London Region Advanced Practice Nurses
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November 13, 2007

Health Professions Regulatory Advisory Council
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Regarding: The College of Nurses of Ontario Submission to HPRAC (Aug 2007) on the Registered Nurse in the Extended Class: Scope of Practice Review

Dear Members of HPRAC;

The advanced practice nurses in London and surrounding region strongly support the College of Nurses proposal in its entirety to improve patient safety and access to health care through expansion of the Extended Class of nursing.

The London Region Advanced Practice Nurses (LRAPN) www.lrapn.org/ is an organization of over eighty advanced practice nurses with a diversity of patient care roles within the London and area hospitals, clinics, health units, long term care facilities and family health teams. Our organization’s membership includes Registered Nurses prepared at the Master’s level or beyond who work as a Clinical Nurse Specialists or Advanced Practice Nurses (formerly known as Acute Care Nurse Practitioner (ACNP)) as well as nurses registered in the Extended Class (RN(EC)) as Primary Health Care Nurse Practitioners (NP-PHC). More than sixty of our members will be eligible to register in the new RN Extended Class categories of NP-Adult and NP-Paediatrics in 2008. We will share with you patient examples to highlight how a few of the changes put forth by the College of Nurses will improve health care of our patients.

The change to Regulation 965 of the Public Hospital Act to permit the RN(EC) various authorities with respect to treating in-patients is paramount for the patients cared for by our members. The ACNP role was introduced into the hospital setting to reduce gaps in care and improve patient flow through the health care system. Currently members struggle with cumbersome, stagnant documents called medical directives to try to facilitate best care for patients in hospitals. The danger with these documents is the length of time it takes to create them and circulate them for approval in light of the rapid change of pharmaceuticals, diagnostic testing and other technology. They are large and once created, are seldom referred to. For NPs within the hospital, medical directives redirect accountability from the practitioner educated with the knowledge, skill and ability, to the physician(s) who sign them. The alteration of Regulation 965 would support timely access to safe care for patients in hospitals and place accountability on the person providing that care.
**Example:**

“I work as an APN (formerly known as ACNP) in an acute care teaching hospital. I am part of the orthopaedic team and work with both inpatients and outpatients. Currently I rely on medical directives to facilitate my scope of practice. The patient population that I care for is primarily elective hip and knee replacement surgery patients. My role allows me to care for these patients across the continuum as they move through the consultation, pre-admission, intra-hospital, and post-operative phases. The patients and their families often comment on the positive benefits of continuity of care while they are journeying through the healthcare system. Unfortunately, reliance on medical directives makes the current system inefficient for patients. While in hospital, I regularly initiate, modify, adjust, and optimize the medications that patients are receiving, particularly pain medications. Providing best practice, evidenced-based care requires that patients continue on the medications they have been routinely taking at home, as well as, new medications initiated while in hospital. Working from a drug list would compromise the ability to provide optimal care for these elective surgery patients, as they often have pre-existing health conditions and a well established drug regimen, not amenable to the current restrictive list of medications available to RN (EC)s.

Often patients are ready for discharge and I must wait for the surgeons to sign the discharge prescriptions. I routinely spend 30 to 60 minutes waiting for the surgeons to finish in the operating room in order to obtain a signature. The surgeons are only available between their surgical cases and I must reach them during this short window of opportunity. Even if they page me once they are free, I must stop whatever I am doing and travel through the hospital to the operating room to get the prescription signature. Additionally, once these patients are discharged, I am unable to communicate with pharmacies to provide direct instructions regarding discharge medications or renew prescriptions which have the potential for sub-optimal medication management or medication errors.”

**Example:**

“In my role as an Advanced Practice Nurse in Pediatric Neurology, I see children who have waited at least six months for an outpatient clinic appointment. I provide a Seizure Clinic and a Headache Clinic, but am unable to practice independently even though the children I see have conditions which are within my scope of practice to manage. The current system expects the Neurologist to see all my new patients, and so patients often have to wait 20 minutes while I wait for the doctor to review the child’s case. This time could be better spent seeing new patients, thus shortening the wait times. As well, I can only see patients when the physician is available. If the physician is away, my clinics are cancelled. This affects timely access to health care. It is very distressing for a family to wait six months for a paediatric Neurology appointment, only to have it cancelled on short notice because a physician is not available. The
change to Regulation 965 of the Public Hospital Act recommended by the College of Nurses of Ontario would enable me to practice within my scope of practice and level of competence thus minimizing wait times, improving cost effectiveness and improving efficiency for the children and their families.

I currently have to prescribe using medical directives. However, I am unable to write outpatient prescriptions since my medical directives only allow me to practice within the hospital. This means that the medications I am competent to prescribe when a child is acutely ill, I am not recognized as being competent to prescribe on an outpatient basis. As a result, children I see in clinic wait a minimum of 15 minutes longer in their appointment while I wait for my physician collaborator to sign their prescription. Once again, this is precious time that could be used to see another patient.”

Removal of drugs and diagnostic tests from legislation and the adjustment to broad diagnostic and prescriptive authority is extremely important to our members. The diversity of practice settings in which our members work makes it impossible to manage a “list” approach. A recent survey of hospital based APNs (formerly ACNP) identified at least 15 specialty practices whose medication and diagnostic needs would vary drastically. Personal examples from our members of how broad authority would improve timeliness of care, improve patient flow and provide best care to patients are illustrated below.

Example:
“In my role as an Advanced Practice Nurse in Pediatric Neurology, I provide a Pediatric Seizure Clinic and a Headache Clinic. The current drug and lab list is too restrictive and would render my role ineffective. In my practice I prescribe a great deal of anticonvulsants, headache medications, diagnostic tests (MRI, MRA MRV, Nuclear Med scan) and a wide variety of non-routine blood work. I currently need to prescribe all these using a medical directive while the children are in the hospital. While I can prescribe these for my acutely ill patients, I am unable to sign the laboratory requisition form for a community laboratory since it requires a doctor’s signature. Once again, children have to wait and this affects other children getting timely access to care.”

Here is an example from a community setting and an NP who has some prescriptive authority through the current list:

Example:
“As a NP-PHC working in the community, my practice focuses on chronic health condition prevention and management. In order to give optimal care while respecting my collaborative physician partner’s time, my patients time and my time, we use medical directives to ensure comprehensive care is provided for those medications and diagnostics outside the RN(EC) lists. I can see two benefits of removal of the list approach to
medications: first, less time would be spent on calling the pharmacist on behalf of the physician making patient visits shorter supporting more time for additional patient appointments, and second when I write a prescription there is less chance of error.

The removal of drug lists also supports immediate access to Best Practices and evidence based care. Here is a personal example: This past spring the RN(EC) drug list was updated and NPs were finally able to prescribe Bupropion for smoking cessation. Ironically that very week the more effective pharmaceutical agent Varenicline was released. To be able to provide the most effective medication I either had to refer patients to my collaborating physicians or develop another medical directive. Overall, health care provision will be more cost effective, time efficient and optimal when my RN(EC) scope of practice allows me to order medications and diagnostic tests as per my competence and the evidence rather than according to lists that are impossible to keep current.”

Lifting restrictions to current controlled acts and the additional controlled acts are needed to ensure timely and safe care is provided to in-patients. With over 20% of Ontario ACNPs working within the cardiac specialty, the ability to apply pacemaker therapy or cardiovert and the ability to order pacemaker therapy, defibrillation or cardioversion will without a doubt save patient lives and potentially decrease length of patient stay due to complications. Our members have again provided examples of patient benefits realized with the removal of limitations and additional controlled acts.

**Example:**

“I work in an intensive care unit in the role of an acute care nurse practitioner. The patients I care for have just had cardiac surgery and are most often unstable on admission. While a physician is responsible for the patients in the unit, he or she is not always present or may be managing another patient’s needs. The greatest risks managed on admission include bleeding and cardiac disturbances both of which are life threatening. Currently I am able to practice caring for these patients using a medical directive. Even with this document I am unable to provide safe efficient care to patients that is within my knowledgebase. There are several aspects of care that cannot be placed in a medical directive, aspects that cannot be delegated or have restrictions on them. For example I do not have the authority to ask the nurse caring for the patient to apply energy to the patient in the form of initiating a pacemaker. When unable to do or order this patients are placed at risk of harm or even death if we were to await the physician. I am uncomfortable placing the patient in this risk thus I must make a decision to act within my knowledgebase but outside of my authority. In addition to the fresh post cardiac surgery patient, my unit cares for patients who have had complications from their surgery and require life support for prolonged periods of time. The families of these patients rely on me for information because I am the consistent person they see
and a relationship develops. Our medical model supports a physician rotation every week meaning that physician on today may not return to work in the unit for several months. As a result I update families on their loved one’s condition to ensure clear and timely information. I have the knowledge to order and interpret tests to determine causes of complications such as stroke, kidney failure and severe infection but restrictions on controlled acts and Regulation 965 do not allow me to share the diagnosis. As a result I am put in the situation of withholding the information, frustrating family members and breaking down the trusting relationship, or practicing outside of my scope and medical directive. It is the constant need to work outside of medical directives to provide acceptable, good quality evidence based care that makes my role so frustrating. The changes in the College of Nurses proposal would allow me to provide appropriate and timely patient care based on my knowledge, skill and judgement thus enhancing the care of the responsible physician.”

In summary, LRAPN respectfully submits to HPRAC that we strongly support the CNO document. The full implementation of the College of Nurses Extended Class Scope of Practice needs to occur in 2008 as early as possible to ensure that Ontarians with health concerns who require hospitalization for short or long term care receive timely, safe and holistic restorative or rehabilitative health care. LRAPN is confident that the Ontario healthcare system will realize a decrease in wait times through improved patient flow and increased quality of care through adherence to best practice standards when the RN(EC) can work to full scope of practice.

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On behalf of the London Region Advanced Practice Nurses