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

June 9, 2006

Hon. George Smitherman
Minister of Health and Long-Term Care
Hepburn Block
10th Floor
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister Smitherman,

We are writing to share our views on the HealthForce Ontario Strategy. We congratulate you and the Ministry on progress toward a comprehensive health human resources plan. However, we have grave concerns about specific elements of the plan. In this letter we outline our views and ask for a formal meeting to further discuss our concerns.

Tuition reimbursement for new nursing graduates returning to practice in rural, remote, and underserviced areas

We are very pleased with, and in full support of, the government's policy to invest $1 million to support tuition costs for nursing students interested in practising in rural, remote and underserviced areas. RNAO has been a strong advocate for this policy since 2003 (RNAO Pre-Budget Submission, 2003). We believe that this incentive should be extended to new graduates who wish to relocate and practice in rural, remote, and underserviced areas.

Full-time guarantee for new nursing graduates

We also fully support the government's policy to offer full-time positions to every new nursing graduate. Full-time employment is essential for integrating newly acquired academic knowledge into actual practice knowledge and skills. New graduates with full-time employment, mentored by senior nurses, will better serve the needs of the public. To successfully integrate new graduates and retain senior nurses, we urge the government to implement the 80/20 strategy across the health care system at the same time. This strategy would provide for nurses, aged 55 and over, to spend 80 per cent of their time in direct patient care and 20 per cent on mentorship and other professional development activities.

RNAO has been advocating for 70 per cent full-time employment for RNs since 1999, and for guaranteed full-time work for new graduates since 2003. More than 94 per cent of young nurses surveyed for RNAO's 70 Per Cent Solution indicated a strong preference for full-time employment, while only 38 per cent had it (RNAO, 2005). Similarly, a 2004 survey by the Nursing Health Services Research Unit showed that while 79 per cent of nursing graduates wanted full-time employment, only 37 per cent were able to attain it. As a result, graduates have had to consider other options: more than 50 per cent of graduates in southwest Ontario were considering

employment in the United States **(**Nursing Health Services Research Unit, 2004).

We urge you to ensure that government moves quickly to implement these initiatives. We believe that the new graduate task force report should report back in time for the policy to be implemented this September. We should not run the risk of losing another year of nursing graduates.

New roles

We congratulate the government on continuing to move forward with Nurse Endoscopists. This expanded role will ameliorate the serious capacity issues Ontario faces in delivering endoscopic services, and will improve health outcomes (Cancer Quality Council of Ontario, 2005). We also believe this role will contribute to retention of senior, highly-skilled RNs. The report of the Ontario Task Force on Large Bowel Endoscopic Services included the following findings:

- Flexible sigmoidoscopy can be performed safely and effectively by specifically educated registered nurses.
- Flexible sigmoidoscopy is within the scope of practise of registered nurses in Ontario.

We hope that you will heed the expert advice provided to your government, and in the interests of patient safety, ensure that this will be an RN role.

We appreciate the public recognition of the Registered Nurse First Assist (RNFA) role in announcement of the Surgical First Assists. RNFAs are an established role within RNs' scope of practise, and can have a significant impact on reduced waits for surgery, particularly in community hospitals (Trypuc and Hudson, 2005). We believe both these expanded roles will have a positive impact on retention for senior nurses, as they provide a more specialized career trajectory.

However, we remain concerned about two issues. Given that the announcement was not accompanied by any ongoing funding for RNFA positions, we wonder when these positions will be filled so that Ontarians begin to benefit from the reductions of wait times that will result from consistent increase in the use of these positions. Our second concern is why the announcement used the term Surgical First Assistant. In our meeting, we will be seeking assurances from you that possession of an RN qualification will be a requirement for these positions.

Finally, we are deeply concerned about the announcement of the new role of Physician Assistant. First and foremost, we are concerned about continuity of care and patient safety. There is already considerable confusion among the public regarding the many health-care workers who already provide care. The introduction of yet another category will only add to this confusion and impose additional costs on our system.

We have grave concerns about the implications for patient safety of introducing a new group of unregulated providers. Minister, you wrote to our president Dr. Mary Ferguson-Paré, clarifying that this role will not be regulated at present, that Physician Assistants will work under delegation from physicians, and, that regulation will be considered in the future. Creating a new group of regulated health care providers raises a number of difficult problems. Setting up educational and regulatory requirements for new providers, who will in large part duplicate the services of existing providers, is time-consuming, costly, and inefficient. Furthermore, setting up new categories of workers that duplicate existing nursing roles is demoralizing to the nursing workforce. Nurses, including NPs,

see these new categories of health care providers as undermining the government's support for and understanding of their skills, knowledge, and potential in the health care system through extended or expanded roles.

We would ask that you rethink this position. You have stated that this role could use the skills of international medical graduates who will not become physicians. We believe that the skills of these individuals could be used by developing an 18 month program designed to bridge them into the established role of RN(EC). I have discussed this with CNO and COUPN, and we would all gladly work with your Ministry to establish an education program geared to these individuals. These graduates would then be integrated into the health care system in an established role, with their own scope of practise. This would be more efficient, less cumbersome, and less costly than establishing a new role. It certainly would be less confusing for Ontarians who need maxi nurses, not mini doctors.

We remain concerned that these announcements were not accompanied by one for the nurse anaesthetist role. Nurse anaesthetists can help address one of the main limiting factors to achieving wait time targets (Trypuc and Hudson, 2005). I have been personally assured by your staff and directly by our Premier that the introduction of the Nurse Anaesthetist role will be announced soon. RNAO would like to know the specific date. We hope that RNs can start to make their specific contribution in this new role, to reduce wait times sooner rather than later. Minister, you first promised movement on this role more than 19 months ago (see attached Toronto Star article). We eagerly await the announcement.

RPN initiation of controlled acts

We are also deeply concerned about the government enacting the regulation providing RPNs with the authority to initiate controlled acts. The former government did not bring this regulation into force, and for good reason. We are concerned about the implications for patient safety and health system outcomes of this decision.

The question of extending authority to initiate to RPNs was extensively discussed in 1993 (when RN initiation was introduced). The conclusion was that the basic foundation on which to develop the competencies for self-initiation is <u>preparation at the RN level</u>. At that time, it was acknowledged that the greater depth and breadth of preparation of the RN facilitates a more comprehensive knowledge base and complex problem-solving skills that are essential for initiation.

In my conversation with Joshua Tepper, he raised two issues: 1. implementation was based on a proposed regulation passed by CNO, and 2. very few RPNs will meet the necessary criteria for initiation. That CNO decision was highly political one, driven by the 49 per cent of council members who were appointed by the previous government.

Indeed, we are concerned that your government's decision to allow RPNs who meet all criteria to initiate controlled acts – a very small group - will only cause confusion among the great majority of RPNs who will continue to be unable to initiate controlled acts. As Dr. Tepper said, one of those requirements is that there be no RN present. This will create an incentive for employers, confused by the new authority for RPNs, to replace RNs with RPNs. Thus, we are concerned both about patient's safety and about the impact of your decision on the quality of care.

The evidence shows that increased RN staffing improves outcomes both in Canada and

internationally. Home care clients cared for by RNs had more positive status outcomes related to their condition at discharge than those cared for by RPNs. Additionally, clients cared for by baccalaureate-prepared RNs had improved outcomes and required fewer home visits (O'Brien Pallas et al. 2001, 2002). Hospitals with higher RN nursing staffing mixes had significantly lower mortality rates (Tourangeau et al, 2002). In other research, a higher proportion of care provided by registered nurses is associated with shorter length of stay, lower rates of urinary infections, and upper gastrointestinal bleeding. A higher proportion of hours of care provided by registered nurses was also associated with lower rates of pneumonia, shock or cardiac arrest, and failure to rescue – death from pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis, or deep venous thrombosis (Needleman et al, New England Journal of Medicine, 2002). A study of in-hospital mortality for patients with heart attacks showed lower mortality associated with higher RN staffing (Person et al, 2004).

Minister, your announcement raised many important and complex issues that will have an impact on the health care workforce, and on the health of Ontarians. We look forward to discussing these issues with you urgently.

With warmest regards,

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Executive Director
Registered Nurses'Association of Ontario