed the government’s pledge to expand the scope of practice for RNs and announced the launch of consultations. On November 4, 2015, the minister referred
the matter to HPRAC to assess three different models for implementing RN prescribing, while being clear that RN prescribing will be proceeding.\textsuperscript{40}

This submission is structured based on HPRAC’s criteria for assessing the three proposed models of RN prescribing specified in the Minister’s mandate letter: independent prescribing, use of protocols, and supplementary prescribing. The definitions provided verbatim by HPRAC are as follows:\textsuperscript{41}

\textit{Independent prescribing:} In this model a nurse may prescribe medications, under their own authority, without restrictions or from a limited or pre-defined formulary within a regulated scope of practice. Independent prescribers are allowed to prescribe any licensed or unlicensed drugs that are within their clinical competency area. As an independent prescriber the RN would be fully responsible for the assessment of the patient’s needs and prescription of medication.

As an independent prescriber, a RN would be similar to a physician in terms of ability to prescribe. However, an RN would not have access to prescribing controlled drugs and substances.

\textit{Use of protocols:} In this model written instructions allow RNs to supply and administer medications within the terms of a predetermined protocol. The use of protocols is used for the supply and administration of named medicines in an identified clinical situation. RNs are only able to supply and administer medications within the strict terms of the predetermined protocol. A RN under this model is responsible for the acceptance of the protocol but the prescribing physician or regulated health professional with prescribing authority* is responsible for the assessment of the patient’s needs and prescription of any medication.

Through the use of protocols, a RN would be able to prescribe specific medications under specific circumstances, similar to how RNs currently prescribe through the use of an order or a medical directive.

\textit{Supplementary prescribing:} Supplementary prescribing is a hybrid of independent prescribing and use of protocols. This model involves a partnership between a RN, physician and patient, where after an initial assessment of the patient’s needs by the physician a nurse may prescribe medication. In this model a patient-specific clinical management plan (CMP) is developed by the nurse and physician that allows the nurse to prescribe within a limited or pre-defined formulary or by class of drugs within their clinical competency area. The collaborating physician shares the responsibility of prescribing and holds full responsibility for the assessment of a patient. There are no restrictions on the type of patient condition or patient population that a CMP could be developed for between a physician and RN.

As a supplementary prescriber a RN, working within a previously established CMP, would be permitted to prescribe for a variety of patient clinical conditions
as long as they are within the RN’s clinical competency.

*Please note: for the purposes of the models outlined above physician and regulated health professional with prescribing authority includes nurse practitioners or any other appropriate non-physician prescriber.

RNAO supports the model of independent prescribing as an enabling framework. There are 96,007 RNs employed in nursing in Ontario. RNs are the largest group of regulated health professionals. They work in all health sectors throughout Ontario. Their diverse distribution throughout the health system positions them to meet the unique needs of Ontarians. Prescribing, along with enabling RNs to order the necessary diagnostic testing as part of their comprehensive health assessment and communicating the diagnosis to the patient would unlock access to the health system.

The limitations inherent in supplementary models and the use of protocols will compromise advancement of the health system goals identified by Minister Hoskins, as well as those identified by the numerous reports outlined above. In both of these models, physicians and NPs will continue to act as gatekeepers as they retain the authority to communicate a diagnosis and order diagnostic testing. They also ultimately maintain accountability for prescribing, which complicates continuity of care and jeopardizes patient safety. Current delegation models (i.e. medical directives and medical orders) do not address a client’s changing or unique health needs and blur accountability as prescribers (NP and physicians) order treatments based on another professional’s (RN) health assessment. Supplementary models and protocols are forms of delegation that would simply perpetuate the same challenges.

While RNAO supports independent prescribing as a regulatory model, it does not suggest that RN prescribing would occur in isolation. Independent RN prescribing refers to a regulatory approach that governs the practice of prescribing. RNs are natural collaborators and independent prescribing would enable the autonomy needed for RNs to thrive in both team environments and in areas where RNs may be the only health provider accessible to Ontarians (i.e. rural, remote and northern communities).
**Risk of Harm & Public Need**

*Risk of Harm*

The risk of harm to patients by independent RN prescribing is minimal. RNAO has developed a model to safely govern independent RN prescribing in Ontario (Figure 1). As regulated health professionals, RNs are required to be aware of their level of competency and practice within it. The College of Nurses of Ontario (CNO) provides RNs with a practice standard that outlines expectations when determining if they have the authority to perform a procedure, if it is appropriate for them to perform that procedure, and if they have the competency to perform the procedure. This could be adapted to regulate independent RN prescribing in a standardized manner across the province.

*Figure 1- RNAO’s Proposed Model to Govern Independent RN Prescribing*

Independent RN prescribing creates an opportunity for RNs to work with their employers to determine the parameters of an expanded scope based on the care being provided and the health needs of the population(s) being served. Under the *Regulated Health Professions Act* employers are responsible for ensuring their employees can
perform the duties of their position without contravening legislation. RNAO recommends that organizations provide role descriptions for RNs practising to an expanded scope, develop a plan to implement the necessary structural and logistical requirements to support RNs in an expanded scope, ensure RNs with an expanded scope have the necessary time and resources to acquire and maintain their competency, including preceptorship and/or mentorship. Peer support should be encouraged between RNs in expanded scopes, nurse practitioners, physicians and others as it boosts confidence and builds relationships within teams.

Currently, when RNs feel a situation is beyond their level of competency, they refer to another appropriate provider. Referrals may involve consultation with another provider, partial transfer of care or a complete transfer of care. This practice will continue as RNs gain the authority to independently prescribe. A qualitative study on RN prescribing in the United Kingdom identified that RNs took a cautious approach to prescribing, felt strongly about their increased responsibility and accountability, and only prescribed medications they were familiar with.

Using protocols as a model of RN prescribing would be re-naming the current status quo of medical directives and perpetuating the same limitations. Protocols will be cumbersome to complete, require regular updating to reflect best practices, fail to address the unique needs of clients, blur professional accountability and become void when the signing practitioner with prescribing authority leaves the organization. In addition, to be done properly, they require that the delegator maintains an ongoing awareness of the specific knowledge, skill and judgment of the delegatee. This is not always practical and creates duplication.

Models of supplementary prescribing have some of the same limitations as protocols and are similar to the current practice of physicians or NPs prescribing PRN (“as needed”) medication. The Canadian government defines PRN medications as “…those prescribed to be given when a client needs them. A PRN prescription includes the frequency with which the medication may be given, such as Q4H PRN.” Supplementary prescribing would require RNs to enter into collaborative practice agreements with physicians or NPs where physicians or NPs will still be responsible for the patient’s initial assessment and diagnosis. Furthermore, the physician or NP will determine which medications the RN could prescribe for that patient. The requirement for a comprehensive clinical management plan limits the applicability of these models to many sectors as they demand long-term and relatively predictable patients. This model is further limited because every change in the patient’s health status will have to be assessed and diagnosed by the physician or NP to be treated. Ultimate accountability for patient care will be blurred, creating significant patient safety concerns, as prescribed treatments could be made under the physician, NP or RN’s authority. This model also has consequences for physicians or NPs that enter into collaborative practice agreements. It will be time consuming for physicians or NPs to develop individual clinical management plans for patients that fall under the agreement and they may be unwilling to assume this additional role. While jurisdictions like the UK initially implemented RN prescribing with these types of restrictions, they were lifted to pursue
independent prescribing as evidence demonstrated positive outcomes on access, safety and person centred care. Indeed, restricting what RNs can do through protocols or clinical management plans are unnecessary regulatory measures that blur accountability and present barriers to clients accessing care.

An evaluation system should be established to track process and outcome indicators during implementation of an expanded RN scope. The framework could engage provider experience, patient satisfaction measures and patient outcome impacts. This evidence will be very useful for Ontario as well as contribute to the international evidence base. As evidence accumulates, the role can evolve and adapt to further meet the needs of Ontarians.

Lastly, and also of importance, all practising nurses, including RNs and NPs, are required by the College of Nurses of Ontario to have professional liability protection (PLP) that protects the public in the unlikely event that negligence or malpractice occurs. RNAO membership meets the PLP requirement and providers members with $10,000,000 of coverage for court-imposed damages, costs, legal expenses and other provisions of the policy.

Public Need

There are approximately 38,503 physicians in Ontario, 2,407 NPs, and 96,007 RNs. With independent prescribing, RNs can unlock access to health services for the public. Below we highlight a few examples, please refer also to Appendix A for a summary of reports highlighting the need to improve access to health services.

1) Public Health

An expanded RN scope is a reasonable extension of public health nursing, especially when working with marginalized and vulnerable populations that are socially excluded or experiencing deprivation. While it is desired to expand comprehensive primary care access throughout the province and progress should continue, some patients/clients may express preference to see the public health nurse for sensitive health concerns. This may occur because long-term and trusting relationships have already been developed. For example, a study of injecting drug users shows they under-utilize primary care physician services due to the discrimination they face when accessing mainstream health services, difficulties keeping set appointments and debilitating co-morbid health conditions. This population preferred to attend a public health nurse-led clinic where they felt less threatened, disclosed more, and accessed continuous primary care services. In these types of settings and through independent prescribing, public health nurses could verify suspected conditions with laboratory testing, communicate the diagnosis to the patient and prescribe the necessary treatment without having to transfer the care to a physician or a NP. However, with supplementary prescribing or protocols, the RN would not be able to intervene for marginalized patients without a physician or NP diagnosis. This leaves RNs unable to treat other conditions they detect through
patient interactions and is a lost opportunity given the infrequent contact marginalized populations have with the health system.

The primary care status quo model of physician-centred solo and small group practices performs the most poorly in meeting the health challenges of people who are experiencing homelessness. Persons experiencing homelessness face numerous challenges in accessing health services: insufficient transportation, no health insurance, lack of a permanent address, distrust of health care providers, and mental health issues. The three models (clinic, fixed outreach, and mobile outreach) that are more effective in meeting the health needs of people who are homeless are interprofessional in nature with heavy reliance on nursing services. RNs strive to break down barriers by building relationships and providing care where marginalized people are including in the shelter, park, or street. Some examples of illnesses RNs prescribe for in this population in other jurisdictions include head lice, pain and fungal infections. These clients may not access care frequently, miss follow up visits or are unable to attend referrals, thus making it challenging to obtain a physician or NP’s diagnosis and develop the comprehensive clinical management plans necessary with supplementary prescribing. Furthermore, given their unique health needs, treatment plans should be based on professional judgment rather than clinical protocols. Having RNs that are able to provide the full spectrum of care (assessment, diagnosis, treatment, and evaluation) will significantly improve access for homeless persons and those living in shelters.

The benefits of independent RN prescribing will also extend to other vulnerable populations, especially those that are continuously facing challenges receiving appropriate health services, such as First Nations, Inuit and Métis persons, refugees and other newcomers to Canada, LGBTQ persons, and persons who are incarcerated in correctional facilities. Additionally, it will serve to improve other long-standing access challenges for diverse ethnic communities and Francophone persons. For example, based on the 2006 census, with a Francophone population in Ontario of over 500,000 and almost 12,000 RNs who declared knowledge of French (and about 7,000 that used it at least regularly), the improvements to accessing health services could be substantive.

Adolescence can be a stressful and complex time of growth and change. Independent RN prescribing complements the critical role of public health nurses in schools. For example, students may feel apprehensive to seek reproductive and/or sexual health services within the traditional routes of the health system. By expanding the scope of practice of the school-based public health nurse, students would be able to receive comprehensive reproductive/sexual health services in an environment that feels safe and comfortable. Along with health promotion strategies, school-based public health nurses with independent prescribing authority, can empower informed decisions, decrease the rate of adolescent pregnancy and enable healthy sexuality.

2) Primary Care

Patients need care closer to home, which encompasses health promotion, disease prevention, and chronic disease prevention and management; RNs already provide these
services. Primary care is the entry-point to the health system and in 2014, 94 per cent of adults reported having a primary care provider (physician or NP). However, the ability of those adults to see their primary care provider on the day or day after they get sick ranged from 28.4 per cent to 57 per cent depending on the LHIN. When analyzing after hours care (evenings and weekends), 45.3 - 73.0 per cent of adults reported difficulty accessing care depending on the LHIN. In 2014, there were 4,277 RNs practising in primary care and given current proposals to restructure the health system, an additional 3,500 RNs can transition to primary care from Community Care Access Centres (CCAC). These RNs will significantly increase the capacity of primary care to deliver health services, including care co-ordination and health system navigation. Authorizing RNs to be fully responsible and accountable for an expanded role through independent prescribing will meet the needs of the public. The Minister of Health and Long-Term Care identifies improving access to primary care as a specific goal to strengthen patient-centred health care in Ontario and studies show that RNs with an expanded scope means clients can get appointments within 48 hours, have more time for consultations, and achieve timely follow up via telephone in primary care. An expanded utilization of RNs in primary care changed team dynamics in the UK as physicians focused on new or complex clients, while RNs focused on clients with predictable conditions. For example, if a client presents in primary care with an uncomplicated urinary tract infection, the RN should be enabled to conduct a thorough assessment (including point of care testing), communicate a diagnosis and initiate treatment. This would avoid unnecessary waits until a physician or NP is available, reduce complications, and lessen walk-in or emergency department visits, thus redirecting health human resources to align with the right provider delivering the right care at the right time.

Supplementary models of prescribing and protocols would not achieve these results. Patients would not be able to get same day or next day appointments for emerging health issues because they would still need to be assessed and diagnosed by the physician or NP. Development of clinical management plans between physicians, NPs and RNs would take time away from direct patient care and represent an administrative burden. Furthermore, every change in authorized treatment would have to be approved by the physician or NP reducing the RNs ability to respond to patients needs. Similarly, if patients’ needs deviate slightly from a clinical protocol, the RN would have to refer them to the physician or NP, thus removing the RNs’ ability to provide care based on their professional judgment.

At present, the bulk of health service delivery in Ontario’s remote communities is provided by RNs. The populations being served are largely First Nations, Inuit and Métis persons. Today, these RNs are already delivering comprehensive care in expanded capacities that include prescribing, providing diagnostic testing and diagnosing illness/conditions. These RNs communicate with physicians or NPs through the use of technology in a consultative capacity. Their work is remarkable, however, they are limited in the scope and application of the medical directives that are used. The effectiveness, safety and accountability of this important role can be enhanced through independent RN prescribing and the ability to autonomously order diagnostic testing and

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the communicate a diagnosis. However, even with these limitations, remote RNs are proof that profession can safely and effectively embrace an expanded role in Ontario’s health system.

3) Acute Care

Provincial wait times in emergency rooms average four hours for low acuity patients and almost 10 hours for high acuity patients. A Canadian policy analysis uncovered overcrowding in emergency rooms was attributed to the challenges patients have accessing their primary care provider. Through independent prescribing models, RNs have the ability to transform primary care access. However, there may be a transition period whereby some Ontarians still pursue unnecessary emergency department care. In those cases, independent RN prescribing would position RNs to lead rapid assessments and provide care that may negate the patient’s need to advance beyond the triage area. Not only does it provide timely care for low acuity patients, it liberates physicians or NPs to care for high acuity patients. These outcomes are unattainable with supplementary or protocol models because physicians and NPs would still have to assess and diagnose the patient. There would be no time to develop clinical management plans required in supplementary models and if the patient deviated slightly from an established protocol, the RN would be unable to provide treatment. Beyond the ER, independent prescribing would enable RNs on in-patient units to monitor changes in patients’ health status and intervene early to minimize the consequences to the patient. Moreover, RNs would be able to independently provide comfort measures in hospitals to treat pain, constipation, nausea, diarrhea, infections, etc without the need for a physician or NPs order. This saves time and money. Supplementary models are contingent on patients having established conditions so medications needed for emerging illnesses may not be included in the clinical management plan. Hospitalized patients are typically admitted because their care needs are rapidly evolving and supplemental/protocol-based RN prescribing would be insufficient to respond to these needs.

4) Home Care

As the health system shifts to increased community care and prompt discharge from hospital, the complexity of care needs for home health-care and support service providers will increase. RNs are integral for assessing patients, providing prompt treatment and evaluating health status in the home. Home care has unique challenges that could be addressed through an expanded scope of RN practice. The RNs practice environment changes with every patient and they work in isolated settings with a significant degree of autonomy that stems from limited opportunities for real-time collaboration with other providers. RNs also gain information at each patient visit and adjust care plans as necessary. Through independent prescribing, RNs will be able to diagnose and treat patients at the point of care. Currently RNs rely on physicians or NPs to prescribe treatment plans based on the RNs assessments and recommendations. Independent prescribing will align professional responsibility with accountability. Supplementary prescribing and protocols do not permit the RNs to promptly respond to
patients’ needs in the home care environment. Patients that receive RN services at home have high needs that require intense care for longer periods of time. Independent RN prescribing removes the need for these patients to physically visit their primary care provider for conditions that fall in the scope of practice of RNs. Instead, the RN could deliver treatment and share this information with the primary care provider to ensure that care is consistent and co-ordinated.

5) Long-Term Care

Although there is an encouraging trend, led by RNAO, to increase access to NPs in long-term care homes, the reality is that for years to come there will continue to be few physicians or NPs in Ontario’s 600+ long-term care (LTC) homes. As of today, physicians and NPs do not practise onsite and instead provide care through scheduled visits or an on call basis. RNAO is delighted that within the next three years there will be 75 attending NPs working permanently within nursing homes. RNAO will continue to insist that all nursing homes should have an NP on-site with a ratio of 1:120 NP per patients, a goal that will take the next 10 to 15 years. We do, however, already have a legislated requirement that every LTC home must have an RN on duty at all times.

Resident care requires consideration of unique characteristics such as chronic disease, polypharmacy, cognitive deficits, and advanced directives. RNs in LTC are experts in managing each of the aforementioned areas. Empowering RNs through an independent prescribing model will facilitate a timely response to residents’ emerging and episodic health needs. As an example, RNs in this sector could manage residents’ pain, hydration, nausea, constipation, etc with a combination of pharmacological and non pharmacological interventions and in concert with the client, their family and other providers through independent prescribing. RNs already provide constant care to residents and would be able to intervene early for the majority of ambulatory care sensitive conditions that currently result in transfers to the emergency department (ED). Supplementary models of prescribing and protocols would be ineffective for emerging health issues because treatment would still be contingent on the resident being assessed and diagnosed by a physician or NP.

Currently, NPs and physicians rely on nursing assessments, management and evaluation to guide residents’ treatment regimes. Resident care plans contain several PRN orders, that may have been set when a resident was initially assessed by a physician or NP and do not address emerging health issues. Use of PRN medication also increases the risks associated with polypharmacy as medications are added to address emerging issues without holistic evaluation of a residents’ pharmaceutical needs. This would continue to be an issue with supplementary models of prescribing and clinical protocols. If a resident experiences a change in health status that the RN cannot manage through historical PRN orders, residents are transferred to EDs. Approximately 22 percent of transfers from nursing homes to EDs are avoidable with responsive primary care. EDs are costly and ill suited to meet the needs of residents in long-term care and risk resident safety. For example, emergency departments can be quite stressful for nursing home residents that are functionally dependent and chronically ill, as they provoke anxiety,
risk complications, reduce continuity of care and decrease quality of life. Of note, these residents have a longer length of stay in EDs because they have to wait for transportation back to their facility or wait longer for inpatient beds. Many long-term care residents present in emergency departments with ambulatory care sensitive conditions including urinary tract infections, dehydration, hypoglycaemia, cellulitis, pneumonia, hypertension, angina, asthma, seizures, congestive heart failure and chronic obstructive pulmonary disease. While some of these conditions warrant acute care, many of these health issues could be appropriately treated and monitored at the long-term care facilities if RNs could order diagnostic testing, communicate diagnoses and independently prescribe medications. A cost analysis found treating ambulatory care sensitive conditions in primary care cost 69 to 86 per cent less than EDs. These cost savings could be achieved by treating these conditions in the long-term care facilities and even prevented with high-quality care management and early intervention through independent RN prescribing.

**Body of Knowledge**

RNAO was the leading advocate insisting that the entry to practice for RNs in Ontario be a baccalaureate degree. We now have among the highest entry to practice requirements in the world. RNs are required to have a broad body of knowledge across many health and medical sciences including pharmacology, immunology, microbiology, anatomy, physiology, pathophysiology, epidemiology, genetics and nutrition. RNs are also required to process data (including laboratory results) and assessment results to evaluate their client’s progress and care outcomes. In other jurisdictions where RNs can prescribe, their foundational education is not as long or comprehensive as it is in Ontario. In the United Kingdom, Australia, and New Zealand baccalaureate nursing degrees are only three years full time while in Ontario baccalaureate nursing degrees are four years full time. The United Kingdom has implemented RN prescribing for the longest period of time and publishes the most evidence on this practice. RNAO supports the model of independent prescribing similar to the UK where RNs were given access to the entire British National Formulary in 2006.

RNs in Ontario have long demonstrated they are capable and keen to expand their scope of practice. In rural and remote areas of the province where RNs may be the only available health-care provider, they act as generalists with high competence in multiple clinical domains and specialties. In Moose Factory Ontario, physicians visit the nursing station once or twice a month with RNs providing primary care, preventative care and stabilizing acute clients the rest of the time. These RNs also respond to codes, complete sutures, conduct full physicals, and remove casting. In Woodstock Ontario RNs provide full reproductive and sexual health care to clients through medical directives and collaboration with an NP. In a northern NP led clinic, RNs assess clients and initiate treatments to enable same-day primary care access (through medical directives).
On many occasions, RNs are the last safety check between a prescription and administration of that medication to the patient. At entry to practice, RNs ensure medication orders are clear, complete, and appropriate considering the patient’s condition, health history, medication history, and possible medication interactions.\textsuperscript{106} It would be irresponsible for an RN to currently implement an order by investing blind faith in the prescriber. RNs have a duty to understand medications (including appropriate storage, transportation, and disposal), provide education to their patients about their medications, understand a medication’s risk of harm and possible adverse events, and manage adverse reactions or near misses (events that could have harmed the patient but was captured before reaching the patient).\textsuperscript{107} RNs already have a strong foundation in assessment and treatment, which can be augmented through additional education to embrace an expanded role, thus enabling RNs to order the necessary diagnostic testing as part of their comprehensive health assessment, communicating the diagnosis to the patient, and prescribing medications.

**Education and Accreditation**

RNAO recommends that current RNs seeking an expanded scope be required to complete an accredited post-graduate course in prescribing/diagnosis in Ontario to receive qualifications to perform these controlled acts. Similar to the UK, the course would be 300 hours including simulation, clinical experience, and mentoring before one is authorized to practise. This course also entails a supervised practicum that was found to be helpful in other jurisdictions.\textsuperscript{108} Delivery of this course could be offered jointly between faculties of nursing, pharmacy and medicine and enable interprofessional education.

RNAO recommends that pursuing independent prescribing be voluntary for current RNs and fully integrated into the baccalaureate nursing curriculum by 2020. Providing the education in this manner will develop expertise from the outset rather than focusing on acquiring competencies afterward and increase standardization of RN practice.\textsuperscript{109} It will help the public and other providers to maintain a consistent understanding of the scope of practice of the RN and minimize confusion. The long-term impact of integrating independent RN prescribing with the baccalaureate program will be felt for generations to come. It means that starting in 2020, RNs would graduate with this competency and become an important driver of access to care and health system efficiencies.

Risk of harm of independent prescribing could be further mitigated through the development of principled standards of practice by the College of Nurses of Ontario (CNO) and through a mechanism to ensure continuing competency through CNO’s existing quality assurance program (i.e. mandating continuing education requirements). CNO’s public registrar can be used to identify those RNs who have successfully completed the required education and have met CNO’s requirements to practise at an expanded scope.
Economic Impact

There is strong evidence to support the expanded scope of the RN, given experiences in the United Kingdom, Ireland and New Zealand. RN prescribing is also being implemented in other Canadian jurisdictions (British Columbia, Saskatchewan and Manitoba). All of this is occurring at a time where health system resources are limited and barriers prevent Ontarians from receiving timely access to care.

Access to care and health system efficiencies will be among the greatest benefits reached through independent RN prescribing. When fully implemented, an expanded scope of RN practice through an enabling framework will help provide Ontarians with same day access to care whether in public health, primary care, street health, shelters, or schools. It will also increase access to health professionals in long-term care and prevent transfers to emergency departments, which represent a significant cost to the system. The provision of ongoing functional assessments, intervening early, providing direct care services, and encouraging independence prevents older adults from needing higher levels of care. This enables them to age in place while reducing costs to the health-care system through decreased hospitalizations and long-term care placements.

RNs are paid through a salary from their publicly-funded employers which range from $60,489 to $85,917 for RNs in Ontario; therefore, there are no direct patient costs for an expanded RN scope. A review of the effectiveness of the first phase of RN prescribing in the UK found that RN prescribing was comparable to physician prescribing. RNs tended to prescribe less costly medications when the effectiveness was similar, and patient need for medication was more frequently re-assessed by RNs. A more recent cost-effectiveness study for antiretroviral treatment found that RNs increased access to care that was not previously available. This study discredits any unfounded belief that enabling RNs to prescribe would lead to over prescribing. In fact, any increase in treatments as a result of RNs working to an expanded scope reflects increased access to care that addressed previously unmet needs. Therefore, impacts to Ontario’s public drug programs would be minimal. In fact, it should help drive efficiencies in the program through upstream and proactive care delivery.

Conversely, supplementary prescribing would create duplication in services between the two health care providers in the collaborative practice agreement. This would create a “double dipping” effect on limited public resources. Protocols would maintain the status quo in the health system which has already been deemed ineffective in providing access to care, consistent care, and utilizing health-care provider time and resources.

Relevance to the Health-Care System and Relationships to Other Professions

Other regulated professionals involved in prescribing, communicating a diagnosis and/or ordering diagnostic testing include: dentists, physicians, NPs, podiatrists, pharmacists, midwives and some physiotherapists. RNs are integral interdisciplinary team members.
that are expected to collaborate with other health professionals, develop care plans and provide continuity of care.\textsuperscript{115} HPRAC previously recommended updating regulatory frameworks to promote interdisciplinary collaboration in \textit{Critical Links: Transforming and Supporting Patient Care}.\textsuperscript{116}

Having regulatory colleges work together towards interdisciplinary collaboration will maximize the competencies and skills of individual providers, improve professional conduct and patient safety, and use regulatory resources more efficiently.\textsuperscript{117} Through collaboration between CNO and other regulators involved with prescribing/diagnosing, the expanded RN scope of practice can be implemented in an effective manner. HPRAC previously described the benefits of an enabling framework to expand NP scope of practice as creating opportunities for interdisciplinary collaboration and recommended applying aspects of this model to other professions undergoing scope of practice reviews.\textsuperscript{118}

Currently RNs are practising in expanded roles through delegation and authorization mechanisms (i.e. medical directives). Of concern, authorization mechanisms such as medical directives differ by organization resulting in discrepancies, while also blurring professional accountability, with delegators not always realizing the professional liability they are assuming. Delegation models assume delegators maintain an ongoing awareness of the specific knowledge, skill and judgment of the delegatee. This is not always practical and creates duplication. Supplementary prescribing models are analogous to delegation models. The physician or NP is required to assess, diagnose and determine medications that the RN could prescribe for the treatment of a patient’s specific condition. Clinical protocols, which are the same as medical directives today, remove the ability for individual providers to tailor treatment plans based on their clinical judgment. They are cumbersome and require processes for updating to reflect changes in best practices. The aforementioned models do not fully acknowledge the breadth of the nursing role, do not consider entire context of patient/client encounters, blurs lines of accountability for patient/client care and increases administrative duties.

In contrast, models of independent prescribing enable development of practice standards and educational pathways that will support safe and effective practice. Independent prescribing allows RNs to be fully accountable for their practice as autonomous regulated health professionals. RNs are champions of working within interprofessional teams and evidence indicates RNs developed collaborative relationships with pharmacists and physicians to support their expanded scope in jurisdictions where independent RN prescribing is implemented.\textsuperscript{119,120} It also enhances interprofessional collaboration by provoking in depth discussions about medications.\textsuperscript{121} Furthermore, while RNs with expanded scope are competent to independently prescribe, many refer to interprofessional care plans when deciding treatment.\textsuperscript{122} RNs with expanded scope will actively engage all interprofessional team members as necessary to promote effective client care.
Relevance to the Profession

Nursing is the largest regulated health profession; RNs comprise the largest share of the workforce and have the greatest distribution across the province and health system (96,007 RNs, 39,109 RPNs, and 2,407 NPs).123 RNs are often actively involved in the prescribing of medication, communicating diagnoses and arranging for diagnostic testing, through delegation. Settings where this frequently occurs include -- but are not limited to: public health units, emergency departments, long-term care, critical care, primary care and nursing stations. However, RNs are limited in this capacity as medical directives do not always respond to the highly contextual cases encountered in the clinical setting. Furthermore, medical directives differ by organization resulting in inconsistent practice and they become void when the signing practitioner leaves the organization. Prescribing through supplementary models or protocols restricts RNs’ clinical judgment, which could leave them vulnerable to accusations of misconduct or unlawful practice due to their lack of authority for particular treatments.124 RNs are ready to have their expanded scope legitimized and to accept full accountability for their practice. Independent prescribing with the authority to prescribe diagnostic testing and communicate a diagnosis is a natural extension to current RN practice. It responds to the many clinical scenarios encountered today where RNs are identifying gaps in care and questioning “if only I could prescribe or initiate testing”. As part of their comprehensive health assessments RNs should be able to order lab testing, swabs, and the collection of specimens. When planning care RNs should be able to include pharmacological treatments as well.

Given that more and more jurisdictions have or are moving to RN prescribing, it is imperative that Ontario move forward in a timely fashion, to improve access to care for Ontarians, enhance health system cost-effectiveness and to retain and attract RNs to our jurisdiction. It is critical that we do so with an enabling model to avoid the pitfalls of our predecessors, who find themselves in a constant corrective mode of moving from restrictive frameworks embedded in protocols, to enabling frameworks such as independent prescribing. There is no doubt that Ontarians will benefit from independent prescribing both in its timely access to health services, as well as by making our province a more attractive destination for RNs who voluntarily choose to relocate here to fully utilize their knowledge, competencies and skills.

Conclusion

Selecting a model of RN prescribing for Ontario is a unique opportunity to advance health system effectiveness by optimizing access to care, providing person and family centred care, increasing health professional accountability, facilitating continuity of care and caregiver, and making our health system more cost-effective. Since 2005 when RN entry to practice was raised to a baccalaureate degree, there have been no significant changes to scope of practice despite the increase in education.125 RNs are integral members of interprofessional teams, have strong clinical assessment skills, pharmacology knowledge and are on the forefront of monitoring and evaluating
patients’ progress. Enabling RNs to order diagnostic testing, communicate a diagnosis and independently prescribe medication aligns their practice and professional accountability. When RNs are responsible for the entire nursing process, care will be person-centred and continuity of care and caregiver will be achieved. Using clinical protocols and fostering collaborative relationships with medical prescribers already happens today and are not producing the urgently needed system-level changes because of their restrictions.

RNAO urges HPRAC, in the strongest possible terms, to recommend the adoption of an independent model of RN prescribing -- inclusive of RNs being authorized to order diagnostic testing, communicate a diagnosis and order medications. We know that HPRAC has the public's interest at heart. We advise you to navigate through any political waters that exist surrounding this matter and do what's right for the public. An evolving population, demands an evolving health system. To sustain and expand Ontario’s cherished publicly-funded and not-for-profit health system and advance the highest possible standard and outcomes of care for the public and the province, we must evolve the scope utilization of all our regulated health professions.
References


RNAO’s HPRAC Submission on Registered Nurse Prescribing


Personal correspondence between Anastasia Harripaul and Crystal Culp on May 12 2015.

Personal correspondence between Anastasia Harripaul and Joanne Andrews on June 2 2015.

Personal correspondence between Anastasia Harripaul and Pam Delgaty on June 1 2015.


Appendix A

Reports on Access to Care in Ontario

Registered Nurses’ Association of Ontario (RNAO)


Access to care is a challenge in Ontario’s rural, remote and northern communities given a multitude of factors, including complexity of care, geographic distance, isolation and limited health human resources. Furthermore, nursing practice in rural, remote and northern areas is unique in that these nurses are often generalists, with a high degree of competency in a number of clinical domains and specialties. A sustainable nursing workforce is needed to promote access to care, better outcomes for people and health system cost-effectiveness in rural, remote and northern settings. However, the retention and recruitment of nurses in these regions is a constant challenge. RNAO engaged a number of stakeholders representative of nursing in rural, remote and northern communities to form a provincial task force, co-chaired by the CEO of the North East LHIN and the Chief Nursing Executive of Health Sciences North, to ensure a stable and sustainable nursing workforce exists in rural, remote and northern areas of Ontario. This report presents barriers and enablers of retention and recruitment in rural, remote and northern areas and recommendations to improve access to care, including an expanded RN scope of practice.


Office of the Auditor General


The office of the Auditor General of Ontario is independent of the Office of the Legislative Assembly and examines areas where the public sector and the broader public sector can make improvements to benefit Ontarians. In the auditor’s most recent report, concerns were raised around access to care in the community. Specifically, long wait times, differing levels of service, geographical discrepancies in service, and differences in per-client funding were identified as issues.


Ministry of Health and Long-Term Care


This discussion paper proposes solutions to address gaps in care including: challenges faced by specific populations when accessing care (Indigenous peoples, Franco-Ontarians, cultural groups, and individuals with mental health and addictions challenges), access to primary care, cumbersome home and community care services, disconnected public health system, and fragmented health services. Key findings include that 57 per cent of Ontarians cannot see their primary care provider the same day/next day when ill, 52 per cent of Ontarians find it difficult to access care in the evening/weekend and low-acuity patients account for 34 per cent of emergency department visits.
Health Quality Ontario


Every year Health Quality Ontario releases a report on how Ontario’s health-care system is performing. Primary care providers are the entry point for the health system and the main contact for follow up and ongoing care. While 94 per cent of Ontarians report having a primary care provider only 44.3 per cent can get a same day or next day appointment, varying from 28.4-57.0 per cent depending on the LHIN region. 52.4 per cent of Ontarians also report that it is very or somewhat difficult to get an evening or weekend appointment. Other areas that emerged as needing improvement for 2015 include wait times for long term care placement from home (longest median wait time is 243 days while the shortest is 50 days), home care services (distressed caregivers have doubled compared to 4 years ago) and unequal progress across the province in avoidable death and rates of hospitalization for ambulatory care sensitive conditions.


Expert Group on Home & Community Care

5. Bringing Care Home (2015)

The Minister of Health and Long Term Care appointed an expert group to provide recommendations to respond to the challenges in home care. From 2008-2013, discharged patients requiring home care services has increased by 42 per cent. Compared to 2009-2010, long stay/high needs clients have increased by 73 per cent. In 2012, 90 per cent of clients receiving home care relied on family caregivers who provide about seven hours of care for every two hours provided by professionals. However, family caregivers do not feel supported by the current home care system. These recommendations in this report propose the planning and delivery of care to be truly client and family-centred, improving support for family caregivers, funding baskets of services, developing capacity planning that considers interrelationships between services, facilitating communication between the sectors especially through primary care, increasing accountability for performance, and enhancing approaches to service delivery.


Primary Health Care Expert Advisory Committee


In late 2013 the Ministry of Health and Long-Term Care convened the Expert Advisory Committee on Strengthening Primary Health Care in Ontario to address current challenges in Ontario’s primary care system. The group identified that there continue to be considerable gaps in both primary health care delivery and overall health system performance. Wait-times to see a primary care provider continue to be an issue, as do unnecessary emergency department utilization and limited access to after-hours primary care services. In response, the Committee proposed a vision for an integrated primary health care system for Ontario, based on a redesign of the province’s existing primary care sector. The foundation of the redesign is a population-based model of integrated primary health care delivery, designed around patient care groups.
Ontario Long Term Care Association

7. This is Long-Term Care 2015

Compared to when the long term care sector was initially developed and funded, residents are more medically complex (97.4 per cent have at least two chronic conditions), are more frail (>50 per cent are over the age of 85), and have higher rates of cognitive impairment. However, funding for the staff required to respond to these greater needs have not kept pace and many homes require renovations to meet current design standards for safety and comfort. The need for skilled and knowledgeable staff that can respond to resident needs in a timely manner is evident when 62 per cent of residents live with a form of dementia, 33 per cent have severe cognitive impairment, 40 per cent have a psychiatric diagnosis, 46 per cent exhibit aggressive behaviour related to a mental health condition, and 40.6 per cent need monitoring for an acute medical condition.

Canadian Institute for Health Information


While consistent with Canadian averages, Ontarians are still waiting an average of three hours in emergency departments for an initial assessment by a physician. Furthermore, admitted patients spend an average of 29.9 hours in an emergency department. From a national perspective, the most common reasons for visiting an emergency department include: acute upper respiratory tract infections, ear infections, fever, abdominal/pelvic pain, throat infections, back pain and urinary system disorders. Canadians (not admitted) spend on average 4-7.4 hours in an emergency department depending on the type of hospital they seek service at.

Registered Nurses’ Association of Ontario (RNAO)

9. Enhancing Community Care for Ontarians 2.0 (2014 and 2012)

Responding to a desperate need to facilitate timely access to care through system integration, this paper provides an overview of the ECCO model to inform and evolve strategies that improve client experience and outcomes, and deliver comprehensive services in a cost-effective and seamless manner. It presents a model of structural realignment that advances a robust foundation for a renewed person-centred health system that emphasizes community care and improves vertical integration across all sectors through a single health system planner and funder – the LHINs. ECCO begins with service and process enhancements by anchoring the system in primary care through horizontal integration (creating primary care networks), expanding the scope of practice utilization of RNs to include prescribing and transitioning the care coordination role function from CCACs to primary care (including the 3,500 care coordinator positions). ECCO is completed with the alignment of public health services with the LHINs, transitioning responsibility for delivering home health-care and support services directly to provider agencies and eliminating the CCAC as a system entity.

In 2014 the Canadian Academy of Health Sciences released a report regarding the optimization of health care professional scopes of practice. These report provided advice to better align health human resource capabilities with health-care services that are relevant to the needs of Canadians. The report suggested modernizing health-care environments so RNs could deliver more care without the need for an order, decreasing the reliance on physicians, increasing the role of NPs and RNs in primary care (i.e. nurse led clinics that provide low complexity primary care), RN-led telemedicine, and enabling RNs to provide follow-up care that will ultimately decrease the number of unnecessary emergency room visits.


11. Primary Solutions for Primary Care (2012)

Recognizing challenges in delivering timely access to primary care, RNAO launched a provincial task force to develop recommendations that optimize the full utilization of primary care nurses - both RNs and RPNs - to strengthen patient outcomes and generate health system effectiveness. The task force was comprised of the major primary care stakeholder organizations, including: Ontario Family Practice Nurses Interest Group, Canadian Family Practice Nurses Association, Canadian Nurses Association, Ontario Medical Association, George Brown College, Association of Ontario Health Centres, Ontario College of Family Physicians, Association of Family Health Teams of Ontario, Nurse Practitioners’ Association of Ontario, Ontario Nurses Association and the Registered Practical Nurses Association of Ontario. It focused on two progressive phases of outcomes. The first phase identified the highest level of scope of practice utilization already present in selected primary care settings in Ontario and recommended an upward harmonization of scope of practice utilization for all primary care nurses, across all sites in Ontario. The second phase involved identifying needed expansions to the existing scope of practice of the primary care RN that would serve to further improve access to primary care for the public. This report presents a review of the literature, historical evolution, nursing human resource analysis, primary care nurse role descriptions, and recommendations.

http://rnao.ca/policy/reports/primary-solutions-primary-care


In advance of the 2012 provincial budget, the government proceeded with a commission to provide advice on how Ontario could receive effective and efficient public services. The commission focused on programs that should be eliminated or redesigned, areas of duplication that could be removed, and areas where return on taxpayer investments could be augmented. The commission had specific recommendations for the health-care system including enabling health-care providers to practice to their full scope and RNs assuming full responsibility for certain aspects of care delivery, shifting responsibilities from physicians to RNs to optimize...
human resource capacity while lowering costs, and enabling RNs to provide follow-up care to increase continuity of care and access.


The Health Care Innovation Working Group

13. From Innovation to Action (2012)

In 2012, the Council of the Federation met to discuss health-care issues on a national level. The premiers agreed that embracing innovation would be a key enabler to improve care. They tasked the Health Care Innovation Working Group with developing recommendations on how best practices within provinces could be shared nationally and how innovation could improve the value of Canada’s health-care systems. A set of recommendations were created on team based models of care which included enabling all members of the interdisciplinary team to practice to their maximum scope of practice.