SPEAKING NOTES

The Standing Committee on Social Policy on **Bill 179**: *Regulated Health Professions Law Statute Amendment Act, 2009.*

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DORIS:

Good afternoon. My name is Doris Grinspun, and I am the Executive Director of the Registered Nurses' Association of Ontario (RNAO). RNAO is the professional organization for registered nurses who practise in all roles and sectors across Ontario. Our mandate is to advocate for healthy public policy and for the role of registered nurses in shaping and delivering health services. I am proud to be joined today by Theresa Agnew, Nurse Practitioner, and member of RNAO's Board of Directors.

RNAO applauds the government's goal to enhance patient safety by increasing access to needed health care through expanding the scope of practice of health professionals within their education, knowledge and competencies.

Though there are a number of welcome changes contained in the Bill that would significantly improve public access and reduce wait times, RNAO is deeply disappointed that without amendment, Bill 179 will continue to underutilize health professionals and unnecessarily limit access -- compromising the health of Ontarians.

We focus our response on four key concerns:

1. Lack of review of scope of practice for Registered Nurses;
2. Legislative limitations placed on nurse practitioners' practice, specifically in relation to the open prescribing of pharmaceuticals; and
3. Regulatory limitations placed on nurse practitioners' practice in relation to admitting, treating and discharging clients to and from inpatient units in hospitals and other settings, the certification of death and NP referral to specialists. While I will speak to the need for legislative amendments to Bill 179, the RNAO also asks the Committee to recommend regulatory changes to the Minister that would be complementary to the objectives of Bill 179 and improve patient care.
4. The need to advance patient safety and strengthen interprofessional practice by transforming Medical Advisory Committees (MACs) into Interprofessional Advisory Committees (IPACs).

<u>Scope of Practice for Registered Nurses</u>

RNAO is gravely concerned with the blatant failure of Bill 179 to review the scope of practice of the nearly 100,000 registered nurses in Ontario and to recognize the RN's high level of education, knowledge and competencies. The practice and role of RNs continuously evolves with changes in work environments, and technology, as well as educational and policy parameters. Bill 179, as it is

currently written, represents a major lost opportunity to better serve Ontario's public by modernizing RN scope of practice.

RNAO calls for an amendment to Bill 179, authorizing registered nurses to dispense, and compound drugs, communicate a diagnosis to a client, and order simple x-rays and mammograms.

In a variety of contexts, RNs already dispense and compound medication utilizing medical directives for patients who meet specific criteria or as a delegated act to respond to a particular client's situation.

For example, RNs and RPNs dispense medication to sufficiently cover hospitalized clients or long-term care residents who have been granted a leave of absence from the facility, like a weekend leave from a psychiatric unit or nursing home, but who need to continue with their medication treatment regime.

RNAO also calls for the authorization for RNs with the appropriate education and knowledge to order simple x-rays of the chest, ribs, arm, wrist, ankle and foot, as well as use energy such as electro-coagulation and defibrillation. Authorizing a RN to order a chest x-ray early in the assessment of an infant in respiratory distress, for example, would aid in the swift assessment and treatment of pneumonia. RNs frequently take the lead in coordinating health promotion programs, such as breast screening clinics, and authorizing a RN to order mammograms would promote the early identification and risk reduction for the client.

The regulation which governs the application of energy also needs updating as it has not kept pace with technological changes. While some acts are outside nursing scope like nerve conduction studies, or electroconvulsive shock therapy; similar acts are now in the public domain, like Cardiac Defibrillators in hockey arenas and shopping malls. RNs regularly perform acts under delegation or medical directive, and RN First Assistants regularly perform electro-coagulation during surgery. We detail these in our submission.

Legislative Limitations on NP Scope of Practice

THERESA:

RNAO is deeply disappointed with the failure of the legislation to lift the onerous limits on NPs' ability to make use of the most appropriate and current medication for their clients. Even the most efficient

listing or de-listing process cannot keep pace with rapid technological change, evolving pharmacological treatments and evidence-based practice, thus leading to real-time delays in client care.

It is not a regulated list of drugs or tests that ensures appropriate prescribing, ordering and monitoring by nurse practitioners. Rather, it is the nurse practitioner's competencies in: health assessment and diagnosis; health-care management and therapeutic intervention; health promotion and prevention of illness, injury and complications; and professional role and responsibility that promote safe practice.

Here is one example. With the imminent arrival of the 2009 Flu season, NPs in the province are preparing for a surge in illness by offering their clients influenza vaccinations. However if the H1N1 Influenza virus remains the primary circulating virus as is predicted, NPs will be unable to prescribe the specific H1N1 vaccine to their clients, as it will not be placed on their designated list in time to be of any good.

RNAO recommends that nurse practitioners be authorized to openly prescribe within the full scope of their practice without having to refer to lists, as is already happening in most Canadian jurisdictions and across the U.S. Ontario would be an isolated outlier if Bill 179 were passed with the proposed list-based approach. This is not the kind of leadership we expect of Ontario.

RNAO also notes the absence of authority for NPs to order MRI and CT Scans, and the anatomical limitations which restrict NP ordering of Diagnostic Ultrasound and x-rays. The level of assessment conducted by a NP prior to the ordering of any diagnostic image or laboratory test is very thorough, and authorizing the ability to order these specialized images would not only increase the overall efficiency of NP assessment and treatment, but will also reduce costs to the system as a whole.

Regulatory Limitations on NP Scope of Practice

RNAO also strongly urges the committee to support regulatory amendments to *Regulation 965* of the *Public Hospitals Act* to authorize nurse practitioners to admit, treat and discharge hospital inpatients, to certify the death of a client, and to refer clients to specialists on the same basis as physicians. We detail the latter two in our written submission.

Regulation 965 significantly limits NPs from opening access to the public by working to their full scope in a hospital inpatient setting. At present, they are only entitled to admit and discharge clients from outpatient settings like clinics or hospital emergency rooms and have not been granted privileges to admit a client from the emergency room to an inpatient unit, or from one inpatient unit to another.

Similarly, the order for the client to be discharged can only be made by the attending physician, midwife or dentist. There are substantive delays in patient flow, which are the direct result of physicians being unavailable to write admission and discharge orders. A clear effective way to reduce client wait times is to grant NPs expanded hospital privileges, promoting a significant improvement in the turnover of clients through the health-care system.

RNAO strongly supports the development of a health-care system utilizing a client-centred model, where Ontarians have access to continuity of care and continuity of caregiver from a Primary Health Care Provider.

In order to achieve the objective of improved and streamlined access to care for clients and full integration of NPs in Ontario's health-care system, full access to referral for consultations by specialists for NPs is essential. For example, in my own practice, under the current system, I can not refer a prenatal client to an obstetrician or someone with an abnormal pap smear to a gynaecologist.

Changes are needed to allow specialists to claim an equitable consultation fee for patient referrals, which are made directly by nurse practitioners. At present, a specialist can only claim the full fee upon referral from a physician.

NPs are the primary care providers for many individuals and families. They must be able to refer to specialists on the same basis as physicians. We recommend amending regulation 552 of the Health Insurance Act to enable specialists to bill for a referral from a nurse practitioner.

DORIS:

Interprofessional Advisory Committees

Lastly, we urge the committee to consider a recommendation to advance patient safety and strengthen interprofessional practice. Medical Advisory Committees (MACs) are responsible for the appointment of physicians, and determining hospital privileges for other staff; as well as the revocation or suspension of the appointment of or refusal to reappoint a member of staff.

The provision for MACs in the *Public Hospitals Act* is a barrier to collaborative practice as it reinforces the inequitable power relations between physicians and other professionals. In addition to client safety being put at risk, power differentials compromise workplace safety for staff. The investigation into the workplace murder of RN Lori Dupont, our colleague in Windsor is an extreme result of this power differential.

We urge you to amend the *Public Hospitals Act* and replace the MAC with an Interprofessional Advisory Committee – IPAC - composed of members from all regulated health professionals. We have already taken this message to the Premier and Health Minister and urge you to do the same. The government can't have it both ways. We cannot advance interprofessional collaboration while maintaining archaic organizational structures that maintain the power in only one profession. It's time to move us all to the 21st century by modernizing hospital structures and sharing power and expertise – the LHINs are already doing so within their advisories.

Thank you.