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

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Dear Ms Sullivan,

The Registered Nurses' Association of Ontario (RNAO) and its members are very supportive of the RHPA and the fundamental concepts that underlie the legislation: protection of the public and self-regulation. This legislative context has accommodated many advances in the health professions over the last 16 years. While the structure of the legislation with overlapping scope of practice, self-regulation and protection of the public remains sound, the legislation does require changes to keep up with the changing practice environment.

It is because we believe that there is a need to update legislation that RNAO supports, in the strongest possible terms, the proposed amendments to the *Nursing Act*, the *Regulated Health Professions Act*, the *Laboratory Specimen and Collection Centre Licensing Act*, the *Healing Arts Radiation Protection Act*, the *Public Hospitals Act*, the *Health Insurance Act*, the *Drug, Pharmacies Regulation Act*, and the *Controlled Acts* regulation that was submitted by the College of Nurses of Ontario (CNO). As the professional organization for registered nurses in the province, RNAO affirms that these changes will serve the public by strengthening the safety and capacity of the care they receive, and that of Ontario's health-care system.

The changes proposed by CNO, including those that provide for new controlled acts or remove restrictions on existing ones, reflect the existing education, competencies and practice of RN(EC)s, performed currently under delegation and medical directives.

Enhancing Client Safety

Enabling all RN(EC)s to function autonomously without medical directives or delegation sharpens lines of accountability. Furthermore, current regulatory restrictions like those limiting RN(EC)s' access to broad prescribing and ordering diagnostic tests result in a slow and cumbersome process that increases risk to the public. These regulatory processes cannot keep pace with evolving technologies and evidence-based practice, thus leading to real-time delays in client care.

RNAO fully supports CNO's proposal to place conditions necessary to protect the public in practice standards rather than in legislation. Monitoring through a regulatory body rather than through the courts will be more consistent with self-regulation, and more appropriate and accessible for

monitoring compliance.

Increasing Access to Health-Care Services

RNAO endorses, in the strongest possible terms, regulatory and legislative changes that will facilitate implementation of the recommendations in numerous reports[1] [2] which urge maximizing the contributions of all health professionals to increase access to health services. The proposed changes will allow RN(EC)s to use their knowledge, skills, and experience to a greater extent, allowing them to practice to their full scope to better serve the needs of Ontarians.

RNAO very strongly supports CNO's recommendation to remove limitations on the following controlled acts currently authorized to RN(EC)s:

a. Prescribing;
b. Communicating a diagnosis; and
c. Administering a substance by injection or inhalation.

RNAO also very strongly supports CNO's recommendations to permit access to the following additional acts for RN(EC)s:

a. Setting or casting a fracture of a bone or a dislocation of a joint;
b. Dispensing, selling or compounding a drug;
c. Applying a form of energy prescribed in regulations under this Act (i.e. RHPA).

The proposed changes will: reflect current education, competencies, and practice of RN(EC)s; increase client access to timely health-care services; increase efficiencies within the system and enhance cost-effectiveness by decreasing duplication; and, clarify and enhance RN(EC) accountability. These changes will also result in improved retention and recruitment of RN(EC)s working in Ontario by enabling them to be utilized to their full capacity, and will thus aid in ameliorating many of the current health system challenges.

Under the current legislative framework, RN(EC) practice is limited by the requirement for delegation to perform these controlled acts: setting or casting a fracture or a dislocation; dispensing, selling or compounding a drug, and applying forms of energy. Over time, because of technological and scientific advancements, changing practice realities, and evolving population health needs, these acts have become incorporated into the day-to-day practice of RN(EC)s.

Today, patients' health is compromised due to delays in treatment, there are system inefficiencies and a great deal of frustration amongst RN(EC)s who feel their education and competencies are not fully utilized. The following are examples of the impact of the current regulatory framework:

1. During cold and flu season, many patients suffer from post-viral coughs. RN(EC)s currently cannot prescribe a bronchial dilator to relieve patients of their symptoms.
2. Patients with diabetes who are having difficulty with hyper-or hypoglycemic episodes cannot currently benefit from RN(EC)s' knowledge and expertise to independently change their pharmaceutical therapy, even though many RN(EC)s specialize in diabetes care and have advanced education and many years of experience in the field.
3. Patients who require specific tests such as X-rays, ultrasounds, lab tests, and mammograms cannot benefit from RN(EC)s' knowledge and expertise as they can only order tests as listed in the Laboratory and Diagnostic Imaging List. For example, RN(EC)s cannot order a spinal, shoulder, or skull X-ray. To be treated for shoulder injuries, which are quite common in active people, the patient must unnecessarily see another health professional (or

emergency department) to have their test ordered. This causes undue stress and treatment delays for the patient, and creates inefficiency in the health-care system.

4. The list also limits the patient's access to appropriate screening services for conditions such as prostate cancer (PSA test) and osteoporosis (Bone mineral density test). Screening and prevention of disease are one of the strong mandates in the Nurse Practitioner's scope of practice (College of Nurses of Ontario, 2004).
5. About 30 per cent of Ontarians living in northern communities do not have a family physician at any given time, and their health is directly compromised by barriers to fully access the care of RN(EC)s.

Removing Limitations on Controlled Acts Currently Authorized to RN(EC)s

Advance practice nurses, previously known as 'acute care nurse practitioners', graduate with the entry competencies to perform the additional controlled acts (both those that are limited to existing RN(EC)s, as well as the newly proposed controlled acts); however, they currently require medical directives or delegation because of Regulation 965 under the *Public Hospitals Act*.

The process for the development of medical directives involves many individuals and a number of committees within hospitals. In many instances, the time from initiation of the process until completion takes up to one year. In addition, because best practice must be led by research, medical directives require frequent revisions in order to incorporate best practice, and each time the medical directive is updated, the process must be repeated. During the time that medical directives are formulated, and as each revision is undertaken, APNs must consult with a physician for every aspect of medical management. The system inefficiencies related to these processes are obvious and so is the frustration it creates for APNs and for patients' as they suffer the consequences of unnecessary delays in treatment.

The proposed legislative and regulatory amendments will advance timely access by enabling RN(EC)s to directly provide needed health services within their legal scope of practice, the practitioner's individual level of competence and in accordance with best practices and the regulatory standards set by CNO. Medical directives or delegation in both in-patient and out-patient settings, is an outdated and inefficient practice that blurs, rather than delineates, lines of accountability for health professionals.

Permitting Access to Additional Controlled Acts for RN(EC)s

Improving access to health services can play a significant role in improving health outcomes. According to recent national reports, one way to facilitate this improvement is to enhance access to health services through the expansion of scopes of practice of health providers.[3] Expanding scopes of practice has the potential to provide clients with access to health care where and when it is needed, reduce wait times, and minimize the stress and economic burden on clients and their families. For example, the proposed additional controlled acts could enable RN(EC)s practicing in emergency departments to address more of their clients' needs. The RN(EC), within his or her level of competency, could order drugs to provide appropriate pain relief, order required x-rays, and set simple fractures and apply a cast without delay. The client would not need to be seen by the physician unless warranted. Enabling the RN(EC) will result in reduced system and client burden.

Similarly, permitting RN(EC) access to the controlled act of dispensing, compounding and selling drugs will provide the public with improved access to health services, particularly for populations

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 making timely client access to appropriate diagnostic tests and drugs essential. Increasing RN(EC) diagnostic and prescriptive authority will lead to early identification and intervention to help reduce complications.

Open Prescribing

In a context of rapid technological change and evolving roles, there is compelling evidence that the current list-based approval process for RN(EC) diagnostic and prescriptive authority is untenable. Open prescribing for diagnostic tests and pharmaceuticals is vital to meet clients' needs. The current list-based system results in delays in treatment, unnecessary duplication and misallocation of resources.

Nurse practitioners in other Canadian jurisdictions have broad prescriptive authority. The College of Registered Nurses of British Columbia has reduced the drug restrictions that limit nurse practitioners' prescribing practices to a very short list. This gives nurse practitioners in BC the flexibility to prescribe broadly in order to meet the needs of their patients. Nurse practitioners in the Northwest Territories can prescribe openly, and, similar to British Columbia, have a short list of restrictions in each system/class of drugs they can prescribe.[4] Nurse practitioners in New Brunswick and Newfoundland and Labrador also can prescribe broadly.[5] [6] NPs in Saskatchewan have broad prescriptive authority.[7]

The same is the case in other developed countries. For example, since May 2006, British nurse practitioners have had the majority of the prescribing restrictions removed and have "been able to prescribe all medication except for some controlled drugs".[8]

As of 2006, NPs in more than half of the states in the United States of America had open prescribing authority to prescribe all medications (Running, Kipp, & Mercer, 2006).[9] NPs can openly prescribe, are not limited by restrictive protocols, and have the flexibility to adjust their clinical responses according to the needs of the patient.[10]

Conclusion

RNAO urges HPRAC to accept CNO's recommendations in their entirety to remove legislative barriers and enable RN(EC)s to practice to their full scope, reflective of their education, competencies, and experience. This is critical at a time when access to health services is challenged by limited human resources and when public safety must be maintained. Providing RN(EC)s with broad authority to order diagnostic tests and prescribe treatments will ensure that RN(EC)s are responsible and accountable for the tests they order and the medications they prescribe – thus strengthening public safety. Furthermore, removing the necessity of medical directives and verbal orders will reduce the risk of blurred accountability and related liabilities. The changes will lead to improved access for the public to health services and greater role satisfaction for nurses, securing higher retention and recruitment of nurses and RN(EC)s -- all of which are essential to ensuring public safety.

RNAO supports, in the strongest possible terms, the approval and submission of the proposed regulatory changes to the Ministry of Health and Long-Term Care. We urge the Minister to move

quickly to implement these recommendations so that RN (EC)s are fully utilized for the benefit of the public.

Thank you for the opportunity to comment on these proposed vital changes that impact the profession of nursing in Ontario and the public we serve. Be assured of our continuing support in seeking ways to better utilize the education, competencies and experience of all nurses to improve the health and health-care system of Ontarians.

With kindest regards,

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President
Registered Nurses' Association of Ontario

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Executive Director
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