Stakeholder Feedback on the
Registered Nurse Prescribing Referral

Stakeholder Submissions

Note:
The responses within have not been edited by the Health Professions Regulatory Advisory Council (HPRAC). HPRAC is not responsible for any errors and omissions found on the submissions. The stakeholder comments are posted according to access to information guidelines (for guidelines visit, http://www.hprac.org/en/privacy.asp)
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Introduction

On February 26, 2015 Premier Kathleen Wynne and Minister Eric Hoskins affirmed the government’s commitment to authorize Registered Nurses (RNs) to prescribe drugs. On November 4, 2015, the Minister of Health and Long-Term Care, the Honourable Dr. Eric Hoskins, directed HPRAC to conduct broad consultations with key partners within the nursing and health care community to assess the following three models for Registered Nurse (RN) prescribing:

- Independent Prescribing;
- Supplementary Prescribing; and
- Use of Protocols.

HPRAC was requested to provide the Minister with the results of its consultation and its recommendations related to which model is most appropriate for Ontario by March 31, 2016. Unlike recent previous HPRAC referrals HPRAC will not be providing recommendations on whether or not a profession should be regulated or granted an expanded scope of practice, but rather, how a scope of practice might take shape.

To provide context for the analysis of the most appropriate model of RN prescribing for Ontario, HPRAC held a consultation session from December 14, 2015 to January 22, 2016, inviting individuals and organizations to participate in the consultation. Considering the Minister's timelines, HPRAC designed a consultation period that was comprehensive but shorter than previous referrals. HPRAC’s consultation process is expected to crystallize broad themes and unanticipated issues and should not be viewed as a quantitative source of stakeholder interests or concerns.

Stakeholders submitted comments through two different types of online surveys, one with primarily closed ended questions, the other with both open and closed ended questions (mixed). Stakeholders also provided their views in the form of a written submission.

By the close of the consultation, 274 submissions were made to HPRAC:

- 254 submissions were submitted online in the form of a survey (both open and closed ended surveys).
- 20 submissions were in the form of a letter. Part II of the stakeholder feedback focuses on these submissions.
The following organizations provided a submission to HPRAC regarding RN prescribing in the form of a survey or in the form of a letter:

- Advocates for the Reform of Prescription Opioids
- Alexandra Hospital Ingersoll
- Association of Ontario Health Centres
- Baycrest
- Campbellford Memorial Hospital
- Canadian Medical Protective Association
- Canadian Nurses Protective Society
- Centre for Addiction and Mental Health
- Chatham-Kent Health Alliance
- Children's Hospital of Eastern Ontario
- Collaborative BScN Program Nipissing University /Canadore College
- College of Chiropodists of Ontario
- College of Medical Laboratory Technologists of Ontario
- College of Midwives of Ontario
- College of Nurses of Ontario
- College of Occupational Therapists of Ontario
- College of Optometrists of Ontario
- College of Physicians and Surgeons of Ontario
- College of Physiotherapists of Ontario
- Collingwood General and Marine Hospital
- Cornwall Community Hospital
- College of Ontario University Programs in Nursing and the Provincial Heads of Nursing, Colleges of Applied Arts and Technology
- First Nations and Inuit Health Branch/Government of Canada
- Hamilton Health Sciences
- Hamilton Health Sciences
- Hawkesbury & District General Hospital
- Health Sciences North
- Holland Bloorview Kids Rehabilitation Hospital
- Hotel Dieu Grace Healthcare
- Institute for Safe Medical Practices
- Kingston General Hospital
- Lake of the Woods District Hospital
- Lakeridge Health
- Leamington District Memorial Hospital
- Leeds Grenville and Lanark District Health Unit
- London Health Sciences Centre
- Manitoulin Health Centre
- Matawa First Nations Mgmt
- Nipissing District Social Services Board
- North West Local Health Integration Network
- Nurse Practitioners Led Clinics (NPLC)
• Nurse Practitioners’ Association of Ontario
• Ontario Association of Public Health Nursing Leaders
• Ontario College of Family Physicians
• Ontario College of Pharmacists
• Ontario Hospital Association
• Ontario Long Term Care Physicians
• Ontario Medical Association
• Ontario Pharmacists Association
• Ontario Public Sector Employees Union
• Ottawa Public Health
• Rainy River District Social Services Administration Board & Rainy River District Emergency Medical Services
• Region of Waterloo Public Health
• Registered Nurses Association of Ontario
• Sault Area Hospital
• Sensenbrenner Hospital
• St. Joseph's Health Care London
• St. Joseph's Healthcare Hamilton
• Tillsonburg District Memorial Hospital
• Trillium Health Partners
• University Health Network
• Victorian Order of Nurses Canada
• Waypoint Centre for Mental Health Care
• Weeneebayko Area Health Authority
Closed Ended Questionnaire:
Survey Results
I am responding:

Member of a regulated health profession

Belonging to regulated health profession

Are you currently practicing?
Would RN prescribing result in more timely access to care?

How likely they are the models of RN prescribing to result in more timely access to care?

Would RN prescribing result in more convenient access to care?

How likely are the models of RN prescribing to result in more convenient access to care?

Would RN prescribing result in fewer emergency room visits?

How likely are the models of RN prescribing to result in fewer emergency room visits?

Would RN prescribing result in better access to care in remote communities?

How likely are the models of RN prescribing to result in better access to care in remote communities?
Would RN prescribing result in better access to care in rural communities?

- Yes: 74.6%
- No: 23.4%

Would RN prescribing result in better access to care in fast growing communities?

- Yes: 55.2%
- No: 44.8%

Would RN prescribing result in patients' better understanding of the prescribed medications?

- Yes: 49.4%
- No: 50.6%

Would RN prescribing result in patients being more compliant with instructions for medication use?

- Yes: 41.3%
- No: 58.7%
Would RN prescribing improve patient satisfaction?

- Yes: 65.5%
- No: 34.5%

Q27

How likely are the models of RN prescribing to improve patient satisfaction?

- Independent prescribing:
  - Least likely: 21.3%
  - Likely: 10.4%
  - Most likely: 68.3%
- Supplementary prescribing:
  - Least likely: 26.2%
  - Likely: 15.9%
  - Most likely: 57.9%
- Use of protocols:
  - Least likely: 52.4%
  - Likely: 31.7%
  - Most likely: 15.9%

Q28

Would RN prescribing improve patient well-being?

- Yes: 52.4%
- No: 47.6%

Q29

How likely are the models of RN prescribing to improve patient well-being?

- Independent prescribing:
  - Least likely: 20.0%
  - Likely: 13.1%
  - Most likely: 67.2%
- Supplementary prescribing:
  - Least likely: 27.7%
  - Likely: 60.0%
  - Most likely: 12.3%
- Use of protocols:
  - Least likely: 52.3%
  - Likely: 26.9%
  - Most likely: 20.6%

Q51

Would RN prescribing facilitate collaborative care?

- Yes: 63.9%
- No: 38.1%

Q32

How likely are the models of RN prescribing to facilitate collaborative care?

- Independent prescribing:
  - Least likely: 57.4%
  - Likely: 51.0%
  - Most likely: 9.0%
- Supplementary prescribing:
  - Least likely: 12.3%
  - Likely: 36.8%
  - Most likely: 33.5%
- Use of protocols:
  - Least likely: 30.3%
  - Likely: 40.0%
  - Most likely: 29.7%

Q33

What would be the impact of the models of RN prescribing on health care system costs?

- Independent prescribing:
  - No change: 20%
  - Cost increase: 34%
  - Cost decrease: 46%
- Supplementary prescribing:
  - No change: 35%
  - Cost increase: 29%
  - Cost decrease: 35%
- Use of protocols:
  - No change: 40%
  - Cost increase: 15%
  - Cost decrease: 45%

Q34

What would be the impact of the models of RN prescribing on risk of harm to patients?

- Independent prescribing:
  - No change to risk: 23.0%
  - Risk decrease: 11.5%
  - Risk increase: 65.5%
- Supplementary prescribing:
  - No change to risk: 41.3%
  - Risk decrease: 25.0%
  - Risk increase: 33.7%
- Use of protocols:
  - No change to risk: 57.5%
  - Risk decrease: 28.2%
  - Risk increase: 14.3%

Q38
How do the models of RN prescribing match RNs' professional skills, knowledge and education?

Which models of RN prescribing is suitable in hospital settings?
Which models of RN prescribing is suitable in community settings?

Which models of RN prescribing is suitable in other settings?
Closed Ended Questionnaire:
Open Ended Responses
If available, please provide any evidence or references to support responses provided in the survey.

<table>
<thead>
<tr>
<th>Response 1</th>
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<tbody>
<tr>
<td>My opinions are based on my experience practising as an RN &amp; nurse practitioner in a variety of settings for 28 years</td>
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<th>Response 2</th>
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<tr>
<td>&quot;In concept, I do not support adding more pharmaceutical responsibilities into the domain of nursing. Although medications are one part of the professional nursing role, they play a small part in recovery - the government needs to support nurses to work within full scope to support trusting therapeutic relationships, counselling, wellness, screening, education, tailoring self-management strategies to support their optimal functioning, developing care and safety plans, facilitating access and needs of vulnerable populations, family counseling, ETC. Medications and prescribing need to move away from the costly, centralized role they are being allowed to play in health care.</td>
</tr>
<tr>
<td>The only exception to this would be to support nursing to independently prescribe supplementary/complementary wellness modalities to prevent acute illness and stress related chronic conditions e.g. nutritional supplements, supplements, stress management/energy work, access to counseling.</td>
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<tr>
<td>Please be cautious of making more 'mini-doctors' or 'mini-pharmacists'- our health care system will be even more costly if we continue to rely on medications and accessing medications. Thank you for seeking input. &quot;</td>
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<th>Response 3</th>
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<td>Based on 18 years of work experience, I do not think RN's professional education is sufficient to implement this type of practice unless it is based on set protocols by Nurse Practitioners. The risk for patients is too high.</td>
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<th>Response 4</th>
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<td>Nurses are inadequately trained and inadequately qualified to prescribe. They do not have an MD's depth of experience, training, and adequate overview of physiology &amp; pathology to safely prescribe. This is only a Government dangerous grasp at ill-conceived cost reduction, not to mention nursing profession territory attack, and patients will suffer massively. The adage applies: 'A little knowledge is dangerous' -especially in this setting. Nurses do not go through the rigorous selection and training and requirement of intellectual horsepower that is demanded of MD's. If approved, prepare for massive number of adverse events, and government paid victim compensation. Be careful what you wish for....</td>
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<th>Response 5</th>
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<td>&quot;The documents being used to support this transition in RN care, clearly do not specify if the articles that have been reviewed were speaking of RNs or NPs. Canada, already has nurse's prescribing, they are known as Advanced Practice Nurse titled with Nurse Practitioner or Registered Nurse Extended Class. The educational requirements in other countries allowing RN prescribing overlap all of the required courses that nurses must be successful in to obtain their NP degrees. A better financial investment would be to utilize the NPs that are currently in...&quot;</td>
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practice and obtaining their NP certificates and help to promote their role and responsibilities in the communities, so that the government can use NPs to their full scope of practice—which includes PRESCRIBING!


Response 6
I believe RN would need extra education and I am concerned that patients will become confused in the role of an NP and a RN and its differences

Response 7
Nurses with extra certification, such as Certified Diabetes Educators who work in a Diabetes Education Centre with a medical director currently have the knowledge, skill and judgment prescribe. Please consider this group

Response 8
In the paramedic practice, we practice with protocols and oversight with self-report. Independent practice would be a good goal but not a good starting point. Least potential for harm first, then evaluate results, then increase scope of practice

Response 9
the protocol method seems much like the (very) old standing orders that often limited nurses in the actual situation. It wouldn't seem to take any major change to bring this back into more common practice but it would be very limiting. Registered Nurses all have education on medications and are already responsible for understanding actions, side effects etc even when prescribed by someone else.

Response 10
RNs should have additional education (Master's nursing) in order to prescribe. In addition, specific expertise in the area they will be prescribing should be mandated. A safe and effective solution to the issue you are raising may be to increase the enrolment in the NP programs across the province, and to create more NP funded positions

Response 11
"RN prescribing has been implemented in many countries across the world, however, these RNs have to have 'additional qualifications and specific expertise' (Nursing and Midwifery Board of Australia) to prescribe. A systematic review of nurse prescribing across Western European and Anglo-Saxon countries (Kroezen, van Dijk, Groenewegen, & Francke, 2011) found that most countries require nurses to have a masters degree before allowing independent prescription by nurses, and that all countries require nurses to successfully complete a prescribing course before granting any degree of prescribing privileges.

A safer and more feasible alternative may be to increase the enrollment into nurse practitioner programs across the province, as well as to introduce more nurse practitioner positions. This will ensure that prescribing individuals have the necessary education and knowledge to prescribe, while still increasing access to, and timeliness of, care and decreasing healthcare costs."

Response 12
"I have worked 2 remote and rural setting and independent prescribing is the most user friendly due to lack of resources and opportunities for collaboration."
The protocol model is already being used.

In urban setting with more resources, I think any model would work."

Response 13

"Over the course of my 40 year nursing career I have worked in community, acute and chronic care hospital settings in both urban, rural and remote settings, as well as in industry. RN prescribing in rural and remote settings, along with other health care settings where physician availability or consultation is not readily available, would be a great benefit to patients. The regulatory environment and standards of nursing practice allow for RNs to take on these additional responsibilities - however, there would likely be a need to strengthen prelicensure and offer continuing education to nurses, which could be provincially developed and locally delivered. As it is now, RNs do a lot of health teaching re medications that patient take (prescribed, over the counter, herbal etc), so RNs are quite knowledgeable about medication.

In the acute care hospital setting, medication could remain a shared responsibility between medicine and nursing, given the complexity and stability of the patients in these settings. Hospital based ambulatory care clinics where patients are seen for ongoing care, are settings where RNs might exercise independent prescribing as electronic patient records provide a means to ensure that the medication profiles of patients are up to date. Patients who present to Emergency for non emergency care (prescription refills for example) might be an example of a group of patients where ER nurses could independently prescribe, but should be agreed upon by Medicine and Nursing. To best support safe and effective care, all health professionals who collaborate in the care of a patient need to be diligent about documenting their care including prescriptions so that periodic review of care can be easily accomplished by the primary care provider(s). We know that many patients don't have a primary care provider, and seek episodic care from a number of different sources, so it is a priority that we have access to a medical record for all patients to facilitate information sharing and documentation of care (including prescriptions). This would certainly help with maintaining immunization information, which we haven't seem to have been able to master to date in Ontario. Hope my comments are helpful, and best of luck in your review."

Response 14

Increased preparation of nurses in Ontario at Baccalaureate level has prepared nurses to prescribe (if they want to).

Response 15

Evidence has shown that it takes an increasingly longer period of time giving access to primary care physician if indeed one is available. Recently with changes to pharmacists being able to reorder some long-term medications this has eliminated unnecessary visits to physicians for the sole purpose of renewing long-term medications. access could be further more easily facilitated if RNs were able to fill this role this leaving the physician freed up to take care of urgent care patients in their practice. as practices are increasingly growing in population and population is aging thus requiring increased need. I feel that was an appropriate level of training and pharmacological information that the nurses would be able to fill this role quite reasonably interims of responding to long-term medication prescription renewals and the need for more simplified medication usage following appropriate assessment.

Response 16
### Response 17
Availability of current on-line resources lessen risk, adding more resources (RN) into equation should mean that more time can be spent on assessment and choice of best medication, suggest that starting with supplemental and progressing to independent would lessen risk, course in pharmacokinetics would be desirable prior to embarking on RN prescribing.

### Response 18
There is a severe lack of health care physicians in Northern Communities which cause many people to go without health care and thus get sicker which results in more emergency room visits and admission to hospital. Registered Nurses would reduce the pressure on the program for sure and they are more than qualified. I would have total confidence in their judgement. Had a RNEC before and was very confident in her ability and she provided BETTER health care.

### Response 19
In many cases RN's already know what medications to prescribe. In fact they are required to know when any type of order is incorrect, therefore they must know what should be correct.

### Response 20
It is RN responsibility now to only administer medication that RN knows what medication is: why it is being given: correct dose and side effects RN would need an increase in pharmacology to prescribe but they have responsibility currently.

### Response 21
"Your provided literature review - higher rates or prescribing and medication errors particularly in high risk populations - much higher rates of high risk populations in hospital

RN expressed fear over incorrect diagnosis and inadequate knowledge base in pharmacology - not feeling confident

Prescribing should always be a supplementary skill - should not be part of initial RN certification and always require further education after 5 years of working experience. "

### Response 22
"I am concerned that when prescribing, there is no onus/ability for the RN to monitor the results of the prescription by ordering blood work.

Suggest that if not specializing, prescribers have access to only first line medication, and that f/u with NP or Dr must occur within a week for reassessment. Also, limited prescription eg 14 days, and no repeats."

### Response 23
Other regulated health professionals, such as Registered Dietitians, have as much or more formal education and clinical experience as Registered Nurses. If prescribing privileges are being considered for RN's, this must be extended to other regulated health professionals to allow them to prescribe discipline appropriate items. Examples include therapeutic diet orders, enteral and parenteral nutrition, basic laboratory electrolyte monitoring, and vitamin/mineral supplementation.

### Response 24
"The NP role should be furthered developed in Canada and support by governments as they have the advanced training towards public safety in terms of prescriptive authority. Nevertheless, RN prescribing would also enhance patient outcomes and accessibility, the model in British
Columbia where RNs receive specialized certification is conducive to safe RN prescribing and supports safety. Priority needs to extend and listen to the voice of NPs and the difficulties they have and are experiencing in their advanced role. Prescribing also require competency in many other areas and regulatory changes including ordering diagnostic test, making diagnoses etc.


Response 25

Nurses at their current level of expertise do not have the pathophysiology to understand prescribing medications and understanding interactions and effect. The use of numerous prescribers increases the chance of error and polypharmacy. IF they are to be given protocols it should not be as part of the RN classification but part of an extended classification and education. Having spent hours talking with RN (ER, ICU, CCC and medical floor) regarding this issues I have not met one who was in favour of this increased responsibility and liability in prescribing medications.

Response 26

Nurses have the knowledge and patience to prescribe medication. Not only are they equipped with great assessment skills. They also can talk to patients about the importance of taking the entire course of the meds (antibiotics), importance of blood tests for certain medications and talk about side effects in a timely manner whereas most drs prescribe and don't talk about any of this, and of course many more topics.

Response 27

"I have been a registered nurse for 27 years. The time for RN prescribing has arrived however within certain limitations. It is best for the patient.

Example, in primary care, to be able to give vaccines according to the public health schedule ensures the patient gets the vaccine and is not delayed or the vaccine is forgotten when the patient sees the doctors."

Response 28

"I am a seven year survivor of Adverse Drug Reactions

My husband has had 30 years in health care as CEO of large hospitals

My grand daughter is a charge nurse in an Ottawa hopital"

Response 29

The province currently has RNs who have received further education, mostly in the form of Master's preparation, who prescribe, they are called RN(EC)s or Nurse Practitioners. You do not need another level of nursing prescribing, especially when the government can't see fit to roll out our role including prescribing controlled substances and proclaiming Bill 179. Patient safety is already hugely at risk because our section of Bill 179 is not yet in effect 7 years after the Bill received Royal Assent. There have been 7 years of abnormal patient reports going to the wrong provider, the MD, who is not interested in having another provider's results in their inbox in addition to their own, who believe incorrectly that the NP is at being copied on tests that NPs cannot order, but would have been able to order had the Bill been proclaimed. Imaging facilities and hospitals consistently IGNORE NP requests to be listed as their patient's primary care
provider which results in NPs NOT getting any information or reports, including abnormals, for their own patients, who do not have any other provider other than the NP and NPs requests to be copied for tests are CONSISTENTLY IGNORED, even though the MDs believe we are being copied. This would all end if our section of Bill 179 is proclaimed. Yet for some political reason this is being sat on. I do not really enjoy having one of my patients in front of me requesting the results of their pregnancy ultrasound only to open the report that I have never seen because it wasn't sent to me when I either ordered the investigation or requested to be copied and determine that the fetus has a fatal defect. NO MD would stand for this and it certainly is a position that no professional should find themselves in, but this happened to me. I have had abnormal reports that I have ordered not come back to me and only become aware that they are abnormal when the patient comes back in asking for the results. My job is difficult enough having 600 patients registered to me alone without having to track down my patient reports. It could be whoever is reading this or your loved one whose abnormal investigation results get filed without any provider seeing them and all because the government won't proclaim a bill. If you did not want NPs to function as primary care providers, why did you implement the role??? We cannot do our job safely yet NOBODY IS DOING ANYTHING ABOUT IT!!!!!! NOBODY!!!!! So, no you should not be moving forward with anything else in the profession of nursing until your provide NPs with the tools to safely perform their role and quit thinking that you can rely on MDs to be God and catch all abnormal results. Some MDs won't even look at the investigation or report if their name is erroneously listed because they do not want to get involved legally. As foolish as this sounds, it happens. If you don't think solely being responsible for the primary care of 600 people without the appropriate tools to practice is difficult, why don't you try it? I spent 8 hours yesterday on my day off working for my 600 patients, writing several referral to specialists, following up on abnormal lab results such as ordering further investigation into an 889 year old possibly having multiple myeloma, arranging re-vaccination of a patient post stem cell transplant etc. The last thing I need is to not receive my reports, especially those that are abnormal. I don't know what the government thinks a primary care NP does but it isn't 'working under' a doctor, it isn't having our care 'overseen' by a doctor. We choose when to consult with the doctor just as as family doctor in primary care chooses when to consult with a specialist. We CANNOT do this if we don't have all the information about our patients that we need. The government has implemented and has educated NPs to do the same roles as primary care MDs and has not given us the same tools. This is resulting in enormous safety issues that the government is refusing to act upon. So if you want to ensure safety of Ontario patients, finish implementing the NP role before you start looking at expanding the role of RNs who have not received any post-graduate education. I imagine I just wasted 30 minutes of my time again explaining this to people who could have any impact on the role of the NP but I hope not. If you want to see what a primary care NP does in comparison to a primary MD or primary RN, come shadow me for a week. In addition, there is ample evidence in the literature that supports NPs in primary care as providing equal outcomes to that of MDs. Susan Monaghan, NP-PHC

**Response 30**

Many RNs will need +++ education to update their knowledge in regards to the pathophysiology of disease and medications, interactions, etc. Their educational background does not prepare them adequately for prescribing medications. As past faculty of nursing in our local community, I can definitely speak to the lack of education around medication preparedness.

**Response 31**
Response 32

"Based my answers from reading The preliminary literature review on the effectiveness of RN prescribing that you provided. Also based on personnel experience. Did work in Northern Ontario in nursing stations; did public health in Northern Ontario in rural communities.

One concern I do have is that the Universities have not adapted their curriculum for many years. Some Universities have not changed there curriculm in 20 years. I am very concerned about that. Please make sure to Survey the Universities, if they feel that their curriculum now would support the 3 models of RN prescribing."

Response 33

MUMS guidelines/protocols, etc..

Response 34

RN prescribing has not shown any increase in safety or improved care. It is very scary to see RN being allowed to prescribe in a health care setting where medications are over prescribed. RNs do not have the education or knowledge base to be prescribing. The only medication that I would feel safe with them begin allowed to prescribe would be simple over the counter medication such as tylenol, advil, gravel, plan B. I strongly believe that allowing this to go through will result in serious negative consequences to our patients. RNs simply do not have the education to prescribe. I have worked in many different settings including remote nursing areas with only RNs and there was NEVER a situation where an RN needed to prescribe. RNs can more safely provide care under medical directive. There is much better ways to be spending our health care resources then pushing this that is not needed nor safe.

Response 35

No. Too many complex patients. Medicine too complicated and risk too high to assume this responsibility. That's what MDS are for. This is beyond RN scope. RN 30 years. Seen many young nurses who don't understand the complexity of the illness and would dismiss it off as something less serious. A bowel obstruction can present many different ways...what if you prescribe Buscopan. .....A simple sore throat can lead to ALS if given the wrong dx no no no. Seriously. Haven't we already grown too far from the bedside. Look what's happened in Windsor. Work side by side with docs in ER. Have seen their thought processes. Not always the same direction as mine and I have done a lot of nursing. So if my thoughts, assessments, are different, what is a younger nurse, who hasn't experienced thinking. Too many drugs. Too many interactions. Too many multiple diagnosis. Not an RN scope of practise.

Response 36

"Please consider the curriculum documents that describe the education required by current RN prescribers: those with RN(EC). This would be absolutely unmanageable and inappropriate to include at the baccalaureate level. Consider also the legislation specifying the controlled acts that authorized for NPs. Open prescribing in the context of the lack of ability to diagnose makes no sense - these individuals will not even have the ability to manage any adverse effects of the medications/treatments they prescribe.

Has anyone consulted RNs to ask if they even want this? It is a big responsibility and quite frankly, the important skills nurses have are much better employed elsewhere."
Response 38

There seems to be very little evidence to support the initiation of RN prescribing from the countries that have already implemented this practice, according to the research done by HPRAC. This is ironic given the amount of money that will need to be spent on preparing nurses properly for taking on this huge responsibility; if we as a province are going to implement a practice in order to address a short-coming within our healthcare system, such as access or cost containment, shouldn't there be evidence that in fact this practice will address these issues and not add more burden to the system? We already have a nursing profession with the knowledge, ability, judgment, and education to prescribe, yet we are not using Nurse Practitioners to their full scope of practice to address issues within our healthcare system. I don't think it's appropriate to introduce another level of prescribing until we have utilized all of our current prescribers to their full scope of practice.

Response 39

Only my own education as an RN, and what I thought I knew, until I got more training as a nurse practitioner and realized I knew nothing before. I am now more aware of what I don't know. RNs would need a lot of training and education to start prescribing independently when they don't have more assessment skills, and if they get more assessment skills, than what is the difference with a nurse practitioner? Unless there is a use of protocols: nurses can learn the listed medications inside and out, can give more thorough client-geared education, and not have to worry about all the other prescribable options.

Response 40

We already have 'Nurse prescribers' in Ontario, they are called Nurse Practitioners. They have the education, clinical training, experience and are prepared academically to assess the patient, order the appropriate diagnostic tests if needed, diagnose and treat many common acute and chronic medical conditions. RN's are not academically prepared for diagnostic OR prescriptive clinical practice. Why we are embarking on creating yet more layers and levels of providers is unclear. Optimizing the scope of practice of current provider mix and influencing government to appropriately structure and fund the health system will add much more value than adding more prescribers to the system!

Response 41

I am a master's trained nurse practitioner. I do not unerring the logistics behind RN prescribing as that is the role of NPs in Ontario. I have completed extensive education and training in assessment, treatment and diagnoses. I went back to get this training to be able to do the things. There is already a blurred line between common knowledge of RN vs NP. RN prescribing would further muddy the water between these two legal designations. What would be the point of NPs in Ontario. Please support the importance of further training and education and keeping the lines clear. It would mean putting NPs out of jobs in Ontario. I do not support this motion and would seek employment in another province out of shear disappointment if Ontario passed such legislature.

Response 42

Having started as an RN and moving into the NP role, I do not feel that RNs are adequately prepared to take on independent prescribing. They are not adequately trained within the current educational programs and would require significant upgrading (such as NPs receive) to perform these actions independently.

Response 43
When I graduated from university a few years ago we had one little online class in pharmacology. How does that suffice to be expected to prescribe meds

Response 44
I have practiced in homecare and primary care, my reference is 'reality'.

RN's need to have advanced assessment skills in place prior to even thinking about prescribing.

A UTI, or strep throat, puffers or renewing BP meds etc. has assessment and interpretation/diagnosis that goes with it.

In 'reality', the majority RN's in FHT and physician office are still simply calling patients in, checking BP-not interpreting or health teaching, and then handing over to MD. Alot of education in required to add prescribing....

As an NP I firmly believe that the RN's are taking a huge risk agreeing to take this on, the appropriate supports and education have to be in place-the only way to ensure this is to make it mandatory that NP's and physicians collaborate closely with each prescription they initiate OR even better.....RN's do some advanced assessment and health teaching...consult with MD and/or NP and then NP/MD write prescription.....that really forces collaboration.

RN's don't need to prescribe , they need to understand what their full scope is and be supported educationally and by the rest of the team in that practice.

Response 45
"My story:

Having worked as an RN in Acute care, remote nursing stations and the community before becoming an NP just this year I can tell you that my ivy league RN education from Ontario did not provide me with the knowledge skill and judgement to prescribe medications in my RN role. After learning everything I did in my NP program over these last 2 years I am amazed that we let RNs prescribe in the north with so little education in thorough physical assessment, pathology and pharmacokinetics. I am not against RN prescribing within protocols for implementation immediately - that is well within the role, any greater freedom in prescribing without sufficient educations and we risk judicial use of resources and further costs to the health care system. "

Response 46
"The RN prescribing model has been done in other jurisdictions in BC example of certified RN may prescribe in very specific situations and the prescription can not be done outside of that area and if they leave the practice it voids the prescription power.

To be able to prescribe requires the ability to make a differential diagnosis and a medical diagnosis. RN can not preform this act or has the ability to run appropriate testing to make the decision to prescribe.

The system has multiple layers including pharmacists who can authorize refills for patients.

RN prescribing is a political move and not in the best interests of patients safety. "

Response 47
As an NP I can attest to the vast amount of knowledge required before prescribing medications. This knowledge was gained through additional, formal education and testing at the graduate level. I have worked in a variety of health care settings including acute care, LTC, primary care and the community and do not believe that registered staff have the current knowledge to adequately diagnosis or treat patients independently. RN and RPN education does not support training for diagnosis, laboratory follow-up, assessing drug interactions, renal function or allergies to safely support independent prescribing.

Response 48

The RN does not presently have the foundational knowledge needed to take on this added responsibility based on the current curriculum offered in the BScN program in Ontario which I have taught in. I feel that the added stress on RNs given the reduction of positions and replacement with RPNs with further create a gap that can presently be filled with the NP role. It is well established and the NPs do not need added changes to their scope as it already is included. Allow the RN role to work to more full scope with assessment and diagnosis and fully integrate the NP role with more medication management.

Response 49

Nurse practitioners have the added education and training to prescribe medications, fulfilling the role of the advanced practice nurse. The extra education is necessary to safely prescribe medication that takes into account the complexities of pharmacology and pathophysiology. Each patient has underlying health issues/family history make prescribing a complex process that could be overlooked causing patient harm. Registered nurses are already understaffed and overworked in many settings, the integration of RN prescribing will be another task the RN has to complete. Standing orders for certain medications makes sense however; they should be ordered originally by a physician or nurse practitioner.

Response 50

"diabetic protocols

sexual health protocols

knowledge and ability to identify drug interactions and possible side effects CPS and other pharmaceutical i.e therapeutic choices, anti infective guidelines, hypertensive guidelines

knowledge of how lab values such as Creainine egfr affect drug toxicity levels. etc.

these are just a few."

Response 51

NPAO has submitted an articulate submission in relation to RN prescribing. As a licensed NP in Primary Care, the form education and experience stream plus passing provincial licensing is the most appropriate route for nurses to prescribe.

Response 52

I did my MScN thesis on medication adherence- people are more likely to start and keep medications if they trust the person prescribing and adequate understanding of the need to take the medications is demonstrated. If I nurse was prescribing- rather than a NP or MD I imagine it is because they either have more time or know the person better. So- other than my 18 years of nursing experience in various settings- I think as long as nurses are attending university with a science degree and the competitive nature of these programs, we have very smart nurses that will
not be satisfied giving medications that they are equally accountable for, but prescribed by MDs, but often assessed for the need by themselves, the RN.

**Response 53**

I don't have references, however as a practicing NP I feel this move defeats everything that NP's have been fighting for. There is no way the CNO can regulate all nurses in this capacity and ensure competency is maintained. Furthermore, in order to properly prescribe medications you need to be able to diagnosis which is outside the scope of RN practice. I would suggest focusing on the NP group and moving forward with controlled substance prescriber which will allow for better access to care and completeness of care that NP's can provide for our patients.

**Response 54**

I am from the UK where nurse prescribing has been in effect for almost 20 years. We were educated to a higher level to understand and become competent in pharmacology and many studies have demonstrated that nurses are safer prescribers than other health care professionals. The Oxford Evidence Based Medicine Program released a report to substantiate this in the early 2000's. Nursing education in Canada would require supplementing as the current education to prepare registered nurses for practice is variable and all the nurses I have supported post graduating have stated that the program was too academic theory based. There is an opportunity here to change the curriculum to prepare nurses to truly practice to a level that would support the patient, system and economic demands. As a former community nurse in the GTA it is shocking to see the cupboards full of medications in patients' homes that are never used, as well as the number of patients that are sent to the hospital because access to a timely prescription is challenging. This amendment is long overdue however implementation should be based on competency and knowledge not over regulation.

**Response 55**

" current CNO practice guidelines support medical directives only. This is based upon independent assessment of nurse educational preparation. Advanced practice nurses have the added education, training, and experience to take on this task. Medication prescription doesn't occur in a vacuum. One must have education, training, and demonstrated skill in the assessment of pathology, physiology, and the subtle interaction between these the anticipated medication prescriptions in addition to the interactions profound and subtle between those medications and the current patient medications.

In an era where our colleagues are demanding higher levels of education, i.e doctorate in Pharmacy, or Masters minimum level entry to practice Physical or Occupational Therapy (none of whom prescribe medications); I find it interesting that the Ministry should see fit to add to the risk of patients by allowing lesser qualified individuals to prescribe in the name of increased efficiency or cost savings."

**Response 56**

NPAO position statement

**Response 57**

as a previous RN working in a remote community the ability to rx would have been helpful. As it was medical directives and protocols were very helpful

**Response 58**

RN do not have the advanced assessment skills to be able to prescribe.

**Response 59**

Prescribing involves assessment and diagnostic which is not in the actual RN training. Education
would be essential to implement the Independent model which is similar to the NP model. No education means possibility of error in assessment and harm to patient.

<table>
<thead>
<tr>
<th><strong>Response 60</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Read and reviewed HPRAC:</td>
</tr>
<tr>
<td>A Preliminary Literature Review on Registered Nurse Prescribing</td>
</tr>
<tr>
<td>A Preliminary Literature Review the Effectiveness of Registered Nurse Prescribing</td>
</tr>
<tr>
<td>Experience working in Acute care as an RN and in the Community as an NP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Response 61</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;RNs do not have the assessment skills of nurse practitioners or physicians,</td>
</tr>
<tr>
<td>They cannot make a diagnosis. Medications are prescribed to address a particular clinical presentation or diagnosis. Extensive knowledge and training related to medications is required which is provided to NPs and physicians.</td>
</tr>
<tr>
<td>The cost of training RNs to the standard needed to properly assess &amp; prescribe medications to safe standards would be a major drain on the Ontario Health system. The cost of random prescribing and mistakes by untrained RNs will be an additional expense and drain on our system&quot;</td>
</tr>
</tbody>
</table>
Mixed Questionnaire: Survey Responses
Questions marked with an * are required

I am responding *
> On behalf of an organization

Organization Name
CMLTO

Geographical Location (choose one) *
> Ontario

Are you a member of a regulated health profession? *
> Yes

Which regulated health profession do you belong to? *
> Medical Laboratory Technologist

Are you: *
> Other  A registered member, but working in a senior administrative role in the regulatory body.

In which of the following settings do you practice? (Check all that apply) *
> Other  Regulatory Body
Do you think that RN prescribing will result in more timely access to care? *
» Yes

Please rank which model of RN prescribing would be ‘Most likely’(1), ‘Likely’(2), or ‘Least likely’(3) to result in more timely access to care. To rank, enter the number (1-3) in the box next to the model. *

Independent prescribing 2
Supplementary prescribing 1
Use of protocols 3
Rank values must be between 1 and 3

Do you think that RN prescribing will result in more convenient access to care? *
» Yes

Please identify which model of RN prescribing would be ‘Most likely’(1), ‘Likely’(2), or ‘Least likely’(3) to result in more convenient access to care. To rank, enter the number (1-3) in the box next to the model. *

Independent prescribing 2
Supplementary prescribing 1
Use of protocols 3
Rank values must be between 1 and 3

Do you think that RN prescribing will result in fewer emergency room visits? *
» Yes

Please rank which model of RN prescribing would be ‘Most likely’(1), ‘Likely’(2), or ‘Least likely’(3) to result in fewer emergency room visits. To rank, enter the number (1-3) in the box next to the model. *

Independent prescribing 2
Supplementary prescribing 1
Use of protocols 3
Rank values must be between 1 and 3

Do you think that RN prescribing will result in better access to care in remote communities? *
» Yes

Please rank which model of RN prescribing would be ‘Most likely’(1), ‘Likely’(2), or ‘Least likely’(3) to result in better access to care in remote communities. To rank, enter the number (1-3) in the box next to the model. *

Independent prescribing 1
Supplementary prescribing 2
Use of protocols 3
Rank values must be between 1 and 3

Do you think that RN prescribing will result in better access to care in rural communities? *
» Yes

Please rank which model of RN prescribing would be ‘Most likely’(1), ‘Likely’(2), or ‘Least likely’(3) to result in better access to care in rural communities. To rank, enter the number (1-3) in the box next to the model. *

Independent prescribing 1
Supplementary prescribing 2
Do you think that RN prescribing will result in better access to care in fast growing communities? * Yes

Please rank which model of RN prescribing would be 'Most likely'(1), 'Likely'(2), or 'Least likely'(3) to result in better access to care in fast growing communities. To rank, enter the number (1-3) in the box next to the model. *

<table>
<thead>
<tr>
<th>Model</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent prescribing</td>
<td>1</td>
</tr>
<tr>
<td>Supplementary prescribing</td>
<td>2</td>
</tr>
<tr>
<td>Use of protocols</td>
<td>3</td>
</tr>
</tbody>
</table>

Rank values must be between 1 and 3

Do you think that RN prescribing would result in patients having a better understanding of the medications prescribed to them? * Yes

Please rank which model of RN prescribing would be 'Most likely'(1), 'Likely'(2), or 'Least likely'(3) to result in patients having a better understanding of the medications prescribed to them?. To rank, enter the number (1-3) in the box next to the model. *

<table>
<thead>
<tr>
<th>Model</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent prescribing</td>
<td>2</td>
</tr>
<tr>
<td>Supplementary prescribing</td>
<td>1</td>
</tr>
<tr>
<td>Use of protocols</td>
<td>3</td>
</tr>
</tbody>
</table>

Rank values must be between 1 and 3

Do you think that RN prescribing would result in patients being more compliant with instructions for medications use? * No

Please rank which model of RN prescribing would be 'Most likely'(1), 'Likely'(2), or 'Least likely'(3) to result in patient compliance with instructions for medication use. To rank, enter the number (1-3) in the box next to the model. *

<table>
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<tbody>
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<tr>
<td>Supplementary prescribing</td>
</tr>
<tr>
<td>Use of protocols</td>
</tr>
</tbody>
</table>

Rank values must be between 1 and 3

Overall, do you think that RN prescribing would improve patient satisfaction? * Yes

Please rank which model of RN prescribing would be 'Most likely'(1), 'Likely'(2), or 'Least likely'(3) to improve patient satisfaction. To rank, enter the number (1-3) in the box next to the model. *

<table>
<thead>
<tr>
<th>Model</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>Supplementary prescribing</td>
<td>2</td>
</tr>
<tr>
<td>Use of protocols</td>
<td>3</td>
</tr>
</tbody>
</table>

Rank values must be between 1 and 3

Overall, do you think that RN prescribing would improve patient well-being? * Yes
Please rank which model of RN prescribing would be ‘Most likely’ (1), ‘Likely’ (2), or ‘Least likely’ (3) to improve patient well-being. To rank, enter the number (1-3) in the box next to the model.

<table>
<thead>
<tr>
<th>Model</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent prescribing</td>
<td>2</td>
</tr>
<tr>
<td>Supplementary prescribing</td>
<td>1</td>
</tr>
<tr>
<td>Use of protocols</td>
<td>3</td>
</tr>
</tbody>
</table>

Do you think that RN prescribing would facilitate collaborative care (e.g., team based, integrated, etc.)? * Yes

Please rank which model of RN prescribing would be ‘Most likely’ (1), ‘Likely’ (2), or ‘Least likely’ (3) to facilitate collaborative care (e.g., team based, integrated, etc.). To rank, enter the number (1-3) in the box next to the model. *

<table>
<thead>
<tr>
<th>Model</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Independent prescribing</td>
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</tr>
<tr>
<td>Supplementary prescribing</td>
<td>1</td>
</tr>
<tr>
<td>Use of protocols</td>
<td>3</td>
</tr>
</tbody>
</table>

Rank values must be between 1 and 3

For each model of RN prescribing please indicate what you think the impact would be on health care system costs?

<table>
<thead>
<tr>
<th>Model</th>
<th>Cost Decrease</th>
<th>Cost Increase</th>
<th>No Cost Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent prescribing</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Supplementary prescribing</td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Use of protocols</td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>

For each model of RN prescribing please indicate what you think could be the impact on risk of harm to patients?

<table>
<thead>
<tr>
<th>Model</th>
<th>Increased Risk of Harm</th>
<th>Decreased Risk of Harm</th>
<th>No Change in Risk of Harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent prescribing</td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Supplementary prescribing</td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Use of protocols</td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How might any increase in the risk of harm to patients be mitigated? (Check all that apply).

<table>
<thead>
<tr>
<th>Model</th>
<th>Independent prescribing</th>
<th>Supplementary prescribing</th>
<th>Use of protocols</th>
</tr>
</thead>
<tbody>
<tr>
<td>Further education and training of RNs</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Regulatory oversight to enforce prescribing standards</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Establishment of clear practice boundaries</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>On-going competency assessment (Quality Assurance Assessment)</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Do not permit prescribing of narcotics or controlled drugs</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Allow prescribing only in settings where collaborative care (e.g., team, integrated, etc.) is taking place</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
Please rank which model of RN prescribing currently ‘Best matches’ (1), ‘Matches’ (2), Least matches’ (3) RNs professional knowledge. To rank, enter the number (1-3) in the box next to the model.

<table>
<thead>
<tr>
<th>Model</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent prescribing</td>
<td>3</td>
</tr>
<tr>
<td>Supplementary prescribing</td>
<td>2</td>
</tr>
<tr>
<td>Use of protocols</td>
<td>1</td>
</tr>
</tbody>
</table>

Rank values must be between 1 and 3

Please rank which model of RN prescribing currently ‘Best matches’ (1), ‘Matches’ (2), ‘Least matches’ (3) RNs professional education. To rank, enter the number (1-3) in the box next to the model.

<table>
<thead>
<tr>
<th>Model</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent prescribing</td>
<td>3</td>
</tr>
<tr>
<td>Supplementary prescribing</td>
<td>2</td>
</tr>
<tr>
<td>Use of protocols</td>
<td>1</td>
</tr>
</tbody>
</table>

Rank values must be between 1 and 3

Thinking about the different health care settings where nurses practice, please indicate which model you consider most suitable for each setting (check all that apply).

<table>
<thead>
<tr>
<th>Setting</th>
<th>Independent prescribing</th>
<th>Supplementary prescribing</th>
<th>Use of protocols</th>
<th>Nurses prescribing not appropriate for this setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital setting – Emergency room</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Hospital setting – Outpatient clinic</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Hospital setting – Acute care</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Hospital setting – Addiction and mental health</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Hospital setting – Complex continuing care</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Hospital setting – Rehabilitation</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Community setting – Community Care Access Centre</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Community setting – Community Health Centre</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Community setting – Community Mental Health Program</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Community setting – Home Care</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Community setting – Public Health Unit</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Community setting – Nurse Practitioner Led Clinic</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Community setting – Remote nursing station</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Community setting – Primary care physician office</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Community setting – Family Health Team</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Community setting - Long Term Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

29 of 192
<table>
<thead>
<tr>
<th>Setting</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Home *</td>
<td>x</td>
</tr>
<tr>
<td>Community setting – Retirement home *</td>
<td>x</td>
</tr>
<tr>
<td>Other setting – College/university *</td>
<td>x</td>
</tr>
<tr>
<td>Other setting – Correctional facility *</td>
<td>x</td>
</tr>
<tr>
<td>Other setting – Commercial or industrial enterprise *</td>
<td>x</td>
</tr>
<tr>
<td>Other setting – School *</td>
<td></td>
</tr>
<tr>
<td>Other setting – Union *</td>
<td>x</td>
</tr>
</tbody>
</table>
Questions marked with an * are required

I am responding *
  » On behalf of an organization

Organization Name
Ontario Public Employees Union (OPSEU)

Your name (optional)
Lucy A Morton

Email address (optional)
lucyamorton@rogers.com

Geographical Location (choose one) *
  » Ontario

Are you a member of a regulated health profession? *
  » Yes

Which regulated health profession do you belong to? *
  » Registered Practical Nurse

Are you: *
  » Currently practising
In which of the following settings do you practice? (Check all that apply) *

» Community setting - Home Care

Do you think that RN prescribing will result in more timely access to care? *

» Yes

Please rank which model of RN prescribing would be ‘Most likely’ (1), ‘Likely’ (2), or ‘Least likely’ (3) to result in more timely access to care. To rank, enter the number (1-3) in the box next to the model. *

- Independent prescribing 2
- Supplementary prescribing 1
- Use of protocols 3

Rank values must be between 1 and 3

Do you think that RN prescribing will result in more convenient access to care? *

» Yes

Please identify which model of RN prescribing would be ‘Most likely’ (1), ‘Likely’ (2), or ‘Least likely’ (3) to result in more convenient access to care. To rank, enter the number (1-3) in the box next to the model. *

- Independent prescribing 2
- Supplementary prescribing 1
- Use of protocols 3

Rank values must be between 1 and 3

Do you think that RN prescribing will result in fewer emergency room visits? *

» Yes

Please rank which model of RN prescribing would be ‘Most likely’ (1), ‘Likely’ (2), or ‘Least likely’ (3) to result in fewer emergency room visits. To rank, enter the number (1-3) in the box next to the model. *

- Independent prescribing 2
- Supplementary prescribing 1
- Use of protocols 3

Rank values must be between 1 and 3

Do you think that RN prescribing will result in better access to care in remote communities? *

» Yes

Please rank which model of RN prescribing would be ‘Most likely’ (1), ‘Likely’ (2), or ‘Least likely’ (3) to result in better access to care in remote communities. To rank, enter the number (1-3) in the box next to the model. *

- Independent prescribing 1
- Supplementary prescribing 2
- Use of protocols 3

Rank values must be between 1 and 3

Do you think that RN prescribing will result in better access to care in rural communities? *

» Yes
Please rank which model of RN prescribing would be 'Most likely'(1), 'Likely'(2), or 'Least likely'(3) to result in better access to care in rural communities. To rank, enter the number (1-3) in the box next to the model. *

- Independent prescribing: 2
- Supplementary prescribing: 1
- Use of protocols: 3

Rank values must be between 1 and 3

Do you think that RN prescribing will result in better access to care in fast growing communities? *

Yes

Please rank which model of RN prescribing would be 'Most likely'(1), 'Likely'(2), or 'Least likely'(3) to result in better access to care in fast growing communities. To rank, enter the number (1-3) in the box next to the model. *

- Independent prescribing: 2
- Supplementary prescribing: 3
- Use of protocols: 1

Rank values must be between 1 and 3

Thinking about the implementation of the different models of RN prescribing, are there other important changes to access to care that could occur?

- More education of prevention
- Consistency of care
- Would allow reduced duplication of services

Do you think that RN prescribing would result in patients having a better understanding of the medications prescribed to them? *

Yes

Please rank which model of RN prescribing would be 'Most likely'(1), 'Likely'(2), or 'Least likely'(3) to result in patients having a better understanding of the medications prescribed to them? . To rank, enter the number (1-3) in the box next to the model. *

- Independent prescribing: 2
- Supplementary prescribing: 1
- Use of protocols: 3

Rank values must be between 1 and 3

Do you think that RN prescribing would result in patients being more compliant with instructions for medication use? *

No

Please rank which model of RN prescribing would be 'Most likely'(1), 'Likely'(2), or 'Least likely'(3) to result in patient compliance with instructions for medication use. To rank, enter the number (1-3) in the box next to the model. *

- Independent prescribing
- Supplementary prescribing
- Use of protocols

Rank values must be between 1 and 3
Overall, do you think that RN prescribing would improve patient satisfaction? *

No

Please rank which model of RN prescribing would be ‘Most likely’ (1), ‘Likely’ (2), or ‘Least likely’ (3) to improve patient satisfaction. To rank, enter the number (1-3) in the box next to the model. *

- Independent prescribing
- Supplementary prescribing
- Use of protocols

Rank values must be between 1 and 3

Overall, do you think that RN prescribing would improve patient well-being? *

Yes

Please rank which model of RN prescribing would be ‘Most likely’ (1), ‘Likely’ (2), or ‘Least likely’ (3) to improve patient well-being. To rank, enter the number (1-3) in the box next to the model.

Independent prescribing  2
Supplementary prescribing  1
Use of protocols  3

Do you think that RN prescribing would facilitate collaborative care (e.g., team based, integrated, etc.)? *

No

Please rank which model of RN prescribing would be ‘Most likely’ (1), ‘Likely’ (2), or ‘Least likely’ (3) to facilitate collaborative care (e.g., team based, integrated, etc.). To rank, enter the number (1-3) in the box next to the model. *

Independent prescribing
Supplementary prescribing
Use of protocols

Rank values must be between 1 and 3

For each model of RN prescribing please indicate what you think the impact would be on health care system costs?

<table>
<thead>
<tr>
<th>Model</th>
<th>Cost Decrease</th>
<th>Cost Increase</th>
<th>No Cost Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent prescribing</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplementary prescribing</td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Use of protocols</td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>

Thinking about the different models of RN prescribing, are there other potential impacts on the healthcare system that are not mentioned above?

This model creates another tier for providing primary care. This has the potential to fragment an already fragmented system. It also has the possibility to delay appropriate treatment, without having quick reliable support from a medical provider with more expertise.

What supports for consultations and at what level?

For each model of RN prescribing please indicate what you think could be the impact on risk of harm to patients?

<table>
<thead>
<tr>
<th>Model</th>
<th>Increased Risk of Harm</th>
<th>Decreased Risk of Harm</th>
<th>No Change in Risk of Harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent prescribing</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Supplementary prescribing</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Use of protocols</td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
How might any increase in the risk of harm to patients be mitigated? (Check all that apply).

<table>
<thead>
<tr>
<th>Further education and training of RNs</th>
<th>Independent prescribing</th>
<th>Supplementary prescribing</th>
<th>Use of protocols</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulatory oversight to enforce prescribing standards</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Establishment of clear practice boundaries</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>On-going competency assessment (Quality Assurance Assessment)</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Do not permit prescribing of narcotics or controlled drugs</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Allow prescribing only in settings where collaborative care (e.g., team, integrated, etc.) is taking place</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

Please rank which model of RN prescribing currently 'Best matches' (1), 'Matches' (2), 'Least matches' (3) RNs professional skills. To rank, enter the number (1-3) in the box next to the model.

<table>
<thead>
<tr>
<th>Model</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent prescribing</td>
<td>3</td>
</tr>
<tr>
<td>Supplementary prescribing</td>
<td>2</td>
</tr>
<tr>
<td>Use of protocols</td>
<td>1</td>
</tr>
</tbody>
</table>

Rank values must be between 1 and 3

Please rank which model of RN prescribing currently 'Best matches' (1), 'Matches' (2), 'Least matches' (3) RNs professional knowledge. To rank, enter the number (1-3) in the box next to the model.

<table>
<thead>
<tr>
<th>Model</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent prescribing</td>
<td>3</td>
</tr>
<tr>
<td>Supplementary prescribing</td>
<td>2</td>
</tr>
<tr>
<td>Use of protocols</td>
<td>1</td>
</tr>
</tbody>
</table>

Rank values must be between 1 and 3

Please rank which model of RN prescribing currently 'Best matches' (1), 'Matches' (2), 'Least matches' (3) RNs professional education. To rank, enter the number (1-3) in the box next to the model.

<table>
<thead>
<tr>
<th>Model</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent prescribing</td>
<td>3</td>
</tr>
<tr>
<td>Supplementary prescribing</td>
<td>2</td>
</tr>
<tr>
<td>Use of protocols</td>
<td>1</td>
</tr>
</tbody>
</table>

Rank values must be between 1 and 3

Thinking about the different health care settings where nurses practice, please indicate which model you consider most suitable for each setting (check all that apply).

<table>
<thead>
<tr>
<th>Setting</th>
<th>Independent prescribing</th>
<th>Supplementary prescribing</th>
<th>Use of protocols</th>
<th>Nurses prescribing not appropriate for this setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital setting – Emergency room</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Hospital setting – Outpatient clinic</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital setting – Acute care</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital setting – Addiction and mental health</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital setting – Complex continuing care</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital setting – Rehabilitation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Setting</th>
<th>35 of 192</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community setting – Community Care Access Centre</td>
<td></td>
</tr>
<tr>
<td>Community setting – Community Health Centre</td>
<td></td>
</tr>
<tr>
<td>Community setting – Community Mental Health Program</td>
<td></td>
</tr>
<tr>
<td>Community setting – Home Care</td>
<td></td>
</tr>
<tr>
<td>Community setting – Public Health Unit</td>
<td></td>
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<tr>
<td>Community setting – Nurse Practitioner Led Clinic</td>
<td></td>
</tr>
<tr>
<td>Community setting – Remote nursing station</td>
<td></td>
</tr>
<tr>
<td>Community setting – Primary care physician office</td>
<td></td>
</tr>
<tr>
<td>Community setting – Family Health Team</td>
<td></td>
</tr>
<tr>
<td>Community setting – Long Term Care Home</td>
<td></td>
</tr>
<tr>
<td>Community setting – Retirement home</td>
<td></td>
</tr>
<tr>
<td>Other setting – College/university</td>
<td></td>
</tr>
<tr>
<td>Other setting – Correctional facility</td>
<td></td>
</tr>
<tr>
<td>Other setting – Commercial or industrial enterprise</td>
<td></td>
</tr>
<tr>
<td>Other setting – School</td>
<td></td>
</tr>
<tr>
<td>Other setting – Union</td>
<td></td>
</tr>
</tbody>
</table>

Thinking about the different health care settings where nurses practice, is there a setting which would most benefit from RN prescribing?

Rural areas, walk in clinics, northern out post areas... anywhere that primary care is unattainable.

Please provide any additional comments related to the three different models of RN prescribing that have not been covered elsewhere in this survey.

Some of these questions are difficult to respond to as the answers are not just a simple 'yes' or 'no'. There is a redundancy with the repetitive questions. I feel that these questions will be up to interpretation. I am not sure that this questionnaire will capture the responses that you are looking for.
Written Submissions
Mr. Thomas Corcoran  
Chair  
Health Professions Regulatory Advisory Council  
56 Wellesley Street West, 12th Floor  
Toronto ON M5S 2S3

Dear Mr. Corcoran:

The Association of Ontario Health Centres (AOHC) is Ontario's voice for community-governed primary health care. We represent 108 community-governed primary health care organizations. Our membership includes Ontario's Community Health Centres, Aboriginal Health Access Centres, Community Family Health Teams and Nurse Practitioner-Led Clinics. We share a strong commitment to advance health equity and recognize that access to the highest attainable standard of health is a fundamental human right. One of our key principles is to ensure that all interprofessional team members work to their optimal scope of practice so we welcome the opportunity to speak to the issue of RN prescribing.

AOHC was an active participant on the Registered Nurses' Association of Ontario's (RNAO) Primary Care Nurse Provincial Task Force in 2012. This task force developed recommendations to optimize the use of nursing human resources in primary care to improve timely access to care. One of the key recommendations provided by the task force was to expand the scope of practice of the registered nurse (RN) to include the ability to prescribe, order diagnostic testing and communicate a diagnosis. AOHC immediately moved to actively embrace these recommendations and made a commitment to achieving full scope of practice for all of health professionals within our settings by 2015. Great progress has been made, however, formally authorizing an expanded scope of practice for RNs is essential to help us fully meet our commitment and ensure timely access for our clients.

There are over 4,000 RNs who currently practice in primary care. We know that this role has been historically underutilized, while clients continue to experience difficulties accessing their primary care needs. Expanding the scope of practice of RNs to include independent prescribing will be a key enabler to improving interprofessional team work optimization and same day access for primary care clients. For example, an RN with an expanded scope of practice will be able to independently assess, diagnose and treat a number of high volume low acuity CHC clients such as those with complaints of an ear ache, upper respiratory infection or throat infection, thus increasing access to primary care, while maximizing continuity of care for the client and minimizing the times a client may seek an alternative level of care such as a walk-in clinic or the Emergency Department. Similarly, an RN with prescribing authority can perform many non-complex
procedures such as pap-smears, well baby clinics, and vaccination programs - just to name a few.

Our member centres are leaders in delivering interprofessional primary health care. Our results are paying off. We know that clients utilizing Community Health Centres have the most complex health and social needs. Yet, through our team-based approaches, our clients have among the lowest emergency department utilization rates. This shows that we are making great impacts towards improving timely access to primary health care. An expanded scope of practice for RNs will help us further these goals, while supporting other system partners.

AOHC fully supports an independent model of RN prescribing. We know that the evidence exists, largely out of the United Kingdom, showing that independent RN prescribing is safe and effective. In our view supplemental and/or protocol based prescribing models are not sufficiently enabling to respond to the care requirements of clients who receive services from our member. AOHC feels that an independent RN prescribing model would give our centres the ability to carve out how the expanded role will be utilized in a way that is responsive, safe and effective. Moreover, an independent model of RN prescribing also lends itself well to further expanding the scope of the RN to include the authority to order diagnostic testing and communicating a diagnosis, both of which are greatly needed for our clients.

Minister Hoskins is currently advancing very ambitious goals for transforming Ontario's health system. Interprofessional care will be a key enabler of this work. We have urged the Minister to expand the reach of interprofessional care, and will continue to do so. As part of this, we recommend in the strongest possible terms to enable an independent RN prescribing model as it will help expand the breadth of interprofessional care across the province, and results in better and improved access to much needed services for Ontarians.

Should you wish to discuss AOHC’s position in greater detail, please feel free to contact Corinne Christie at corinne@aohc.org to arrange a time to meet.

Sincerely,

Adrianna Tetley
CEO, Association of Ontario Health Centres
January 18, 2016

By Mail and Email: HPRACWebMaster@ontario.ca

Mr Thomas Corcoran
Chair, Health Professions Regulatory Advisory Council
56 Wellesley St W., 12th Floor
Toronto ON M5S 2S3

Dear Mr Corcoran:

Re: HPRAC Consultation – Registered Nurse Prescribing

The Canadian Medical Protective Association (“CMPA”) welcomes the opportunity to comment on the issue of prescribing by registered nurses (“RNs”) as part of the ongoing consultations by HPRAC following the Minister’s request for advice on this topic.

The CMPA is generally supportive of initiatives to promote collaborative care, including providing independent regulated healthcare professionals, such as nurses, with an appropriate level of expanded authority to perform selected tasks. Such initiatives are typically intended to maximize physicians’ time to address other aspects of patient care. In any collaborative care model, it is important to ensure that patients continue to receive appropriate care and that those involved in the patient’s care, including nurses and physicians, are not exposed to unnecessary medical-legal risk.

In previous submissions on issues related to collaborative care, the CMPA has consistently stated that the three key components of any collaborative care model are:

1. Clear accountabilities so that each member of the healthcare team is aware of their individual responsibilities;

2. Adequate and timely communication between participating healthcare professionals; and

3. A requirement that all members of the collaborative healthcare team have adequate liability protection.

The CMPA’s comments below are intended to stress the importance of these three components to the development and implementation of a successful collaborative care model.
CMPA’s Mandate

As you may know, the CMPA is the principal provider of medical-legal assistance to physicians in Ontario and across Canada. We are a not-for-profit mutual defence organization operated for physicians, by physicians. The most obvious expression of the CMPA’s assistance to its members is the provision of legal representation, including representing members when a claim or complaint is brought against them and assisting members when their privileges are being threatened. Equally significant, however, are the broader advisory services the CMPA provides to its members on a multitude of medical-legal issues designed to promote safe medical care, including education and research into risk management and practice improvement.

In this regard, the CMPA is an interested stakeholder in proposals that might have implications for Ontario physicians, including expanding the scope of practice of other healthcare professionals. As alluded to above, the CMPA previously participated in consultations in Ontario and in other provinces regarding the proposed expansion of the scopes of practice of healthcare professionals to include prescribing.

Clear Accountabilities

Any model for RN prescribing should require that the responsibilities and accountabilities of each member of the healthcare team be clearly defined. It is essential for continuity of care, patient safety, and the management of medical-legal risk that accountabilities of a collaborative care delivery model are clear and that each member of the team, and the patient, are aware of individual roles and responsibilities in the delivery of care to the patient.

Clearly understood responsibility for follow-up care and informed consent are two examples of issues that warrant particular attention in this context.

Follow-Up Care

In the context of recommending to the Minister any proposed new prescribing authority for RNs, consideration should be given to the issue of responsibility for follow-up care after a RN has exercised such authority. The CMPA urges HPRAC to recommend that a RN who initiates a prescription will be responsible for ensuring that the patient receives the necessary follow-up care and for communicating the plan to the patient’s treating healthcare professional(s).

Where a RN issues or modifies a prescription, it should be clear who will be responsible for the patient’s ongoing care related to that prescription. The physician, the RN and the patient must all clearly understand each other’s obligations, expectations and roles. Failure to properly coordinate
the ongoing care of a patient could give rise to patient harm, and legal liability for healthcare providers responsible for such a failure.

For example, the RN must be satisfied before modifying or initiating treatment that there is adequate ongoing monitoring by the RN or another appropriate healthcare professional available to the patient. It is important that each individual understand who will be responsible for following up with the patient while on the medication, and that this be clearly documented in the patient record.

**Informed Consent**

RNs who are authorized to prescribe should be expressly obligated to obtain the patient’s informed consent for the prescription. The CMPA urges HPRAC to recommend to the Minister that the legislation or regulations include a general and express requirement that RNs obtain the patient’s informed consent in all cases where the RN initiates, adapts, or extends a prescription.

It is important to eliminate any uncertainty that might exist about who is responsible for obtaining the patient’s consent in these circumstances. In addition to reducing the risk of harm to patients by ensuring that informed consent is obtained, such clarity in the legislation or regulations will benefit all treating healthcare professionals by reducing the risk that informed consent is not obtained from the patient as a result of a mistaken belief that someone else will do it.

**Adequate Communication**

The CMPA encourages HPRAC to recommend that when exercising their authority to prescribe, RNs should be required to take reasonable steps to identify the healthcare providers with whom the patient is consulting at that time and ensure that those professionals whose care of the patient might be affected by the RN’s prescribing decision are appropriately notified. The timing and manner of the notification should be expressly stated in the legislation or regulations.

A necessary component of any collaborative care model is adequate and timely communication between participating healthcare professionals. Not only is this a courtesy as between professionals, but it is also prudent and necessary for managing ongoing patient care and ensuring patient safety in a collaborative care delivery model, particularly when the duties and responsibilities of providers may overlap.

RNs who prescribe must make reasonable efforts to identify the patient’s other treating healthcare professionals and to ensure that those whose treatment is expected to be affected by the RN’s prescription are notified of same in a timely fashion. Such notification should be made promptly, in writing, and include details of the prescription and any instructions given to the
patient, particularly with respect to follow up care related to the prescription. For example, if a RN modifies a treatment plan prescribed by a physician, at a minimum the prescribing physician should be notified. In some cases, it may be necessary to notify other treating health professionals, especially where it is unclear who is the most responsible for the patient’s care.

**Mandatory and Adequate Liability Protection**

The CMPA encourages HPRAC to consider as part of its current review whether the present minimum liability protection requirement for RNs will be sufficient given the increased exposure to liability risk for RNs as a result of an expanded prescribing authority.

The By-Laws of the College of Nurses of Ontario currently require as a condition of licensure that RNs maintain a minimum of $1 million per claim in professional liability insurance. While it is encouraging that RNs are required to have professional liability protection, it is important to regularly re-evaluate the minimum amount of such protection in light of any increased medical-legal risk posed by changes to the scope of practice of RNs, including the expanded authority to prescribe.

While the CMPA is not in a position to comment specifically on the quantum of minimum protection that should be required for RNs with the authority to prescribe, the CMPA’s general experience in this area suggests that there are typically two primary issues that should be considered:

1. The level of the protection or indemnification must be commensurate with the degree of medical-legal risk associated with the act of prescribing by RNs and sufficient to satisfy a potential damages award or settlement in a legal action.

2. The sufficiency of liability protection should also consider the possibility that a claim may not be initiated immediately following an adverse event. For those professionals with claims-made protection, as opposed to occurrence-based protection, adequate liability protection should include tail coverage (or an extended reporting clause) to provide protection for claims initiated many months or years following the provision of the care in question.

Mandatory and adequate professional liability protection for healthcare providers is important to ensure that patients proven to have been harmed by negligent medical care are appropriately compensated. From the CMPA’s perspective, an additional rationale for ensuring that RNs have adequate liability protection is the potential for joint and several liability, and in some cases vicarious liability. Healthcare professionals working in a collaborative setting need to have reassurance that the other healthcare professionals with whom they work are adequately
protected so that neither is inappropriately held financially responsible for the acts or omissions of others.

The following example illustrates the potential application of joint and several liability and the importance of ensuring that all members of the healthcare team have adequate liability protection based on their degree of clinical responsibility. A patient suffers harm while receiving medical care and commences legal proceedings alleging negligence on the part of those involved in his/her care. The Court finds that several of the defendants were responsible for the plaintiff’s injuries, and awards the plaintiff damages. However, the plaintiff experiences challenges collecting from one or more of the liable defendants their portion of the award. In most Canadian jurisdictions, the legal principle of joint and several liability allows the plaintiff to collect from any one of the defendants found to be liable the full amount of the damages, even if that defendant was found by the Court to be only 1% liable for the plaintiff’s injuries.

Conclusion

The CMPA is supportive of initiatives aimed at enhancing collaborative care, which are an important part of ensuring the efficient delivery of safe medical care to patients. For more information about some of the potential medical-legal issues that can arise in collaborative care settings, and solutions to consider to reduce such risks, HPRAC may be interested in the CMPA’s publication entitled, *Collaborative care: A medical liability perspective*, which is available on our website: [www.cmpa-acpm.ca](http://www.cmpa-acpm.ca).

The CMPA would be pleased to provide additional comments on any proposal or draft legislation that may result from this consultation.

Yours sincerely,

Hartley S. Stern, MD, FRCSC, FACS
Executive Director/Chief Executive Officer

HSS/ig

C: Dr Edward Crosby, CMPA President

*CMPA Councillors (ON)*:

Dr Alexander C. Barron
Dr W. Bryan Callaghan
Dr Gerard P. Craigien
Dr Elliot Halparin
Dr Christopher Wallace

Dr Debra Boyce
Dr Robert Cooper
Dr Gordon A. Crawford
Dr Birinder Singh
26 January 2016

Thomas Corcoran  
Chair, Health Professions Regulatory Advisory Council  
56 Wellesley St W., 12th Floor  
Toronto, Ontario, Canada  
M5S 2S3  
HPRACWebMaster@ontario.ca

Dear Mr. Corcoran,

Re Registered Nurse (RN) Prescribing

Thank you for the opportunity to provide input in the context of Health Professions Regulatory Advisory Council’s [HPRAC] consultation on RN prescribing.

The Canadian Nurses Protective Society [CNPS] is a not for profit organization which provides professional liability protection, including risk management services, to more than 125,000 nurses across Canada. The CNPS does not set professional standards for nursing in Ontario and will defer to the College of Nurses of Ontario, the nursing associations and the Ministry of Health and Long Term Care with respect to the advisability and scope of nurse prescribing. It is part of the CNPS, however, to offer comments from a legal and risk management perspective when new models of care delivery are contemplated and it is pleased to respond to the HPRAC’s invitation to comment on risk management considerations related to the proposed models of nurse prescribing.

In August 2015, as a stakeholder, the CNPS provided a written submission to the Nursing Policy and Innovation Branch of the Ministry of Health and Long Term Care outlining key risk management considerations for RN prescribing in Ontario. We understand that the CNPS submission has been forwarded to HPRAC since it has been mandated to conduct broad consultations with key partners within the nursing and health care community to assess three models for RN prescribing. One of the recommendations contained in that submission is that the scope of practice of registered nurses should be expressly expanded to include prescribing and related activities (whether for all registered nurses or for nurses who are expressly authorized to prescribe), such that the authorized prescribing activities fall clearly within the nursing scope of practice. For the reasons outlined in that submission, we view this as being very important for the protection of the public and to ensure that nurses are not unnecessarily placed in a vulnerable position. We understand from Minister Hoskins’
letter to you of 04 November 2015 that all three models of RN prescribing under consideration are to be within an expanded scope of nursing practice and therefore do not propose to comment further on this recommendation in this submission. We would be pleased, however, to address any questions you may have relating to our original submission to the Ministry.

We understand that the HPRAC wishes stakeholder comments to focus on the three models of RN prescribing currently under review. This will be the purpose of this submission. Before doing so, it would be helpful to outline some of the general risk management considerations relating to the prescribing of medication.

**General risk management considerations**

Canadian courts have had several opportunities to consider the standard of care applicable to health care professionals (traditionally physicians and now nurse practitioners) who prescribe medications. It is well established that to meet the applicable standard of care, health care professionals who prescribe medications are generally expected to:

a) ascertain that the medications are indicated; this requires that adequate inquiries be undertaken (through examination, taking a proper history as well as laboratory or imaging diagnostic tests, if indicated) to identify the pathology that requires treatment, which in turn requires that the health care professional has the ability to order the necessary diagnostic tests and the necessary foundational knowledge to identify other potential different diagnoses in order to rule them out or establish a reasonable plan of care in the face of differential diagnoses that are considered less likely but have not yet been entirely eliminated.
b) ascertain that the medication is not contraindicated for the particular patient;
c) establish the appropriate dosage, mode and frequency of administration;
d) monitor the effectiveness of the medication and identify any potential complication(s) and;
e) educate the patient as to expected results, as well as the signs and symptoms of potential complications such that the patient will know when to seek further medical attention, if necessary, in reference to that pathology or treatment.

These elements of the standard of care necessarily require that the prescribing professional have the necessary foundational knowledge regarding the medications, a wide array of pathologies and contraindications.

It is in reference to these standards that we share our analysis of the benefits and drawback of each proposed prescribing model, from a risk management perspective.
Independent Prescribing

The HPRAC RN Prescribing Referral Survey describes this model as follows:

In this model a nurse may prescribe medications, under their own authority, without restrictions or from a limited or pre-defined formulary within a regulated scope of practice. Independent prescribers are allowed to prescribe any licensed or unlicensed drugs that are within their clinical competency area. As an independent prescriber the RN would be fully responsible for the assessment of the patient’s needs and prescription of medication.

As an independent prescriber, a RN would be similar to a physician in terms of ability to prescribe. However, an RN would not have access to prescribing controlled drugs and substances.

The scope of this model is the broadest of all the models. If implemented, it would have the greatest impact on access to care: increasing convenience and timeliness for patients; and decreasing the involvement or need for referrals to other prescribing health professionals.

Authorizing nurses to rely on the exercise of clinical judgment to prescribe medication, instead of strict protocols, provides flexibility to adapt the treatment to the specific circumstances of the patient, taking into account evolving standards of care and guidelines. However, the foundational knowledge to prepare competent independent RN prescribers would have to be comprehensive for them to access the full formulary or even a restricted formulary. It would be necessary to ensure independent RN prescribers have the ability to elaborate on differential diagnoses, identify contraindications, determine the appropriate medication and dosage, as well as identify and manage potential complications.

In order to recognize a treatable condition and rule out other conditions, the independent RN prescriber must also have the ability to order the necessary laboratory and radiological investigations. Otherwise, resort would have to be had to other health care professionals to order such tests. Independent RN prescribers would still need to be able to consult with other health professionals about their patients and re-direct or refer patients if the patient’s condition requires investigation or treatment outside the nurse’s scope of practice or competency.

Finally, we note that even in circumstances where health care professionals are expected to rely on their education and clinical judgment, practice guidelines are helpful reference guide to optimize patient care. Practice guidelines incorporate recommendations generally emanating from experts in a particular clinical area that reflect the generally accepted clinical management in specific circumstances. Unlike protocols, they do not require professionals to adhere necessarily to a strict approach, to the exclusion of others. Compliance with clinical guidelines is not always mandatory and it is understood that health care professionals can still exercise their clinical judgment to adapt the treatment to the specific circumstances of each patient, if necessary.
Use of Protocols

The HPRAC RN Prescribing Referral Survey describes this model as follows:

In this model written instructions allow RNs to supply and administer medications within the terms of a predetermined protocol. The use of protocols is used for the supply and administration of named medicines in an identified clinical situation. RNs are only able to supply and administer medications within the strict terms of the predetermined protocol. A RN under this model is responsible for the acceptance of the protocol but the prescribing physician or regulated health professional with prescribing authority* is responsible for the assessment of the patient’s needs and prescription of any medication.

Through the use of protocols, a RN would be able to prescribe specific medications under specific circumstances, similar to how RNs currently prescribe through the use of an order or a medical directive.

As noted in your survey, this model reflects the existing practice of RNs taking action pursuant to a medical directive. Although it is indicated that nurses currently “prescribe through the use of an order or a medical directive”, our understanding is that their authority is in fact limited to dispensing and administering medication pursuant to the directive; they currently do not in fact issue a prescription. Since the nurse does not issue a prescription the patient can submit to a pharmacy outside the nurse’s workplace, the need to ascertain that a nurse is properly authorized to dispense or administer medication is confined to the nurse’s workplace.

We also note that nurses who provide treatment pursuant to a directive need to ascertain that the presenting pathology is the one described in the directive or protocol and in doing so, may be required to rule out other conditions; they also need to monitor the patient’s response to the treatment and if the patient is an outpatient, provide adequate discharge instructions to the patient. Accordingly, they must have the necessary knowledge, skill and judgment to do so. It is therefore not surprising that such directives (or protocols) are usually relied upon when the nurse is already familiar with the clinical area of practice. Finally we note that the responsibility of ascertaining that the registered nurses authorized to act upon such directives have the necessary knowledge, skills and judgment is currently the responsibility of the author of the directive or the employer. The use of medical directives does not confer on the nurse the authority to act beyond his or her scope of practice. The registered nurse is rather implementing orders on a larger scale.

It is not clear to what extent the new prescribing model would be different from the existing medical directives. If registered nurses are permitted to issue prescriptions, rather than dispense and administer medication or other forms of treatment pursuant to protocols, the following questions will have to be considered:
1. Who will determine whether a registered nurse can prescribe and in what circumstances: will it be the College of Nurses, in accordance with a certification process and protocols that it will have developed (in a process akin to the one that exists in British Columbia, for instance), or will the Nursing Act expand the scope of practice of registered nurses to grant them the authority to prescribe when expressly authorized to do so by a prescribed person (presumably, either the patient’s most responsible health care professional or the nurse’s employer)?

2. If the registered nurse is not expressly certified to prescribe by the College of Nurses of Ontario, how will the patient and other health care professionals (in particular, the pharmacist who may be asked to fill the prescription) ascertain that the nurse has the authority to fill the prescription?

3. Will there be a mechanism by which the registered nurse will have the ability to confirm a diagnosis or order laboratory investigations to monitor the condition of the patient?

By way of more general comment, since this model would only be deployed in certain clinical situations, the foundational preparation of these nurses could be somewhat more streamlined but there would have to be sufficient preparation for a nurse to appropriately exercise clinical judgment, namely to ensure that the patient presents with the condition contemplated in the protocol and not another condition. If, as noted above, protocols are used “for the supply and administration of named medicines in an identified clinical situation” and “RNs are only able to supply and administer medications within the strict terms of the predetermined protocol”, the use of protocols can be restrictive. The registered nurse could not, for instance, in the exercise of his or her professional judgment, contemplate a course of treatment for a specific patient other than what is expressly contemplated in the protocol. If the nurse determines that the protocol may not be the most appropriate course of action for a particular patient, notwithstanding that the patient meets the application criteria, the nurse would have no recourse but to refer to another health care professional for an appropriate course of treatment. It would be important to reinforce that the existence of protocols does not replace the exercise of clinical judgment. It would also be important that there be in place a mechanism to update the protocols as needed to meet the evolving standard of care.

Finally, if the RN is not granted corresponding authority to order diagnostic and screening tests, it would lessen the scope and effectiveness of the RN prescriber role. There is less potential systemic benefit in terms of freeing up time other prescribers would otherwise spend on a patient’s course of care. Patients may not experience the benefit of improved access to care.
Supplementary Prescribing

The HPRAC RN Prescribing Referral Survey describes this model as follows:

Supplementary prescribing is a hybrid of independent prescribing and use of protocols. This model involves a partnership between a RN, physician and patient, where after an initial assessment of the patient’s needs by the physician a nurse may prescribe medication. In this model a patient-specific clinical management plan (CMP) is developed by the nurse and physician that allows the nurse to prescribe within a limited or pre-defined formulary or by class of drugs within their clinical competency area. The collaborating physician shares the responsibility of prescribing and holds full responsibility for the assessment of a patient. There are no restrictions on the type of patient condition or patient population that a CMP could be developed for between a physician and RN. As a supplementary prescriber a RN, working within a previously established CMP, would be permitted to prescribe for a variety of patient clinical conditions as long as they are within the RN’s clinical competency.

In this hybrid model, the responsibility to ascertain that the treatment is indicated is initially that of the physician, who will establish the diagnosis, rule out other possible pathologies and ascertain that the treatment is not contraindicated for the particular patient. The prescribing nurse will still have to monitor the effectiveness of the treatment, ascertain whether it remains indicated and provide instructions to the patient, but would not have to establish the initial diagnosis.

If an RN prescriber is to be certified by the College of Nurses to practice in any setting, the preparation to be an RN supplementary prescriber would have to be quite broad. If, on the other hand, the nurse would not be generally certified as a prescriber by the College but would only be authorized to prescribe in specific circumstances within an established CMP, that authority would still need to be recognized through an amendment to the Nursing Act, such as to fall within the nursing scope of practice. There would need to be a mechanism by which a nurse could demonstrate to the patient and other health care professionals (the pharmacist or the professional who will administer the treatment, for instance) that she is specifically authorized to prescribe in accordance with the CMP.

As with other models, the authority to prescribe would have to include the ability to order the relevant laboratory tests to monitor the patient’s response to treatment or appropriately titer the dosage of the medication, where necessary.

A determination will have to be made as to whether the limited or pre-defined formulary or class of drugs is within the nurse’s competency area and how this changes with time, if need be.

The model is most flexible if left to the prescribing physician and RN prescriber. It has the advantage of a patient-specific clinical management plan, which requires overt communication between the physician and the nurse. The RN supplementary prescriber has ready access to a physician who
knows the patient and the physician knows the parameters of care within which the RN supplementary prescriber will act. These advantages may be experienced by the patient as seamless care.

The issue of controlled drugs and substances should be overtly addressed in this model. Their prescription by an independent RN prescriber is prohibited in the description of that model but is not mentioned in the supplementary RN prescriber model description. Registered nurses are not included in the definitions of authorized prescribers in the Controlled Drugs and Substances Act or its regulations. Therefore unless the legislation or regulations are amended, it should be an overt element of supplemental RN prescribing model that those classes of drugs are not available for an RN to prescribe.

Other alternative

Another model which does not appear to have been contemplated is a more narrow version of the independent prescriber model, in which the registered nurse is provided, through certification by her regulatory body, with the authority to address specific issues in a particular area of practice and in the absence of pre-determined contraindications, which authority would then be ideally supported with the use of clinical practice guidelines.

This model would require that the nurse have, in those narrow areas of practice, the foundational knowledge and the tools (ability to order laboratory test and diagnostic imaging, for instance) to determine that the patient presents with the condition that he or she is authorized to treat, and to rule out other conditions that may have a similar presentation. The use of clinical guidelines rather than strict protocols would allow the nurse to exercise her clinical judgment in the best interest of the patient and allow the nurse’s practice to evolve taking into account evolving standards of care.

This model may require greater preliminary work to identify the circumstances in which nurses could be certified as prescribers and to ascertain that a registered nurse has the necessary knowledge, skills and judgment to operate in the circumstances described above. The model is not as flexible as the “Supplementary Prescribing” model in that the circumstances in which registered nurses could prescribe would be pre-determined by the nursing regulator. However, through a certification process, the model would incorporate the means to ascertain formally that a prescribing nurse has the requisite qualifications. The existence of this certification could be easily ascertained through an inquiry with College.

Conclusion

As noted, the CNPS will defer to the appropriate authority to determine the best prescribing model. We believe that the potential for liability will be reduced, patient safety will be enhanced and there will be fewer barriers to RN prescribing if the following conditions exist:
1. Legislative and regulatory amendments are made such that the RN ability to prescribe (whether it extends to all RNs or a subcategory of RNs) is clearly within the nursing scope of practice.

2. The pharmaceuticals that RN prescribers can prescribe take into account any limitations contained in the *Controlled Drugs and Substances Act* and its regulations.

3. All prescribing RNs have the necessary knowledge, skill and judgment to prescribe in their respective clinical area of practice, whether acquired through formal education or practice.

4. There is a reliable process in place to verify that prescribing RNs have the necessary knowledge, skill and judgment to do so pursuant to which the privilege of RN prescribing will be extended.

5. Members of the public and other health care professionals can easily ascertain that the RN has the necessary qualifications to prescribe.

We hope that the foregoing will be of assistance.

Yours truly,

Chantal L. Léonard, LLB
Chief Executive Officer

Elaine Borg, BNSc, RN, LLB
Legal Advisor
January 13, 2016

Mr. Thomas Corcoran  
Chair  
Health Professions Regulatory Advisory Council  
56 Wellesley St W.,  
12th Floor  
Toronto, Ontario, Canada  
M5S 2S3

Dear Mr. Corcoran:

registered Nurse Prescribing Referral

The College has had an opportunity to review the 3 proposed models of prescribing for RNs. All three models deal with a pre-determined formulary of drugs. Chiropodists and podiatrists in Ontario also prescribe and administer substances from a prescribed list of drugs and substances. Such a model presents many challenges including, but not limited to, the listing of individual drugs as opposed to classes of drugs, the currency of the list and an inability to prescribe new drugs as they come on the market. Any additional or different drugs or substances requires the amendment of the regulation. Given the length of time it takes for such approval, practitioners are oftentimes precluded from using new and updated drugs or substances and must continue to deal with a list that is outdated and too specific because of the listing of individual drugs and substances and not classes. If the latter was available, it would eradicate the problem. The College raises this issue only to share our experience with a pre-determined formulary of drugs.

This College is supportive of RNs prescribing using a model that best ensures the protection of the public, provides expanded opportunities for the citizens of Ontario to access health care and includes the necessary tools that compliments the RN scope of practice.

Thank you for this opportunity to provide the College's comments.

Yours truly,

Felecia Smith, LL.B  
Registrar
January 21, 2016

By E-mail

Mr. Thomas Corcoran, Chair
Health Professions Regulatory Advisory Council (HPRAC)
56 Wellesley St. West, 12th floor
Toronto, Ontario  M5S 2S3

Dear Mr. Corcoran:

Re: Consultation on Registered Nurse (RN) Prescribing Models

The College of Nurses of Ontario (CNO) is pleased to respond to HPRAC’s request for input regarding RN prescribing in Ontario. We are one of many system stakeholders that have an interest in promoting safe health care delivery. Regardless of the RN prescribing model implemented, CNO, within its mandate to regulate nursing in the public interest, will mitigate risk of harm through appropriate regulatory mechanisms.

There are several factors to consider when selecting an RN prescribing model. Any model should be evidence-informed. In selecting and developing a model, a key consideration is that safe prescribing occurs as part of a broader continuum of care, which generally includes a health assessment, diagnosis, therapeutic management and follow-up. Prescribing does not happen in isolation. Independent prescribers need the knowledge, skill and judgment to safely and effectively perform assessments, order and interpret tests, diagnose and monitor/follow-up with clients.

CNO acknowledges HPRAC’s request for completion of the survey. However, this letter represents CNO’s formal submission to HPRAC as a substitute for a survey response. This format enables CNO to raise relevant considerations related to the proposed models. CNO’s response is structured as follows:

- CNO’s contributions in reducing risk of harm;
- implications for practice;
- regulating current independent RN prescribers (RNs in the Extended Class who are also known as Nurse Practitioners or NPs);
- system considerations;
- jurisdictional variation; and,
- seeking clarity regarding the proposed models.
CNO’s Contributions in Reducing Risk of Harm

Depending on the prescribing model and corresponding legislative framework, CNO will consider a number of regulatory mechanisms to reduce the risk of harm to the public. These mechanisms will apply right touch principles¹ and must be feasible to implement. They will take into consideration the diversity of nursing practice, such as variations in nursing roles and settings where care is provided and client populations served.

Taking into account jurisdictional variations, where possible, CNO will work with RN regulators in other Canadian jurisdictions to harmonize requirements in this emerging area (e.g., harmonizing education requirements where there is a comparative role in another jurisdiction). In order to support labour mobility commitments, Ontario’s legislative framework should be broad enough to allow for as much national harmonization as possible.

Based on CNO’s expertise in nursing regulation, and information from other jurisdictions that currently regulate both RN prescribers and NPs, the items outlined below demonstrate what may be required for CNO to meet its mandate. In general, the regulatory mechanisms needed to support public protection will depend on the level of independence of this new RN prescriber role (i.e., more independence → higher risk to the public → additional regulatory mechanisms needed to ensure initial and ongoing safe practice).

**Assuring Initial Competence**
Prescribing a drug is not an entry-to-practice competency for RNs in the General Class. CNO expects that candidates will complete additional education to gain the knowledge, skill and judgment to be able to safely prescribe a drug. Given that prescribing does not happen in isolation, depending on the model implemented, they would also need education related to other new activities associated with this authority (e.g., communicating a diagnosis and ordering tests). The additional competencies required of RN prescribers will be determined by CNO to support education and assessment requirements. CNO will also consider practice experience requirements (e.g., clinical experience required before obtaining the authority to prescribe).

**Ongoing Practice, Continuing Competence and Enforcement**
CNO will establish ongoing requirements and processes to support safe practice, and intervene when practice standards are breached.

Practice standards and resources will be developed to describe the required behaviours and expectations of RN prescribers, and may include collaboration requirements (e.g., collaboration with a physician or NP).

¹ Please see the following link for more information: [http://www.professionalstandards.org.uk/policy-and-research/right-touch-regulation](http://www.professionalstandards.org.uk/policy-and-research/right-touch-regulation)
CNO will consider specific requirements to maintain eligibility to practice in an RN prescriber role. For example:

- Should RN prescribers be expected to maintain clinical practice experience?
- Do liability protection requirements address the risk associated with this expanded scope?

Nurses are expected to stay current in order to safely apply their knowledge, skill and judgment. Appropriate Quality Assurance requirements and assessments will be developed by CNO. These requirements assure the public that nurses demonstrate their commitment to continuing competence and continuing quality improvement.

Finally, CNO will need strategies to monitor and enforce practice requirements for RN prescribers. For example, processes will be required to evaluate potential reports about RNs prescribing controlled substances from the Ministry of Health and Long-Term Care’s Narcotics Monitoring System (NMS).

**Regulation Development**

Subject to Council’s regulation-making authority under the *Nursing Act, 1991*, appropriate regulations and by-laws will be required to support CNO’s ability to implement the requirements deemed necessary to protect the public. For example, CNO may draft regulations related to registration and practice requirements to support safe prescribing.

**Building on Existing Mechanisms**

Should the protocol-based model be implemented, CNO may be able to build on what already exists in Ontario related to the use of authorizing mechanisms. The Federation of Health Regulatory Colleges of Ontario has developed a *Guide to Medical Directives and Delegation*: [http://mdguide.regulatedhealthprofessions.on.ca/why/default.asp](http://mdguide.regulatedhealthprofessions.on.ca/why/default.asp). This guide, based on a framework of client interest and public protection, was developed to address questions regarding the use of orders and delegation to facilitate interprofessional care.

CNO has expectations and guidance for all nurses with respect to authorizing mechanisms. As an example, this is a link to CNO’s guideline on *Authorizing Mechanisms*: [http://www.cno.org/globalassets/docs/prac/41075_authorizingmech.pdf](http://www.cno.org/globalassets/docs/prac/41075_authorizingmech.pdf).

**Learning from Regulatory Experience**

CNO has expertise in establishing regulatory mechanisms that work effectively to protect the public, including working with a list of drugs designated in regulation. A list did not efficiently respond to evolving clinical practice or individual client need. It was impossible to establish a list that was reflective of all possible client populations and

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2 While this is provided as an example of the guidance currently provided that can be built on, CNO’s regulations and guidance will need to be evaluated in light of the new RN prescriber role to determine whether changes are required.

3 Up until October 2011, NP authority to prescribe medication was limited to drugs designated in regulation.
practice settings. If the model of RN prescribing involves a limited or pre-defined formulary consideration should be given to how the formulary is maintained and what body is accountable to for maintaining it. We would be pleased to share our experience with HPRAC in greater detail if needed.

Implications for Practice

Introducing new RN prescribers in Ontario will result in significant changes to nursing practice and the practice of other professions. Without clarity on the model and legislative framework, it is difficult to anticipate how these will unfold. Early policy questions include:

- Will RNs and Registered Practical Nurses (RPNs) be authorized to administer a medication based on RN prescribers’ orders?
- Will pharmacists be authorized to dispense medication ordered by RN prescribers?
- Should delegation be permitted by RN prescribers?
- Should RNs and RPNs continue to be permitted to accept directives to be able to provide a drug to a client if an RN prescriber role exists?
- What are the impacts on interprofessional collaboration?

Current Independent RN Prescribers: NPs

Ontario currently has independent RN prescribers: NPs. Nurses, other health professionals and the public will need clarity on how new RN prescribers differ from NPs. CNO’s development of regulatory mechanisms will consider the need to minimize confusion in the health system and among the public.

In NP practice, prescribing is considered as part of a continuum of care, which includes a health assessment, diagnosis, therapeutic management and follow-up. As independent prescribers, NPs have the legal authority to diagnose and order tests. These are reflected in legislation and standards of practice to which NPs are accountable.

The NP Practice Standard can be found at the following link:
http://www.cno.org/globalassets/docs/prac/41038_strdmec.pdf

Relevant regulations associated with NPs’ expanded scope can be found at the following link (including those related to prescribing a drug):
http://www.ontario.ca/laws/regulation/940275#BK38
System Considerations

The introduction of a new RN prescriber model will have system implications. Resources will be required to support system integration of this role (e.g., curricula development, protocol development). An increase in membership fees may be required to cover the regulatory costs associated with implementation of this new RN accountability.

Information Needs to Mitigate Risk of Harm

CNO has a mandate to regulate nursing practice in the public interest. System supports enable CNO to provide the most effective regulation of nurses.

Prescribing drugs is a high-risk activity, which is difficult to regulate irrespective of the health professional involved. To support regulation of prescribers, and implementation of the RN prescriber role, provincial systems should be in place to assist CNO in monitoring and enforcing safe prescribing practices. In particular, CNO will continue to work with other stakeholders to identify the type of information that could support CNO in meeting its regulatory mandate (e.g., data about prescribing patterns, medication errors and adverse events). For example, an integrated e-prescribing system could reduce the risk of unauthorized prescriptions and prescribing out-of-scope, while enabling Colleges to better monitor prescribing practices.

Although NPs do not have the authority to prescribe controlled drugs (e.g., opioids), NPs appear on Ministry reports from the NMS for a myriad of reasons. Depending on the model of RN prescribing, we may find RN prescribers appearing in these reports. The NMS assists Colleges in monitoring the prescribing and dispensing of controlled substances. CNO will continue to collaborate with the Ministry and others to promote a system that also mitigates the risk of professionals prescribing out-of-scope.

Jurisdictional Variation

When developing evidence-informed recommendations, CNO advises caution when drawing comparisons across jurisdictions because they may define prescribing and RN practice differently. For example, the College of Registered Nurses of British Columbia has Certified Practices for RNs (in addition to having NPs). However, Certified Practice RNs do not prescribe drugs; rather, these nurses are legally authorized to dispense and administer prescription drugs without an order (they cannot write a prescription that can be dispensed at a pharmacy). Certified Practice RNs must follow approved Decision Support Tools, which may be similar to what is being proposed in the protocol based model. (Unlike Ontario, the legislative framework in BC does not enable health professionals to use directives.) Contrasting BC and Ontario is just one example of how difficult it is to make comparisons across jurisdictions. There are also jurisdictions that have implemented an RN prescriber role which may be comparable to Ontario’s NP role (e.g., some RN roles in the UK). CNO recommends looking at jurisdictions that regulate both NPs and RN prescribers.
Seeking Clarity Regarding the Proposed Models

To provide detailed input about the relevant regulatory considerations, CNO will need to understand how the models will be implemented (e.g., what provisions would be in the Act). Also, some of the terminology used to describe the models is unclear (e.g., unlicensed drug).

The following questions arose when reviewing the proposed models. Answers to these questions would help CNO provide further input with respect to risk of harm and regulatory considerations.

1. What does the evidence say regarding the need for these new prescribers (e.g., access, population health needs, system gaps, benefits of the change)?
2. Will RN prescribers have access to the controlled act of prescribing a drug?
3. How does an independent RN prescriber differ from an NP?
4. Will there be an impact on internationally educated nurses?
5. If an RN is authorized to independently prescribe a drug, would this RN also have access to other controlled acts (e.g., communicating a diagnosis) and other procedures (e.g., authority to order tests)?
6. If an RN is authorized to prescribe a drug, will they also be authorized to independently dispense or administer that drug?
7. In the supplementary model, has a physician or NP already made a diagnosis?
8. How does the protocol based model differ from what already exists in the province (e.g., through directives)?
9. In the protocol based model, will an RN be permitted to complete prescriptions and/or administer/dispense a drug based on a protocol?
10. What system supports are envisioned/planned for each of the models?

Ultimately, CNO encourages a development and implementation plan that promotes safe health care delivery and positive client outcomes. Thank you for the opportunity to participate in this consultation. If you have any questions or require further information, I would be pleased to hear from you.

Sincerely,

Anne L. Coghlan, RN, MScN
Executive Director and CEO

RNs in the General Class do not have the entry-to-practice competencies to perform these additional restricted activities. They would need additional education to perform these activities safely.
January 19, 2016

Mr. Thomas Corcoran  
Chair, Health Professions Regulatory Advisory Council  
56 Wellesley St. W., 12th Floor  
Toronto, ON, M5S 2S3

Dear Mr. Corcoran,

Thank you very much for requesting the feedback of the College of Optometrists of Ontario regarding prospective Registered Nurse (RN) prescribing in Ontario.

The College of Optometrists (‘the College’) supports the College of Nurses’ authority to regulate, and recognize the competency of, RNs who would prescribe drugs in Ontario. The College also supports the College of Nurses’ ability to recognize classes of drugs that RNs could competently prescribe.

The College further supports a drug prescribing authority which references classes or categories of drugs, rather than a list of individual drugs. It has been the experience of the College that a list of drugs, in regulation, is difficult to update or amend, and creates a barrier to access to newer drugs which are often the indicated best-treatment for patients.

Thank you very much for the opportunity to comment on this initiative.

Sincerely,

Paula L. Garshowitz, OD  
Registrar  
College of Optometrists of Ontario
January 26, 2016

Thomas Corcoran  
Chair  
Health Professions Regulatory Advisory Council  
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Dear Mr. Corcoran:

Thank you for requesting the College of Physicians and Surgeons of Ontario’s (the College) feedback on Registered Nurse (RN) Prescribing in Ontario. The College appreciates the invitation to participate in the Health Professions Regulatory Advisory Council’s (HPRAC) consultation on this issue.

Our understanding is that HPRAC is looking for comment on three models of RN prescribing for Ontario, in principle, as a specific objective or challenge that motivated consideration of RN prescribing hasn’t been identified. Overall, this response expands on the informal comments on RN prescribing the College provided to the Ministry of Health and Long-Term Care (Ministry) at a meeting on July 14, 2015, and the College’s preliminary position on RN prescribing that was submitted to the Ministry on August 24, 2015.

The College values initiatives that encourage the inter-professional and collaborative delivery of health care and ensure that every health care professional can work to their full scope of practice. The College is supportive in principle of RN prescribing, as long as RNs have the appropriate knowledge, skill and judgment to prescribe in a safe and effective manner. The College’s specific comments on the three models of RN prescribing and the impacts of RN prescribing are set out below.

**Independent Prescribing**

The College’s understanding is that in this model, RNs may prescribe medications under their own authority, either without restrictions (i.e. they can prescribe any drug), OR from a limited or pre-defined formulary within a regulated scope of practice (i.e. they can only prescribe certain drugs found on a list). Independent prescribers are allowed to prescribe any licensed or unlicensed drugs that are within their clinical competency area. As an independent prescriber, the RN would be fully responsible for the assessment of the patient’s needs and prescription of medication. As independent prescribers, RNs would be similar to physicians and nurse practitioners (NPs) in terms of ability to prescribe. However, RNs would not have access to prescribing controlled drugs and substances as they are not authorized to do so under the Controlled Drugs and Substances Act.

Patient safety considerations are paramount when any regulated health care professional has the authority to independently prescribe drugs. The College’s Prescribing Drugs policy sets out expectations for physicians who prescribe drugs. The policy contains a number of requirements physicians are expected to comply with in order to prescribe in a safe and
effective manner. To ensure patient safety is maintained, any health care professional who independently prescribes should do so in a manner that is consistent with the College’s expectations for physicians. The College’s support for independent RN prescribing would be contingent on this.

Key requirements in the College’s policy specify that in order for physicians to prescribe in a safe and effective manner, they must conduct an appropriate clinical assessment prior to prescribing, which may include diagnostic and/or laboratory testing. The physician would also have to make a diagnosis and/or have a clinical indication based on the clinical assessment. Further, patients need follow-up care after prescribing, to monitor whether any changes to the prescription are required, and to manage a response to therapy or its complications. This may require further clinical assessments and/or diagnoses. Currently, it is not clear whether independent RN prescribing would include not only access to the controlled act of prescribing, but also the authority to order and interpret diagnostic and laboratory tests and to communicate a diagnosis. The College is concerned that patient safety and quality of care may be compromised if independent RN prescribing does not include the ability to order and interpret tests and communicate a diagnosis, as they are essential to safe and effective prescribing.

Patient safety must also be considered when any regulated health care professional has the authority to order and interpret diagnostic and laboratory tests. The College’s Test Results Management policy sets out expectations for physicians regarding the management of all types of test results. The policy contains a number of requirements physicians are expected to comply with in order to ensure an effective system for managing test results is developed and maintained, and that test results are followed up on appropriately. To ensure patient safety is maintained, any health care professional who orders and interprets tests should do so in a manner that is consistent with the College’s expectations for physicians. As such, the College believes that if RNs order tests in the context of independent prescribing, they should also have expectations to track and follow up on test results, as set out in the College’s Test Results Management policy.

As RNs currently do not have the authority to prescribe independently, they will require appropriate education and training in order to do so safely and effectively. Appropriate education and training in prescribing is particularly important given the potential risks to patient safety that are inherent in independent prescribing. Prescribing is a complicated clinical act and potentially inappropriate medications or potentially inappropriate prescriptions can lead to adverse drug events, hospitalization, a poorer health-related quality of life, and death. The media has reported that the Government would extend RN prescribing to “minor skin conditions”. However, even when prescribing drugs that may seem harmless (such as those

2. See: http://globalnews.ca/news/1336105/wynne-promises-to-let-nurses-write-basic-prescriptions/
used for minor conditions), there is potential for patient harm by misdiagnosis and/or inappropriate prescribing. For example, some skin cancers can masquerade as benign appearing skin conditions. We also know that inappropriate prescribing of antibiotics may further increase the development of antibiotic resistant organisms.

The College notes for HPRAC’s information that education and training for physicians is significant. For example, physicians receive comprehensive training in pharmacology at the basic sciences level, followed by the application of pharmacotherapeutic principles in clinical practice. In considering independent RN prescribing, HPRAC must be assured that RNs have the appropriate education, training, and clinical judgment to prescribe in a safe and effective manner.

As stated earlier, since safe and effective prescribing also requires the ability to order and interpret tests and communicate a diagnosis, RNs who prescribe independently would also require the authority to perform these other controlled acts. It is essential that RNs be required to complete additional education and training in these areas as well to ensure that RNs possess the competencies to practise safely within their expanded scope.

Although patient safety should be the primary consideration as HPRAC considers independent RN prescribing, HPRAC may also want to consider the fact that providing RNs with the authority to prescribe, order and interpret tests, and to communicate a diagnosis would bring the scope of practice of RNs almost in line with the current scope of NPs, and would likely have a broader impact on the delivery of health care across the province. For example, it may lead to confusion amongst patients regarding scopes of practice for physicians, and nurses (NPs and RNs) and uncertainty as to which health care professional is ultimately responsible for the patient. HPRAC may wish to consider any potential impacts as it considers whether independent RN prescribing is an appropriate model for Ontario.

HPRAC may also want to consider the impacts on patients and other impacts on the health care system more broadly given fact that RNs would not have access to prescribing controlled drugs and substances as they are not authorized to do so under the Controlled Drugs and Substances Act. The College strongly supports this restriction, as prescribing controlled drugs and substances, and monitoring patients who are prescribed these drugs and substances, is extremely complex, especially given the associated significant patient and public safety risks. Access to prescribing controlled drugs and substances should not be provided to additional health care professions until prescribers are able to get real-time access to patient medication histories. Having said that, the College questions whether independent RN prescribing with this restriction would benefit patients and the health care system. If patients see an RN but require controlled drugs or substances, the patient would have to also see a regulated health care professional that has the authority to prescribe these drugs. This may not increase access to care or be convenient for patients, and may impact any efficiencies to the health care system that may be gained by adopting independent RN prescribing in Ontario. These potential impacts would also apply if independent RN prescribing is restricted to a limited or pre-defined formulary within a regulated scope of practice.
Use of Protocols

This model appears to reflect the status quo, in which RNs are permitted to prescribe via delegation (under direct orders or medical directives). The College’s understanding is that in this use of protocols model, written instructions from a prescribing physician or regulated health professional with prescribing authority will allow RNs to supply and administer medications within the terms of a predetermined protocol. The use of protocols is used for the supply and administration of named medicines in an identified clinical situation. RNs are only able to supply and administer medications within the strict terms of the predetermined protocol. RNs under this model are responsible for the acceptance of the protocol but the prescribing physician or regulated health professional with prescribing authority is responsible for the assessment of the patient’s needs and prescription of any medication. Through the use of protocols, RNs would be able to prescribe specific medications under specific circumstances, similar to how RNs currently prescribe through the use of an order or a medical directive.

HPRAC may be aware that the College’s Delegation of Controlled Acts policy enables physicians to delegate controlled acts (under direct orders or medical directives), including prescribing, to health care professionals such as RNs under appropriate circumstances. For example, this could include prescribing oral contraception for family planning purposes or penicillin for confirmed Group A streptococcal pharyngitis. There are safeguards in place for physicians to ensure delegation is done in a safe and effective manner, as articulated in the College’s policy. These include the following: only delegating when it is in the best interests of the patient and in the context of an existing physician-patient relationship (unless patient safety and best interests dictate otherwise); limiting delegation to acts that the physician is competent to perform personally; ensuring the delegate has the appropriate knowledge, skill and judgment to perform the delegated act, and that the delegate is able to accept the delegation; obtaining the patient’s informed consent for the act; identifying the risk involved in delegating the act and any resources and equipment necessary to reduce risk; ensuring the appropriate level of supervision to ensure the act is performed safely and appropriately; and ongoing monitoring and evaluation of the act being performed.

Given that the use of protocols model proposes that a regulated health professional with prescribing authority other than a physician can allow RNs to supply and administer medications within the terms of a predetermined protocol, similar safeguards as set out in the College’s Delegation of Controlled Acts policy must be in place to ensure this is done in a safe and effective manner. As such, if the Ministry proceeds with the protocols model, it may wish to consider the positions that have been adopted by other Colleges and ensure that there are requirements that are consistent with those set out in the College’s Delegation of Controlled Acts policy.

It is the College’s view that delegation of prescribing through direct orders or medical directives can and does work effectively. Appropriate delegation of controlled acts can result in more timely delivery of health care, and can promote optimal use of health care resources and personnel. HPRAC may wish to consider whether delegation is being fully utilized in Ontario
and if not, whether changes could be made to the existing delegation framework that would achieve the Ministry’s objectives in enabling RN prescribing.

**Supplementary Prescribing**

It is the College’s understanding that supplementary prescribing is a hybrid of independent prescribing and use of protocols. This model involves a partnership between RNs, physicians and patients, where after an initial assessment of the patient’s needs by the physician, a nurse may prescribe medication. In this model a patient-specific clinical management plan (CMP) is developed by the nurse and physician that allows the nurse to prescribe within a limited or pre-defined formulary or by class of drugs within their clinical competency area. The collaborating physician shares the responsibility of prescribing and holds full responsibility for the assessment of a patient. There are no restrictions on the type of patient condition or patient population for which a physician and RN could develop a CMP. As a supplementary prescriber a RN, working within a previously established CMP, would be permitted to prescribe for a variety of patient clinical conditions as long as they are within the RN’s clinical competency.

The College’s comments above regarding independent RN prescribing and use of protocols apply to this model. Given the potential risks to patient safety when independently prescribing, some of these key comments are highlighted here as well. For example, to ensure patient safety is maintained, RNs who prescribe independently, even if it is only from a limited or predefined formulary or class of drugs, should do so in a manner that is consistent with the College’s expectations for physicians as set out in the College’s Prescribing Drugs policy. As RNs currently do not have the authority to prescribe independently, they will require appropriate education and training in order to do so safely and effectively. Since safe and effective prescribing also requires the ability to communicate a diagnosis, RNs who prescribe independently under this model would also require the authority to perform this controlled act in order to develop patient-specific CMPs. However, because RNs do not currently have the authority to communicate a diagnosis, they will also require appropriate education and training in this area in order to do so safely and effectively.

Additionally, the College questions whether there would be the potential for confusion regarding which health care professional is ultimately responsible for the assessment, making a diagnosis, obtaining patient consent and writing the prescription under this model.

HPRAC may want to consider the impact this model may have on patients. For example, the fact that the model only allows the RN to prescribe within a limited or pre-defined formulary or by class of drugs within their clinical competency area may not benefit patients and the health care system. If the patient sees an RN and requires a drug that the RN cannot prescribe, they would have to also see a regulated health care professional that has the authority to prescribe that drug. This may not increase access to care or be convenient for patients, and may impact any efficiencies to the health care system that may be gained by RN prescribing under this model in Ontario. Further, it may lead to confusion amongst patients regarding scopes of
practice for physicians and RNs, and uncertainty as to which health care professional is ultimately responsible for the patient.

HPRAC may also want to consider whether this model will achieve the Ministry’s objectives in enabling RN prescribing.

**Impacts of RN Prescribing**

The College notes that HPRAC’s online survey asks specific questions regarding the impact of RN prescribing, the risk of harm and readiness to prescribe. The College has raised potential impacts of RN prescribing throughout this letter, but wanted to specifically comment on a few others.

In regard to the impact of RN prescribing on better access to care in remote and rural areas, the College believes that this can and currently is being achieved in Ontario a number of different ways. For example, some RNs and NPs are physically located in remote and rural areas to provide care to patients either via delegation (RNs) or independently (NPs), and care is also being provided in these areas via telehealth. Information and communication technologies are currently being used, which benefit patients, physicians and other health care providers and the broader health care system by improving access to care, and increasing efficiencies in the delivery of care. HPRAC may want to consider whether delegation, NPs and telehealth are being fully utilized in Ontario and if not, whether changes could be made in these areas to achieve the Ministry’s objectives in enabling RN prescribing.

In respect to the impact of RN prescribing on patients, including whether RN prescribing will help patients have a better understanding of the medications prescribed to them, result in patients being more compliant with instructions for medication use, and improve patient well-being, the College cannot predict whether or not these benefits would be realized with RN prescribing. The College understands that HPRAC will be reviewing the preliminary literature reviews on RN prescribing and the effectiveness of RN prescribing, and suggests that this may be the best way to determine the impact of RN prescribing on patients.

In conclusion, the College believes that inter-professional collaboration and coordination of care remain key enablers to safe, effective, high-quality and patient-centred care. The College is supportive of changes that improve these systemic issues and ensure that all health care professionals are working to their full scopes of practice. In regard to the three models of RN prescribing for Ontario, the College is supportive of the use of protocols model as it appears to reflect the status quo, where RNs are able to prescribe via delegation. The College has experience with a delegation model and believes that is strikes an appropriate balance between access to care and patient safety, particularly given the safeguards in place via the College’s Delegation of Controlled Acts policy. It is the College’s view that delegation of prescribing through direct orders or medical directives can and does work effectively. The College’s support of any model that contemplates independent RN prescribing is contingent on whether the patient safety considerations identified are addressed.
Yours very truly,

Rocco Gerace MD
Registrar
January 21, 2016

Health Professions Regulatory Advisory Council
56 Wellesley St W.,
12th Floor
Toronto, Ontario, Canada
M5S 2S3

To Whom It May Concern:

I am writing to you on behalf of the College of Physiotherapists of Ontario to offer input into HPRAC’s consideration of the Minister’s Referral on Registered Nurses Prescribing.

The College has considered the Registered Nurses Prescribing Referral’s Criteria for Assessment of Prescribing Models as well as other relevant information.

The College has also reviewed the online feedback tool that has been offered to facilitate the collection of input from stakeholders.

The College is of the view that the relationship between the three proposed prescribing models and the many criteria that have been identified as being important in the consultation process is more complex than seems to be suggested by the online collection tool.

The tool seems to suggest that no matter which criterion is being considered, there is a straightforward and clear way to evaluate whether it can be classed into one of the three categories offered. While this mechanism of assessment may be desirable from the standpoint of analysing the input, it is the view of the College that it seems like a substantial oversimplification of reality. This is especially true since the respondent is given no opportunity to qualify their response based on particular circumstances.

Another factor that undermines the validity of the response is that the only opportunity to add references or resources indicating the origin of a respondent’s opinion is in one question at the very end of what is a very long survey, which seems to make it difficult, if not impossible to link the evidence with the opinion offered.

With these considerations in mind the College, although its capacity to offer expert advice on this issue is limited, has chosen to offer its feedback on the issue in written form.

As noted above, in the view of the College, the relationship between the three proposed prescribing models and the Criteria for Assessment of Prescribing Models is quite complex. In fact, we believe that each of the prescribing models has its own set of particular risks and benefits associated with it, which may be in part driven by the needs of particular practice populations or locations.
Further, the College believes that while the desire for consistency might support the recommendation of one province-wide prescribing model, it may be worthwhile to assess this assumption using the criteria, especially risk of harm and public need, from a broader perspective. In other words, a particular practice model, for example, independent prescribing, might be associated with a marginally higher risk of harm to patients arising due to the actual prescribing. If the need for care in a particular population is great, and access to care is limited, the real risks to patients associated with not receiving care may be substantially higher than the risks associated with this kind of prescribing model. However, the degree of risk associated with independent prescribing may be less acceptable in circumstances where access to care is easier to obtain. This kind of broader and balanced analysis again points out the complex interrelationships between the prescribing models and the assessment criteria that we believe need to be considered.

While the expertise of the College in providing such detailed analysis is limited, we do believe that only when these complex interrelationships are fully explored can good advice be developed. We are concerned that an assessment mechanism that appears to be largely based on the assigned point values of individual opinions may not meet the test of decision making that is based on evidence or the real needs of Ontario’s public.

Thank you for the opportunity to provide feedback into this review.

Sincerely,

Rod Hamilton

Associate Registrar, Policy
February 4, 2016

Mr. Thomas Corcoran, Chair
Health Professions Regulatory Advisory Council
56 Wellesley St W.,
12th Floor
Toronto, Ontario, Canada
M5S 2S3

Dear Mr. Corcoran:

On behalf the Deans of the Council of Ontario Faculties of Medicine (COFM), we are writing to encourage the Health Professions Regulatory Advisory Council (HPRAC) to support the educational recommendations provided by the Council of Ontario University Programs in Nursing (COUPN), the Deans and Directors of the 14 university schools of nursing, and the provincial subcommittee on nursing, Colleges of Applied Arts and Technology (CAATs), the Chairs of the 24 college nursing schools regarding the educational requirements for Registered Nurse (RN) prescribing.

The COFM Deans defer to the knowledge, skill and expertise of our nursing colleagues. As the experts in nursing education and entry-to-practice competencies required to practice the art and science of nursing, they are the right people to provide informed advice on this matter.

COUPN and CAATs have recommended that supplemental prescribing with additional postgraduate education and clinical experience would be one way to introduce RN prescribing in Ontario. Independent prescribing would require the education of a Nurse Practitioner who has the additional knowledge, skill and judgement to provide safe, effective care across a range of patient populations.

Thank you for the opportunity to provide input in the consultation regarding RN prescribing.

Sincerely,

Dr. L. Trevor Young
Co-Chair, COFM

Dr. Richard Reznick
Co-Chair, COFM

c. Council of Ontario Faculties of Medicine Deans
Council of Ontario University Programs in Nursing Deans and Directors
Educational Implications of RN prescribing

Submitted to: The Health Professional Regulatory Advisory Board

Submitted by: the Council of Ontario University Programs in Nursing and the Provincial Heads of Nursing, Colleges of Applied Arts and Technology (CAATs)

Jan. 25, 2016
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Nurse Educators in Ontario - Who We Are

Entry-to-practice nursing education in Ontario is formally represented by two organizations – the Council of Ontario University Programs in Nursing (COUPN), and the Provincial Heads of Nursing, Colleges of Applied Arts and Technology (CAATs).

COUPN is composed of the Deans and Directors of the 14 Ontario university nursing programs. The universities provide education programs (often in collaboration with colleges) and grant degrees for over 4000 baccalaureate nursing graduates in Ontario each year. Most of these graduates go on to become practicing Registered Nurses (RNs) in Ontario and elsewhere. The universities also offer 10 Master of Nursing programs, including five Nurse Practitioner (NP) programs (including a 10-site consortium program), and five PhD programs.

CAATs is composed of the 24 Chairs of the college nursing programs. Twenty-two of the 24 Ontario colleges collaborate with universities in providing the baccalaureate nursing programs. All 24 of Ontario’s colleges offer Practical Nurse (PN) diploma programs. These graduates generally go on to register as Registered Practical Nurses and work with more stable, less complex patients than RNs do.

Many universities and community colleges also offer continuing education programs for RNs, RPNs and NPs.

Questions Posed by HPRAC to COUPN and CAATs

Staff supporting Health Professional Regulatory Advisory Council (HPRAC) asked COUPN and CAATs to respond to a number of questions to help elucidate the educational implications of RN prescribing, including:

1. Differences in scope of practice, competencies, and current education of Nurse Practitioners in comparison to RNs;
2. What kind and how much additional education and training would be required for an RN to be able to safely prescribe drugs, in relation to the three models of prescribing provided in the consultation survey (independent prescribing, use of protocols & supplementary prescribing); and
3. Thoughts on Registered Nurses Association of Ontario’s proposal of 300 hours of education for RN prescribing.

We address these questions below. Our analysis and advice are provided primarily in terms of the twin criteria of patient safety and public need for greater access to prescribing.

1. **Scope of Practice of RNs vs NPs**

Under the *Nursing Act*, the scope of practice for all categories of nursing is described in the same way:
The practice of nursing is the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function. (*Nursing Act*, S.O. 1991)

Within this scope, however, NPs have additional authority to perform controlled acts under the *Nursing Act*, including communicating a diagnosis, prescribing drugs, setting a fracture, and ordering various tests and treatments.

The chart below outlines the different authority of RNs and NPs in relation to controlled acts under the *Nursing Act*. Major differences are bolded.

<table>
<thead>
<tr>
<th>RN Authorized Controlled Acts</th>
<th>NP Authorized Controlled Acts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Performing a prescribed procedure below the dermis or a mucous membrane.</td>
<td>1. Communicating to a patient or to his or her representative a diagnosis made by the member identifying, as the cause of the patient’s symptoms, a disease or disorder.</td>
</tr>
<tr>
<td>2. Administering a substance by injection or inhalation.</td>
<td>2. Performing a procedure below the dermis or a mucous membrane.</td>
</tr>
<tr>
<td>3. Putting an instrument, hand or finger,</td>
<td>3. Putting an instrument, hand or finger,</td>
</tr>
<tr>
<td>i. beyond the external ear canal,</td>
<td>i. beyond the external ear canal,</td>
</tr>
<tr>
<td>ii. beyond the point in the nasal passages where they normally narrow,</td>
<td>ii. beyond the point in the nasal passages where they normally narrow,</td>
</tr>
<tr>
<td>iii. beyond the larynx,</td>
<td>iii. beyond the larynx,</td>
</tr>
<tr>
<td>iv. beyond the opening of the urethra,</td>
<td>iv. beyond the opening of the urethra,</td>
</tr>
<tr>
<td>v. beyond the labia majora,</td>
<td>v. beyond the labia majora,</td>
</tr>
<tr>
<td>vi. beyond the anal verge, or</td>
<td>vi. beyond the anal verge,</td>
</tr>
<tr>
<td>vii. into an artificial opening into the body.</td>
<td>vii. into an artificial opening of the body.</td>
</tr>
<tr>
<td>4. Applying or ordering the application of a prescribed form of energy.</td>
<td></td>
</tr>
<tr>
<td>5. Setting or casting a fracture of a bone or dislocation of a joint.</td>
<td></td>
</tr>
</tbody>
</table>
6. Administering a substance, by injection or inhalation, in accordance with the regulations.

7. Administering a substance by injection or inhalation as provided for in subsection (2).

8. Prescribing, dispensing, selling or compounding a drug in accordance with the regulations.

As can be seen, the major differences in the NP authority regarding controlled acts centre on communicating a diagnosis and prescribing. RNs are currently not authorized to diagnose or prescribe, but they administer medications that are prescribed by a physician or NP. RNs can also administer medications under medical directives or standing orders that originate with a physician or NP.

2. Competencies of RNs vs NPs

Both RNs and NPs in Ontario must meet established competencies in order to be safe to practice. For RNs, these competencies are outlined in the College of Nurses of Ontario, “Competencies for Entry-Level Registered Nurse Practice.”¹ For NPs the competencies are outlined in the Canadian Nurses Association, “Canadian Nurse Practitioner: Core Competency Framework.”²

The chart below provides a sample of competencies for RNs and NPs from the documents noted above, competencies that can be seen to be somewhat parallel for the two categories of nurse, in order to show the differences in focus between the two.

<table>
<thead>
<tr>
<th>RN Competencies</th>
<th>NP Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>26. Demonstrates a body of knowledge in the health sciences, including anatomy, physiology, pathophysiology, psychopathology, pharmacology, microbiology, epidemiology, genetics, immunology and nutrition.</td>
<td>1.4 Incorporates knowledge of developmental and life stages, pathophysiology, psychopathology, epidemiology, environmental exposure, infectious diseases, behavioural sciences, demographics and family processes when performing health assessments, making diagnoses and providing overall therapeutic management.</td>
</tr>
</tbody>
</table>

¹ [https://www.cno.org/globalassets/docs/reg/41037_entrytopracitic_final.pdf](https://www.cno.org/globalassets/docs/reg/41037_entrytopracitic_final.pdf)
<table>
<thead>
<tr>
<th>RN Competencies</th>
<th>NP Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>38. In collaboration with the client, conducts an assessment of physical,</td>
<td>2.1 Performs a focused health assessment and/or an advanced comprehensive health</td>
</tr>
<tr>
<td>emotional, spiritual, cognitive, developmental, environmental, social and</td>
<td>assessment, using and adapting assessment tools and techniques based on client</td>
</tr>
<tr>
<td>learning needs, including the client’s beliefs about health and wellness.</td>
<td>needs and relevance to client stage of life.</td>
</tr>
<tr>
<td>39. Collects information on client status using assessment skills such as</td>
<td>2.3 Performs a complete or focused physical examination, and identifies and</td>
</tr>
<tr>
<td>observation, interview, history taking, interpretation of data and physical</td>
<td>interprets normal and abnormal findings as appropriate to client presentation.</td>
</tr>
<tr>
<td>assessment, including inspection, palpation, auscultation and percussion.</td>
<td></td>
</tr>
<tr>
<td>40. Analyzes and interprets data obtained in client assessments to draw</td>
<td>2.5 Formulates differential diagnoses through the integration of client</td>
</tr>
<tr>
<td>conclusions about client health status.</td>
<td>information and evidence-informed practice</td>
</tr>
<tr>
<td>49. Anticipates potential health problems or issues for clients and their</td>
<td>2.6 Anticipates and diagnoses emergent, urgent and life-threatening situations.</td>
</tr>
<tr>
<td>consequences and initiates appropriate planning.</td>
<td>3.4 Initiates interventions for the purpose of stabilizing clients in emergent,</td>
</tr>
<tr>
<td>50. Collaborates with other health care team members to develop health care</td>
<td>urgent and life-threatening situations.</td>
</tr>
<tr>
<td>plans that promote continuity for clients as they receive conventional, social,</td>
<td>3.2 Explores therapeutic options, considering implications for clients through</td>
</tr>
<tr>
<td>complementary and alternative health care.</td>
<td>the integration of client information and evidence-informed practice.</td>
</tr>
<tr>
<td>61. Performs therapeutic interventions safely (e.g., positioning, skin and</td>
<td>3.3 Determines care options and initiates therapeutic interventions in</td>
</tr>
<tr>
<td>wound care, management of intravenous therapy and drainage tubes, and</td>
<td>collaboration with clients, while considering client perspectives, feasibility</td>
</tr>
<tr>
<td>psychosocial interaction).</td>
<td>and best outcomes.</td>
</tr>
<tr>
<td>62. Implements safe and evidence-informed medication practices.</td>
<td>3.9 Prescribes pharmacotherapy based on the client’s health history, disease,</td>
</tr>
<tr>
<td>70. Utilizes a critical inquiry process to continuously monitor the</td>
<td>disorder, condition and stage of life, and individual circumstances.</td>
</tr>
<tr>
<td>effectiveness of client care.</td>
<td>3.10 Applies knowledge of pharmacotherapy and evidence-informed practice in</td>
</tr>
<tr>
<td></td>
<td>prescribing, monitoring and dispensing drugs.</td>
</tr>
<tr>
<td></td>
<td>3.16 Collaborates with clients in monitoring their response to therapeutic</td>
</tr>
<tr>
<td></td>
<td>interventions and in adjusting interventions, as needed.</td>
</tr>
</tbody>
</table>

As can be seen, the RN entry-to-practice competencies reflect the more limited scope of the RN role, whilst for NPs the competencies are often identified in the
relation to the authorized acts of diagnosing and prescribing and the greater autonomy of the role in relation to these authorized acts.

**Differential Diagnosis**

The ability to formulate a differential diagnosis, identified as competency # 2.5 in the chart above, is a fundamental part of prescribing competency. This is the ability to apply clinical reasoning to distinguish a particular mechanism of disease or condition from others that present with similar symptoms. The ability to take a clinical history, perform a physical examination and formulate a differential diagnosis is critical in determining the need for laboratory and diagnostic tests which will serve to rule in or rule out a diagnosis. Determination of therapeutic treatment options for a patient is comprised of complex, interdependent advance practice clinical skill sets. An example of development of simple to complex diagnostic reasoning skills is demonstrated by the clinical skill sets needed to assess a healthy young adult presenting with an upper respiratory infection (URTI) in an acute situation versus the advanced clinical reasoning competencies required to assess a patient with multiple health issues, chronic illnesses and treatments, but presenting with an URTI. The clinician must have the ability to assess how different and chronic health problems can interact with each other to produce symptoms, and how drugs may interact with each other to produce side, masked, additive or cumulative effects that can look like symptoms. Differential diagnosis is a complex set of skills that requires both advanced education and clinical practice, as noted below.

### 3. Education of RNs vs NPs

As outlined in the chart below, RNs in Ontario currently require a university baccalaureate degree as part of the requirements for entry-level practice, while NPs undertake a two year Master’s degree that incorporates NP specific courses, or a one year post-Master’s diploma made up of NP-specific courses.

<table>
<thead>
<tr>
<th>RN Education</th>
<th>NP Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canadian baccalaureate nursing degree or equivalent (4 years, or 2 year second entry)</td>
<td>Canadian (or equivalent) Baccalaureate nursing degree</td>
</tr>
<tr>
<td></td>
<td>+ 2 years full-time clinical practice</td>
</tr>
<tr>
<td></td>
<td>+ 2 year Master’s degree including one year of NP specific courses OR a 1 year post-Master’s Diploma within an NP specialty area--Primary Health Care, Adult, Pediatrics, or Anaesthesia.</td>
</tr>
</tbody>
</table>
In addition to the Master’s degree or post-Master’s diploma, NPs must have worked two years full-time in RN clinical practice in order to qualify for entry to an NP education program.

The two year Master’s NP program consists in foundational nursing courses for advanced nursing practice, which generally includes theory, research methods, and evidence-based practice. This education is critical in ensuring the nurse practitioner is prepared for the autonomy and broad-based responsibilities of the role.

As well, the programs include NP-specific courses in pathophysiology, roles and responsibilities, advanced health assessment and diagnosis, therapeutics, and integrated practicum, all within the clinical area of specialty. Clinical experiences are integrated throughout these courses. The one year post-Master’s diploma consists only in the NP specific courses within the specialty area, since the candidate already has the foundational Master’s competencies.

The curriculum mapping document for the COUPN Primary Health Care Nurse Practitioner Consortium program, the largest NP program in Ontario and Canada, identifies the following learning outcomes for the NP courses that are clearly relevant to diagnosis and prescribing:

- Application of diagnostic reasoning frameworks to advanced interviewing and history-taking skills;
- The ability to select and interpret diagnostic and screening tests in the advanced practice role for specific populations;
- Synthesis of knowledge of the pathophysiology of principle systemic disorders;
- Synthesis of evidence to evaluate current best standards of practice; and
- Synthesis and integration of the knowledge of research, theory, philosophy, ethics, clinical care, education, and leadership to provide primary health care to diverse populations across the lifespan.

Overall, the courses and the learning outcomes for the NP programs show that they are highly targeted at developing the knowledge, skills and abilities related to clinical reasoning, diagnosis, treatment planning and prescribing within the specialty area.

Most students who pursue the RN educational pathway take a four year baccalaureate degree in nursing science. There are also some “second entry” programs that take students who already have a university degree or some foundational university courses that contribute towards the achievement of the BScN. These latter programs are two years in length. Some universities also

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3 The COUPN PHCNP Consortium program involves seven NP specific courses. Other NP programs at McMaster and University of Toronto may vary slightly, depending on the specialty and program, but tend to cover pathophysiology, advanced health assessment and diagnosis, and therapeutics.
offer “compressed” routes where students take the four year program but can continue through the summer and graduate in fewer than four years. In addition, RPN to BScN routes are three year bridging transitions that enable Registered Practical Nurses to become RNs.

Besides the difference in length of education and clinical experience, there is difference in degree of specialization between RNs and NPs. NPs pursue their studies in a specialized area—primary care for all ages, adult, children's or anesthesia. RNs, on the contrary, are educated as generalists so that, upon graduation, they could take up employment: across patient populations—from maternal newborn to older adults; across care settings—acute, community, primary, and long-term care; and across types of care—therapeutic, supportive, rehabilitative, palliative, and preventive.

4. Additional education and training recommended for safe prescribing by RNs

The government literature review provided by HPRAC as background for the consultations on RN prescribing outlines three categories of RN prescribing, based on an analysis of RN practice in various jurisdictions other than Canada. The definitions of these categories are quoted below from the literature review:

1. Independent Prescribing – In this model a nurse may prescribe medications, from a limited or pre-defined formulary, within a regulated scope of practice.

2. Supplementary Prescribing – This model involves a patient-specific partnership between a physician and RN, where after initial diagnosis by the physician and with the patient’s agreement, a nurse may prescribe medication from a limited formulary.

3. Use of Protocols – In this model, multi-disciplinary teams develop written instructions which allow RNs to supply and administer medications within the terms of the predetermined protocol.

The definition of “independent prescribing” in the literature review, because it did not review prescribing practice in Canadian jurisdictions, does not capture the current authority of NP prescribing in Canada, which is significantly broader. NPs are not restricted to a pre-existing formulary or list in their prescribing, and they are also able to prescribe controlled drugs and substances. It is important that the NP authority be reflected in the analysis and recommendations by HPRAC.

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5 The federal Controlled Drugs and Substances Act names NPs as authorized prescribers, but provinces must pass accompanying legislation and standards to enable this authority to come into effect. All provinces to date have implemented, or are implementing this enabling regulation, with the exception of Ontario.
In order to correct for this limitation in the framework of analysis offered by the government literature review, we have added an additional “independent” category that reflects the NP authority in Canada.

<table>
<thead>
<tr>
<th>Category of Prescribing authority</th>
<th>Education and training recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Independent prescribing (NPs)</strong></td>
<td>NP education, including:</td>
</tr>
</tbody>
</table>
| • Broader prescribing authority and includes controlled drugs and substances | • 2 years of Master’s level courses that include pathophysiology, advanced health assessment and diagnosis, therapeutics and integrated practicum within the specialty area; and  
• clinical experience within the specialty area |
| "Independent prescribing" (from a limited formulary) within a scope of practice | NP education (as above) |
| • Includes authority to diagnose | |
| **Supplementary** | RN education plus: |
| • Does not include authority to diagnose | • Master’s-level courses in pathophysiology, advanced health assessment and diagnosis, and therapeutics; and  
• 2 to 3 years of practice with the client population |
Use of protocols

RN education:
- Protocols in the form of medical and NP directives; standing orders; standardized order sets; “as needed” medications (e.g. for pain); sliding medication scales (e.g. heparin and insulin) verbal medical orders; care maps; the situation, background, assessment, recommendation (SBAR); communication tools; and so on are already in use by RNs for administering medication and are within the competencies of all RNs; and
- Use of protocols needs some experience in the clinical area.

As the chart above shows, COUPN and CAATs are recommending NP education and training for the more limited “independent prescribing” outlined in the government literature review.

For “supplementary” RN prescribing, COUPN and CAATs are recommending two to three years of practice with the client population or in the specialty clinical area, in addition to Master’s-level courses in pathophysiology, advanced health assessment and diagnosis, and therapeutics. These courses are part of NP training and specifically focus on developing the competencies surrounding mechanisms of disease, history taking, physical assessment, pharmacological and non-pharmacological therapies.

The recommendation above for the education related to supplementary RN prescribing is based on a project that the COUPN Primary Health Care Consortium engaged in several years ago in relation to outpost RNs. From 2011 to 2013, the First Nations Inuit Health Branch (FNIHB) collaborated with the COUPN Primary Health Care NP program to enhance educational preparation for outpost RNs. The RNs took three of the NP courses—in pathophysiology, advanced health assessment and diagnosis, and therapeutics—in order to develop their competencies in theoretical knowledge and mechanisms of disease, history taking and physical assessment. This could be seen as a kind of “NP-lite” education, because it does not involve the foundational Master’s-level courses in theory, research, and evidence-informed practice, or the full suite of NP courses.

5. Competencies required for safe independent prescribing

The competencies required for both categories of independent prescribing outlined in the chart above include:
Diagnostic reasoning.
Differential diagnosis.
Formulation and initiation of a treatment plan, including non-pharmacological and pharmacological treatment.
Knowledge, critical analysis, and communication skills surrounding the above competencies.

These are competencies of NPs and thus require the full NP education.

6. Competencies required for safe supplementary prescribing

Supplemental prescribing requires knowledge and clinical reasoning in relation to a particular client population, such as those with diabetes. This is gained through clinical practice in the RN role with this client population. The prescribing aspect of this role also requires:

- Knowledge of pathophysiology;
- Advanced health assessment and diagnosis;
- Knowledge of pharmaco-therapeutics.

As described above, because the RN is not diagnosing, but working within an established physician diagnosis, a more limited set of NP courses related to assessment, diagnosis and therapeutics would facilitate the achievement of the competencies necessary for this category of prescribing.

7. Competencies required for safe use of protocols

This involves:

- Knowledge of and familiarity with the client population;
- Ability to safely administer therapies and medications;
- Clear understanding of accountability and responsibility related to medication prescribing and administration;
- Understanding of the role of the health care team to consult as required.

The last three of these are acquired through RN education; the first would require some experience within a clinical area.

Other Considerations Related to RN Prescribing and Education

1. Physician prescribing

Physicians are the main prescribing group in Ontario’s healthcare system. Hence it is useful to look at their educational pathway towards safe prescribing.

Medical students have four years of undergraduate MD education (with at least two years of undergraduate before admission) and may start to
prescribe under strict supervision of the most responsible physician in their last two years. They start independent prescribing only in their post-graduate residency period, under supervision, gradually becoming more independent as the residency progresses. Minimally, they have six years of education before they are fully independent prescribers—the same length of time as Nurse Practitioners.

2. NP and RN Prescribing Internationally

The government literature review shows that RN independent prescribers have largely developed in jurisdictions such as Ireland, the UK and Sweden where the Nurse Practitioner (NP) role has not been developed. An exception to this is New Zealand, which has both the NP model and a newly developing model of RN independent prescribing within certain specialty areas. Training for this latter involves three years practice experience and a postgraduate diploma in prescribing plus a supervised practicum. Conditions involve working in an interdisciplinary team and prescribing from a very limited formulary (e.g., 26 diabetes drugs).

3. Evaluation data on RN and NP prescribing

Recently some articles have been published on Canadian NP prescribing patterns in Canada.\(^6\) We do not, however, yet have evaluation data on NP prescribing in Canada since this authority was expanded in 2011.

The evaluation data on RN prescribing in the government literature review on evaluation of RN prescribing notes the following:

- Very little information was identified which explicitly examined RN prescribing; most literature identified examined ‘nurse’ prescribing in general or considered nurses within the broader category of ‘non-medical prescribers’.
- Research literature on nurse prescribing is very limited. Further, little information was identified regarding the impact of nurse prescribing on patient outcomes.

RNAO's proposal for education related to RN prescribing

The Registered Nurses Association of Ontario (RNAO) has identified that RNs would need 300 hours of additional education in order safely to undertake RN prescribing, and that this would prepare RNs for prescribing in the independent category. RNAO proposes that this education should initially be offered as post-graduate education, but

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that by 2020 it should be integrated into the baccalaureate programs, so that all graduates receive this content prior to entering into practice as RNs.\(^7\)

COUPN and CAATs have identified above that an abbreviated model of NP prescribing education, such as was offered to outpost nurses through the First Nations and Inuit Health Branch project, would be appropriate for supplemental prescribing, but not for independent prescribing. In addition, we have identified that such prescribing authority would require significant clinical experience in the area in which the prescribing will occur, in order to develop the knowledge and clinical reasoning skills. Such prescribing authority is not appropriate at the entry-to-practice level.

As already mentioned, RNs are educated to be generalists, and must have a broad range of knowledge and practice experience so that they could safely take up employment as an RN in any part of the health-care system, with any kind of health population. This very general scope of RN practice at the entry-to-practice level means that:

- educators must fit a lot of content into the baccalaureate nursing programs; and
- new RNs generally need a period of internship after graduation to be comfortable in a particular practice setting.\(^8\)

Newly graduated RNs need a period of time in clinical practice in order to become proficient and confident, before they should undertake the education required for prescribing. NPs also require two years in full-time RN practice before they can be admitted to the NP program. Neither independent nor supplemental prescribing can be integrated into RN entry-to-practice education. Furthermore, no country identified in the literature review provides diagnostic and prescribing education at the RN entry-to-practice level.

COUPN and CAATs agree that education related to RN prescribing should be offered as post-graduate education, and that extensive dialogue amongst government, the regulator, educators, associations, unions, employers, and other relevant stakeholders would be required before any decision could be made regarding integrating diagnosis and prescribing into RN entry-to-practice education.

**COUPN and CAATs Position on RN Prescribing**

Given the limitations in the evaluation surrounding both NP and RN prescribing, and the broader educational requirements to develop the competencies related to prescribing, COUPN and CAATs recommend a cautious approach to RN prescribing in Canada,


\(^8\) Currently a majority of RNs qualify for employment through MOHLTC’s New Graduate Guarantee (NGG), which provides funds to the employer in order to integrate the new RN into a full-time position for up to six months in a supernumerary capacity. This means that the new RN receives the support and mentorship they need in order to integrate into a particular RN role and setting successfully. The NGG has the support of all nursing employers as it is seen to be a critical aspect of RN integration into the workforce.
looking at the supplemental model initially and evaluating after experience with this model.

An alternate approach to expanding patient access to prescribers is to expand the number of funded seats for NPs in Ontario. Currently, the COUPN Primary Health Care NP program is capped by Ministry of Health and Long-Term Care at 200 admissions per year. Additionally, the cap on the number of NPs in nurse-practitioner-led clinics could be increased, so that more patients could be accommodated.

Expanding prescribing authority in Ontario also needs to be looked at in terms of broader healthy lifestyle approaches to patient care. Health care providers who spend more time assessing underlying causes of symptoms can propose non-pharmacological approaches to care (e.g., diet and decreased salt intake to moderate hypertension). While evidence from the US shows that prescribing patterns are similar between NPs and physicians, it also shows that Nurse practitioners tended to prescribe more over-the-counter medications and recommend more non-pharmacological treatments to patients.9

Another way of expanding access to prescribers in Ontario is to speed up the process to enable NPs to prescribe controlled drugs and substances. As mentioned above, in 2012 the federal government added NPs as authorized practitioners under the Controlled Drugs and Substances Act, but Ontario has not moved to develop the regulatory tools to legally authorize such prescribing. Facilitation of NP prescribing of controlled drugs and substances in Ontario would enhance patient access to prescription renewal, particularly for pain medications.

COUPN encourages HPRAC to consider the above points in the context of patient access to prescribing.

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January 8, 2016

Mr. Thomas Corcoran  
Chair  
Health Professions Regulatory Advisory Council  
56 Wellesley St. W  
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Toronto, Ontario  
M5S 2S3

Dear Mr. Corcoran:

Thank you for the opportunity to present a written submission regarding prescription models for registered nurse prescribers (RN Prescriber) working in First Nations Communities to the Health Professions Regulatory Advisory Committee (HPRAC). Within the First Nations and Inuit Health Branch, Ontario Region (FNIHB-OR) context, an independent model of prescribing within targeted disease entities or disease clusters is seen to best support clients and inter-professional health teams.

First Nations and Inuit Health Branch Ontario Nursing Context
FNIHB-OR serves 133 First Nation communities, of which 34% are geographically remote and isolated. Nurses deliver primary health care and home care services through nursing stations (remote and isolated settings), health centres with treatment (semi-isolated), and health centres (non-isolated). Services are provided by approximately 360 nurses.

Some challenges of working in these remote and isolated communities include retention and recruitment of qualified RNs, as well as nurse practitioners (NPs) and registered practical nurses (RPNs). Although FNIHB-OR is not responsible for physician services, the recruitment of this valuable resource also presents challenges in these geographic areas. The nurses work in complex and complicated environments involving three health care systems - First Nations, Provincial and Federal. Clients 'move' between these systems to obtain care. Within these environments, nurses often provide the initial (and consistent) client contact with the health care system. The RNs work within an interdisciplinary health team including other regulated professionals such as RPNs, NPs and physicians, and non-regulated providers such as program community-based workers, community health representatives and personal service workers. Programs and services include: chronic disease and health promotion; primary care; public health, including communicable disease and health emergency, and environmental health; home and community care; non-insured health benefits; and the policy development and partnerships to support positive client health outcomes. The priority areas, within this context, include chronic disease management and prevention, infectious disease and infection control, and mental health and addictions support.

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1 Remote isolated: no scheduled flights, minimal telephone or radio services, no road access. Isolated: scheduled flights, good telephone services, no year around road access.

2 Semi-isolated: road access greater than 90 km to physician services.

3 Non-isolated: road access less than 90 km to physician services.
Examples of some of the tools that nurses use to support their work include: medical directives to guide public health activities; FNIHB Clinical Practice Guidelines for Nurses in Primary Care; FNIHB Pediatric Clinical Practice Guidelines for Nurses in Primary Care; FNIHB Nursing Drug Classification System and Drug Formulary; and the FNIHB Policy and Procedures on Controlled Substances for First Nations Health Facilities.

Registered nurse prescribing has the potential to address a significant challenge within our environment. Requirements and tools to support care and respond to the health needs of individuals living in First Nation communities are evolving and becoming more complex but the RN scope of practice remains static. Supporting the 'right care by the right provider at the right time' is essential to enhancing access to care. RN prescribers working within a collaborative care team, as an independent RN prescriber, will contribute significantly to this goal.

**Independent RN Prescribers**

RN prescribing models in other jurisdictions acknowledge that the ability to order diagnostic tests and make a medical diagnosis are prerequisites for RN prescribing. It is our assumption that the selected model in Ontario would incorporate these dependencies into relevant legislation updates. The depth and breadth of nursing practice within the FNIHB-OR context is significant. Nurses are often the first point of contact between the client and health care system and must use all of their professional and educational resources to ensure that clients access appropriate care. Working within targeted priority areas, the RN prescriber could ensure timely access to care, significantly contribute to the collective knowledge and practice base of the interprofessional team, and ultimately facilitate a client centred approach to care. It should be noted that nurses with defined clinical and client care expertise (e.g., certified diabetes educators, certified asthma educators, wound care specialists) are successfully fulfilling many of the competencies required to safely and accurately prescribe. The regulation of RN Prescribers would clarify expectations and competencies for both providers and the public and offer consistency within and across employers and organizations.

The risk of harm, as with the overall scope of practice, is mitigated by education and a demonstration that learning has occurred and is maintained. This demonstration can be, for example, in the form of registration or certification examinations, successful completion of a designated number of clinical hours, completion of a prescribed number of continuing professional development hours, peer reviews or a combination thereof. Multiple avenues already exist for professionally recognized certification, for example: Canadian Network for Respiratory Care⁴ (Certified Asthma Educator, Certified Respiratory Educator); Canadian Diabetes Educator Certification Board⁵ (Certified Diabetes Educator); and the Canadian Nurses Association⁶ (which provides certification in over 20 specialties including psychiatry and mental health nursing, rehabilitation nursing, enterostomal therapy nursing, emergency nursing and hospice palliative care nursing). In the FNIHB-OR context, the RN prescriber working under an independent prescribing model, but within a particular clinical domain, could significantly contribute to positive health outcomes in the following areas.

**Public Health**

RNrs who prescribe immunizations within the publicly funded schedule would enhance access to this service. Currently within FNIHB-OR, immunization is offered under an organizational medical directive. These directives are issued by a FNIHB-OR employed physician. Because there are persistent staffing

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⁴ See http://cnrchome.net/whatitis.html
⁵ See http://www.cdecb.ca/
⁶ See https://nurseone.ca/en/certification/what-is-certification/competencies-per-specialty-area
challenges, medical directives may become invalid, resulting in delays in access to immunization particularly in isolated and remote communities. RN prescribers working within an interprofessional team and who have proven competencies to prescribe immunizations could potentially increase access to vaccines, decrease the incidence of vaccine preventable diseases, and through regulation, assure the public and employers that their professional service expectations are being met.

Well care of infants and children provides another opportunity for RN prescribers. In addition to completing an age appropriate health assessment and administering immunizations, the ability to prescribe vitamin D, for example, or to access appropriate point of care testing (e.g., hemoglobin or complete blood count) and prescribe ferrous sulfate at the time of the mother/baby clinical visit could support appropriate follow-up and positive health outcomes.

Other examples include the treatment and control of communicable infections. Currently, within the FNIHB-OR the RN adheres to specific medical directives to screen and treat communicable infections. These nurses have the competency to do this work within both a public health and primary care environment; however, given the persistent turnover of medical personnel and the often extended vacancies of these positions, the validity of the medical directive is frequently nullified. With each new physician, the directives must be reviewed, re-signed and re-issued. In addition to this administrative burden, from a regulatory perspective it is becoming more challenging to develop and issue these medical directives; thereby, potentially delaying treatment, risking complications and the spread of infection.

**Chronic Disease Management and Prevention**

The Certified Diabetes Educator (CDE) and the Certified Asthma Educator (CAE) are current models upon which an RN prescriber practice could be built. The nurses who have obtained these certifications have, in addition to their nursing competencies, developed advanced skills in these respective disease domains. These skills in combination with the client-nurse therapeutic relationship are instrumental to increasing access to quality client-centred care, benefiting both the client and the health care system. For example, in Canada the reported average cost for treating a moderate Chronic Obstructive Pulmonary Disease (COPD) exacerbation is $641; for a major exacerbation, the cost is $10,086. In the case of respiratory disease, RN prescribers could be significantly impactful prescribing and closely monitoring interventions, such as nicotine replacement products, exercise, inhaled corticosteroids and bronchodilators. With an estimated 8.3% of the Ontario population diagnosed with either Type 1 or Type 2 diabetes in 2010 and the number expected to increase to 11.9% (with an economic burden of $6.9 billion) by 2020, the positive contributions of a RN prescriber increasing access to care within this disease domain could be significant. Working collaboratively with other providers, these RN prescribers could make immediate treatment changes that positively impact client outcomes, for example, avoiding or delaying hospitalization.

Wound care presents another important area in which RN prescribers could affect positive client outcomes. Within FNIHB-OR there is a unique role of 'nurse authorizer'. The nurse authorizers have the authority, within the organization, to order client-specific wound supplies from a pre-approved supply list (formulary) when a general treatment order from a physician or NP is provided. The nurse authorizers work in collaboration with the local health care team including physicians, NPs and other

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RNs to bring this important component of care to the client's home and facilitate positive health outcomes. This role represents an organizational solution to the challenges presented when practicing in a unique environment. These nurses have accrued a level of expertise, judgment and skill that may not be recognized outside of their current organization. Recognizing these competencies from a regulatory perspective and including the ability of the RN to prescribe brings additional and non-organizational dependent transparency to the role of wound care specialists, and assures the public of the provider's knowledge, skills and abilities. These RN prescribers would be able to access the appropriate laboratory tests and initiate therapy in a timely manner without external dependencies (e.g., physician not available to visit, physician clinic schedule full, NP not available, planes cannot leave or arrive in community because of inclement weather).

RN prescribers, within the domain of mental health and addictions, would also assist populations in remote, isolated and semi-isolated areas. Applying the competencies required to assess, diagnose, design and implement a treatment plan within this practice domain that is starved of accessible human resources would be beneficial. Working within an inter-professional team, the RN prescriber would not only increase access to mental health services, but through a holistic nursing approach, promote mental health as more than the absence of mental illness.

In Ireland\textsuperscript{9} and the United Kingdom\textsuperscript{10}, RN prescribers have been met positively by the public, supporting efficiencies and bringing nurses' knowledge, skills and abilities to the forefront. Within our Canadian context, there are other examples of RN prescriber models\textsuperscript{11,12} that focus on specific geographic areas, or diseases and conditions, all of which limit prescribing to a regulated list, and access to laboratory/diagnostic testing to restricted investigations. Within the FNIHB-OR nursing context, the health care system would benefit most from a disease or disease cluster orientation but with the authority to prescribe independently and to access the laboratory and diagnostic investigations that would support this authority within the designated domain. Restrictive lists become barriers to care when their review and revisions become out of step with the rapid advancement of best practice.

Summary

The competencies required to fulfill the activities of an RN prescriber are present to a significant degree in the current regulated scope of practice as demonstrated by the nurse being a member of the regulated college. Additional education (initial and ongoing) would be needed in the area of pharmacotherapeutics and health assessment, including appropriate use of diagnostics. The intent is not to introduce another solo practitioner but to integrate an expanded skill set into an intra and interprofessional health care team to increase its efficiency and increase client access to care. RN prescribers will have the knowledge, skill and ability to carry out the responsibilities of the role. Approaching this role from a regulated perspective will assure the public and other professionals that there is a consistent level of education and that the education requirements have been met. This offers more assurance than the variation present in today's system. The education institutions have a significant responsibility in this endeavour. Employers would have a responsibility to critically examine how this 'new' provider could better serve their constituents through new or revised policies. Delayed

\textsuperscript{11} Ordre des infirmières et infirmiers du Québec, See \url{https://www.oiiq.org/pratique-infirmiere/prescription-infirmiere/activites-visees} (December 29, 2015).
\textsuperscript{12} College of Registered Nurses of Manitoba, See \url{https://www.crnmb.ca/about/registered-nursing/registered-nurse-authorized-prescriber} (December 29, 2015)
treatment can result in increased morbidity and mortality, negative impacts on social determinants of health and disability adjusted life years. With the introduction of the provincial quality improvement standards, it is anticipated that client transportation costs will rise, as will the practice expectations placed on community health care providers. Clients are returning home to the community with more complex needs. These clients are requiring access to an interprofessional health care team that includes physicians, NPs, RNs, RN prescribers and others. This is critically important in an environment of staff shortages and persistent staff turnover. Success is dependent on clear, efficient and timely communication between providers and clients, and a mutual understanding of roles and responsibilities working toward a client-centered model of care.

Thank you for the opportunity to contribute to this important consultation.

Sincerely,

Shari Glenn, NP(PHC), MScN, MA
Director of Nursing
First Nations and Inuit Health Branch, Ontario Region
Presentation to the Health Professions Regulatory Advisory Council
Registered Nurse Prescribing January 14, 2016

Who are we?

ISMP Canada is an independent, not-for-profit organization. We collect reports about medication incidents from health professionals and consumers. By reviewing incident reports, we often identify system issues that can increase the chances of harmful errors occurring. This helps us to suggest safer ways to prescribe, package, dispense or give medication. ISMP Canada's recommendations have informed more than 50 medication management standards and required organizational practices for hospital accreditation and have also informed professional standards of practice.

Our recommendation:

We support nurse prescribing in Ontario. Access to needed medications can bring benefits to the health of Ontarians and safety can be designed into the system.

We recommend a Prescribing Model that includes:

- a defined list of medications;
- a select list of conditions for which nurses can prescribe;
- defined clinical decision supports readily available (e.g. treatment algorithms);
- a collaborative inter-disciplinary working environment that supports nurse assessment and prescribing authority (e.g. family health team);
- defined requirements for assessing competency

Prescribing comes with inherent risks, and there are steps that can be taken to reduce the risks in developing the optimal model for RN prescribing. We offer the following discussion of challenges and strategies to reduce the likelihood of associated errors. Appendix 1 provides additional supporting information.

What is needed for safe prescribing?

The prescriber must have:

- the necessary skills and competency
- knowledge of the condition being treated
- knowledge of non-pharmacological options
- knowledge of the medications
- knowledge of the patient
  - Symptoms
  - Current and pre-existing health conditions, including medication allergies
  - Comprehensive medication history
A key challenge for prescribers is weighing the balance of risk (potential harm) and benefits inherent in any medication. The number of medications on the market increases the complexity of prescribing. Prescribing becomes even more challenging when a person has more than one medical condition and/or the person is taking several medications.

Ultimately, we need to ensure that prescribers, together with patients and other health professionals involved in the care of the patient, have enough information to make educated decisions about medication treatment.

**What specific measures can we put in place to make RN prescribing safer?**

Systems must be proactively designed to support safe prescribing.

Specific safety measures include:

- Point-of-care access to patient information and drug information.
- Clinical decision support tools that embed key considerations and procedures for prescribing. Some clinical decision support tools (e.g. algorithms) can be paper-based and ideally, decision supports are components of electronic systems. Clinical decision support can:
  - provide prompts and information to verify that the medication is being used for an appropriate indication;
  - check for contraindications, drug allergies, drug-disease interactions and drug-drug interactions;
  - guide dosing based on patient's kidney function, liver function, age and weight.
  - help ensure that the minimal effective dose is provided, and maximum daily dose communicated.
  - help ensure adequate monitoring (e.g. lab tests, follow-up visits).
  - limit duration of use of certain medications (e.g. antibiotics and opioids) and guide the proper quantity to be prescribed/dispensed.
  - suggest non-pharmacologic options for disease management.
  - build in reminders for patient counselling (e.g., side effects to monitor)

Clinical decision support tools can be made available to other healthcare team members involved in the circle of care of the patient. These tools should be evidence-based yet also allow flexibility in the care of individual patients.

- Electronic order entry systems prevent errors associated with illegible hand-writing, prevent the use of dangerous dose designations or abbreviations, and provide high leverage safeguards such as allergy and drug interaction checking.
- A system for initial and continuing competency assessment should be in place to avoid wide variations in competencies.
- Education pertaining to prescribing should be non-commercial based. However, note that education is a lower leverage system safeguard in terms of designing systems for clinical decision support - i.e., relying on human memory at the point of care can be very difficult.
• Processes designed to ensure communication with other healthcare professionals involved in the care of the patient provide safety checks and help prevent fragmentation of patient care.

How will we know that the system is safe?

Evaluation of prescribing is critical. ISMP Canada uses reporting and surveillance to analyze medication incidents and to develop strategies for safety. Our organization leads the Canadian Medication Incident Reporting and Prevention System (CMIRPS), a program that collects and analyzes incident reports and shares learning from incidents through safety bulletins and informs standards development. We cannot overstate the value of this surveillance and the opportunity that monitoring actual and potential errors and adverse events can contribute to evaluation efforts. Our experience shows that reporters tend to report the severe and unexpected cases of harm from medications, and this helps to detect new signals. Analysis and investigation of causes must occur so that strategies for improvement and prevention of future events may be identified and implemented.

Attachment: Appendix I: What has ISMP Canada learned about safe prescribing through analysis of incident reports?

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Appendix I: What has ISMP Canada learned about safe prescribing through analysis of incident reports?

Prescribing errors are common, and can cause harm or even death. Of 92 harmful incidents reported to the Ontario Critical Incident Reporting Program between Oct 2011 and Dec 2014, 18 incidents (20%) were associated with prescribing. Of these, 16 resulted in harm and 2 resulted in death. It is important to note that these incidents occurred in hospitals where systems and safeguards to prevent prescribing errors typically exist.

Many types of incidents can occur during the prescribing process. For example:

- The patient may receive:
  - The wrong medication (or a medicine that is not the best choice for that person).
  - The wrong dose.
  - A medication to which he/she has a known allergy.
  - A medication that interacts with another medication that the person is taking.
  - The right medication and dose but at the wrong time/frequency/schedule.

- The patient may receive a medication that is not needed (over-prescribing or therapeutic duplication).
- The patient may not receive a needed medication.

Some drugs are more likely than others to cause harm when a mistake occurs. Medication errors can occur with any drug and in any setting, but certain medications are more likely to cause significant harm when a mistake occurs. These medications are called "high alert" medications. Examples include anticoagulants, opioids and antidiabetic agents. All prescribers need to be aware of high alert medications. Additional tools or protocols may be needed in order to ensure safe prescribing of high alert medications. The ISMP List of High-Alert Medications in Acute Care Settings is available at https://www.ismp.org/tools/institutionalhighAlert.asp; and the ISMP List of High-Alert Medications in Community/Ambulatory Healthcare is available at https://www.ismp.org/communityRx/tools/ambulatoryhighalert.asp.

Drug names that look alike or sound alike can increase the chances of an error occurring. The risk of this type of mix-up causing harm to a patient increases if handwritten orders are not legible, if typical doses for the medications overlap, or if the indication for the drug is not known by the persons dispensing or administering the drug. The ISMP's List of Confused Drug Names is available at https://www.ismp.org/tools/confuseddrugnames.pdf.

- For specific examples of errors during the prescribing process, refer to Appendix I. "Results from the ISMP Canada Knowledge Mobilization Tool (KMT)" (an internal program used to search published ISMP Canada Safety Bulletins for incidents related to prescribing errors).

Over-prescribing is an important issue. We are a society that is quick to reach for medications and not as quick to consider non-pharmacological solutions (e.g. diet, exercise and relaxation). Communications from the pharmaceutical industry are extensive and effective.

- According to the U.S. Centers for Disease Control and Prevention, the excessive prescribing of opioid analgesics is fuelling an epidemic of addiction and death.
- Over-prescribing of antibiotics has led to antimicrobial resistance.
- Over-prescribing of psychotropics has led to medication-related falls.
- Perverse incentives to prescribe large quantities exist (e.g., to avoid dispensing fees).
- There are currently safety initiatives called "de-prescribing" and these efforts are designed to counter over-prescribing of medications. Further information regarding "de-prescribing" is available at http://www.open-pharmacy-research.ca/research-projects/emerging-services/deprescribing-guidelines.
January 22, 2016

Thomas Corcoran, ICD.D, MBA, B.Sc., P.Eng.
Chair, Health Professions Regulatory Advisory Council
56 Wellesley St W., 12th Floor
Toronto, Ontario, Canada
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Dear Mr. Thomas Corcoran:

Re: HPRAC Consultation on RN Prescribing Models

The Nurse Practitioners’ Association of Ontario (NPAO), the voice of 2,600 Nurse Practitioners in Ontario, welcomes the opportunity to provide its perspective on the Health Professions Regulatory Advisory Council’s (HPRAC’s) consultation directed by the Minister of Health and Long-Term Care regarding the three models proposed for RN prescribing.

We are pleased to participate in this important consultation, and delighted the Minister referred RN prescribing to HPRAC. We believe it is incumbent on us to point out some challenges and concerns we have related to the referral and the process. First, we believe that the timing of the referral (public as of December 14, 2015) and short timeframe for the consultation itself is troublesome, particularly as half of the consultation occurred over the holiday season. This may impact the number and potential thoroughness of the responses HPRAC receives. Second, the information provided to guide the consultation is very limited, and does not include the typical documentation associated with a referral of this nature (such as no jurisprudence review or jurisdictional review). No doubt this may be a result of the tight timelines imposed on HPRAC, but it may also impact the responses received. Further, while the literature review provided is welcome, it is, in our view, preliminary in nature and does not give stakeholders sufficient information regarding the models proposed, particularly in relation to patient safety, patient access and cost-effectiveness. We recognize that literature in the area is still emerging given the newness of the role in other jurisdictions and the impact that has on preparing the literature reviews.

Third, and perhaps more significantly, the question posed implies that the decision has already been made, that RNs (general class) will be in fact be granted the authority to prescribe under one of the three proposed models. The authority to prescribe is a significant change in the scope of practice of nursing in Ontario (and for that matter in Canada), and while we respect and acknowledge it is the Minister’s prerogative to refer
the matter in the manner he chooses [RHPA, 1991, S. 11 (2) (f) and S. 12 (1)], we believe the manner is which the question was posed may impact the advice received regarding whether RN prescribing should proceed at all.

Finally, the language used to describe the prescribing models is also somewhat unclear, particularly in terms of how the definitions, which appear to be primarily based on models used in the United Kingdom — a substantially different health care and regulatory system than Canada — are intended to be interpreted in the context of Ontario (i.e., the controlled acts under the Regulated Health Professions Act, 1991). This lack of clarity may impact the ability of respondents to be certain as to the meaning of each definition in terms of ultimate provider accountability and the controlled acts that the RN prescriber may be accessing, and therefore impact the advice provided by stakeholders regarding the most appropriate model.

Despite these limitations and concerns, NPAO asserts that independent RN prescribers already exist in Ontario: these RNs are Nurse Practitioners or Registered Nurses in the Extended Class [RN(ECs)] who have successfully completed a graduate educational program and meet and maintain rigorous registration requirements as set out by the College of Nurses of Ontario. To be an independent RN prescriber, the safest and most effective method is for the RN to become an NP. NPAO also believes that there are many other ways to increase public access to timely and safe care including enhancing the use of protocols, a tool that already exists in Ontario, and through a very limited use of a supplementary RN prescribing model. Details outlining NPAO’s perspective and advice regarding the RN prescribing models are found in the attached submission. Each of HPRAC’s Criteria for the RN Prescribing Referral have been integrated into NPAO’s response.

The government has made commitment to act in open and transparent way, and in accordance with that we look forward to the opportunity to review submissions of other organizations on the HPRAC public website as per typical protocol. In closing, if you require additional information or wish to discuss NPAO’s response, please do not hesitate to contact me. We would be happy to meet with HPRAC.

Regards,

Theresa Agnew
Executive Director, NPAO

c. Wendy McKay, President, NPAO
NPAO’s Submission to HPRAC Regarding RN Prescribing Models

Introduction

The Nurse Practitioners’ Association of Ontario (NPAO) is the professional voice of more than 2,600 Nurse Practitioners (NPs) in Ontario. Every Nurse Practitioner is a Registered Nurse. This response is based upon an extensive review of the literature completed by NPAO, reviews of the literature provided by HPRAC on Registered Nurse (RN) Prescribing, a survey of NPAO members, and consideration of other factors provided by the NPAO Board and staff. Our response relies on ongoing work and consultation on this issue undertaken over the past year, predating the current call for feedback. This HPRAC referral has specifically asked for consultation on the three models and recommendations for the one most appropriate for RN prescribing in Ontario, therefore the NPAO submission will primarily focus on the controlled act of prescribing. It will not discuss in any detail other controlled acts that may be involved in the models given the lack of information provided. We will also suggest modifications to the models proposed where appropriate.

This submission is organized in three parts. The first part states NPAO’s position on each of the three models. The second part draws on the extensive literature review conducted by NPAO and pre-existing knowledge of the issues, using HPRAC’s Criteria for the RN Prescribing Referral to categorize our literature research and observations. The third part includes NPAO’s conclusion and summary of recommendations.
PART 1 - NPAO’s Position on the Three RN Prescribing Models

1. RN Independent Prescriber

NPAO asserts that independent RN prescribers already exist in Ontario. These are Registered Nurses in the Extended Class [RN(ECs)], more commonly called Nurse Practitioners (NPs). NPs are graduate-prepared Registered Nurses, regulated since 1998 in the Extended Class by the College of Nurses of Ontario (CNO), and must meet rigorous requirements and standards to enter and maintain ongoing registration in Ontario. NPs independently, and in collaboration with health care professionals, provide health care services for all ages and across the health spectrum (e.g., primary care, acute care and long-term care). In Ontario, NPs are authorized to:

- Complete a comprehensive health history and assessment;
- Formulate and communicate a diagnosis, taking a differential diagnosis into consideration;
- Prescribe all medications except for controlled substances;
- Dispense, sell, and compound medications;
- Set and cast fractures and dislocated joints;
- Order and interpret all laboratory tests;
- Admit, treat and discharge patients from hospitals; and
- Order some diagnostic imaging tests (CNO, 2016).

Every province and territory regulates NPs and, while scope of practice continues to evolve, there is much consistency in regards to scope of practice, educational preparation at the graduate level, and regulation of the profession across the country (Spence, Agnew, & Fahey-Walsh, 2015).

To become an independent RN prescriber and to gain access and authority to autonomously and safely perform additional controlled acts such as communicating a diagnosis, prescribing medications, and ordering treatments and diagnostic tests, the RN must become an NP. To be eligible to become an NP in Ontario the RN must be a graduate of a four year Baccalaureate degree in Nursing and must have at least two years of full-time clinical practice experience (although the average is 17 years according to CRaNHR, 2012). This is followed by successful completion of a Master’s program. The Master’s program is two years (seven courses) and takes two full calendar years or 24 months to complete. The program includes courses in advanced health assessment, advanced pathophysiology, therapeutics, and roles and responsibilities, as well as 728 clinical practice hours in the primary health care NP program and 800 clinical hours in the Paediatric or Adult NP program. Courses are sequenced, coordinated and integrated so that each course builds on the previous one. For example, over the course of the

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1 NPAO noted an error on page 4 - footnote b of HPRAC's A Preliminary Literature Review of Registered Nurse Prescribing. It states “In Ontario, NPs are usually” RNs....” This is an inaccurate statement as NPs are always RNs.
program NP students develop increasingly complex sub-concepts and processes such as diagnostic reasoning, formulation of a differential diagnosis and treatment plan, and prescription. The completion of the course work and integrated clinical practicum leads to the final exam and Objective Structured Clinical Evaluation (OSCE). These final exams ensure that students have acquired the necessary knowledge and skills to be competent, safe and ethical NPs.

Following successful completion of the NP program, graduates are then eligible to write and must successfully complete the NP exam for the specialty area of practice, as designated by the College of Nurses (CNO), to become registered as an NP. To maintain registration, NPs are scrutinized through CNO’s rigorous quality assurance program that may include online tests, an Objective Structured Clinical Evaluation (OSCE) and/or a practice assessment (chart audit) (CNO, 2014a). This advanced education prepares the NP to develop a differential diagnosis, which is a critical component of prescribing knowledge, skill and judgment.

To become a Registered Nurse in the general class in Ontario as of 2005 the RN must be prepared at the Baccalaureate level. Unlike NPs, Baccalaureate-prepared nurses are prepared to safely administer medications, but not formulate a diagnosis or prescribe. Pharmacological knowledge is integrated throughout the four-year full-time program. Furthermore, the pharmacology content in the BScN program is not standardized throughout Ontario. The BScN education prepares the RN student to apply pharmacology knowledge and develop competencies in the safe administration of therapies and medications. The BScN RN is prepared as clinical knowledge, skill and judgment is gained through clinical experience to implement protocols or directives. It should also be noted that, prior to 2005, entry-to-practice in ON to become an RN was at the diploma level, a shorter and less comprehensive nursing education program.

NPs have demonstrated high levels of efficacy, safety and cost-effectiveness. No other group of health care professionals has been studied as much as NPs (Horrocks, Anderson, & Salisbury, 2002; Venning, Durie, Roland, et al., 2000; Stanik-Hutt, Newhouse, White, et al., 2013; and Martin-Meisener, Harbman, Donald, et al., 2015). As noted in HPRAC’s A Preliminary Literature Review on the Effectiveness of Registered Nurse Prescribing (December, 2015) there is very little literature on the effectiveness of RN prescribing and much of the literature that is available, for example, Laurant, Reeves, Hermens, et. al (2005) (a cochrane database review), as was presented in RNAO’s Primary Solutions for Primary Care (2012), is in fact prescribing by NPs or Advanced Practice Nurses (APNs) with graduate preparation. The importance of having advanced education cannot be overstated and the possible introduction of RN prescribers without it threatens the good results that NPs and APNs have established over the past several decades (Chen-Scarabelli, 2002). Given this, and because the context for independent prescribing in other jurisdictions such as the UK is different from Ontario, there is no
evidence to support the introduction of a new category of independent RN prescribers who are not prepared as NPs.

We further note that the HPRAC Referral definition for RN independent prescribing excludes the prescribing of controlled drugs and substances. This is also the current state of prescriptive authority for NPs in Ontario, however NPAO strongly encourages HPRAC to include advice to government to enable NP authority to prescribe controlled drugs without further delay. Ontario is the only jurisdiction in Canada that does not permit NPs to prescribe controlled drugs and substances, despite enabling changes to the federal *Controlled Drugs and Substances Act* in 2012 (Spence, Agnew, & Fahey Walsh, 2015; and CRNBC, 2016).

2. Protocols

Protocols (or directives as NPAO interprets the definition in the HPRAC Referral) already exist in Ontario. Directives are “an order for a procedure, treatment, drug or intervention for more than one individual” (CNO, 2014b, p. 3). The use of directives may also include the delegation of controlled acts from an authorized profession to another. Many regulated health professionals practitioners can delegate controlled acts including nurses, physicians, pharmacists, midwives and dentist. Tools and resources have been developed by the Federation of Health Regulatory Colleges of Ontario to support the development of directives and the delegation process (2007).

Medical directives are more commonly used in Ontario whereby physicians, through a directive, grant another profession such as an RN the authority to perform the specified procedure (e.g., supply and administer medications to a group of patients). The CNO’s standards for directives specifying the requirements for NPs and nurses to help ensure their safe use should be followed, including clear indications, contradictions, precautions and limitations based upon current evidence (CNO, 2014b). Further, practice guidelines could also be developed and utilized to support nurses meet the requirements established by the CNO.

NPAO believes that the expanded use of protocols, including NP directives to authorize RNs to perform procedures such as supplying and administering medications, is an effective way to optimize RN scope of practice and enhance patient access to timely and safe care. NPAO stipulates, however, that a protocol can only be implemented as long as a diagnosis has been made by the NP or physician, clear lines of accountability are established, and CNO directive standards are met. Given the number of NPs in the province (2,600 and growing), and the number of other health care practitioners who can delegate (e.g., physicians, NPs, midwives, pharmacists, dentists, optometrists, and

2 Delegation is a process by which a health care professional who has legal authority to perform a controlled act transfers that authority to an unauthorized person (CNO, November 26, 2013).
promotion of this authorizing mechanism may have a significant impact on patient access to care, including those in underserviced and rural areas. It should be noted that modifications to regulated health professional regulations and practice standards may be required to facilitate the expansion of the use of protocols or directives.

3. Supplementary Prescribing

It is the position of NPAO that a very limited version of supplementary prescribing may be appropriate for RNs, but only in explicit clinical settings or roles in Ontario (i.e., Sexual Health Clinics; Reproductive Health Clinics; Travel Health Clinics; and Health Promotion / Disease Prevention such as smoking cessation and over-the-counter medications). If this model were to go forward, NPAO recommends that a phased approach for the introduction of RN supplementary prescribing be considered before implementation of any role. The phased approach should include clinical trials to assess efficacy, safety and cost-effectiveness of the role prior to the implementation of any other roles. Further, NPAO asserts, should the role be implemented by government, that the following criteria be met for safe, effective and appropriate implementation, and that the criteria below be included in regulations under the Nursing Act, 1991. Criteria should include:

- a patient specific written clinical management plan (CMP) must be completed in collaboration with the patient, RN and the NP or physician;
- a diagnosis must have already been made by the NP or physician;
- a CMP must always be in writing and include the patient’s name, and specific conditions, and agreement to the plan must be recorded by both the NP or physician and the RN;
- the CMP must be signed off by a physician or NP before implementation;
- the patient condition must be stable and the outcomes predictable;
- a CMP policy must be established by the employer;
- the CMP must remain current and be updated and signed off on a regular basis;
- established clinical guidelines and/or protocols may also be used in the CMP;
- authority to prescribe must be limited to a formulary or class of drugs as defined in regulations under the Nursing Act, 1991; and
- to become a supplementary prescriber, an RN must have a minimum of three years of clinical experience in the specialty area, acquire additional education (including courses at the NP level – e.g., pathophysiology and pharmacotherapeutics), and acquire a new certification in a “supplementary prescriber” class under the Nursing Act, 1991 and regulations to prescribe certain drugs to specific population groups under prescribed circumstances.
Supplementary prescribing role is not appropriate in LTC homes or in-patient units. In addition, CNO standards and guidelines would need to be established should this role be introduced in Ontario. It is also the position of NPAO that where a diagnosis has not been established and/or where laboratory testing or diagnostic imaging is required to establish a diagnosis, monitor a condition or for therapeutic reasons, patients should have direct access to a physician or an NP (in person, by phone, by Ontario Telemedicine Network (OTN) or by other electronic means). This helps to ensure that the costs associated with laboratory testing and diagnostic imaging are contained. It is also ensures that a qualified health care practitioner undertakes a thorough and comprehensive assessment, and formulates a diagnosis taking into consideration the client context, local and global trends, and all potential differential diagnoses.
PART 2 – Application of HPRAC’s Criteria

This part of NPAO’s response is based on an extensive literature review conducted by NPAO over the past year, drawing on a deep organizational knowledge of the underlying issues. The response is categorized using HPRAC’s Criteria for the RN Prescribing Referral as it relates to the three models. The portion in italics at the beginning of each section is quoted directly from HPRCA’s Criteria.

1a: Risk of Harm

If the proposed model(s) of RN prescribing presents an increased risk of harm, methods to mitigation (sic) risk must be consistent with the education, training and competencies of members of the profession and provide assurance that patients or clients will be cared for within evidence-based best practices.

A: Antibiotic resistance is a worldwide problem. There are an increasing number of antibiotic-resistant strains of infection each year in Canada. Leading causes of antibiotic resistance include the overuse or inappropriate prescribing of antibiotics for infections that are not caused by bacteria (Public Health Agency of Canada, 2013).

Pharyngitis and acute otitis media are two conditions frequently cited by advocates for RN prescribing in Ontario as being appropriate solutions (RNAO, 2012). However, Choosing Wisely, a Canadian practice improvement site, recommends that practitioners limit the prescriptions they provide for antibiotics because the vast majority of upper respiratory tract infections are viral and do not require an antibiotic (Choosing Wisely, 2014a). Bacterial infections of the respiratory tract, when they do occur, are generally a secondary problem caused by complications from viral infections such as influenza. While it is often difficult to distinguish bacterial from viral sinusitis, nearly all cases are viral. Though cases of bacterial sinusitis can benefit from antibiotics, evidence of such cases does not typically surface until after at least seven days of illness. A large study of otitis media also points to the need to curtail the prescribing of antibiotics (Canadian Pediatric Society, 2009).

B: In addition, the over-diagnosis and over-prescription of antibiotic therapy to treat urinary tract infections (UTIs) in long-term care (LTC) settings is a problem that has recently come under the scrutiny of clinicians, medical directors, policymakers, and regulators. The growing number of LTC homes recently cited with inappropriate antibiotic use highlights a need to revisit the way in which UTIs are identified and managed in LTC settings. An article by Crnich and Drinka (2014) describes a new protocol to help prevent, identify and triage UTIs in LTC. Further, Choosing Wisely (2014b) have also developed clinical recommendations for Geriatrics that provides advice to clinicians on de-prescribing and appropriate prescribing with geriatric patients.
C: The importance of developing a differential diagnosis, which is a critical component of prescribing knowledge, skill and judgment and which can only be attained through advanced education and clinical preparation, cannot be overstated. One might think that a person presenting with urinary frequency and urgency who also has a urine sample that shows positive for leukocytes and microscopic blood has a “simple UTI”. However, the same results can be found with bladder cancer, tuberculosis, interstitial cystitis and pyelonephritis. The same presentation in seniors and in elderly residents of LTC homes, often with multiple co-morbidities, adds further layers of complexity potentially leading to mismanagement and complications. Delirium, sepsis and other conditions may be at play. The diagnostic reasoning process which includes formulating and communicating a diagnosis cannot and should not be delegated. In Manitoba, a recent coroner’s case cited lack of training and experience as a key factor in the death of an infant who was receiving care from an RN in a remote northern community. The judge recommended increased training and recommended that nurses be trained at the NP level in this recent case (Dec 15, 2015). Further, another recent report, this one by the Auditor General of Canada (Spring 2015), called for the need for more substantial and ongoing training for RNs who work in remote communities. The report cites ongoing issues related to inadequate training and completion of mandatory training. These concerns were raised previously in a 2010 Health Canada internal audit report.3

D: Potential unintended consequences of adding more prescribers include sending a message to the public that Ontario needs more prescribers and more access to drugs. With concerns and issues about over-prescribing and risks related to poly-pharmacy as noted above, this may not be the most appropriate message to send to the public. Further, with more prescribers there is a risk of confusing patients regarding the role and responsibility of their primary care provider or Most Responsible Provider (MRP).4 When a patient signs a Patient Enrollment Form, the person is committing to not seek care from anyone other than their MRP. Adding a new RN prescriber role may confuse patients regarding whom they should seek a prescription from, which could undermine the accountability of the MRP or primary care provider. The RN prescriber model also has the potential for one patient to receive prescriptions from multiple prescribers including an MD, an NP, a physician assistant, a pharmacist and an RN. In the absence of a shared and comprehensive Electronic Health Record for each and every patient, there is great potential for duplication and medication mismanagement.

3 http://www.oag.bvg.gc.ca/internet/English/parl_oag_201504_04_e_40350.html#p27
4 The provider who has the overall responsibility for directing and coordinating the plan of care and management of an individual patient at a specific point in time.
1b: Public Need

A significant public need would be met as a result of the adoption of the proposed model(s) and puts patients first by increasing access to care.

A: There is no strong evidence to indicate that the people of Ontario need more independent prescribers. If there is a need for more prescribers, NPAO believes that the more obvious solution would be to increase the current numbers of existing prescribers (e.g., physicians, Nurse Practitioners, pharmacists) rather than create a new class of independent prescribers. Physician growth rates between 2007 and 2011 have outpaced population growth rates three fold (13.9% versus 4.7%) and the doctor to population ratio rose from 176 per 100,000 people in 2007 to 195 in 2011, close to an all-time high (Canadian Institute for Health Information, 2011). In addition, the percentage of new Nurse Practitioners between 2013 and 2014 has also outpaced the growth in the population (7.4% versus 4.7%) (CNO, 2015).

The Ministry of Finance for Ontario (2014) projected that the average annual population growth for Ontario is 1% annually between 2013-2041. With the number of graduates of Family Medicine and Nurse Practitioner programs expected to continue to outpace the population growth, it is more difficult to justify the need for more independent prescribers. Additionally, implications for health human resource (HHR) planning to adequately meet the needs of the aging population which is projected to more than double in the same time period (and with that increased co-morbidities and complex health issues) must be taken into consideration to ensure HHR, including NPs and RNs, are used to their optimal scope of practice.

NPAO acknowledges that there continues to be a maldistribution of physicians with 14.6% of Family Medicine graduates serving 18.1% of the population living in rural areas. The ratio of Nurse Practitioners working in the north (18.7%) is more closely aligned to the northern population, indicating one potential solution to this issue.

B: The population of Ontario as of July 1, 2014 is approximately 13,680,000. According to data from the Health Care Experience Survey 2014, it appears that 6.4% of the Ontario population or 863,000 people report not having a designated primary care practitioner (Ministry of Health and Long-Term Care (MOHLTC), Health Analytics Branch, October 2014). This means that currently 93.6% of the population of Ontario (or approximately 12.6 million people) is served by approximately 12,000 Family Physicians and 2,600 Nurse Practitioners. It is unclear if the addition of approximately 100,000 RN prescribers is necessary to meet the needs of 6.4% of the population, even if they occasionally supplement the care of the other 94%. As noted above, with a physician growth rate of 13.9% and a Nurse Practitioner growth rate of 7.4%, both of which
greatly outpace the population growth, how long would it take for the unattached people to find an MD or NP?

C: Timely access to primary care is a pressing problem in Ontario. The Commonwealth Fund Survey (Schoen & Osborn, 2010) ranked Canada as tied for last out of 11 countries regarding same-day or next day access. Although 90% of Ontarians were able to see their primary care provider when they were sick, only 43.1% were able to see their primary care provider on the same day or next day. Timely access to same day or next day was higher (55.2%) for fee-for-service physicians than for those patients enrolled in a FHO (Family Health Organization), FHN (Family Health Network) or FHT (Family Health Team) model (MOHLTC, Health Analytics Branch, 2013), despite the fact that the government has invested heavily in inter-professional health teams in FHNs and FHTs. Open access and same-day access scheduling tools appear to be helpful in improving the timeliness of care. As to how the government and primary care teams can work together to better address timely access to care, we believe RNs working to their optimized scope of practice (e.g., triage, screening, assessment and history taking, point of-care testing, etc.), for example working in fast-track clinics or urgent-care centres, can play a significant role in increasing access to service. In addition, technology can play an important role in addressing the needs of Ontarians (e.g., e prescribing and emailing prescriptions or conducting a virtual consultation through OTN, etc.). HPRAC should urge the government to remove barriers to the use of technology (e.g., the use of securely encrypted email to send a prescription to a pharmacy is currently illegal in Ontario) and to pharmacists renewing prescriptions.

D: Creating more access to prescribed medications does not equate to creating access to primary care. Primary care includes four key elements (or 4Cs): Contact access, Coordination, Comprehensiveness and Continuity of care over a lifetime (Starfield, 1998). It also involves a partnership between a care provider(s) and an individual and/or family. Walk-in clinics have been denounced as providing stop-gap, fragmented care with a focus on medication prescribing. It appears likely that RN prescribing in a walk in clinic type of setting may lead to more fragmented care.

E: There is no evidence that independent RN prescribing would divert people from Emergency Departments (EDs) or enhance patient health outcomes. One study regarding unnecessary visits to EDs actually reports that most of the reasons for those ED visits were minor injuries and accidents, not diagnoses requiring medications (Johnson, Ghildayal, Ward, et al., 2012).

Findings from a recent study by Canadian Institute for Health Information (CIHI, 2014) entitled Sources of Potentially Avoidable Emergency Department Visits demonstrated that 20% of ED visits were for conditions that could have been managed more appropriately in a family physician’s office. Young children (especially infants) and
people living in rural communities are over-represented in the population presenting with family practice sensitive conditions to an ED. Only 17% of these patients (i.e., 17% of 20%) received an intervention such as a prescription for medication. Most (5 out of 6 people) were discharged home with no intervention. Of those people seen in EDs for conditions that could have been dealt with by a Family Physician or Nurse Practitioner, each person still required an assessment, a physical examination, the consideration of differential diagnoses, the formulation of a diagnosis, and the development of a treatment plan. It is unclear how the addition of RN prescribers would change this process.

In the same study, it was noted that seniors living in Long-Term Care (LTC) facilities represent less than 1% of Emergency Department visits (CIHI, 2014,). Of these visits, 24% were for conditions such as urinary tract infections, pneumonia and falls. These conditions could have been treated within the LTC facility if the resident had timely access to a primary care provider. There is excellent evidence that the utilization of Nurse Practitioners within LTC Homes would be the optimal solution (Donald, Martin Misener, Carter et al., 2011). This underscores the imperative to have a ratio of one Nurse Practitioner for every 150 LTC residents (NPAO, 2014).

2. Body of Knowledge

There is a systematic body of knowledge within the profession to perform the model(s) of RN prescribing and the adoption of the model(s) is broadly accepted within the profession.

A: The scope of practice of RNs in Ontario does not include the controlled act of prescribing. This controlled act is reserved for RNs(EC) or NPs (Nursing Act, 1991). The body of knowledge required to become a NP is specified in Part 1.

B: RNs are currently able to implement protocols or directives in Ontario as discussed in Part 1 with the requisite knowledge, skill, judgment and clinical experience and as long as the standards set by the CNO are followed. Additional training may be required to ensure the RN has the competency to meet the standards.

C: As prescribing is not part of RN scope of practice in Ontario, RNs are not educated to prescribe through the diploma or BScN program. The focus of the BScN program is the safe administration of medications prescribed by another provider as discussed in Part 1 and see below – Education and Accreditation.

D: A recent report by the RNAO (2012) states that RNs are already prescribing medications to patients. It is unclear in this report where and how often RNs are prescribing under delegation. In addition, it is not stated how well this authorizing
mechanism is working. If it is working well, this approach could be augmented and supported, however we were unable to find literature specific to Ontario on this point. Conversely, in the recent report by the Auditor General of Canada (Spring, 2015) referenced previously, a number of concerns are outlined. The audit examined remote First Nations communities in Ontario and Manitoba and found that many nurses working in these communities lacked adequate training in advanced medical techniques and procedures. The audit found that only one RN out of a sample of 45 had completed the mandatory training courses set by Health Canada, despite the auditor having previously flagged this issue. In addition, the audit found that RNs working in these communities sometimes worked outside of their legislated scope of practice with no medical directives in place. The report strongly recommended that Health Canada work to ensure that medical directives are in place and that Health Canada hire more Nurse Practitioners. NPAO recommends that the government look at ways Nurse Practitioners can work more closely with RNs in northern, remote and rural communities.

E: Other jurisdictions in Canada have introduced or are considering very limited RN prescribing to increase access to care. In some cases this is because physicians have been reluctant to continue with delegation. For example, the Saskatchewan Medical Association moved to phase out Transfer of Medical Function (delegation) thereby necessitating the development of alternate authorizing mechanism. In Ontario, there has been no indication from the Ontario Medical Association, the Ontario College of Family Physicians or the College of Physicians and Surgeons of Ontario that its members intend to withdraw their support for medical delegation. In fact, the role of the Physician Assistant in Ontario is predicated on medical delegation. The potential for Nurse Practitioners to delegate more functions and authorities to other members of the health care team has not been fully realized.

3. Education and Accreditation

Members of the profession have, or will have, the knowledge, training, skills and experience necessary to carry out the duties and responsibilities involved in the proposed model(s) of RN prescribing. In addition, education programs are, or will be, appropriately accredited by an approved accreditation body.

A: NPAO conducted a series of key informant interviews to learn about curricula at five Ontario universities in 2015. These interviews revealed that the existing four-year BScN program does not prepare RNs to prescribe medication nor does it prepare graduates to independently develop a pharmacotherapeutic plan of care. Pharmacology is integrated into the BScN program and places emphasis on the safe administration of oral and
parenteral medication, dosage calculation, age-related calculations, and dispensing and classes of medications as they relate to various conditions. There is no current provincial standard in the undergraduate-nursing program regarding the amount of curriculum hours devoted to pharmacology.

B: The existing BScN program does not prepare RNs to order, interpret and follow up on laboratory tests and diagnostic imaging tests. The curriculum would require a complete overhaul and additional hours of in-class and practicum experience. In fact, that is what the NP programs provides BScN graduates.

C: The existing BScN program does not prepare RNs to formulate and/or communicate a medical diagnosis. The diagnostic reasoning process is not covered in the BScN program. Graduates of the BScN program do not learn how to consider differential medical diagnosis and to consider what laboratory tests and/or diagnostic imaging tests should be ordered to rule in or rule-out a medical diagnosis. The curriculum would require a complete overhaul and additional hours of in-class and practicum experience. Again, that is an important component of what the NP program provides for RNs wanting to work in an expanded role.

D: The NP program provides advanced health assessment, advanced pathophysiology, advanced counseling and pharmacotherapeutics. The NP program takes approximately two years to complete (See Part 1). With the possibility that Nurse Practitioners might be able to prescribe controlled drugs and substances, the current curriculum is strained. In addition, Nurse Practitioners are compelled to update their knowledge and skills through continuing professional development.

E. NPs gain their prescribing knowledge through extensive coursework and clinical practica experience that consolidates and integrates that knowledge. Prescribing knowledge is vast and includes knowing: the best therapy or modality that could be pharmacological or non-pharmacological to treat the patients (e.g., counselling); the indications, contraindications and pharmacokinetics of medications; drug drug interactions and drug-food interactions; potential side-effects, adverse reactions, allergic responses and sensitivities to drugs; proper dosage including pediatric dosage; impact of medication on renal function, immuno compromised status, and autoimmune conditions; consideration of global and local sensitivities and resistance; how to monitor medication regime; and how to do a comprehensive medication reconciliation which includes over-the-counter and herbal preparations, etc. This is done in in the context of comprehensiveness and continuous care.

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5 Six Rights for Medication Administration: 1) Right person; 2) Right medication; 3) Right dose; 4) Right time; 5) Right route; and 6) Right documentation
F: The models proposed in the HPRAC Referral are based on those operating in the UK. A recent literature synthesis on nurse prescribing draws heavily from the UK experience (RNAO, 2012). Caution should be taken in extrapolating the findings to the Canadian landscape as discussed in Part 1. Clear understanding of the level of preparation held by the nurse respondents is not evident in the majority of the studies cited. Acute care and primary care studies cannot be considered a combined experience, given the vastly different components of each practice. These limitations in the literature were also identified in the preliminary literature reviews conducted by HPRAC.

4. Economic Impact

The potential economic impact resulting from the adopting of a model(s) of RN prescribing on the profession, the public and the health care system is understood.

A: As identified in Part 1, over the past 40 years, the safety, efficacy and cost effectiveness of Nurse Practitioners have been studied and confirmed (Horrocks, Anderson, & Salisbury, 2002; Venning, Durie, Roland, et al., 2000; & Stanik-Hutt, Newhouse, White, et al., 2013; Martin-Meisener, Harbman, Donald, et al., 2015). The government of Ontario has invested millions of dollars in the education, promotion and implementation of the NP role including the introduction of NP-led clinics that serve over 60,000 patients (and growing). Introduction of another nurse prescriber may undermine this initiative and investments made to date.

B: The cost of adding potentially 100,000 new prescribers will increase total drug costs. For example, through changes in regulations for nursing in Scotland, an evaluation conducted on nurse prescribing showed that the number of nurse prescribers rose over a ten-year period (from 6 in 1996 to 3,200 in 2006). Further, the number of prescriptions from nurse prescribers rose from less than 200 to 447,000 in the same time period with “an average gross ingredient cost” rising from £15,000 to over £7,000,000 (Watterson, Turner, Coull et al., 2009). Since the HPRAC Referral appears not to be proposing that RNs order any laboratory or diagnostic imaging tests, these additional costs have not been included.

C: In the UK, RN prescribers work alongside salaried physicians who are paid through the Local Health Authorities. In addition, their employer or work site must sponsor them to become an RN prescriber. In the UK, there is no disincentive for the physician to have another colleague prescribe. In Ontario, the vast majority of physicians are remunerated through fee for-service billing and the alternate funding arrangement in EDs. NPAO asserts that there is perverse volume incentives built into these remuneration mechanisms. NPAO has received extensive feedback from Nurse Practitioners working in Emergency Departments and in primary care settings who state that they are encouraged to see the more complicated patients with multiple comorbidities so that
the physicians can see a greater number of lower acuity patients. Registered Nurses may well face the same systemic challenge.

D. In the UK prescribers prescribe from the National Formulary of Benefits (NFB), a pre defined formulary that restricts all prescribers to drugs contained listed in the NFB. In Ontario, while there are restrictions set by some programs (e.g., Ontario Drug Benefits), in general prescribers are not restricted, and may prescribe from the comprehensive Compendium of Pharmaceuticals and Specialties (CPS). As noted by the UK’s Royal College of Nursing (2014), “there is still very little empirical evidence that supports the clinical and economic outcomes for nurse prescribing” (p. 4).

E: Additional costs include increased malpractice coverage for RN prescribers, as well as increased costs for lawsuits and settlements. The current premiums for Nurse Practitioners are three times that of an RN and climbing. For example, in the supplementary model, the NP or physician who is collaborating with the RN assumes additional accountability and responsibility, potentially leading to increased malpractice premiums.

F: The increased societal cost of antibiotic resistance may need to be factored in to this decision, as discussed in the Risk of Harm section.

G: It would be anticipated that RNs who are prescribing would demand to be paid at a higher level commensurate with their increased scope, responsibility and accountability, potentially leading to an increase in RN costs. Additional costs related to professional development and mandatory training should also be considered.

H: Other concerns raised are the increased workloads on nurse prescribers and costs of mentoring nurse prescribers. In an evaluation study of expanding Nurse Prescribing in Scotland, researchers found that there are no obvious and suitable medicines management systems in place to track the costs of prescribing accurately and to document any related benefits (Watterson, Turner, Coull et al., 2009.) Another study examined the economic and qualitative aspects of nurse prescribing in a UK health region of eight sites. The researchers concluded the overall impact on prescribing costs was neutral, yet the first year of implementing costs were £240,000 (Ferguson, Luker, Smith, et al., 1998). Training and start-up costs must be factored into any economic analysis studies. More health economic research is this area is recommended.
5. Relevance to the Health Care System and Relationship to other Professions

The model(s) of RN prescribing is consistent with the evolution of the health care delivery system, and is conducive to integrated, team-based, collaborative care models.

A: The Ontario Pharmacists Association previously put forward a submission to HPRAC in 2008 and the resulting recommendations by HPRAC were approved by the legislature as part of Bill 179 in 2009 to expand the scope of practice of pharmacists. These changes provided pharmacists with the authority to prescribe certain medications for minor ailments. Pharmacists in Ontario are now authorized to renew and adapt prescriptions, and are also authorized to provide flu shots. This role could be expanded to include the provision of other vaccines. Given that there are approximately 14,000 pharmacists in Ontario; pharmacists now complete a PharmD degree (a minimum of seven years of post-secondary education with a dedicated focus on medication management); and that many pharmacies have extended hours, we believe expansion of the pharmacist prescriber role would be more consistent with the evolving roles in our health care system. In addition, if Nurse Practitioners were integrated into more pharmacies as they are in the US, this too would help to address timely access to primary care.

B: The implementation of a comprehensive Electronic Health Record / Electronic Medical Record (EHR/EMR) is critical to enhancing timely access to care. EHR/EMR will ensure that all members of the health care team can access essential information about clients in a timely manner. Important steps have been taken in the province to implement e-prescribing and to enhance communication between patients and practitioners with secure email, however more can be done. Other members of the health care team could also be used more effectively. As noted above, Pharmacists can play a more significant role. Further, Clinical Psychologists, who complete a residency program following a PhD, could also be considered by government to be authorized to initiate, renew or adjust certain medications.

6. Relevance to the Profession

The proposed model(s) of RN prescribing is rationally related to the practice of the profession, providing recognition and authority for existing competencies, and to the qualifications and competencies of members of the profession.

A: It is not clear whether a significant majority of RNs in Ontario actually want access to the controlled act of prescribing. In a survey conducted by the RNAO, 87% of its members were identified as being in favour of RN prescribing (RNAO, 2012). However, while this survey, was sent to approximately 38,000 RNs, only 223 members responded (Personal Communication to NPAO from T. Lenartowych, 2015). While 87% of the 223
members indicated positive support, this is only 0.5% of the surveyed population, and conclusions about the membership at large must be drawn very carefully. This response suggests there may not be a significant desire for this change in scope of practice among RNs.

B: RNAO’s Primary Solutions for Primary Care (2012) features prominently a statistic that “only 61% of Canadian RN respondents report practicing to their full scope of practice”. This statistic is drawn from a study of a total of only 127 RN respondents working in family practice settings in Canada (Allard, Frego, Katz, et al., 2010). In the same study, Family Practice RNs recommended that more should be done to clearly articulate the role and optimize the current utilization of Family Practice nurses (Allard, Frego, & Katz, et al., 2010). The results of this survey do not in our view support RN prescribing as the method for Family Practice Nurses to find more job satisfaction.

C: Lack of time, heavy workload and high patient acuity were identified as barriers to RN and Registered Practical Nurse (RPN) optimization of scope of practice in a study of acute practice settings (Oelke, White, Besner, et al., 2008). In this study, some the nurses had difficulty defining scope of practice, and it was recommended that team collaboration and support from nurse educators and managers would help facilitate nurses working to full scope. This study in our view suggests optimizing current scope of is more important to enhancing job satisfaction.

D. NPAO believes that the role of the RN is essential in all practice settings. RNs are integral members of the health care team across all practice settings. RNs provide holistic, patient-centred care to their clients. RNs are skilled clinicians who help their patients heal from physical and emotional injury. They assist people to come into the world, they assist people through life’s transitions, and help them to die with dignity and respect. RNs are navigators, care coordinators, team collaborators, and spend time listening to their patients to understand their needs, and supporting and guiding their clients in making healthy life decisions. RNs are skilled at providing mental health services and in particular at helping those with prescription addictions.

The proposed RN independent prescribing model would shift the role of the RN from providing exceptional nursing care (including coaching, education, counselling and health promotion) to providing medical care. RN expertise in addressing the social determinants of health (SDH) goes well beyond the medical model. Prescribing medications does not directly address the SDH. Prescribing does not appear to be desired by the RN profession as identified in these studies and surveys. Placing emphasis on addressing barriers to RN current scope of practice and supporting ways to fully optimize the RN role would be in our view a better way to enhance patient access to excellent care and RN satisfaction.
Part 3 - Conclusion and Summary of Recommendations

NPAO is fully supportive of mechanisms and strategies that support the full utilization of RN scope of practice. Having RNs work to their current full scope of practice in all settings is crucial for the sustainability of the health care system. The role of the RN as care coordinator, system navigator, and partners in chronic disease management, health promotion, and illness prevention has not been optimized.

Recommendations:

1. **Restrict RN independent prescribing to NPs.** RN independent prescribers are NPs. To become an independent RN prescriber and to gain access and authority to autonomously and safely perform additional controlled acts such as communicating a diagnosis, prescribing medications, and ordering treatments and diagnostic tests, the RN must become an NP.

2. **Expand the use of protocols or directives.** Protocols or directives already exist in Ontario. NPAO believes that the expanded use of protocols, including NP directives to authorize RNs to perform procedures such as supplying and administering medications, is an effective way to optimize RN scope of practice and enhance patient access to timely and safe care. NPAO stipulates, however, that a protocol can only be implemented as long as a diagnosis has been made by the physician or NP, clear lines of accountability are established, and CNO directives/standards are met.

3. **Introduce a very limited RN supplementary prescribing role,** should the government choose to proceed. It is the position of NPAO that should government proceed with this role it should be a very limited version of supplementary prescribing which may be done through the use of protocols and may be appropriate for BScN prepared RNs, but only in explicit clinical settings or roles, and with additional education and clinical experience. A registration certification process established by the College of Nurses of Ontario would also be recommended.

4. **Use a phased approach for the introduction of RN supplementary prescribing,** should the government choose to proceed, starting with one role. The phased approach should include clinical trials to assess efficacy, safety and cost effectiveness of the role prior to the implementation of other roles.

5. **Establish conditions to safeguard the limited implementation of RN supplementary prescribing,** should the government choose to proceed. Conditions to be set out in regulations under the *Nursing Act, 1991* and be met before supplementary prescribing can occur:
a. a patient-specific written clinical management plan (CMP) must be completed in collaboration with the patient, RN and the NP or physician;

b. a diagnosis must have already been made by the NP or physician;

c. the CMP must be written and include the patient’s name and specific conditions, and agreement to the plan must be recorded by both the NP/physician and the RN;

d. CMP must be signed off by the NP or physician;

e. the patient’s condition must be stable and the outcomes predictable;

f. CMP policy must be established by the employer;

g. the CMP must remain current and be updated and signed off on a regular basis;

h. established clinical guidelines and/or protocols may also be used the CMP; and

i. authority to prescribe must be limited to a formulary or class of drugs as defined in regulations under the Nursing Act, 1991.

6. **Additional education is mandatory to become a supplementary prescriber** should the government choose to proceed. To become a supplementary prescriber an RN must have a minimum of three years of clinical experience in the specialty area, acquire additional education (including courses at the NP level – e.g., pathophysiology and pharmacotherapeutics), and acquire certification in a “supplementary prescriber” category under the Nursing Act, 1991 and regulations to prescribe certain drugs to specific population groups under prescribed circumstances.

7. **A medical diagnosis should be made by a physician or an NP.** For conditions that require a medical diagnosis, laboratory tests, diagnostic imaging, and/or the development of a pharmacotherapeutic plan, patients should always be referred to a primary care provider, that is, a physician or an NP.

In conclusion, NPAO believes that the recommendations stated in this document are in the best interests of the public and the health care system. These recommendations enhance access to inter-professional collaborative care. Our primary directive is the health and well being of Ontarians.
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January 25, 2016

Mr. Thomas Corcoran,
Chair, HPRAC

The Ontario Association of Public Health Nursing Leaders (OPHNL) has submitted a paper to HPRAC responding to the questions that had been posed in their consultation request. OPHNL has now had the opportunity to further consult with the Public Health Chief Nursing Officers, members of the OPHNL, in order to be able to endorse one of the 3 models put forward. Please ensure that this letter accompanies the report that was submitted to HPRAC on January 15, 2016 which was prepared by York Region Public Health on behalf of our association.

It is our recommendation that the Independent RN Prescribing Model would be best suited for the public health nursing sector in Ontario. This model allows for the role of nurses to be expanded allowing for a broader scope of nursing practice. This is clearly a role that nurses can embrace given their knowledge and skill level. As well, this model will support access to care for many in our most rural and isolated communities. Nurses have taken on nursing role expansion, such as that of the Nurse Practitioner with concise, safe and thorough examination of the nursing practice issues that could arise.

We feel confident that public health nurses must be a part of the dialogue of an Independent RN Prescribing Model and look forward to collaborating with our colleagues in other sectors to ensure the smooth transition forward.

Yours sincerely,

Maureen Cava RN, BScN, MN, President

Kelly Farrugia RN, BScN, MA, CNO, President-Elect
The Ontario Association of Public Health Nursing Leaders
Leading the Way for Public Health Nursing

January 11, 2016

Dear Mr. Corcoran:

The Ontario Association of Public Health Nursing Leaders (OPHNL) formerly known as ANDSOOHA has developed a paper in response to the issue of RN Prescribing.

The OPHNL has representation from the Chief Nursing Officers (CNOs) from the 36 Public Health Units in Ontario. On behalf of OPHNL, the RN prescribing paper development has been led by Julia Rottenberg, Chief Nursing Officer of York Region Public Health.

We are pleased to submit for your consideration, the RN prescribing paper, which includes input from 16 of the 36 Public Health Units in Ontario. Any comments or questions in regards to the paper should be sent to Julia Rottenberg at 905 830-4444 x 74024 or at julia.rotenberg@york.ca.

Yours Sincerely,

Maureen Cava
President, OPHNL

Julia Rottenberg
CNO, York Region Public Health
Registered Nurse Prescribing in Public Health

Prepared by York Region Public Health on Behalf of the Ontario Association of Public Health Nursing Leaders

Contributors: Hamida Bhimani, Head of Nursing Practice & Alliah Over, Nursing Practice Lead January 15, 2016
Executive Summary:

This paper has been created in response to the Health Professions Regulatory Advisory Council's request on key stakeholder input regarding three proposed options for RN Prescribing Models; independent, supplementary and use of protocols/group directives.

What We Did

In November and December of 2015, a review of literature and an environmental scan on RN prescribing was completed. As part of the environmental scan, a survey was conducted with Chief Nursing Officers in the 36 Public Health Units (PHU) to gather information on which of the three RN prescribing models would be preferred for implementation at their PHU. The survey also asked participants about the advantages and challenges/barriers to implementing their preferred prescribing model.

What We Found Out

A total of 44% (16 out of 36) of Public Health Units consented to participate and completed the survey. Of those who completed the survey there was a 50/50 split in their first choice selected. Of the Public Health Units surveyed:

- 43.8% selected the independent RN prescribing model as their first choice
- 43.8% selected the use of protocols/group directives RN prescribing model as their first choice
- 12.5% preferred the supplementary RN prescribing model as their first choice

Advantages and Challenges/Barriers for Implementation:

Independent RN Prescribing Model:

- **Top Three Advantages:** Increased RN autonomy, enhanced service/access for clients and increased collaboration among the health care team, including with clients and stakeholders
- **Top Three Challenges/Barriers:** Regulatory/legislative requirements needed, education/training/ongoing competency considerations for RNs, and buy-in from other members of the healthcare team.

Use of Protocols/Group Directives RN Prescribing Model:

- **Top Three Advantages:** This model is currently being used in health units and it has demonstrated consistency in practice, is explicit and least likely to result in medical errors.
- **Top Three Challenges/Barriers:** Requires creation of more medical directives, need to frequently review and ensure directives are up-to-date, and requires more organizational commitment and buy-in to support increase in RN scope of practice.
Differences in ratings of the preferred prescribing models may be explained by local availability of primary care partners, the nature of programs at the particular Public Health Units, and the socio-political context as well as the rural versus urban geographic location of the PHU.

**Consideration for Actions**
Based on information gleaned from the literature and key stakeholder survey results, several factors must be considered as we move towards RN prescribing in Ontario Public Health Units.

- Implement continuous quality monitoring/improvement measures to decrease risk and legal liability issues. This could include clinical audits and continuing professional development/educational opportunities

- Ensure the needs of public, particularly local access to care and medications are met, including safety in delivery of care

- Secure legislative authority and verify that prescribing standards are in place, from both the College of Nurses of Ontario and the Public Health Unit's perspective

- Encourage nurses to meet the educational/practice requirements of prescribing according to regulatory bodies such as the College of Nurses of Ontario

- Consider financial impacts of RN prescribing on organizations and the healthcare system as a whole, such as training costs, time release costs, etc.

- Reflect on how RN prescribing impacts the critical social theoretical underpinnings of nursing practice (since currently prescribing is viewed under medicine's bio-medical theory model)
Introduction

This report provides information regarding Registered Nurse (RN) prescribing within the context of Public Health. The focus of this report will be on the three types of prescribing models proposed by the Ministry of Health and Long-term Care: independent prescribing; supplementary prescribing; and use of protocols/group directives. This report will include:

A. Prescribing model conceptual definitions
B. A review of the literature
C. An environmental scan of Public Health Units in Ontario with preferred RN prescribing model recommendations from key stakeholders
D. Considerations for implementing RN prescribing in Ontario Public Health Units

Conceptual Definitions

The following conceptual definitions derived from the literature review are used to describe the nurse prescribing models listed in this report.

1. **Independent Prescribing:** This is when the nurse is legally permitted and responsible for clinical assessment, establishment of diagnosis and decisions about the appropriateness of treatment or medication for a patient (Kroezen, Van Dijk, Groenewegen & Francke, 2011). Usually this form of prescribing is done with a limited formulary (a list containing a limited and defined number of medications that can be prescribed) or an open formulary (Gielen, Dekker, Francke, Mistiaen & Kroezen, 2014).

2. **Supplementary Prescribing:** This is when there is a voluntary partnership between an independent prescriber—a doctor and a supplementary prescriber—usually a nurse. Initial diagnosis of a patient’s condition is performed by the independent prescriber; the nurse then may prescribe from an open or limited formulary and will consult/collaborate with the independent prescriber before issuing the prescription (Kroezen, Van Dijk, Groenewegen & Francke, 2011).

3. **Use of Protocols/Group Directives:** This is when there are written instructions for the supply and administration of named medicines in an identified population of patients with a specific condition. The nurse still uses their own assessment of patient needs, but they...
are only allowed to supply and administer medications within the strict terms of a predetermined protocol formulary (Gielen, Dekker, Francke, Mistiaen & Kroezen, 2014).

**Literature Review**

A literature search was conducted using Google Scholar and CINHAL literature databases using the key words 'nurse prescribing' and 'nurse prescribing models'. 8 articles were deemed appropriate; however upon further investigation 4 articles discussed nurse prescribing at the Master’s level or higher, and therefore were not included in the review. Studies or systematic reviews conducted after 2011 providing evidence on the clinical appropriateness, safety and quality of nurse prescribing were included in this review.

Three themes were identified from the literature:

1. RN prescribing models vary based on environmental context
2. There is evidence that implementing RN prescribing improves patient access to care and fosters enhanced nursing practice
3. There is preliminary evidence that RN prescribers have adequate educational preparation to prescribe medication appropriately and safely

RN prescribing has also been found to have a positive impact on patient outcomes and enhances autonomy and expands scope of practice for nurses. Though studies conducted thus far have been small, there is encouraging preliminary data that RN medication prescribing decisions are appropriate when compared to physicians. Appendix A provides a detailed comprehensive review of key themes identified in the literature.

**Environmental Scan**

An environmental scan of Public Health Units was conducted to determine which RN prescribing model key stakeholders preferred to be implemented.

An initial telephone consultation survey was completed with selected nursing practice leaders at three Public Health Units to discuss the advantages and challenges/barriers of implementing their top preferred RN prescribing models.
Subsequent to the telephone consultation survey, a FluidSurvey was developed and sent to Chief Nursing Officers (CNOs) at all 36 Public Health Units to solicit their input on the preferred RN prescribing model. Survey participants were asked to rank order their preferences for RN prescribing models, provide advantages and challenges/barriers to implementation, and indicate any factors that required further consideration prior to implementing the selected nurse prescribing model.

**Methods**

The initial telephone consultation survey was conducted by providing the nursing practice leaders with conceptual definitions of the three proposed RN prescribing models and asking them to review the *CNA Framework for Registered Nurse Prescribing in Canada* prior to the telephone consultation/survey. During the telephone consultation, the nursing practice leaders (NPLs), who are responsible for supporting CNOs in achieving their mandate, were asked questions related to their top two preferred models of RN prescribing for their particular Public Health Unit. A list of key stakeholder survey questions is provided in Appendix B.

Subsequent to the telephone consultations, Chief Nursing Officers were asked to complete an online survey via FluidSurvey. The same key stakeholder survey questions asked of the nursing practice leaders were asked of the CNOs.

**Summary of Findings**

The following map of Ontario provides information on the top two preferred RN prescribing models related to Public Health Units' geographic locations. 16 of 36 Public Health Units or 44% of Public Health Units completed the survey as of January 7th 2016.
A. Key Stakeholder’s First Choice for RN Prescribing Model by Public Health Unit

43.8% independent RN prescribing (Haliburton, Kawartha, Pine Ridge District, Hastings and Prince Edward Counties, Niagara Regional Area, Oxford County, Eastern Ontario, Thunder Bay & Wellington-Dufferin-Guelph)

43.8% use of protocols/group directives (Durham, Grey Bruce, City of Hamilton, Chatham-Kent, Timiskaming, Windsor-Essex County & York Region)

12.5% supplementary RN prescribing (Simcoe Muskoka District & City of Toronto)

The city of Toronto, York Region and Durham Region Public Health Unit surveys participated in telephone consultations with nursing practice leaders. All remaining surveys were completed by Public Health Unit CNOs. All respondents surveyed consented to share the findings in this report.
Based on information obtained from surveys, the following tables summarize the advantages, and challenges/barriers of implementing two of the RN prescribing models selected by the PHUs as their preferred choices.

**A. Independent RN Prescribing Model: Advantages and Challenges/Barriers to Public Health Unit Implementation**

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Challenges/Barriers</th>
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<tbody>
<tr>
<td>• Increases PHN independent scope of practice</td>
<td>• Increase/initiate training to ensure nurses have the knowledge, skill and confidence to diagnose and prescribe</td>
</tr>
<tr>
<td>• Improves nurses' understanding of assessment, treatment and supportive care for clients</td>
<td>• Ensure continuous education is required and monitoring is in place(audits)</td>
</tr>
<tr>
<td>• Enhances service, access and continuity of care for clients, particularly priority populations</td>
<td>• Foster a shift from a generalist model to a specialist model</td>
</tr>
<tr>
<td>• Improves compliance for best practice treatment guidelines</td>
<td>• Ensure maintenance of PHN competency etc. Lack of opportunity to do 1:1 work in public health, may be difficult to maintain competency skills</td>
</tr>
<tr>
<td>• Prevents delays in implementing treatment for STIs, prescription of oral contraceptives and TB medications</td>
<td>• Develop a of a plan for capacity/support, policy and procedure and risk management</td>
</tr>
<tr>
<td>• Reduces consultation needs with the MOH</td>
<td>• Dialogue and increase communication to other professionals (MD/NP) as to shift in roles Ensure buy-in/trust of clients and other members of the health care team</td>
</tr>
<tr>
<td>• Provides the opportunity to work collaboratively with primary care partners</td>
<td>• Initiate changes to the regulatory and legislative requirements needed</td>
</tr>
<tr>
<td></td>
<td>• Mitigate possible reluctance on the part of the Ministry of Health for this model by leveraging opportunities cited.</td>
</tr>
</tbody>
</table>
B. Use of Protocols/Group Directives RN Prescribing Model: Advantages and Challenges/Barriers to Public Health Unit Implementation

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Challenges/Barriers</th>
</tr>
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<tbody>
<tr>
<td>• Allows nurses to practice independently</td>
<td>• Require creating and maintaining more medical directives</td>
</tr>
<tr>
<td>without relying on support from a physician</td>
<td>• Ensure directives are up to date</td>
</tr>
<tr>
<td>• Already using medical directives in practice</td>
<td>• Collaborate with the MOH</td>
</tr>
<tr>
<td>• Ensures consistency in clinical practice</td>
<td>• Need to review additional medications that may apply and provide appropriate education for the nurses around these changes</td>
</tr>
<tr>
<td>• This model is least likely to result in errors for the identified populations</td>
<td>• Nurses not practicing in the clinical situation full-time would not likely meet the threshold of clinical experience needing to prescribe</td>
</tr>
<tr>
<td>• Explicit and encompasses the direction from a physician</td>
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Conclusions from the Environmental Scan

Among surveyed Public Health Units, the independent RN prescribing model and the use of protocols/group directives model were the equally preferred model of RN prescribing. The survey data also validates that many Public Health Units are already practicing the use of protocols/group directives to support nursing practice. Differences in ratings of preferred prescribing model may be explained by local availability of primary care partners, nature of programs at particular Public Health Units, Public Health Unit socio-political context and rural versus urban geographic location of the PHU.
Registered Nurse Prescribing: Considerations for Implementation

Several key issues must be addressed before considering which RN prescribing model would be most appropriate for public health. These issues include risk of harm to patients, public need, professional body of knowledge, accredited educational institutions to train RNs regarding the proposed practice model, economic viability of the proposed practice model, relevance of the proposed model to the healthcare system and how it impacts other professions and the relevance of the proposed prescribing model on the nursing profession.

Based on information gleaned from the literature review, and data obtained from key stakeholder consultations/surveys, several key issues are discussed below.

**Risk of Harm**

Regardless of prescribing model implemented, the CNO and Public Health Unit employers/organizations must ensure continuous quality monitoring/improvement measures particularly quality and safety measures that are responsive to patient outcomes, such as clinical audits, continuing professional development, and best practices. In order to ensure risk of harm is well mitigated, medication formulary lists, protocols/group directives and/or and decision support tools must be updated and evaluated regularly with input from the appropriate individuals at timed intervals. To mitigate risk for harm with respect to medication/drug formularies, whether a limited or open prescribing model is implemented, the prescription of controlled substances should be considered as part of a final step in the implementation of preferred a prescribing model.

**Public Need**

Adopting an independent prescribing model versus a protocol-based prescribing model, would better enhance access to care for patients, particularly in rural areas underserviced by physicians. Considering Canada’s aging population, and the complexity of medication management this cohort typically requires, an independent prescribing model may be better suited as specific protocol-based prescribing may be too cumbersome to respond to individual patient needs. It is also important to
note that accessibility to care could also be effected by the type of formulary used (restricted, limited or open) regardless of model, as this has a direct impact on what the nurse is permitted to prescribe.

**Body of Knowledge**

Current College of Nurses of Ontario (CNO) standards of practice regarding medication, directives and authorizing mechanisms delineate which controlled acts are authorized for RNs to perform. Current practice does not support RNs in the general class to diagnose patients with a medical condition, or prescribe a direct medication order for an individual patient independent of a physician/NP. The CNO standards support the use of medical directives; however a number of processes and organizational policies must be in place prior to implementation, including consultation with the medical authority and relevant senior administration, as directives typically apply to a very specific population (College of Nurses of Ontario, *Directives*, 2015). Though the Registered Nurses' Association of Ontario (RNAO) and the Canadian Nurses' Association (CNA) supports legislative change to enhance and broaden the scope of RN practice, additional legislative changes must occur if implementation of a RN independent prescribing model is desired (Registered Nurses' Association of Ontario, 2012; Canadian Nurses' Association, 2015).

**Education and Accreditation**

Currently, there are no educational institutions in Ontario offering additional training/courses for RNs in the general class to obtain the knowledge, skill and practice required for RN independent/prescribing. In British Columbia however, they have developed a model of Certified Practice that allows nurses, who have completed a certain number of clinical hours and a course, the authority to dispense medications in specific situations and settings (Canadian Nurses' Association, 2015). Currently, Ontario does not have any such model.

**Economic Impact**

There are many factors regarding the economic impact of RN prescribing on nurses, employers, external organizations (such as the CNO, RNAO and CNA) and the healthcare system as a whole.
These factors include allocation of funds for developing, delivering and paying for RN prescribing education; how an increase in nurses will require this education and over what time span must they complete this education, must be considered. It is also important to factor in costs of CQI (developing a process for assessing/evaluating quality and patient outcomes) and releasing time or time lost for RNs and employers/external organizations implementing or providing support for this change in practice. Another important consideration is with respect to professional liability insurance/malpractice insurance requirements for RNs within the prescribing role. A positive impact on budgets may be experienced as Public Health Units may employ more nurses as opposed to physicians, resulting in an overall cost savings.

Relevance to the Health Care System and Relationship to Other Healthcare Professionals

Overall, implementing an RN prescribing model will improve access to medications for Canadians and result in long-term cost savings for the healthcare system, though it may cause some confusion for patients and potentially conflict with other health care providers, particularly physicians. Previously the task of prescribing medicines has been within the domain of the medical profession but with the development and implementation of nurse prescribing, particularly a model such as independent prescribing, there may be perceived incursion on the medical profession's jurisdiction over prescribing (Kroezen et al., 2011, p. 2). However; all three prescribing models will require the RN prescriber to collaborate with the physician at times when patient complexity requires more advanced prescribing and/or medical knowledge.

Relevance to Profession

Traditionally, nurses are educated to practice holistically, using a critical social theory perspective. As prescribing has historically been part of the physician’s role, and has been heavily influenced by the bio-medical practice model, there is potential that moving towards RN prescribing may have an impact on nursing's theoretical philosophy of practice. There must be a consideration of this prior to development and implementation of an RN prescribing model that meets the needs of the public, as it must complement the current nursing discipline and philosophy.
**Conclusion**

In conclusion, further consultation with other professional groups such as family and hospital physicians, pharmacists, and HPRAC would be advantageous to further explore how other healthcare professionals (such as pharmacists in Alberta) have implemented prescribing as part of their practice. Additionally, HPRAC could consult with other countries/jurisdictions internationally, such as the UK, Ireland or Australia, to determine how they implemented RN prescribing and lessons learned from the process/change in practice.
Appendix A- Comprehensive Literature Review

Environmental Contextual Factors Impacting Nurse Prescribing

Environmental factors which impact nurse prescribing and prescribing model implemented include legal, educational and organizational conditions within specific geographic locations which vary country-country and in urban versus rural settings (Kroezen, Van Dijk, Groenewegen & Francke, 2011). Studies and systematic reviews indicate that nurse prescribing occurs in a variety of clinical specialty environments and across all age ranges and demographics occurring most often in primary care settings, followed by secondary care settings and lastly in acute care settings (Gielen, Dekker, Francke, Mistiaen & Kroezen, 2013).

Improved Access to Care

Evidence in the literature indicates that quicker and more efficient access to care requiring medication for patients was a key factor in the implementation of RN prescribing in the UK and Ireland (Kroezen et al., 2011). RN prescribing also helped reduce workloads of physicians and mitigate physician shortages in remote locations, ultimately improving access to and timeliness of care for patients being serviced (Kroezen et al., 2011). Across urban and rural areas, RN prescribing may also reduce the number of patient visits to hospital emergency departments; ultimately ensuring patients are accessing the right provider at the right time for the right patient.

Medication Appropriateness and Patient Safety

Preliminary evidence in studies and systematic reviews indicate that RN prescribers prescribe medication appropriately and safely. One study (Naughton, Drennan, Hyde, Allen, O’Boyle, Felle & Butler, 2012) implemented the Medication Appropriateness Index (the MAI) to evaluate drugs prescribed by RN prescribers based on drug indication, effectiveness, dosage, directions, practicality, drug-drug interaction, drug-disease interaction, unnecessary duplication, duration and expensiveness. It was determined that the majority of prescribing decisions were appropriate and similar to physician prescribing practice. Studies from the literature have been small, with results that are difficult to
generalize. As such, there are recommendations to complete larger studies, specifically randomized control trials, to verify these findings (Gielen et al., 2014).

Enhanced Nursing Practice
Systematic reviews found that implementation of RN prescribing enabled nurses to broaden their scope of practice, improve the use of nurses’ knowledge and skills, increase nurse autonomy and overall yield a cost savings for health care systems (Gielen et al., 2013).

Education and Continuing Professional Development
One systematic review (Kroezen et al., 2011) noted that nurses interested in becoming an RN prescriber in Western European Anglo-Saxon countries are required to complete a prescribing course, which includes an academic and practice component prior to supplementary or independently prescribing practice. Eligibility to enroll in the prescribing course requires the nurse to have a certain level of academic education completed and clinical experience required—which varies according to country and practice setting. Some countries also require nurses arrange a Designated Medical Practitioner (DMP) to supervise the nurse’s clinical assessment and decision making as part of taking the course. Once the nurse completes the course successfully, they are then permitted to begin prescribing. One study (Smith et al., 2014) noted nurse prescribers working as health visitors or district nurses in the community and/or in primary care had less access to DMPs to supervise their assessment and diagnosis skills as part of the requirements for prescribing. Furthermore, after this population successfully completed the prescribing course, and began prescribing practice, they reported less access to continuing professional development opportunities as a result of a lack of staff coverage, and lack of support (Smith et al., 2014). Studies and systematic reviews highlight the importance of continuing education and organizational support for RN prescribers, particularly in ensuring positive patient outcomes and safety requirements are met (Smith et al., 2014).
## Appendix B- List of Survey Questions for Key Stakeholders

Please rank the following prescribing models in order of preference for implementation at your particular Public Health Unit, where 1 is the most desirable and 3 is the least desirable model:

<table>
<thead>
<tr>
<th>Prescribing Model</th>
<th>Rank Order (1, 2, or 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Prescribing</td>
<td></td>
</tr>
<tr>
<td>Supplementary Prescribing</td>
<td></td>
</tr>
<tr>
<td>Use of Protocols/Group Directives</td>
<td></td>
</tr>
</tbody>
</table>

1. With regards to your top choice of prescribing model...
   a) What are the advantages of implementing this model to public health nursing at your particular Public Health Unit?
   b) What are the challenges or barriers of implementing this model related to public health nursing at your particular Public Health Unit?

2. With regards to your second choice of prescribing model...
   a) What are the advantages of implementing this model to public health nursing at your particular Public Health Unit?
   b) What are the challenges of implementing this model related to public health nursing at your particular Public Health Unit?

3. What other factors need to be considered in order to implement a prescribing model at your Public Health Unit?

4. What is the name of your Public Health Unit?

5. Please Provide Your Name & Contact Information

6. Do you authorize your approval for us to share your input and findings in a report that will be shared with the Ministry of Health and Long-term Care's Nursing Policy and Innovation Branch and/or the Health Professions Regulatory Advisory Council (HPRAC)? (Please note that we will also share the final report with the new Ontario Association of Public Health Nursing Leaders to promote distribution of the findings).
References


Registered Nurses' Association of Ontario (2012). *Primary solutions for primary care: Maximizing and expanding the role of the primary care nurse in Ontario*. Toronto, ON; Registered Nurses' Association of Ontario (RNAO).
Mr. Thomas Corcoran  
Chair  
Health Professions Regulatory Advisory Council  
56 Wellesley St W.,  
12th Floor  
Toronto, Ontario, Canada  
M5S 2S3  

January 21, 2016  

Dear Mr. Corcoran,  

We appreciate the opportunity to provide our input to the Health Professions Regulatory Advisory Council’s current consultation on RN prescribing. We understand your consultation period is shorter given the due date on your response to the Minister of Health and Long-Term Care and trust this will not compromise the due diligence required on the issue to fully understand the consequences of the three models being assessed.

The OCFP reviewed the models you are proposing and would only recommend the Use of Protocols should RN prescribing be approved. We have reviewed the criteria for assessment of the prescribing models and our feedback is provided against these.

1. Risk of harm and public need
   The OCFP agrees that these two criteria are critical to HPRAC’s assessment of the models for RN prescribing. As stated in our earlier feedback to the MOHLTC, it remains unclear what public and system need is driving the need for RN prescribing given access to other prescribers in Ontario’s health system, notably physicians and nurse practitioners. Without a clear and transparent statement of need (or the problem being addressed), it seem unreasonable to understand how either of the proposed solutions will best achieve the identified need. Many national initiatives are aimed at protecting patients from over-prescribing or ensuring appropriate treatments such as the Choosing Wisely initiative, and the OCFP’s Practicing Wisely education program. The provincial government has also been diligently trying to manage the cost of its drug budget in Ontario, and yet proposes adding another prescriber to the system. We would ask that HPRAC’s advice to the Minister includes an assessment of the cost of adding another prescriber on the provincial drug budget and to clearly define the need for and beyond ‘improving access’.

   Prescribing must go hand in hand with a full and complete medical history and assessment of a patient and diagnosis. Given the importance of continuity of care, the OCFP asserts the importance for patients to have access to a clinician responsible for their care, supported by interdisciplinary teams. The patient’s clinical lead is either a family physician or a nurse practitioner. The use of protocols currently exists through medical directives in many primary care practices. Building on these directives would afford evaluation of the spread and scale of RN prescribing to ensure its intended goals are being met.

Based on our previous submission to the MOHLTC, the OCFP strongly believes that any change in scope of practice must not compromise patient safety or quality of care. Expanding scope of practice must not be a short-term fix but should be based on stringent criteria, evidence of efficacy, and consideration for the existing model of care and patients being served within these models.
2. **Body of knowledge**  
The OCFP believes in the importance of an interdisciplinary care team where all providers are working within their scope of practice. Independent prescribing does not support the Ministry’s new direction for greater integration and alignment in the health system. Based on the literature review provided by HPRAC, there is limited evaluation of RN prescribing internationally, and there is more to do in Ontario to further implements elements of Bill 179 (the *Regulated Health Professions Statute Law Amendment Act, 2009*) and these, along with pharmacist prescribing, should be reviewed and considered prior to adding another prescriber.

3. **Education and Accreditation**  
The OCFP agrees with the findings in your jurisdictional review that all RN’s must complete post-graduate education before they can prescribe. Additionally, there will be a need to enhance RN education beyond facility-based training and have nurses trained in primary care, which will also support better interprofessional relationships among team members and enable appropriate use of protocols. The OCFP also believes that accredited continuing professional development related to appropriate prescribing should be part of ongoing certification for registered nurses. It is essential that the training requirements and practice boundaries for each profession, including the diagnoses that may be made and the medications that may be prescribed, are clearly defined.

Polypharmacy issues especially among seniors in long-term care, contraindications and drug interactions, need to be part of expanded and enhanced education and ongoing certification requirements.

4. **Economic impact**  
As noted above, the costs of adding another prescriber need to be offset against what issue is being addressed. If the intent of RN prescribing is reducing emergency room visits for issues better seen in primary care, will the ministry then hold accountable registered nurses to decrease ED visits? In the case of patients who are rostered to several primary care models (FHO, FHN, FHT), the family physicians are negatively impacted if their rostered patients seek care in the ED or in walk-in clinics. The large question of ‘access’ - to whom and for what - has not been appropriately defined. The ministry will also need to undertake outreach to patients to inform them about which providers they can see and for what, and in which settings.

5. **Relevance to the health-care system and relationship with other professions**  
RN prescribing must go hand in hand with clarity of roles between healthcare professionals, and this also needs to be understood by patients. The use of protocols must consider:

- Understanding of the diagnosis, prescribing/renewing/ modifying prescriptions, monitoring side effects, responding to adverse drug reactions
- Counselling patients regarding medication use and optimizing positive impacts
- Developing and maintaining complete medication profiles
- Communication of changes to medication regime to all health professionals, notably the MRP, in the circle of care and with the patient/caregiver.
Many team-based environments such as Family Health Teams and Community Health Centres, community palliative care, and long-term care make use of protocols and medical directives in clear clinical situations where diagnoses are made with history and physical examinations by physicians or nurse practitioners. These provide an important foundation upon which to build. Protocols can be effective in serving remote communities and may help to resolve some access issues in these communities, however improving access would not be solved by RN prescribing alone, since access is more often related to issues regarding social determinants of health and not prescribing more medications.

6. Relevance to the profession
The ministry and Health Quality Ontario have indicated that close to 94% of the population in Ontario is attached to a primary care practitioner. While there may be a misdistribution of health care providers in the province creating some issues to access, RN prescribing cannot solve access without a clearer integrated health human resources strategy. Additionally, access needs to be much better defined - to whom and for what - to understand whether the solution proposed (RN prescribing) is the appropriate one to address the problem.

The National College of the OCFP, the College of Family Physicians of Canada, developed a Position Statement, “Prescribing Rights for Health Professionals” in January 2010 that describes a number of important considerations that the OCFP supports. This report is available here: CFPC Prescribing Rights for Health Professionals 2010

On behalf of over 10,500 family physician members practicing in Ontario, we are firmly committed to an accessible and sustainable health-care system. The vision of the states that every Ontarian receives high quality, comprehensive and continuing care. According to the goals stated in the Patient’s Medical Home, the OCFP believes that patients are provided with a broad scope of services carried out by teams or networks of providers, including each patient's clinical lead - a family physician or nurse practitioner - working together with peer physicians, registered nurses and others. Changing the scope of practice of one profession requires careful thought and consideration about the potential impact and consequences on other professionals, patients and the health-care system.

Sincerely,

Dr. Sarah Newbery
President

Ms. Jessica Hill
CEO

141 of 192
January 4, 2016

Mr. T. Corcoran  
Chair  
Health Professions Regulatory Advisory Council  
56 Wellesley St. West  
12th Floor  
Toronto, ON M5S 2S3

Dear Mr. Corcoran:

Thank you for your letter notifying the Ontario College of Pharmacists (OCP) of the consultation process established by the Health Professions Regulatory Advisory Council regarding nurse (RN) prescribing in Ontario. We understand the models being considered are Independent Prescribing, Use of Protocols and Supplementary Prescribing. While Use of Protocols has already been established, (http://www.regulatedhealthprofessions.on.ca/for-practitioners.html) and Supplementary Prescribing seems unduly complex, Independent Prescribing appears to offer the greatest societal benefit. The Ontario College of Pharmacists offers support for whichever model is chosen for RN prescribing.

The Ontario College of Pharmacists is confident that the College of Nurses of Ontario (CNO) will establish the appropriate limits, conditions and processes to ensure that RN prescribing will be safe and effective. OCP will work collaboratively with the CNO to ensure that there will be effective understanding and communication between the registrants of our respective colleges.

Sincerely,

[Signature]

Marshall Moleschi, R.Ph., B.Sc.(Pharm), MHA  
CEO and Registrar
Submission to the Health Professions Regulatory Advisory Council (HPRAC)

Registered Nurse Prescribing Referral

Ontario Hospital Association

February 2016
Ontario Hospital Association

The Ontario Hospital Association (OHA) is the voice of Ontario's 147 public hospitals. Founded in 1924, the OHA uses advocacy, education and partnerships to build a strong, innovative and sustainable health care system for all Ontarians.

Introduction

The OHA welcomes the opportunity to respond on behalf of its members to the Health Professions Regulatory Advisory Council's (HPRAC) Registered Nurse (RN) Prescribing Referral. The OHA has been very supportive of expanding scopes of practice and promoting interprofessional care, and remains committed to working with system partners to enhance patient access to timely, safe, high-quality, patient-centred care.

Given the time constraints associated with HPRAC's consultation, the OHA conducted an abbreviated consultation with its hospital members on the prescribing authority of RNs in the province. As such, the OHA's comments are based upon a small subset of hospitals that responded to our request for feedback; however, we understand that some hospitals may have responded directly to HPRAC through its online survey. Given the diversity of our members' views on RN prescribing, the comments provided in this document should be construed as feedback for consideration, rather than broad representative endorsement of a particular perspective.

Overview of Member Feedback

In general, the subset of hospitals that responded to the request for feedback support the need to explore strategies that enhance public access to health care services, while maintaining quality and patient safety, and promoting interprofessional collaboration. While the introduction of RN prescribing to the Ontario health care system has the potential to enhance timely access to care, particularly in smaller, northern, remote and underserviced communities, it also presents possible risks related to patient safety. Hospital members acknowledge that RNs possess some of the knowledge that is required for prescribing; however, the depth of this knowledge could be enhanced in the context of making and communicating a diagnosis and subsequent prescription of medications.

Key to the successful implementation of RN prescribing in Ontario is the collaboration between RNs and members of other professions that currently prescribe, such as physicians and midwives. Mechanisms to facilitate clear communication and support team-based, collaborative care will need to be implemented.

To promote interprofessional care and minimize potential unintended consequences, other recommendations that HPRAC may wish to consider are outlined below:

- Recognizing that each organization has unique circumstances and readiness for change, the OHA encourages HPRAC to allow each hospital or patient care organization the flexibility to implement RN prescribing based on local circumstances such as organizational readiness.

- In an environment of significant transformation, it may be challenging for employers such as hospitals to support implementation of RN prescribing without additional support. The OHA
encourages HPRAC to recommend providing transitional resources to support employers with change management and implementation of RN prescribing.

- Raising awareness and educating the public about RN prescribing can help to avoid confusion and clarify roles, responsibilities and expectations among providers and patients. As part of the communication and implementation strategy, the OHA encourages the Ministry of Health and Long-Term Care to develop an awareness and education campaign targeted at the public to inform patients of the changes.

**HPRAC’s Criteria for Assessment of Prescribing Models**

Based on what we received from member hospitals, and considering HPRAC’s criteria for assessment of prescribing models, the OHA would like to highlight the following issues for HPRAC's consideration:

**Relevance to the Health Care System and Relationship to Other Professions**

RN prescribing has the potential to improve timely access to care for patients across the health care system, particularly in smaller, rural and northern communities, by:

- Enabling outpatient care settings to provide more holistic care;
- Relieving some of the pressure on primary care physicians by enabling RNs to renew prescriptions for chronic conditions; and
- Dedicating time to provide patient education regarding medications to ensure they have a better understanding of their medications.

As with the expansion of scope of practice for any profession, the relationship between RNs and members of other professions that currently prescribe (e.g. physicians, midwives) may experience some conflict, particularly as roles and responsibilities overlap and overall accountability becomes unclear. Mechanisms to facilitate communication and support collaborative care among team members will need to be implemented.

Clear roles, responsibilities and accountabilities need to be developed and articulated to providers as well as patients to promote a clear understanding of who is the Most Responsible Physician (MRP), and what that means. It may also be useful to establish an interprofessional team to develop the clinical decision supports for RN prescribing including front-line RNs with the requisite specialized knowledge and experience, advanced practice nurses, pharmacists, psychiatrists and physicians.

**Risk of Harm and Public Need**

Prescribing rights must go hand-in-hand with the ability to make a medical diagnosis, take into account a differential diagnosis, and interpret results of an appropriate medical workup. Under the *Nursing Act*, NPs are authorized to communicate to a client, or a client’s representative, a diagnosis made by the NP identifying as the cause of the client’s symptoms, a disease or disorder. Given the relationship between medical diagnoses and prescribing, any contemplation of RN prescribing rights should also include a review of the controlled act related to diagnosis under the *Regulated Health Professions Act*.

In the hospital setting, although care is provided in a team-based approach, there is a clear line of accountability. The MRP, who may be a physician, nurse practitioner or midwife, is responsible to
account for all prescribed and over-the-counter medications when making treatment decisions. Only that MRP can authorize administration of medications through individual prescription, signing of order sets, or signing off on applicable medical directives. Hence, it is relatively easy within a hospital to monitor the recommendations of supplementary care providers such as RN wound experts, consultants, or pharmacists.

As patients transition between the hospital setting and the community, quality assurance mechanisms that facilitate clear communication of both the intentions and details of prescribing efforts must be developed to minimize the possibility of polypharmacy (i.e. the practice of administering or using multiple medications especially concurrently); minimize prescribing errors; track incidents; and mitigate potential harm to patients as well as medical-legal risk to providers.

Medication reconciliation and management, which is already a significant challenge in the health care system, may become more difficult with the addition of RNs prescribing across the province, particularly in the absence of a patient-specific electronic health record. To enhance the medication reconciliation process, Ontario’s health care system needs to evolve to have a provider-accessible registry of all medications prescribed and dispensed to Ontario patients regardless of who has ordered them or where the prescription has been filled.

Education and Accreditation

As with any profession that experiences an expanded scope of practice, new curricula would have to be developed to support the addition of controlled acts. While RNs can provide care to a variety of patient populations and various conditions, the breadth of training and experience required to make and communicate a diagnosis and then prescribe medications may require additional training. In addition to developing new curricula, internships and learning opportunities would also need to be established and funded to support practical learning and application of learning related to prescribing.

Relevance to the Profession

The nursing profession continues to evolve to meet the changing needs of the patient population it serves. For example, the NP role has developed and expanded into all areas of the health care system. The Registered Practical Nurse (RPN) scope of practice has increased over the past several years as well. The expansion of the RN scope of practice to include prescribing may have a potential impact on these roles (i.e. less definition between an NP and an RN).

To avoid confusion, clear delineation of scope of practice expectations should be developed between RNs and RPNs, and RNs and NPs, related to RN prescribing. HPRAC may wish to also consider:

- The extent to which an expanded scope of practice requires current RNs to significantly update their training and qualifications;
- Whether or not prescribing RNs and non-prescribing RNs can co-exist, and the potential impact on title; and
- The impact of these considerations on organizations currently employing RNs.
Endorsement of a Preferred RN Prescribing Model in Ontario

With respect to implementing a single RN prescribing model in Ontario, hospital members have indicated that some models may be more effective depending on the setting. Given the diverse perspectives and abbreviated consultation on this issue, the OHA is not in a position to endorse one particular RN prescribing model on behalf of the broader membership at this time. To assist HPRAC with providing advice to the Minister of Health, the OHA would be pleased to facilitate a more fulsome consultation with the hospital sector to identify the most appropriate model from the hospital perspective.

Conclusion

The OHA welcomes the opportunity to provide HPRAC with the views of our hospital members on the issue of RN prescribing. While the introduction of RN prescribing to the Ontario health care system has the potential to enhance access and timeliness of care, the impact on patient safety, the public need, and the economic input need to be considered.

The OHA remains committed to partnering with the Ministry of Health and Long-Term Care and other key stakeholders to target a shared goal of improving patient access to services in the province. We would be pleased to discuss this submission further and consult more broadly with our membership on this issue. We look forward to participating in any future HPRAC consultation to provide advice on optimizing the RN scope of practice in the hospital setting.
January 20, 2016

Mr. Tom Corcoran
Chair,
Health Professions Regulatory Advisory Council
56 Wellesley St W., 12th Floor
Toronto, Ontario, M5S 2S3

Dear Mr. Corcoran,

Re. Registered Nurse Prescribing

Thank you for the opportunity to comment on the proposed expanded scope of practice of Registered Nurses to include prescribing. We understand the Minister of Health and Long-Term Care has asked HPRAC to consider which of the models - independent prescribing, supplementary prescribing or use of protocols - provides the most appropriate framework for Registered Nurse prescribing.

We note that this consultation deviates significantly from the usual HPRAC process which we believe limits our ability to participate in meaningful discussions about this proposal. First, there is no evidence brief or submission from the applicant seeking the scope change. We also note that the question being posed to stakeholders is unusual. Typically, when it comes to a scope of practice change, HPRAC presents the question of whether or not a scope of practice change is appropriate in the context of HPRAC's criteria. However, the current consultation asks how the scope change should be implemented. We do not believe stakeholders have been given an opportunity to comment on the appropriateness of the expansion in the first instance.

When it comes to independent prescribing, we believe a mechanism is already in place to enable this. It is the Extended Class Registered Nurse or Nurse Practitioner. Based on the preliminary literature reviews provided by HPRAC, it appears that RN prescribing taking place in other jurisdictions amounts to NP prescribing in Ontario. In those jurisdictions referenced in the HPRAC materials, RNs with an expanded scope possess graduate level training that includes advanced health assessment as well as knowledge of formulating and communicating a diagnosis.
Moreover, it is unclear (in part due to the absence of a synthesizing application) that independent RN prescribing meets the majority of HPRAC criteria. For example, there is no evidence presented that speaks to the public need.

While we do not believe that independent RN prescribing is an appropriate model for Ontario, the other option presented by HPRAC, the use of protocols merits further discussion. This framework is already in place in Ontario with the use of medical directives and represents one way we can fully utilize RN scope of practice. We would be pleased to explore this existing framework to determine if opportunities exist for enhanced collaborative care between RNs, primary care providers and family physicians.

Sincerely,

Dr. Mike Toth, MD, CCFP, FCFP
President,
Ontario Medical Association
January 22, 2016

Mr. Thomas Corcoran
Chair, Health Professions Regulatory Advisory Council (HPRAC)
56 Wellesley Street. W., 12th Floor
Toronto, ON M5S 2S3

Dear Mr. Corcoran:

The Ontario Pharmacists Association ('OPA' or the 'Association') welcomes the opportunity to participate in the public consultation regarding nurse prescribing.

The Ontario Pharmacists Association is committed to evolving the pharmacy profession, and advocating for excellence in practice and patient care. As Canada's largest advocacy organization, continuing professional development and drug information provider for pharmacists, the Association represents the views and interests of pharmacy professionals (including pharmacists, pharmacy students and pharmacy technicians) across Ontario. By leveraging the unique expertise of pharmacy professionals, enabling them to practice to their fullest potential, and making them more accessible to patients, OPA is working to improve the efficiency and effectiveness of the healthcare system.

Consistent with our core objectives of inspiring excellence in practice and patient care, we are pleased to provide our comments to the Health Professions Regulatory Advisory Council (HPRAC) for consideration.

As the needs and expectations of Ontarians continue to grow and evolve with respect to healthcare delivery, so too will our provincial health system need to adapt and evolve to meet the needs and expectations of patients. With finite financial resources, decisions around how and where healthcare dollars are spent need to be made in a manner that optimizes the patient experience while enabling all of Ontario's healthcare providers to practice to their fullest ability and in accordance with their training and scope of practice. It is critical that this system is coordinated and integrated so that patients can get the right care from the right providers in a timely and easily accessible manner. Equally important is the concept of system navigation, whereby patients gain a greater understanding of how the system works and how they can find the care they need when and where they need it.

Ontario's pharmacists are frontline primary healthcare providers who work alongside physicians, nurse practitioners and registered nurses, and who are critical to the success of any patient-focused and accessible care model. As the professional association representing pharmacists across all clinical settings, the Ontario Pharmacists Association is qualified to comment on a scope of practice expansion that includes non-physician prescribing.

In any analysis of non-physician prescribing, it is important to keep sight of our primary focus—the patient. It is therefore integral to this discussion that patient safety, care coordination and integration remain at the forefront and are not compromised. As we consider the merits and challenges associated with enabling prescriptive authority for nurses, we should dissect the individual processes that are involved in prescribing and consider the nurse's ability to perform these processes as compared to the benchmark set by traditional prescribers—physicians, nurse practitioners, and dentists, as well as the more recent development of rules for prescribing by pharmacists in some jurisdictions in Canada (to a very limited degree in Ontario, but more broadly in Alberta, Saskatchewan, Nova Scotia and Quebec).
Background

In 1995, de Vries, et al outlined for the World Health Organization a six-step approach\(^1\) to prescribing, suggesting that prescribers should (1) evaluate and clearly define the patient’s problem; (2) specify the therapeutic objective; (3) select the appropriate drug therapy; (4) initiate therapy with appropriate details and consider non-pharmacologic therapies; (5) give information, instructions, and warnings; and (6) evaluate therapy regularly (e.g., monitor treatment results, consider discontinuation of the drug). Two additional steps were added by Pollock, Bazaldua and Dobbie in 2007\(^2\), calling for (7) the consideration of drug cost when prescribing; and (8) the use of computers and other tools to reduce prescribing errors. These eight steps have been summarized in Table 1, with some adaptation to juxtapose the roles, scopes of practice and training of nurses and pharmacists as non-physician prescribing (NPP) is being assessed. The Table offers an excellent overview of what patients should expect from their chosen prescriber. The processes involved in prescribing require the provider to exercise multiple skills.

- patient-based – dependent on the patient’s characteristics and how the patient presents him/herself,
- product-based – a function of understanding the pharmacology and pharmacokinetics of the drug product under consideration, and
- patient/product hybrid – an understanding of how the drug may or may not work well in a particular patient, based on other medications on board, impact of therapy on the patient’s lifestyle.

As conventional prescribers, physicians have a very good grasp on each of these skill sets and for the most part apply them quite efficiently. However, it should be noted that the pharmacy curriculum also prepares pharmacists with a substantial level of training in these skills, and rightfully so. Since pharmacists are the gatekeepers of pharmaceutical therapy, they have an obligation to mirror the prescriptive process in their analysis of each prescription to ensure that it is, in fact, the right drug at the right time and at the right dose and frequency for the right patient. As we consider expanding the role of nurses to include prescriptive authority, we are obliged to ask if nurses possess the same set of skills as exercised by physicians and pharmacists to safely and effectively prescribe independently, through defined protocols, or in a supplemental manner.

Considerations for the current issue

It is the opinion of the Ontario Pharmacists Association that nurses could have the ability to embrace independent prescriptive authority if they undergo a substantive training program that prepares them for the responsibility and accountability associated with the necessary assessments. The Association is well-positioned to help lead, develop and deliver best-in-class inter-professional training that could accelerate the process. Even so, independent prescriptive authority may be too large and bold a jump in scope at this time: perhaps a more cautious initial approach (for example, the introduction of a hybrid process that is a blend of protocols such as medical directives for some conditions and independent authority for lower-risk therapeutic products) would be warranted. What we would guard against, however, is the use of defined medication ‘lists’; wherever this has been applied, it has proven to put a burden on the system as it struggles to add new/best practice therapies. As we have suggested for our own profession, it may be better to indicate for which conditions authority is granted, with the appropriate health care professional (independently or collaboratively) selecting the best therapy given their assessment of the patient and their history.

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\(^1\) [http://apps.who.int/medicinedocs/pdf/whozip23e/whozip23e.pdf](http://apps.who.int/medicinedocs/pdf/whozip23e/whozip23e.pdf)

The HPRAC consultation template has sought input on several areas that the Minister must consider in the determination of the appropriate nurse prescribing model. As it pertains to matters related to the impacts on patients and the health system, as well as the risk of harm and readiness to prescribe, this submission covers the Association's perspective and suggestions to HPRAC. With respect to access to care, it is OPA's belief that, in certain circumstances, patient access may be increased with independent prescriptive authority. This may include nurses working in remote locations where there is poor or no access to other prescribers, as well as nurses working in hospital or long-term care settings overnight or when a prescriber is not readily available. In many other situations, however, collaborative approaches to prescribing, such as with the use of protocols and medical directives, may be more optimal. The Ontario Pharmacists Association notes that while physicians, nurse practitioners, dentists, and pharmacists all work with a defined set of patient records, we caution that community-based nurses do not generally work with their own individual set of patient records. Timely access to the patient's medical and medication records may pose an important logistical challenge as record keeping and documentation are critical to prescribing. The Association does acknowledge that registered nurses practicing within hospitals, long-term care homes and retirement homes typically have much greater access to patient records and are more involved in medication administration. Accordingly, they would be in a better position to appropriately document their activities, thereby contributing to an accurate patient health record, and perhaps these would be the places to start as a more phased approach to enabling prescriptive authority for nurses.

Conclusion
The Ontario Pharmacists Association would like to thank HPRAC for providing the opportunity to provide insights and commentary on the question of nurse prescribing. Should you have any questions with respect to this submission, please feel free to contact me by email at amalek@opatoday.com or by phone at 416-441-0788.

Yours sincerely,

Allan H. Malek, B.Sc(Bio), B.Sc(Pharm)
Senior Vice President, Professional Affairs

cc: The Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care
Mr. Dennis A. Darby, Chief Executive Officer, Ontario Pharmacists Association
Mr. Sean Simpson, Chair of the Board, Ontario Pharmacists Association
Mr. Marshall Moleschi, Registrar, Ontario College of Pharmacists
Table 1: Eight-Step Approach to Appropriate Prescribing

<table>
<thead>
<tr>
<th>Step</th>
<th>Prescribing (Prescription and Over-The-Counter)</th>
<th>Physician/Dentist/Nurse Practitioner</th>
<th>Pharmacist</th>
<th>Registered Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Assessment of the Patient's Problem</td>
<td>• Within current scope of practice and/or training.</td>
<td>• Within current scope of practice and/or training.</td>
<td>• Not currently within scope of practice and/or training. Notwithstanding lack of access to the patient record, pharmacologic refresher will be required.</td>
</tr>
<tr>
<td></td>
<td>• The prescriber will evaluate and clearly define the patient's problem. This includes:</td>
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<tr>
<td></td>
<td>• Taking an appropriate patient history, including the most complete and accurate list possible of drugs the patient is taking;</td>
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<tr>
<td></td>
<td>• Taking into account any previous adverse reactions to drugs;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Obtaining and/or verifying information by checking previous records and databases, when available;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Obtaining prescription and/or other relevant medical information;</td>
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<tr>
<td></td>
<td>• Performing any additional examinations and or investigations as may be required.</td>
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<td></td>
</tr>
<tr>
<td>2</td>
<td>Specification of the Therapeutic Objective</td>
<td>• Diagnosis is within current scope of practice.</td>
<td>• Diagnosis is NOT within current scope of practice at this time.</td>
<td>• Diagnosis is NOT within current scope of practice at this time. Diagnostic knowledge is within the scope of training.</td>
</tr>
<tr>
<td></td>
<td>• Prescribers are expected to direct prescribing to a clear goal with expected outcomes.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3</td>
<td>Selection of the Appropriate Drug Therapy</td>
<td>• Within current scope of practice/training</td>
<td>• Within current scope of practice/training</td>
<td>• Not currently within scope of practice/training. Pharmacologic refresher will be required.</td>
</tr>
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<td></td>
<td>• Prescribers will select a therapy that considers the dosage form, frequency of dosing, likelihood of side effects (including the ability of the patient to manage them), and affordability.</td>
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1 http://napra.ca/Content_Files/Files/SupplementalStandardsofPracticeIandIIJune2005.pdf
<table>
<thead>
<tr>
<th>STEP 4</th>
<th>INITIATION OF THERAPY</th>
<th>PHYSICIAN/DENTIST/NURSE PRACTITIONER</th>
<th>PHARMACIST</th>
<th>REGISTERED NURSE</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Prescribers may Initiate therapy with appropriate details and will consider use of non-pharmacologic therapies.</td>
<td>• Within current scope of practice.</td>
<td>• Validation of selected therapy is within current scope of practice and/or training.</td>
<td>• Validation of selected therapy is not currently within scope of practice and/or training.</td>
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<tr>
<th>STEP 5</th>
<th>PATIENT COUNSELLING</th>
<th>PHYSICIAN/DENTIST/NURSE PRACTITIONER</th>
<th>PHARMACIST</th>
<th>REGISTERED NURSE</th>
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<tbody>
<tr>
<td></td>
<td>Prescribers are to provide patients with information, instructions, and warnings.</td>
<td>• Within current scope of practice.</td>
<td>• Within current scope of practice and training.</td>
<td>• Pending completion of pharmacologic training, this would be within the skill set.</td>
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<tr>
<th>STEP 6</th>
<th>MONITORING AND EVALUATION</th>
<th>PHYSICIAN/DENTIST/NURSE PRACTITIONER</th>
<th>PHARMACIST</th>
<th>REGISTERED NURSE</th>
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<tbody>
<tr>
<td></td>
<td>Prescribers will evaluate therapy regularly with a view toward:</td>
<td>• Within current scope of practice.</td>
<td>• Within current scope of practice and/or training.</td>
<td>• Pending completion of pharmacologic training, this would be within the skill set.</td>
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<td></td>
<td>• Maintaining therapeutic regimen. Medication is deemed to be effective and well-tolerated;</td>
<td></td>
<td></td>
<td>• Access to patient’s EMR and medication record would be required.</td>
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<tr>
<td></td>
<td>• Adjusting therapeutic regimen. Addition to and/or change to current therapy such as the drug, dose, formulation, or directions for use. Often done due to suboptimal response or side effects with initial therapy, or patient non-adherence;</td>
<td></td>
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<td></td>
<td>• Stopping therapeutic regimen. May be a function of therapeutic success (patient problem has resolved), therapeutic failure (patient exhibited no response or worsening of problem/condition, or poor tolerability including allergy, to name a few reasons.</td>
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<td>STEP 7</td>
<td>CONSIDERATION OF HEALTH SYSTEM IMPACT</td>
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<td></td>
<td>• Prescribers will consider the impact of drug cost to the patient and to the health system when prescribing.</td>
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<td></td>
<td>• Designed to introduce an awareness of the challenges to health system sustainability.</td>
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<td>• This includes the economic impact of therapy on both the public and private health systems.</td>
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<tr>
<th>STEP 8</th>
<th>USE OF SUPPLEMENTAL INFORMATION FROM VARIOUS SOURCES</th>
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<tbody>
<tr>
<td></td>
<td>• Prescribers will utilize computers and other technologies to mitigate prescribing and dispensing errors.</td>
</tr>
<tr>
<td></td>
<td>• Prescribers will utilize and consult other sources, when necessary, to support their clinical rationale.</td>
</tr>
<tr>
<td></td>
<td>• Prescribers will document their decisions and other relevant patient information within the patient electronic health record.</td>
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<tr>
<th></th>
<th>PHYSICIAN/DENTIST/NURSE PRACTITIONER</th>
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<tbody>
<tr>
<td></td>
<td>• Within current scope of practice.</td>
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<tr>
<td></td>
<td>• Prescribers would benefit from a greater appreciation of therapeutic costs.</td>
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<td></td>
<td>• EMRs may be helpful in this regard.</td>
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<tr>
<th></th>
<th>PHARMACIST</th>
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<tbody>
<tr>
<td></td>
<td>• Within current scope of practice and/or training.</td>
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<tr>
<th></th>
<th>REGISTERED NURSE</th>
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<tbody>
<tr>
<td></td>
<td>• Would benefit from a greater understanding of therapeutic costs.</td>
</tr>
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<td></td>
<td>• With access, EMRs may be helpful in this regard.</td>
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<tr>
<th></th>
<th>DOCUMENTATION</th>
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<tr>
<td></td>
<td>• Documentation is largely enabled within pharmacy practice management systems (PPMS).</td>
</tr>
<tr>
<td></td>
<td>• Mandated subscription access to real-time, unbiased drug information service.</td>
</tr>
<tr>
<td></td>
<td>• Mitigation of dispensing errors will be enhanced with the introduction of electronic prescribing technologies such as computerized &quot;prescriber&quot; order entry.</td>
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<tr>
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<th>UNCLARITY</th>
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<tr>
<td></td>
<td>• Unclear on documentation ability given that nurses do not roster patients in the same manner as physicians and pharmacists.</td>
</tr>
<tr>
<td></td>
<td>• Would require real-time access to clear, unbiased drug information service.</td>
</tr>
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</table>
|       | • Mitigation of dispensing errors will be enhanced with the introduction of electronic prescribing technologies such as computerized "prescriber" order entry.
APPENDIX – SUMMARY OF NON-PHYSICIAN PRESCRIBING MODELS UNDER CONSIDERATION

INDEPENDENT PRESCRIBING:

In this model a non-physician prescriber (NPP) may prescribe medications, under their own authority, without restrictions or from a limited or pre-defined formulary within a regulated scope of practice. Independent prescribers are allowed to prescribe any licensed or unlicensed drugs that are within their clinical competency area. As an independent prescriber, the NPP would be fully responsible for the assessment of the patient’s needs and prescription of medication. As an independent prescriber, the NPP would be similar to a physician in terms of ability to prescribe; however, an NPP would not have access to prescribing controlled drugs and substances.

USE OF PROTOCOLS:

In this model written instructions allow NPPs to supply and administer medications within the terms of a predetermined protocol. The use of protocols is used for the supply and administration of named medicines in an identified clinical situation. NPPs are only able to supply and administer medications within the strict terms of the predetermined protocol. Under this model, the NPP is responsible for the acceptance of the protocol but the prescribing physician or regulated health professional with prescribing authority is responsible for the assessment of the patient’s needs and the prescription of any medication. Through the use of protocols, a NPP would be able to prescribe specific medications under specific circumstances, similar to how NPPs currently prescribe through the use of an order or a medical directive.

SUPPLEMENTARY PRESCRIBING:

Supplementary prescribing is a hybrid of independent prescribing and use of protocols. This model involves a partnership between a NPP, physician and patient, where after an initial assessment of the patient’s needs by the physician a NPP may prescribe medication. In this model a patient-specific clinical management plan (CMP) is developed by the NPP and physician and allows the NPP to prescribe within a limited or pre-defined formulary or by class of drugs within their clinical competency area. The collaborating physician shares the responsibility of prescribing and holds full responsibility for the assessment of the patient. There are no restrictions on the type of patient condition or patient population that a CMP could be developed for between a physician and NPP. As a supplementary prescriber a NPP, working within a previously established CMP, would be permitted to prescribe for a variety of patient clinical conditions as long as they are within the NPP’s clinical competency.
Registered Nurse Prescribing Referral

Submission to the
Health Professions Regulatory Advisory Council
(HPRAC)

January 15, 2016
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Summary of RNAO Recommendations for HPRAC

1) The Minister of Health and Long-Term Care amend necessary legislation and regulations by the end of 2016 to authorize registered nurses (RN) to autonomously perform the following controlled acts as specified in the Regulated Health Professions Act:
   a. 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.
   b. Applying or ordering the application of a form of energy.
   c. Prescribing, selling and compounding a drug as defined in the Drug and Pharmacies Regulation Act.

2) RNs’ expanded scope of practice must be based on an enabling framework (independent prescribing as defined by HPRAC) and not restricted by lists, protocols or collaborative practice agreements.

3) The Ministry of Health and Long-Term Care, in collaboration with the Ministry of Training, Colleges and Universities and educators implement an expanded RN scope of practice through a phased-in approach. Beginning with current RNs in 2016 through a voluntary university-level continuing education course, followed by incorporation of the expanded scope into the baccalaureate nursing curriculum by 2020.

4) The College of Nurses of Ontario implement a communications system for both the public and other health providers to know which RNs are eligible to practice within an expanded scope (i.e. through the public registrar).

5) The Ministry of Health and Long-Term Care and the Registered Nurses’ Association of Ontario partner to disseminate a public education campaign to inform Ontarians and other health providers about the expanded scope of practice for RNs.

6) Health system planners and researchers develop an evaluation system to track progress on process and outcome indicators related to an expanded RN scope of practice.
RNAO response to HPRAC’s Registered Nurse Prescribing Referral

Background

The Registered Nurses’ Association of Ontario (RNAO) is the professional association representing registered nurses (RN), nurse practitioners (NP) and nursing students in all settings and roles across Ontario. For over 90 years RNAO has advocated for opportunities to improve the health of Ontarians by addressing health and health-care imperatives, including optimizing the use of health professions. For example, RNAO was the catalyst behind the proclamation of NP legislation, the baccalaureate entry to practice requirement for RNs, implementation of NP-led clinics, and the funding of NP positions in long-term care. We have actively participated in many HPRAC consultations dating back to 1998. For example, RNAO has developed submissions on the regulation of chiropody and podiatry in Ontario,1,2 the regulation of paramedics under the Regulation Health Professions Act (RHPA),3,4 the regulation of physician assistants under the RHPA,5 the use of the “Doctor Title” in Traditional Chinese Medicine,6 the scope of practice of NPs,7,8 interdisciplinary collaboration among Health Colleges and Regulated Health Professionals,9,10 non-physician prescribing and administration of drugs,11 and the five year review of the RHPA.12

Many organizations across the province have identified areas where the health system needs to improve, including reducing wait times,13 eliminating fragmentation and breaking down geographical discrepancies in service,14,15,16 improving afterhours access to service in primary care,17,18 and minimizing rates of hospitalization and emergency room visits for ambulatory care sensitive conditions.19,20 In December 2015, the Ministry of Health and Long-Term Care released a discussion paper with plans to address the structural issues that affect these areas listed above. The objectives cited in the paper include reducing inequities in access to care, integrating the health system and standardizing care delivery.21 Implementing RN prescribing through an enabling framework (independent prescribing as defined by HPRAC) is an opportunity to achieve these health system goals. In other jurisdictions where RNs practise to an independent expanded scope, clients have same day or next day appointments in primary care,22 increased continuity of care and caregiver,23,24 improved chronic disease management (i.e. refilling prescriptions),25 increased access to care for vulnerable populations (i.e. homeless clients with communicable illnesses)26 and timely access to care for those living in rural or remote areas.27,28,29

Full utilization of health human (HHR) resources is essential if we want to improve the health system. An optimized HHR workforce will fuel the Ministry of Health and Long-Term Care’s goals to provide integrated and locally responsive health services, timely access to primary care, and continuity of care between sectors.

We appreciate the opportunity to offer feedback on a proposal to expand the scope of practice of the RN to include the authority to prescribe. RNAO has been urging an expanded RN scope of practice for many years. In 2012, RNAO released the
recommendations of the provincial Primary Care Nurse Taskforce on optimizing the full utilization of primary care nurses to strengthen patient outcomes and generate health system effectiveness in *Primary Solutions for Primary Care*. The taskforce included: Canadian Family Practice Nurses Association (CFPNA), Canadian Nurses Association (CNA), Ontario Medical Association (OMA), George Brown College, Association of Ontario Health Centres (AOHC), Association of Family Health Teams of Ontario (AFTHO), Ontario College of Family Physicians (OCFP), Ontario Nurses’ Association (ONA), Registered Practical Nurses Association (RPNAO), Nurse Practitioners’ Association of Ontario (NPPO), Ontario Family Practice Nurses (OFPN), and Community Health Nurses’ Initiatives Group (CHNIG). The taskforce determined the time had come to authorize an expanded scope for RNs in Ontario, including prescribing, the ability to order diagnostic testing and the authority to communicate a diagnosis, given the strong evidence on the benefits internationally.

In 2012, the nations' Premiers and Territorial Leaders, recommended through the Council of the Federation’s working group on Health Care Innovation to enable all members of the interdisciplinary team to practise to their maximum scope of practice.

Also in 2012, the Drummond Commission, which conducted a full review of public services, recommended enabling health professionals to practise to their full scope with RNs assuming full responsibility for certain aspects of care delivery, shifting responsibilities from physicians to RNs to optimize human resource capacity while lowering costs, and enabling RNs to provide follow-up care to increase continuity of care and access.

In 2014, the Canadian Academy of Health Sciences suggested modernizing the health-care environments so RNs could deliver more care without the need for an order, thereby, decreasing the reliance on physicians, increasing the role of RNs and NPs in primary care (i.e. nurse led clinics that provide low complexity primary care), implementing RN-led telemedicine, and enabling RNs to provide follow-up care that will ultimately decrease the number of unnecessary emergency room visits.

In 2015, the provincial Rural, Remote and Northern Area Provincial Nursing Task Force, re-confirmed the need to expand the RN scope to meet health needs in rural, remote and northern regions. Also in 2015, the Ontario Long Term Care Association advocated for more skilled and knowledgeable staff that could respond to resident needs in a timely manner.

In recognition of RNs’ capacity, Premier Kathleen Wynne first committed to expanding the RN scope of practice to include prescribing at RNAO’s 88th Annual General Meeting in 2013. Supportive public opinion was reflected in an editorial in the Toronto Star. In 2014, the Liberal government made RN prescribing a commitment of its re-election platform, and at RNAO's Queen’s Park Day in 2015, Minister Hoskins re-confirmed the government’s pledge to expand the scope of practice for RNs and announced the launch of consultations. On November 4, 2015, the minister referred
the matter to HPRAC to assess three different models for implementing RN prescribing, while being clear that RN prescribing will be proceeding.40

This submission is structured based on HPRAC’s criteria for assessing the three proposed models of RN prescribing specified in the Minister’s mandate letter: independent prescribing, use of protocols, and supplementary prescribing. The definitions provided verbatim by HPRAC are as follows:41

**Independent prescribing:** In this model a nurse may prescribe medications, under their own authority, without restrictions or from a limited or pre-defined formulary within a regulated scope of practice. Independent prescribers are allowed to prescribe any licensed or unlicensed drugs that are within their clinical competency area. As an independent prescriber the RN would be fully responsible for the assessment of the patient’s needs and prescription of medication.

As an independent prescriber, a RN would be similar to a physician in terms of ability to prescribe. However, an RN would not have access to prescribing controlled drugs and substances.

**Use of protocols:** In this model written instructions allow RNs to supply and administer medications within the terms of a predetermined protocol. The use of protocols is used for the supply and administration of named medicines in an identified clinical situation. RNs are only able to supply and administer medications within the strict terms of the predetermined protocol. A RN under this model is responsible for the acceptance of the protocol but the prescribing physician or regulated health professional with prescribing authority is responsible for the assessment of the patient’s needs and prescription of any medication.

Through the use of protocols, a RN would be able to prescribe specific medications under specific circumstances, similar to how RNs currently prescribe through the use of an order or a medical directive.

**Supplementary prescribing:** Supplementary prescribing is a hybrid of independent prescribing and use of protocols. This model involves a partnership between a RN, physician and patient, where after an initial assessment of the patient’s needs by the physician a nurse may prescribe medication. In this model a patient-specific clinical management plan (CMP) is developed by the nurse and physician that allows the nurse to prescribe within a limited or pre-defined formulary or by class of drugs within their clinical competency area. The collaborating physician shares the responsibility of prescribing and holds full responsibility for the assessment of a patient. There are no restrictions on the type of patient condition or patient population that a CMP could be developed for between a physician and RN.

As a supplementary prescriber a RN, working within a previously established CMP, would be permitted to prescribe for a variety of patient clinical conditions.
as long as they are within the RN’s clinical competency.

*Please note: for the purposes of the models outlined above physician and regulated health professional with prescribing authority includes nurse practitioners or any other appropriate non-physician prescriber.

RNAO supports the model of independent prescribing as an enabling framework. There are 96,007 RNs employed in nursing in Ontario. RNs are the largest group of regulated health professionals. They work in all health sectors throughout Ontario. Their diverse distribution throughout the health system positions them to meet the unique needs of Ontarians. Prescribing, along with enabling RNs to order the necessary diagnostic testing as part of their comprehensive health assessment and communicating the diagnosis to the patient would unlock access to the health system.

The limitations inherent in supplementary models and the use of protocols will compromise advancement of the health system goals identified by Minister Hoskins, as well as those identified by the numerous reports outlined above. In both of these models, physicians and NPs will continue to act as gatekeepers as they retain the authority to communicate a diagnosis and order diagnostic testing. They also ultimately maintain accountability for prescribing, which complicates continuity of care and jeopardizes patient safety. Current delegation models (i.e. medical directives and medical orders) do not address a client’s changing or unique health needs and blur accountability as prescribers (NP and physicians) order treatments based on another professional’s (RN) health assessment. Supplementary models and protocols are forms of delegation that would simply perpetuate the same challenges.

While RNAO supports independent prescribing as a regulatory model, it does not suggest that RN prescribing would occur in isolation. Independent RN prescribing refers to a regulatory approach that governs the practice of prescribing. RNs are natural collaborators and independent prescribing would enable the autonomy needed for RNs to thrive in both team environments and in areas where RNs may be the only health provider accessible to Ontarians (i.e. rural, remote and northern communities).
Risk of Harm & Public Need

Risk of Harm

The risk of harm to patients by independent RN prescribing is minimal. RNAO has developed a model to safely govern independent RN prescribing in Ontario (Figure 1). As regulated health professionals, RNs are required to be aware of their level of competency and practise within it. The College of Nurses of Ontario (CNO) provides RNs with a practice standard that outlines expectations when determining if they have the authority to perform a procedure, if it is appropriate for them to perform that procedure, and if they have the competency to perform the procedure. This could be adapted to regulate independent RN prescribing in a standardized manner across the province.

Figure 1- RNAO’s Proposed Model to Govern Independent RN Prescribing

Enabling Legislation and Regulation
(Government of Ontario)

Principle-Based Practice Standard
(College of Nurses of Ontario)

Policies/Procedures
(Employers)

Self-Assessment
(RNs)

Enablers:
- CNO’s Quality Assurance Program
- Continuing education
- Clinical practice guidelines

Independent RN prescribing creates an opportunity for RNs to work with their employers to determine the parameters of an expanded scope based on the care being provided and the health needs of the population(s) being served. Under the Regulated Health Professions Act employers are responsible for ensuring their employees can
perform the duties of their position without contravening legislation. RNAO recommends that organizations provide role descriptions for RNs practising to an expanded scope, develop a plan to implement the necessary structural and logistical requirements to support RNs in an expanded scope, ensure RNs with an expanded scope have the necessary time and resources to acquire and maintain their competency, including preceptorship and/or mentorship. Peer support should be encouraged between RNs in expanded scopes, nurse practitioners, physicians and others as it boosts confidence and builds relationships within teams.

Currently, when RNs feel a situation is beyond their level of competency, they refer to another appropriate provider. Referrals may involve consultation with another provider, partial transfer of care or a complete transfer of care. This practice will continue as RNs gain the authority to independently prescribe. A qualitative study on RN prescribing in the United Kingdom identified that RNs took a cautious approach to prescribing, felt strongly about their increased responsibility and accountability, and only prescribed medications they were familiar with.

Using protocols as a model of RN prescribing would be re-naming the current status quo of medical directives and perpetuating the same limitations. Protocols will be cumbersome to complete, require regular updating to reflect best practices, fail to address the unique needs of clients, blur professional accountability and become void when the signing practitioner with prescribing authority leaves the organization. In addition, to be done properly, they require that the delegator maintains an ongoing awareness of the specific knowledge, skill and judgment of the delegatee. This is not always practical and creates duplication.

Models of supplementary prescribing have some of the same limitations as protocols and are similar to the current practice of physicians or NPs prescribing PRN (“as needed”) medication. The Canadian government defines PRN medications as “…those prescribed to be given when a client needs them. A PRN prescription includes the frequency with which the medication may be given, such as Q4H PRN.” Supplementary prescribing would require RNs to enter into collaborative practice agreements with physicians or NPs where physicians or NPs will still be responsible for the patient’s initial assessment and diagnosis. Furthermore, the physician or NP will determine which medications the RN could prescribe for that patient. The requirement for a comprehensive clinical management plan limits the applicability of these models to many sectors as they demand long-term and relatively predictable patients. This model is further limited because every change in the patient’s health status will have to be assessed and diagnosed by the physician or NP to be treated. Ultimate accountability for patient care will be blurred, creating significant patient safety concerns, as prescribed treatments could be made under the physician, NP or RN’s authority. This model also has consequences for physicians or NPs that enter into collaborative practice agreements. It will be time consuming for physicians or NPs to develop individual clinical management plans for patients that fall under the agreement and they may be unwilling to assume this additional role. While jurisdictions like the UK initially implemented RN prescribing with these types of restrictions, they were lifted to pursue...
independent prescribing as evidence demonstrated positive outcomes on access, safety and person centred care.\(^{48}\) Indeed, restricting what RNs can do through protocols or clinical management plans are unnecessary regulatory measures that blur accountability and present barriers to clients accessing care.

An evaluation system should be established to track process and outcome indicators during implementation of an expanded RN scope. The framework could engage provider experience, patient satisfaction measures and patient outcome impacts. This evidence will be very useful for Ontario as well as contribute to the international evidence base. As evidence accumulates, the role can evolve and adapt to further meet the needs of Ontarians.

Lastly, and also of importance, all practising nurses, including RNs and NPs, are required by the College of Nurses of Ontario to have professional liability protection (PLP) that protects the public in the unlikely event that negligence or malpractice occurs.\(^{49}\) RNAO membership meets the PLP requirement and providers members with $10,000,000 of coverage for court-imposed damages, costs, legal expenses and other provisions of the policy.\(^{50}\)

**Public Need**

There are approximately 38,503\(^{51}\) physicians in Ontario, 2,407\(^{52}\) NPs, and 96,007\(^{53}\) RNs. With independent prescribing, RNs can unlock access to health services for the public. Below we highlight a few examples, please refer also to Appendix A for a summary of reports highlighting the need to improve access to health services.

1) **Public Health**

An expanded RN scope is a reasonable extension of public health nursing, especially when working with marginalized and vulnerable populations that are socially excluded or experiencing deprivation.\(^{54}\) While it is desired to expand comprehensive primary care access throughout the province and progress should continue, some patients/clients may express preference to see the public health nurse for sensitive health concerns.\(^{55}\) This may occur because long-term and trusting relationships have already been developed. For example, a study of injecting drug users shows they under-utilize primary care physician services due to the discrimination they face when accessing mainstream health services, difficulties keeping set appointments and debilitating co-morbid health conditions.\(^{56}\) This population preferred to attend a public health nurse-led clinic where they felt less threatened, disclosed more, and accessed continuous primary care services.\(^{57}\) In these types of settings and through independent prescribing, public health nurses could verify suspected conditions with laboratory testing, communicate the diagnosis to the patient and prescribe the necessary treatment without having to transfer the care to a physician or a NP. However, with supplementary prescribing or protocols, the RN would not be able to intervene for marginalized patients without a physician or NP diagnosis. This leaves RNs unable to treat other conditions they detect through
patient interactions and is a lost opportunity given the infrequent contact marginalized populations have with the health system.

The primary care status quo model of physician-centred solo and small group practices performs the most poorly in meeting the health challenges of people who are experiencing homelessness. Persons experiencing homelessness face numerous challenges in accessing health services: insufficient transportation, no health insurance, lack of a permanent address, distrust of health care providers, and mental health issues. The three models (clinic, fixed outreach, and mobile outreach) that are more effective in meeting the health needs of people who are homeless are interprofessional in nature with heavy reliance on nursing services. RNs strive to break down barriers by building relationships and providing care where marginalized people are including in the shelter, park, or street. Some examples of illnesses RNs prescribe for in this population in other jurisdictions include head lice, pain and fungal infections. These clients may not access care frequently, miss follow up visits or are unable to attend referrals, thus making it challenging to obtain a physician or NP’s diagnosis and develop the comprehensive clinical management plans necessary with supplementary prescribing. Furthermore, given their unique health needs, treatment plans should be based on professional judgment rather than clinical protocols. Having RNs that are able to provide the full spectrum of care (assessment, diagnosis, treatment, and evaluation) will significantly improve access for homeless persons and those living in shelters.

The benefits of independent RN prescribing will also extend to other vulnerable populations, especially those that are continuously facing challenges receiving appropriate health services, such as First Nations, Inuit and Métis persons, refugees and other newcomers to Canada, LGBTQ persons, and persons who are incarcerated in correctional facilities. Additionally, it will serve to improve other long-standing access challenges for diverse ethnic communities and Francophone persons. For example, based on the 2006 census, with a Francophone population in Ontario of over 500,000 and almost 12,000 RNs who declared knowledge of French (and about 7,000 that used it at least regularly), the improvements to accessing health services could be substantive.

Adolescence can be a stressful and complex time of growth and change. Independent RN prescribing complements the critical role of public health nurses in schools. For example, students may feel apprehensive to seek reproductive and/or sexual health services within the traditional routes of the health system. By expanding the scope of practice of the school-based public health nurse, students would be able to receive comprehensive reproductive/sexual health services in an environment that feels safe and comfortable. Along with health promotion strategies, school-based public health nurses with independent prescribing authority, can empower informed decisions, decrease the rate of adolescent pregnancy and enable healthy sexuality.

2) Primary Care

Patients need care closer to home, which encompasses health promotion, disease prevention, and chronic disease prevention and management; RNs already provide these
services. Primary care is the entry-point to the health system and in 2014, 94 per cent of adults reported having a primary care provider (physician or NP). However, the ability of those adults to see their primary care provider on the day or day after they get sick ranged from 28.4 per cent to 57 per cent depending on the LHIN. When analyzing after hours care (evenings and weekends), 45.3 - 73.0 per cent of adults reported difficulty accessing care depending on the LHIN. In 2014, there were 4,277 RNs practising in primary care and given current proposals to restructure the health system, an additional 3,500 RNs can transition to primary care from Community Care Access Centres (CCAC). These RNs will significantly increase the capacity of primary care to deliver health services, including care co-ordination and health system navigation. Authorizing RNs to be fully responsible and accountable for an expanded role through independent prescribing will meet the needs of the public. The Minister of Health and Long-Term Care identifies improving access to primary care as a specific goal to strengthen patient-centred health care in Ontario and studies show that RNs with an expanded scope means clients can get appointments within 48 hours, have more time for consultations, and achieve timely follow up via telephone in primary care. An expanded utilization of RNs in primary care changed team dynamics in the UK as physicians focused on new or complex clients, while RNs focused on clients with predictable conditions. For example, if a client presents in primary care with an uncomplicated urinary tract infection, the RN should be enabled to conduct a thorough assessment (including point of care testing), communicate a diagnosis and initiate treatment. This would avoid unnecessary waits until a physician or NP is available, reduce complications, and lessen walk-in or emergency department visits, thus re-directing health human resources to align with the right provider delivering the right care at the right time.

Supplementary models of prescribing and protocols would not achieve these results. Patients would not be able to get same day or next day appointments for emerging health issues because they would still need to be assessed and diagnosed by the physician or NP. Development of clinical management plans between physicians, NPs and RNs would take time away from direct patient care and represent an administrative burden. Furthermore, every change in authorized treatment would have to be approved by the physician or NP reducing the RNs ability to respond to patients needs. Similarly, if patients’ needs deviate slightly from a clinical protocol, the RN would have to refer them to the physician or NP, thus removing the RNs’ ability to provide care based on their professional judgment.

At present, the bulk of health service delivery in Ontario’s remote communities is provided by RNs. The populations being served are largely First Nations, Inuit and Métis persons. Today, these RNs are already delivering comprehensive care in expanded capacities that include prescribing, providing diagnostic testing and diagnosing illness/conditions. These RNs communicate with physicians or NPs through the use of technology in a consultative capacity. Their work is remarkable, however, they are limited in the scope and application of the medical directives that are used. The effectiveness, safety and accountability of this important role can be enhanced through independent RN prescribing and the ability to autonomously order diagnostic testing and
the communicate a diagnosis. However, even with these limitations, remote RNs are proof that profession can safely and effectively embrace an expanded role in Ontario’s health system.

3) Acute Care

Provincial wait times in emergency rooms average four hours for low acuity patients and almost 10 hours for high acuity patients. A Canadian policy analysis uncovered overcrowding in emergency rooms was attributed to the challenges patients have accessing their primary care provider. Through independent prescribing models, RNs have the ability to transform primary care access. However, there may be a transition period whereby some Ontarians still pursue unnecessary emergency department care. In those cases, independent RN prescribing would position RNs to lead rapid assessments and provide care that may negate the patient’s need to advance beyond the triage area. Not only does it provide timely care for low acuity patients, it liberates physicians or NPs to care for high acuity patients. These outcomes are unattainable with supplementary or protocol models because physicians and NPs would still have to assess and diagnose the patient. There would be no time to develop clinical management plans required in supplementary models and if the patient deviated slightly from an established protocol, the RN would be unable to provide treatment. Beyond the ER, independent prescribing would enable RNs on in-patient units to monitor changes in patients’ health status and intervene early to minimize the consequences to the patient. Moreover, RNs would be able to independently provide comfort measures in hospitals to treat pain, constipation, nausea, diarrhea, infections, etc without the need for a physician or NPs order. This saves time and money. Supplementary models are contingent on patients having established conditions so medications needed for emerging illnesses may not be included in the clinical management plan. Hospitalized patients are typically admitted because their care needs are rapidly evolving and supplemental/protocol-based RN prescribing would be insufficient to respond to these needs.

4) Home Care

As the health system shifts to increased community care and prompt discharge from hospital, the complexity of care needs for home health-care and support service providers will increase. RNs are integral for assessing patients, providing prompt treatment and evaluating health status in the home. Home care has unique challenges that could be addressed through an expanded scope of RN practice. The RNs practice environment changes with every patient and they work in isolated settings with a significant degree of autonomy that stems from limited opportunities for real-time collaboration with other providers. RNs also gain information at each patient visit and adjust care plans as necessary. Through independent prescribing, RNs will be able to diagnose and treat patients at the point of care. Currently RNs rely on physicians or NPs to prescribe treatment plans based on the RNs assessments and recommendations. Independent prescribing will align professional responsibility with accountability. Supplementary prescribing and protocols do not permit the RNs to promptly respond to
patients’ needs in the home care environment. Patients that receive RN services at home have high needs that require intense care for longer periods of time. Independent RN prescribing removes the need for these patients to physically visit their primary care provider for conditions that fall in the scope of practice of RNs. Instead, the RN could deliver treatment and share this information with the primary care provider to ensure that care is consistent and co-ordinated.

5) Long-Term Care

Although there is an encouraging trend, led by RNAO, to increase access to NPs in long-term care homes, the reality is that for years to come there will continue to be few physicians or NPs in Ontario’s 600+ long-term care (LTC) homes. As of today, physicians and NPs do not practise onsite and instead provide care through scheduled visits or an on call basis. RNAO is delighted that within the next three years there will be 75 attending NPs working permanently within nursing homes. RNAO will continue to insist that all nursing homes should have an NP on-site with a ratio of 1:120 NP per patients, a goal that will take the next 10 to 15 years. We do, however, already have a legislated requirement that every LTC home must have an RN on duty at all times.

Resident care requires consideration of unique characteristics such as chronic disease, polypharmacy, cognitive deficits, and advanced directives. RNs in LTC are experts in managing each of the aforementioned areas. Empowering RNs through an independent prescribing model will facilitate a timely response to residents’ emerging and episodic health needs. As an example, RNs in this sector could manage residents’ pain, hydration, nausea, constipation, etc with a combination of pharmacological and non pharmacological interventions and in concert with the client, their family and other providers through independent prescribing. RNs already provide constant care to residents and would be able to intervene early for the majority of ambulatory care sensitive conditions that currently result in transfers to the emergency department (ED). Supplementary models of prescribing and protocols would be ineffective for emerging health issues because treatment would still be contingent on the resident being assessed and diagnosed by a physician or NP.

Currently, NPs and physicians rely on nursing assessments, management and evaluation to guide residents’ treatment regimes. Resident care plans contain several PRN orders, that may have been set when a resident was initially assessed by a physician or NP and do not address emerging health issues. Use of PRN medication also increases the risks associated with polypharmacy as medications are added to address emerging issues without holistic evaluation of a residents’ pharmaceutical needs. This would continue to be an issue with supplementary models of prescribing and clinical protocols. If a resident experiences a change in health status that the RN cannot manage through historical PRN orders, residents are transferred to EDs. Approximately 22 percent of transfers from nursing homes to EDs are avoidable with responsive primary care. EDs are costly and ill suited to meet the needs of residents in long-term care and risk resident safety. For example, emergency departments can be quite stressful for nursing home residents that are functionally dependent and chronically ill, as they provoke anxiety,
risk complications, reduce continuity of care and decrease quality of life. Of note, these residents have a longer length of stay in EDs because they have to wait for transportation back to their facility or wait longer for inpatient beds. Many long-term care residents present in emergency departments with ambulatory care sensitive conditions including urinary tract infections, dehydration, hypoglycaemia, cellulitis, pneumonia, hypertension, angina, asthma, seizures, congestive heart failure and chronic obstructive pulmonary disease. While some of these conditions warrant acute care, many of these health issues could be appropriately treated and monitored at the long-term care facilities if RNs could order diagnostic testing, communicate diagnoses and independently prescribe medications. A cost analysis found treating ambulatory care sensitive conditions in primary care cost 69 to 86 per cent less than EDs. These cost savings could be achieved by treating these conditions in the long-term care facilities and even prevented with high-quality care management and early intervention through independent RN prescribing.

**Body of Knowledge**

RNAO was the leading advocate insisting that the entry to practice for RNs in Ontario be a baccalaureate degree. We now have among the highest entry to practice requirements in the world. RNs are required to have a broad body of knowledge across many health and medical sciences including pharmacology, immunology, microbiology, anatomy, physiology, patho/psychopathophysiology, epidemiology, genetics and nutrition. RNs are also required to process data (including laboratory results) and assessment results to evaluate their client’s progress and care outcomes. In other jurisdictions where RNs can prescribe, their foundational education is not as long or comprehensive as it is in Ontario. In the United Kingdom, Australia, and New Zealand baccalaureate nursing degrees are only three years full time while in Ontario baccalaureate nursing degrees are four years full time. The United Kingdom has implemented RN prescribing for the longest period of time and publishes the most evidence on this practice. RNAO supports the model of independent prescribing similar to the UK where RNs were given access to the entire British National Formulary in 2006.

RNs in Ontario have long demonstrated they are capable and keen to expand their scope of practice. In rural and remote areas of the province where RNs may be the only available health-care provider, they act as generalists with high competence in multiple clinical domains and specialties. In Moose Factory Ontario, physicians visit the nursing station once or twice a month with RNs providing primary care, preventative care and stabilizing acute clients the rest of the time. These RNs also respond to codes, complete sutures, conduct full physicals, and remove casting. In Woodstock Ontario RNs provide full reproductive and sexual health care to clients through medical directives and collaboration with an NP. In a northern NP led clinic, RNs assess clients and initiate treatments to enable same-day primary care access (through medical directives).
On many occasions, RNs are the last safety check between a prescription and administration of that medication to the patient. At entry to practice, RNs ensure medication orders are clear, complete, and appropriate considering the patient’s condition, health history, medication history, and possible medication interactions. It would be irresponsible for an RN to currently implement an order by investing blind faith in the prescriber. RNs have a duty to understand medications (including appropriate storage, transportation, and disposal), provide education to their patients about their medications, understand a medication’s risk of harm and possible adverse events, and manage adverse reactions or near misses (events that could have harmed the patient but was captured before reaching the patient). RNs already have a strong foundation in assessment and treatment, which can be augmented through additional education to embrace an expanded role, thus enabling RNs to order the necessary diagnostic testing as part of their comprehensive health assessment, communicating the diagnosis to the patient, and prescribing medications.

**Education and Accreditation**

RNAO recommends that current RNs seeking an expanded scope be required to complete an accredited post-graduate course in prescribing/diagnosis in Ontario to receive qualifications to perform these controlled acts. Similar to the UK, the course would be 300 hours including simulation, clinical experience, and mentoring before one is authorized to practise. This course also entails a supervised practicum that was found to be helpful in other jurisdictions. Delivery of this course could be offered jointly between faculties of nursing, pharmacy and medicine and enable interprofessional education.

RNAO recommends that pursuing independent prescribing be voluntary for current RNs and fully integrated into the baccalaureate nursing curriculum by 2020. Providing the education in this manner will develop expertise from the outset rather than focusing on acquiring competencies afterward and increase standardization of RN practice. It will help the public and other providers to maintain a consistent understanding of the scope of practice of the RN and minimize confusion. The long-term impact of integrating independent RN prescribing with the baccalaureate program will be felt for generations to come. It means that starting in 2020, RNs would graduate with this competency and become an important driver of access to care and health system efficiencies.

Risk of harm of independent prescribing could be further mitigated through the development of principled standards of practice by the College of Nurses of Ontario (CNO) and through a mechanism to ensure continuing competency through CNO’s existing quality assurance program (i.e. mandating continuing education requirements). CNO’s public registrar can be used to identify those RNs who have successfully completed the required education and have met CNO’s requirements to practise at an expanded scope.
Economic Impact

There is strong evidence to support the expanded scope of the RN, given experiences in the United Kingdom, Ireland and New Zealand. RN prescribing is also being implemented in other Canadian jurisdictions (British Columbia, Saskatchewan and Manitoba). All of this is occurring at a time where health system resources are limited and barriers prevent Ontarians from receiving timely access to care.

Access to care and health system efficiencies will be among the greatest benefits reached through independent RN prescribing. When fully implemented, an expanded scope of RN practice through an enabling framework will help provide Ontarians with same day access to care whether in public health, primary care, street health, shelters, or schools. It will also increase access to health professionals in long-term care and prevent transfers to emergency departments, which represent a significant cost to the system. The provision of ongoing functional assessments, intervening early, providing direct care services, and encouraging independence prevents older adults from needing higher levels of care. This enables them to age in place while reducing costs to the health-care system through decreased hospitalizations and long-term care placements.

RNs are paid through a salary from their publicly-funded employers which range from $60,489 to $85,917 for RNs in Ontario; therefore, there are no direct patient costs for an expanded RN scope. A review of the effectiveness of the first phase of RN prescribing in the UK found that RN prescribing was comparable to physician prescribing. RNs tended to prescribe less costly medications when the effectiveness was similar, and patient need for medication was more frequently re-assessed by RNs. A more recent cost-effectiveness study for antiretroviral treatment found that RNs increased access to care that was not previously available. This study discredits any unfounded belief that enabling RNs to prescribe would lead to over prescribing. In fact, any increase in treatments as a result of RNs working to an expanded scope reflects increased access to care that addressed previously unmet needs. Therefore, impacts to Ontario’s public drug programs would be minimal. In fact, it should help drive efficiencies in the program through upstream and proactive care delivery.

Conversely, supplementary prescribing would create duplication in services between the two health care providers in the collaborative practice agreement. This would create a “double dipping” effect on limited public resources. Protocols would maintain the status quo in the health system which has already been deemed ineffective in providing access to care, consistent care, and utilizing health-care provider time and resources.

Relevance to the Health-Care System and Relationships to Other Professions

Other regulated professionals involved in prescribing, communicating a diagnosis and/or ordering diagnostic testing include: dentists, physicians, NPs, podiatrists, pharmacists, midwives and some physiotherapists. RNs are integral interdisciplinary team members.
that are expected to collaborate with other health professionals, develop care plans and provide continuity of care. HPRAC previously recommended updating regulatory frameworks to promote interdisciplinary collaboration in Critical Links: Transforming and Supporting Patient Care.

Having regulatory colleges work together towards interdisciplinary collaboration will maximize the competencies and skills of individual providers, improve professional conduct and patient safety, and use regulatory resources more efficiently. Through collaboration between CNO and other regulators involved with prescribing/diagnosing, the expanded RN scope of practice can be implemented in an effective manner. HPRAC previously described the benefits of an enabling framework to expand NP scope of practice as creating opportunities for interdisciplinary collaboration and recommended applying aspects of this model to other professions undergoing scope of practice reviews.

Currently RNs are practising in expanded roles through delegation and authorization mechanisms (i.e. medical directives). Of concern, authorization mechanisms such as medical directives differ by organization resulting in discrepancies, while also blurring professional accountability, with delegators not always realizing the professional liability they are assuming. Delegation models assume delegators maintain an ongoing awareness of the specific knowledge, skill and judgment of the delegatee. This is not always practical and creates duplication. Supplementary prescribing models are analogous to delegation models. The physician or NP is required to assess, diagnose and determine medications that the RN could prescribe for the treatment of a patient’s specific condition. Clinical protocols, which are the same as medical directives today, remove the ability for individual providers to tailor treatment plans based on their clinical judgment. They are cumbersome and require processes for updating to reflect changes in best practices. The aforementioned models do not fully acknowledge the breadth of the nursing role, do not consider entire context of patient/client encounters, blurs lines of accountability for patient/client care and increases administrative duties.

In contrast, models of independent prescribing enable development of practice standards and educational pathways that will support safe and effective practice. Independent prescribing allows RNs to be fully accountable for their practice as autonomous regulated health professionals. RNs are champions of working within interprofessional teams and evidence indicates RNs developed collaborative relationships with pharmacists and physicians to support their expanded scope in jurisdictions where independent RN prescribing is implemented. It also enhances interprofessional collaboration by provoking in depth discussions about medications. Furthermore, while RNs with expanded scope are competent to independently prescribe, many refer to interprofessional care plans when deciding treatment. RNs with expanded scope will actively engage all interprofessional team members as necessary to promote effective client care.
Relevance to the Profession

Nursing is the largest regulated health profession; RNs comprise the largest share of the workforce and have the greatest distribution across the province and health system (96,007 RNs, 39,109 RPNs, and 2,407 NPs). RNs are often actively involved in the prescribing of medication, communicating diagnoses and arranging for diagnostic testing, through delegation. Settings where this frequently occurs include -- but are not limited to: public health units, emergency departments, long-term care, critical care, primary care and nursing stations. However, RNs are limited in this capacity as medical directives do not always respond to the highly contextual cases encountered in the clinical setting. Furthermore, medical directives differ by organization resulting in inconsistent practice and they become void when the signing practitioner leaves the organization. Prescribing through supplementary models or protocols restricts RNs’ clinical judgment, which could leave them vulnerable to accusations of misconduct or unlawful practice due to their lack of authority for particular treatments. RNs are ready to have their expanded scope legitimized and to accept full accountability for their practice. Independent prescribing with the authority to prescribe diagnostic testing and communicate a diagnosis is a natural extension to current RN practice. It responds to the many clinical scenarios encountered today where RNs are identifying gaps in care and questioning “if only I could prescribe or initiate testing”. As part of their comprehensive health assessments RNs should be able to order lab testing, swabs, and the collection of specimens. When planning care RNs should be able to include pharmacological treatments as well.

Given that more and more jurisdictions have or are moving to RN prescribing, it is imperative that Ontario move forward in a timely fashion, to improve access to care for Ontarians, enhance health system cost-effectiveness and to retain and attract RNs to our jurisdiction. It is critical that we do so with an enabling model to avoid the pitfalls of our predecessors, who find themselves in a constant corrective mode of moving from restrictive frameworks embedded in protocols, to enabling frameworks such as independent prescribing. There is no doubt that Ontarians will benefit from independent prescribing both in its timely access to health services, as well as by making our province a more attractive destination for RNs who voluntarily choose to relocate here to fully utilize their knowledge, competencies and skills.

Conclusion

Selecting a model of RN prescribing for Ontario is a unique opportunity to advance health system effectiveness by optimizing access to care, providing person and family centred care, increasing health professional accountability, facilitating continuity of care and caregiver, and making our health system more cost-effective. Since 2005 when RN entry to practice was raised to a baccalaureate degree, there have been no significant changes to scope of practice despite the increase in education. RNs are integral members of interprofessional teams, have strong clinical assessment skills, pharmacology knowledge and are on the forefront of monitoring and evaluating
patients’ progress. Enabling RNs to order diagnostic testing, communicate a diagnosis and independently prescribe medication aligns their practice and professional accountability. When RNs are responsible for the entire nursing process, care will be person-centred and continuity of care and caregiver will be achieved. Using clinical protocols and fostering collaborative relationships with medical prescribers already happens today and are not producing the urgently needed system-level changes because of their restrictions.

RNAO urges HPRAC, in the strongest possible terms, to recommend the adoption of an independent model of RN prescribing -- inclusive of RNs being authorized to order diagnostic testing, communicate a diagnosis and order medications. We know that HPRAC has the public's interest at heart. We advise you to navigate through any political waters that exist surrounding this matter and do what's right for the public. An evolving population, demands an evolving health system. To sustain and expand Ontario’s cherished publicly-funded and not-for-profit health system and advance the highest possible standard and outcomes of care for the public and the province, we must evolve the scope utilization of all our regulated health professions.
References


103 Personal correspondence between Anastasia Harripaul and Crystal Culp on May 12 2015.

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Appendix A

Reports on Access to Care in Ontario

Registered Nurses’ Association of Ontario (RNAO)


Access to care is a challenge in Ontario’s rural, remote and northern communities given a multitude of factors, including complexity of care, geographic distance, isolation and limited health human resources. Furthermore, nursing practice in rural, remote and northern areas is unique in that these nurses are often generalists, with a high degree of competency in a number of clinical domains and specialties. A sustainable nursing workforce is needed to promote access to care, better outcomes for people and health system cost-effectiveness in rural, remote and northern settings. However, the retention and recruitment of nurses in these regions is a constant challenge. RNAO engaged a number of stakeholders representative of nursing in rural, remote and northern communities to form a provincial task force, co-chaired by the CEO of the North East LHIN and the Chief Nursing Executive of Health Sciences North, to ensure a stable and sustainable nursing workforce exists in rural, remote and northern areas of Ontario. This report presents barriers and enablers of retention and recruitment in rural, remote and northern areas and recommendations to improve access to care, including an expanded RN scope of practice.


Office of the Auditor General


The office of the Auditor General of Ontario is independent of the Office of the Legislative Assembly and examines areas where the public sector and the broader public sector can make improvements to benefit Ontarians. In the auditor’s most recent report, concerns were raised around access to care in the community. Specifically, long wait times, differing levels of service, geographical discrepancies in service, and differences in per-client funding were identified as issues.


Ministry of Health and Long-Term Care


This discussion paper proposes solutions to address gaps in care including: challenges faced by specific populations when accessing care (Indigenous peoples, Franco-Ontarians, cultural groups, and individuals with mental health and addictions challenges), access to primary care, cumbersome home and community care services, disconnected public health system, and fragmented health services. Key findings include that 57 per cent of Ontarians cannot see their primary care provider the same day/next day when ill, 52 per cent of Ontarians find it difficult to access care in the evening/weekend and low-acuity patients account for 34 per cent of emergency department visits.
Health Quality Ontario

4. **Measuring Up: A Yearly report on how Ontario’s health system is performing (2015).**

Every year Health Quality Ontario releases a report on how Ontario’s health-care system is performing. Primary care providers are the entry point for the health system and the main contact for follow up and ongoing care. While 94 per cent of Ontarians report having a primary care provider only 44.3 per cent can get a same day or next day appointment, varying from 28.4-57.0 per cent depending on the LHIN region. 52.4 per cent of Ontarians also report that it is very or somewhat difficult to get an evening or weekend appointment. Other areas that emerged as needing improvement for 2015 include wait times for long term care placement from home (longest median wait time is 243 days while the shortest is 50 days), home care services (distressed caregivers have doubled compared to 4 years ago) and unequal progress across the province in avoidable death and rates of hospitalization for ambulatory care sensitive conditions.


Expert Group on Home & Community Care

5. **Bringing Care Home (2015)**

The Minister of Health and Long Term Care appointed an expert group to provide recommendations to respond to the challenges in home care. From 2008-2013, discharged patients requiring home care services has increased by 42 per cent. Compared to 2009-2010, long stay/high needs clients have increased by 73 per cent. In 2012, 90 per cent of clients receiving home care relied on family caregivers who provide about seven hours of care for every two hours provided by professionals. However, family caregivers do not feel supported by the current home care system. These recommendations in this report propose the planning and delivery of care to be truly client and family-centred, improving support for family caregivers, funding baskets of services, developing capacity planning that considers interrelationships between services, facilitating communication between the sectors especially through primary care, increasing accountability for performance, and enhancing approaches to service delivery.


Primary Health Care Expert Advisory Committee

6. **A report on behalf of the Primary Health Care Expert Advisory Committee (2015)**

In late 2013 the Ministry of Health and Long-Term Care convened the Expert Advisory Committee on Strengthening Primary Health Care in Ontario to address current challenges in Ontario’s primary care system. The group identified that there continue to be considerable gaps in both primary health care delivery and overall health system performance. Wait-times to see a primary care provider continue to be an issue, as do unnecessary emergency department utilization and limited access to after-hours primary care services. In response, the Committee proposed a vision for an integrated primary health care system for Ontario, based on a redesign of the province’s existing primary care sector. The foundation of the redesign is a population-based model of integrated primary health care delivery, designed around patient care groups.
Ontario Long Term Care Association

7. This is Long-Term Care 2015

Compared to when the long term care sector was initially developed and funded, residents are more medically complex (97.4 per cent have at least two chronic conditions), are more frail (>50 per cent are over the age of 85), and have higher rates of cognitive impairment. However, funding for the staff required to respond to these greater needs have not kept pace and many homes require renovations to meet current design standards for safety and comfort. The need for skilled and knowledgeable staff that can respond to resident needs in a timely manner is evident when 62 per cent of residents live with a form of dementia, 33 per cent have severe cognitive impairment, 40 per cent have a psychiatric diagnosis, 46 per cent exhibit aggressive behaviour related to a mental health condition, and 40.6 per cent need monitoring for an acute medical condition.

Canadian Institute for Health Information


While consistent with Canadian averages, Ontarians are still waiting an average of three hours in emergency departments for an initial assessment by a physician. Furthermore, admitted patients spend an average of 29.9 hours in an emergency department. From a national perspective, the most common reasons for visiting an emergency department include: acute upper respiratory tract infections, ear infections, fever, abdominal/pelvic pain, throat infections, back pain and urinary system disorders. Canadians (not admitted) spend on average 4-7.4 hours in an emergency department depending on the type of hospital they seek service at.

Registered Nurses’ Association of Ontario (RNAO)

9. Enhancing Community Care for Ontarians 2.0 (2014 and 2012)

Responding to a desperate need to facilitate timely access to care through system integration, this paper provides an overview of the ECCO model to inform and evolve strategies that improve client experience and outcomes, and deliver comprehensive services in a cost-effective and seamless manner. It presents a model of structural realignment that advances a robust foundation for a renewed person-centred health system that emphasizes community care and improves vertical integration across all sectors through a single health system planner and funder – the LHINs. ECCO begins with service and process enhancements by anchoring the system in primary care through horizontal integration (creating primary care networks), expanding the scope of practice utilization of RNs to include prescribing and transitioning the care co-ordination role function from CCACs to primary care (including the 3,500 care co-ordinator positions). ECCO is completed with the alignment of public health services with the LHINs, transitioning responsibility for delivering home health-care and support services directly to provider agencies and eliminating the CCAC as a system entity.
Canadian Academy of Health Sciences


In 2014 the Canadian Academy of Health Sciences released a report regarding the optimization of health care professional scopes of practice. These report provided advice to better align health human resource capabilities with health-care services that are relevant to the needs of Canadians. The report suggested modernizing health-care environments so RNs could deliver more care without the need for an order, decreasing the reliance on physicians, increasing the role of NPs and RNs in primary care (i.e. nurse led clinics that provide low complexity primary care), RN-led telemedicine, and enabling RNs to provide follow-up care that will ultimately decrease the number of unnecessary emergency room visits.


Registered Nurses’ Association of Ontario (RNAO)

11. Primary Solutions for Primary Care (2012)

Recognizing challenges in delivering timely access to primary care, RNAO launched a provincial task force to develop recommendations that optimize the full utilization of primary care nurses - both RNs and RPNs - to strengthen patient outcomes and generate health system effectiveness. The task force was comprised of the major primary care stakeholder organizations, including: Ontario Family Practice Nurses Interest Group, Canadian Family Practice Nurses Association, Canadian Nurses Association, Ontario Medical Association, George Brown College, Association of Ontario Health Centres, Ontario College of Family Physicians, Association of Family Health Teams of Ontario, Nurse Practitioners’ Association of Ontario, Ontario Nurses Association and the Registered Practical Nurses Association of Ontario. It focused on two progressive phases of outcomes. The first phase identified the highest level of scope of practice utilization already present in selected primary care settings in Ontario and recommended an upward harmonization of scope of practice utilization for all primary care nurses, across all sites in Ontario. The second phase involved identifying needed expansions to the existing scope of practice of the primary care RN that would serve to further improve access to primary care for the public. This report presents a review of the literature, historical evolution, nursing human resource analysis, primary care nurse role descriptions, and recommendations.

http://rnao.ca/policy/reports/primary-solutions-primary-care

Ministry of Finance


In advance of the 2012 provincial budget, the government proceeded with a commission to provide advice on how Ontario could receive effective and efficient public services. The commission focused on programs that should be eliminated or redesigned, areas of duplication that could be removed, and areas where return on taxpayer investments could be augmented. The commission had specific recommendations for the health-care system including enabling health-care providers to practice to their full scope and RNs assuming full responsibility for certain aspects of care delivery, shifting responsibilities from physicians to RNs to optimize
human resource capacity while lowering costs, and enabling RNs to provide follow-up care to increase continuity of care and access.


The Health Care Innovation Working Group

13. From Innovation to Action (2012)

In 2012, the Council of the Federation met to discuss health-care issues on a national level. The premiers agreed that embracing innovation would be a key enabler to improve care. They tasked the Health Care Innovation Working Group with developing recommendations on how best practices within provinces could be shared nationally and how innovation could improve the value of Canada’s health-care systems. A set of recommendations were created on team based models of care which included enabling all members of the interdisciplinary team to practice to their maximum scope of practice.
