Submission to
Health Professions Regulatory Advisory Council

Non-Physician Prescribing
November 2008
PROFESSION INFORMATION

1. Name of Organization:
   Registered Nurses’ Association of Ontario

2. Address/website:
   158 Pearl Street, Toronto, Ontario. M5H 1L3
   http://www.rnao.org

3. Telephone and fax numbers:
   Phone: (416) 599-1925
   Fax: (416) 599-1926

4. Contact Person:
   Doris Grinspun    Wendy Fucile
   Executive Director    President
   Phone: (416) 599-1925    Phone: (416) 599-1926
   Email: dgrinspun@rnao.org    Email: wendyfucile@trentu.ca

5. Other professions, organizations or individuals who could provide relevant information.

   College of Nurses of Ontario

   Nurse Practitioner Association of Ontario

   Canadian Nurses Association

6. Names and positions of the senior directors and officers
   President- Wendy Fucile RN, BScN, MPA, CHE
   Past President- Mary Ferguson-Paré RN, PhD, CHE
   Executive Director- Doris Grinspun, RN, MSN, PhD (Candidate), O.ONT
The Registered Nurses’ Association of Ontario (RNAO) would like to thank the Health Professions Regulatory Advisory Committee (HPRAC) for considering our submission on Non-Physician Prescribing. RNAO is the professional organization representing Registered Nurses (RNs), including NPs working in all roles and sectors across Ontario.

RNAO fully endorses the detailed submission provided by the Nurse Practitioners’ Association of Ontario (NPAO) on Non-Physician Prescribing. The need for a broad, open prescribing approach for NPs is thoroughly discussed in RNAO’s November 2007 submission to HPRAC (see Appendix 1). We support, in the strongest possible terms, 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 were submitted in April 2007 by the College of Nurses of Ontario (CNO).

In a context of rapid pharmacological development, technological change, and evolving roles, there is compelling evidence that the current list-based approval process for Registered Nurse Extended Class (RN(EC)) diagnostic and prescriptive authority is ineffective and inefficient. The current list-based system results in treatment delays, unnecessary duplication, and misallocation of resources. Open prescribing for diagnostic tests and pharmaceuticals already exists in several Canadian jurisdictions, including Saskatchewan, Manitoba and British Columbia.i ii As of 2000, in the United States there were 25 states that gave full prescriptive authority to nurse practitioners, including for controlled substancesiii.

RNAO reiterates that enabling all RN(EC)s to function autonomously without medical directives or delegation sharpens the lines of accountability and strengthens public safety. 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 compromises access to health services and increases risk to the public. These regulatory processes cannot keep pace with advanced technologies, evolving pharmacological treatments and evidence-based practice, thus leading to real-time delays in client care. iv

The Provincial Government has committed to fund 25 additional NP-led clinics in Ontario to increase access to primary health care. Proposed regulatory and legislative changes, including RN(EC)s’ access to broad prescribing, will optimize the utilization and contributions of NPs, and will increase access to health services. At a time when Ontarians desperately need access to timely and quality health services, it makes no sense to hamstring the hands and minds of NPs by limiting their authority to practice autonomously and to their full scope. The time has come for the public to fully benefit from their competencies and expertise. RNAO continues to take the position that the scope of practice of all RNs, including NPs, must be expanded to ensure Ontarians have access to the best quality and most timely health care from the most appropriate provider.
Although outside the scope of this specific referral, RNAO has also proposed the following expansion of all RNs’ scope of practice:

1. 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;
2. Setting or casting a fracture of a bone or a dislocation of a joint;
3. Applying a form of energy prescribed by the regulations under this Act (i.e. RHPA); and
4. Dispensing a drug as defined in subsection 117 (1) of the Drug and Pharmacies Regulation Act.

RNs should have the authority to perform these acts within nursing scope of practice based on knowledge, skill, and experience. This will ensure timely access to high quality care, reduce the need for unnecessary delegation, and support progression of care management in a timely way.

RNAO 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.

In summary, it is in the public interest that RNs and RN(EC)s have independent access to controlled acts that are an integral part of their practice. These acts change both as nursing practice and roles evolve and as knowledge advances. Without this independent access, the profession is not truly self-regulating. Just as important, expanded scope of practice for RNs and RN(EC)s 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 RN(EC)s are fully accountable for their practice. Removing the necessity of medical directives and verbal orders will reduce the risk of blurred accountability and related liabilities, decrease duplication, increase public safety, as well as increase efficiencies and cost-effectiveness within the system. Changes will lead to improved access for the public to health services and optimal utilization of RNs and RN(EC)s to their full capacity, resulting in greater role satisfaction and higher retention and recruitment of RNs and RN(EC)s. All these are central to ensuring public safety, timely access, and quality services across the province and in all sectors.

Thank you for the opportunity to comment on Non-Physician Prescribing, an important topic that impacts 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 RNs and NPs to improve the health and health-care system of Ontarians.
With kindest regards,

Wendy Fucile RN, BSCN, MPA, CHE
President
Registered Nurses’ Association of Ontario

Doris Grinspun, RN, MSN, PhD (cand),
O.ONT.
Executive Director
Registered Nurses’ Association of Ontario
Barbara Sullivan  
Health Professions Regulatory Advisory Council  
55 St. Clair Avenue West  
Suite 806, Box 18  
Toronto, Ontario, Canada  
M4V 2Y7  

HPRACSubmissions@ontario.ca  

November 15, 2007  

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\(^v\)\(^vi\) 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. 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. Nurse practitioners in New Brunswick and Newfoundland and Labrador also can prescribe broadly. NPs in Saskatchewan have broad prescriptive authority.

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”.

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). 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.

**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,

Mary Ferguson Paré, RN, PhD, CHE
President
Registered Nurses’ Association of Ontario

Doris Grinspun, RN, MSN, PhD (cand), O.ONT.
Executive Director
Registered Nurses’ Association of Ontario