Registered Nurse in the Extended Class: Scope of Practice Review

Submission to the Health Professions Regulatory Advisory Council

August 24, 2007

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INTRODUCTION

The College of Nurses of Ontario (CNO), as the regulatory body for more than 140,000 nurses, is pleased to respond to the Health Professions Regulatory Advisory Council’s (HPRAC’s) “applicant questionnaire”, sent July 16, 2007, regarding increasing the scope of practice for registered nurses in the extended class [RN(EC)s].

Our recommendations in this submission are congruent with the intent and philosophical thrusts of the Regulated Health Professions Act, 1991, including self-regulation. If self-regulation is to be a meaningful and effective governance process, RN(EC)s require clarity regarding their authority to perform controlled acts that have become an expected, essential part of their practice and that contribute to increased access to, and timeliness of care. The changes proposed herein are meant to provide that clarity and enable the profession’s commitment to set the necessary standards and accountability mechanisms to protect the public.

In September 2006, CNO Council approved recommendations to change the controlled acts section for RN(EC)s in the Nursing Act, 1991 and approved consequential amendments to Regulation 275/94 under the Act. In addition, Council also supported changes to other, auxiliary, pieces of legislation related to successful implementation of the proposed amendments. These changes were forwarded to the Minister of Health and Long-Term Care and are the subject of the Minister’s referral to HPRAC.

At present, the RN(EC) category of registration is available only to primary health care nurse practitioners (PHCNPs). The Ontario government is considering amendments to Regulation 275/94 under the Nursing Act, 1991, which would authorize acute care nurse practitioners (ACNPs) to register in the extended class\(^1\). This would result in new RN(EC) specialty certificates: NP-Adult, NP-Paediatrics and NP-Anaesthesia. Current RN(EC)s have already met registration requirements and will be granted the specialty certificate “NP-Primary Health Care”. The regulation amendments are a significant development - for the first time since 1998, Ontario will have a consistent regulatory framework for all NPs. Since this submission may directly impact all RN(EC)s, present and future, the terms NP and RN(EC) are both used, as appropriate.

GUIDING PRINCIPLES & DEFINITIONS

CNO’s mission is to protect the public’s right to quality nursing services by providing leadership to the nursing profession in self-regulation. All nursing practice is guided by the profession’s scope of practice statement:

\(^1\) CNO anticipates government approval of the proposed regulations by September 2007.
“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”

Although RN(EC)s’ legal scope of practice (i.e., their access to specific controlled acts) overlaps with medicine’s, they do not replace physicians. The NP approach to practice is grounded in nursing knowledge and expertise. NPs are educated to fulfil the above nursing scope of practice statement at an advanced level and the proposals discussed in this submission are meant to facilitate RN(EC) access to controlled acts that are consistent with such practice.

In 2005, CNO Council adopted the Canadian Nurse Practitioner Core Competency Framework. This framework (Appendix A) was developed through national consensus among nursing regulators across the country. The Framework identifies the core competencies common to all NPs regardless of context of practice (i.e., PHCNP and ACNP) and categorizes the competencies into four main areas:

1. Health Assessment and Diagnosis;
2. Health-Care Management and Therapeutic Intervention;
3. Health Promotion and Prevention of Illness, Injury and Complications; and
4. Professional Role and Responsibility.

The competencies are holistic, specific and comprehensive. CNO Council uses them to guide decision making, such as approval of NP education programs and regulatory exams for entry into the extended class. The various CNO proposals discussed in this submission are directly linked to this competency framework.

To become registered in the extended class in Ontario, nurses must meet the following requirements:

- demonstrate at least two years of recent, safe nursing experience – including one year in an advanced nursing practice role;
- have graduated from an approved NP education program;
- have passed a regulatory exam; and
- be registered, or eligible for registration, as a registered nurse (RN).

Finally, all NPs work collaboratively with other health providers. In particular, they consult with physicians for a variety of clinical reasons, including when they have reached the limit of their legal scope of practice or individual competency level. This collaboration and consultation is embedded in the core competency framework. Likewise, CNO has been informed that many physicians refer clients to NPs, acknowledging the unique and specific expertise of these practitioners as they participate in the inter-professional care of clients.

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2 Copyright permission granted by the Canadian Nurses Association.
3 These are the key, non-exemptible requirements. They apply to current and future RN(EC)s. There are additional, exemptible requirements (i.e., fluency).
This document uses the following national definition for the term “NP”, which applies to both PHCNPs and ACNPs:

“Nurse practitioners are registered nurses with additional educational preparation and experience who possess and demonstrate the competencies to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform specific procedures within their legislated scope of practice.”

Applicant’s Questionnaire

Profession Information

All applicants should answer the following question:

1) Does your current scope of practice accurately reflect your profession’s current activities, functions, roles and responsibilities?

No. Legislative evolution of the NP role in Ontario has failed to keep pace with practice realities, health system developments, technological advancements and population health needs. Although NPs have worked in Ontario since the 1970s, it took almost 30 years to legislate an expanded scope of practice for these nurses. In 1998, the Expanded Nursing Services for Patients Act gave Registered Nurses in the Extended Class [RN(EC)s] limited access to an additional three controlled acts not authorized to Registered Nurses and Registered Practical Nurses. The additional controlled acts are:

- communicating a diagnosis
- ordering the application of a form of energy prescribed in regulation
- prescribing a drug designated in the regulations.

Further, the Expanded Nursing Services for Patients Act did not allow for ACNPs to be registered in the extended class, leaving Ontario with inconsistent regulatory frameworks for its NP workforce.

There have been a number of amendments to auxiliary legislation over the years, many of them modernizing existing Acts and regulations to reflect introduction of the RN(EC) role. However, since 1998 there have been no changes to RN(EC)s’ access to controlled acts, despite changes in practice realities (e.g., frequent changes in evidence supporting best practice), advances in technology

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4 Limited because of conditions placed on the RN(EC)’s performance of these controlled acts. For example, the RN(EC)’s authority to prescribe drugs is limited by the condition that those drugs be designated in the regulations.

5 Registered Nurses and Registered Practical Nurses have authority to controlled acts # 2, 5 and 6.

6 As noted in the introduction, there are steps currently underway to correct this.

7 These amendments are discussed in section 13.
(e.g., introduction of automatic external defibrillators), health system developments (e.g., health human resource shortages, especially in remote and rural communities, and a public insistence on more timely access to health care services), and population health needs (e.g., aging population).

Although the regulatory framework has remained stagnant, the education sector has responded to the above factors and RN (EC)s are graduating with the competencies to meet the needs of their clients and respond to health system developments. Currently, RN(EC)s rely heavily on authorizing mechanisms, such as delegation and medical directives. Consequently, accountability for the performance of controlled acts is blurred between the delegator and the nurse, rather than resting more clearly on the self-regulatory responsibilities of the nurse. Furthermore, while delegation and medical directives serve a purpose, they should not be necessary where the performance of an act or procedure is a common part of the profession’s practice and is a core competency developed in education and maintained through practice.

If the answer to question #1 is no, then please answer the remaining questions (only those that apply) as thoroughly as possible.

2) Name the profession for which a change in scope of practice is being sought, and the professional Act that would require amendment.

Profession: Nursing; specifically, RN(EC)s.
Professional Act: *Nursing Act, 1991* and regulations under the *Nursing Act (Regulation 275/94)*

3) Describe the change in scope of practice being sought.

In short, the proposed scope of practice for RN(EC)s involves:

   i) permitting access to the following three additional controlled acts:
      • setting or casting a fracture of a bone or a dislocation of a joint;
      • dispensing, selling or compounding a drug;
      • applying a form of energy prescribed in regulations

   and

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8 According to the *Federation of Health Regulatory Colleges of Ontario*, delegation is a “process whereby a regulated health professional authorized to perform a controlled act procedure under a health profession Act confers that authority to someone - regulated or unregulated - who is not so authorized; a medical directive is an “order” given in advance by physicians/ordering authorizers to enable an implementer to decide to perform the ordered procedure(s) under specific conditions without a direct assessment by the physician or authorizer at the time”.

9 Most often a physician.

10 RN(EC)s have authority to “prescribe”, which is part of the same controlled act (i.e., #8 in the list of controlled acts listed in the *Regulated Health Professions Act, 1991*).

11 RN(EC)s have authority to order the application of a form of energy, which is part of the same controlled act (i.e.,#7 in the controlled acts list).
ii) **removing limitations** on the following controlled acts currently authorized to RN(EC)s:

- communicating a diagnosis;
- administering a substance by injection or inhalation;
- prescribing

Please see question #12 and Appendix B for further detail of the changes being sought.

4) **Name of the College/association/group making the request, or sponsoring the proposal for change, if applicable.**

The College of Nurses of Ontario.

5) **Address/website/e-mail.**

Address: 101 Davenport Road
          Toronto, Ontario
          M5R 3P1

Website: [www.cno.org](http://www.cno.org)

E-mail: cno@cnomail.org

6) **Telephone and fax numbers.**

Telephone:
416-928-0900

or

Toll Free in Ontario:
1-800-387-5526

Fax:
416-928-6507

7) **Contact person (including day telephone numbers).**

    Anne Coghlan
    Executive Director, College of Nurses of Ontario
    416-928-0900 ext. 7525
8) List other professions, organizations or individuals who could provide relevant information applicable to the proposed change in scope of practice of your profession. Please provide contact names, addresses and contact numbers where possible.

There are a number of professions, organizations and individuals who could provide relevant information applicable to the proposed changes, including regulatory bodies, professional associations, unions, academic institutions, employers and government.

The following is a recommended list of organizations and individuals that CNO has collaborated with in a number of RN(EC) related initiatives:

**Regulatory Bodies:**
College of Physicians & Surgeons of Ontario
Rocco Gerace, Registrar
80 College St.
Toronto, ON M5G 2E2
416-967-2603

Ontario College of Pharmacists
Deanna Williams, Registrar
483 Huron St
Toronto, ON M5R 2R4
416-962-4861 or 1-800-220-1921
Fax: 416-847-8200

Royal College of Dental Surgeons of Ontario
Irwin Fefergrad, Registrar
6 Crescent Road
Toronto, ON M4W 1T1
416-961-6555

College and Association of Registered Nurses of Alberta
Debbie Phillipchuk, Nursing Consultant Policy and Practice
11620-168 Street
Edmonton, AB T5M 4A6
1-800-252-9392 ext. 517

College of Registered Nurses of Manitoba
Peggy Martens, Nursing Practice Consultant
890 Pembina Hwy
Winnipeg, MB R3M 2M8
204-784-5189
Nurses Association of New Brunswick  
Ruth Rogers, Nursing Practice Consultant  
165 Regent Street  
Fredericton, NB E3B 7B4  
506-459-2853

College of Registered Nurses of British Columbia  
Laurel Brunke, Executive Director  
2855 Arbutus Street  
Vancouver BC V6J 3Y8  
604-736-7331

College of Registered Nurses of Nova Scotia  
Linda Hamilton, Executive Director  
#600 - 1894 Barrington Street  
Halifax NS B3J 2A8  
902-491-9744 ext. 223

Nursing Professional Associations:

Registered Nurses’ Association of Ontario  
Doris Grinspun, Executive Director  
158 Pearl St.  
Toronto ON M5H 1L3  
416-408-5600

Nurse Practitioners’ Association of Ontario  
Pamela Pogue, President  
The Trillium Health Centre  
#500 - 90 Burnhamthorpe Rd. West  
Mississauga ON L5B 3C3  
905-848-7580 ext. 2556  
416-662-8395

Jane Sanders, Executive Director  
Executive Director, NPAO  
#1410-180 Dundas Street West  
PO Box 14  
Toronto ON M5G 1Z8  
416-593-8746  
647-300-6726
Canadian Nurses Association
Christine Rieck Buckley, Nurse Policy Consultant
50 Driveway
Ottawa ON K2P 1E2
613-237-2159 ext. 229
1-800-361-8404

Employer Associations:
Council of Academic Hospitals of Ontario
Winnie Doyle, Chair of Chief Nursing Executive Committee
St. Joseph’s Health Care – Centre for Mountain Health Services
Hamilton, ON L9C 3N6
905-522-1155 ext 32212

Ontario Hospital Association
Greg Shaw, Vice President, Strategic Human Resources Management
# 2800-200 Front Street West
Toronto ON M5V 3L1
416-205-1382

Ontario Association on Non Profit Homes and Services for Seniors
Margaret Ringland, Director, Member Relations & Professional Services
#700-7050 Weston Road
Woodbridge, ON L4L 8G7
905-851-8821 ext. 244

Ontario Long Term Care Association
Nancy Cooper, Director Policy & Professional Development
345 Renfrew Drive, 3rd Floor
Markham, ON, L3R 9S9
905-470-8995 ext 34

Employers:

Hospital for Sick Children
Margaret Keatings, Vice President, Professional Practice and Chief Nurse Executive
416-813-8083
Pam Hubley, Associate Chief of Nursing, Practice
416-813-8959
555 University Avenue
Toronto ON M5G 1X8
Kingston General Hospital
Eleanor Rivoire, Senior Vice President, Patient Care & Chief Nursing Executive
76 Stuart Street,
Kingston ON K7L 2V7
613-549-6666 ext 6004

Sunnybrook Health Sciences Centre
Dr. Sue VanDeVelde-Coke, Executive Vice President Programs
Chief Health Professions & Nursing Executive
2075 Bayview Avenue
Toronto ON M4N 3M5
416-480-6100 ext. 4113

Trillium Health Centre
Pamela Pogue, Chief Nurse and Professional Practice Executive
100 Queensway West
Mississauga, ON L5B 1B8
905-848-7580 ext 2556

Thunder Bay Regional Health Sciences Centre
Regional Cancer Care
Susan Pilatzke, R.N., B.Sc.N., MPH
Director of Clinical Oncology Systems
980 Oliver Road
Thunder Bay, ON P7B 6V4
807-684-7215

Victorian Order of Nurses
Liz Baker, Director of NP Programs
110 Argyle Avenue
Ottawa ON K2P 1B4
613-233-5694 ext 2226

Saint Elizabeth Health Care
Helene Lacroix, Nursing Practice Officer
#300-90 Allstate Parkway
Markham ON L3R 6H3
905-940-9655

**Government:**

Ministry of Health and Long-Term Care
Vanessa Burkoski, Provincial Chief Nursing Officer
12th Floor - 56 Wellesley St W
Toronto ON M5S 2S3
416-326-5176
Ministry of Health and Long-Term Care
Marilyn Wang, A/Director
Health Professions Regulatory Policy and Programs Branch
12th Floor-56 Wellesley St
Toronto ON M5S2S3
416-327-8888

Academic Organizations / Researchers:
Dr. Alba DiCenso, RN, PhD
Professor, Nursing and Clinical Epidemiology & Biostatistics
McMaster University
CHSRF/CIHR Chair in Advanced Practice Nursing
Director, Ontario Training Centre in Health Services & Policy Research
McMaster University School of Nursing
1200 Main Street West HSC 3N25B
Hamilton, Ontario L8N 3Z5
905-525-9140 ext. 22277

Council of Ontario University Programs in Nursing
Audrey Danaher, Senior Policy Analyst
#1100-180 Dundas Street West
Toronto ON M5G 1Z8
416-979-2165 ext. 226

McMaster University, School of Nursing
Dr. Janet Pinelli, Professor and Coordinator of the Advanced Neonatal Nursing
Graduate Diploma Program
McMaster University
Faculty of Health Sciences - 3N25E
1200 Main Street West
Hamilton ON L8N3Z5
905-525-9140 ext. 22253

University of Toronto, Lawrence S. Bloomberg, Faculty of Nursing
Siohban Nelson, Dean and Professor
#225-155 College St.
Toronto ON M5T 1P8
416-978-2862
In addition, the following organizations have also expressed an interest:

College of Audiologists & Speech Language Pathologists of Ontario

College of Physiotherapists of Ontario

Ontario Dental Association

In response to HPRAC’s survey, CNO contacted a number of stakeholders inviting them to self-identify as interested parties, including many of those listed above. In addition, some organizations approached us directly to be added to the list. CNO understands that this is not an exclusive or exhaustive list and that any interested party can participate in HPRAC's review by contacting the Council directly.

FOR ASSOCIATIONS

9) Names and positions of the directors and offices.

Not applicable (NA)

10) Length of time the association has existed as a representative organization for the profession.

NA

11) List name(s) of any provincial, national or international association(s) for this profession with which your association is affiliated or who have an interest in this application. Please provide contact names, addresses and contact numbers where possible.

NA

DETAILS OF THE PROPOSAL

Legislative Changes

12) What are the exact changes that you propose to the profession’s scope of practice (scope of practice statement, controlled acts, title protection, harm clause, regulations, exemptions or exceptions that may apply to the profession, standards of practice, guidelines, policies and by-laws developed by the College, other legislation that may apply to the profession, and other relevant matters)? How are these proposed changes related to the profession and its current scope of practice?
Appendix B contains an overview of the proposed legislative changes and their rationales. Key statutes and regulations affected include:

Table 1:

<table>
<thead>
<tr>
<th>Legislation / Regulation</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Act, 1991 and Regulation 275/94 under the act;</td>
<td>Changes to the controlled acts sections of both to permit the changes proposed herein</td>
</tr>
<tr>
<td>Healing Arts Radiation Protection Act, 1990</td>
<td>Permit broad diagnostic authority to order x-rays and computerized axial tomography (CAT scans)</td>
</tr>
<tr>
<td>Regulation 682 under the Laboratory Specimen and Collection Centre Licensing Act</td>
<td>Permit broad diagnostic authority to order lab tests and authority to perform simple diagnostic lab test in office (e.g., urine dipstick analysis)</td>
</tr>
<tr>
<td>Regulation 107/96 under the Regulated Health Professions Act, 1991</td>
<td>Specify forms of energy that RN(EC)s may prescribe and apply</td>
</tr>
<tr>
<td>Regulation 965 under the Public Hospitals Act, 1990</td>
<td>Permit RN(EC)s various authorities with respect to treating in-patients, inclusive of anesthesia related care⁴¹²</td>
</tr>
<tr>
<td>Regulation 552 under the Health Insurance Act, 1990</td>
<td>Permit payment to employers for the services provided to in-patients under the RN(EC)’s authority; consequential amendments related to the request for broad diagnostic and prescriptive authority</td>
</tr>
<tr>
<td>Drug and Pharmacies Regulation Act, 1990</td>
<td>Provide authorities related to the proposed controlled act for RN(EC)s of compounding, dispensing and selling a drug.</td>
</tr>
</tbody>
</table>

The proposed changes are intended to:
- reflect current practice, education and competencies of RN(EC)s;
- increase client access to timely health care services;
- enable RN(EC)s to provide health services to hospitalized in-patients;
- increase efficiencies within the system and enhance cost effectiveness by decreasing duplication; and
- clarify and enhance RN(EC) accountability.

As noted in question #3, the proposed scope of practice for RN(EC)s involves:
  i) permitting access to three new controlled acts; and
  ii) removing restrictions on some of the controlled acts currently authorized to RN(EC)s.

⁴¹² For the NP-Anesthesia specialty.
The new controlled acts are:
- setting or casting a fracture of a bone or a dislocation of a joint;
- dispensing, selling or compounding a drug\textsuperscript{13}
- applying a form of energy prescribed in regulation\textsuperscript{14}

The restrictions that have been removed from legislation are:

<table>
<thead>
<tr>
<th>Controlled Act</th>
<th>Condition / Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>communicating a diagnosis</td>
<td>That the member comply with prescribed standards of practice respecting consultation with members of other health professions.</td>
</tr>
<tr>
<td></td>
<td>Limitations on the type of laboratory and diagnostic tests (i.e., x-rays, ultrasounds) that RN(EC)'s are permitted to order\textsuperscript{15}.</td>
</tr>
<tr>
<td>administering a substance by injection or inhalation</td>
<td>Limited to substances that RN(EC)'s are permitted to prescribe</td>
</tr>
<tr>
<td>prescribing</td>
<td>Limited to drugs, or categories\textsuperscript{16} of drugs, designated in regulations</td>
</tr>
</tbody>
</table>

An overview of the forms of energy prescribed in the proposed regulation are:

<table>
<thead>
<tr>
<th>Forms of energy that RN(EC)s may apply</th>
<th>Forms of energy that RN(EC)s may order another provider to apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Electricity for:</td>
<td>1) Electricity for:</td>
</tr>
<tr>
<td>• cardiac pacemaker therapy,</td>
<td>• cardiac pacemaker therapy,</td>
</tr>
<tr>
<td>• cardioversion,</td>
<td>• cardioversion,</td>
</tr>
<tr>
<td>• defibrillation,</td>
<td>• defibrillation,</td>
</tr>
<tr>
<td>• electrocoagulation,</td>
<td>• electrocoagulation,</td>
</tr>
<tr>
<td>• fulguration,</td>
<td>• electromyography,</td>
</tr>
<tr>
<td>• transcutaneous cardiac pacing.</td>
<td>• fulguration,</td>
</tr>
<tr>
<td>2) Soundwaves for diagnostic ultrasound.</td>
<td>• nerve conduction studies, or</td>
</tr>
<tr>
<td></td>
<td>• transcutaneous cardiac pacing.</td>
</tr>
<tr>
<td></td>
<td>2) Electromagnetism for magnetic resonance imaging.</td>
</tr>
<tr>
<td></td>
<td>3) Soundwaves for diagnostic ultrasound.</td>
</tr>
</tbody>
</table>

\textsuperscript{13} RN(EC)s have authority to “prescribe”, which is part of the same controlled act (i.e., #8 in the list of controlled acts listed in the \textit{Regulated Health Professions Act, 1991}.  
\textsuperscript{14} RN(EC)s have authority to order the application of a form of energy, which is part of the same controlled act (i.e., #7 in the controlled acts list).  
\textsuperscript{15} These include limitations in other statutes (e.g., \textit{Healing Arts Radiation Protection Act}).  
\textsuperscript{16} Recent amendments via the \textit{Health System Improvements Act, 2007} allowed for categories of drugs to be designated in regulations. The definition of “categories” has not yet been defined.
CNO recommends that any conditions necessary to protect the public be placed in the RN(EC) Practice Standard rather than in legislation. By moving these conditions and limitations to the Practice Standard, a member not practising in accordance with the standard would more appropriately face a professional conduct review rather than potentially be subject to criminal charges.

Draft changes were made to the RN(EC) Practice Standard (Appendix C) to support the proposed changes in legislation. The revised Practice Standard outlines restrictions to controlled acts that are necessary to protect the public. Some examples are outlined below.

- The conditions on setting / casting a fracture prohibits the NP from performing the procedure on a fracture that is “open, displaces a growth plate / epiphysis, extends into a joint, is a pathologic fracture, or is a fracture of an elbow, hip, pelvis or femur….or where blood vessels ligaments, nerves or muscles are damaged.”

- The application of forms of energy is limited to specific types and for specific treatment purposes. For example, “the NP shall not operate a high-frequency diagnostic ultrasound machine; or perform ultrasonography”; or, the “NP shall only perform fulguration or electrocoagulation in consultation with a physician”.

- The NP sells drugs in situations in which there are client access barriers. They shall do so in accordance with federal and provincial legislation, ensure a written prescription for each drug sold, and document the transaction and rationale for selling drugs in the client record each time a drug is sold.

A complete list of the restrictions is included in Appendix C. The proposed changes were made through an extensive consultation process involving input from expert focus groups, teleconferences, legal council, and broad stakeholder involvement from multiple practice settings and geographical locations.

Overall, the proposed changes, whether they are for new controlled acts or to remove restrictions on existing ones, are intended to reflect current NP competencies and practice, currently enabled through delegation and medical directives.

These changes recognize the diverse client populations and degree of specialization represented by the four proposed RN(EC) specialty certificates. Restrictive regulatory frameworks are challenging to implement for professions that provide health services to a diverse population in a wide variety of practice settings. NPs provide health services to people of all ages, in all parts of the

17 The proposed Practice Standard was circulated to membership for feedback in 2006.
province, multiple sectors and in various stages of wellness to illness. This diversity and specialization will be even more evident when ACNPs are regulated in the extended class. Approximately 300-400 RNs currently self-identify as ACNPs and may be eligible for registration in the extended class. Their inclusion emphasizes the need for changes that enable their practice.

The changes, as proposed, allow RN(EC)s to order tests and medications within their scope of practice and level of competence, and in accordance with evidence-based clinical practice guidelines, thus minimizing duplication of services and promoting client safety. RN(EC)s will continue to consult with collaborating physicians for situations that are beyond their knowledge, skill and judgement. As discussed above, any limitations or conditions surrounding diagnostic and prescriptive authority deemed appropriate will be included in the practice standard.

While delegation is an appropriate mechanism to allow an authorized profession such as medicine or pharmacy to give RN(EC)s the authority to perform procedures beyond their current legal scope, there comes a time, in the true meaning of self-regulation, that the delegated activities need to be subsumed within the receiving profession itself. The resultant comprehensive legislated scope of practice allows the governing body to establish comprehensive entry-to-practice requirements and standards of practice, in order to fulfil its public protection mandate. The legislated scope of practice describes the appropriate range of activities carried out by practitioners of a profession, describes the range of activities over which the public can expect to be protected, and serves as a reference for the development of required curricula content for entry-to-practice and/or continuing competency programs that assist RN(EC)s to be knowledgeable in the performance of their professional responsibilities. An updated scope of practice for RN(EC)s, in essence, defines the practice of the profession and the parameters of regulatory authority with respect to the development of practice standards and guidelines, and clearly establishes RN(EC) accountability for their professional activities.

18 That is, they self-identify as ACNPs and indicate that they have graduated from an relevant education program.
19 All references to “diagnostic” authority or “diagnostic” testing in this document includes laboratory tests, x-rays / CAT scans, and various forms of energy as prescribed in the proposed regulation.
20 On a technical note, changes to the Nursing Act, 1991 require restructuring of the controlled act sections for RN(EC)s (i.e., Sections 4 and 5.1) by grouping all controlled acts authorized to RN(EC)s under Section 5.1. This change is intended to clarify RN(EC) authority respecting the performance of and the authority to order other members of CNO to perform controlled acts. These changes, in addition to the consequential amendments to Regulation 275/94 and other pieces of legislation are described in Appendix B.
13) How does current legislation (profession-specific and/or other) prevent or limit members of the profession from performing to the full extent of the proposed scope of practice?

**Nursing Act & Regulations**

Under the current legislative framework, RN(EC) practice is limited by requiring delegation to perform the additional controlled acts (i.e., setting / casting fractures; dispensing / selling / compounding drugs; and applying forms of energy), which have over time, because of technological / scientific advancements, changing practice realities and evolving population health needs, become incorporated into the day-to-day practice of RN(EC)s\(^{21}\). As discussed above, the existing limitations on controlled acts are inconsistent with the proposed legal scope of practice.

Although ACNPs graduate with the entry competencies to perform the additional controlled acts (both those that are limited to existing RN(EC)s, as well as the newly proposed controlled acts), they currently require delegation because they are not yet eligible for extended class registration.

CNO, as the self-regulatory body for nursing, is responsible for examining the current boundary of nursing’s scope of practice and making recommendations to amend it, should it be deemed in the public interest to do so. Movement from delegation to autonomous legislative authority more clearly establishes the RN(EC)’s\(^{22}\) direct accountability for his / her safe practice. It also clarifies the RN(EC)’s direct accountability to members of the public. A recent discussion paper on inter-professional practice commissioned by Health Canada suggested that given the reallocation of clinical responsibilities among health care professionals, “accountability should be reallocated accordingly”\(^{iv}\). This approach is also in keeping with the original principles of the *Regulated Health Professions Act (RHPA), 1991*. It supports the evolution of practice and recognizes overlapping scopes.

When physicians or pharmacists withdraw their support of RN(EC)s performing a delegated controlled act because of concerns over accountability and liability, or when they resign from practice or re-locate to another community\(^{23}\), RN(EC)s, who have competently been performing delegated activities as a part of their practice are left without an authorization mechanism to continue. CNO has been informed of such situations, which leave RN(EC)s and other nurses, particularly in isolated and under-serviced areas, with the decision of either continuing to

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\(^{21}\) In many cases, RNs and RPNs in the general class are also routinely performing some of these procedures under delegation (e.g., casting and dispensing).

\(^{22}\) All references to RN(EC) in this paragraph include future RN(EC)s (i.e., ACNPs who will be regulated in the extended class).

\(^{23}\) In reference to remote / underserviced communities.
perform the controlled act without authorization, or of leaving the client with no one to perform the necessary care.

Other Acts & Regulations

In addition to the proposed changes to the Nursing Act, 1991, changes are also required to other legislation and regulations to permit RN(EC)s to practice to the full extent of their current and proposed scope of practice. These statutes and regulations are listed in question #12 (Table 1). Over the past several years, there have been positive amendments to enable RN(EC)s to function according to their legal scope of practice. For example, in 2003, regulations under the three long-term care (LTC) facility statutes and Regulation 965 under the Public Hospitals Act, 1990 were amended to enable RN(EC) practice. More recently, the Ontario government has amended regulations to permit RN(EC)s to complete accessible parking permits for their clients (Regulation 581 under the Highway Traffic Act, 1990); provide health services to children in the province's care (Regulation 70 under the Child and Family Services Act, 1990); and acknowledge RN(EC)s as providers in public health legislation such as the Health Protection and Promotion Act, 1990 and the Immunization of School Pupils Act, 1990. Over the years, these amendments have been made in recognition that RN(EC)s provide services under these legislative frameworks as part of the current legal scope of practice. While these developments are positive and have increased client access to health services, many were peripheral in nature (i.e., they updated various statutes / regulations – many of which had not been updated since the extended class was introduced in 1998).

Other auxiliary legislation exists that impedes the RN(EC)ʼs current authority to perform controlled acts. For example, RN(EC)s practising in public hospitals with in-patients must continue to rely on medical directives in order to communicate a diagnosis, prescribe drugs or order treatments unless additional changes are made to Regulation 965 under the Public Hospitals Act. This barrier to practice will greatly intensify when the proposed regulation introducing NP-Paediatrics, NP-Adult and NP-Anaesthesia becomes law, as these NPs work primarily in acute care settings. Consequential amendments to auxiliary legislation/regulations would also enable the performance of additional controlled acts as proposed in this submission, without the use of delegation.

A number of the statutes and regulations that will influence the ability of RN(EC)s to implement current and proposed controlled acts are listed in question #12 (Table 1). While not an all-inclusive list, these statutes and regulations are deemed to be the most important ones requiring change to enable RN(EC)s to practice the full extent of their current and proposed scope of practice.

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24 Including future RN(EC)s (i.e., ACNPs who will be regulated in the extended class).
Collaboration

14) Do members of your profession practice in a collaborative or team environment where a change in scope of practice and the recognition of existing or new competencies will contribute to multidisciplinary health care delivery? Please describe any consultation process that has occurred with other professions.

RN(EC)s work within inter-professional teams. Consistent with the core competencies and in accordance with the current Practice Standard, RN(EC)s collaborate with other professions and consult with physicians as part of their practice. An enhanced scope of nursing practice will contribute to inter-professional health care delivery.

When the proposed regulations were circulated for feedback, some physicians also responded to the proposals, specifically citing the contribution this change would have on health care teams. For example, a physician involved in a neonatology program indicated that there is a history of successful collaborative inter-professional practice, including neonatal NPs, within the neonatology program. In this physician’s experience, neonatal NPs are keenly aware of their scope of practice and regularly consult with colleagues in other professions whenever client needs arise that are outside their competency. Echoing these statements, a chief physician from a paediatric program indicated that the neonatal NP role has been an integrated part of the inter-professional team for over 15 years, which has broadened the nature of the care provided and has allowed the team to provide more comprehensive care to a vulnerable and critically ill client population.

Please see question # 19 for a more complete summary of consultation with other professions.

Public Interest

15) Describe how the proposed changes to the scope of practice of the profession are in the public interest. Please consider and describe the influence of any of the following factors:

a. Gaps in professional services

The gaps that exist in Ontario’s health service sector are a reality. In order to address the gaps, the province requires a coordinated and integrated health human resource plan. Historically, NP roles were initiated and evolved to address gaps in health services. For example, early NP funding initiatives focussed on placing RN(EC) positions in rural, remote and underserviced communities, where there were few or no other primary health care providers; and the decline
in resident availability for neonatal intensive care units led to the introduction of neonatal NPs\textsuperscript{vi}.

Some populations are at greater risk of falling through the gaps in our health system’s infrastructure. These include those living with mental illness, those living with complex chronic diseases, new immigrant and refugee populations, the elderly – particularly those who are isolated, homeless and/or poor, Aboriginal and geographically isolated populations. A number of Ontario’s NPs\textsuperscript{25} already work to facilitate access to better care for these higher risk populations.

Overall, the proposed legislative and regulatory amendments will reduce gaps created by unnecessary delays in access to care. When a client needs access to a test, medication, or procedure currently not authorized to RN(EC)s, they may perform the activity via delegation and medical directive, consult with a physician to obtain the necessary authorization, refer the client to a physician for the service, or refer the client to an emergency department. The proposed changes will facilitate more timely access as NPs will be able to directly provide needed health services according to their legal scope of practice and the practitioner’s individual level of competence and in accordance with clinical guidelines.

Some examples are provided below.

**Osteoporosis**

Over half a million Ontarians have some degree of osteoporosis and related fragility fractures are associated with increased mortality, decreased function and quality of life\textsuperscript{vii}. There is evidence to suggest that people at risk for osteoporosis are not being screened, diagnosed and treated according to best practice guidelines. While a minority of Ontarians with osteoporosis are diagnosed before they arrive at an acute care hospital with a fracture\textsuperscript{viii}, up to 20% of diagnostic tests performed in Ontario are on low risk populations\textsuperscript{ix}. Bone Mineral Density (BMD) tests are considered the ‘gold standard’ in diagnosing osteoporosis, the best available form of BMD measurement is dualenergy x-ray absorptiometry, which is used to measure bone mass in the spine, hip and total body\textsuperscript{x}. The Ontario Ministry of Health & Long-Term Care (MOHLTC) is taking steps to improve BMD utilization according to best practice guidelines\textsuperscript{xi}.

RN(EC)s have the authority to order x-rays of certain body parts, that are listed in the *Healing Arts Radiation Protection Act*. Although RN(EC)s are educated to play a significant role in illness prevention, screening, chronic disease monitoring and management, including osteoporosis; however, the legislation does not permit them to order the best available form of BMD measurement. CNO’s proposal for broad diagnostic authority would eliminate this restriction. Further, there is evidence to suggest that involving ACNPs in client care activities improves compliance with best practice guidelines\textsuperscript{xii}; therefore, current Ministry efforts to improve BMD utilization could benefit by involving NPs.

\textsuperscript{25} PHCNPs and ACNPs.
Long-Term Care
Ontario’s residents living in LTC homes are fragile and at risk for adverse events. These residents are also increasing in their complexity. In her recent review of the LTC homes sector, Monique Smith, MPP and Parliamentary Assistant to the Minister of Health and Long-Term Care, identified the need for more NPs in the LTC homes sector. Preliminary feedback from LTC homes in Ontario that staff NPs indicated that the NPs provide: comprehensive admission assessments, more timely assessments for residents experiencing acute episodes, support to other staff, effective communication with residents and family members, more effective communication and the development of collaboration with physicians and community outreach. Among the positive contributions of NPs identified in the literature is the potential to reduce avoidable emergency room visits and decrease the number of hospital admissions and length of stay. CNO’s proposal for broad diagnostic and prescriptive authority would facilitate more timely and direct access to preventative primary health care as well as straightforward urgent care within the walls of LTC homes.

b. Epidemiological trends in illness and disease

To describe how the proposed scope of practice changes for NPs are in the public interest respecting epidemiological trends, a synopsis of the major trends in disease and illness impacting the health of Canadians is outlined below.

Overall Trends in Health

Today, Canadians are living healthier and longer lives. Since the 1930s the average life expectancy has increased almost 18 years, to 75.4 years of age for men, and 81.2 for women. “Since the implementation of Medicare at the beginning of the 1970s, Canadians’ life expectancy has risen approximately one year for every five calendar years.” Developments in and application of new knowledge and technologies related to health, economic and social services over the past century have impacted patterns of disease. The major causes of mortality have shifted from communicable diseases – while still prevalent and potentially dangerous with the ease of global transportation – to non-communicable or chronic diseases, such as cardiovascular disease, cancer and accidental injuries.

While death rates caused by cancer in men have been slowly decreasing and have remained relatively unchanged for women since 1990, the incidence in lung cancer in women has steadily increased. This is explained in part by the fact that teenage girls are now more likely than adolescent boys to smoke. While women live longer than men, they are more likely to suffer from depression and stress overload and chronic conditions, such as arthritis and osteoporosis, and injuries and death resulting from family violence.
Hospitalization rates for chronic conditions that can typically be managed in the community, such as heart disease and diabetes, are higher in some of the larger health regions - the overall Canadian average for hospitalizations at 389 per 100,000. "While not all of these hospitalizations are avoidable, research suggests that differences in primary health care and chronic disease prevention and management may contribute to variations in hospitalization rates."\textsuperscript{xxv}

Accidental injuries such as falls continue to be prevalent among seniors and children under the age of 12 and account for the highest rates of hospital admissions in Canada\textsuperscript{xxvi}. In Ontario, for example, playground related injuries account for 23 children to visit emergency departments every day. According to the Canadian Institute for Health Information (CIHI), “for those visiting the emergency department after a playground injury in 2004–2005, the largest proportion (51%), were seen for orthopaedic injuries, mainly fractures of the upper limbs (such as a broken arm, wrist or elbow), followed by head injuries (22%). Similarly, for admissions to hospital (of at least one night) the most commonly reported injury was an upper arm fracture (80%)”\textsuperscript{xxvii}.

Canadians, in general, appear to be taking active steps to improve their health by making healthier lifestyle choices\textsuperscript{xxviii}. However, unless steps are taken to improve access and choice, disparities in health attributed to socioeconomic inequities and geographical limitations will continue to negatively impact the health of certain groups (e.g. marginalized populations and residents of remote or under-services communities). For example, the prevalence of diabetes among Aboriginal populations in Canada continues to rise and is at least three times that of the Canadian population\textsuperscript{xxix}.

Improving accessibility to health services can play a significant role in improving health outcomes. According to recent national reports, one way to facilitate this improvement is to enhance access to health services through the expansion of scopes of practice of health providers\textsuperscript{xxx}. Expanding scopes of practice has the potential to provide clients with access to health care where and when it is needed, reduce wait times, stress and economic burden for clients and their families.

\textit{NP Scope of Practice & Epidemiological Trends}

According to a 2003 study, 96% of RN(EC)s indicated that they monitor chronic illness, spending approximately 25% of their time doing so\textsuperscript{xxxi}. If granted the proposed expanded scope of practice, RN(EC)s\textsuperscript{27} would be well-positioned, as members of collaborative teams, to address and manage these epidemiological trends in disease and illness. For example, access to the controlled act of setting and casting fractures and expanded diagnostic and prescriptive authorities under the \textit{Healing Arts Radiation Protection Act, Laboratory and Specimen Collection Centres Licensing Act} and \textit{Nursing Act}, could enable NPs practising in

\textsuperscript{27} Including future RN(EC)s (i.e., ACNPs who will be regulated in the extended class).
emergency departments to address the needs of their paediatric clients suffering from playground related injuries. The RN(EC), within his or her level of competency, could autonomously order drugs to provide appropriate pain relief, order requisite x-rays, and set and apply a cast for simple fractures without delay. The client would not need to be seen by the physician unless warranted (as outlined in the proposed RN(EC) Practice Standard, (Appendix C). Enabling the RN(EC) in this situation may reduce system and client burdens. For example, the need for hospitalization or client transfer may be eliminated.

Similarly, permitting RN(EC) access to the controlled act of dispensing, compounding and selling drugs could provide the public with improved access to health services; particularly for aging populations who may not be able to readily access services of a pharmacist due to disease processes such as Alzheimer’s or degenerative joints (the incidence of both are anticipated to increase as the population ages). CNO’s proposal would mean that these at risk clients would be able to access the drug on site from the NP rather than making a separate trip to a pharmacy. This is particularly appropriate when there is concern that the client might not access the drug due to a history of non-compliance or lack of resources.

Further, with the incidence of chronic diseases, such as cardiovascular disease, diabetes and cancer remaining high, and because people are living longer with chronic diseases, timely client access to appropriate diagnostic tests and drugs is necessary. Increasing RN(EC) diagnostic and prescriptive authority may help to reduce complications and degeneration, and contribute to early identification / intervention. This includes referral to other members of the health care team, as required.

c. Changing public need for services and increased public awareness of available services

Changing public need for health services is covered in sections a, b and g.

There is greater awareness of the NP role among the Canadian public. According to a public poll commissioned by the Canadian Nurses’ Association in April 2005: 95% of Canadians say it is an advantage to have NPs work collaboratively with doctors; and 91 % agree that NPs would speed up the time for clients to be diagnosed and treated. CNO’s proposal would mean that these at risk clients would be able to access the drug on site from the NP rather than making a separate trip to a pharmacy. This is particularly appropriate when there is concern that the client might not access the drug due to a history of non-compliance or lack of resources.

The number of NPs in Ontario has increased, which enables more members of the public to have direct interaction with an NP. In 2006, there were over six hundred (639) RN(EC)s employed in nursing in Ontario; and, as of June 2007, Health Canada is currently proposing amendments to regulations under the Controlled Drugs and Substances Act that would permit NPs to prescribe narcotics for pain management, among other controlled substances. Actual implementation would require enabling provincial regulations as well.

The sample size of 1,554 Canadians provides a sampling error of plus or minus 2.5%.

This number was approximately 300 when the role was introduced in 1998.
over 800 nurses were registered in the extended class. As noted in question #12, an estimated 300-400 nurses currently self identify as ACNPs and may be eligible to register in the extended class\textsuperscript{31}. In fact, the need to protect the NP title in Ontario\textsuperscript{32} stemmed from the increased public awareness of the role. The Ontario government has doubled the number of NP education seats, with plans for future increases\textsuperscript{xxxiv} and Ministry initiatives to expand community health centres, introduce Family Health Teams, shorten wait times for key procedures and promote inter-professional collaboration may all lead to increased public awareness of the NP role and its contribution to client care.

Members of the public who are familiar with NP services express positive satisfaction ratings. A recent survey of clients admitted to hospital for cardiovascular, orthopaedic, neurosurgery and cancer care found that respondents receiving ACNP care were more satisfied than those who did not\textsuperscript{xxxv}. In particular, clients express satisfaction with how ACNPs communicated with them and other nurses about client care\textsuperscript{xxxvi}.

According to a 2003 survey\textsuperscript{xxxvii}, clients were very satisfied with the:

- way the RN(EC) spoke and listened to them (91%);
- amount of time the RN(EC) spent with them (88%); and
- care or advice received from the RN(EC) (87%).

These findings are not isolated. A 2002 systematic review of randomised controlled trials (11) and prospective observational studies (23) found that PHCNP care results in: similar\textsuperscript{33} outcomes in client health status and higher levels of client satisfaction\textsuperscript{xxxviii}.

Enhancement of the RN(EC) scope of practice would increase the number of health care services that could be provided by NPs.

Increasing public awareness on matters related to health care, the health care system, technological advances and Ontario’s changing demographic has led to a more informed client population, one that makes more active and informed decisions in its own health care. Client choice is one factor that influences the diagnostic and prescriptive activities of health professionals. Ontario’s current regulatory restrictions impede RN(EC)s’ abilities to support client choice in situations that are otherwise clinically feasible. For example, advances in technology frequently result in new drug formats, such as Nuvaring – a convenient, and for many women, a preferred and clinically feasible birth control option. Nuvaring had been available in Canada for 2 years before it was added to the RN(EC) drug list.

\textsuperscript{31} Proposed regulatory amendments to include acute care NPs in the extended class are currently with government for approval.

\textsuperscript{32} The \textit{Health System Improvements Act}, 2007 limits use of the title to members of CNO. Proposed regulatory amendments cited above will further limit its use to RN(EC)s.

\textsuperscript{33} The review looked at studies comparing NP and physician outcomes in primary care settings.
d. Waiting times for health care services

As discussed elsewhere in this submission, the proposed changes to RN(EC) scope of practice could reduce delays and wait times for health services. By increasing RN(EC) access to controlled acts, clients will have timely, first line treatment with fewer delays and/or inconveniences necessitated by unnecessary referrals.

In 2007, the Wait Times Expert Panel reported that wait time initiatives in Ontario have included increasing training and employment opportunities for NPs. For example, in February of 2006, the McGuinty government announced the additional training of as many as 100 new NPs to help reduce wait times. Also, the McGuinty government announced the creation of the NP-Anesthesia role to support the reduction of wait times.

There is literature to suggest that NPs may be part of the solution in reducing wait times, including evidence to show that NPs can reduce wait times in Emergency Departments. One NP indicates that her hospital has reduced the percentage of clients who “leave without being seen” by adding NP staff to the emergency department. This represents a client-group at risk for adverse events. In addition to reducing Emergency Department wait times, NPs have also had an impact within Family Health Teams (FHTs). For example, a recent news article reported that, following the hiring of three NPs, patients of the FHT will be able to see a doctor or NP within three days of calling for specific complaints as part of a wait time reduction program.

Stakeholder feedback from 2006 indicated that increasing RN(EC) access to controlled acts will reduce some of the wait time pressures on the health care system. Examples are outlined below:

- An NP indicated that increased access to cardiac medication should allow drugs to be prescribed earlier in the course of the disease, which would help to handle the cardiac surgery load (because it would be reduced), and therefore shorten wait times for the operating room.

- An NP wrote that in the Urgent Care Centre, these changes will allow the RN(EC) to order venipuncture to be performed by RNs and will enable the RN(EC) to set and cast non-displaced fractures.

- An NP wrote about her role as an NP for Palliative Care, and Pain and Symptom Management. Due to limitations in her legal scope, patients must wait, sometimes in excruciating pain, until the surgeon is finished operating or the attending physician calls back. The NP wrote about a recent experience where a woman in the last days of her struggle with

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34 Patients leave because of long wait times. Chatham-Kent Health Alliance experienced over 3% reduction in clients who leave without being seen since the addition of NP staff to the emergency department.
lung cancer had to suffer in severe dyspnea and wait until her doctor called back to approve and prescribe the NP’s suggestions for bronchodilators and opioids\textsuperscript{35}.

- Some NP stakeholders indicated that the changes would result in more timely discharge from hospital, thereby decreasing wait times. For example, one NP provided feedback that having prescriptive authority in the in-patient setting will facilitate timely discharge. This would improve efficiency of patient transfer, as beds become available sooner for patients waiting in the recovery room, the intensive care unit and the emergency department. One NP recounted her experience where a patient was ready for discharge; however, the team decided to keep the patient in hospital for an extra four days to prevent risk of a blood clot. If the NP had access to the necessary blood tests and drugs, the team would have been able to safely discharge the patient with appropriate community follow-up by the NP.

e. Geographic variation in availability and diversity of health care providers across the province

Geographic variations are covered in section m below.

f. Changing technology

Advances in scientific knowledge and rapidly changing technology positively impact access to the most effective health care services including drugs and diagnostic tests\textsuperscript{xlvi}. Additionally, improvements in medical technology and changes in health care delivery over the past several decades have also meant that many health services can now be provided outside hospitals and by professionals other than physicians\textsuperscript{xlvii}.

CNO’s proposal to increase RN(EC)\textsuperscript{36} scope of practice relates to changing technology. Increasing access to the ordering of diagnostic testing such as electromyography or CAT scans may facilitate earlier and more accurate diagnoses by both RN(EC)s and their collaborating physicians.

The Ontario Telemedicine Network (OTN) is one vehicle facilitating greater and more cost efficient access to health services by enabling health practitioners to provide services to clients across long distances. The network provides for a range of electronic services including videoconferencing, electronic health records and a province-wide diagnostic imagery system\textsuperscript{xlviii}. The system also

\textsuperscript{35} Health Canada is currently proposing amendments to regulations under the Controlled Drugs and Substances Act that would permit NPs to prescribe narcotics for pain management, among other controlled substances. Actual implementation would require enabling provincial regulations as well.

\textsuperscript{36} Including future RN(EC)s (i.e., ACNPs who will be regulated in the extended class).
promotes access for populations at greater risk, including First Nations communities.

NPs practising in remote and under-serviced areas, such as Armstrong and Longlac, currently use telehealth technology to facilitate diagnosis and consultation with other professions. Greater efficiencies in the system and better outcomes for clients may be achieved if RN(EC)s were permitted access to the additional controlled acts, reducing the need for unnecessary duplicate consultations with physicians and possibly reducing transfer of clients by air ambulance at significant costs. For example, telehealth technology may be used to: expedite on-site diagnosis of a fracture in a client (through the transmittance of x-rays); formulate treatment plans; and refer to specialists, should it be required. With an expanded scope, RN(EC)s could immediately order the appropriate radiological and laboratory tests, prescribe appropriate medication to relieve pain \(^{20}\) and, depending on the circumstances, dispense the drug to the client, and set and cast the fracture all without the client needing to be transported away from his or her community.

**g. Demographic trends**

Over the next 20 years, Ontario’s population growth is expected to average 1.1% annually; the resulting increase in population to 2025 is projected to be 3.1 million\(^{xlix}\). Between 2006 and 2031, new migration (mostly immigration) will account for 74% of total population growth\(^{i}\). At the same time, the population continues to age as “baby boomers” begin to turn age 65 starting in 2011 and reach ages 60-79 in 2025. The share of seniors will increase from 13 per cent of the population in 2005 to almost 20 per cent in 2025. This coincides with the long-term trend of seniors living longer\(^{ii}\).

NPs currently possess the competencies needed to adapt to Ontario’s changing demographic. For example, the concepts of developmental, age and culturally appropriate care are explicitly embedded throughout the competency framework\(^{iii}\).

Further, Ontario’s demographic trend points to increasing population health needs over the next two decades\(^{iii}\). As noted in various sections throughout this document, CNO’s proposal to expand RN(EC) scope of practice could result in more direct and timely access to health services, especially in the management of chronic diseases.
h. Promotion of collaborative scopes of practice

Overlapping scopes of practice and collaborative practice are in the public interest. There is a general trend across the country and across sectors (including education) to move towards inter-professional collaborative practice in health service delivery. This movement has been supported by millions of dollars invested by federal and provincial governments. This trend was motivated by increasing awareness that inter-professional collaborative client-centred practice contributes to improved population health/client care and improved access to health care, among other positive benefits. The concept of inter-professional care was recently introduced as an object of the health regulatory colleges. CNO is supportive of this object and looks forward to its implementation. Much work will need to be carried out, however, to ensure that health providers share a common understanding of the meaning of inter-professional practice.

CNO is aware that its proposal to move the requirement that RN(EC)s consult with members of other health professions from the Nursing Act, 1991 to the RN(EC) Practice Standard (Appendix C) may be misperceived by some as having a negative affect on inter-professional practice. We do not agree with this perception, nor do we believe that it makes sense to legislate this requirement for only one profession. RN(EC)s will continue to consult and collaborate with physicians, and other providers, in the best interests of their clients. Specific requirements for consultation required in the public interest will be specified in the RN(EC) Practice Standard.

As discussed in the introduction, CNO has adopted the Canadian Nurse Practitioner Core Competency Framework. CNO approves NP education programs based on whether they teach these competencies in their curricula. The competency framework includes specific indicators regarding NP consultation and collaboration with other health professions, as well as collaboration with clients and family. Question #22 provides an overview of some of the relevant competencies.

The regulatory examinations for NPs also test collaborative practice and consultation competencies. The current QA program for RN(EC)s requires a mandatory practice review at the first 1800 hours of practice, or the first 3 years,

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37 Although they are often confused, “consultation” and “collaboration” are separate concepts. Consultation is an explicit request by an RN(EC) for a physician to become involved in the care of a patient for which the RN(EC) has primary responsibility at the time of the request. Collaboration involves working with one or more members of the health team, who each make a unique contribution based on his/her scope of practice. RN(EC)s are expected to consult and collaborate, as appropriate, to ensure their client’s overall health service needs are met. In practice, consultation and collaboration may overlap.

38 Examinations for the NP-Adult, NP-Paediatric and NP-Anesthesia specialties have not yet been approved by Council.
whichever is sooner. The focus of this review is to demonstrate to the QA
commitee that the RN(EC) has:

- established an appropriate network for consultation with members of
  other professions; and
- practised in accordance with CNO’s expectations for consulting with
  physicians.

To date, 95% RN(EC)s have been successful in practice review. Finally,
according to a 2003 survey of physicians who work with RN(EC)s, 89.6% are
satisfied that RN(EC)s consult with physicians when appropriate\textsuperscript{viii}.

\textbf{i. Patient safety}

According to the study \textit{Patient Safety and Healthcare Error in the Canadian
Healthcare System}, patient safety has been defined as “the avoidance,
prevention, and amelioration of adverse outcomes or injuries stemming from the
processes of health care; these events include ‘errors’, ‘deviations’, and
‘accidents’”\textsuperscript{lix}.

Promoting patient safety is a shared responsibility involving many entities of the
health system. As the regulatory body for the nursing profession in Ontario,
CNO’s role is to protect the public. This is achieved through:

- setting the criteria for entry to the profession, or in this case, entry to the
  extended class;
- establishing practice standards;
- administering QA; and
- enforcement.

By fulfilling this mandate, CNO strives to ensure the provision of safe and ethical
nursing practice by its members. In addition, employers, professional
associations, unions, researchers, individual providers and health provider teams
have key roles to play in promoting patient safety.

CNO is proposing changes to the regulatory framework that may raise patient
safety concerns among some stakeholders. An example is CNO’s
recommendations to remove restrictions on RN(EC)s’ diagnostic and prescriptive
authorities from the legislation. However, it is not the regulated list of drugs or
tests that ensures appropriate prescribing, ordering and monitoring by the
RN(EC). Rather, it is the RN(EC)’s competencies in: health assessment and
diagnosis; health-care management and therapeutic intervention; health
promotion and prevention of illness, injury and complications; and professional
role and responsibility\textsuperscript{lx} that promote safe practice.

An important message from the study mentioned above is that although adverse
events may involve human error, they are often more closely related to systems
that do not adequately support providers in the practice environment. The study
also identified the need for better reporting systems across health sectors (i.e.,
not limited to acute care)\textsuperscript{lx}. CNO agrees with both of these concepts and would
support better data collection regarding the diagnostic and prescriptive practices of all relevant professions\(^{39}\), across sectors, in an effort to promote patient safety.

Finally, there are concerns with the current regulatory restrictions that create risk to the public. Updating lists/categories of drugs or diagnostic tests embedded in regulation or legislation is a slow and cumbersome process. The process cannot keep pace with evolving evidence-based practice and leads to real-time delays in client care. Sometimes these delays are for reasons as simple as a client has an allergy to a drug that is on the RN(EC) list; however, the most comparable / best alternative is not on the list. Finally, CNO has heard anecdotal reports that providers may work together to develop strategies to address the current limitations. For example, RN(EC)s carrying prescription pads that have been “pre-signed” by their collaborating physicians, so that when they encounter the need for prescriptions that are within their competence – but not within their legal scope of practice – they need not consult with the physician unnecessarily.

\subsection*{Wellness and health promotion}

Wellness and health promotion are central to the practice of all Ontario nurses. The concept of health promotion is embedded in nursing’s scope of practice statement (see introduction). “Health promotion, disease prevention and population health” are entry to practice competencies for Ontario’s registered nurses\(^{\text{lxii}}\). NPs\(^{40}\) build upon these requirements by demonstrating advanced practice competencies in health promotion and prevention of illness, injury and complications\(^{\text{lxiii}}\). These competencies apply to individuals, families and entire populations. According to United States (U.S.) research, while a physician and an NP may treat a specific acute illness in the same way, NPs evaluate the illness differently, emphasizing disease prevention, health education and health promotion\(^{\text{lxiv}}\).

A 2005 survey of RN(EC)s found that they make health promotion a priority in their practice: 92\% of RN(EC)s said their practice included a focus on health promotion and disease prevention\(^{\text{lxv}}\). These are consistent with findings in a 2003 study, which found 99\% of RN(EC)s provide wellness care, spending approximately 38\% of their time doing so\(^{\text{lxvi}}\). The same 2003 study found that, 90\% physicians who collaborate with RN(EC)s indicate that RN(EC)s provide valuable contributions to wellness care/health promotion\(^{\text{lxvii}}\).

NPs’ contributions to client wellness and health promotion are well documented and these services are those that are commonly thought to have the potential to improve a client’s quality of life, reduce morbidity and mortality and lower health care costs. The current regulatory restrictions have impeded RN(EC)s’ abilities to

\(^{39}\) The need for better data collection applies to all providers that order diagnostic tests and prescribe.
\(^{40}\) All NPs. These core competencies are embedded in ACNP education programs and practice as well as that of PHCNPs.
fully utilize their knowledge and skills in these areas. For example, in September 2005, CNO requested a regulatory amendment to permit RN(EC)s to prescribe Zyban to clients to support smoking cessation; the drug was not added to the list until March 2007. Historically, many of CNO’s proposed regulatory amendments to add vaccines to the RN(EC) schedule have taken as long to approve. A third example is that provided in question #15, section a, related to screening for osteoporosis and the inability of RN(EC)s to order the necessary diagnostic tests.

k. Health human resource issues

In May 2006, the Ontario government launched its health human resources strategy, Health Force Ontario, to address the province’s shortage of health professionals. This strategy includes efforts to:

- better predict the right number and mix of health professionals needed to meet Ontario’s evolving population health needs;
- recruit and retain health professionals by making Ontario the “employer of choice” for health professions, making the province more competitive with other jurisdictions; and
- introduce new provider roles (i.e., physician assistants) or new roles for existing providers (i.e., nurse endoscopists, nurse practitioners in anesthesia, surgical first assists, clinical specialist radiation therapists and anaesthesia assistants) to improve public access to health services.

The shortage of health professionals has led governments to re-think how health services are delivered, who delivers them and where. Changes are needed to meet the demographic and epidemiologic impacts discussed in question #15, section b of this document. Not only are new providers necessary, but according to Ontario’s health human resource strategy - the system must make “the best possible use of existing people, knowledge and skills.” CNO’s proposal to increase NP scope of practice is well aligned with Health Force Ontario objectives as it involves making better use of the nursing workforce’s knowledge and skills. The proposal may also improve the flexibility of the province’s NP workforce, making it easier to deploy it in ways to meet Ontario’s evolving population health needs. Further, enabling Ontario’s NPs to use the full extent of their knowledge, skills and judgement may make this a province “of choice” - increasing its ability to compete for scarce and valuable nursing human resources. This may be particularly true in border communities, where Ontario NPs can easily work in other jurisdictions, such as the U.S. For example, during recent CNO teleconferences regarding proposed regulatory amendments affecting the extended class, employers in border communities have cited their attempts to repatriate Ontario nurses who are working as NPs in the U.S. These administrators report that when the NPs learn about the restrictions in Ontario’s regulations that will limit their practice, they indicate that they would prefer to remain in the U.S. until such time that scope of practice is expanded in Ontario.
Feedback from CNO’s stakeholder consultations support the notion that the proposed changes are consistent with Ontario’s health human resource planning effort:

- the Hospital for Sick Children indicated that the proposed changes are congruent with current approaches to health human resource planning and will greatly enhance the capacity of nurses to better serve the public in the delivery of specialized health services; and

- the Ontario Long Term Care Association indicated “we…see these amendments as important steps in supporting provincial health human resource strategies required to make full use of the skills of health professionals in providing efficient and effective health care.”

I. Professional competencies not currently recognized

The Canadian Nurse Practitioner Core Competency Framework identifies the core competencies common to all NPs regardless of client populations or practice environments (i.e., PHCNP and ACNP). This framework is discussed in the introduction (Appendix A) and referenced throughout this document.

The competency framework includes specific indicators regarding NP diagnosing and prescribing activities. Of particular interest, the following competencies are directly related to CNO’s proposal to expand scope:

- Competency 1.5: the NP “orders appropriate screening and diagnostic investigations (e.g. laboratory tests, x-rays, ultrasound) and interprets reports based on sound clinical reasoning scientific evidence and critical thinking” \(^{41}\); and

- Competency 2.3: the NP “applies knowledge of pharmacology in selecting, prescribing, monitoring and dispensing drugs and performs these competencies as appropriate for the nurse practitioner’s scope of practice, level of competency and clinical practice setting” \(^{40}\)

The competencies represent the foundation for clinically sound decision making; they do not change based on specific diagnostic tests or drugs that may, or may not, be listed in legislation. It is acknowledged within the framework that the NP practises within his or her own level of individual competency, and that to enable competencies related to ordering diagnostic tests and prescribing, additional regulatory authority may be needed at the provincial level. While NPs are educated to practice the competencies specified in the framework, the authority to perform those associated with diagnosis and treatment in Ontario in some circumstances may only be achieved through delegation and medical directives.

\(^{41}\) Reproduced with permission from the Canadian Nurses Association.
CNO is seeking greater regulatory clarity regarding accountability for controlled acts commonly performed by RN(EC)s. Such clarity is preferred over the current blurred authority and accountability that exist between the RN(EC) and physician. Clarifying this accountability will facilitate CNO’s ability to set specific regulatory expectations for:

- entry to the extended class, and therefore access to the additional controlled acts, by approving education programs and regulatory exams, which teach and test the core competencies, including those specifically linked to the new controlled acts; and

- safe performance of the additional controlled acts through the proposed RN(EC) Practice Standard and QA mechanisms that assess ongoing performance of the core competencies, including those specifically linked to the new controlled acts.

Given that RN(EC)s already possess the competencies at entry-level and are safely performing the expanded acts through delegation, CNO believes that granting the additional authorities to RN(EC)s will help enhance transparency and public safety.

m. Access to services in remote, rural or under serviced areas

As noted in question #15, section a, early NP funding initiatives focussed on placing RN(EC)s in rural, remote and underserviced communities. NPs have a long history of promoting access to services in remote, rural and underserviced areas.

A study exploring the concept of “underserviced” areas or populations, describes the positive contributions that NPs offer northern and underserviced communities. The study indicates that restrictions on NP scope of practice are a barrier to recruiting NPs to these areas. Similarly, a 2003 study found that one of the top two predictors determining NPs’ willingness to relocate to rural or remote areas is the ability to work to the full scope of practice.

In response to CNO’s proposed changes, one member wrote that many people in the community do not have access to a vehicle to get to the closest pharmacy, in another town. Dispensing, as a controlled act authorized to RN(EC)s, would increase access in his community.

Although CNO’s proposed changes are not focussed on RN(EC)s practicing in rural, remote or underserviced communities, they have the potential to influence access to people in those communities. They may also support local recruitment and retention of NPs. According to a research fact sheet by the Centre for Rural and Northern Health Research, the work of NPs has been well received in rural
communities and further use of the role is recommended. However, “regulatory rigidities” could hamper the integration of NP roles in these communities.

16) How would this proposed change in scope of practice affect the public’s access to health professions of choice?

As discussed in question #15, section c, client satisfaction with NP care is high. CNO’s proposal means that clients, who according to the research literature, are already highly satisfied with NP care, would be able to receive more of their health services directly from their NPs.

Although members of the public may choose health care delivered by NPs, current restrictions to RN(EC) legal scope of practice limit their access. For example, RN(EC)s responded to CNO’s consultation regarding the proposed changes and some described situations when they had to send clients to walk-in clinics or emergency departments to receive health services that were within their competence, but not their legal scope of practice.

17) How would the proposed change in scope of practice affect current members of the profession? Of other health professions? Of the public?

Describe the effect the proposed change in scope of practice might have on:

a. Practitioner availability;

In 2006, CNO received feedback about the proposal to increase scope of practice: that these changes will improve efficiency of the health care system and facilitate timely access to physicians and specialists. The Nurse Practitioner Association of Ontario echoed this comment and wrote that the changes would promote more effective utilization of physician resources.

b. Education and training programs, including continuing education;

The proposed change in scope would have a minimal impact on education and training programs because all NP programs in Ontario teach to the Canadian NP core competencies, which are linked with the proposed increase in scope of practice. CNO posed this question to representatives in the education sector. NP education programs incorporate practice examples (i.e., case studies, etc) throughout the curricula. The Ontario Primary Health Care Nurse Practitioner Program indicated that should the proposed acts be incorporated into the RN(EC) legal scope of practice, they could make modifications within the existing curricula to incorporate them into the examples. For example, workshops, which include clinical mentoring, could be developed for the controlled act of “setting or casting”. Similarly, practice examples for the acts “dispensing, selling

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42 Similar to existing workshops held for suturing.
or compounding a drug” and “application of a form of energy” could be incorporated into the therapeutics course. University of Toronto (U of T) indicated that it has already incorporated strategies to enable graduates of the program to perform the new proposed controlled acts. McMaster University indicated that no changes are required in its education program in relation to the proposed increase in legal scope of practice.

Please see question # 28 for information about continuing education and bridging programs.

c. Enhancement of quality of services;

At present, RN(EC)s have access to specific diagnostic tests and drugs set in regulation. The process to update these regulations is time-consuming, cumbersome and resource intensive for all parties involved. As a result, keeping the regulations current is not possible, especially considering the continual advances in health care and the speed at which they occur. Clients may experience delays in their treatments or decreased access to the drug therapies of choice as recommended in current clinical practice guidelines. Through interview with health care teams, a study determined that some laboratory tests and drugs were not on the current lists for RN(EC)s, resulting in unnecessary restrictions to RN(EC) practice.\textsuperscript{lxxiii}

CNO has received additional feedback related to this issue. In response to the proposed changes, 19 members wrote that the removal of list-based prescribing will allow up-to-date treatment for the public. One member wrote that the current drug, laboratory and diagnostic lists are inadequate and outdated. As a result, the arbitrary limits caused by the lists have caused delays in obtaining the most appropriate care for the client as well as placing unnecessary burdens on other members of the health care team. Similarly, an NP stated that being able to dispense birth control pills and samples of drugs to marginalized clients would better serve clients and improve overall access to quality health care. Quality of care would be enhanced for members of the public if RN(EC)s had access to current, evidence-based drugs, and laboratory and diagnostic tests.

d. Costs to patients or clients;

Please see question # 17, section h, and question #34 for an overview of how the proposed changes affect costs (financial and non-financial) for clients.

e. Access to services;

A recent Canadian Institute for Health Information report indicates “decision makers at all levels recognize the contribution that NPs can offer in providing timely access to quality of care\textsuperscript{lxiv}. According to feedback received from a number of stakeholders representing varied health care sectors and practice
settings, the proposed changes to scope of practice will increase access to service. Specifically, 33 members wrote that the change would result in increased access, quality and continuity of care. A cardiologist wrote: “(I) am well aware of the significant contributions nurse practitioners have made to enhanced access (and) the provision of high quality health care services.”

Several organizations felt that increasing scope of practice would increase access. Representatives from the education sector indicated “these changes...will provide improved access and timely care to the citizens of Ontario”. The Nurse Practitioner Association of Ontario echoed this statement. Similarly, the Ontario Association of Non-Profit Homes and Services for Seniors indicated that broadening RN(EC) diagnostic and prescriptive authority will enhance access to care by Ontarians.

f. Service efficiency

There are inefficiencies related to current RN(EC) scope of practice particularly within public hospitals and relating to in-patient care. RN(EC)s competently work beyond their current legal scope through authorizing mechanisms⁴³; however, the development of these mechanisms is time consuming and resource intensive. In addition, the use of these mechanisms results in blurred accountabilities.

A 2003 study identified various challenges associated with fragmented client-care associated with restricting RN(EC)s from participating in the in-patient care of their clients. “RN(EC)s reported limitations related to hospital admission privileges, lack of access to information on care provided during the acute care stay (diagnostic tests, laboratory results etc.) or lack of access to the discharge summary notes impacted continuity and quality of patient care⁴⁴. This concern was most often expressed by NPs who do not have regular access to a physician for consultation and collaboration and whose patients require hospital-based care. This was also a significant issue in practices where NPs provide primary health care to “orphan” clients.⁴⁵

CNO has received feedback from a number of stakeholders about this issue, including physicians. A physician involved in a neonatal program stated that the current need to develop, and re-approve annually, medical directives is increasingly labour intensive and time consuming. Similarly, a chief physician of a paediatric program stated that in order for neonatal NPs to practice to their full scope, medical directives must be developed, approved and then revised and re-approved on an annual basis - a process that is both laborious and bureaucratic. A cardiologist wrote: “under the current regulations, NPs in chronic disease management clinics must rely on verbal consults with specialists to order lab tests or mediations outside of their (legal) scope of practice. This is very time consuming. The NP, in many cases, is well aware of the appropriate treatment

⁴³ Delegation and medical directives.
but must delay care to phone for a consultation. Access to drug and lab prescribing would eliminate the laborious task of medical directives and enhance client safety and professional autonomy."

According to a recent survey, medical directives used by ACNPs are signed by an average of 6.6 physicians; the total number of physicians who had signed respondents' medical directives ranged from a low of zero to a high of 30. Approximately 30% of ACNP respondents indicated difficulty with using medical directives, including rigid and restrictive directives, limitations to where they can be used (i.e., within a particular hospital) and lengthy approval processes lxxvii.

g. Inter-professional care delivery;

Section 15 g discusses collaborative scopes of practice and how NPs demonstrate that they collaborate and consult with other professions. Many of the same client populations that have been identified as at high risk of falling through ‘gaps’ in the health system are the same groups that benefit from inter-professional, collaborative, care. This type of practice is best suited to assist clients, families and populations dealing with complex health issues lxxviii.

NPs already demonstrate the competencies associated with inter-professional care delivery 44. CNO’s proposed changes will enable NPs to better contribute to client care activities – whether they are working independently in isolated practice settings or in a team environment. CNO believes that the proposed changes will have a positive affect on “intra” (within nursing teams) and “inter” (across professions) professional care, both of which support improved health services for the public.

According to recently commissioned federal papers on the topic of inter-professional care, restrictive scopes of practice are impediments to inter-professional collaboration: “the fact that scopes of practice have become overlapping does not prevent (them) from being a barrier to the development and full deployment of certain professions to broader inter-professional practice lxxix.

Supporters of truly collaborative inter-professional practice recognize that collaboration and autonomous practice are not mutually exclusive concepts. Research shows that there are key, interdependent, elements that support positive collaboration xvii, lxxx, lxxxi These are: co-operation, assertiveness, accountability, autonomy, communication, co-ordination, mutual trust and respect.

44 The Canadian Nurse Practitioner Core Competency Framework includes specific indicators related to collaborative practice.
h. Economic issues;

A key objective of Ontario’s health human resources strategy (*Health Force Ontario*) is to make the province more competitive in recruiting and retaining health professionals, or an “employer of choice”\(^{lxxxii}\). Ten years ago when the RN(EC) category was introduced, Ontario led the country – being the first province to legislate an expanded role for nurses. Please see question # 32 regarding other jurisdictions. Since then, most other provinces and territories have followed suit\(^{45}\); many adopting more liberal regulatory approaches, particularly for diagnostic and prescriptive authorities. NPs, like all professionals, want and expect to practice according to the knowledge and skills they’ve acquired in their education and past clinical experiences. According to a recent article exploring waiting lists “it is hoped that supporting nurses to work to the maximum level of their training and skills, and developing nursing specialities, will enrich (their) career paths…and keep them in the profession”\(^{lxxxiii}\). According to a 2003 survey, 62% of RN(EC)s indicated that the most positive aspect of their job is the autonomy\(^{lxxxiv}\). CNO’s proposal may offer Ontario a more competitive advantage to recruit and retain NPs.

According to a 2003 study, MOHLTC directly invests over $30 million each year on NP related initiatives\(^{lxxxv}\). This investment has undoubtedly increased since that time as the Ministry has doubled the number of NP education seats, increased funding levels of existing positions and committed funding to new positions in settings such as Community Health Centres, Family Health Teams, and a new NP clinic in the Sudbury area. Because the current regulatory framework does not enable full use of the workforce’s competency, it fails to support a full return on investment of the public funds directed to NP related initiatives.

Finally, CNO’s proposed changes will mean that clients will have more direct access to health services. In many cases, clients will take less time off work for unnecessary referrals to other health professionals for services that are within the NP’s scope of practice. This is particularly true in rural settings where a referral to another provider may involve extensive time and travel for the client.

i. Other impacts.

NA

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\(^{45}\) Yukon is the exception.
18) Are members of your profession in favour of this change in scope of practice? Please describe any consultation process and the responses achieved.

In summer 2006, the proposed regulations were circulated to all members for the 60-day statutory consultation period. Members were asked to comment on changes to the controlled acts regulation. Close to two hundred (196) responses were received, the majority of the feedback was positive with 166 or 85% of the respondents expressing support for the proposal. These respondents indicated that the regulations were enabling, supportive of NP practice, and provided adequate public protection. Although 17 neonatal NPs initially expressed concern regarding some of the registration requirements (i.e., the regulatory exam for NP-Paediatrics)\(^{46}\), they supported the proposed controlled act amendments.

Yearly, all members are asked to provide feedback regarding increasing RN(EC) drugs, and lab and diagnostic tests lists. Each year, a number of members have indicated a need to change the regulatory framework to remove lists embedded in legislation. Some indicate that there is unnecessary time spent consulting physicians to renew prescriptions that are within RN(EC) competencies.

CNO has also held a number of expert panels and teleconferences, with nurses representing a wide range of settings across the province, to obtain input from members on the proposed changes. The feedback from these teleconferences and panels supported moving forward with the proposal.

19) Describe any consultative process with other professions that might be impacted by these proposed changes.

CNO held a number of stakeholder consultation sessions in addition to the 60-day member consultation in summer 2006 (see Appendix B). All regulatory bodies were consulted in relation to the proposed changes to regulations related to the extended class. CNO held specific meetings with the following regulatory bodies\(^{47}\):

- College of Medical Laboratory Technologists of Ontario
- College of Physicians and Surgeons of Ontario
- College of Medical Radiation Technologists of Ontario
- College of Respiratory Therapists of Ontario
- Ontario College of Pharmacists

to share information and gather feedback on the proposed changes.

The Ontario Medical Association (OMA) strongly opposes the proposal. The OMA identified that the proposed amendments are a significant change to the regulatory framework and recommended a referral to HPRAC.

\(^{46}\) CNO has worked with these members to address their concerns.

\(^{47}\) Those directly affected by the proposed changes.
Individual physicians responded in support of the proposed changes to regulations for the extended class, including changes to the controlled acts regulation. For example, a physician involved in a neonatology program indicated that there is a considerable body of literature attesting to the positive impact of neonatal NPs on infant and family care. The physician stated that the neonatal NPs prove, on a daily basis, that they are skilled at coordinating the care of infants and families, including: initiating specialized procedures, diagnostic investigations, developing treatment plans, evaluating infant responses and communicating with families. In another example, a medical director of a LTC home wrote about working with an NP who performs a wide variety of tasks, including: assessing, ordering diagnostics and prescribing for more than 150 residents; however, under the current scope of practice the NP must consult with the physician because the current drug list does not include many of the first line treatments. Over the years, physicians working with RN(EC)s also expressed support for additions to drug, laboratory and diagnostics lists. Specific comments from the regulatory bodies most closely affected by CNO’s proposed changes are captured below.

**College of Medical Radiation Technologists**
- Supports the initiative, no objections.

**College of Physicians and Surgeons of Ontario**
- Supports the intention to facilitate access to care.
- Believes that expansion of scope is consistent with CPSO’s commitment to fostering collaborative health care models if undertaken with the appropriate concern for ensuring the adequate knowledge, skill and judgment of the professionals involved.
- Expresses no objection to changes in principle – emphasizing the need for the utmost regulatory rigour as the legislative restrictions on scope are reduced.
- Provides support for the proposals, which is based on the intention for the changes to be implemented within a collaborative care model; and hopes that two colleges will continue to work together to promote collaborative care by physicians and nurses.

**College of Respiratory Therapists of Ontario**
- Supports the proposed amendments to the *Nursing Act*.
- Calls attention to the restrictions posed by Regulation 965 under the *Public Hospitals Act*.
- Expresses concerns regarding the specialty NP- Anaesthesia:
  - questions impact on existing roles and programs – e.g. anaesthesia assistant;

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48 CNO has already communicated to government as per Council’s approval in June that amendments are required to this Regulation along with other legislative and regulatory changes to support the *Nursing Act*, 1991 and proposed regulation changes.
perceives the role of NP-Anaesthesia as “exclusionary” – will not be open to other disciplines;  
suggests avoiding focus on one health care discipline to solve current and future shortages, rather encourages CNO and Ministry to explore multi-disciplinary model of care; and  
recommends further dialogue and continued collaboration with groups such as anaesthesiologists, nurses, respiratory therapists and other health care providers.

Ontario College of Pharmacists (OCP)
•  Supports the proposed amendments to remove drug and diagnostic lists from legislation.
•  Does not support RN(EC) access to the controlled acts of dispensing, selling and compounding of drugs for the following reasons:
  o  Drug and Pharmacies Regulation Act sets out detailed requirements for these activities, including procedural standards, record keeping and labelling, etc.; CNO’s proposal does not address these requirements; and
  o  An inherent conflict exists where professionals prescribe and dispense; this also removes an important check and balance in the system.
•  Supports enhancement of a profession’s role through collaborative practice and believes that identified needs can be, and already are, in many instances, accomplished through the delegation/medical directive process currently permitted under the Regulated Health Professions Act, 1991.

Risk of Harm

20) How will the risk of harm to the patient or client be affected by the proposed change in scope of practice?

Self-regulation means that a profession is responsible for defining and monitoring the practice of its members in the public interest and in accordance with governing legislation. As the self regulatory body for the Ontario nursing profession, CNO assesses the risk of harm associated with its proposed changes and takes the following steps to minimize these risks:
•  has proposed regulatory amendments that will restrict use of the NP title to members of the extended class;
•  sets rigorous entry requirements to the extended class, including a regulatory exam;
•  sets practice standards associated with the performance of the additional controlled acts;

49 CNO has responded to the College to clarify our understanding that the NP – Anesthesia would be part of a multi-disciplinary care team and is in no way exclusionary of other roles, including the Anesthesia Assistant and RT-Anesthetist.
50 CNO recognizes the changes that are required to the Drug and Pharmacies Regulation Act, and recommends consequential amendments to various pieces of auxiliary legislation, including this one.
51 Physicians have the authority to sell, compound and dispense as well as prescribe.
• administers quality assurance (QA) targeted specifically to the extended class; and
• proposed regulatory amendments specifying requirements associated with delegation by members of CNO, including the extended class.

Title protection protects the public from unqualified practitioners who inappropriately refer to themselves as something - that by education, experience, and competence - they are not. This is an essential component should the proposed RN(EC) scope of practice be expanded.

CNO is reviewing its QA program for all nurses. Future QA for the extended class is expected to be more relevant to NP practice, including the changes proposed herein to their legal scope of practice. In particular, QA practice assessments will not be limited to the consultation standards. The assessments will also reflect other nursing standards, including the RN(EC) Practice Standard, and the core competencies. In addition, practice assessment will not be limited to a single, point in time review, but include cyclical reviews as well.

As noted, CNO has proposed changes to the RN(EC) Practice Standard that are more closely linked to the core competencies and incorporate certain expectations and limitations pertaining to each of the controlled acts (new and expanded). This draft practice standard was developed in consultation with stakeholders and members and approved by Council in December 2006.

Finally, CNO has also reduced the risk of harm by restricting the RN(EC)'s delegation of controlled acts. CNO Council approved the proposed delegation regulation (Appendix D) in June 2007 and authorized it to be sent to government for cabinet approval. The regulation provides RN(EC)s with the authority to delegate the performance of an act authorized to the member pursuant to section 5.1 of the Act, but excludes delegation of acts which may result in a greater risk of harm to the client, specifically:
• prescribing a drug; and
• ordering the application of a form of energy.

52 The current QA program for RN(EC)s includes annual reflective practice (which is a requirement for all nurses) and an initial, single point in time, practice assessment that focuses on the RN(EC) Practice Standard (specifically, the consultation requirements).
21) What other regulated and unregulated professions are currently providing care with the competencies proposed as an expansion to your scope of practice? By what means are they performing it? (under delegation, supervision or on their own initiative?)

CNO’s proposed scope of practice for RN(EC)s involves:

i) permitting access to the following three additional controlled acts:
   • setting or casting a fracture of a bone or a dislocation of a joint;
   • dispensing, selling or compounding a drug\(^{53}\); and
   • applying a form of energy prescribed in regulations\(^{54}\)

and

ii) removing limitations on the following controlled acts currently authorized to RN(EC)s:
   • communicating a diagnosis;
   • administering a substance by injection or inhalation; and
   • prescribing

Under the Medicine Act, 1991, physicians have access to all of the above controlled acts. In addition to physicians:

• Chiropodists, chiropractors, dentists and optometrists are authorized to “communicate diagnoses”. The access is limited to diagnoses relevant to the provider’s practice, that is respectively, limited to diagnoses associated with disorders of the foot, spinal and joint structures, oral-facial complex and eye / vision system.

• Chiropodists, dentists midwives and optometrists are authorized to “prescribe”. There are no limitations on dentists’ prescriptive authority; access for the other providers is limited to drugs, or categories of drugs, designated in regulations.

• Pharmacists are authorized to “dispense, sell or compound a drug”. Dentists are authorized to “dispense”.

• Dentists and optometrists are authorized to “apply” a prescribed form of energy.

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\(^{53}\) RN(EC)s have authority to “prescribe”, which is part of the same controlled act (i.e., #8 in the list of controlled acts listed in the Regulated Health Professions Act, 1991.

\(^{54}\) RN(EC)s have authority to order the application of a form of energy, which is part of the same controlled act (i.e.,#7 in the controlled acts list).
Chiropodists, dentists, medical radiation technologists, midwives and respiratory therapists are authorized to “administer a substance by injection or inhalation”. There are no limitation on dentists’, medical radiation technologists’ and respiratory therapists’ access to this act. Chiropodists are limited to injections into the feet and midwives are limited to substances designated in the regulations.

Dentists are authorized to “set a fracture” limited to a bone of the oral-facial complex.

In addition to RN(EC)s, other regulated and unregulated professions have been granted access to activities that fall under these controlled acts through delegation. For example, pharmacy technicians soon to be regulated under the Pharmacy Act, have for many years been delegated activities associated with the controlled act of compounding, dispensing and selling drugs. Orthopaedic Technicians perform acts associated with “setting and casting”. The Ontario government initiative to introduce physician assistants will also rely on the use of delegation for the performance of controlled acts, likely to include – but not limited to\(^{55}\) – those identified above. Finally, other nurses (RNs and RPNs) also perform some of the above controlled acts through the process of delegation, as described below:

- In addition to RN(EC)s, RNs and RPNs have been applying casts, removing old ones and reapplying new ones in fracture clinics throughout the province, inclusive of northern isolated areas, urban centres and rural areas.

- RNs in northern areas have been responsible for setting simple fractures, either manually, or with the application of splinting mechanisms. As the only health professional available, these nurses are sometimes required to reduce a dislocation or a partial dislocation of an extremity.

- RNs and RPNs in LTC homes, community, outpost and school settings have been reducing chronic dislocations of shoulders, fingers, and jaws for their clients. RNs in emergency departments have been assessing and reducing partial dislocations such as the subluxation of a radial head in children.

- RNs and RPNs dispense medications to hospitalized clients or LTC home residents who have been granted a leave of absence and must continue with their medication regime. Clients who present to an emergency department in the middle of the night may be given sufficient doses of a medication upon discharge in order to begin timely treatment until a community pharmacist is available to fill a prescription. RNs working in isolated areas routinely dispense medications to clients from the nursing station medication stock.

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\(^{55}\) All controlled acts authorized to a physician may be delegated by the physician to a physician assistant in accordance with requirements set by the College of Physicians and Surgeons of Ontario.
• RNs and RPNs in community health centres or public health units routinely dispense medications to clients who are financially disadvantaged and in need of immediate treatment. They also dispense to clients whose compliance is in question e.g. clients who leave with a prescription but there is no assurance that they will fill the prescription and begin necessary treatment. Nurses also frequently dispense prophylactic medications in travel clinics.

• In some clinical settings, there is a minimum charge to the client for medication that is dispensed/sold to them by nurses. Because this is such common practice among nurses, CNO and the Ontario College of Pharmacists worked together to develop guidelines associated with delegating the dispensing of drugs. However, nurses currently are legally prohibited from participating in the selling process. If there is no pharmacist available, the nurse is left with the option of violating the law, or the client is left with no medication.

22) Specify the circumstances (if any) under which a member of the profession should be required to refer a patient/client to another health professional, both currently and in the context of the proposed change in scope of practice.

RN(EC)s are currently required to consult in accordance with the Nursing Act, 1991 which states:

“A member is not authorized to communicate a diagnosis…unless the member has complied with the prescribed standards of practice respecting consultation with members of other health professions” xxxvi.

The current RN(EC) Practice Standard (Appendix E) referred to in the act contains definitions of consultation and collaboration, as outlined below.

Consultation is: “an explicit request by an RN(EC) for a specific physician to become involved in the care of the client for which the RN(EC) has primary responsibility at the time of the request. Consultation happens when the nurse reaches the limit of the RN(EC) scope of practice, beyond which she/he cannot provide care independently and additional information and/or assistance is required from a professional with a more extensive knowledge base related to the specific client situation” xxxvii.

Collaboration is: “the cornerstone of multidisciplinary care, involves working with one or more members of the health care team who each make a unique contribution from within the limits of her/his scope of practice. RN(EC)s are expected to consult and collaborate with other health professionals as appropriate, to ensure that their clients’ overall health care needs are met” xxxviii.

The current RN(EC) Practice Standard also outlines explicit requirements for consultation and collaboration including detailed clinical and procedural expectations. Procedural expectations focus on communication between the RN(EC) and physician, documentation of the request and ensuring the physician has access to the client’s health record. The clinical expectations are focussed
on PHCNP practice, which is currently the only NP that is eligible for registration in the extended class. Examples of these clinical and procedural expectations include:

- signs of recurrent or persistent infection;
- a fever of 39 degrees Celsius, or higher, in a child aged 3 to 36 months with no identifiable focus of infection; and
- any sign(s)/symptom(s) of illness in a child less than 3 months old.

As noted elsewhere in this document, CNO Council has adopted the *Canadian Nurse Practitioner Core Competency Framework*. This framework contains specific competencies and indicators associated with consulting with, and referring to, other professions, these are outlined below.

- When performing health assessment and diagnosis, the NP initiates timely, effective consultation, collaboration and/or referral to physicians, other healthcare professionals and social service providers, as appropriate, to assess and diagnose client health/illness status.

- When engaging in health care management and therapeutic interventions, the NP:
  - uses sound clinical reasoning skills and established outcome criteria to evaluate the initial and ongoing outcomes of the plan of care, including consultation/referral;
  - documents the plan of care, including consultation/referral;
  - demonstrates pharmacological knowledge, including consultation, collaborating with and/or referring to physicians and pharmacists as appropriate; and
  - initiates timely and appropriate consultation, referral and collaboration with other healthcare providers.

- When fulfilling their professional role and responsibility, the NP demonstrates an understanding of scopes of practice, formally requesting consultation and referring clients to physicians or other members of the health-care team at any point in the care process when the client’s condition is assessed as beyond the nurse practitioner scope of practice, or the individual nurse practitioner's competence.

Finally, also noted elsewhere in this document, CNO has drafted revisions to the RN(EC) Practice Standard to accommodate the proposed expansion of the extended class to include ACNPs as well as the proposed scope of practice changes. The proposed revisions provide principles, based on the core competency framework, to guide RN(EC) decision making regarding consultation and referrals. This revised draft Practice Standard (Appendix C) was approved by Council in December 2006.
If this proposal is in relation to a current supervisory relationship with another regulated health profession, please explain why this relationship is no longer in the public interest. Please describe the profession’s need for independence/autonomy in practice.

As self-regulated professionals, there is no direct supervisory relationship between nurses and the providers who delegate controlled acts. RN(EC)s currently perform the additional and expanded controlled acts by accepting the delegated authority from another provider, usually a physician, and frequently through authorizing mechanisms, such as medical directives. ACNPs currently require delegation and medical directives to access/perform any controlled act not currently authorized to RNs in the general class.

As regulated health professionals, RN(EC)s and ACNPs are responsible for assuring they are qualified and competent to perform any delegated procedure (i.e., the decision to perform the act), the performance of the act, as well as assessing the availability of any health care resource that may be required as a result of performing delegated procedures. The physician is responsible for the decision to delegate and for the appropriateness of the delegation. The nurse is responsible for the performance of the delegation and for the appropriateness of accepting the delegation.

Each profession has its own interpretation of accountability and responsibility associated with delegation. According to the College of Physicians and Surgeons of Ontario’s, physicians are also accountable for the supervision of the delegation and “the nature of the supervision will vary according to the assessment of risk, taking into account the specific act being delegated, the circumstances under which the act will be performed and the qualifications and experience of the person performing it.”

While the need for continued collaboration with physicians and other health professionals is essential in today’s fast paced health care environment, ongoing reliance on the use of delegation to authorize access to controlled act activities, which over time have been subsumed within the day-to-day practice of RN(EC)s, is not in the public interest. Although delegation is a useful tool that enables access to health services and protects clients from harm - ongoing delegation fails to recognize that practice realities constantly change and competencies evolve to address those realities.

It is CNO’s responsibility to review the scope of practice of its members over time and to propose changes to nursing’s legal scopes of practice if warranted by a public protection concern. By moving from delegation to autonomous legislative

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56 The first two items are embedded in the proposed Delegation regulation that is pending government approval. The last relates to practice setting realities, as many practitioners and employers require this.

57 All remaining references to RN(EC) is this paragraph include future RN(EC)s (i.e., ACNPs who will be regulated in the extended class).
authority, accountability for the profession’s activities is more clearly established. This is because the regulatory college is in the best position to determine entry to practice and continuing competence requirements, and to set standards and practice guidelines for the profession’s scope of practice in order to promote safe practice and protect the public.

Further, reliance on delegation rather than recognition of changing scopes of practice through ongoing legislative updates can in some circumstances place the public at risk. For example, individual physicians and medical associations have periodically expressed concern about physician liability and accountability when delegating to NPs and other health professions. As mentioned in question # 13 when physicians, or other delegators, withdraw their support NPs and other nurses, particularly in isolated and underserviced areas, are left with the decision of either continuing to perform the controlled act without authorization, or of leaving the client with no one to perform the necessary care.

As noted in the introduction, in order for self-regulation is to be a meaningful governance process, regulated health professionals need to have independent access to controlled acts that have become an expected and essential part of their practice, and that contribute to increased access and timeliness of care. The performance of the controlled act should no longer be dependent upon the need for delegation once providers have demonstrated their competence in performing the activities safely. The accountability for the performance of a controlled act should be clear and should rest with the member’s professionalism and self-governance.

24) Does the proposed change in scope of practice require the creation of a new controlled act or an extension of or change to an existing controlled act? Does it require delegation or authority to perform an existing controlled act or subset of an existing controlled act?

The proposed changes to RN(EC) scope of practice do not require the creation of new controlled acts nor an extension of, or change to, an existing controlled act under the Regulated Health Professions Act, 1991.

The proposal does not require delegation or authority to perform an existing controlled act or subset of an existing controlled act. Rather, the proposed changes are intended to remove the need for delegation for the performance of controlled acts (or aspects of controlled acts) that have become, or always have been, a common part of NP practice.
25) If the proposed change in scope of practice involves an additional controlled act being authorized by the profession, specify the circumstances (if any) under which a member of the profession should be permitted to delegate that act. In addition, please describe any consultation process that has occurred with other regulatory bodies that have the authority to perform and delegate this controlled act.

The Federation of Health Regulatory Colleges of Ontario has developed guidelines in relation to the use of authorizing mechanisms. These guidelines are intended to facilitate the delegation of a controlled act. Therefore, some of the controlled acts authorized to RN(EC)s could be delegated if certain expectations are fulfilled (i.e., assure practice readiness, authority and clinical appropriateness). There are two exceptions to this delegation authority made in the public interest, as cited in question #20, RN(EC)s will not be permitted to delegate the controlled acts of "prescribing of a drug" and "ordering the application of a form of energy". These limitations are specified in CNO's delegation regulation, which has been submitted to the government for approval.

Please see question # 19 for a summary of CNO's consultation with other regulatory bodies, including the College of Physicians and Surgeons of Ontario and the Ontario College of Pharmacists – the two most likely professions that would delegate the controlled acts in question to nurses.

Competencies/Educational requirements for practice

26) Are the entry-to-practise (didactic and clinical) education and training requirements of the profession sufficient to support the proposed change in scope of practice? What methods are used to determine this sufficiency? What additional qualifications might be necessary?

CNO’s proposed changes to NP scope of practice are in keeping with the Canadian Nurse Practitioner Core Competency Framework. CNO assesses the curricula of NP education programs based on whether they teach the competencies (typically through a combination of didactic and clinical learning). Program approval is based on this assessment. Other criteria used by CNO to evaluate NP education programs include:

- Minimum of 600 clinical hours throughout the program;
- Diverse clinical practice settings, as appropriate, to allow adequate application and demonstration of the Canadian Nurse Practitioner Core Competencies;
- A portion of the student’s clinical practice must be directly supervised by a Nurse Practitioner; and
- Objective evaluation methods are comprehensive to demonstrate that the Canadian Nurse Practitioner Core Competencies are met.
NP education programs teach the use of best practice guidelines, evidence-based research, reflective practice and critical thinking all of which are part of the competency framework.

CNO also posed HPRAC’s question to representatives in the education sector. Overall, they’ve confirmed that the entry-to-practice education and training requirements for NPs is sufficient to support the proposed change in scope of practice. As noted in question # 17, section b, any changes necessary to reflect the proposed legal scope can be done by modifying existing curricula, which already teach the core competencies, which include the proposed expanded scope of practice.

The Ontario Primary Health Care Nurse Practitioner Program is offered through a consortium of ten universities. The program teaches the necessary critical thinking and problem solving associated with the expanded controlled acts, as well as the basic principles of self-regulation and reflective practice. This forms a strong foundation upon which to build the additional skills and knowledge that would be required. Program representatives indicate that no additional qualifications are required. McMaster University offers the Advanced Neonatal Nursing program, which graduates neonatal NPs. It has a long history, its current foundation established in 1986. The curriculum is currently sufficient to support the proposed change in scope of practice and program representatives indicate that no additional qualifications are required. The University of Toronto (U of T) offers the Master of Nursing, Nurse Practitioner program, which graduates ACNPs in either the Adult or Paediatric specialty. The program is sufficient to support the entry-to-practice for ACNPs. U of T has begun a review of course materials with respect to the new proposed controlled acts (i.e., “dispensing, selling or compounding a drug”).

The above programs have been assessed against the above mentioned criteria, including the core competency framework. The Ontario Primary Health Care Nurse Practitioner Program is currently an approved program, it will be recommended for re-approval. The other programs will be recommended to Council for approval in September 2007, pending government approval of proposed regulations.

27) Do members of the profession currently have the competencies to perform the proposed scope of practice? Does this extend to some or all members of the profession?

As noted in question #26, the proposed scope of practice is aligned with the Canadian Nurse Practitioner Core Competency Framework and CNO assesses programs based on this framework. As noted in the guiding principles (page 3) and question # 15, section I, CNO also assesses regulatory exams based on the

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58 These programs are for the NP-Adult and NP-Paediatrics specialties, regulations for which are pending government approval
competency framework. Successful completion of an approved education program and examination are non-exemptible requirements for entry into the extended class. Although it is commonly understood that no one individual in the profession has all of the knowledge and skills to perform all aspects of the profession’s scope of practice\textsuperscript{xciv}, all NPs enter the extended class with these minimum entry-level\textsuperscript{59} competencies and they build upon these competencies throughout their practice.

28) What effect will the proposed change in scope of practice have on members of your profession who are already in practice? How will they be made current of the changes, and how will their competency be assessed? What quality improvement/quality measurement programs should or will be put into place? What educational bridging programs will be necessary for current members to practice with the proposed scope?

How will they be made current of the changes?

Because of the extensive consultation process, including the statutory 60-day member consultation period in summer 2006, most Ontario NPs are aware that CNO proposed these changes to RN(EC) scope of practice. CNO continues to receive questions from members, professional stakeholders and educators about the status of the proposal, including the Minister’s referral to HPRAC. Building upon this existing level of awareness, members will be made current of the changes through:

- individual mailing to all RN(EC)s;
- articles and information provided in CNO publications, including *The Standard and Quality Practice*\textsuperscript{60};
- CNO’s website;
- liaison with professional associations and unions (Nurse Practitioner Association of Ontario, Registered Nurses Association of Ontario, Ontario Nurses’ Association);
- conference presentations;
- teleconferences with members;
- updates and revisions provided to members through practice standards, guidelines and fact sheets; and
- the network of CNO’s Outreach Consultants.

\textsuperscript{59} Entry level for advanced practice.

\textsuperscript{60} The Standard is a member publication, Quality Practice is geared to employers.
How will their competency be assessed?

Please see the “Guiding Principles” for a summary of CNO requirements for entry into the extended class. As discussed, these requirements are directly linked to the Canadian Nurse Practitioner Core Competency Framework.

What effect will the proposed change in scope of practice have on members of your profession who are already in practice?

The proposed changes to legal scope of practice were requested by our NP members in practice because they routinely provide the relevant health services. As noted throughout this document, RN(EC)s routinely access the proposed new and expanded controlled acts via delegation and medical directives. Until ACNPs are registered in the extended class, they use delegation and medical directives to perform any controlled act beyond those authorized to other nurses. Therefore, the most significant effect on RN(EC)s and ACNPs will be the need to understand the differences in accountability associated with the new legal scope of practice. As regulated health professionals and members of CNO, accountability is already a professional practice standard that they are obligated to meet.

An additional effect for many NPs, particularly those in remote and rural communities, is that the proposed changes may alleviate personal legal and ethical concerns associated with over-reliance on somewhat tenuous delegation from other health professionals and medical directives.

What quality improvement/quality measurement programs should or will be put into place?

The current QA program for RN(EC)s includes annual reflective practice and an initial, single point in time, practice assessment that focuses on the RN(EC) Practice Standard (specifically, the consultation requirements).

Please see questions # 20 and 29 for further information about QA.

What educational bridging programs will be necessary for current members to practice with the proposed scope?

Life-long learning is a professional obligation of all nurses and is embedded in CNO’s QA program for all nurses. CNO expects that all NPs will engage in continuing education that is appropriate to their individual practice and employment settings, including continuing education that may be a direct result of scope of practice changes.

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61 RN(EC)s and ACNPs.
CNO also posed HPRAC’s question to representatives in the education sector. McMaster University does not anticipate the need for bridging programs for its graduates. The Ontario Primary Health Care Nurse Practitioner Program indicated that continuing education (combination didactic and clinical) would be helpful to NPs, pending funding availability. This program often holds continuing education clinical workshops (i.e., suturing) for existing NPs at professional conferences; similar workshops could be produced for setting/casting fractures. U of T is currently hiring a Director of Continuing Education and is in the process of planning continuing education programs for all nurses, including NPs.

29) How should the College ensure that members maintain competence in this area? How should the College evaluate the membership’s competence in this area? What additional demands might be put on the profession?

A well-rounded, rigorous and comprehensive QA program enables CNO to ensure that members maintain competence respecting the new and expanded controlled acts. While the current QA framework is presently under review, the proposed requirements for the extended class are designed to ensure that nurses are able to provide safe and ethical care by applying College standards in their practice settings. The proposed QA requirements also enable attention to changes in work environments and advances in technology.

A two stage approach is being proposed based on the standards of practice. In the first stage, all members will be required to participate in Reflective Practice on a yearly basis, which includes a self assessment of one’s ability to provide safe and ethical care. This self assessment enables an RN(EC) to identify strengths and areas of improvement, which are used as the basis for the development of a learning plan. A selection of RN(EC)s will be required to provide evidence of Reflective Practice. The second stage is a Practice Assessment, which RN(EC)s will be required to participate in on an ongoing, cyclical basis. At this second stage, RN(EC)s will be selected to participate in an objective assessment that will provide a measure of competence relating to standards. In the event that RN(EC)s do not perform well in the initial assessment, there are additional levels of assessment that may be applied as well as remediation to ensure that nurses return to a safe and ethical level of practice.

30) Describe any obligations or agreements on trade and mobility that may be affected by the proposed change in scope of practice for the profession. What are your plans to address any trade/mobility issues?

CNO considered Canadian labour mobility requirements under the federal/provincial Agreement on Internal Trade (AIT) in its development of the draft extended class regulations. A labour mobility regulation to facilitate the mobility of
RN(EC)s has been incorporated into the proposed regulations which are pending government approval (See Appendix B, section 8.3 of the regulation).

The regulation of NPs across the country is still in its infancy. Jurisdictions have in recent years attempted to collaborate where possible to facilitate consistency in approach, as demonstrated by the endorsement of the Canadian Nurse Practitioner Core Competency Framework by CNO and other jurisdictions. While there are similarities across the country in terms of the regulation of NPs, there are also differences. For example, two provinces, Québec and British Columbia, have endorsed a specialty-type approach for regulation similar to what is now being proposed in Ontario. These differences in approaches reflect that jurisdictions need to make sure the unique needs of their own populations are met so that public safety is protected. With this in mind, CNO proposed to regulate NPs (i.e., the specialities) as broadly as possible, while at the same time recognize the differences among them within this broad regulatory framework.

In addition to CNO’s awareness of its obligations on trade and mobility, CNO is an active participant on the Mutual Recognition Agreement (MRA) National Working Group for RNs and NPs. This group is tasked with the mandate to develop a revised MRA for RNs that in turn will form the basis for a MRA for NPs.

Public education

31) How do you propose to educate or advise the public of this change in scope of practice?

The public will be advised of the changes through elements of CNO’s public relations program:

- customer service line to respond to calls from the public;
- the annual newsletter for the public (Here for You);
- an announcement advising the media of the changes;
- frequent updates to the public section of the website;
- materials provided to our members to support their communication with clients; and
- liaison with professional associations (Nurse Practitioner Association of Ontario, Registered Nurses Association of Ontario).

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62 Among the similarities, the definition of the term “NP” provided in the “Guiding Principles” section of this document was developed by the Canadian Nurse Practitioner Initiative, led by the Canadian Nurses’ Association, in broad consultation with national stakeholders.
Other jurisdictions

32) What is the experience in other Canadian jurisdictions? Please provide copies of relevant statutes and regulations.

All provinces and territories in Canada with the exception of the Yukon have NP legislation. The Yukon has broad legislation, which allows for NPs to function in advanced practice roles, but it does not create a separate roster for NPs. In addition, as noted earlier, nursing regulatory bodies across Canada endorsed the Canadian Nurse Practitioner Core Competency Framework. This document, created through the federally funded Canadian Nurse Practitioner Initiative outlines the common core competencies essential to the practice of all NPs.

The scope of practice for NPs in Canadian jurisdictions is identified in legislation and enabled through various means including legislation, regulations, by-laws, standards and practice guidelines. While there are marked similarities in legal scopes across the country (i.e., NPs may diagnose, prescribe, and treat their clients) there are differences in breadth of scope and how scope is enabled. Some jurisdictions place greater restrictions on diagnostic and prescriptive authority by limiting it to specific lists of drugs or diagnostic tests in regulation, while others provide for more open prescribing as defined by schedules of drugs from the provincial / territorial drug regulations. In addition, some jurisdictions regulate streams or specialty NP practice based on client populations served, including:

- Newfoundland and Labrador (NL) - primary and specialty – acute care focused;
- Nova Scotia (NS) primary and specialty – acute care focused;
- Québec (QC) - Nephrology, Neonatology, and Cardiology; and
- British Columbia (BC) – Family All Ages, Adult and Paediatric.

As a result, in some of these jurisdictions, the drugs and diagnostic tests that the NP may order may be limited by their class or category (i.e., primary or specialty). Of note, NS has recently passed legislation (2006) and is developing regulations that move away from a restrictive process to determine NP diagnostic and prescriptive authority (i.e., that set by a Diagnostics and Therapeutics Committee) to a broader, more flexible process emphasizing QA / monitoring practices. This approach is intended to be more responsive to the care needs of clients and contexts of practice, while maintaining public safety.

In terms of the three additional controlled acts that CNO has proposed for RN(EC)s, BC, the most recent province to regulate NP practice63, permits NPs to perform some similar controlled acts, including: “set and cast closed simple fractures or reduce dislocated joint” and “dispense drugs”64.

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63 Regulated in 2005.
64 BC also permits NPs to apply x-rays for diagnostic purposes.
Saskatchewan (SK), Manitoba (MB), Alberta (AB) and BC all permit broad prescribing enabled through access to parts of their respective provincial drug schedules and all of these provinces with the exception of MB permit NPs to dispense or distribute drugs as per the conditions or limitations set out in provincial standards or guidelines. In both AB and BC, NPs have broader ordering authority for forms of energy and in some cases authority to apply x-rays, other radiological procedures, and forms of energy.

Federally, Health Canada has recently proposed changes to regulations under the *Controlled Drugs and Substances Act* to permit designated practitioners (i.e., NPs, podiatrists, and midwives) to “possess, administer, prescribe, sell or provide and/or transport” certain controlled substances as defined by the regulation. These changes are proposed in recognition of changing practice roles, evolving scopes of practice, and the need to increase client access to care.

Appendix F provides a synopsis of NP scope as defined in legislation and regulation across Canada. This table was developed based on information gleaned from *Legislation and Regulation of NPs Responsibility of Provinces and Territories* and the *Regulation and Supply of Nurse Practitioners in Canada*. In addition, NP regulatory college/association websites and government websites were reviewed to assess currency of the information. This included, where required, a review of relevant legislation, regulations, by-laws, standards and guidelines which define scope of practice in the jurisdictions. Please see Appendix G for copies of relevant statutes and regulations.

**33) What is the experience in other International jurisdictions?**

Regulation of the NP role has, over the past several years, become more common in OECD countries. For example, New Zealand and Australia introduced legislation to regulate NPs in 2003 and 2004, respectively. Scope of practice for NPs, similar to Canada, may be defined in legislation, regulations, practice standards or guidelines. Also similar to Canada, scopes of practice may include the promotion of health and prevention of disease; assessment and management of health needs; and diagnosing, ordering, conducting and interpreting diagnostic and laboratory tests and administering therapies.

While there are similarities to Ontario and other jurisdictions in Canada, there is also variability in NP scope of practice among countries, as well as within countries. These differences are mostly in relation to the depth or breadth of scope. The U.S. for example, which has the longest standing history of regulating the role and where regulation occurs at the state level, has many inconsistencies in scope. For instance, authority to prescribe controlled substances ranges from independent authority to limits regarding which drugs can be prescribed and whether physician involvement is required. Despite these inconsistencies, in 2006, the U.S. made great strides by removing practice barriers for NPs and

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65 Organisation for Economic Co-operation and Development
other advanced practice nurses in 20 states (e.g., changes in prescriptive authority and reimbursement)\textsuperscript{cii}.

The United Kingdom (U.K.) has recently made significant changes respecting scope of practice, not just in relation to NPs, but also other nurses. Authorities have recently been granted to permit both the prescribing and supplying of medications in accordance with practice guidelines and relevant regulations\textsuperscript{ciii}.

Review of specific legislation or regulations to identify where there are consistencies in scope between other countries and the proposed new controlled acts for NPs was not completed. However, as noted in the preceding paragraph, there are similarities in scope of practice between countries such as the U.S. and U.K. and Canada, particularly in regards to broader prescribing authority and authority to dispense and sell drugs. In addition, in the U.S. and Canada NPs work in a range of practice settings providing a range of services based on the client population, the acuity and complexity of needs and availability of services (e.g. adults, children, mental health, neonatology, anaesthesia, etc.). Given this, it is interesting to review the perspective of the National Council of State Boards of Nursing (NCSBN)\textsuperscript{66} on licensure and scope of practice. According to NCSBN, “scope is the broadest range of practice the license allows and must be clearly implied by the license. It is predicated upon basic, broad preparation for entry into practice; it does not denote expertness. Just as other professions (e.g. law, dentistry, pharmacy, etc) are licensed to authorize the entire scope of the professional practice, so must advanced nursing be licensed for the greatest intended breadth of practice.”\textsuperscript{civ}

\textbf{Costs/Benefits}

34) What are the potential costs and benefits to the public and the profession in allowing this change in scope of practice? Please consider and describe the impact of any of the following economic factors:

- a. Direct patient benefits/costs;

As noted in question # 15, section c, the number of NPs in Ontario is increasing allowing more members of the public the opportunity to have direct interaction with an NP. That section also discussed the positive satisfaction expressed by NPs’ clients. A potential direct benefit to clients is that the proposed scope of practice changes will mean that they can receive more health care services directly from NPs. Clients may perceive a number of benefits, including: interaction with a provider with whom they’ve already established a therapeutic relationship, comfort and convenience.

\textsuperscript{66} The organization representing the regulatory boards of nursing in the U.S.
Another possible cost is the risk of negative health outcomes associated with the delay or need for referral to another health professional. For example, in situations where the client cannot, or simply does not, access the required service (e.g. a pharmacy in the next community) the client may later suffer negative health consequences at potentially greater personal and health system costs.

A direct financial cost to the client is also highlighted in question #17, section h, where clients may be required to take time off work, sometimes unpaid, and incur personal travel costs (particularly in rural and remote communities).

b. Benefits and costs to the broader health care service delivery system;

There is evidence to demonstrate NPs’ contributions, financial and otherwise, to the health care service delivery system. For example, a recent literature review found gaps in care for people with chronic illness, including that they are not receiving effective therapy, have poor control over their disease and are unhappy with their care.\textsuperscript{cv} Findings from various studies show that the involvement of NPs in Canadian heart failure clinics resulted in substantial improvement in the overall quality of care and health system cost savings, including:
- greater proportion of clients initiated /up-titrated / maintained on beta-blocker;
- highest proportion of clients on target doses;
- lowest length of time from initiation to target dose;
- lower readmission rates (at 90 days and 1 year);
- higher rates of ‘event-free’ survival;
- decreased length of stay;
- decreased mortality rate; and
- improved use of ACE inhibitors\textsuperscript{cv}.

CNO’s recommendation to remove limitations on the RN(EC)’s diagnostic and prescriptive authorities and make consequential amendments to regulations under the Public Hospitals Act may raise concern that these changes will increase utilization, and therefore costs. The potential trade-offs, from a cost – benefit perspective are outlined below.

- The client does not receive the health service\textsuperscript{67} or experiences delays in accessing the service, creating the potential for future “downstream” costs to the individual and the system.

- The client is referred to a collaborating physician who carries out a repetitive second assessment to order the necessary tests and medications that are not accessible to the RN(EC). This consultation or second assessment occurs not

\textsuperscript{67} Particularly in rural and remote communities or highly marginalized populations.
because the RN(EC) lacks the knowledge skills and judgement to make appropriate investigative or treatment decisions – but because of the restrictive lists. This represents an inefficient use of time for the client, the RN(EC) and the physician. It also represents poor use of system resources.

- The RN(EC) provides the service via delegation and medical directives. For many practice settings, particularly public hospitals, medical directives are a resource and time intensive endeavour – reducing their use would allow these resources to be directed to other client-care activities.

These trade-offs were re-affirmed by our members and other professions during stakeholder consultation. For example, a medical director wrote about an NP in a LTC home who cares for more than 150 residents. When the NP does not have access to the first line treatment and a physician is not available by telephone, the client may have to be transported to the emergency department, a much more costly and disruptive alternative.

c. Benefits and costs associated with wait times;

Please see question #15, section d, for an overview of the benefits and costs related to wait times.

d. Workload, training and development costs; and

As noted in question # 20, as a self-regulating profession, CNO expects all members to engage in continuing education that is appropriate to their individual practice and employment settings. This expectation is embedded in CNO’s QA program for nurses. The expectation includes continuing education that may be a direct result of scope of practice changes.

For the most part, the costs associated with continuing education are a part of professional practice, absorbed by individual practitioners or their employers and sometimes reimbursed by government programs\(^{68}\). In addition, there are PHCNP continuing education programs, funded through the Ministry of Health and Long-Term Care and offered through the Council of Ontario University Programs in Nursing, that could be adapted, pending funding support, to respond to RN(EC) continuing education learning needs as required.

e. Costs associated with educational and regulatory sector involvement.

Any CNO related costs associated with the proposed scope of practice changes are expected to be incurred in the areas of communication to members, stakeholders (including other professions and employers) and the public, as well

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\(^{68}\) The Nursing Education Initiative reimburses nurses and employers for up to $1500 per year per nurse in tuition costs. The program is competitive; funding is awarded on an application basis.
as QA. The communication activities are described in questions # 28 and 31. The QA activities are discussed in question # 29.

CNO also posed this question to representatives in the education sector. Overall, the academic sector felt that there would be minimal costs associated with CNO’s proposed changes. The Ontario Primary Health Care Nurse Practitioner Education Program indicated that a number of educational strategies could be employed, as required. These could include adapting continuing education courses, developing workshops within existing curricula, etc. The costs for these types of endeavours would vary. McMaster indicated that the proposed changes do not require a change in the curriculum and, therefore, there are no costs to the university. U of T did not specify costs associated with the proposed change.

35) Is there any other relevant information that HPRAC should consider when reviewing your proposal for a change in scope of practice?

NA.
REFERENCES


vii Ontario Ministry of Health and Long-Term Care (November 2006). *Utilization of DXA bone mineral density testing in Ontario*. Available at: http://www.health.gov.on.ca/english/providers/program/mas/tech/reviews/sum_bmd_110106.html#2


ix See vii above.

x See viii above.

xi See vii above.


See xvi above.

See xvi above.


See xxi above.


See xx above.

Canadian Institute for Health Information. (2007). *Health Indicators*, page 10. Available at: [http://secure.cihia.ca/chiweb/products/hi07_health_indicators_2007_e.pdf](http://secure.cihia.ca/chiweb/products/hi07_health_indicators_2007_e.pdf)

See xxi above.


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See iii above.


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See xxxi above

See xxxi above, page 239.

See lxv above


See iv above.


See xxxi above


See i above.


See lxxvii above.

See ii above.


Changes in Health Care Professions’ Scope of Practice: Legislative Considerations. Available at: https://www.ncsbn.org/ScopeofPractice.pdf


See lxxiv.


See cv above.