



COLLEGE OF NURSES  
OF ONTARIO  
ORDRE DES INFIRMIÈRES  
ET INFIRMIERS DE L'ONTARIO

THE STANDARD OF CARE.

# Interprofessional Collaboration among Health Colleges and Professions

Submission to the Health Professions  
Regulatory Advisory Council

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## **INTRODUCTION**

The College of Nurses of Ontario (CNO), the regulatory body for 146,000 Ontario nurses, is pleased to respond to the Health Professions Regulatory Advisory Council's (HPRAC) consultation on issues related to interprofessional collaboration. CNO supports interprofessional practice by all health providers and believes that interprofessional collaboration is an essential prerequisite for effective and efficient patient and family-centered care. Interprofessional collaboration is introduced in the entry-level curriculum of nursing's educational programs and an emphasis on collaboration continues throughout a nurse's career. Consequently, nurses develop and maintain throughout their careers the knowledge, skill and judgement necessary to carry out their roles as integrated members of collaborative practice health care teams.

Our recommendations in this submission are congruent with the original intent and philosophical thrusts of the *Regulated Health Professions Act, 1991 (RHPA)*. While the regulatory mandate for interprofessional collaboration among Colleges was recently introduced as an object of the health regulatory Colleges, our comments address public protection through collaboration among Colleges and the efficient and effective self-regulation of our members, many of whom practice collaboratively with members of other professions.

We are intent on continuing to carry out this responsibility in a way that fosters the safe evolution of practice for all health care professionals and that enables the achievement of better outcomes, increased access to timely care, and efficient use of clinical resources. We are mindful of the fact that the *RHPA* intends to regulate each profession in a fair and equitable manner, and that the decisions for the provision of competent services need to be based on the ability of competent providers to deliver safe, effective and ethical, care within their respective scopes of practice.

Our submission is structured under the following headings:

- A) Defining interprofessional collaboration;
- B) Eliminating barriers to collaboration among the Colleges and professionals, and;
- C) Structural mechanisms needed to enhance collaboration

### **(A) Defining Interprofessional Collaboration**

CNO agrees that there are many ways to describe interprofessional collaboration in the provision of health services and is supportive of the identification and creation of a common definition agreed to by all health care providers. In our Standards documents we currently define collaboration for our members as “working together with one or more members of the health care team who each make a unique contribution to achieving a

common goal. Each individual contributes from within the limits of her/his scope of practice”.<sup>1</sup>

This definition captures many of the elements put forth by HPRAC in its discussion document. However, CNO is supportive of working together with our regulatory counterparts to further refine the term collaboration, and to better incorporate into a definition the concepts of mutual respect, maximum use of collective resources, and awareness of individual accountabilities, and competence and capabilities within respective scopes of practice.

In terms of learning more about each other and the extent to which knowledge is shared and where it diverges, CNO believes that this groundwork needs to be laid within the foundational educational programs of the individual professions, through interprofessional courses. Our educational counterparts in universities and colleges are encouraged to work conjointly with the provincial government and regulatory bodies to examine undergraduate and graduate education and its influence on the working relationships between health professionals and to pursue the development of mutual trust and respect.

## **(B) Eliminating Barriers to Collaboration among the Colleges & Professionals**

### RHPA

The introduction of the *RHPA* marked a significant, progressive change from the licensure exclusivity of practice that was characteristic of the traditional professions such as medicine and dentistry. Each of the regulated professions under the *RHPA* benefited from a defined scope of practice statement in their profession specific legislation that, in addition to describing the “what, how and why” of the profession, also provided a frame of reference for access to specific controlled acts relevant to the profession’s practice.

The *RHPA* is organized to facilitate the evolution of scopes, allowing for overlapping scopes of practice, and a sharing of controlled acts. As such, CNO finds nothing inherently wrong with the structure of the *RHPA* as it relates to the promotion of interprofessional practice.

Recent updates made to the *RHPA* reflect current realities of practice. The concept of interprofessional care was recently introduced as an object of the health regulatory Colleges. CNO is supportive of this object and looks forward to its implementation. It recognizes that much work will need to be carried out, however, to ensure that health care professionals and stakeholders share a common understanding of and a commitment to the meaning of interprofessional practice.

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<sup>1</sup> College of Nurses of Ontario. 2005. *Practice Guideline: Utilization of RNs and RPNs*, p. 18.

## Auxiliary Legislation

CNO supports a review of auxiliary legislation and associated regulations that restrict or limit health care providers from practising to the maximum of their competencies within their respective scopes of practice. Many auxiliary acts are prescriptive and specific in limiting the responsibilities of self-regulating professions. Some limit on the basis of the location of the service, some are patient population or provider specific. They ignore any evolution in practitioners' competencies. These restrictive requirements need to be amended in order to promote efficiencies, timely access to care, and patient choice.

Most legislation was created prior to the enactment of the *RHPA* and before the emergence of collaborative team-based care. As a result, many pieces of legislation do not reflect the current role of regulated health care providers. For example, regulations under the *Nursing Act* give nurses who meet certain conditions the authority to initiate specific controlled acts. These nurses may decide based on their knowledge and expertise that a specified procedure is required and initiate that procedure in the absence of a direct order or medical directive from a physician. While Registered Nurses and Registered Practical Nurses have the authority to initiate, the opportunity is limited in practice by the *Public Hospitals Act, Regulation 965*. This regulation requires a medical patient care order for the initiation of treatment and diagnostic procedures.

This same regulation also places limitations on Nurse Practitioners (NPs). They are not granted the authority to diagnose, prescribe for or treat inpatients without the use of a medical directive. However, 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. They can also perform these same activities within a community setting. The core competencies remain the same, regardless of the setting, but the authorizations for performance do not.

Other auxiliary legislation exists that impedes nurses' current authority to perform controlled acts. Under the current *Healing Arts Radiation and Protection Act* the authority to ordering X-rays is granted to physicians and granted narrowly to NPs who may order X-rays of the “chest, the ribs, the arm, the leg, the ankle or the foot”. These limited allowances for NPs and the failure to recognize the ordering of basic X-rays by nurses working in areas such as emergency departments or fracture clinics lead to inefficiencies within the system, unnecessary delays in treatment and inconvenience for the patient.

Updating auxiliary legislation such as the *Public Hospitals Act* and *Healing Arts Radiation and Protection Act* to reflect the contribution that health care providers can make within their professional competencies reinforces the collective contributions of the health care team to patient outcomes and will bring about a better use of clinical resources and more timely access to care. Removing barriers that limit the development of effective interprofessional collaboration will contribute to improve health care delivery for the public and will increase mutual trust and respect amongst the providers of care.

## Liability Issues

The issue of professional liability coverage has come to the forefront in light of the proposed recommendation from HealthForceOntario calling for all caregivers participating in collaborative care to agree on terms and conditions for adequate mandatory liability coverage.<sup>2</sup> Professional liability coverage is not currently mandatory for nurses. However, most nurses have professional liability coverage through an employer, professional association, or the Canadian Nurses Protective Society. NPs who are employed under the terms of an Ontario Ministry of Health and Long-Term Care contract are required by the Ministry to carry liability coverage appropriate to their role.

CNO recognizes that the lack of mandatory liability coverage for all health care providers is a concern, as some health providers are hesitant to engage in interprofessional care given their perception that specific health professionals will be found liable for the conduct of others in the interprofessional team. CNO is not convinced that the making of liability coverage mandatory will eliminate all areas of resistance to interprofessional collaboration. However, CNO Council will be revisiting this issue and the College will continue to engage in educating its members about the importance of adequate coverage.

## **(C) Structural Mechanisms Needed to Enhance Collaboration**

### Quality Assurance

Given the examples of interprofessional practice that are happening at the clinical level in Family Health Teams and Community Health Centres, and knowing how difficult it is to attribute patient outcomes to specific health care disciplines or providers, CNO is supportive of working with its regulatory partners on an interprofessional quality assurance (QA) model for such interprofessional settings. This would be in addition to member specific continuing competency programs.

CNO believes that regulatory bodies are in a unique position to identify systems issues particularly through aggregate data obtained from their Inquiries, Complaints and Reports (ICR) and QA processes. The sharing of this aggregate information and collaborative action by regulatory bodies, health professions, government, and health care facilities may lead to systems changes with a positive impact on public safety.

In “*Adjusting the Balance*”, HPRAC recommended establishing a taskforce to develop a system for reporting and dealing with health care delivery errors resulting in significant adverse patient outcomes and prevention of future errors. CNO endorses establishing a task force and involving relevant stakeholders such as the regulatory colleges in the process as a proactive means of addressing system issues that are often beyond the mandate of any one group.

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<sup>2</sup> HealthForceOntario (July 2007). *Interprofessional Care: A Blueprint for Action in Ontario*, Interprofessional Care Steering Committee. Government of Ontario, p. 25.

## Inquiries, Complaints and Reports

CNO commends and fully supports the changes made under the *Health System Improvements Act, 2001* that promote common processes to deal with complaints and investigations and that allow for the limited sharing of information amongst Colleges.

While there may be merits for a single complaints model in Ontario, for complaints related to practice in interprofessional settings, CNO is concerned that it would replicate the role of a college's own complaint department, be costly to administer and may be no quicker at reaching a conclusion. CNO is confident that colleges can work together to develop a process for dealing with multidisciplinary complaints that is responsive to complainants without jeopardizing each college's peer review process. CNO's current complaint resolution process has successfully addressed systems issues in practice settings with multidisciplinary teams and is one example of existing approaches that could be explored further.

In order to conduct a joint investigation or resolution, each member of the multidisciplinary team would need to be informed of the identities of the other members named in the complaint. The amendments have authorized Colleges to freely share information with each other, but do not make clear whether Colleges can inform individual members about other health care professionals who are named in the complaint. With additional clarification that this disclosure was an exception to the duty to keep all information confidential, Colleges could facilitate the resolution of interdisciplinary complaints.

CNO suggests that Colleges consider sharing independent legal advice and administrative support of adjudicative committees and that they pursue centralized scheduling and orientation supports. Merging administrative support of adjudicative committees would result in a more streamlined and efficient process and enhance the perception of independence of adjudicative processes. Hearings would still take place at the individual colleges thus increasing efficiencies. This would replicate the success the Federation of Health Regulatory Colleges of Ontario has already achieved in the development of a joint interprofessional committee for discipline orientation. Operational efficiencies would improve and better use would be made of staff resources in such areas as orientation and ongoing education. Processes and resources would not be duplicated or subject to extraneous steps.

## Professional Guidelines, Tools and Templates

CNO recognizes that there is a lack of consistency on the use of regulatory tools and instruments across the Colleges. Resources and support at the regulatory level are necessary to introduce innovative models of collaborative care. CNO supports the development of guidelines, tools and templates that health regulators could use to help facilitate collaboration among Colleges. We would also be supportive of working on

selected interprofessional standards that are relevant across Colleges such as ethics, privacy or consent.

CNO suggests that the Federation of Health Regulatory Colleges of Ontario, which includes membership from all health regulated professions, could take on the responsibility of identifying areas where common standards may be appropriate. Colleges have already had the benefit of working with the Federation to develop tools and templates that regulators can use to facilitate collaboration. It has already facilitated the development of joint interprofessional committees for quality assurance and discipline orientation and has also developed numerous toolkits, practice manuals, frameworks and other resources related to enhancing and facilitating interprofessional collaboration amongst its members.

## **Conclusion**

The requirement to consider issues from the point of view of the public enables regulatory Colleges to provide a distinctive perspective on interprofessional collaboration. CNO looks forward to participating in further discussions and debates on how best to address the challenges and opportunities arising from enhanced interprofessional collaboration.