Saad Akhter (right) predicts a better quality of life for long-term care residents like John Wood (left) once RNs are allowed to prescribe.

PREScribing change

With RN prescribing comes reduced wait times and advanced chronic disease prevention and management. By Daniel Punch
long-term care RN enters a resident’s room late at night and finds him sick, confused and scared. His blood sugar is through the roof and if it doesn’t come down soon, he could be in real trouble.

The nurse knows he needs insulin, but it’s not within an RN’s scope of practice to provide it without an order from a physician. The home’s only doctor isn’t due in until next week, and isn’t answering the phone. To make matters worse, the resident suffers from dementia, and has just settled in after being transferred from hospital.

“What does the RN do at this point?” asks Saad Akhter, director of care for a Niagara area long-term care home. “Instead of giving insulin, they send the resident to hospital.” At best, the trip to the emergency department will be traumatic. At worst, he’ll come back with a hospital-acquired infection or pressure ulcer, Akhter says.

“(Going to hospital) is not in the best interest of the resident. Their quality of life decreases,” Akhter laments. “If you could provide that care in the home, why wouldn’t you?”

This is why Akhter is a strong advocate for giving RNs the right to prescribe medications. He calls unnecessary transfers to hospital “the biggest challenge in long-term care,” and he believes Ontario could cut expensive and unnecessary transfers in half by allowing RNs to prescribe.

That kind of potential for streamlined care is behind RNAO’s pursuit for expanded scope for RNs as well. The association’s 2012 report Primary Solutions for Primary Care describes an Ontario where primary care becomes the anchor of a health system that provides same-day access, and hinges largely on RNs being able to prescribe in all areas.

“(Expanding RNs’ scope) is going to make us more competent, it’s going to make us more efficient, and it’s going to improve the quality of our care,” says Akther. “In the next five years, you’ll see a big change (in the health system) if you let us do this.”

In 2013, Premier Kathleen Wynne first announced that she would be expanding the scope of Ontario RNs to a roomful of nurses at RNAO’s annual general meeting. At Queen’s Park Day 2015, Wynne and Health Minister Eric Hoskins reiterated this pledge, and announced that consultations in collaboration with RNAO would begin this year.

“RN prescribing is simply a perfect fit with our vision of a health-care system that puts patients first,” Hoskins explains.

RNAO has already laid out its vision for expanded scope, including three major changes: RNs in the general class should be able to prescribe medications; communicate a diagnosis; and order diagnostic testing and imaging. “RN prescribing is critical to unlocking the power of our health system, reducing wait times in all sectors and services, and advancing chronic disease prevention and management,” says RNAO CEO Doris Grinspun. “Health services in Ontario will be transformed when the province’s 105,703 RNs become eligible to prescribe. It will improve health outcomes and health system efficiency.”

Under RNAO’s proposed plan for prescribing, RNs currently working in Ontario who choose to pursue an expanded scope – it will not be mandatory – would be required to complete a 300-hour course focusing on pharmacology, and including classroom hours, simulation, clinical experience and mentored practice. A final evaluation will ensure that these RNs have all the necessary competencies to prescribe. Once they are authorized to prescribe, their status as prescribers would be tracked by the College of Nurses of Ontario (CNO), which could enhance its quality assurance program to ensure RNs maintain competency. For future RNs, the new prescribing curriculum would be incorporated into undergraduate nursing programs by 2020, making it an entry-to-practice competency.

It’s similar to the path nurses took in the United Kingdom, where RNs were first given the authority to prescribe in 2003. The results speak for themselves. A 2010 report from the Scottish government showed RN prescribing resulted in better care, faster access to medication, and better use of both nurses’ and physicians’ time. Polls have also indicated that public satisfaction and confidence in RN prescribing is high.

RNAs are also prescribing in Australia, Finland, Ireland, New Zealand, Norway, South Africa, the Netherlands and the United States. Closer to home, at least six other Canadian provinces have expanded, or are at various stages of expanding, the scope of their RNs.

But you don’t have to look overseas, or even across provincial lines, to find RNs prescribing. Many Ontario RNs are ordering tests, making assessments, and providing
crucial medications every day under medical directives (orders that defer authority to perform tasks traditionally only performed by physicians). These directives are commonly used to expedite patient care in health-care environments where a physician may not be immediately available.

Natalie Fawcett is supervisor of an Ontario sexual health clinic, where RNs have been working with medical directives for years. Among other things, the clinic’s

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HEALTH MINISTER ERIC HOSKINS

RNs order tests to screen asymptomatic clients for sexually transmitted infections, then diagnose and prescribe treatments based on positive lab results.

Physicians and nurse practitioners aren’t always available, so allowing nurses to provide these services increases access and promotes continuity of care, Fawcett says. And if a potentially HIV-positive client comes in, they need to be tested and diagnosed as soon as possible in order to prevent spread of the disease. Having the medical directive helps the clinic provide the best care, allowing nurses to screen “well” clients and free up time for physicians to deal with more complex health needs, she says.

But it’s not a perfect system.

The directives must be updated at least once every two years – a process that Fawcett calls “a real rigma role.” Policies, procedures and training must also be renewed along with the directives. Her clinic has the resources to make this happen, but many others do not, which speaks to a disparity in care across the province.

“It would be much easier going forward with RN prescribing,” she says.

Fawcett, a nurse practitioner, is responsible for training RNs on their expanded duties, and says most thrive when working with a broader scope. More important, perhaps, it allows for timely care – particularly for marginalized populations, she adds.

Many of the clinic’s clients are new immigrants, refugees, or members of the LGBTQ community and “they don’t always have an easy time accessing medical systems,” Fawcett notes. Since nurses in many sectors work out in the community, allowing them to couple health promotion with prescribing things like vaccines and contraception would help them meet the needs of people who often fall through the cracks, she says.

Few Ontarians are more marginalized than those living in the isolated communities of the north. Recruiting and retaining health professionals in northern, rural and remote communities is notoriously difficult. This is the reason behind the 2015 RNAO-led task force that produced Coming Together, Moving Forward: Building the Next Chapter of Ontario’s Rural, Remote and Northern Nursing Workforce. RN prescribing is a key recommendation in that report.

In communities like Chapleau, a town of 2,000 located more than a two-hour drive from Timmins, RN prescribing is not only a necessity; it’s a reality. Under medical directives, RNs in the Chapleau Health Services emergency department can assess a patient, order diagnostic tests, and treat with certain medications. In a community with only three physicians – who cycle through the local hospital, family health team and long-term care home – it keeps patients from waiting and sometimes expedites life-saving care, says Anne Morris, Chapleau Health Services’ director of clinical services.

INTERNATIONAL

AUSTRALIA
RNs who complete supplementary education can prescribe scheduled medicines in rural and isolated practices, as part of mental health care, pediatrics, and care for people with disabilities.

IRELAND
After completing additional education, RNs can prescribe from a list representing four clinical areas: drugs for pain relief in hospital, drugs for palliative care, drugs for midwifery, and drugs for neonatal care in hospital.

SOUTH AFRICA
RNs with expanded scope have authority to prescribe treatments for HIV, which helps manage the country’s high rate of the disease.

UK
Since RN prescribing was first implemented in 2003, more than 19,000 RNs have qualified to prescribe in two categories: independent prescribers whose prescribing capabilities are on par with physicians, and include controlled drugs; and supplementary prescribers who prescribe in partnership with a doctor.

IN CANADA

BC
RNs who have the competencies and educational preparation to do so, can order ultrasounds/x-rays and administer schedule I and II drugs without an order in certain circumstances. They can also initiate wound care, including suturing, and manage labour when a primary maternal care provider is absent.

SASKATCHEWAN
The provincial regulatory body has created an additional designation called “authorized practice,” which allows RNs with additional education to diagnose, prescribe and order certain tests based on use of clinical decision-making tools.
“Technically, without a medical directive, if someone comes in with a coronary, the nurse isn’t even supposed to put oxygen on them,” Morris points out.

But medical directives still put the onus on the physician for the care they delegate. With province-wide expanded scope, Morris says RNs could take responsibility for the medications they prescribe and ongoing assessment to ensure they are effective.

“If (registered) nurses are prescribing, it’s their responsibility...and you don’t have to involve the physician until it is necessary,” she says.

Nearly 900 kilometres to the southeast, in a hospital with more staff members than Chapleau has residents, the CEO has seen similar benefits from allowing RNs to initiate medical treatments. The emergency department RNs at Ottawa’s Children’s Hospital of Eastern Ontario (CHEO) use medical directives to treat children suffering from fever, asthma, infections and other ailments.

If all CHEO RNs could have that same prescriptive authority, CEO Alex Munter says children could avoid extended waits for care.

“The more empowered our RNs are, the more effective our operation will be, and the better the quality of care and patient experience will be,” Munter says.

Looking at the broader health system, Munter says the biggest benefits from RN prescribing could be for long-term care and community settings, but these improvements would reverberate through the entire system. The more Ontario can increase the capacity of health professionals working in the community, the healthier people will be at home, and the less they will visit emergency departments, he says.

Facing deficits and an aging population, the Ontario government released its 2015 Action Plan for Health Care with a focus on shifting care out of hospitals and into the community. This, coupled with increasingly complex patients, requires all staff in home and community care to practise to their fullest scope, says Helene Lacroix, a two-decade veteran of the sector. She says RN prescribing will help home care practitioners initiate treatment as soon as issues arise – particularly after hours, when access to physicians is limited.

“Picking up on issues and concerns sooner and being able to respond to them sooner... could have an impact on overall system utilization,” says Lacroix, suggesting cautiously that “…it could be big if the systems and structures and processes are put in place.” This VP of nursing for Saint Elizabeth Health Care is not alone in adding this caveat when discussing such large-scale change for the profession. Many RNs who support an expanded scope also express concern that it will not be as effective without adequate education, clear guidelines, and increased communication between all members of the health-care team and their patients.

Three recent examples of expanding scope of practice could serve as models. Since 2012, nurse practitioners have had the power to admit, treat, transfer and discharge patients in hospitals. This year, 30 nurse practitioner positions will be funded as “attending NPs” in long-term care homes – a role previously reserved for physicians. And, last year, RNs were given the authority to dispense medications, which until 2014 was a delegated act.

“All of these initiatives were triggered and shepherded to the finish line by RNAO,” says Grinspun, and the goal was always to improve timely and quality access. “Such is the goal with RN prescribing,” she adds.

Some may wonder how RN prescribing might affect role clarity, and whether having RNs prescribe could overlap with the responsibilities of NPs and doctors. With this in mind, RNAO involved a diverse variety of health-care stakeholders in its research into expanding RNs’ scope through the Primary Care Nurse Task Force. The association is advocating that RNs prescribe within their scope and competency – depending on their role, experience and setting – rather than from a predetermined list. Given their higher level of education, NPs will continue to have a broader scope than RNs.

As an NP working in a sexual health clinic where RNs already prescribe, Fawcett sees a potential change in scope as a positive. “As long as parameters are very clearly spelled out, I think we can certainly work alongside each other very effectively,” she says.

Akhter says he doesn’t foresee RN prescribing affecting the dynamics between his staff members in long-term care. If there is some overlap in duties, he says it could foster healthy discussions on behalf of patients’ best interests. Ultimately, he says RN prescribing will lead to major benefits for the broader health system – which is good for all Ontarians.

“Our health-care system isn’t in the best place right now, we all know that, so we need to improve and go forward,” Akhter says. “Give us the ability to do more so we can help build a better system.”

**CHEO CEO ALEX MUNTER**

### When could RNs prescribe?

RNAO offers an illustrative (but not comprehensive) list of scenarios where RNs could order tests, diagnose and prescribe. These are divided into three categories:

**PREVENTATIVE CARE**
- Vaccines
- Reproductive and sexual health
- Prophylactic treatments
- Diagnostic testing (i.e. bloodwork)
- Disease screening (i.e. fecal occult blood test, mammography, tuberculosis)
- Foot care

**CHRONIC DISEASE MANAGEMENT**
- Refills for established medications
- Cardiovascular disease
- Diabetes
- Asthma and respiratory health
- Osteoporosis
- Chronic mental health
- Blood clotting
- Wound care

**EPISODIC ILLNESS**
- Otitis media (middle ear infections)
- Uncomplicated urinary tract infections
- Dehydration
- Strep throat
- Dermatological conditions
- Nausea/vomiting
- Non-opioid pain management
- Constipation

**Daniel Punch is staff writer for RNAO.**