Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

RNAO Speaking Notes:

Bill 141: Health Protection and Promotion Amendment Act, 2011
The Standing Committee on Social Policy

March 22, 2011

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Speaking Notes

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Bill 141: Health Protection and Promotion Amendment Act, 2011

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. We appreciate the opportunity to address the Standing Committee on Social Policy on Bill 141.

Nurses are in a unique position to provide feedback on a pandemic response. We are the health professionals who deal directly with members of the public during a pandemic and help coordinate and provide care. Safeguarding the public by preventing the rapid spread of virulent sickness and disease is without question, a high priority.

At the outset, I extend, on behalf of RNAO our warmest congratulations to the Chief Medical Officer of Health, Dr. Arlene King, on her courageous and expert leadership.

It served to galvanize the collaboration of health-care providers across this province towards a common goal: overcoming H1N1; a new virus that had the potential to be deadly. RNAO also wishes to salute the thousands of health-care professionals, among them nurses, including those who work in public health, who painstakingly developed and revised their pandemic plans and implemented their roles with the utmost professionalism and care.

RNAO supports Bill 141 in general. We have several amendments that, if adopted, will strengthen Ontario's emergency public health response and address serious omissions in the legislation.

The province's goal is to improve the response for the next public health emergency by implementing supportive legislation. Our goal is the same.

However, this bill addresses only three areas of concern, while many solid recommendations made in various ministry reports and at meetings of the Ontario Health Plan for an Influenza Pandemic have not been adopted in this bill - a lost opportunity in our view.

It is true that Ontario's response to public health emergencies today (including H1N1) is much more robust than what we experienced during SARS, especially in terms of communication, coordination and in seeking the advice of nurses. For someone like me, who lived through both events, the difference in response is like night and day. And yet, we cannot stop at the half-way mark.

The legislation as it stands, neglects the need for additional surge capacity and fails to clarify the roles and responsibilities for LHINs and primary care providers under the direction of the Chief Medical Officer of Health. An integrated system response, which we urgently need, is still eluding us. In light of these gaps, RNAO offers several recommendations, which are detailed in our written submission. I will speak to four of them.

First, RNAO is pleased to endorse the provisions in Bill 141 that would strengthen local leadership within each public health unit, including those that would standardize the qualifications of each Medical Officer of Health. With nine out of 36 public health units currently operating with an acting MOH, it is hoped that this legislated process will result in more consistent, qualified and knowledgeable officers.

A new provincial requirement to have a Chief Nursing Officer (CNO) in every public health unit by 2013 – a progressive step that the RNAO very strongly supports - further strengthens the growing leadership capacity in public health at the local community level.

Nursing leadership is essential during a pandemic response, and yet this role is not mentioned in this bill. Chief Nursing Officers (CNO) are necessary to ensure clear lines of communication within Public Health Units.

While the chain of command for Chief Medical Officers of Health will be extended by this bill, there is an assumption that the Chief Medical Officers

of Health and the Medical Officer of Health understand the full professional competencies and responsibilities of nurses and public health nurses. Unfortunately this assumption does not always hold true.

Considering that nurses and public health nurses make up half of the human resources in public health, the Chief Nursing Officer role is a strong and welcome step in the right direction. With this new-found capacity, Medical Officers of Health and the Chief Medical Officers of Health should plan to use Chief Nursing Officers to inform planning, strengthen emergency response and facilitate process and outcome evaluations. Integrating Chief Nursing Officers will not cost the government anything and will lead to better outcomes.

A Chief Nursing Officer will also be able to clarify for both nurses and other professions how nurses may or may not practise within the set scope as set out by the College of Nurses of Ontario. This type of clarity is critical in pandemics such as H1N1 when nurses are redeployed out of their usual practice setting.

For these reasons, the RNAO urges that the Chief Nursing Officer role be fully integrated in Bill 141.

Our second recommendation relates to planning for the worst case scenario. It would be nice to think that the world's next pandemic may be similar to H1N1, yet we all know a much more deadly attack looms on the horizon. The question is: Are we ready for the worst case scenario? More powerful directives and better qualifications are not all that is required for coordinated system response. As the Chief Medical Officer of Health noted in her report:

"The caution is this: Had the pandemic been of a significantly more severe nature, we might not have been as ready. Our acute care system managed, but had many more people swarmed our emergency rooms for much longer, that might very well have tipped the system. In addition, had there been many more deaths early on, the demand for health-care services might have overwhelmed an already taxed delivery system."

In developing legislation such as Bill 141 and policies to prepare for the worst case scenario, the following questions must be asked:

- How can we strengthen this bill so we can protect the public even if our prevention strategies fail?
- How will our ERs accommodate treatment for thousands more when they are already operating beyond capacity?
- How will ambulances respond when they are already waiting at hospitals to offload?
- What surge capacity can you count on when RN positions are being cut and expert nurses are offered early-retirement packages through hospital restructuring processes?

If we address system shortfalls, with better surge capacity and stronger coordination of services, we will be able to manage the next emergency.

Thus, RNAO recommends the following:

- That the Ontario government build, monitor and strengthen the surge capacity of registered nurses, and public health nurses in particular,

by meeting its commitment to increase the nursing workforce by 9,000 additional positions by 2011. Ontario has already added 5,579 nurses during the first two years of the McGuinty government's current mandate, thus we are well on our way to achieve the targeted 9,000. We now need to hire 3,421 additional nurses to meet this target. Given that Ontario's RN per population ratio, as compared to the national average, is worrisomely low -- requiring in fact 14,000 more RNs in Ontario to catch up -- it is crucial that the remaining 3,421 positions be full-time RNs.

- That the government establish a subcommittee of the Ontario Health Plan for an Influenza Pandemic that consists of registered nurses, including public health nurses, ER physicians, and ambulance personnel.

The third recommendation we want to address relates to the need for better coordination of LHINs, public health and primary care.

All available resources must be mobilized when planning and creating a coordinated system of emergency response. Any local health integrated network that is not mandated to include public health services

compromises public safety by not being able to respond as effectively to a pandemic threat. It's time the LHINs were made a formal part of the system by mandating their role and clarifying the direction they receive from the Chief Medical Officer of Health to ensure the most coordinated response when called on.

With the establishment of Nurse Practitioner-Led Clinics across the province – 26 are expected to be up and running by September of this year and the substantial increase in the number of practising Primary Health Care Nurse Practitioners, RNAO believes that accurate reporting should include nurse practitioners as key primary care providers.

The RNAO recommends the following:

- Create an integrative role and function for LHINs, public health units and primary care providers in their planning, response and evaluation of public health emergencies while clarifying the Chief Medical Officer of Health's chain of command to each; and,
- Include Nurse Practitioners (NPs) and NP-led clinics among family health teams (FHTs) and community health centres (CHCs), within a

more integrated, consistent and planned “system” response to public health emergencies.

Finally, it is crucial that pandemic plans not forget those who are most vulnerable and have difficulty accessing pandemic services.

Planning must include drop-ins, shelter-based health services and street outreach services, not just mainstream services such as hospitals and other residential settings. Methods must be found to reliably conduct surveillance and health promotion among vulnerable populations, including the homeless and those who live in shelters.

RNAO has appreciated being involved as a partner in pandemic planning and in the review of the H1N1 response from the outset.

We offer these recommendations to improve future pandemic responses. Thank you for the opportunity to comment on this important bill.