RNAO SUBMISSION TO:

The Standing Committee on Social Policy

Bill 179: *Regulated Health Professions Law Statute Amendment Act, 2009.*

October 5, 2009

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

Dr. Shafiq Qaadri, MPP
Chair of the Standing Committee on Social Policy
Room 1405, Whitney Block
Queen's Park
Toronto, Ontario, Canada
M7A 1A2

October 5, 2009

Dear Dr. Qaadri,

Thank you for the opportunity to respond to Bill 179 – *Regulated Health Professions Statute Law Amendment Act, 2009*. The Registered Nurses' Association of Ontario (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.

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

There are a number of welcome changes contained in the Bill that would significantly improve public access to essential health services and reduce wait times. However, RNAO is deeply disappointed that Bill 179, without amendments, misses critical opportunities to ensure the best quality care is provided by the most appropriate health professional practising to full scope. Most notable is the singular failure of the legislation to review the scope of practice of registered nurses (RN) practising in Ontario and to recognize the realities of everyday practice and RNs' education, knowledge and competencies.

A glaring omission is the failure of the legislation to lift artificial restrictions which limit the public's access to nurse practitioners (NPs). This includes restrictions on prescribing pharmaceuticals and enabling NPs to admit, treat and discharge patients, to and from, inpatient settings.

Open prescribing, a practice not currently included in this legislation, is one that exists across Canada and the U.S., and is well within NPs' knowledge, skills and experience. Requiring NPs to prescribe from a narrow, pre-determined list limits them from practising to their full scope resulting in undue delays in treatment and much frustration for clients and NPs.

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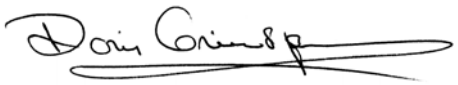
In the accompanying submission, the RNAO proposes a number of legislative amendments that would, if approved by the Committee, improve access to the best health care from the most appropriate professional providing continuity of care.

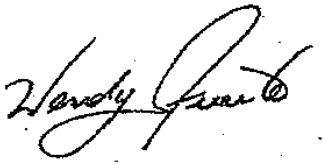
However, attaining the goal of making the best use of professional education, knowledge and competencies requires regulatory as well as legislative reform. For example, nurse practitioners working in an inpatient setting are restricted by *Ontario Regulation 965* of the *Public Hospitals Act* from admitting, treating and discharging patients without medical directives, though NPs working in outpatient settings, including emergency departments, do have the necessary regulatory authority.

It is a restriction that is artificial, inefficient, contrary to the public's interest and makes no sense. We call on the Committee to join RNAO in urging the government to amend regulations consistent with the goals in Bill 179.

Thank you for the opportunity to comment on this important bill, which impacts nursing and all regulated health professions in Ontario and the public we serve. Ontario nurses are unwavering in their commitment to use their knowledge, competencies and experience to improve the health and health-care system for all Ontarians.

Kindest Regards,





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Legislative Recommendations

RNAO calls for:

1. An amendment to the *Nursing Act, 1991 to authorize* registered nurses (RN) to dispense, compound and sell drugs, and registered practical nurses (RPN) to dispense drugs.
2. An amendment to the *Nursing Act, 1991 to* authorize RNs to perform the additional controlled acts of communicating a diagnosis, ordering the application of a form of energy prescribed by proposed regulations under this Act, and the authority for RNs with the appropriate education, knowledge and competencies to set and cast simple fractures and dislocations.
3. An amendment to the *Nursing Act, 1991* to authorize open prescribing of pharmaceuticals by nurse practitioners (NP), with no restrictions by list, category or schedule and in accordance with standards upheld by the College of Nurses of Ontario. With this legislation in place, a regulation comparable to the existing authorities for physicians and dentists can then be imposed by the College of Nurses, based on individual competencies and a legislated scope of practice.
4. An amendment to the *Nursing Act, 1991* to authorize NPs to dispense, compound and sell drugs, as well as administering a drug by injection or inhalation.
5. An amendment to the *Nursing Act, 1991* to authorize NPs to order oxygen, blood and blood products.
6. An amendment to the *Healing Arts Radiation Protection Act, s. 6(1)* adding authority for NPs to order the additional diagnostic imaging modality of Computed Tomography (CT) scans.
7. An amendment to the *Medical Radiation Technology Act, 1991, Sections 3, 4 and 5,* to include authority for NPs to order procedures to be carried out by Medical Radiation Technologists, such as the administering substances by injection or inhalation, tracheal suctioning of a trachaeostomy, and administering contract media by various means as outlined in the legislation.
8. An amendment to the *Public Hospitals Act, c.P.40, s. 35(1),* to replace the Medical Advisory Committee (MAC) with an Interprofessional Advisory Committee (IPAC) composed of members that represent all regulated health professionals involved in interprofessional practice in the hospital setting.
9. Scrapping the proposed amendment to the *Regulated Health Professions Act, 1991* which would allow the Minister of Health and Long-Term Care the authority to appoint a Health Regulatory College Supervisor.
10. An amendment to the *Regulated Health Professions Act, 1991* to limit the mandate of expert committee strictly to those matters pertaining to Colleges' direct requests, and that reports of these committees are made public.
11. A clarification of s.24 (13) of the *Regulated Health Professions Act, 1991,* to reflect the requirement for regulatory colleges to ensure their members are in possession of adequate and appropriate liability protection, as opposed to requiring the regulatory colleges to actually provide this liability protection.

12. The addition of a clause to s. 24 (13) of the *Regulated Health Professions Act, 1991*, to ensure that the mandated liability protection be provided independently to that of the employer.
13. Substituting the term "professional liability protection" for the term "professional liability insurance" in s.24 (13) of the *Regulated Health Professions Act, 1991*.
14. Clarification in the wording of the *Regulated Health Professions Act, 1991* to reflect the requirement that regulatory colleges are not responsible for the provision of liability protection, but simply enforcing the requirement for their members to hold appropriate and adequate professional liability protection from the provider of their choice.
15. An amendment to the *Healing Arts Radiation Protection Act* s. 6 (2) and (3), to authorize RNs with the appropriate education and knowl*edge to order simple x-rays of the chest, ribs*, arm, wrist, hand, leg, ankle or foot, and mammograms.
16. An amendment to the proposed legislation in the *Naturopathy Act, 2007*, to reflect the addition of the controlled act of prescribing, dispensing, selling and compounding natural substances for the profession of Naturopathy.
17. An amendment to the proposed legislation to reflect the removal of the term "naturopathic" before diagnosis in section 4, paragraph 5 of the *Naturopathy Act, 2007.*
18. An amendment to the *Pharmacy Act,* 1991 which would require standards to be developed by the College of Pharmacists to assure that the public can distinguish between a commercial marketing campaign and legitimate health promotion and education.
19. An amendment to the *Physiotherapy Act, 1990* to extend the authority of physiotherapists to order diagnostic imaging to include Magnetic Resonance Imaging, Computed Tomography and Diagnostic Ultrasound.
20. An amendment to the *Highway Traffic Act, 1990, s. 203 (1),* adding the authority for nurse practitioners to conduct assessments of clients' fitness to drive.
21. An amendment to the *Mental Health Act, 1990, s. 15.1 – 15.5,* authorizing nurse practitioners to complete and sign a Form 1 (Application for Psychiatric Assessment).

Regulatory Recommendations

RNAO calls for:

1. An amendment to *Regulation 965, s. 11(1) and (2); s. 16 (1) and s. 25,* of the *Public Hospitals Act, 1990*, to authorize nurse practitioners to admit, treat and discharge in in-patient settings.
2. A complementary amendment to *Regulation 965, s. 17 (1) and (2)* of the *Public Hospitals Act, 1990* to authorize the certification of death in hospital by NPs, to reflect those changes already made to the *Vital Statistics Act*.
3. An amendment to *Regulation 965, s. 24* of the *Public Hospitals Act, 1990*, to authorize physiotherapists to initiate or order treatments or diagnostic procedures in hospital.
4. An amendment to *Regulation 107/96* s. 5.1, 5.2 (a), (b) and (c) and to s. 7.1 (2b) of the *Regulated Health Professions Act, 1991,* to extend the authority to nurse practitioners to order the following forms of energy:
    - Electromagnetism for magnetic resonance imaging;

5. Removal of anatomical restrictions in s. 7.1 (2b) for diagnostic ultrasound which nurse practitioners are authorized to order; and the extension of authority for both nurse practitioners and registered nurses to order the following forms of energy:
    - Electricity for: fibrillation; cardiac pacemaker therapy; cardioversion; defibrillation; electro coagulation; fulguration; and transcutaneous cardiac pacing.
6. An amendment to *Regulation 552* of the *Health Insurance Act* to authorize specialists and hospitals to claim consultation fees for patient referrals and orders made directly by a NP.
7. A regulation under *Section 10(1)* of the *Patient Restraint Minimization Act, 2001* authorizing nurse practitioners to order the restraint or confinement of a client in a hospital or facility or to use a monitoring device on such a client.
8. An amendment to *Regulation 741* of the *Mental Health Act*, authorizing NPs to complete and sign a Form 1 (Application for Psychiatric Assessment)
9. An amendment to *Regulation 340* of the *Highway Traffic Act (1990)* to enable NPs to sign seatbelt exemptions.

Endorsements

RNAO supports the following provisions in Bill 179:

1. Including psychotherapy as a controlled act which NPs may perform, and expanding title protection to include any nominated members of regulated professions who share the scope of practice of psychotherapy.
2. Eliminating barriers and limitations for NP ordering of x-rays, including mammograms, and authorizing physiotherapists to order x-rays in the *Healing Arts Radiation Protection Act, s. 6(1)*
3. The introduction and implementation of Remote Dispensing Devices in the Province of Ontario as per the *Drugs and Pharmacies Regulation Act, s. 1(1), 146 (1.0.1), 149, and161 (1)*
4. Amending the Scope of Practice statement for medical radiation technologists in the *Medical Radiation Technology Act, 1991, s. 3, 4 and 5*
5. Providing additional controlled acts which midwives are authorized to perform in the *Midwifery Act, 1991, s. 4, 11 (1) (b)*
6. Authorizing pharmacists to provide information and education, and promote health, prevention and the treatment of diseases, disorders and dysfunctions through monitoring and management.
7. Authorizing pharmacists to prescribe medication therapy management under the regulations, administer drugs by inhalation, and perform procedures on tissue below the dermis.
8. Allowing physiotherapists to communicate a diagnosis identifying a disease, dysfunction or disorder within the limits of the practice of physiotherapy.
9. Authorizing physiotherapists to perform the controlled act of treating a wound by cleansing, soaking, irrigating, probing, debriding, packing and/or dressing.

10. Authorizing physiotherapists to administer a substance by inhalation.
11. Allowing physiotherapists to perform the controlled acts of putting an instrument, hand or finger beyond the labia majora or anal verge to manipulate the tailbone for the purpose of assessment and interventions related to the pelvic musculature associated with incontinence.
12. Requiring all regulated health professionals to have and maintain professional liability protection.

Nursing Act, 1991

As the professional organization for registered nurses in the province, RNAO firmly believes that many of the changes in Bill 179 will serve the public interest by responding to demands for increased client and patient access to appropriate care, improving continuity of care and continuity of caregiver, providing access to essential health services in the most equitable and cost-effective manner, and assuring higher patient safety and full accountability through greater clarity in the roles of professionals working collaboratively in Ontario's health-care system.

However, with regards to the nursing profession, Bill 179 misses a rare opportunity to review the role of nursing in the province. By being largely silent on the scope of practice of registered nurses, the legislation fails to recognize the reality of everyday practice and the current level of education, competencies, and knowledge that registered nurses have.

Even the amendments to the *Nursing Act, 1991* that acknowledge the need to expand the scope of practice of nurse practitioners suffer significant omissions that left unaddressed will represent a major barrier to the public's access to health services and patient safety. A particularly egregious example is the failure of the legislation to lift restrictions limiting the access of nurse practitioners (NPs) to prescribe pharmaceuticals, a practice that is safe, and well within their knowledge, skills and experience. By requiring NPs to prescribe from a narrow, pre-determined list or schedule and limiting them from practising to their full scope, the Bill entrenches an arcane and inefficient practice that will exacerbate over time with greater acuity, rapid technological and scientific advancements, evolving practice realities and population health needs. It would be an unfortunate regressive step in terms of promoting client safety, access to health services and a major source of frustration among NPs whose education and professional expertise are not being fully utilized.

RN Scope of Practice: Increased Access to Controlled Acts

The practice and role of RNs continuously evolves with changes in work environments, technology, and educational and policy parameters. As a result, regulatory regimes do not necessarily reflect current practices. They must be updated to provide RNs with independent access to controlled acts that have become an integral part of their practice and essential to good patient care. Without this independent access, the profession is not truly self-regulating and the public is denied full access to RNs working to their full scope of practice. Bill 179, as it is currently written, represents a major lost opportunity to update RN scope of practice in Ontario.

Adding controlled acts for RNs where appropriate will bring the following benefits: increased patient access to quality and timely care; greater retention and recruitment of nurses; and decreased administrative complexity and costs associated with delegation of acts that should be within the scope of nursing.

Dispensing Authority for RNs and RPNs – the Reality

In a variety of contexts, RNs dispense medication as a routine part of implementing medical directives, generally for clients who meet specific criteria or as a delegated act to respond to a

particular client's situation. This is common in remote communities but also pertinent in the following common situations:

- 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, such as a weekend leave from a psychiatric unit, but who need to continue with their medication treatment regime.
- On night shifts or weekends, when there is no pharmacist on duty in a hospital, an RN may need to dispense drugs from their hospital unit stock, in order to supply drugs for a client's prescription on a different unit.
- In an outpatient clinic, an RN may dispense an insulin pen to a client with diabetes to take home.
- In an emergency room, an RN may dispense a sufficient dose of a medication upon discharge of an antibiotic for a child with an ear infection in the middle of the night in order to initiate timely treatment until a community pharmacist is available to fill a prescription.
- RNs and RPNs frequently dispense prophylactic medications in travel clinics.
- RNs and RPNs often dispense medication in public and sexual health clinics in response to client need, especially marginalized populations (e.g., an individual who could not otherwise afford birth control).
- RNs and RPNs in correctional facilities repackage and label stock medications for inmates.
- Public health RNs dispense medication such as Ritalin, insulin, or allergy shots in a school setting.
- RNs and RPNs working in remote and isolated areas routinely dispense medications to clients from the nursing station medication stock to facilitate timely treatment until the prescription is delivered by plane from a pharmacy in a larger and distant community.
- RNs and RPNs who work in community health centres or public health units routinely dispense medications to clients who are financially disadvantaged and in need of immediate treatment. They also dispense to clients whose compliance is in question (e.g., clients who leave with a prescription but there is no assurance that they will fill the prescription and begin necessary treatment).

Ontario lacks a common definition of terms for "dispensing" and "administering" with relation to drugs, and interpretation of existing definitions varies. Generally, the difference between administration and dispensation is the timeframe in which the drug is delivered to the client. Administration implies the drug is consumed by the client immediately, whereas dispensation implies the drug is consumed by the client at a later time or date. Prior to the *Regulated Health Professions Act* (*RHPA), 1991,* dispensing was a routine part of a nurse's role in a variety of settings and situations.[1] It remains so today, but utilizing medical directives or delegation. CNO's Medication Practice Standard states that dispensing involves the following phases:

- receiving/reading the prescription;
- adjusting the order according to approved policy (e.g., substitution), if appropriate;
- selecting the drug to dispense;

- checking the expiry date;
- reconstituting the product, if needed;
- repackaging the drug;
- labelling the product; and
- Completing a final physical check to ensure the accuracy of the finished product.

The Ontario College of Pharmacists' document *Delegation of Dispensing*[2] states that there is "considerable overlap" between the technical and cognitive components of preparing a drug for administration and dispensing a drug. In order to administer or dispense a drug, an RN or RPN requires an order from a professional who has the legislated authority to prescribe the particular drug.

Registered nurses are authorized to administer a drug, which is a function that is central to nursing practice in a number of health-care settings. Given that dispensing a drug is routinely and safely performed by nurses by medical directive or delegation, a change in legislation to authorize dispensation of drugs by RNs is appropriate for the following additional reasons:

- The accountability for the performance of dispensing is blurred;
- Currently, if physicians or pharmacists withdraw their support of nurses performing the delegated controlled act because of concerns over shared accountability and liability, nurses who have competently been dispensing a drug are left without the authority to continue. As a result, clients at risk particularly in isolated and under serviced areas, may be left without access to appropriate health care;
- The College of Nurses of Ontario (CNO) sets standards relevant to controlled acts that are authorized to nurses; therefore, CNO would be able to ensure comprehensive standards, in order to fulfill its public protection mandate, and ensure transparency and public safety;
- Ongoing delegation fails to recognize that dispensing a drug is an everyday practice reality for nurses and fails to recognize that RNs have the education and skills to dispense; and,
- Developing authorizing mechanisms when the practice is routine wastes resources, which would be better directed to other client-care activities.

<u>Compounding and selling authority for RNs.</u>

Compounding is the act of combining two or more elements to create a distinct pharmaceutical product. Examples include preparing non-sterile topical and oral preparations for medically necessary reasons, such as to change the form of the medication from a solid pill to a liquid, to obtain the exact dose needed that is not commercially available or to make a medication more tolerable by altering its taste. Compounding is not currently authorized to nurses, and is currently performed under medical directive or delegation for a variety of situations.

For example, a topical antibiotic ointment can be compounded with an anti-inflammatory steroid ointment to create a single-application blend of drug. In addition, RNs in a variety of settings frequently dissolve a tablet in a small amount of water to create an oral solution, or extract oil from a capsule with a needle and syringe in order to provide a dose of medication to a

paediatric or disabled client who has difficulty swallowing, and especially to administer the dose through gastrostomy (G-tube) or nasogastric (NG-tube) tubes.

RNs should also be authorized to sell drugs within the practice setting as long as there is a clear policy preventing client/patient exploitation, and that client/patients know that they have the right to a written prescription that can be filled elsewhere. The sale of drugs in this case would increase access and efficiency of the provision of health care for the client. For example, arthritic patients who visit a rheumatologist for pain management are currently required to obtain a prescription for corticosteroids, exit the office to go to the local pharmacy, wait to have the prescription filled, then return to the office to wait again, with the medication in hand, in order for the corticosteroid to be injected into their painfully arthritic joints. By allowing RNs to sell drugs in the practice setting, patients who require this course of treatment would have a safe and more efficient level of care provided.

RECOMMENDATION: Amend Bill 179 to grant registered nurses (RNs) the authority to dispense, sell and compound drugs and registered practical nurses (RPNs) to dispense drugs.

Communication of a Diagnosis

Communicating a diagnosis is often required to obtain consent for intervention and treatment. In a number of practice settings, RNs cannot practise honestly and transparently with their clients without communicating a diagnosis. They must either go through a time-consuming and expensive process of delegation or conduct their practice in a manner that does not technically violate the Act, but does in fact create moral distress by raising issues of ethical principles and values. Examples of situations in which RNs need to communicate a diagnosis for good patient care include:

- RNs in acute care settings who are caring for clients with secondary conditions, such as urinary tract infections, cannot communicate why they are administering drugs or other treatment. This hinders initiatives directed at clients to be attentive to medications and other treatments that they are receiving in order to protect themselves against iatrogenic mishaps. Waiting for a physician to disclose a urinary tract infection could delay treatment, while an evasive answer about this new medication could undermine trust and rapport between the nurse and client.
- In an emergency department, RNs cannot communicate the results of a pregnancy test. This results in clients waiting for long periods while physicians deal with more acute cases.
- Public health RNs work under medical directives to communicate the results of pregnancy tests and refer clients who test positive for counselling. Similarly, in sexual health clinics, public health RNs must operate under medical directives to communicate diagnoses about sexually transmitted diseases.
- For marginalized clients, direct interaction between the community health RN and the client may occur only once at a single point in time. One of the critical methods of reducing marginalization involves open, honest, transparent disclosure as a means of establishing trust with individuals and groups with good reason not trust.

RECOMMENDATION: Amend Bill 179 to authorize registered nurses to perform the additional controlled act of 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 in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.

Ordering the application of a form of energy – simple x-rays and mammograms

RNAO recommends that the authorization to order simple x-rays of the chest, ribs, arm, wrist, ankle and foot be extended to RNs with the appropriate education and knowledge. In many cases, Clinical Best Practice Guidelines and algorithms exist, to guide the assessment of an injury or disorder. Guidelines, such as the Ottawa Ankle Rules[3], help in the decision making process of when to use radiography for clients with injuries to the ankle. At the end of the assessment, the RN would use clinical judgment to decide whether to order an x-ray. Images would be interpreted by a radiologist, and results are discussed in an interprofessional team setting.

Other examples include allowing a RN to order a chest x-ray. Having this sort of image early on would aid in the swift assessment and diagnostic process of pneumonia in an infant in respiratory distress who is brought to the emergency room. In many instances, RNs take the lead in coordinating health promotion programs, such as breast screening clinics. Allowing an RN to order mammograms would promote the early identification and risk reduction for the client.

RECOMMENDATION: Amend Bill 179 to authorize registered nurses with the appropriate education and knowledge to order x-rays of the chest, the ribs, the arm, the wrist, the hand, the leg, the ankle or the foot, and mammograms.

Setting or Casting a Bone Fracture or Joint Dislocation

Community health RNs working in remote settings have often been responsible for setting or casting a simple bone fracture or joint dislocation. RNs with the required knowledge, skills, and experience should be authorized to set and cast, which are both currently performed under delegation or medical directives. Delegation and medical directives for these acts consume large amounts of time and resources, resources that would be better directed to providing client care.

RECOMMENDATION: Amend Bill 179 to add the controlled act of setting or casting a simple bone fracture or joint dislocation for those registered nurses with the required knowledge skills and experience.

Section 14(1) - Prescribing, Dispensing, and Administering

Nurse Practitioners

RNAO recommends in the strongest possible terms, that NPs should be allowed to prescribe drugs and other substances* within the full scope of their practice without having to reference any lists, in a similar fashion as they do in most other jurisdictions.[4]

Reliance on any form of inclusionary drug schedule, both individual and classes of drugs, is a barrier to NP practice within the full scope, and represents a significant restriction on client access to the highest quality of care. Placing limits on NPs' ability to make timely use of the most appropriate and current medication is detrimental to public safety and best interests of clients.

It is not the regulated list of drugs or tests that ensures appropriate prescribing, ordering and monitoring by the nurse practitioner. 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. In addition, the College of Nurses of Ontario is responsible for regulating all nurses in order to safeguard the public interest, establish and enforce standards of nursing practice, and assure the quality of practice of the profession and the continuing competence of all nurses. In a context of rapid technological change and evolving roles, there is compelling evidence that the proposed list-based approval process for NP diagnostic and prescriptive authority is untenable and that its inadequacy compromises client access and safety.[5] Non list-based or open prescribing for diagnostic tests and pharmaceuticals is vital to meet clients' needs.

Artificial solutions, such as those proposed in Bill 179 are ineffective and inefficient. A list-based system, even one that's ostensibly streamlined, flexible and triggered by application from the College of Nurses of Ontario, would only result in treatment delays for clients, unnecessary duplication of services, and misallocation of resources.

RNAO strongly urges amendments to Bill 179 that would authorize open prescribing of pharmaceuticals, non list-based, approach for NPs, much like in the rest of Canada and across the US. Enabling all NPs to function autonomously and without the need for medical directive or delegation sharpens the lines of accountability and promotes public safety. Legislative restrictions limiting NP access to broad prescribing results in a slow and cumbersome process that compromises access to health services and increases risk to the public. Even the most efficient 'list' process cannot keep pace with advanced technologies, evolving pharmacological treatments and evidence-based practice, thus leading to real-time delays in client care.[6]

Removing the list-based system and moving to open prescribing has many other advantages. Open prescribing will lead to improved public access to essential health services and the optimal utilization of NPs to their full capacity, resulting in greater role satisfaction and higher

* Substances include gases such as oxygen or nitrous oxide, as well as blood and blood products.

retention and recruitment of NPs, all of which are central to ensuring public safety, timely access, and quality services across the province and in all sectors.

Following are some of the many examples of how failure to have open-prescribing of pharmaceuticals is not in the public interest:

- During cold and flu season, many clients suffer from post-viral coughs. NPs currently cannot make an initial prescription for a bronchial dilator like *Ventolin,* to alleviate their clients' symptoms.
- Nurse practitioners are authorized to prescribe the vaccine for seasonal influenza. All signs indicate that the 2009 novel H1N1 influenza virus will be the dominant circulating virus this flu season. However if a specific pandemic influenza vaccine is developed, since it would not be on the approved list, and would likely not be listed in a fast enough manner to do any good, nurse practitioners will be unable to prescribe it for their clients, This could have serious consequences if, as predicted, we are entering a peak period for H1N1 incidence.
- *Twinrix* is a commonly prescribed vaccine which combines protection from both Hepatitis A and B. NPs are currently only authorized to prescribe either the Hepatitis A or B vaccine, but not the combined vaccine, because it is not on the "approved list". [7]
- Clients with diabetes who are having difficulty with hyper-or hypoglycaemic episodes currently cannot benefit from their NPs' specialized knowledge and expertise to independently change their pharmaceutical therapy, even though many NPs specialize in diabetes care and have advanced education and many years of experience in the field.
- A client who requires birth control, and has experienced side effects from other prescriptions needs to travel 250 km down a dangerous logging road to the nearest physician to be prescribed a new product which was not on the NP "approved list", but is clearly within the NP scope.

Permitting NP access to the controlled act of prescribing and dispensing will provide the public with improved access to health services, particularly for individuals who may not be able to readily access services of a pharmacist. The incidence of chronic diseases, such as cardiovascular disease, diabetes and cancer remains high, and people are living longer with chronic diseases. Ensuring timely client access to drugs is essential. Increasing NP prescriptive authority will lead to early intervention, help reduce complications, and lead ultimately to better health outcomes and an overall reduction in the consumption of health care resources.

Broad and open prescriptive authority for pharmaceuticals already exists in most Canadian jurisdictions[†], leaving Ontario as an isolated outlier with Bill 179's proposed listing process. [8, 9, 10, 11, 12] Ontario must regain its historic position as the leader in access to essential health services.

[†] Jurisdictions that have open prescribing which permits nurse practitioners to prescribe broadly and without reference to any list include British Columbia, Alberta Saskatchewan, Manitoba, New Brunswick, Nova Scotia and Newfoundland and Labrador.

RNAO believes the authority for NPs to dispense, compound and sell drugs would be particularly beneficial to those individuals who are unable to readily access a pharmacy, or to dispense reconstituted liquid antibiotic prescriptions for children. Dispensing drugs is an entry-level competence for all RNs in Ontario. Selling and compounding drugs is part of the foundational education of NPs. While the benefits of expanding NP authority to dispense, compound and sell pharmaceuticals are great, the risks can be mitigated by ensuring appropriate standards and quality assurance programs are in place.

An open prescribing system by NPs would tremendously benefit the overall functioning and achievement of cost-savings for the health-care system. Without independent access, the profession is not truly self-regulating. Expanding the scope of practice for RNs and NPs will increase public access to quality and timely care across the province and in all sectors, as well as strengthen public safety by ensuring that RNs and NPs are fully accountable for their practice.

Oxygen, Blood and Blood Products

In broadening prescriptive authority RNAO recommends that authority also include ordering blood and blood products and oxygen. NPs order both oxygen and blood, but do so under delegation and medical directives authorized by physicians. It is unclear at this time where these items fit in the controlled acts model, i.e., are they classified as a drug or substance? Therapeutic oxygen has been classified as a drug that midwives may order and administer under the *Midwifery Act, 1991 - Designated Drugs Regulation*.[13]

Despite this classification, efforts to provide NPs with the authority to order oxygen under the NP drug regulations have been unsuccessful. RNAO's expert group, the Nurse Practitioners' Association of Ontario has raised this issue with government since early 2002. [14] With respect to ordering blood and blood products NPAO appreciates both federal and provincial policy or regulations may need to be changed to grant authority, however NPs in other jurisdictions in Canada such as Alberta already have the authority to order blood / products.[15] In Nova Scotia, proposed regulations will provide NPs with the authority to order blood and blood products. [16]

RECOMMENDATION: Amend Bill 179 to authorize open prescribing of pharmaceuticals by nurse practitioners, with no restrictions by list, category or schedule, and in accordance with standards upheld by the College of Nurses of Ontario. With this legislation in place, a regulation comparable to the existing authorities for physicians and dentists can then be imposed by the College of Nurses, based on individual competencies and a legislated scope of practice.

RECOMMENDATION: Authorize the dispensing, compounding and selling of drugs by nurse practitioners, as well as authorizing nurse practitioners to administer a drug by injection or inhalation

RECOMMENDATION: Authorize the ordering of oxygen, blood and blood products by nurse practitioners.

Subsection 5.1 (1) Paragraph 9 - Psychotherapy

Psychotherapy is a controlled act which is performed by several regulated professions in Ontario, including RNs, and though title restriction may be in the public interest, restricting this title from other trained, registered professionals who have the knowledge, skills and ability to perform this act within their scope of practice may ultimately lead to public confusion. In addition, RNAO feels those individuals who are practising psychotherapy but are not registered professionals from the list of collaborating colleges should be disallowed from using this protected title.

ENDORSEMENT: RNAO supports the Bill 179 proposal that includes psychotherapy as a controlled act which nurse practitioners may perform, and to expand title protection to include any nominated members of regulated professions who share the scope of practice of psychotherapy.

Regulated Health Professions Act, 1991

Section 24 of Bill 179 amends the *Regulated Health Professions Act, 1991*. While the RNAO supports some of the amendments, particularly the requirement of professional liability protection for all members of the profession, we have significant concerns about the roles of College Supervisor and expert committees as described in the legislation. In addition, RNAO strongly suggests that the legislation must prescribe that the liability protection be independent of the employer.

College Supervisor

Proposed changes to Bill 179 would allow the Minister to appoint a Supervisor to take over the administration of a regulatory College, which in effect allows government to take over all of the functions of a self-regulating body for practically any reason. The proposed authority of a College Supervisor is very extensive and includes all the powers of a College Council, or any other College official or employee. No specific legislative criteria have been provided which the Minister must follow in order to initiate the appointment of a Supervisor; the decision to do so rests solely on the Minister's discretion.

The amendment overlooks the fact that many of the health regulatory colleges have a solid accountability structure already in existence. Public members are appointed by government and are active and vital participants in regulatory processes. Section 5 of the *RHPA* (particularly subsections (c) and (d)) already provides more than ample authority to the Minister to discipline a poorly administered, incompetent, or noncompliant College. It is important to know that no Minister has ever resorted to the authorities available under section 5 in the 15 years since the *RHPA* was proclaimed, however this doesn't mean that the Minister's powers would not work if it were used. There is no question that decisions and processes of self-governing bodies must be accountable and transparent and subject to scrutiny.

The proposed role of the Supervisor is unrestricted. Despite whatever boundaries the Lieutenant Governor in Council may place on the Supervisor's mandate, subsection (7) stipulates that (once a Supervisor is in place) any act of a Council "is valid only if approved in writing by the College supervisor".

This proposed change radically affects the central principle of self-regulation and flies in the face of the underlying rationale of the *Regulated Health Professions Act* to give the Minister of Health untrammelled and exclusive authority over all regulated professions in the province. At no time has the Minister explained why s.5 of the *RHPA* is inadequate to meet its purpose and why he is taking such an extraordinary and draconian step. RNAO strongly rejects the proposed power to appoint a College Supervisor, and insists that these processes remain independent and not subject to the threat of political influence.

RECOMMENDATION: Scrap proposed legislative amendments to the *Regulated Health Professions Act, 1991* allowing the Minister of Health and Long-Term Care the authority to appoint a Health Regulatory College Supervisor.

Expert Committees

Though the drug regulation-making process significantly needs restructuring, RNAO questions the need for a general authority to establish multiple expert committees for unspecified purposes, particularly committees which would report exclusively to the Minister and to which Colleges would be mandated to provide any and all information required. Section 24(9) of Bill 179 empowers the Lieutenant Governor-in-Council to "establish one or more expert committees" and "specifying the functions, duties, powers and membership" of the expert committees. Even the "content" of reports of the expert committees can be set by regulation which, if intended, suggests that expert committee reports would be pre-ordained by the Minister. As with the College Supervisor above, the Minister has at no time explained why such a broad and unrestricted power is necessary.

RNAO strongly rejects the need for such a general, "blank cheque" power to establish expert committees under the Act. At a minimum, there must be a requirement of consultation in the establishment of expert committees and that the reports of the committees be made public.

RECOMMENDATION: Amend the proposed legislation to limit the mandate of expert committees strictly to those matters pertaining to Colleges' requests, require consultation in the establishment of expert committees, and mandate that reports of these committees be made public.

Professional Liability Protection

Each health care professional, both individually and as a member of a collaborative interprofessional team, is accountable for his or her own professional practice. An employer or facility may also be found negligent and be held directly liable for breaching duties it owed to the client.

Professionals can be liable jointly and severally for the damages awarded. This means the claimant may recover full compensation from any one of the negligent professionals, even though one professional may then be paying for more than their share of the damages. RNAO supports the requirement that regulated health professionals and their employers have appropriate and adequate professional liability protection in place.

However, requiring only the professionals to have this protection is not sufficient. The principle of vicarious liability provides that the employer, which may either be an individual or an institution, can be held financially responsible for the negligence of its employees. When an employment relationship exists, regardless of the scope of practice of the employee, the employer is responsible to ensure oversight of the employee and is responsible for the actions of every employee. The employer bears responsibility for the cost of the liability, and it is the employer who is financially responsible for any awards made by a court for the actions of an employee. In order to protect the public, RNAO believes there should be a mandatory legislated requirement for all health-care employers to carry and provide proof of appropriate and adequate liability insurance. Requiring the employee to prove their employer carries such insurance would be very difficult to prove.

RNAO does support the proposed legislation which would require health professionals to have and maintain basic professional liability protection. This is based on the fact that health professionals are not necessarily protected for incidents which occur outside of the workplace. Though the *Good Samaritan Act, 2001*[17] provides protection from liability for a health-care professional who provides emergency health care services or first aid assistance to a person who is ill, injured or unconscious as a result of an accident or other emergency outside of the professional's workplace, this protection does not cover the individual against damages that may have been caused by gross negligence.

RNAO strongly urges a rewording of s.24 (13) of Bill 179 in order to incorporate several important concepts.

First, liability coverage must be independent from that of the employer. In addition to ensuring accountability for the general public, mandating liability protection which is independent of the employer would guarantee health professionals the ability to speak freely ("whistleblower protection") without the uncertainty of whether open communication in the clients' interest would impact negatively on their liability protection.

Second, the term "protection" should be substituted in place of "insurance". Liability protection for many eligible nurses in Ontario and other provinces is provided by a non-profit society created, owned and operated by nurses for nurses in the public interest, which is specifically tailored to meet the professional liability needs of nurses in all nursing roles. Other professions such as medicine[18] also have a non-profit association as the provider of liability protection. The Canadian Nurses Protective Society[19] is a legal support system for nurses, as opposed to a for-profit insurance company. Other nurses may receive protection through their union. Requiring that liability protection come in the form of insurance would significantly increase the cost and limit the options health professionals are able to choose from, increase the likelihood of competitive bidding in the for-profit insurance market, and put professionals at risk, by not fully understanding the terms of their insurance policies.

Third, the wording of s.24 (13) paragraph 13.1 in Bill 179 should be clarified so that the regulatory college is not responsible for the provision of liability protection, but simply enforcing the requirement for professionals to hold appropriate and adequate professional liability protection from the provider of their choice, annually during the professional registration renewal process.

ENDORSEMENT: RNAO strongly supports the proposed legislation requiring all regulated health professionals and their employers to have and maintain professional liability protection.

RECOMMENDATION: Require the mandatory liability protection in s.24 (13) of the Act to be independent from that of the employer.

RECOMMENDATION: Substitute the term "professional liability protection" for the term "professional liability insurance" in s.24 (13) of the Act.

RECOMMENDATION: RNAO calls for clarification of the wording of s.24 (13) paragraph 13.1, to reflect the requirement that regulatory colleges are not responsible for the provision of liability protection, but simply enforcing the requirement for their members to hold appropriate and adequate professional liability protection from the provider of their choice.

Psychotherapist Title

Psychotherapy is a controlled act which is performed by several regulated professions in Ontario, including registered nurses, and though title restriction may be in the public interest, restricting this title from other trained, registered professionals who have the knowledge, skills and ability to perform this act within their scope of practice may ultimately lead to public confusion. Therefore, RNAO strongly supports the proposed legislation which would expand title protection to include any nominated members of professions who share the scope of practice of psychotherapy, including registered nurses. RNAO extends this support in ensuring the identification of professionals by their regulated title, followed by the title psychotherapist, both orally and in writing. In addition, RNAO feels those individuals who are practising psychotherapy but are not registered professionals from the list of collaborating colleges should be disallowed from using this protected title.

ENDORSEMENT: RNAO strongly supports the amendment of the *Regulated Health Professions Act, 1991,* to extend the protected title of psychotherapist to those professionals who have the knowledge, skills and judgment to perform the controlled act of psychotherapy, and who are members of the identified regulated health professions.

Regulatory Changes

Controlled Acts Regulation, O. Reg. 107/96

The regulation which governs the application of energy needs to be updated. 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 like defibrillation are now in the public domain, for example, in hockey arenas and shopping malls. RNs regularly perform acts such as adjusting cardiac pacemakers, and RN First Assistants perform electrocoagulation under delegation or medical directive.

RECOMMENDATION: Complementary amendments be made to *Regulation 107/96*, s. 5.1, 5.2 (a), (b) and (c) and to s. 7.1 (2b) of the *Regulated Health Professions Act, 1991*, to extend the authority for nurse practitioners to order the following forms of energy:

- **Electromagnetism for magnetic resonance imaging;**
- **Removal of anatomical restrictions in s. 7.1 (2b) for diagnostic ultrasound which nurse practitioners are authorized to order.**

and to extend the authority for both nurse practitioners and registered nurses to order the following forms of energy:

- **Electricity for: fibrillation; cardiac pacemaker therapy; cardioversion; defibrillation; electro coagulation; fulguration; and transcutaneous cardiac pacing.**

Public Hospitals Act

RNAO calls for a comprehensive review of the *Public Hospitals Act*, especially since questions are repeatedly being raised about the effectiveness, development and implementation of medical directives, which in many cases are barriers to collaborative practice. However, there are significant regulatory reforms that the government can implement immediately to improve client and patient care and public access to the most appropriate health professional working to full scope of practice. RNAO urges the Social Policy Committee to recommend the following key regulatory changes to the Ministry of Health and Long-Term Care.

Admission, treatment, and discharge of clients, and the certification of death by NPs.

RNAO most strongly urges amendments to *Regulation 965* of the *Public Hospitals Act, 1990* to authorize nurse practitioners to admit, treat and discharge inpatients, in hospital settings and other facilities, between inpatient units and between facilities.

Regulation 965 limits NPs from working to their full scope in inpatient settings. They cannot diagnose, prescribe for, or treat inpatients without the use of medical directives. In contrast, NPs who work in outpatient settings – such as an emergency department or ambulatory clinic – can diagnose, prescribe for and treat hospital outpatients under their own legislative authority; however they are unable to admit their clients to the hospital for further treatment. This is also the case for NPs in the community. This limitation on NPs in inpatient settings is inconsistent, uses resources inefficiently, and unnecessarily delays patients' access to adequate treatment. This restriction also creates system inefficiencies.

Currently, according to the *Hospital Management Regulation, R.R.O. 1990, Reg. 965: section 11*, no person shall be admitted to a hospital as a client except, on the order or under the authority of a physician who is a member of the medical staff an oral and maxillofacial surgeon who is a member of the dental staff or a midwife who is a member of the midwifery staff.[20] This restriction causes unnecessary delays in admission for clients, which at times may further compromise their condition. For example, a client who is transferred from a nursing home and requires admission to hospital would benefit from their NP's authority to admit him or her directly to the appropriate in-patient medical unit rather than enduring an unnecessary long wait in emergency where not only the patient risks becoming confused, but could also potentially develop a pressure ulcer. Other examples are patients who need admission to hospital or hospice for palliative and end-of life care.

Though nurse practitioners are authorized to order some procedures for treatment for inpatients according to s. 24 of the *Hospital Management Regulation, R.R.O. 1990, Reg. 965,* the vast majority of treatment is done using medical directives and delegation; a tedious and inefficient process.

In addition, s. 16 of the same regulation states that if a client is no longer in need of treatment in the hospital, the order that the client be discharged and the communication of the order to the client may be made by the attending physician, midwife or dentist.[21] There are many examples to illustrate the disadvantages of this limitation on NPs, one of which is hospitalist programs

which have an NP attached though currently working under medical directives. This is a glaring under utilization of NP competencies and resources. This limitation on NPs in inpatient settings is inconsistent and makes poor and inefficient use of resources. It contributes to delays in patients' discharge from inpatient units as well as system inefficiencies and increased wait times.

At present, NPs are already entitled to admit and discharge clients from outpatient settings like hospital emergency rooms and clinics. In addition, according to Section 134 (1) (c) (ii) of the *Nursing Homes Act, 1990,* Regulation 832,[22] nurse practitioners are also authorized to conduct admission assessments for new residents of Nursing Homes who are admitted by a Community Care Access Centre coordinator: typically a registered nurse. They have not, however, been granted privileges to admit a client to a hospital inpatient unit.

The examination of root causes of wait times has had significant attention paid to a variety of systemic solutions, including the expansion of home care, home supports and continuing care. RNAO strongly believes that one of the best ways to aid in the overall reduction of client wait times is to grant NPs expanded hospital privileges, allowing them to use their advanced knowledge, skills, and judgment to assess the needs of their clients, including admission and discharge from inpatients units in hospitals and other settings.

Certifying death, according to the College of Nurses of Ontario,[23] means determining the cause of death and signing the Medical Certificate of Death. There is a legal requirement for a medical practitioner to certify death, and NPs may pronounce death, when the death of a client is expected, in the community or in a health care facility. Though extension of the right to certify death has been extended to NPs in the *Vital Statistics Act*[24,25] it has not yet been reflected in regulations under the *Public Hospitals Act.*[26]

RNAO recommends, in the strongest possible terms, regulatory changes under the *Public Hospitals Act,* by amending the following subsections[27] to read:

"11. (1) No person shall be admitted to a hospital as a patient except,

(d) On the order or under the authority of a nurse practitioner

(2) No physician, dentist, midwife or nurse practitioner shall order the admission of a person to a hospital unless, in the opinion of the physician, dentist, midwife or nurse practitioner, it is clinically necessary that the person be admitted.

"16. (1) If a patient is no longer in need of treatment in the hospital, one of the following persons shall make an order that the patient be discharged and communicate the order to the patient:

1. The attending physician, midwife or nurse practitioner, or, if the attending dentist is an oral and maxillofacial surgeon, the attending dentist.

2. A member of the medical, dental, midwifery or nurse practitioner staff designated by a person referred to in paragraph 1. *O. Reg. 346/01/s4.*

"17. (1) When a patient dies in a hospital, the attending physician or nurse practitioner shall cause a copy of the medical certificate of death required by subsection 21 (3) of the Vital Statistics Act to be filled in the medical record pertaining to the patient. *R.R.O. 1990, Reg. 965, s17 (1).*

(2) Where subsection 21(4) of the Vital Statistics Act requires a coroner to complete the medical certificate of death and the coroner does not provide the attending physician or nurse practitioner with a copy of the medical certificate of death, the attending physician or nurse practitioner shall complete a report in Form 1 and cause a copy of the report to be filed in the medical record pertaining to the patient. *R.R.O. 1990, Reg. 965, s. 17(2).*

Patients currently may wait several hours even until the next day for physicians to sign their discharge orders, negatively impacting patient satisfaction and blocking patient flow through the system. The most representative example occurs when surgeons are occupied in the operating room performing their key role - i.e. surgery, and are unable to attend the unit in a timely manner to sign a patient's discharge order.

Sometimes this delay can extend even over a weekend, when a patient who is sufficiently recovered could have been discharged. The proposed regulatory changes would enable NPs to use their knowledge, competencies and experience to a greater extent, as well as promote a significant reduction in hospital wait times, by improving the turnover of clients through the healthcare system.

RECOMMENDATION: Amend *Regulation 965* of the *Public Hospitals Act, 1990*, to authorize admission, treatment, and discharge of hospital inpatients by nurse practitioners.

RECOMMENDATION: Amend *Regulation 965* of the *Public Hospitals Act, 1990* to authorize the medical certification of death by nurse practitioners, to reflect those changes already made to regulations for the *Vital Statistics Act R.S.O. 1990*.

RECOMMENDATION: Amend *Regulation 965* of the *Public Hospitals Act,* 1990 to authorize physiotherapists to initiate or order treatments or diagnostic procedures for inpatients in a hospital setting.

Medical Advisory Committee

According to the *Public Hospitals Act, 1990,* the purpose of the Medical Advisory Committee (MAC) is to carry on activities for the purpose of studying, assessing or evaluating the provision of health care with a view to improving or maintaining the quality of health care, or the level of skill, knowledge and competence of the persons who provide health care.

Duties of the MAC are to consider and make recommendations to the board respecting any matter referred to it,[28] including the appointment of physicians to a group of the medical staff, and determining hospital privileges to be granted to any members of the medical, dental,

midwifery and nurse practitioner staff; as well as the revocation or suspension of the appointment of or refusal to reappoint a member of staff.[29]

RNAO firmly believes that all health professionals must have equal access to decision making, bringing their competencies, knowledge and skills to best serve the public and the organizations in which they work. Equal access to decision making will serve to advance respect amongst all professionals, true team work and staff retention and recruitment.

RNAO supports all regulatory colleges and their members working together to implement and strengthen interprofessional, client-centred care across health sectors which is grounded in mutual respect and shared knowledge. The provision for a MAC in the *Public Hospitals Act* is a barrier to collaborative practice. It reinforces the inequitable power relations between physicians and other providers, and provides inequitable access to senior decision-makers (e.g. the Board) that are not available to other health professionals and staff within the organization. Currently, the legislation requires boards to form MACs composed strictly of members of the medical staff.[30]

Such a structure does not contribute to team work and perpetuates power differentials that compromise workplace safety. The investigation into the death of Lori Dupont, RN, as a result of violence by a physician with a well-known history of abuse[31] resulted in this important inquest recommendation:

> "Ensure that patient and staff safety, as well as patient care, must be the most important factors and not be superseded by a physician's right to practice and that hospitals be able to exercise the appropriate degree of authority over physicians working within their institutions consistent with that of other regulated health professionals".[32]

To reflect commitment to truly interprofessional collaboration with the goals of Bill 179, the *Public Hospitals Act* must be amended to replace the Medical Advisory Committee with an Interprofessional Advisory Committee (IPAC) composed of members that represent all regulated health professionals involved in interprofessional practice. This is already the case with the Local Health Integration Networks (LHINs), and it should be the same for hospitals.

RECOMMENDATION: Amend the *Public Hospitals Act, 1990*, s. 35 – 37, to replace the Medical Advisory (MAC) with an Interprofessional Advisory Committee (IPAC) composed of members that represent all regulated health professionals involved in interprofessional practice in the hospital setting.

Drugs and Pharmacies Regulation Act

Subsections 1(1), 146 (1.0.1), 149, and161 (1)

The bulk of the changes to the *Drugs and Pharmacies Regulation Act* surround the introduction and implementation of remote dispensing machines, which have been piloted in Ontario for some time. The drug storage devices electronically dispense medications in a controlled fashion, and though they are in use in a variety of settings, are particularly practical in remote locations, such as communities without a pharmacy.

RNAO strongly supports changes to the *Drugs and Pharmacies Regulation Act* to reflect the introduction and implementation of this technology, as it would increase timely access to pharmaceutical treatment, especially for individuals who are geographically isolated. In many communities, particularly in rural and remote parts of the province, clients are able to obtain a starting dose of some medications from the nursing station; however they are usually required to wait several days and sometimes up to several weeks for prescriptions to be delivered from pharmacies outside their communities. This is exacerbated by the unpredictable nature of weather and technical delays when airplanes used to deliver the prescriptions are unable to fly. The implementation of remote dispensing machines in locations such as outpost nursing stations would decrease the likelihood of potential complications for individuals who require regular medication.

ENDORSEMENT: RNAO supports the introduction and implementation of Remote Dispensing Devices in the Province of Ontario.

Healing Arts Radiation Protection Act

Subsection 6(1)

RNAO strongly supports the elimination of barriers and limitations for NPs to order x-rays and mammograms. Recognizing that NPs are key professionals who provide high quality, client-centred primary and acute care, RNAO is proud to support this portion of the legislation. In addition, RNAO proposes the inclusion of RNs and supports the inclusion of physiotherapists as additional professions that should be authorized to order certain x-rays.

RNAO has, however, noted the absence of the authority for NPs to order Magnetic Resonance Imaging (MRI), Computed (CT) Tomography Scans, and the anatomical limitations for Diagnostic Ultrasound. The level of assessment conducted by a NP prior to the ordering of any diagnostic image 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.

For example, currently NPs are required to refer the client to a physician in order to have a Magnetic Resonance Image ordered. This process in itself is time consuming and costly. However, should a NP have the ability to order the image, the results would be interpreted by a radiologist, and then can be discussed in a multidisciplinary setting. The duplication of services will decrease, with the potential to be eliminated altogether with the advent of electronic technology, and digital imaging.

In addition, RNAO recommends that the authorization to order simple x-rays of the chest, ribs, arm, wrist, ankle and foot be extended to RNs with the appropriate education and knowledge, as discussed earlier under the *Nursing Act.* .

ENDORSEMENT: RNAO supports the elimination of barriers and limitations for NP ordering of x-rays, including mammograms, and the authority for physiotherapists to order x-rays.

RECOMMENDATION: RNAO calls for the inclusion of legislated authority for nurse practitioners to order CT scans.

RECOMMENDATION: RNAO calls for the authorization of registered nurses with the appropriate education and knowledge to order simple x-rays of the chest, the ribs, the arm, the wrist, the hand, the leg, the ankle or the foot, and mammograms

Health Insurance Act, 1990

Regulation 552

RNAO supports the development of a client-centred health-care system where Ontarians have access to continuity of care and continuity of caregiver from the provider of their choice. 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 necessary and desirable.

Changes to the Schedule of Benefits for Physician Services are needed to allow specialists to claim an equitable consultation fee for patient referrals which are made directly by a nurse practitioner. At present, Ontario's *Schedule of Benefits - Physician Services under the Health Insurance Act*[33] outlines a contractual relationship between a referring physician (commonly the family physician) and a consulting physician (specialist). When a written request is made by a family physician for referral to a specialist, the specialist must render the appropriate assessment and communicate in writing his/her findings to the referring physician. The specialist claims a medical specific assessment fee as well as a consultation fee.

Patients can self refer and other primary health-care providers, including NPs, can directly refer to a specialist. Without a request from a physician, however, the specialist can only claim the medical specific assessment fee, and not the consultation fee. Consequently, the remuneration to the specialist physician is approximately 24-39 per cent lower when the referral is from a NP. Further, without the consultant fee there is no requirement for the specialist to communicate a plan of care in writing to the referring care provider.

According to the standards of practice[34] for NPs, the College of Nurses of Ontario states that they offer "the full scope of primary health care practice, including consultation with physicians or other health care professionals when the client requires care beyond the NP's scope of practice." Further, they are "accountable for establishing a consultative relationship with a physician".

The *IBM McMaster Report on the Integration of Primary Health Care Nurse Practitioners into the Province of Ontario*[35] identified that over 90 per cent of NPs refer their clients for consultation by specialists. Eighty-eight per cent of those who do refer report they write the consultation note and the collaborating family physician simply allocates their billing number and signs the referral. Less than 10 per cent of NPs reported that they refer the client to the family physician (who sees the client and writes the consultation note) or have the family physician write the consult note after discussing the matter with the NP (p. 92). These strategies do not promote streamlined access to care nor contribute to an effective and efficient health-care system.

Real stories frequently cited by NPs and physicians provide evidence of the challenges for clients and inefficiencies for the system. For example, a NP sees a woman who desires sterilization. It is within the NP scope of practice to make a referral for consultation by a gynaecologist. To accomplish this, the NP must either circumvent the system as outlined

previously or create delays in referral by arranging an appointment to an already overburdened family physician that in turn will refer the client to the specialist.

NPs are the primary care providers for many clients, individuals and families. One of the few options for the client who needs a specialist consultation is a lengthy visit to a hospital emergency department. This is not only an inappropriate use of the emergency department, but it also results in fragmentation of care when the NP, as a primary care provider, is not in direct communication with the specialist. In the current model, physicians would receive the reports for patients they may have not necessarily assessed and there are delays in conveying this information to the NP as the primary care provider. It also results in duplication of assessment, and unnecessary system costs. Timely follow-up with the patient is not achieved and an additional burden for physicians and/or emergency departments is created.

NPs collaborate and consult with physician team members according to the CNO Standards of Practice, and for the benefit of the client. The most effective health-care teams are built on a foundation of trust and respect for each other's skills, knowledge and expertise. These effective high-functioning teams use a variety of referral patterns and make choices that best meet the health-care needs of the client. Enabling specialists to bill for a referral from a nurse practitioner would not alter the existing respectful, supportive and collaborative relationship NPs currently enjoy with physicians and other members of the interprofessional team and would drastically improve access for clients.

RECOMMENDATION: Amend the "Schedule of Benefits – Physician Services" under *Regulation 552* of the *Health Insurance Act* to authorize specialists to claim an equitable consultation fee when patient referrals are made directly by a NP.

Medical Radiation Technology Act, 1991

Sections 3, 4 and 5

The profession of Medical Radiation Technology, which is regulated by the College of Medical Radiation Technologists of Ontario, encompasses four distinct applications of energy such as ionizing radiation or electromagnetism.

MRTs perform a variety of Radiological Diagnostic Imaging, including x-rays, ultrasounds, mammograms, and computerized tomography (CT) scans. They use electromagnetism to produce diagnostic images, like Magnetic Resonance Images (MRI). Nuclear Medicine technologists inject, or have the client swallow or inhale low-level radioactive substances for the purpose of producing diagnostic images such as bone or lung scans. Radiation Therapists intricately plan, and use focused beams of radiation to precisely target and destroy diseased cells in the body, such as cancer.

In recognition of the significant technical and technological advances[36] in this field since the *Medical Radiation Technology Act* of 1991, RNAO firmly supports the legislative change to the current scope of practice statement, and to add controlled acts which are currently performed under delegation or medical directive. RNAO recognizes and supports the necessity for MRTs to have the authority to perform a procedure on tissue below the dermis, for instance to perform injections or start IV locks or lines for the purpose of administering contrast media. As diagnostic modalities have advanced significantly over the past 20 years, RNAO firmly supports the proposed legislation which includes the application of electromagnetism as a form of energy within the scope of practice for Medical Radiation Technologists.

RNAO supports the proposed legislative change to authorize an MRT to put an instrument hand or finger beyond the larynx, for the purpose of suctioning secretions from tracheostomies, and beyond the Labia Majora, opening of the urethra and the anal verge or into an artificial opening into the body. Though we recognize and support the authorization for MRTs to perform all these procedures, RNAO firmly believes that nurse practitioners should be included as a profession which is authorized to order those procedures in Section 5, paragraph 1, by revising the current statement to read:

> "A member shall not perform a procedure under the authority of paragraphs 1 to 4 of section 4 unless the procedure is ordered by a member of the College of Physicians and Surgeons of Ontario, or a member of the College of Nurses of Ontario who is a nurse practitioner under the *Nursing Act, 1991*.

Adding these controlled acts for purposes such as providing radiation brachytherapy, the administration of contrast media by catheter or other means for diagnostic imaging, or the insertion of markers during treatment planning is critical to the practice of Medical Radiation Technology. Including nurse practitioners in this portion of legislation will lead to reduction of redundancy in health services and the optimal utilization of NPs to their full capacity. Ontario

would see the results by achieving timely access, ensuring public safety and quality services across the province and in all sectors.

ENDORSEMENT: RNAO supports the amendment to the Scope of Practice statement for Medical Radiation Technologists,

RECOMMENDATION: Authorize nurse practitioners to order procedures to be carried out by Medical Radiation Technologists, such as administering substances by injection or inhalation, tracheal suctioning of a trachaeostomy, and administering contrast media by various means as outlined in the *Medical Radiation Technology Act, 1991*.

Midwifery Act, 1991

Section 4, 11 (1) (b)

Midwives have a significant role in primary maternity care in Ontario, by providing care to women during normal, healthy pregnancies and deliveries. RNAO supports the proposed legislation to add several new authorized acts which would allow Midwives to practice to their full scope. Though this legislation would include the prescription and administration of drugs identified in regulation, RNAO in no way supports the creation of any form of lists within these classes. The use of drug lists significantly restricts midwives and other professionals from practicing to their full scope of practice and places limits on their ability to make use of the most clinically appropriate and current medication for their client.

We firmly believe it is in the best interests of the client that the midwife has full ordering and administering authority for pharmaceuticals including oral contraceptives, and for antibiotics, for example those related to the treatment of Bacterial Vaginosis, Urinary Tract Infections, Group B Streptococcus (GBS) and other infections. Delay or lack of treatment of GBS, for instance, is the leading cause of neonatal septicaemia which can lead to long-term sequelae such as hearing loss or even neonatal death.[37]

RNAO supports a process in which limits are self-imposed by the College, based on individual competencies and a legislated scope of practice. For example, the drug Oxytocin could be regulated in a similar fashion as in other Canadian provinces, such that midwives without advanced midwifery certification would not be given the authority to prescribe and administer that drug.

ENDORSEMENT: RNAO supports the amendments to the legislation, which provides additional controlled acts which midwives are authorized to perform.

RECOMMENDATION: Remove all drug prescribing lists that midwives and other professionals must use, and implement an open non list-based prescribing system, that would be diligently regulated by the individual professional colleges.

Naturopathy Act, 2007

Providing Naturopathic Doctors (ND) with the ability to prescribe, dispense, compound and sell natural substances which are defined as either a 'drug' or 'prescription therapeutic product' will ensure that NDs will continue to have the ability to function within their full scope of practice.

There is a significant omission in Bill 179 of the controlled act whereby NDs would be authorized to prescribe, dispense, and sell natural substances, and compound substances such as high dose vitamins. Without this controlled act NDs would be unable to practice to their full competencies, or exercise to their full scope of practice based on knowledge, skills and judgment. RNAO firmly believes that NDs can play a significant role in primary care, and improve access to care for Ontarians who choose this primary care alternative and may assist in reducing pressures on emergency rooms.

In addition, Section 4, paragraph 5 of the *Naturopathy Act,* 2007 indicates that NDs are authorized to communicate a "naturopathic diagnosis" identifying, as the cause of an individual's symptoms, a disease, disorder or dysfunction that may be identified through an assessment that uses naturopathic techniques." Though diagnoses are performed in many different professions, the application of knowledge and experience in determining the cause and effect relationship makes diagnosis a universal concept. Therefore specifying the added term "naturopathic" prior to "diagnosis" makes this controlled act unclear, and potentially runs the risk of becoming a barrier to collaborative practice.

RECOMMENDATION: Add the controlled act of prescribing, dispensing, selling and compounding natural substances for the profession of Naturopathy.

RECOMMENDATION: Remove the term "naturopathic" before diagnosis in section 4, paragraph 5 of the *Naturopathy Act, 2007*.

Pharmacy Act, 1991

Section 3

Within the context of Pharmacy's role as a self-regulating profession working collaboratively with other health care professions, each to their greatest scope of practice, RNAO is very supportive of the proposed legislation. Specifically, RNAO supports the amendment and augmentation of the Scope of Practice statement for Pharmacy to include the provision of information and education, as well as the promotion of health and prevention and treatment of diseases, disorders and dysfunctions through monitoring and management.

Section 4

In addition, RNAO supports authorizing pharmacists to prescribe medication therapy management under the regulations. Pharmacists remain the authority in pharmaceuticals, and by employing their knowledge and utilizing their skills, they bring their expertise to create an increasingly effective system of drug therapy. It also recognizes the potential impact of poly-pharmacy related morbidity and mortality.[38] For all these reasons, RNAO believes providing pharmacists with the ability to undertake medical therapy management to be in the public interest, and is consistent with the principle of inter-professional collaboration within the health care team. It can even result in an overall cost savings[39] of direct client care in the community.

Similarly, authorizing pharmacists to administer drugs by inhalation and perform procedures on tissue below the dermis[40] would not only support the proposed amendments to the pharmacists' scope of practice, but provide the client with a readily accessible resource for health promotion in the community. The ability to demonstrate procedures to clients[41] in addition to effectively communicating information to the public also can result in better health outcomes through reducing error and increasing compliance.

There is, however, an area of concern. Armstrong and Milligan[42] discuss the changing nature of the retail pharmacy sector in North America and the liberalization of drug regulatory regimes. In particular, they cite the Consumers' Association of Canada concerns about client safety, loss of confidentiality, and potential accrued costs to consumers as a consequence of moving basic health services into a "one-stop shopping" retail-oriented environment. Although retail pharmacies have recently taken the positive step of providing wellness and awareness education, assuring that the public can distinguish between a commercial marketing campaign and legitimate health promotion and education should be made a priority through legislation, regulation or standards developed by the College of Pharmacists.

RNAO reiterates, however, that any regulation authorizing therapeutic classes of drugs would not provide health professionals such as pharmacists and nurse practitioners with enough latitude to practice to their full scope of practice. RNAO believes that the existence of lists within classes will become onerous and restrict the professional's ability to adapt, modify or extend prescriptions.

ENDORSEMENT: RNAO supports the amendment and augmentation of the Scope of Practice statement for Pharmacy to include the provision of information and education, as well as the promotion of health and prevention and treatment of diseases, disorders and dysfunctions through monitoring and management.

ENDORSEMENT: RNAO supports the proposed legislation which would authorize pharmacists to prescribe medication therapy management under the regulations, administer drugs by inhalation, and perform procedures on tissue below the dermis.

RECOMMENDATION: Authorize open, non list-based prescribing of pharmaceuticals by Pharmacists and nurse practitioners, with no restrictions by list, category or schedule. Regulations can then be imposed by the respective regulatory colleges, based on individual competencies and legislated scope of practice.

RECOMMENDATION: Require standards to be developed by the College of Pharmacists to assure that the public can distinguish between a commercial marketing campaign and legitimate health promotion and education.

Physiotherapy Act, 1991

RNAO recognizes that physiotherapists are one of the key health professionals who make the difference between client dependence and client independence, and we are proud to support the proposed amendments to legislation. Physiotherapists currently perform several controlled acts under medical directives and delegation, and according to the College of Physiotherapists of Ontario, may be working beyond their legislated scope of practice, even though most have the knowledge skills and ability to do so. As with other health professionals, it is time to update this legislation to reflect the reality, levels of education and competence, and support the collaboration of physiotherapists with other members of the inter-professional team.

RNAO supports the proposed legislation which would allow physiotherapists to communicate a diagnosis identifying a disease, dysfunction or disorder within the limits of the practice of physiotherapy. Physiotherapists often have the firsthand knowledge of the abilities of their client, and can discern whether a particular infirmity is physically dysfunctional in nature, or whether it requires referral to other medical professionals for treatment.[43]

Important elements in physiotherapy are the management of cardiopulmonary functions and mobilization of clients. Though wound care has traditionally been within the scope of practice of registered nurses, RNAO supports the proposed legislation which would authorize physiotherapists to perform the controlled act of treating a wound by cleansing, soaking, irrigating, probing, debriding, packing and/or dressing. We recognize that in order for physiotherapists to assess and provide the best possible care, often they will need to undress a wound to skin level and/or beyond. In addition, clients with certain pulmonary disorders may require inhaled drugs or substances prior to their physiotherapy sessions or in conjunction with their therapy. Therefore, allowing physiotherapists to have the legislated authority to perform the advanced controlled act of treating a wound and administering an inhaled drug or substance would ultimately benefit the client.

Physiotherapists perform multiple techniques with a wide variety of clients in order to help their respiratory status, and so by allowing them to administer a substance by inhalation, they are able to assist the client attain a higher level of holistic well being, for example, providing supplemental oxygen when mobilizing a client with Chronic Obstructive Pulmonary Disorder, or providing oxygen to a client having just received chest physiotherapy or postural drainage.[44] RNAO supports the proposed legislation which would authorize physiotherapists to administer a substance by inhalation.

As the age of the population increases, the incidence of urinary or fecal incontinence will likely increase. Studies[45] have shown that physiotherapy can benefit some forms of incontinence, and some physiotherapists currently perform, under medical directive or delegation, the controlled act of putting an instrument, hand or finger beyond the labia majora or anal verge to manipulate the tailbone for the purpose of assessment and interventions related to the pelvic musculature associated with incontinence. Authorizing both of these controlled acts would help physiotherapists promote the increased well being of the client. RNAO firmly supports both of these proposed changes to legislation.

With regards to the ordering of diagnostic imaging modalities, such as Magnetic Resonance Imaging, Diagnostic Ultrasound, and X-Ray, the level of assessment conducted by a physiotherapist prior to the ordering of any of these tests is very thorough. Authorizing the ability to order these tests would not only increase the overall efficiency of physiotherapy treatment, but will also reduce costs to the system as a whole. Duplication of services will decrease, and may be eliminated altogether with the advent of electronic technology, and digital imaging. Authorizing physiotherapists to order such diagnostic imaging promotes inter-professional collaboration, and RNAO strongly supports this proposed legislation.

Physiotherapists play an instrumental role in the day-to-day functioning of their clients. As health care providers and members of the inter-professional team, physiotherapists conduct assessments and provide treatment for a variety of dysfunctions and disorders, for which they have received a high level of education. It is because of this education and experience that RNAO strongly supports the expansion of the legislated scope of practice statement for physiotherapy to include the descriptors “neuromuscular”, “musculoskeletal”, and “cardio respiratory”, as well as to include the concepts of diagnosis as well as the treatment, rehabilitation and prevention of diseases or disorders that are associated with physical dysfunction, injury or pain.

ENDORSEMENT: RNAO supports the proposed legislation which would allow physiotherapists to communicate a diagnosis identifying a disease, dysfunction or disorder within the limits of the practice of physiotherapy.

ENDORSEMENT: RNAO supports the proposed legislation which would authorize physiotherapists to perform the controlled act of treating a wound by cleansing, soaking, irrigating, probing, debriding, packing and/or dressing.

ENDORSEMENT: RNAO supports the proposed legislation which would authorize physiotherapists to administer a substance by inhalation.

ENDORSEMENT: RNAO supports the proposed legislation which would authorize physiotherapists to perform the controlled acts of putting an instrument, hand or finger beyond the labia majora or anal verge to manipulate the tailbone for the purpose of assessment and interventions related to the pelvic musculature associated with incontinence.

RECOMMENDATION: Extend legislative authority to allow physiotherapists to order Magnetic Resonance Imaging, Computed Tomography and Diagnostic Ultrasound.

Patient Restraints Minimization Act

The College of Nurses of Ontario (CNO) Practice Standard: Restraints[46] (2004) states that restraints are environmental, chemical, or physical measures used to control the behavioural or physical activity of a person or a portion of her/his body. What is considered a physical restraint may vary by practice setting, however RNAO acknowledges that nurses have a valuable role to play in determining the appropriate definition and use of restraints for their specific practice setting. Through the creation of the Nursing Best Practice Guideline entitled *Prevention of Falls and Fall Injuries in the Older Adult,*[47] a systematic review of evidence related to client injury and physical restraint devices was conducted. All nurses are able to use this readily accessible resource in determining the best course of action with regards to minimizing the use of restraints.

The *Patient Restraints Minimization Act* seeks to minimize the use of restraints and encourage the use of alternative methods whenever possible, and especially when it is necessary to prevent serious bodily harm by a client to himself or herself or others. Reasons for using restraints include protecting clients from injury, maintaining treatment and controlling disruptive behaviour.

Currently, only a physician or a person specified by regulation is authorized to write an order to restrain or confine a client in a hospital or facility or to use a monitoring device on a client. There are currently no regulations in place which would allow nurse practitioners to use their knowledge skill and judgment in the ordering of client restraints. In fact, in the *Long Term Care Homes Act, 2007*,[48] which is awaiting proclamation, physical restraints may be included in a resident's plan of care if ordered by nurse practitioners. It is appropriate to make a complementary amendment to reflect this authority.

Nurses use their knowledge and clinical judgment in making the best choices for the client. When determining the need to restrict movement or control the behaviour of the client, the nurse would:

- Assess the client's behaviour. An in-depth assessment identifies the factors that lead to difficult behaviour for which restraint may be considered. The assessment includes contributing factors related to medication or to a physical need
- Examine the options including alternative solutions
- Collaborate with team members in developing and implementing the plan of care and in evaluating resident's response and effectiveness of restraint
- Develop a plan of care that includes outcomes
- Document the assessment using appropriate facility tools
- Obtain consent as per facility policy
- Update written plan of care including time restraint ordered, and frequency of monitoring as per facility and legislative requirements e.g. a minimum of every two hours
- Document interventions used to address behaviour and potential causes prior to implementing restraint
- Document evaluation of intervention, referrals and discontinuation of restraint

The goal is always to avoid the use of restraints. Restraints are to be used only after less restrictive alternatives have failed. The least restrictive, safest and most effective method is used based upon an assessment of the client's clinical situation. Restraints are used only with due consideration to the client's comfort, rights, and dignity. The cause of falls, wandering, combative behaviour, disrupting intravenous lines or other therapeutic measures must be determined, and attempts must be made to alleviate the cause, not just treat the symptoms with use of restraints.

The College of Nurses of Ontario states that the use of professional judgment is integral to the decision making process, however a workplace's Least Restraint policy does not mean that nurses are required to accept abuse. According to the RNAO Healthy Work Environment Best Practice Guideline on *Preventing and Managing Violence in the Workplace,*[49] sustained exposure to violence in the workplace, including aggression, abuse, and bullying can have serious physical and psychological consequences, causing some nurses to consider leaving the profession.

Nurses believe strongly in the right of clients to make their own decisions regarding care. When the client is not competent, the substitute decision maker is expected to make the same decision the client would have made if he/she were competent. Nurses, as client advocates, are responsible for ensuring that the client has received information and has been a partner in planning and consenting to the proposed plan of care.

RECOMMENDATION: Enact a regulation under Section 10(1) of the *Patient Restraint Minimization Act, 2001* authorizing nurse practitioners to order the restraint or confinement of a client in a hospital or facility or to use a monitoring device on such a client.

Mental Health Act and O. Reg. 741

Form 1 is also referred to as an APA (Application for Psychiatric Assessment).[50] The Form 1 allows the admission of a client to hospital for up to 72 hours to complete a psychiatric assessment. The assessment would include determination of whether the client is at risk for harming themselves or others and determines whether the client requires the care and supervision that a psychiatric hospital or inpatient unit can provide.

Currently, only a physician may complete and sign a Form 1,[51] whether the client is in the community or in hospital. A Form 1 also ensures that another professional will examine the person with the mental health problem. In addition, other mental health professionals (e.g., nurses, psychologists and social workers) may meet with the person and his or her involved family members, friends or caregivers to get additional information. Once the assessment is completed, the client must be released, admitted as a voluntary or informal patient, or admitted as an involuntary patient utilizing a Form 3. A Form 42 or Notice of the Act of Application for Psychiatric Assessment Form must be completed, in order to notify the person and inform them of why they're being held.

NPs frequently assess patients in crisis in a variety of clinical and non-clinical settings, including emergency rooms, outpost nursing stations, homeless shelters and drop-in centres. Authorizing NPs to complete and sign a Form 1 would help to provide client access to a system of comprehensive, effective, efficient, proactive and population-specific services and supports.

One in five people in Ontario has a mental health problem at some point in his or her life. Only about 30 per cent of these people seek any kind of help. There are several reasons for this. People may not recognize that they have a problem. They may not know what kind of help is available. Or they may know what exists but not be able to use the services because of barriers, such as cost, language and transportation. And they may have difficulty finding what they want when there is a wide range of services, and no one place to access them. In some cases, there won't be the right services nearby for their specific concerns.

RECOMMENDATION: Amend the *Mental Health Act, 1990,* and *Regulation 741* authorizing nurse practitioners to complete and sign a Form 1 (Application for Psychiatric Assessment).

Highway Traffic Act

Every primary health-care provider who examines a client for the purpose of determining fitness to drive must always consider both the interest of the client and the welfare of the community that will be exposed to the client's driving. In the course of the examination, the primary health-care provider should look not only for physical disabilities but should also endeavour to assess the client's mental and emotional fitness to drive safely. Either a single major impairment or multiple minor defects may make it unsafe for the person to drive.

According to the *Highway Traffic Act, 1990*, only legally qualified medical practitioners are required to report to the Registrar the identity and clinical condition of a client who, in their opinion, is suffering from a condition which may make it dangerous for the person to operate a motor vehicle.[52]

Primary Health Care Nurse Practitioners provide care for many clients, individuals and families who do not have a family physician. During their interaction, a nurse practitioner may find that the client is unfit to continue operating a motor vehicle, or requires a seatbelt exemption. With the current restriction in place, the NP must refer the client for further assessment to a family physician during which time, the client would continue to operate a motor vehicle, or be required by law to use a seatbelt, putting their own safety, and the safety of the community at risk.

This duplication of assessment is an inappropriate use of the family physician resource, and also results in fragmentation of care when the NP, as a primary care provider must transfer the assessment and follow up to another professional. It results in a delay in the surrender of the driving license, a duplication of assessment, unnecessary system costs, inconvenience for the client and additional burden for physicians.

RECOMMENDATION: Amend the *Highway Traffic Act, 1990* authorizing nurse practitioners to conduct assessments of clients' fitness to drive.

RECOMMENDATION: An amendment to *Regulation 340* of the *Highway Traffic Act (1990)* to enable NPs to sign seatbelt exemptions.

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