RNAO QPOR QUEEN's PARK ON THE ROAD 2018

Reclaiming the role of the RN

Ontario has a shortage of RNs and the lowest RN-to-population ratio in the country. Will you support improving patient safety and health outcomes by mandating that:

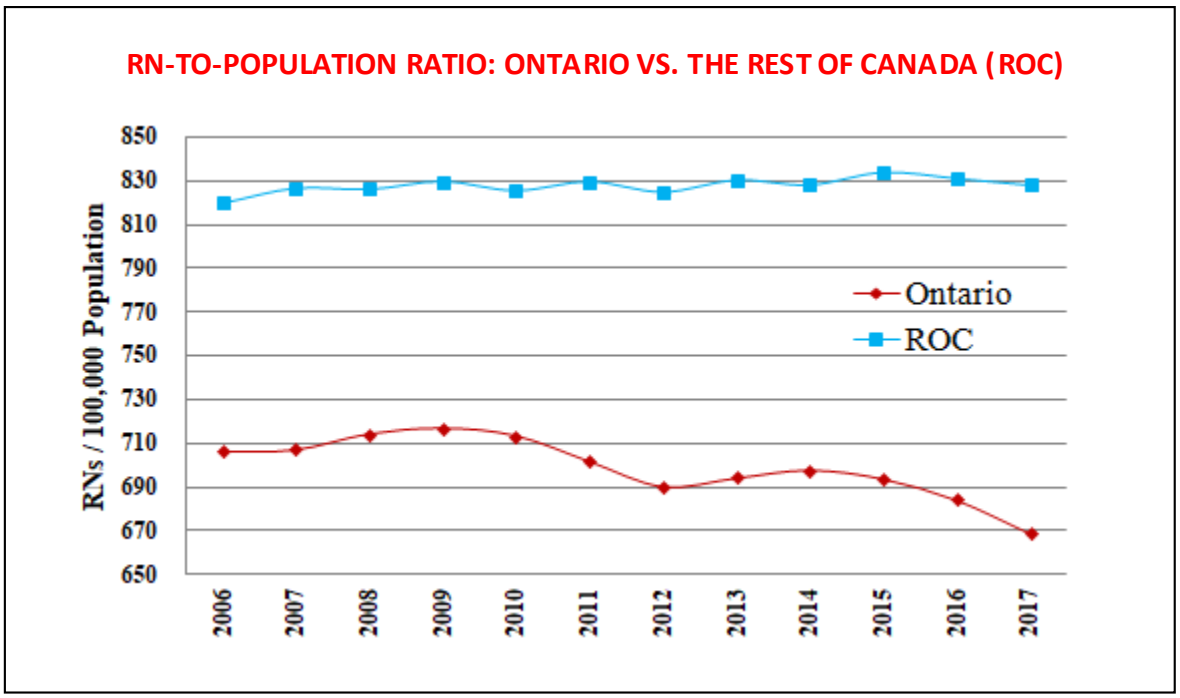
- **10,000 RN vacancies in hospitals be immediately posted and filled**
- **All new nursing hires in acute care and cancer care hospitals be RNs**
- **All first home care assessments be conducted by an RN**

Will you support increasing access to health services by ensuring that:

- **Independent RN prescribing is implemented**
- **RNs are allowed to continue to initiate and perform the controlled act of psychotherapy**

Ontario needs more RNs

Ontario has a shortage of RNs. Despite evidence that RNs deliver better results for lower cost, this year – for the third year in a row – the RN-to-population ratio in our province is the lowest in Canada.[1] [2] The Canadian Institute for Health Information figures show that Ontario has only 669 RNs per 100,000 people compared to an average of 828 RNs per 100,000 people in the rest of Canada.[3]

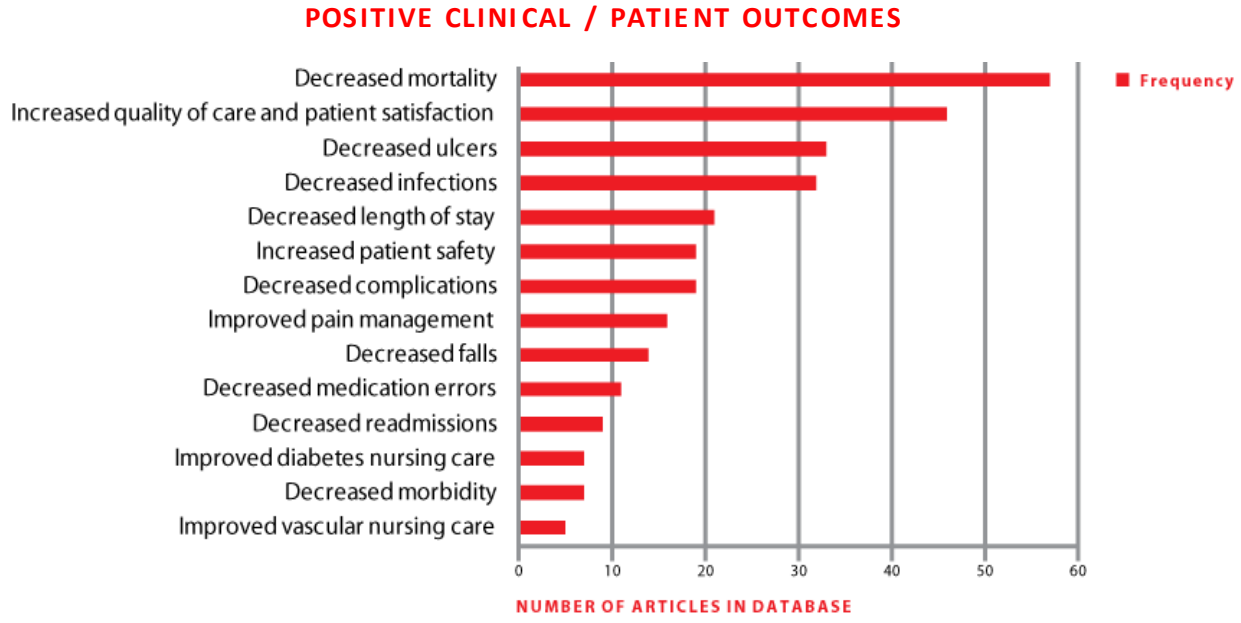


These numbers are a wake-up call for people concerned with the state of our health-care system. Patients and families are all too familiar with the phenomenon of hallway nursing. This problem exacerbates and highlights the RN deficit. Calculations by the Ontario Nurses' Association show there are more than 10,000 vacant RN positions in hospitals across the province.[4] **RNAO calls on the Ontario government to immediately post and fill the 10,000 RN vacancies in hospitals.**

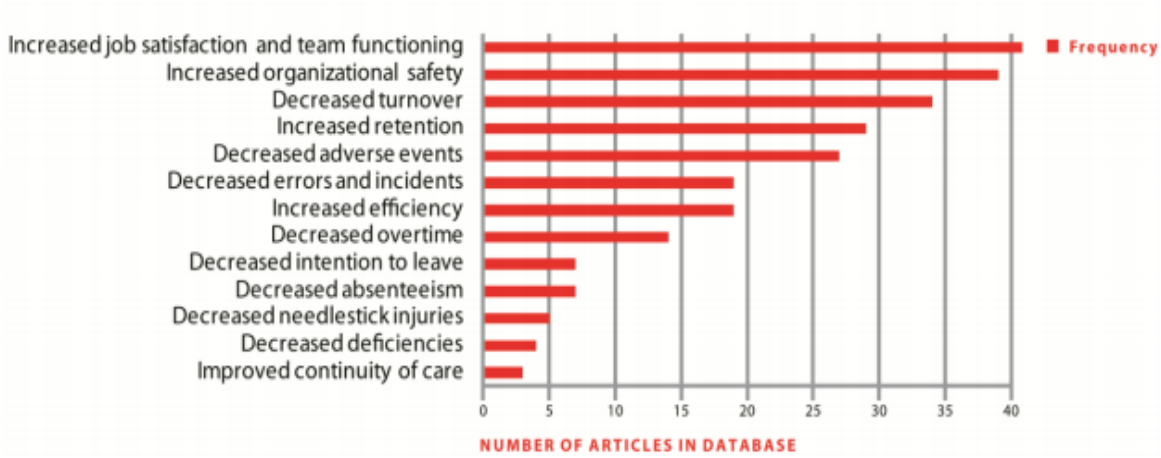
RN care results in a more effective and efficient health system

Decades of studies conclusively show that RNs are essential for better clinical, organizational, and financial outcomes in our health system.[5] The largest publicly available database of research on RN effectiveness, released in 2017 – comprised of 626 studies – shows that when RNs provide care, there is higher patient satisfaction and that those patients are less likely to experience infections, falls, pressure sore injuries, pneumonia, cardiac arrests, and death.[6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25] As well, patient outcomes improve when RNs provide direct care instead of assuming primarily a supervisory role.[26] RN care is linked to shorter lengths of stay in hospital, fewer medication errors, lower readmission rates, and improved organizational effectiveness.[27 28 29 30 31 32 33 34 35 36 37 38] A greater proportion of RNs also results in greater costs savings to our health system.[39 40 41 42]

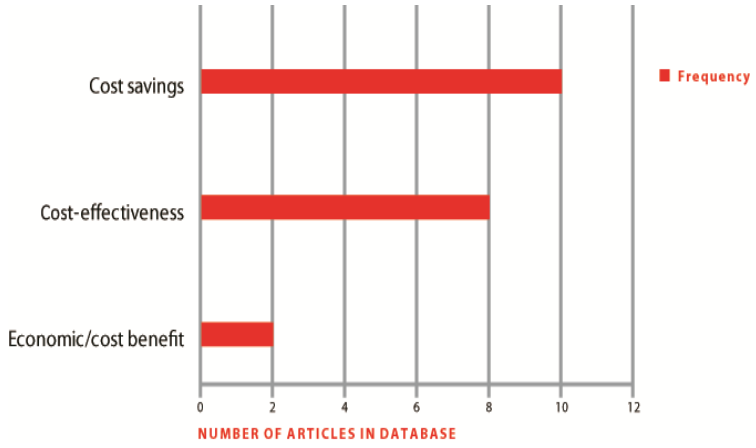
Overall the result of RN care is a more effective and efficient health system.[43] **Given this overwhelming evidence, it is imperative that Ontario reverse the damaging trend of the declining RN-to-population ratio.** Ontarians can't afford the consequences.



POSITIVE ORGANIZATIONAL AND NURSE OUTCOMES



POSITIVE FINANCIAL OUTCOMES



The right nurse in the right place

For patients to have the best possible outcomes, it is essential to match the appropriate nurse with the needs of the patient.[44] The College of Nurses of Ontario (CNO) outlines three factors that should guide decision-making in determining the appropriate care provider assignment: the client, the nurse, and the environment.[45] These factors inform which category of nurse to match with which patients based on patient complexity, predictability, and risk of negative outcomes. More complex patients with less predictability and less stable environments should be cared for by RNs. Less complex patients, with more predictability and a stable environment may be cared for by RPNs.[46]

Nursing workforce distribution is also known as nursing skill mix. Effective nursing skill mix decisions are essential to ensure timely access to safe and quality care, and to improve outcomes for patients, organizations, and the health system. In the landmark 2016 report, *Mind the safety gap in health system transformation: Reclaiming the role of the RN*, RNAO highlighted how

nursing skill mix is being diluted.[47] The RN share of Ontario's nursing workforce is plummeting, in part because of the troubling trend of replacing RNs with less appropriate health-care providers for patient complexity. This practice puts patient outcomes and safety at risk, and is especially concerning at a time when patient complexity is increasing across all health-care sectors. Yet RNAO continues to hear of these trends across the provinces in various health-care settings and sectors.

In acute care and cancer care hospitals, the vast majority of patients require the advanced knowledge, competencies, and judgment of RNs. These centres are designed to provide care specifically to persons with high degrees of complexity and instability. Diluting RN care in these settings is a risk for patients and the system that Ontarians can't afford to take. **RNAO urges that all new nursing hires in acute care and cancer care hospitals be RNs.**

The complexity and prevalence of patients receiving home care have also increased as patients are being discharged from hospital much earlier than ever before.[48] The practice of home care nursing requires a diverse knowledge base to manage patient care across the lifespan.[49] During the initial visit, the complexity and stability of the patient is often unknown.[50] It is critical that all initial home health-care visits be provided by an RN because they have the expert knowledge, skill, and judgment required to perform a comprehensive assessment and develop a care plan that ensures a patient's complex needs are met safely in their homes.[51] **RNAO is calling on the Ontario government to mandate all first home care visits be completed by RNs.**

Models of nursing care

Patient safety is of the utmost importance in choosing the appropriate organizational model of nursing care delivery.

Functional models of nursing care fragment care based on tasks, which results in miscommunication and errors. This practice, also known as "functional nursing", was abandoned in the 1970s due to its detrimental impact on patient experience and outcomes. It has now re-emerged as "team nursing." Functional models view nursing as a broad set of tasks (e.g.: medication administration, dressing changes, and baths) that can be carried out by a variety of workers (e.g.: RNs developing care plans, RPNs performing vital signs, and PSWs giving baths).[52] With the care provider focused on the task at hand rather than connecting all aspects of care to form a complete picture of the person's health, they are not able to intervene in a timely manner when necessary. This practice puts patients at risk for negative outcomes.

Implementation of functional nursing models is often goes hand-in-hand with replacement of RNs by other providers, and is often motivated by budgetary restraints. This is a misguided attempt to save money and control local health-care spending by placing greater reliance on cheaper staff to deliver nursing services to the detriment to patients, nurses, and the system.

In contrast, professional models of nursing care, also known as "primary nursing", assign individual patients to the most appropriate nurse, RN or RPN, who acts as their primary nurse throughout the entire care process. The primary nurse provides all aspects of nursing care, ensuring care continuity. Employing this model of nursing care facilitates comprehensive care of clients and is linked to improved patient outcomes, as the nurse is better able to detect threats to patient safety and intervene promptly to avoid adverse events.[53]

Primary nursing is associated with improved outcomes for patients, nurses, and work environments when implemented through a supportive culture.[54] When nurses practise in primary nursing models, they have more autonomy, increased accountability for the care they provide, and improved clinical decision-making skills.[55] Evidence indicates that models of primary nursing are less costly for organizations than team-based models due to the decrease in administrative and supervisory activities.[56 57]

RNAO urges the government to enable health care organizations to implement models of care that advance care continuity and avoid care fragmentation.

Increase access to care by increasing RN scope of practice

RNs are autonomous health professionals who practise independently and collaboratively within interprofessional teams. With more than 100,000 RNs registered to practise with the College of Nurses of Ontario, [58] expanding their scope will secure timely access to quality health services across Ontario, and lead to a more effective and efficient health system.

RN prescribing

RNAO's *Primary Solutions for Primary Care* report, released in 2012, recommends expanding the scope of practice for RNs to include prescribing medications.[59] The report was fully endorsed by all political parties and other key stakeholders.[60]

In 2017, the *Stronger, Healthier Ontario Act (Budget Measures)* amended the *Nursing Act* to give RNs the authority to prescribe medications and communicate a diagnosis for the purpose of prescribing a medication.[61] Following legislative changes, CNO received direction from the Ministry of Health and Long-Term Care to do the necessary work to enable RN prescribing. RNAO is urging the CNO to move forward with drafting regulations to allow RNs to independently prescribe medications.

RNAO supports the independent RN prescribing model as the right framework to improve access to care. Independent prescribing will allow RNs to prescribe medications under their own authority within a regulated scope of practice and within their clinical competency area, and not restricted by lists, protocols, or collaborative practice agreements. This model has been successfully used in the United Kingdom for over 10 years.[62]

RNAO urges a phased approach to the implementation of independent RN prescribing to support adequate preparation of the nursing workforce in all sectors inclusive of diagnostic tests. The first phase would expand the scope of currently practising RNs who choose to integrate prescribing into their practice. These RNs would be required to complete and pass an approved postgraduate course. Upon successful completion, they will be granted a designation on their registration enabling them to practice to an expanded scope. The second phase would incorporate the curriculum from the course into undergraduate nursing programs by 2020. The new competencies would be reflected in RNs' entry-to-practice exam and become part of entry-to-practice requirements.

Current plans by the CNO appear to limit RN prescribing based on practice area, with a focus on immunizations, contraception, smoking cessation, travel health, and wound care.[63] This is a

wasted opportunity, limiting the full potential of independent RN prescribing to increase access to care. The efficacy of Ontario's health system depends on advancing access to care through innovative and evidence-informed enhancements, and independent RN prescribing is an effective example of how to achieve that. Therefore, **RNAO calls on the government to support the implementation of a phased approach leading to independent RN prescribing by 2019, and incorporation of RN prescribing into baccalaureate entry-to-practice by 2020.**

There is additional work to be done to fully enable independent RN prescribing. The 2017 legislative amendments are missing a necessary aspect of formulating a diagnosis: the ability to order diagnostic tests. RNs need the authority to order, perform, and interpret diagnostic tests to inform their diagnosis and appropriately prescribe medications. Making these changes will allow Ontarians to achieve the full benefits of independent RN prescribing. **RNAO calls on the Ontario government to amend the *Laboratory and Specimen Collection Centre Licensing Act* to allow RNs to order, perform, and interpret diagnostic tests, an essential aspect of safe prescribing.**

The other significant limitation to realizing independent RN prescribing is the exclusion of RNs working in Ontario hospitals. This is significant as RNs working in remote outpost nursing stations that are governed by a provincial hospital will not be authorized to prescribe medications. To increase access to care for patients in the most rural and remote areas of Ontario, **RNAO urges the government to amend the *Public Hospitals Act* to give all RNs the authority to order diagnostic tests, communicate a diagnosis, and prescribe medications within their regulated scope of practice and within their clinical competency area.**

Psychotherapy

In December 2017, the Ontario government proclaimed psychotherapy as a controlled act.[64] Nurses, along with five other regulated professions (social workers, occupational therapists, physicians, psychologists, psychotherapists), are authorized to continue to treat patients using psychotherapy techniques during a two-year exemption period before the controlled act will be enforced.

In preparation for this change, the regulatory colleges for the authorized professions were directed to develop, implement, and enforce their own minimum qualifications and standards of practice specific to psychotherapy. The reality is a large number of qualified RNs, including nurses working in mental health, are already initiating and performing psychotherapy, and have been doing so for many years. RNAO believes RNs who have the appropriate education and training should be able to continue initiating the controlled act of psychotherapy. And in September 2018, the CNO Council agreed. CNO is now drafting regulations for RNs to independently initiate and perform psychotherapy.

RNAO supports this decision. As far back as 2014, RNAO has urged CNO to include initiation in the regulation of psychotherapy now that it is a controlled act.[65] [66] [67] [68] There is a large body of evidence which supports the need for mental health services, especially in primary care settings, and a need for professionals who have the adequate skills, training, and knowledge to deliver them.[69] [70] Ensuring that RNs who have the knowledge and training to practise psychotherapy have the ability to initiate the controlled act will improve access to vital mental

health services for Ontario's most marginalized populations. **RNAO calls on the Ontario government to ensure CNO has a regulation in place before the end of the exemption period to authorize RNs to continue to initiate and perform the controlled act of psychotherapy.**

RNAO's RECLAIMING THE ROLE OF THE RN ASKS

- Immediately post and fill 10,000 RN vacancies in Ontario hospitals.
- Require all new nursing hires in acute care and cancer care hospitals be RNs.
- Require all first home care assessments be conducted by an RN.
- Enable health care organizations to implement models of care that advance care continuity and avoid care fragmentation.
- Support the implementation of independent RN prescribing in all sectors and inclusive of diagnostic tests by 2019, and the integration of RN prescribing into the baccalaureate nursing curriculum by 2020.
- Allow RNs to continue to initiate and perform the controlled act of psychotherapy.

References:

[1] Registered Nurses' Association of Ontario (RNAO). (2017). *70 years of RN effectiveness*. Retrieved from http://mao.ca/bpg/initiatives/RNEffectiveness.

[2] RNAO. (2018). *Ontario has the worst RN-to-population ratio in Canada: Province must hire more RNs to end hallway nursing* [Media Release]. Retrieved from https://mao.ca/news/media-releases/2018/06/14/ontario-has-worst-m-population-ratio-canada-province-must-hire-more-.

[3] RNAO. (2018). *Ontario has the worst RN-to-population ratio in Canada: Province must hire more RNs to end hallway nursing* [Media Release]. Retrieved from https://rnao.ca/news/media-releases/2018/06/14/ontario-has-worst-m-population-ratio-canada-province-must-hire-more-.

[4] RNAO & ONA. (2018). *Ontarians need more registered nurses* [Backgrounder]. Retrieved from http://mao.ca/sites/rnao-ca/files/RNAO_ONA_Backgrounder_May72018.pdf.

[5] RNAO. (2017). *70 years of RN effectiveness*. Retrieved from http://mao.ca/bpg/initiatives/RNEffectiveness.

[6] Aiken, LH., Sloane, DM., Bruyneel, L., Van den Heede, K., Griffiths, P., Busse, R., Diomidous, M., Kinnunen, J., Kozka, M., Lesaffre, E., McHugh, MD., Moreno-Casbas, MT., Rafferty, AM., Schwendimann, R., Scott, RA., TIshelman, C., van Achterberg, T. & Sermeus, W. (2014). Nurse staffing and education and hospital mortality in nine European countries: A retrospective observational study. The Lancet, 383(9931), 1824-1830.

[7] Blegen, M. A., Goode, C. J., & Reed, L. (1998). Nurse staffing and patient outcomes. Nursing Research, 47(1), 43-50

[8] Cho, E., Sloane, DM., Kim, E., Kim, S., Choi, M., Yoo, IY., Lee, HS. & Aiken, LH. (2015). Effects of nurse staffing, work environments, and education on patient mortality: An observational study. International Journal of Nursing Studies, 52(2), 535-542.

[9] Clark, P. A., Leddy, K., Drain, M., & Kaldenberg, D. (2007). State nursing shortages and patient satisfaction: more RNs--better patient experiences. Journal of Nursing Care Quality, 22(2), 119-127; quiz 128-119.

[10] Dubois, C., D'amour, D., Tchouaket, E., Clarke, S., Rivard, M. & Blais, R. (2013). Associations of patient safety outcomes with models of nursing care organization at unit level in hospitals. International Journal for Quality in Health Care, 25(2), 110-117.

[11] Estabrooks, CA., Midodzi, WK., Cummings, GG., Ricker, KL. & Giovannetti, P. (2005). The impact of hospital nursing characteristics on 30-day mortality. Nursing Research, 54(2), 74-84.

[12] Glance, LG., Dick, AW., Osler, TM., Mukamel, DB., Li, Y. & Stone, PW. (2012). The association between nurse staffing and hospital outcomes in injured patients. BMC Health Services Research, 12, 247.

[13] Harless, DW. & Mark, BA. (2010). Nurse staffing and quality of care with direct measurement of inpatient staffing. Medical Care, 48(7), 659-663.

[14] Kane, RL., Shamliyan, TA., Mueller, C., Duval, S. & Wilt, TJ. (2007). The association of registered nurse staffing levels and patient outcomes: Systematic review and meta-analysis. Medical Care, 45(12), 1195-1204.

[15] Kutney-Lee, A., Sloane, DM. & Aiken, LH. (2013). An increase in the number of nurses with baccalaureate degrees is linked to lower rates of postsurgery mortality. Health Affairs, 32(3), 579-586.

[16] McCloskey, J. M. (1998). Nurse staffing and patient outcomes. Nursing Outlook, 46(5), 199-200.

[17] McGillis Hall, L., Doran, D., & Pink, G. H. (2004). Nurse staffing models, nursing hours, and patient safety outcomes. Journal of Nursing Administration, 34(1), 41-45.

[18] Needleman, J., Buerhaus, P., Mattke, S., Stewart, M. & Zelevinsky, K. (2002). Nurse-staffing levels and the quality of care in hospitals. The New England Journal of Medicine, 346(22), 1715-1722.

[19] Seago, J. A., Williamson, A., & Atwood, C. (2006). Longitudinal analyses of nurse staffing and patient outcomes: more about failure to rescue. Journal of Nursing Administration, 36(1), 13-21.

[20] Stratton, K. M. (2008). Pediatric nurse staffing and quality of care in the hospital setting. Journal of Nursing Care Quality, 23(2), 105-114.

[21] Sovie, M. D., & Jawad, A. F. (2001). Hospital restructuring and its impact on outcomes: nursing staff regulations are premature. Journal of Nursing Administration, 31(12), 588-600.

[22] Tervo-Heikkinen, T., Kvist, T., Partanen, P., Vehvilainen-Julkunen, K., & Aalto, P. (2008). Patient satisfaction as a positive nursing outcome. Journal of Nursing Care Quality, 23(1), 58-65.

[23] Twigg, D., Duffield, C., Bremner, A., Rapley, P. & Finn, J. (2012). Impact of skill mix variations on patient outcomes following implementation of nursing hours per patient day staffing: A retrospective study. Journal of Advanced Nursing, 68(12), 2710-2718.

[24] West, G., Patrician, PA. & Loan, L. (2012). Staffing matters – every shift. American Journal of Nursing, 112(12), 22-27.

[25] Woodward, J. L. (2009). Effects of rounding on patient satisfaction and patient safety on a medical-surgical unit. Clinical Nurse Specialist: The Journal for Advanced Nursing Practice, 23(4), 200-206.

[26] Alenius, LS., Tishelman, C., Runesdotter, S. & Lindqvist, R. (2014). Staffing and resource adequacy strongly related to RNs' assessment of patient safety: A national study of RNs working in acute-care hospitals in Sweden. *BMJ Quality and Safety, 23 (3)*, epub.

[27] Blegen, M. A., & Vaughn, T. (1998). A multisite study of nurse staffing and patient occurrences. Nursing Economics, 16(4), 196-203.

[28] Dubois, C., D'amour, D., Tchouaket, E., Clarke, S., Rivard, M. & Blais, R. (2013). Associations of patient safety outcomes with models of nursing care organization at unit level in hospitals. International Journal for Quality in Health Care, 25(2), 110-117.

[29] Flanagan, J., Stamp, K. D., Gregas, M., & Shindul-Rothschild, J. (2016). Predictors of 30-Day Readmission for Pneumonia. Journal of Nursing Administration, 46(2), 69-74.

[30] Frith, K. H., Anderson, E. F., Tseng, F., & Fong, E. A. (2012). Nurse staffing is an important strategy to prevent medication error in community hospitals. Nursing Economics, 30(5), 288-294.

[31] Han, K. T., Kim, S. J., Jang, S. I., Kim, S. J., Lee, S. Y., Lee, H. J., & Park, E. C. (2015). Positive correlation between care given by specialists and registered nurses and improved outcomes for stroke patients. Journal of the Neurological Sciences, 353(1-2), 137-142.

[32] Kim, S. J., Park, E.-C., Han, K.-T., Kim, S. J., & Kim, T. H. (2016). Nurse Staffing and 30-day Readmission of Chronic Obstructive Pulmonary Disease Patients: A 10-year Retrospective Study of Patient Hospitalization. Asian Nursing Research, 10(4), 283-288.

[33] Lasater, K. B., & McHugh, M. D. (2016). Nurse staffing and the work environment linked to readmissions among older adults following elective total hip and knee replacement. International journal for quality in health care : journal of the International Society for Quality in Health Care, 28(2), 253-258.

[34] Ma, C., McHugh, M. D., & Aiken, L. H. (2015). Organization of Hospital Nursing and 30-Day Readmissions in Medicare Patients Undergoing Surgery. Medical Care, 53(1), 65-70.

[35] McCloskey, J. M. (1998). Nurse staffing and patient outcomes. Nursing Outlook, 46(5), 199-200.

[36] McGillis Hall, L., Doran, D., & Pink, G. H. (2004). Nurse staffing models, nursing hours, and patient safety outcomes. Journal of Nursing Administration, 34(1), 41-45.

[37] Patrician, P. A., Loan, L., McCarthy, M., Fridman, M., Donaldson, N., Bingham, M., & Brosch, L. R. (2011). The association of shift-level nurse staffing with adverse patient events. Journal of Nursing Administration, 41(2), 64-70.

[38] Seago, J. A., Williamson, A., & Atwood, C. (2006). Longitudinal analyses of nurse staffing and patient outcomes: more about failure to rescue. Journal of Nursing Administration, 36(1), 13-21.

[39] Dall, T. M., Chen, Y. J., Seifert, R. F., Maddox, P. J., & Hogan, P. F. (2009). The economic value of professional nursing. Medical Care, 47(1), 97-104.

[40] Horn, S. D. (2008). The business case for nursing in long-term care. Policy, Politics, & Nursing Practice, 9(2), 88-93. doi:http://dx.doi.org/10.1177/1527154408320420

[41] McKenna, E., Clement, K., Thompson, E., Haas, K., Weber, W., Wallace, M., . . . Roda, P. I. (2011). Using a nursing productivity committee to achieve cost savings and improve staffing levels and staff satisfaction. Critical Care Nurse, 31(6), 55-65.

[42] Shamliyan, T. A., Kane, R. L., Mueller, C., Duval, S., & Wilt, T. J. (2009). Cost savings associated with increased RN staffing in acute care hospitals: simulation exercise. Nursing Economics, 27(5), 302-314, 331.

[43] RNAO. (2017). *70 years of RN effectiveness*. Retrieved from http://mao.ca/bpg/initiatives/RNEffectiveness.

[44] Bylone, M. (2010). Appropriate staffing: more than just numbers. *AACN Advanced Critical Care, 21(1)*, 21-3

[45] College of Nurses of Ontario (CNO). (2014). *RN and RPN practice: The client, the nurse and the environment* [Practice guideline]. Retrieved from http://www.cno.org/globalassets/docs/prac/41062.pdf.

[46] CNO. (2014). *RN and RPN practice: The client, the nurse and the environment* [Practice guideline]. Retrieved from http://www.cno.org/globalassets/docs/prac/41062.pdf.

[47] RNAO. (2016). *Mind the safety gap in health system transformation: Reclaiming the role of the RN*. Retrieved from http://rnao.ca/sites/mao-ca/files/HR_REPORT_May11.pdf.

[48] Home Care Ontario & OCSA Nursing Practice Council. (2017). *Optimizing nursing in Ontario's renewed home care system*. Retrieved from http://homecareontario.ca/docs/default-source/position-papers/optimizing-nursing-in-ontario-home-care-ontario-ocsa-final-july-2017.pdf?sfvrsn=4.

[49] Home Care Ontario & OCSA Nursing Practice Council. (2017). *Optimizing nursing in Ontario's renewed home care system*. Retrieved from http://homecareontario.ca/docs/default-source/position-papers/optimizing-nursing-in-ontario-home-care-ontario-ocsa-final-july-2017.pdf?sfvrsn=4.

[50] RNAO. (2016). *Mind the safety gap in health system transformation: Reclaiming the role of the RN*. Retrieved from http://rnao.ca/sites/mao-ca/files/HR_REPORT_May11.pdf.

[51] RNAO. (2016). *Mind the safety gap in health system transformation: Reclaiming the role of the RN*. Retrieved from http://rnao.ca/sites/mao-ca/files/HR_REPORT_May11.pdf.

[52] Dubois, C., D'Amour, D., Tchouaket, E., Clarke, S., Rivard, M. & Blais, R. (2013). Associations of patient safety outcomes with models of nursing care organization at unit level in hospitals. *International Journal for Quality in Health Care. 25(2),* 110-117.

[53] Dubois, C., D'Amour, D., Tchouaket, E., Clarke, S., Rivard, M. & Blais, R. (2013). Associations of patient safety outcomes with models of nursing care organization at unit level in hospitals. *International Journal for Quality in Health Care. 25(2),* 110-117.

[54] Matila, E., Pitkanen, A., Alanen, S., Lino, K., Luojus, K., Rantanen, A. & Aalto, P. (2014). The effects of the primary nursing care model: A systematic review. *Journal of Nursing Care, 3(6),* epub.

[55] Wolf, GA. & Greenhouse, PK. (2007). Blueprint for design: Creating models that direct change. *Journal of Nursing Administration, 37(9),* 381-387.

[56] Wolf, GA. & Greenhouse, PK. (2007). Blueprint for design: Creating models that direct change. *Journal of Nursing Administration, 37(9),* 381-387.

[57] Dubois, C., D'Amour, D., Tchouaket, E., Clarke, S., Rivard, M. & Blais, R. (2013). Associations of patient safety outcomes with models of nursing care organization at unit level in hospitals. *International Journal for Quality in Health Care. 25(2),* 110-117.

[58] CNO. (2017). Membership statistics report 2017. Author: Toronto. Retrieved from http://www.cno.org/globalassets/docs/general/43069_stats/2017-membership-statistics-report.pdf.

[59] RNAO. (2012). *Primary Solutions for Primary Care*. Retrieved from http://rnao.ca/sites/rnaoca/files/Primary__Care_Report_2012_0.pdf.

[60] RNAO. (2012). *Provincial task force action plan will ensure same day access for patients, system effectiveness, and cost savings* [Media Release]. http://rnao.ca/news/media-releases/2012/06/28/provincial-task-force-action-plan-will-ensure-same-day-access-patient.

[61] Stronger, Healthier Ontario Act (Budget Measures), 2017 (S.O. 2017, c. 8 - Bill 127). Retrieved from https://www.ontario.ca/laws/statute/S17008.

[62] Royal College of Nursing. (2012). *RCN Fact Sheet: Nurse Prescribing in the UK*. Retrieved from https://www.rcn.org.uk/about-us/policy-briefings/pol-1512.

[63] CNO. (2018, January 18). *Q&As: RN Prescribing*. Retrieved from http://www.cno.org/en/trending-topics/journey-to-rn-prescribing/qas-rn-prescribing/.

[64] Psychotherapy Act, 2007 (S.O. 2007, c. 10, Sched. R). Retrieved from https://www.ontario.ca/laws/statute/07p10.

[65] RNAO. (2014). Letter to CNO: Requiring an order to perform psychotherapy. Retrieved from http://rnao.ca/policy/letters/cno-re-requiring-order-perform-psychotherapy.

[66] RNAO. (2014). Letter to CNO: Recommendation to rescind requirement to perform psychotherapy. Retrieved from http://rnao.ca/policy/letters/cno-rnao-recommendation-rescind-requirement-order-perform-psychotherapy.

[67] RNAO. (2015). Letter to CNO: Initiation of RN psychotherapy. Retrieved from http://rnao.ca/policy/letters/cno-initiation-rn-psychotherapy.

[68] RNAO. (2017). Letter to CNO: Request that CNO pursue a regulation to enable RN initiation of psychotherapy. Retrieved from http://rnao.ca/policy/letters/pursue-regulation-rn-psychotherapy.

[69] Carter, R. (2015). Delivering cognitive behaviour therapy in a secure setting. *Mental Health Practice*. 19(3), 23-26.

[70] McLeod, K. & Simpson, A. (2017). Exploring the value of mental health nurse working in primary care in England: A qualitative study. *Journal of Psychiatric Mental Health Nursing*. 24, 387-395,