



Registered Nurse Prescribing: Putting Patients First

Volume 1

March 31, 2016

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister,

The Health Professions Regulatory Advisory Council (HPRAC) is pleased to present this report, which provides recommendations on the most appropriate model of registered nurse (RN) prescribing for Ontario.

As part of our assessment process, we completed three literature reviews, which included information on RN prescribing in other jurisdictions. We also conducted an extensive consultation program with a broad group of stakeholders.

In developing our advice, HPRAC follows an established process that is thorough, timely and efficient, and that reflects the principles of independence, fairness, transparency and evidence-based decision-making. HPRAC's recommendations related to RN prescribing are based on which model most effectively met the criteria established for the referral, which focused on meeting public need (improving access to patient-centred care) while simultaneously ensuring that risk of harm can and would be properly minimized and mitigated.

HPRAC determined that two models of RN prescribing would best serve the people of Ontario at this time: a registered nurse specialist practice (a variation on the supplementary model) and a registered nurse advanced practice (a variation on the protocol model). HPRAC also recommends that the Ministry of Health and Long-Term Care consider taking steps to increase the number of nurse practitioners (NPs) and physicians in rural and remote locations, consider measures to improve the use of protocols in these communities and continue to reduce barriers to the use of telemedicine. HPRAC makes these recommendations based on its finding that currently, RNs are not educated or trained to safely independently prescribe drugs.

In the event that HPRAC's three recommendations are accepted as outlined above, and concerns persist that there is a need for greater access to patient-centred care that would be addressed directly by RN prescribing, the Minister may, at that time, wish to consider a model of RN independent prescribing in Ontario based on the United Kingdom experience, and put mechanisms in place to ensure that RNs are competent to prescribe drugs independently.

We look forward to meeting with you to discuss the findings and recommendations in this report.
Sincerely,



Thomas Corcoran, Chair



Rex Roman, Vice Chair



Jeanette Dias D'Souza, Member



Bob Carman, Member



Said Tsouli, Member



Mary Gavel, Member



Paul Macmillan, Member

Registered Nurse Prescribing: Putting Patients First

Report by the Health Professions Regulatory Advisory Council

March 2016

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Executive Summary

Overview of the Referral

On November 4, 2015, the Minister of Health and Long-Term Care, the Honourable Dr. Eric Hoskins, directed HPRAC to conduct broad consultations with key partners within the nursing and health care community to assess the following three models for registered nurse (RN) prescribing:

- independent prescribing;
- supplementary prescribing; and
- use of protocols.

HPRAC has been requested to provide the Minister with the results of its consultation and its recommendations related to which model is most appropriate for Ontario by March 31, 2016.¹ Please see Appendix A for a copy of the Minister's letter.

Most requests submitted to HPRAC from the Minister focus on whether or not a decision should be taken — for example, whether a profession should be regulated, or if a regulated profession should be granted an expanded scope of practice. This referral directed HPRAC to provide recommendations on which model of RN prescribing is most appropriate for Ontario. HPRAC therefore viewed this referral not in terms of whether or not an expanded scope of practice should be granted, but, rather, how a scope of practice change should take place.

Nursing in Ontario

In Ontario, the practice of nursing is described in the *Nursing Act, 1991*, as “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.”²

Although Ontarians consider nursing to be a single profession, there are two classes of membership (registered nurses and practical nurses), and several classes of certificates of registration.³ Of these classes of certificates of registration, two are relevant to this referral: the general class for RPNs and RNs, and the extended class, for registered nurses in the extended class (RN ECs), also known as NPs. Most nurses in Ontario are members of the general class (i.e., RPNs and RNs),⁴ while a much smaller segment of the nursing profession belongs to the RN extended class (i.e., NPs).

¹ Health Professions Regulatory Advisory Council (HPRAC), “Registered Nurse Prescribing,” <http://www.hprac.org/en/projects/Registered-Nurse-Prescribing.asp>, accessed February 22, 2016.

² *Nursing Act, 1991*, s. 3., <https://www.ontario.ca/laws/statute/91n32>.

³ There are six classes of registration in Ontario for RNs and five for RPNs. For example, classes for RNs included general, extended, non-practising, special assignment temporary and emergency. See <http://www.cno.org/en/become-a-nurse/classes-of-registration>.

⁴ College of Nurses of Ontario (CNO), “Classes of Registration,” <http://www.cno.org/en/become-a-nurse/classes-of-registration>, accessed March 4, 2016.

HPRAC's Process

For this referral, HPRAC undertook a comprehensive yet streamlined review process that began with preliminary research and a consultation on the three models of RN prescribing. This was followed up by further research, analysis and recommendation development. For every referral, HPRAC attempts to understand all perspectives on an issue, including those of regulated and unregulated health care providers, clients and patients, other affected health care professionals, advocates and regulators.

HPRAC's Recommendations for RN Prescribing

HPRAC revised its existing scope of practice application guide to develop a new guide, the *Registered Nurse Prescribing Referral: Criteria for Assessment of Prescribing Models*,⁵ which it used to evaluate the different models of RN prescribing.

Throughout this review, two criteria were weighted more heavily than others: risk of harm, and public need. The risk of harm criterion examines whether the proposed model presents an increased risk of harm to the public. The public need criterion examines whether the model would meet a significant public need by putting patients first and increasing access to care.

Having conducted its review of the different models of RN prescribing, HPRAC recommends that:

- A registered nurse specialist practice (RNSP) certificate of registration be established by the College of Nurses of Ontario (CNO). The RNSP, in collaboration with a physician or NP, would develop a clinical management plan (CMP) that would enable prescribing. The CMP would be patient specific and designed to be long term, and would focus on specific disease clusters (e.g., diabetes, wound care, pulmonary disorders, etc.);
- A registered nurse advanced practice (RNAP) certificate of registration be established by CNO. The RNAP would, with the assistance of decision-support tools (DSTs), assess, order diagnostic tests and prescribe drugs; and
- The Ministry of Health and Long-Term Care (MOHLTC) continue to increase the number of NPs and physicians in rural and remote locations, consider measures to improve the use of protocols in these communities and continue to reduce barriers to the use of telemedicine.
- If HPRAC's three recommendations, as outlined above, are accepted and concerns persist about the need for greater access to patient-centred care that would be addressed directly by RN prescribing, the Minister may, at that time, wish to consider a model of RN independent prescribing in Ontario that is based on the United Kingdom (UK) experience, and put mechanisms in place to ensure that RNs are competent to prescribe drugs independently.

⁵ See <http://www.hprac.org/en/resources/Criteria-RN-Prescribing-2015-11-23.pdf>.

Chapter I: Background

Referral Request

On November 4, 2015, the Minister of Health and Long-Term Care, the Honourable Dr. Eric Hoskins, directed HPRAC to conduct broad consultations with key partners within the nursing and health care community to assess the following three models for RN prescribing:

- independent prescribing;
- supplementary prescribing; and
- use of protocols.

The Premier of Ontario and the Minister of Health and Long-Term Care have made a commitment to the profession to permit RNs to prescribe drugs.

HPRAC has been requested to provide the Minister with the results of its consultation and its recommendations related to which model is most appropriate for Ontario by March 31, 2016.⁶

Departure from a Typical Referral

Most requests submitted to HPRAC from the Minister focus on whether or not a profession should be regulated, or whether or not a profession should be granted an expanded scope of practice. However, unlike previous requests, this referral requested that HPRAC conduct broad-based consultation amongst key partners in order to assess the three models and provide recommendations related to which model of RN prescribing is the most appropriate for Ontario.

As noted in the Minister's letter, "the decision has been made that this change in scope will occur, this referral to the Health Professions Regulatory Advisory Council (HPRAC) is not seeking advice on whether the scope of practice of RNs should be expanded but rather, I am asking HPRAC to conduct broad consultation with key partners within the nursing and health care community to assess"⁷ independent prescribing, supplementary prescribing and the use of protocols. Since the decision for a change in scope had already occurred, HPRAC did not seek an applicant to advocate for the specific scope change.

HPRAC therefore viewed this referral not in terms of whether an expanded scope of practice should be granted, but, rather, as an assessment of the three defined models of prescribing and a recommendation of the most appropriate model that would benefit Ontarians.

⁶ HPRAC, "Registered Nurse Prescribing."

⁷ Letter from Dr. Eric Hoskins, Minister of Health and Long-Term Care, to Thomas Corcoran, HPRAC Chair, November 4, 2015.

HPRAC's Process

When a referral is received from the Minister of Health and Long-Term Care, HPRAC determines relevant public interest concerns and questions. HPRAC attempts to understand all perspectives on an issue, including those of regulated and unregulated health care providers, other affected health care professionals, clients and patients, advocates and regulators. Each issue proceeds through a multi-stage process in which information and responses are requested from and shared with stakeholders.⁸

HPRAC's process for this referral consisted of the following major milestones:

- preliminary research and analysis by HPRAC;
- a consultation on the three proposed models of RN prescribing, including key informant interviews; and
- data analysis/validation, recommendation development and submission of the final report to the Minister.

How Did HPRAC Review the RN Prescribing Referral Request?

In developing its advice to the Minister, HPRAC attempts to ensure that its processes are thorough, timely and efficient, and that they reflect principles of independence, fairness, transparency and evidence-based decision-making. HPRAC undertakes research to secure evidence for its conclusions, drawing on organizations and individuals with expertise in the matters under consideration, both in Ontario and elsewhere. As well, HPRAC tailors its consultation process to the individual matters under consideration.

HPRAC's criteria for the RN prescribing referral are:

1. Risk of Harm

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

Public Need

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

⁸ HPRAC, "Registered Nurse Prescribing."

2. Body of Knowledge

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

3. Education and Accreditation

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

4. Economic Impact

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

5. Relevance to the Health Care System and Relationship to other Professions

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

6. Relevance to the Profession

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

Risk of harm and public need are considered equally and were the criteria most heavily weighted by HPRAC when considering RN prescribing. The remaining criteria are ranked in order of importance, and each criterion is carefully considered by HPRAC.

Chapter II: Nursing in Ontario

What is the Nursing Scope of Practice?

The scope of practice statement in the *Nursing Act, 1991*, states: “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.”⁹ This scope of practice statement applies to all nurses in Ontario.

The term “scope of practice” is used in the context of the regulation of health professionals to generally define the procedures, actions and processes performed by persons practising the profession. A regulated health professional is usually limited to practising the areas of the profession’s scope of practice in which she or he has received education and clinical experience, and in which she or he has demonstrated competency. Each jurisdiction has its own legislative framework governing entry to practice education requirements as well as required additional training and practice.

The scope of practice model under Ontario’s health professions’ legislative framework has four key elements:

- a scope of practice statement;
- controlled acts;
- the harm clause; and
- title protections.¹⁰

Classes of Nurses in Ontario

While Ontario considers nursing as a single profession, there are two classes of membership (registered nurses and practical nurses) and several classes of certificates of registration.¹¹ Of these classes of certificates of registration, two are of particular relevance for this referral: the general class for RPNs and RNs, and the extended class, for registered nurses in the extended class (RN ECs), also known as NPs. As of 2014, there were 104,298 RNs and 42,018 RPNs registered as practising members with a general class of certificate of registration.¹² NPs are a much smaller

⁹ *Nursing Act, 1991*, s. 3.

¹⁰ HPRAC, *Review of a Professional Scope of Practice under the Regulated Health Professions Act, 1991: Application Guide, August 2014*, http://www.hprac.org/en/projects/resources/Scope_of_Practice_Review_Application_Guide.pdf, accessed June 17, 2015.

¹¹ There are six classes of registration in Ontario for RNs and five for RPNs. For example, classes for RNs included general, extended, non-practising, special assignment temporary and emergency. See <http://www.cno.org/en/become-a-nurse/classes-of-registration>.

¹² College of Nurses of Ontario, *Membership Statistics Highlights 2014*, http://www.cno.org/globalassets/docs/general/43069_stats/43069_membershipstatistics-highlights.pdf, accessed March 4, 2016.

segment of the nursing profession, with 2,362 registered and practising in the extended class of registration.¹³

RNs and NPs are examined in greater detail in this report because the Minister has asked HPRAC to make recommendations on the most appropriate model for RN prescribing. NPs currently have the ability to independently prescribe. HPRAC looked at NPs to better understand the nursing profession in which independent prescribing is already occurring, and to assist HPRAC in its thinking about how RN prescribing would fit within a system that already permits NPs to prescribe.

Where Do Nurses Work?

Nurses practise in a number of different settings, including hospitals, primary care and physician offices, long-term care (LTC) facilities, home care, correctional facilities, mental health settings, rehabilitation centres, schools and many other settings.¹⁴

The Education of Ontario Nurses

HPRAC heard that while “all nursing students learn from the same body of nursing knowledge, RNs study for a longer period of time — allowing for greater depth and breadth of foundational knowledge; RPNs study for a shorter period of time, resulting in a more focused body of foundational knowledge.”¹⁵ RPNs obtain a two- or three-year diploma in practical nursing.¹⁶ RNs must obtain a baccalaureate nursing degree, typically four years in duration, whereas an NP has the educational credentials of an RN in addition to a master’s degree or post-master’s diploma, and two years of full-time clinical practice experience.¹⁷

It was explained to HPRAC that RNs are educated as generalists “so that, upon graduation, they could take up employment: across patient populations — from maternal newborn to older adults; across care settings — acute, community, primary, and long-term care; and across types of care — therapeutic, supportive, rehabilitative, palliative, and preventive.”¹⁸ NPs, however, have the generalist education of an RN and are required to pursue studies in a specialized area of practice, such as “primary care for all ages, adult, children’s or anesthesia.”¹⁹ NPs undertake additional education, including courses in pathophysiology, advanced health assessment and diagnosis, therapeutics and other practicum that would all be specific to an NP’s clinical speciality area²⁰ and

¹³ Ibid.

¹⁴ Canadian Nurses Association, “Where Do Nurses Work?”, <https://www.cna-aic.ca/en/becoming-an-rn/where-do-nurses-work>, accessed February 25, 2016.

¹⁵ Health Force Ontario, “Nursing Roles, http://www.healthforceontario.ca/en/Home/Nurses/Training_%7C_Practising_Outside_Ontario/Nursing_Roles, accessed February 1, 2016.

¹⁶ Ibid.

¹⁷ HPRAC, *Stakeholder Feedback on the Registered Nurse Prescribing Referral: Stakeholder Submissions*, pp. 77-78, <http://www.hprac.org/en/resources/RN-Prescribing-Stakeholder-Comments-2016-03-29.pdf>.

¹⁸ Ibid., p. 79.

¹⁹ Ibid., p. 79.

²⁰ Ibid., p. 79.

that, as noted by one stakeholder group, prepares them for the “autonomy and broad-based responsibilities of the role.”²¹

Competencies of Nurses in Ontario

In their submission to HPRAC, the Council of Ontario University Programs in Nursing (COUPN) and the provincial heads of nursing at the Colleges of Applied Arts and Technology (CAAT), note that the NP scope of practice is “identified in relation to the authorized acts of diagnosing and prescribing and the greater autonomy of the role in relation to these authorized acts,” whereas the RN practice competencies reflect a more limited scope.²²

One of the most essential competencies related to prescribing identified by stakeholders was the ability to formulate a differential diagnosis, which is “the ability to apply clinical reasoning to distinguish a particular mechanism of disease or condition from others that present with similar symptoms.”²³

A differential diagnosis, and the ability to develop one, require a complex set of skills based on advanced education and clinical practice, which must include the ability “to assess how different and chronic health problems can interact with each other to produce symptoms, and how drugs may interact with each other to produce side, masked, additive or cumulative effects that can look like symptoms.”²⁴ Because of their additional education, experience and competency, NPs have demonstrated “competencies to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform procedures within their legislated scope of practice.”²⁵

What Controlled and Authorized Acts Are Nurses Authorized to Perform?

In Ontario, each regulated health profession-specific statute establishes the scope of practice for its profession and specifies which of the controlled acts listed in the *Regulated Health Professions Act, 1991* (RHPA) members of the college are authorized to perform (if any). Under section 27(2) of the act, 13 procedures are listed that, if not performed by a qualified practitioner, may pose a risk of harm to the public. These procedures are known as “controlled acts.” In Ontario, controlled acts may only be performed by authorized health care professionals, persons who have been delegated the act by an authorized professional or persons in circumstances otherwise identified.²⁶

RPNs and RNs may perform the controlled acts listed below provided they are authorized under the regulations under the *Nursing Act, 1991*, or are ordered by an authorized regulated health professional:

²¹ Ibid., p. 78.

²² Ibid., pp. 76-77.

²³ Ibid., p. 77.

²⁴ Ibid., p. 77.

²⁵ Health Force Ontario, Nursing Roles.

²⁶ *Regulated Health Professions Act, 1991* (RHPA), <https://www.ontario.ca/laws/statute/91r18>, ss. 27 and 29.

- performing a prescribed procedure below the dermis or a mucous membrane
- administering a substance by injection or inhalation
- putting an instrument, hand or finger:
 - beyond the external ear canal;
 - beyond the point in the nasal passages where they normally narrow;
 - beyond the larynx;
 - beyond the opening of the urethra;
 - beyond the labia majora;
 - beyond the anal verge; or
 - into an artificial opening into the body.
- dispensing a drug²⁷

The General Regulation under the *Nursing Act, 1991*, provides that RNs may initiate (perform the act without an order) more of the aforementioned controlled acts than can an RPN (who must receive an order to perform the controlled act), so long as she or he meets the conditions set out in the regulations. For example, an RN may, without an order, debride, pack or dress a wound below the dermis, or may engage in venipuncture to obtain intravenous access, whereas a RPN may not.²⁸

NPs may perform the same controlled acts as RNs/RPNs, as well as the following controlled acts:

- communicating to a patient or to his or her representative a diagnosis made by the member identifying, as the cause of the patient's symptoms, a disease or disorder
- applying or ordering the application of a prescribed form of energy
- setting or casting a fracture of a bone or dislocation of a joint
- prescribing, dispensing, selling or compounding a drug in accordance with the regulations²⁹

NPs may also perform certain authorized acts,³⁰ such as ordering laboratory tests, X-rays and the collection of specimens.³¹ As HPRAC heard, the major differences between an RN and an NP are that an NP can communicate a diagnosis, order certain diagnostic tests and prescribe drugs without an order.³²

It is important to note that, specific to the act of prescribing, RNs can dispense a drug prescribed by a physician or an NP (or other authorized regulated health professional) pursuant to delegation. They can also administer medication under medical directives or standing orders authorized by a physician, NP or other authorized regulated health professional.

²⁷ *Nursing Act, 1991*, s. 4.

²⁸ *Ibid.*, General Reg. 275, s. 15.

²⁹ *Ibid.*, s. 5.1.

³⁰ For the purposes of this report, references to authorized acts include acts authorized under other legislation, such as the *Healing Arts and Radiation Protection Act* (<https://www.ontario.ca/laws/statute/90h02>) and the *Laboratory and Specimen Collection Centre Licensing Act* (<https://www.ontario.ca/laws/statute/90l01>).

³¹ *Nursing Act*, Reg. 683.

³² HPRAC, *Stakeholder Feedback on the Registered Nurse Prescribing Referral: Stakeholder Submissions*, p. 7.

Delegation, Orders and Medical Directives

Delegation is a method by which a regulated health professional who is authorized to perform a controlled act gives authority to perform that act to another person who would otherwise be prohibited from performing it. When delegation occurs, the ultimate responsibility for the patient's care is on the delegating professional.

An order permits a regulated health professional to perform a controlled act within her or his scope of practice, but the decision to perform the procedure is “ordered” by another regulated health professional who has the authority to perform the act. For example, the physician, midwife or NP is responsible and accountable for the decisions made when prescribing a given drug.

A medical directive is a written order given by a regulated health professional who has the authority to perform the act to other health care providers that pertain to any patient who meets the criteria set out in the medical directive. When a particular directive requires a delegated act, the medical directive “provides the authority to carry out the treatments, procedures, or other interventions that are specified in the directive, provided that certain conditions and circumstances exist.”³³

Delegation, orders and medical directives are foundational elements of the “use of protocols,” a model of RN prescribing that the Minister requested HPRAC to assess. The use of delegation, orders and medical directives is currently in practice throughout the health care system in Ontario, in multiple health care settings.

³³ College of Physicians and Surgeons of Ontario (CPSO), “Delegation of Controlled Acts,” <http://www.cpso.on.ca/policies-publications/policy/delegation-of-controlled-acts>, accessed March 1, 2016.

Chapter III: What HPRAC Heard

For all referrals, HPRAC engages in broad-based consultation that seeks stakeholder input to help in its analysis and recommendation development for the Minister of Health and Long-Term Care. Upon commencing this referral, HPRAC began determining relevant public interest, concerns and questions, and attempting to understand all perspectives on RN prescribing in Ontario, including those of patients/clients, regulated and unregulated health care professionals, advocates and regulators.

Consultation Program

HPRAC conducted a public consultation program from December 14, 2015, to January 22, 2016. To ensure that the broader community of interest had the opportunity to participate in this referral, HPRAC asked a number of groups, organizations and individuals to comment on the issue, including:

- regulatory health colleges;
- regulated health professions' associations;
- regulated health care professionals;
- academics and subject matter experts with an interest and/or expertise in the regulation of health professions, nursing and other relevant issues;
- organizations/groups with an interest in health professions, nursing and other relevant issues;
- hospital chief executive officers (CEOs);
- educational facilities;
- insurance providers;
- local health integration network (LHIN) CEOs; and
- the public/patients.

The following key principles are used to develop the consultation program:

- An expectation that the consultation process will crystallize and confirm broad themes, as well as highlight unanticipated “outlier” issues. The data collected should *not* be interpreted as empirical evidence of, or opposition to, a particular topic. Respondents self-selected (i.e., sought out participation) in the consultation process and thus may not be representative of a larger group;
- The inclusion of interested stakeholders and members of the public at a level of involvement that reflects their needs and interests;
- Flexibility in responding to unanticipated issues and stakeholder input throughout the referral period;
- A commitment to incorporating issues, concerns, comments and perspectives into the recommendation-making process; and
- Ensuring that all consultation material is available in both official languages and in accessible formats.

HPRAC's website was the main communications vehicle for the consultation process. An RN prescribing web page was established as a repository for relevant background material. The page included a link to an online survey, through which members of the public were invited to express their views.

Stakeholders submitted comments through two different types of online surveys: one with primarily closed-ended questions, the other with both open- and closed-ended questions. Stakeholders also provided their views in the form of a letter.

The survey questionnaire and request for written comments were based on the Minister's referral to HPRAC and sought to address key aspects of the referral, specifically asking stakeholders to assess the three models of RN prescribing (independent prescribing, supplementary prescribing and the use of protocols), based on which model would be the most appropriate for Ontario.

For the purposes of the consultation, HPRAC provided high-level definitions of the models provided by the Minister:

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

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

Use of protocols: In this model, written instructions allow RNs to supply and administer medications within the terms of a predetermined protocol. The use of protocols is used for the supply and administration of named medicines in an identified clinical situation. RNs are only able to supply and administer medications within the strict terms of the predetermined protocol. An RN under this model is responsible for the acceptance of the protocol, but the prescribing physician or regulated health professional with prescribing authority³⁴ is responsible for the assessment of the patient's needs and prescription of any medication.

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

Supplementary prescribing: This model is a hybrid of independent prescribing and use of protocols. It involves a partnership between the RN, the physician and the patient wherein, after an initial assessment of the patient's needs by the physician, a nurse may prescribe medication. A patient-specific clinical management plan (CMP) is developed by the nurse and physician that allows the nurse to prescribe within a limited or pre-defined formulary or by class of drugs within their clinical competency area. The collaborating physician shares the responsibility of prescribing and holds

³⁴ For the purposes of the models outlined above, physicians and regulated health professionals with prescribing authority include NPs or any other appropriate non-physician prescriber.

full responsibility for the assessment and diagnosis of a patient. There are no restrictions on the type of patient conditions or patient populations for which a CMP could be developed between a physician and an RN.

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

Survey Responses

The majority of responses received were completed as online surveys. A total of 254 completed surveys were received from stakeholders, in both open- and closed-ended survey format.

Survey Findings

Respondent Demographics

There were 254 responses received, of which 83% were from individuals and 17% were submitted on behalf of organizations (see Figure 1). The respondents were primarily (93%) members of a regulated health profession; 94.9% of them were still practising. Most respondents (82.9%) were involved in the nursing profession as RNs (43.2%), NPs (38.9%) or RPNs (less than 1.0%) (see Figure 2).

Figure 1: Survey Respondents

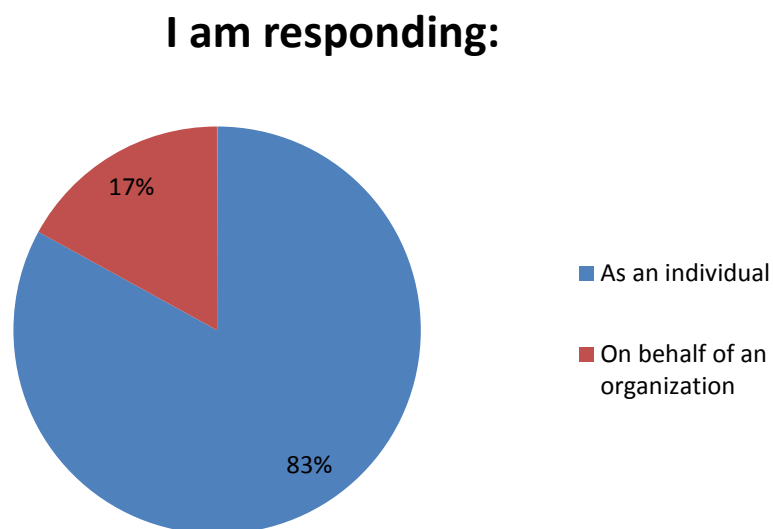
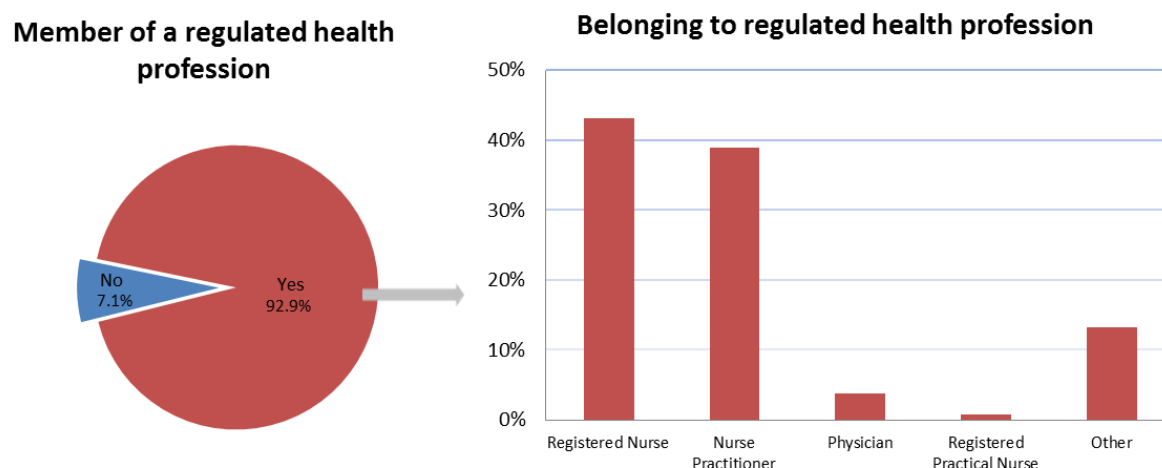


Figure 2: Respondents' Professions



Timely and Convenient Access to Care

Almost three-quarters of the respondents thought that RN prescribing would result in more timely and more convenient access to care (71.2% and 73.0%). However, less than half (46.8%) felt that RN prescribing would reduce emergency room (ER) visits.

Independent prescribing was selected most often as the model most likely to improve the timeliness (60.1%) and the convenience (67.0%) of access to care.

Improving Access in Remote, Rural and Rapidly Growing Communities

The majority of respondents indicated that RN prescribing would result in better access to care in remote (84.9%) and rural (74.6%) communities, while 55.2% were of the opinion that access to care in rapidly growing communities would benefit from RN prescribing.

The independent prescribing model was rated as most likely to have a positive impact on access to care in all these communities: 70.9% of respondents, for remote communities; 70.7%, for rural communities; and 69.8%, for rapidly growing communities.

Patient Understanding of and Compliance with Prescriptions

Respondents were almost equally split when asked whether or not RN prescribing would result in patients better understanding their medications, with 41.3% indicating that RN prescribing would improve patient medication compliance. Independent prescribing was viewed by more than two-thirds of the respondents as most likely to achieve this benefit.

Patient Satisfaction and Individual/System Impact

Two-thirds (65.5%) of respondents agreed that RN prescribing would make patients more satisfied with care, and 61.9% indicated that RN prescribing would facilitate collaborative patient care. Just over one half of respondents (52.4%) felt that it would improve patient well-being.

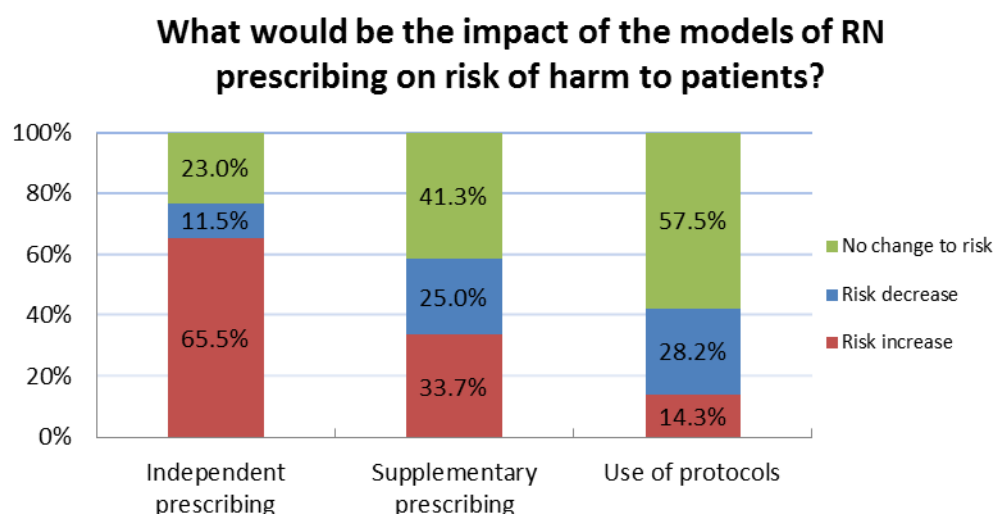
Impact on Health Care Costs

When asked about the potential impact of RN prescribing on health care system costs, responses were mixed. At least one-third of respondents indicated that all three models — independent prescribing, supplementary prescribing and the use of protocols — would result in a cost decrease (46%, 35.3% and 45.2%, respectively). However, approximately one-third of respondents also indicated that independent prescribing and supplementary prescribing would result in a cost increase (33.7% and 29.3%, respectively). More than one-third of respondents indicated that supplementary prescribing and the use of protocols would have no effect on health system costs (35.3% and 40.0%, respectively).

Risk of Harm to Patients

When asked about the risk of harm to patients, 65.5% of respondents indicated that independent prescribing would increase the risk of harm to patients. Less than one-third of respondents indicated that any of the models would result in a decreased risk. More than half of respondents indicated that the use of protocols would have no impact on the risk of harm (57.5%), and 41.3% indicated that supplementary prescribing would have no impact on the risk of harm to patients (see Figure 3).

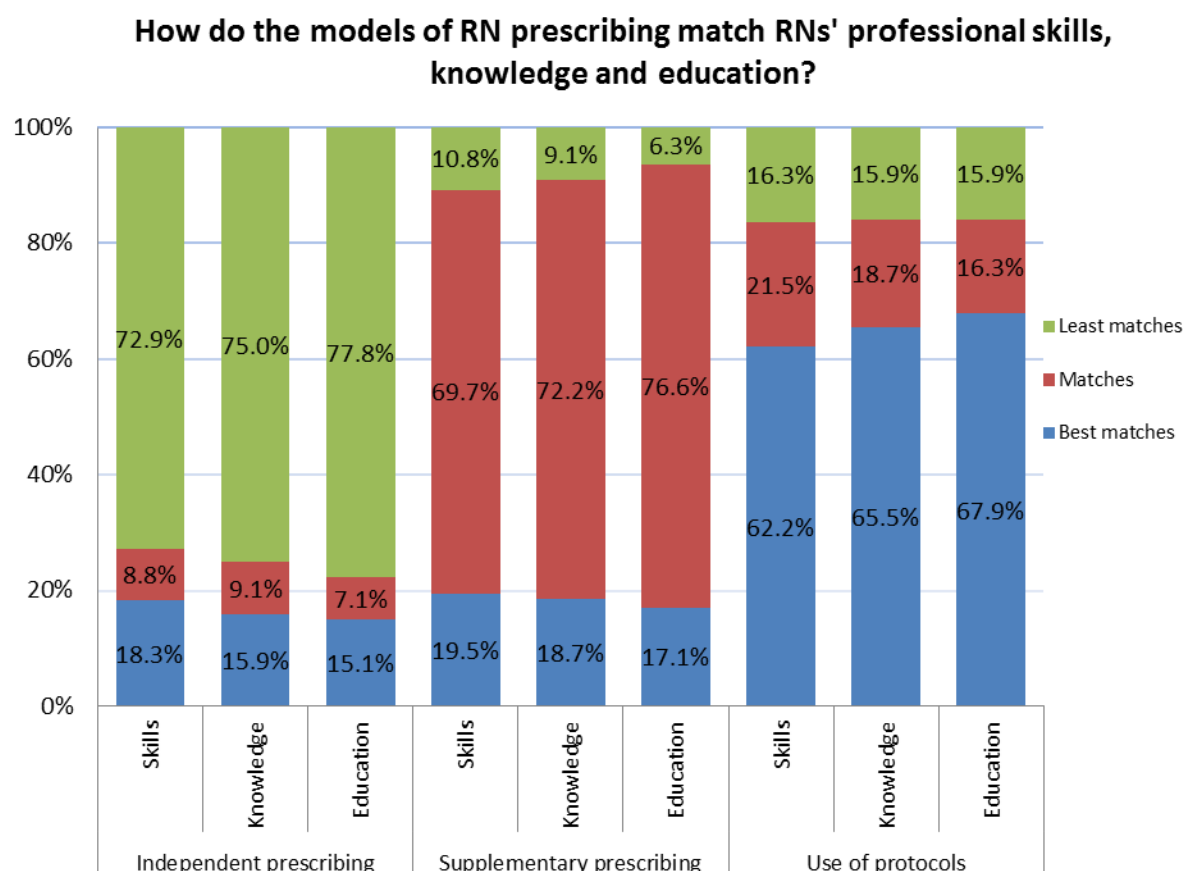
Figure 3: Impact of RN Prescribing on Risk of Harm to Patients



Skills, Knowledge and Education

The use of protocols was reported to be the “best match” of nurses’ skills (62.2%), knowledge (65.5%) and education (67.9%), while independent prescribing was reported to be the “least matched” to skills (72.9%), knowledge (75.0%) and education (77.8%) (see Figure 4).

Figure 4: How Models of RN Prescribing Match RNs' Skills, Knowledge and Education



RN Prescribing Models in Different Practice Settings

Hospital Setting

In the hospital setting, respondents identified the use of protocols as the most suitable in the ER (43.4%), outpatient clinic (37.1%), addiction and mental health (33.5%), complex continuing care (33.5%) and rehabilitation (33.1%). Although 33.9% of respondents felt that the use of protocols was most suitable for the acute care setting, a nearly equal number (35.1%) of respondents indicated that RN prescribing was not appropriate in this setting.

Community Setting

In the community setting, respondents identified the use of protocols as the most suitable model for seven of the 11 settings: community care access centres (35.1%), community health centres (31.9%), community mental health programs (31.5%), home care (30.1%), public health units (41.8%), LTC homes (35.9%) and retirement homes (37.1%).

In the family health-team setting, respondents were just as likely to indicate that supplementary prescribing and the use of protocols were most suitable (30.7% each). Respondents also identified supplementary prescribing as the most suitable model in primary care physician offices (33.1%). Independent prescribing was chosen by respondents as the most suitable model in nurse practitioner-led clinics (39.9%) and remote nursing stations (56.2%).

Other Settings

Respondents clearly indicated that the use of protocols was the most appropriate model in college/university (35.1%) and correctional facility (38.7%) settings. In commercial/industrial enterprise and school settings, respondents were almost equally divided about the use of protocols (33.9% and 35.1%, respectively), noting that RN prescribing was not appropriate in these settings (33.5% and 34.7%, respectively).

Summary of Online Survey Findings

Respondents stated the following in the online survey:

- RN prescribing will result in more timely and convenient access to care.
- RN prescribing will result in improved access in remote and rural communities, but will have less of an impact in rapidly growing communities.
- Respondents were divided as to whether or not RN prescribing will reduce ER visits.
- RN prescribing will not result in patients' better understanding their medications, or improved patient compliance, but will improve patient satisfaction and support collaborative care.
- Less than half of respondents felt that RN prescribing will result in decreased costs to the health care system.
- The independent prescribing model is most likely to increase the risk of harm to patients.
- The use of protocols is the best match for RNs' current skills, education and experience.
- The use of protocols was identified as the most appropriate model in the majority of settings (hospital, community and other).
- RN independent prescribing is the least appropriate model in most settings.

Written Responses

Although comments from stakeholders were both extensive and broad in focus, certain comments and issues were more frequently raised in open-ended survey responses and written comments. These comments and issues are discussed below, and are listed based on the frequency with which they appeared, with those most frequently expressed appearing first.³⁵

The Importance of Education and Training

The most dominant comment/issue was that it is essential for RNs to have sufficient knowledge, skill, education and judgment to prescribe independently. The majority of stakeholders who made this comment noted that RNs did not currently possess these essential competencies.

Many stakeholders recognized that RNs will require upgrading and more experience to prescribe independently. The College of Nurses of Ontario (CNO) stated that "prescribing a drug is not an entry-to-practice competency for RNs in the general class. CNO expects that candidates will complete additional education to gain the knowledge, skill and judgment to be able to safely prescribe a drug."³⁶

³⁵ Written responses were identified as any written text derived from the open-ended online survey response, as well as independent written submissions.

³⁶ HPRAC, *Stakeholder Feedback on the Registered Nurse Prescribing Referral: Stakeholder Submissions*, p. 55.

Consistent with this, when stakeholders mentioned that RNs did not possess competencies to prescribe independently, several commented that RNs are able to prescribe competently through delegation; however, many stakeholders agreed that RNs would have to complete additional course work to upgrade their knowledge and competency if they are to safely perform this expanded role.^{37,38,39,40,41,42,43,44,45,46}

For instance, the Ontario Association of Public Health Nursing Leaders (OPHNL) supported the independent RN prescribing model, but acknowledged that “current practice does not support RNs in the general class to diagnose patients with a medical condition, or prescribe a direct medication order for an individual patient independent of a physician/NP.”⁴⁷ OPHNL also noted that “currently, there are no educational institutions in Ontario offering additional training/courses for RNs in the general class to obtain the knowledge, skill and practice required for RN independent/prescribing.”⁴⁸

A number of stakeholders recommended that, for RNs to independently prescribe, they should obtain the same competencies and education and have access to the same controlled and authorized acts as RN ECs/NPs. The Nurse Practitioners Association of Ontario (NPAO) stated that “to become an independent RN prescriber and to gain access and authority to autonomously and safely perform additional controlled acts such as communicating a diagnosis, prescribing medications, and ordering treatments and diagnostic tests, the RN must become an NP.”⁴⁹ Without changes to their education, stakeholders generally felt that RNs would not have the competencies to prescribe independently.⁵⁰

It was also noted in stakeholder comments that in order to prescribe effectively and safely, a health care practitioner would need the appropriate competencies to communicate a diagnosis and order diagnostic and/or imaging tests.^{51,52} CNO stated that:

a key consideration is that safe prescribing occurs as part of a broader continuum of care, which generally includes a health assessment, diagnosis, therapeutic management and follow-up. Prescribing does not happen in isolation. Independent prescribers need the knowledge, skill and judgment to safely and effectively perform assessments, order and interpret tests, diagnose and monitor/follow-ups with clients.⁵³

³⁷ Ibid., p. 12.

³⁸ Ibid., p. 13.

³⁹ Ibid., p. 15.

⁴⁰ Ibid., p. 17.

⁴¹ Ibid., p. 18.

⁴² Ibid., p. 19.

⁴³ Ibid., p. 20.

⁴⁴ Ibid., p. 55.

⁴⁵ Ibid., p. 62.

⁴⁶ Ibid., p. 146.

⁴⁷ Ibid., p. 132.

⁴⁸ Ibid.

⁴⁹ Ibid., p. 98.

⁵⁰ Ibid., p. 21.

⁵¹ Ibid., p. 20.

⁵² Ibid., p. 47.

⁵³ Ibid., p. 54.

The College of Physicians and Surgeons of Ontario (CPSO) also raised concerns about the independent prescribing model, noting that it was unclear whether independent prescribing would also include the authority to order and interpret diagnostic tests and to communicate a diagnosis. CPSO stated that “patient safety and quality of care may be compromised if independent RN prescribing does not include the ability to order and interpret tests and communicate a diagnosis, as they are essential to safe and effective prescribing.”⁵⁴ A number of stakeholders (the Ontario Association of Public Health Nursing Leaders [OAPHNL], COUPN and CAAT, NPAO, the Ontario College of Family Physicians [OCFP], CNO and CPSO), however, commented that RNs did not currently possess the competencies to perform most of the above mentioned controlled and authorized acts.^{55,56,57,58,59,60,61,62,63,64,65}

Alternatives to RN Prescribing

The second-most cited comment of stakeholders was that NPs currently function as independent RN prescribers.^{66,67,68,69,70} CNO reinforced that:

Ontario currently has independent RN prescribers: NPs. In NP practice, prescribing is considered as part of a continuum of care, which includes a health assessment, diagnosis, therapeutic management and follow-up. As independent prescribers, NPs have the legal authority to diagnose and order tests. These are reflected in legislation and standards of practice to which RN ECs or NPs are accountable.⁷¹

Many stakeholders (e.g., CNO, COUPN and CAAT, NPAO and CPSO) advocated for maintaining the current system, which allows NPs to prescribe independently because they have the necessary competencies to do so.^{72,73,74,75,76} Consistent with this, a number of stakeholders recommended increasing the number of seats for NPs as an alternative solution to having RNs who are not in the extended class prescribe independently.⁷⁷ For instance, COUPN and CAAT recommended

⁵⁴ Ibid., p. 62.

⁵⁵ Ibid., p. 132.

⁵⁶ Ibid., p. 77-79.

⁵⁷ Ibid., p. 98-99.

⁵⁸ Ibid., p. 140.

⁵⁹ Ibid., p. 55.

⁶⁰ Ibid., p. 62-63.

⁶¹ Ibid., p. 12.

⁶² Ibid., p. 19.

⁶³ Ibid., p. 21.

⁶⁴ Ibid., p. 22.

⁶⁵ Ibid., p. 84.

⁶⁶ Ibid., p. 12.

⁶⁷ Ibid., p. 16.

⁶⁸ Ibid., p. 19.

⁶⁹ Ibid., p. 98.

⁷⁰ Ibid., p. 149.

⁷¹ Ibid., p. 57.

⁷² Ibid., pp. 57-58.

⁷³ Ibid., p. 85.

⁷⁴ Ibid., pp. 98-100.

⁷⁵ Ibid., p. 66.

⁷⁶ Ibid., p. 16.

⁷⁷ Ibid., p. 13.

“expanding the number of funded seats for NPs in Ontario. Currently, the COUPN Primary Health Care RN EC program is capped by MOHLTC at 200 admissions per year. Additionally, the cap on the number of RN ECs in nurse-practitioner led clinics could be increased so that more patients could be accommodated.”⁷⁸ One stakeholder noted that increasing the number of NPs could mean significant cost savings for the health care system, because it would be less costly than upgrading the education for RNs, would minimize the confusion and frustration of having another prescriber and would provide efficient, safe care to patients in a timely manner.⁷⁹

CPSO noted, when suggesting alternatives to RNs prescribing, that access to care can be managed and is being achieved in remote and rural areas in Ontario in a variety of different ways. CPSO explained that “some RNs and NPs are physically located in remote and rural areas to provide care to patients either via delegation (RNs) or independently (NPs), and care is also being provided in these areas via telehealth.”⁸⁰ Consequently, CPSO requested that HPRAC “consider whether delegation, NPs and telehealth are being fully utilized in Ontario and if not, whether changes could be made in these areas to achieve the Ministry’s objectives in enabling RN prescribing.”⁸¹

Prescribing Model: Use of Protocols

A variety of written comments expressed support for the use of protocols.^{82,83} CPSO stated that “delegation of prescribing through direct orders or medical directives can and does work effectively.”⁸⁴ NPAO clarified that the use of protocols/directives may also include the delegation of controlled acts from an authorized profession to another. It noted that the “expanded use of protocols, including NP directives to authorize RNs to perform procedures such as supplying and administering medications, is an effective way to optimize RN scope of practice and enhance patient access to timely and safe care.”⁸⁵

A number of stakeholders felt that independent prescribing is higher risk, and many stakeholders asserted that RNs did not currently possess the appropriate competencies to prescribe independently from a physician or NP.^{86,87,88,89}

Role Clarity: Confusion

HPRAC heard, on a number of occasions, that allowing RNs in the general class to prescribe independently could cause confusion.⁹⁰ Stakeholders stated that granting independent prescribing to RNs may cause confusion for patients and potentially conflict with other health care providers’ roles, particularly NPs, physicians and midwives.^{91,92,93,94} It was noted by CPSO that “it may lead

⁷⁸ Ibid., p. 85.

⁷⁹ Ibid., pp. 110-111.

⁸⁰ Ibid., p. 66.

⁸¹ Ibid.

⁸² Ibid., p. 141.

⁸³ Ibid., p. 150.

⁸⁴ Ibid., p. 64.

⁸⁵ Ibid., p. 100.

⁸⁶ Ibid., p. 18.

⁸⁷ Ibid., p. 19.

⁸⁸ Ibid., p. 20.

⁸⁹ Ibid., pp. 62-63.

⁹⁰ Ibid., p. 57.

⁹¹ Ibid., p. 13.

⁹² Ibid., p. 19.

to confusion amongst patients regarding scopes of practice for physicians, and nurses (NPs and RNs) and uncertainty as to which health care professional is ultimately responsible for the patient.”⁹⁵ In order to minimize confusion between other prescribers, OHA commented on the need to clearly define the responsibilities and accountabilities of each member of the health care team.⁹⁶

The Canadian Medical Protective Association (CMPA) stated that “it is essential for continuity of care, patient safety, and the management of medical-legal risk that accountabilities of a collaborative care delivery model are clear and that each member of the team, and the patient, are aware of individual roles and responsibilities in the delivery of care to the patient.”⁹⁷ CNO reaffirmed this sentiment by noting that “nurses, other health professionals and the public will need clarity on how new RN prescribers differ from NPs.”⁹⁸

Impact on Patients and on Access to Care

A number of stakeholders supported RNs being able to prescribe (regardless of the model) as a way to improve efficiencies in specific health care settings:

Many organizations across the province have identified areas where the health system needs to improve, including reducing wait times, eliminating fragmentation and breaking down geographical discrepancies in service, improving afterhours access to service in primary care, and minimizing rates of hospitalization and emergency room visits for ambulatory care sensitive conditions.⁹⁹

A small number of stakeholders mentioned that RN prescribing may reduce the number of patient visits to hospital emergency departments (EDs).^{100,101} For example, one stakeholder provided a scenario in which RN prescribing will result in efficient care:

An RN with an expanded scope of practice will be able to independently assess, diagnose and treat a number of high volume, low acuity CHC [community health centre] clients such as those with complaints of an ear ache, upper respiratory infection or throat infection, thus increasing access to primary care, while maximizing continuity of care for the client and minimizing the times a client may seek an alternative level of care such as a walk-in clinic or the Emergency Department.¹⁰²

Stakeholders commented that RN prescribing would improve access to medications and result in timely care. “It would have the greatest impact on access to care: increasing convenience and timeliness for patients; and decreasing the involvement or need for referrals to other prescribing health professionals.”¹⁰³

⁹³ Ibid., p. 22.

⁹⁴ Ibid., p. 145.

⁹⁵ Ibid., p. 63.

⁹⁶ Ibid., p. 145.

⁹⁷ Ibid., p. 41.

⁹⁸ Ibid., p. 57.

⁹⁹ Ibid., p. 161.

¹⁰⁰ Ibid., p. 15.

¹⁰¹ Ibid., p. 135.

¹⁰² Ibid., p. 38.

¹⁰³ Ibid., p. 47.

Stakeholders also communicated that RNs prescribing independently would assist in the delivery of efficient care in northern, rural and remote areas.^{104,105,106} One stakeholder organization exclaimed that “adopting an independent prescribing model versus a protocol-based prescribing model, would better enhance access to care for patients, particularly in rural areas underserved by physicians.”¹⁰⁷

Similarly, stakeholder comments noted that independent RN prescribing would be appropriate when used in conjunction with an approved list of illnesses/conditions for which RNs can independently prescribe.¹⁰⁸ “An independent model of prescribing within targeted disease entities or disease clusters is seen to best support clients and inter-professional health teams.”¹⁰⁹ HPRAC heard that “working within targeted priority areas, the RN prescriber could ensure timely access to care, significantly contribute to the collective knowledge and practice base of the interprofessional team, and ultimately facilitate a client centred approach to care.”¹¹⁰ Clinical domains where RNs could independently prescribe include immunizations, treatment and control of communicable infections, wound care and mental health and addiction services for populations in remote, isolated and semi-isolated areas.^{111,112,113}

Other Issues

The following noteworthy issues were raised by stakeholders but were not identified as frequently as those mentioned above.

Key Elements of Safe Prescribing

A small number of stakeholders spoke about tools and mechanisms that should be considered if the government proceeds with RNs’ independently prescribing (or whatever prescribing model that is preferred). CPSO and CNO provided a number of possible mechanisms for the effective oversight and management of safe prescribing.

CPSO explained that if RNs are able to prescribe independently, it logically follows that they will need to possess the ability to order and interpret tests and communicate a diagnosis. CPSO noted that “it is essential that RNs be required to complete additional education and training in these areas as well to ensure that RNs possess the competencies to practice safely with their expanded scope.”¹¹⁴

RNAO asserted that the risk of harm to patients would be mitigated, because “RNs are required to be aware of their level of competency and practice within it.”¹¹⁵ RNAO also explained that “the College of Nurses of Ontario provides RNs with a practice standard that outlines expectations when determining if they have the authority to perform a procedure, if it is appropriate for them to

¹⁰⁴ Ibid., p. 14.

¹⁰⁵ Ibid., p. 87.

¹⁰⁶ Ibid., p. 145.

¹⁰⁷ Ibid., p. 131.

¹⁰⁸ Ibid., p. 20.

¹⁰⁹ Ibid., p. 86.

¹¹⁰ Ibid., p. 87.

¹¹¹ Ibid., p. 13.

¹¹² Ibid., pp. 87-89.

¹¹³ Ibid., p. 101.

¹¹⁴ Ibid., p. 63.

¹¹⁵ Ibid., p. 165.

perform that procedure, and if they have the competency to perform the procedure.”¹¹⁶ Consistent with this, CNO stated that “regardless of the RN prescribing model implemented, CNO, within its mandate to regulate nursing in the public interest, will mitigate risk of harm through appropriate regulatory mechanisms.”¹¹⁷

The Institute for Safe Medication Practices Canada (ISMP) also suggested a variety of safety processes that could be implemented if RNs are able to prescribe. For instance, ISMP recommended a prescribing model that would include a pre-defined list of medications and conditions a nurse could prescribe for, readily available clinical DSTs, an inter-professional care approach that supports nurse assessment and prescribing, and clearly defined requirements as they relate to assessing competency.¹¹⁸

OHA recommended the following:

implementing quality assurance mechanisms that facilitate clear communication of both the intentions and details of prescribing efforts must be developed to minimize the possibility of polypharmacy (i.e., the practice of administering or using multiple medications especially concurrently); minimize prescribing errors; track incidents; and mitigate potential harm to patients as well as medical-legal risk to providers.¹¹⁹

OHA also suggested that it would be “useful to establish an interprofessional team to develop the clinical decision supports for RN prescribing including front-line RNs with the requisite specialized knowledge and experience, advanced practice nurses, pharmacists, psychiatrists and physicians.”¹²⁰

Stakeholders other than the OHA also raised concerns related to polypharmacy. It was explained by OCFP how polypharmacy is currently an issue of concern among seniors in LTC facilities, noting that enhanced education and ongoing certification on this issue are required.¹²¹ Other stakeholders claimed that increasing the number of prescribers could increase the chance of polypharmacy.¹²²

Insufficient Evidence

Limited comments were received related to a lack of available evidence regarding the need for RN independent prescribers. One stakeholder suggested “that there seems to be very little evidence to support the initiation of RN independently prescribing from other jurisdictions.”¹²³ OMA suggested that “RN prescribing taking place in other jurisdictions amounts to NP prescribing in Ontario.”¹²⁴ NPAO clarified that much of the literature available about RNs prescribing effectively and safely is related to NP prescribing.¹²⁵ NPAO also stated that “it is not clear whether a significant majority of RNs in Ontario actually want access to the controlled act of prescribing. In a

¹¹⁶ Ibid.

¹¹⁷ Ibid., p. 54.

¹¹⁸ Ibid., p. 91.

¹¹⁹ Ibid., p. 146.

¹²⁰ Ibid., p. 145.

¹²¹ Ibid., p. 140.

¹²² Ibid., p. 16.

¹²³ Ibid., p. 19.

¹²⁴ Ibid., p. 149.

¹²⁵ Ibid., p. 99.

survey conducted by RNAO, 87% of its members were identified as being in favour of RN prescribing (RNAO 2012). However, while this survey was sent to approximately 38,000 RNs, only 223 (<1%) members responded.”¹²⁶

Key Informant Interviews

A number of key informant interviews were conducted in order to identify stakeholders’ interests and concerns and to assist HPRAC with recommendation development. Information was sought via correspondence or through face-to-face meetings with persons or organizations with an identified expertise or stake in the issue.

In considering the RN prescribing referral, HPRAC conducted interviews with the following key informants:

Organization	Representative
Council of Ontario University Programs in Nursing and the provincial heads of nursing at Colleges of Applied Arts and Technology	Jennifer Medves, Professor and Vice-Dean (Health Sciences), Director of the School of Nursing, Queen’s University; Chair, Council of Ontario University Programs in Nursing Karen Poole, Director and Associate Professor, Lakehead University School of Nursing; Vice-Chair, Council of Ontario University Programs in Nursing Gail Orr, Chair, School of Health, Human and Justice Studies, Loyalist College; Executive Member, Provincial Heads of Nursing Subcommittee, Colleges of Applied Arts and Technology Michelle Cyr, Director, Council of Ontario Universities Rita McCann, Provincial Director, Ontario Primary Health Care Nurse Practitioner Program Alice Ormiston, Senior Policy Analyst, Council of Ontario Universities
First Nations and Inuit Health Branch, Health Canada	Shari Glenn, Director of Nursing Claire Goldie, Assistant Director of Nursing
Institute for Safe Medication Practices Canada	Sylvia Hyland, Vice President and Chief Operating Officer Julie Greenall, Director of Projects and Education

¹²⁶ Ibid., pp. 112-113.

	Kim Streitenberger, Project Lead
Nursing and Midwifery Council (United Kingdom)	Anne Trotter, Assistant Director, Education and Standards
Ontario Long Term Care Association	Nancy Cooper, Director, Quality and Performance
Ontario Telemedicine Network	Karen Waite, Senior Telemedicine Consultant Dr. Rob Williams, Chief Medical Officer
Patients Canada	Francesca Grosso, Board Member and caregiver
Registered Nurses' Association of Ontario	Doris Grinspun, Chief Executive Officer Tim Lenartowych, Director of Nursing and Health Policy Anastasia Harripaul, Nursing Policy Analyst

Chapter IV: Access-to-Care Challenges

The Premier of Ontario and the Minister of Health and Long-Term Care have made a commitment to the nursing profession to permit RNs to prescribe drugs. They have done so, as noted in their letter to HPRAC, because it “aligns with our vision for a health care system that puts patients first by increasing access to care.”¹²⁷

The Minister’s letter is clear: Any recommendation related to a model of RN prescribing is based on “which model is most appropriate for Ontario.” HPRAC’s assessment of appropriateness will be informed by not only HPRAC’s criteria, but also specifically by which model(s) has the greatest potential to increase access to care and best puts patients first.

HPRAC sought to learn more about patient-care access challenges in Ontario to be better informed to make recommendations that directly respond to the Minister’s request.

Key Patient-Care Access Challenges in Ontario

Three major areas were identified as key patient-care access challenges in Ontario:

1. accessing primary health care
2. wait times for primary and secondary health care
3. out-of-pocket costs

Each key issue has its own unique challenges as it relates to patient access to care.

Accessing Primary Care

A significant challenge identified in the literature was the inability of patients to access primary care during evenings and weekends, and during holiday hours. This was exemplified in a 2013 study, which found that 58% of Ontarians found it difficult to access primary care during these hours and ended up going to the ER instead.¹²⁸

Although the inability to access one’s primary care provider during “non-business” hours proved to be difficult for many Ontarians, a 2015 study suggests that 9% of Ontarians (1.2 million people)¹²⁹

¹²⁷ Letter from Dr. Eric Hoskins, Minister of Health and Long-Term Care, to Thomas Corcoran, HPRAC Chair, November 4, 2015.

¹²⁸ Health Council of Canada, *Where you live matters: Canadian views on health care quality. Results from the 2013 Commonwealth Fund International Health Policy Survey of the General Public*, Canadian Health Care Matters, Bulletin 8, Toronto: January 2014, http://publications.gc.ca/collections/collection_2014/ccs-hcc/H173-1-8-2014-eng.pdf, accessed January 4, 2016.

¹²⁹ Statistics Canada, Population by year, by province and territory (Number), <http://www.statcan.gc.ca/tables-tableaux/sum-som/101/cst01/demo02a-eng.htm>, accessed March 8, 2016.

do not have a regular place to access primary care, and that 13% of Ontarians report difficulty accessing such care. These findings — being unable to access primary care during non-business hours, and not having a regular place to access care — could explain the results from a 2015 OMA policy paper, which noted that 15% of Ontarians report that the time they must wait for primary care is unacceptable.¹³⁰

While barriers to accessing primary care exist, HPRAC learned that one should not conclude that because an individual has access to primary care, she or he does not face difficulty in obtaining the care that is best for her or him as a patient. HPRAC learned that patients who are not affiliated with a family health team (FHT)¹³¹ or a community health centre (CHC)¹³² had varying degrees of access to programs, services and supports that they required, and may have received less coordinated care and assistance navigating their care compared with patients who were affiliated with an FHT or CHC.¹³³

Moreover, the literature review found that Ontarians face a number of challenges when attempting to access properly coordinated care. One Ontario study concluded that nearly 20% of respondents received conflicting information, either from their physician or from another health care professional.¹³⁴ Evidence from this study also showed that one-third of Ontario patients surveyed encountered physicians or a health care provider who was not up to date or informed about care they had recently received.¹³⁵

Consistent with these findings, the study presented to HPRAC demonstrated that more than one-third (38%) of patients received care from a physician or health care provider who was not aware of important clinical information related to their medical history.¹³⁶ These findings, of uncoordinated, non-patient-centric care, could explain, in part, another finding in the literature review, which noted that almost half of Ontarian patients (46%) felt that their physician or health care provider did not spend enough time with them.¹³⁷

Many Ontarians face barriers to accessing primary care; however, those in underserved geographical areas (rural and remote locations) — approximately 15% of the population — face particularly acute challenges to accessing primary care services. Ontarians living in underserved

¹³⁰ Ontario Medical Association (OMA), *An Integrated Health Network Approach to Address Priority Populations in Family Practice in Ontario*, OMA Policy Paper, June 2015, <http://primarycarenetwork-mh.ca/wp-content/uploads/2015/11/OMA-IntegratedHealthNetworkPolicyPaper2015-06-25.pdf>, accessed December 22, 2015.

¹³¹ Ministry of Health and Long-Term Care (MOHLTC): “Family Health Teams are primary health care organizations that include a team of family physicians, nurse practitioners, registered nurses, social workers, dietitians, and other professionals who work together to provide primary health care for their community.” “Family Health Teams,” <http://www.health.gov.on.ca/en/pro/programs/fht>, accessed March 7, 2016.

¹³² Settlement.org: “Community Health Centres (CHCs) are non-profit organizations that provide primary health care for individuals, families and communities. CHCs have health professionals such as doctors, nurses, and nurse practitioners on staff.” “What Are Community Health Centres,” <http://settlement.org/ontario/health/community-and-public-health/public-and-community-health/what-are-community-health-centres>, accessed March 7, 2016.

¹³³ OMA, *An Integrated Health Network Approach to Address Priority Populations in Family Practice in Ontario*.

¹³⁴ Health Council of Canada.

¹³⁵ Ibid.

¹³⁶ Ibid.

¹³⁷ Ibid.

regions of the province experienced shortages in local health care providers, which translated to significant issues with accessing primary care.¹³⁸

The shared experiences encountered by Ontario patients when attempting to access primary care spoke to just a small segment of some of the challenges in the current health care system, which severely limit the ability of patients to access timely care that is patient-centred.

Wait Times for Primary and Secondary Health Care

A number of Ontarians face challenges in accessing patient-centred care. While some Ontarians struggle to simply have access to care, others who do eventually get access to care find that they must wait to receive that care.

In a study of 11 high-income countries, Canada had the lowest percentage of patients who could receive an appointment with their physician or nurse the same day or the next day when they were sick or needed medical attention. The same study reported that only 42% of Ontarians could access care the same or next day. Moreover, when attempting to reach their regular doctor's office, only 65% of Ontarians received an answer the same day they called.¹³⁹

Findings related to the ability of Ontarians to access the ER demonstrated similar challenges in accessing care. Ontarians have to wait longer than patients in other high-income nations to gain access to an ER. HPRAC learned that, in 2013, almost a quarter of Ontario residents had to wait four or more hours the last time they visited an ER.¹⁴⁰

Wait times to access a specialist also proved to be an issue for Ontarians. Respondents from a 2013 study most frequently cited wait times to access specialist care as the most frequent issue experienced by patients in the last 12 months.¹⁴¹

Finally, wait times were also found to profoundly affect new immigrants to Ontario. HPRAC learned that new Ontarians were faced with a three-month waiting period before being able to access care under the Ontario Health Insurance Plan (OHIP). While often encouraged to purchase private insurance, many immigrants found this insurance to be insufficient or unavailable, and, ultimately, did not purchase it.¹⁴²

¹³⁸ Brundisini, F. et al., Chronic disease patients' experiences with accessing health care in rural and remote areas: a systematic review and qualitative meta-synthesis, *Ontario health technology assessment series*, September 2013;13(15):1-33, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3817950/pdf/ohas-13-33.pdf>, accessed January 4, 2016.

¹³⁹ Health Council of Canada.

¹⁴⁰ Ibid.

¹⁴¹ Harrington, D. W., Wilson, K., Rosenberg, M., & Bell, S., Access granted! barriers endure: determinants of difficulties accessing specialist care when required in Ontario, Canada, *BMC health services research*, 22 April 2013;13(1):146, <http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-13-146>, accessed January 4, 2016.

¹⁴² OMA, *Reviewing the OHIP Three-Month Wait: an unreasonable barrier to accessing health care*, OMA Policy Paper, April 2011, https://www.oma.org/Resources/Documents/Apr11_OHIP_feature_pp13-18.pdf, accessed January 4, 2016.

Out-of-Pocket Costs

The cost of prescription medications was found to be an obstacle for Ontarians, both in terms of the perceived ability to access pharmaceutical care and the actual ability to adhere to recommended pharmaceutical treatment regimes. Exemplifying this, in one study presented to HRPAC, more than one-fifth of Ontarians were either “not at all” or “not very” confident that, in the event they became seriously ill, they would be able to afford the care they needed.¹⁴³

Moreover, HPRAC learned that Ontarians will not fill a prescription, or will abandon a course of treatment, due to its cost. For example, cancer patients with high out-of-pocket costs for drugs were found to abandon their medication regime because of the cost.¹⁴⁴ More generally, in a study over a 12-month period, just over one in ten Ontarians (11%) were found to either skip or not fill a prescription because of its cost, a slightly higher number than the national average (8%).¹⁴⁵

Although Ontario does provide mixed population-based coverage — for those aged 65 and above, for those on social assistance and for catastrophic drug coverage — HPRAC became aware that one in three working Ontarians did not have access to employer-provided prescription drug benefits.¹⁴⁶

Cost is, as HPRAC found, a barrier to care that was well documented in a number of studies and the literature.^{147,148,149,150} While cost is a challenge for many Ontarians, it presents a particular concern for those in rural and remote communities. For these Ontarians, transportation to a urban centre and its associated costs (parking, etc.) were reported in a number of studies as common burdens for patients/participants.^{151,152,153}

¹⁴³ Health Council of Canada.

¹⁴⁴ Starner, C.I., Gleeson, P.P., & Gunderson, B.W., Oral Oncology Prescription Abandonment Association with High Out-of-Pocket Member Expense, *Journal of Managed Care Pharmacy* 16(2):161-162, cited in: Taylor, D.W., Benefits outweigh costs in universal healthcare: business case for reimbursement of take-home cancer medicines in Ontario and Atlantic Canada, *American Journal of Medicine and Medical Sciences*, 2014;4(4):126-38, <http://www.cancerdurein.ca/media/926488/10.5923.j.ajmms.20140404.05.pdf>, accessed January 4, 2016.

¹⁴⁵ Health Council of Canada.

¹⁴⁶ Wellesley Institute, *Low Earnings, Unfilled Prescriptions: Employer-Provided Health Benefit Coverage in Canada*, July 2015, <http://www.wellesleyinstitute.com/wp-content/uploads/2015/07/Low-Earnings-Unfilled-Prescriptions-2015.pdf>, accessed January 4, 2016.

¹⁴⁷ Kapur, V., & Basu, K., Drug coverage in Canada: who is at risk? *Health Policy* 71(2):181-193, cited in: Law, M.R., Cheng L., Dhalla I.A., Heard, D., & Morgan, S.G., The effect of cost on adherence to prescription medications in Canada, *Canadian Medical Association Journal* 2012;184(3):297-302, <http://www.cmaj.ca/content/early/2012/01/16/cmaj.111270.full.pdf+html>, accessed January 4, 2016.

¹⁴⁸ Law et al.

¹⁴⁹ Wellesley Institute.

¹⁵⁰ Health Council of Canada.

¹⁵¹ King, K. M., Thomlinson, E., Sanguins, J., & LeBlanc, P., Men and women managing coronary artery disease risk: Urban–rural contrasts, *Social science & medicine* 2006;62(5):1091-1102, cited in: Brundisini et al., Chronic disease patients’ experiences with accessing health care in rural and remote areas: a systematic review and qualitative meta-synthesis, *Ontario health technology assessment series* 2013;13(15):1, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3817950/pdf/ohas-13-33.pdf>, accessed January 4, 2016.

¹⁵² Tessaro I, Smith SL, & Rye, S, Knowledge and perceptions of diabetes in an Appalachian population, *Prev Chronic Dis.* 2005;2(2), as cited in: Brundisini et al.

¹⁵³ Caldwell P., Arthur H.M., & Rideout E., Lives of rural women after myocardial infarction, *Canadian Journal of Nursing Research* 37(1):54-67, as cited in: Brundisini et al.

HPRAC also learned that the impact of cost on cancer patients accessing care in rural and remote locations is well documented. In two separate studies, one from 2007 and one from 2013, travel costs were noted as a challenge for cancer patients in rural and remote communities. Travel costs were found to be the most problematic issue related to accessing care,¹⁵⁴ with families from Northern Ontario and remote segments of the province having comparatively higher costs in terms of travel, lost wages and family care.¹⁵⁵

Although out-of-pocket costs were highlighted as a concern, HPRAC focused on two of the major access challenges listed above: accessing primary care, and wait times for primary and secondary care. These two access challenges were assessed as being directly applicable to the models of care that HPRAC was requested to evaluate.

¹⁵⁴ Longo, C. J., Deber, R., Fitch, M., Williams, A. P., & D'Souza, D., An examination of cancer patients' monthly 'out-of-pocket' costs in Ontario, Canada (abstract only), *European journal of cancer care*, 2007;16(6):500-507, <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2354.2007.00783.x/abstract>, accessed December 17, 2015.

¹⁵⁵ Canadian Cancer Society (Manitoba Division), Canadian Cancer Action Network, *Five year action plan to address the Financial Hardship of Cancer in Canada: A Call for Action*, November 2013, 17-18, cited in: Taylor.

Chapter V: What HPRAC Learned

Limitations of RN Prescribing

As outlined in the referral letter to HPRAC, the Premier of Ontario and the Minister of Health and Long-Term Care have committed to RNs' ability to prescribe.¹⁵⁶

While HPRAC was asked to make recommendations that are most appropriate for Ontario (i.e., that improve access and patient-centred care), HPRAC determined during its deliberations that granting RNs the authority to prescribe is only one of the many potential policy levers that the Ministry of Health and Long-Term Care (MOHLTC) could use to resolve access-to-care issues faced by Ontarians.

It was also noted by HPRAC that, in the course of conducting this review, evidence was presented related to RN prescribing that generally failed to demonstrate a clear, causal relationship between granting RNs the ability to prescribe and improvements in patient-centred access to care. Evidence presented to HPRAC was often contradictory, for example, and, when evaluations of RN prescribing did exist, it was often difficult to discern which class of nurse (RN or NP) was being evaluated.

Although limitations were identified in the evidence available to HPRAC, it was evident that the introduction of any form of RN prescribing could result in greater patient-centred access to care. As noted in Chapter IV, coordinated, timely, accessible primary care is a significant issue for many Ontarians. RN prescribing was viewed by HPRAC as a means to improve patient-centred care by increasing access to care. However, it should be noted that gains to patient-centred care and access to care may relate not only to the ability of RNs to prescribe, but to an increase in interactions with patients and an expanded role in a variety of care settings, particularly primary care.

Jurisdictional Analysis of RN Prescribing

In order to assess which model of RN prescribing is most appropriate for Ontario, HPRAC conducted an analysis of RN prescribing in other jurisdictions. This examination of other jurisdictions' models was used to determine the key elements of RN prescribing that could be reproduced in Ontario if the province wants to introduce a model(s) that would have the greatest impact on access and patient-centred care.

Summary of Findings

In the course of its review of other jurisdictions, HPRAC found certain overarching themes, including the following:

¹⁵⁶ Letter from Dr. Eric Hoskins, Minister of Health and Long-Term Care, to Thomas Corcoran, HPRAC Chair, November 4, 2015.

- Nurses must complete post-graduate programs or courses in prescribing (and other subject matter) prior to being authorized to prescribe medications. These programs are voluntary and must be sought out by individual practitioners.
- Nurses must have a minimum amount of clinical/practice experience (the UK, Ireland and New Zealand [proposed] require three years of clinical experience) prior to enrolling in a nurse prescriber program.
- Of the RN prescriber models reviewed, the majority are limited to specific situations, either based on complexity of condition (often, non-complex common conditions) or specific to a particular disease cluster (e.g., diabetes).
- Literature evaluating prescribing models was limited. The evaluation evidence that was available often examined NP prescribing.
- Over a 20-year period, the UK has evolved a framework that enables RNs to independently prescribe, albeit in limited clinical domains and after rigorous skills development and qualification.

Findings by Jurisdiction

HPRAC reviewed a number of models of RN prescribing that contained specific elements that HPRAC believed could be imported to Ontario, with beneficial results. These models are reviewed below. HPRAC notes that this summary is limited and should not be considered an exhaustive analysis of the models or a complete reproduction of all of the components that make up each model.

A more extensive examination of RN prescribing by jurisdiction is available in the document *Registered Nurse Prescribing Referral: A Preliminary Literature Review on Registered Nurse Prescribing*.¹⁵⁷

Saskatchewan

RN with Additional Authorized Practice (AAPRN)

In this model, the AAPRN has a broader scope than that of other RNs in Saskatchewan. The AAPRN model includes the diagnosis and treatment of individuals with limited common medical disorders (e.g., gastrointestinal, musculoskeletal, respiratory, skin, women's health, eye, ear, nose, throat and mouth, etc.),¹⁵⁸ as identified in a specific clinical DST. Common medical disorders are characterized by a number of specific features, which include but are not exclusive to: being episodic in nature, having defined signs and symptoms, having predictable outcomes and having an assigned clinical DST that is available to the AAPRN.¹⁵⁹ Because AAPRNs may only diagnose and

¹⁵⁷ See <http://www.hprac.org/en/resources/PLR-on-Registered-Nurse-Prescribing-2015-12-07.pdf>, accessed February 3, 2016.

¹⁵⁸ Saskatchewan Registered Nurses' Association, "CDTs – Clinical Decision Tools," <http://www.srna.org/index.php/component/content/article/17-main-section/280-leading-change-cdts>, accessed March 11, 2016.

¹⁵⁹ Saskatchewan Registered Nurses Association, *Standards and Competencies for the RN with Additional Authorized Practice*, May 2013, pp. 17-18, http://www.srna.org/images/stories/Nursing_Practice/Leading_Change/2016_Standards_and_Competencies_for_the_RN_with_Additional_Authorized_Practice_2016_03_17.pdf, accessed February 1, 2016.

treat limited medical diseases and disorders, their field of practice is narrower than that of NPs in Saskatchewan.¹⁶⁰

The AAPRN independently manages only those health conditions that are within the limited common medical disorder definition and for which a clinical DST exists.¹⁶¹ This model requires a nurse to consult and seek guidance from a physician or NP when the care required for the patient is beyond the nurse's scope of practice or competency. It also requires that the nurse seek a physician or NP if she or he would be required to deviate from the clinical DST to properly treat the patient, if the patient's symptoms persist or if the patient's condition deteriorates, despite treatment.¹⁶²

AAPRNs collect specimens, order specific, limited diagnostic tests, interpret results, take appropriate action when necessary and assume the responsibility for timely follow-up and referral to other health care professionals when required.¹⁶³

British Columbia

RN Certified Practice

RNs in British Columbia who are certified by the College of Registered Nurses of British Columbia (CRNBC) can independently carry out some restricted activities that normally require an order. For example, nurses certified in reproductive health can independently diagnose and treat some diseases (e.g., gonorrhoea) with prescription medications (e.g., antibiotics) by following a CRNBC-approved DST.¹⁶⁴

Certified practice RNs carry out their duties independently and are solely accountable for the diagnosis and treatment of the patient. They may diagnose certain diseases and disorders, as outlined in a DST, and may carry out certain restricted activities that would in other cases require an order.¹⁶⁵

Three certified practice categories have been established with CRNBC: reproductive health, remote practice and RN first call. After completing the necessary certification, a reproductive health nurse may provide contraceptive management, and diagnose and treat sexually transmitted infections.¹⁶⁶ A nurse who is certified in remote practice typically functions, according to CRNBC, in communities where "there is no resident physician or nurse practitioner, but where physicians or nurse practitioners visit the community periodically and are available to provide consultation to the registered nurse."¹⁶⁷ These nurses may, depending on the DST, diagnose and treat minor acute

¹⁶⁰ Saskatchewan Registered Nurses Association, *Interpretation of the RN Scope of Practice*, p. 12, http://www.srna.org/images/stories/Nursing_Practice/Interpretation_of_the_RN_Scope_2015_04_24.pdf, accessed February 1, 2016.

¹⁶¹ Saskatchewan Registered Nurses Association, *Standards and Competencies for the RN with Additional Authorized Practice*, p. 6.

¹⁶² Ibid.

¹⁶³ Ibid., p. 11.

¹⁶⁴ College of Registered Nurses of British Columbia, "Nursing Standards, Certified Practice," <https://www.crnbc.ca/Standards/CertifiedPractice/Overview/Pages/Default.aspx>, accessed February 1, 2016.

¹⁶⁵ Ibid.

¹⁶⁶ Ibid.

¹⁶⁷ Ibid.

illnesses. They may also carry out any and all activities that an RN certified in reproductive health could perform.¹⁶⁸

Finally, the RN first call works predominantly in diagnostic and treatment centres, and in small acute care hospitals. Nurses who complete this certification “diagnose and treat minor acute illness (including administering, compounding or dispensing Schedule I medications without an order) as set out in decision support tools.”¹⁶⁹ Certified practice RNs do not prescribe.¹⁷⁰

United Kingdom

The UK has multiple types of nurses who can prescribe.

Independent Prescriber

Nurse independent prescribers are specially trained nurses who are allowed to prescribe any drugs within their clinical competence. Since 2006, these nurses have had full access to the British National Formulary (BNF) within their clinical competency, which puts these nurses on a par with physicians in terms of their prescribing capabilities.¹⁷¹ Since April 2012, these nurses have been permitted to prescribe most controlled drugs within their competency.¹⁷²

A subset of the independent prescriber is the community practitioner nurse prescriber. These nurses are a distinct group under independent prescribers. They consist of district nurses,¹⁷³ health visitors¹⁷⁴ and school nurses,¹⁷⁵ who are allowed to independently prescribe from a limited formulary called the Nurse Prescribers Formulary (NPF) for community practitioners, which includes 13 prescription-only medicines, over-the-counter drugs, wound dressings and appliances. This training program no longer exists, however, so nurses holding this qualification are permitted to prescribe from the NPF for community prescribers.¹⁷⁶

¹⁶⁸ Ibid.

¹⁶⁹ Ibid.

¹⁷⁰ College of Registered Nurses of British Columbia, “Certified Practice – FAQ,” <https://www.crnbc.ca/Standards/CertifiedPractice/FAQ/Pages/Default.aspx>, accessed February 1, 2016.

¹⁷¹ Royal College of Nursing, “RCN Fact Sheet, Nurse Prescribing in the UK,” https://www2.rcn.org.uk/_data/assets/pdf_file/0004/462370/15.12_NursePrescribing_in_the_UK_RCN_Factsheet.pdf, accessed February 2, 2016.

¹⁷² Ibid.

¹⁷³ National Health Service (NHS), “Health Careers: District nurse.” District nurses visit people in their homes or in residential care homes, and provide increasingly complex care for patients and supporting family members. District nurses also have a teaching and support role, working with patients to enable them to care for themselves or, with family members, teaching them how to give care to their relatives. They are also accountable for their own patient caseloads. See <https://www.healthcareers.nhs.uk/explore-roles/nursing/district-nurse>.

¹⁷⁴ NHS, “Health Careers: Health visitor.” Health visitors are registered nurses or midwives who undertake further training (post-registration) in health visiting. They see patients and families in a variety of settings, including their homes, clinics and general practitioner surgeries. See <https://www.healthcareers.nhs.uk/explore-roles/public-health/health-visitor>.

¹⁷⁵ NHS, “Health Careers: School nurse.” School nurses provide a variety of services such as health and sex education within schools, carrying out developmental screening, undertaking health interviews and administering immunization programs. School nurses can be employed by the local health authority, community NHS providers, or by a school directly. See <https://www.healthcareers.nhs.uk/explore-roles/public-health/school-nurse>.

¹⁷⁶ Royal College of Nursing, “RCN Fact Sheet, Nurse Prescribing in the UK.”

Supplementary Prescriber

Supplementary prescribing¹⁷⁷ is a voluntary partnership between an independent prescriber (e.g., a physician) and a supplementary prescriber (e.g., an RN) who implement an agreed-upon, patient-specific CMP with the patient's agreement.¹⁷⁸ In this model, a physician provides the initial diagnosis and the supplementary prescriber may prescribe medications from a pre-specified list of medicines, as outlined in the patient's CMP. Although these medicines must be within the supplementary prescriber's area of competence,¹⁷⁹ there is no specific formulary or list of medicines, nor are there legal restrictions on the clinical conditions that a supplementary prescriber may treat.¹⁸⁰ Supplementary prescribers may prescribe from the entire BNF, including controlled drugs, provided they are listed in a CMP.¹⁸¹ The collaborating physician shares the responsibility of prescribing and holds full responsibility for the assessment and diagnosis of the patient.¹⁸²

Patient Group Directions

Patient Group Directions (PGDs) are another method through which nurses can prescribe. PGDs refer to written instructions, developed by a multidisciplinary team (e.g., physicians, pharmacists, nurses), for the supply and administration of named medicines in an identified clinical situation. PGDs are specifically designed for a particular group of patients with a specific condition (i.e., not individual patients). Nurses are only able to supply and administer medications within the strict terms of the predetermined protocol.¹⁸³

Preparation and Training

To become a nurse prescriber in the UK, an RN must complete post-graduate studies approved by the Nursing and Midwifery Council.^{184,185,186} Courses are taught at a undergraduate level, and students are required to become knowledgeable in consultation skills, clinical pharmacology,

¹⁷⁷ NHS, *Review of Prescribing, Supply & Administration of Medicines: Final Report*, March 1999, p. 39, http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digital_assets/@dh/@en/documents/digitalasset/dh_4077153.pdf, accessed March 10, 2016.

¹⁷⁸ Bissell, P., et al., *An evaluation of supplementary prescribing in nursing and pharmacy: Final Report for the Department of Health*, http://www.shef.ac.uk/polopoly_fs/1.441641/file/Supplementary_prescribing.pdf.

¹⁷⁹ Courtenay, M., Carey, N., & Burke, J., Independent extended and supplementary nurse prescribing practice in the UK: A national questionnaire survey, *International Journal of Nursing Studies*, 2007;44(7):1093-1101, http://scele.org/web_scele/archivos/Prescripcion%20enfermera_2007.pdf.

¹⁸⁰ The National Archives, Medicines and Healthcare Products Regulatory Agency, "Supplementary Prescribing," <http://webarchive.nationalarchives.gov.uk/20141205150130/http://www.mhra.gov.uk/Howweregulate/Medicines/Availabilityprescribingandsupplyingofmedicines/ExemptionsfromMedicinesActrestrictions/Supplementaryprescribing/index.htm>, accessed March 16, 2016.

¹⁸¹ Kroezen, M., van Dijk, L., Groenewegen, P.P., & Francke, A.L., Nurse prescribing of medicines in Western European and Anglo-Saxon countries: A systematic review of the literature, *BMC Health Services Research*, 2011;11:127, <http://link.springer.com/article/10.1186/1472-6963-11-127>.

¹⁸² Ibid.

¹⁸³ Ibid.

¹⁸⁴ Kroezen, M., van Dijk, L., Groenewegen, P.P., & Francke, A.L., Nurse prescribing of medicines in Western European and Anglo-Saxon countries: A systematic review of the literature – Additional File 4 – Description of nurse prescribing in nine Western European and Anglo-Saxon countries according to core themes, *BMC Health Services Research*, 2011;11:127, <http://www.biomedcentral.com/content/supplementary/1472-6963-11-127-s4.doc>.

¹⁸⁵ Kroezen et al., Nurse prescribing of medicines in Western European and Anglo-Saxon countries: A systematic review of the literature.

¹⁸⁶ Royal College of Nursing, "RCN Fact Sheet, Nurse Prescribing in the UK."

evidence-based practice, decision-making, the legal and ethical aspects of prescribing and other subject matter. To be eligible for these studies, a nurse must have three years of clinical experience, with one of those years taking place in the clinical field in which she or he will ultimately practise. The nurse must also arrange for a designated medical practitioner to supervise her or him during the practice period.^{187,188}

HPRAC notes that in the UK, nurse prescribers cannot order diagnostic or laboratory tests or X-rays just by virtue of the prescribing program. A nurse consultant or advanced practice nurse who has completed a master's-level nursing program (four years) can diagnose, order diagnostic tests and X-rays and prescribe medication if she or he has learned to do so as part of her or his course.¹⁸⁹

History of Non-Medical Prescribing in the UK

Nurse prescribing in the UK has progressed significantly since its inception, with nurses given prescribing powers very gradually. The *Cumberlege Report* concluded that district nurses and health visitors involved in neighbourhood nursing should be allowed limited prescribing rights.¹⁹⁰ This conclusion led to an advisory group being established by the Department of Health (DoH) in 1989, chaired by Dr. June Crown, which examined nurse prescribing and concluded that there were inefficient practices in primary care that nurse prescribing could rectify.

By 1994, a national NPF for district nurses and health visitors had been established, and prescribing without a physician's order was undertaken in several pilot sites.¹⁹¹ From 1998 onward, all suitably trained district nurses and health visitors could prescribe from the NPF.

A further report by Dr. Crown, which reviewed the prescribing, supply and administration of medicines, was published in 1999.¹⁹² The review recommended that prescribing authority should be extended to other groups of nurses with training and expertise in specialist areas.¹⁹³ In 2001, support was given by the government for this extension. Funding was made available for other nurses, as well as those currently qualified to prescribe, to undergo the necessary training to enable them to prescribe from an extended formulary. A number of medicines and conditions were added to the formulary between 2003 and 2005 (including medicines for emergency and first contact care). In 2006, legislation was passed enabling nurses to independently prescribe any medicines for any condition within their area of clinical competency, including controlled drugs.¹⁹⁴

¹⁸⁷ Kroezen et al., Nurse prescribing of medicines in Western European and Anglo-Saxon countries: A systematic review of the literature – Additional File 4 – Description of nurse prescribing in nine Western European and Anglo-Saxon countries according to core themes.

¹⁸⁸ Kroezen et al., Nurse prescribing of medicines in Western European and Anglo-Saxon countries: A systematic review of the literature.

¹⁸⁹ Email dated January 28, 2016, from Anne Trotter, Assistant Director, Education and Standards, Nursing and Midwifery Council.

¹⁹⁰ Department of Health and Social Security (DHSS), *The Cumberlege Report, Neighbourhood Nursing: A Focus for Care*, London: HMSO, 1986.

¹⁹¹ Legislation.gov.uk, Medicinal Products: Prescription by Nurses etc. Act 1992, <http://www.legislation.gov.uk/ukpga/1992/28/contents>, accessed March 10, 2016.

¹⁹² NHS, *Review of Prescribing, Supply & Administration of Medicines: Final Report*.

¹⁹³ Courtenay, M., & Griffiths, M., *Independent and Supplementary Prescribing: An Essential Guide, Second Edition*, Chapter 1, p. 2, Cambridge, UK: Cambridge University Press, 2010.

¹⁹⁴ Ibid., pp. 2-3.

New Zealand

In New Zealand, diabetes nurse specialists (DNSs) can prescribe 26 different medications that are commonly used to treat health concerns associated with diabetes.¹⁹⁵

Following an evaluation of DNSs, the Nursing Council of New Zealand undertook consultations on two proposals from RN prescribing. The proposed models were community nurse prescriber (CNP) and specialist nurse prescriber (SNP). A CNP with three years of practice experience and course work in community prescribing would be authorized to diagnose and treat minor ailments and infections in normally healthy people, and promote health and prevent disease by prescribing contraceptives, vaccines and other medicines.¹⁹⁶ The SNP, with three years of practice experience and post-graduate studies in prescribing, would be authorized to prescribe medicines for patients who have long-term conditions (e.g., diabetes, chronic respiratory disease) within a collaborative interdisciplinary team.¹⁹⁷

While there was support for the proposal and an extension of nurse prescribing, there were divergent views about some aspects within both proposals, particularly the lists of prescription medicines available to these nurses and the proposed qualifications and training for community nurse prescribers.¹⁹⁸

Evaluation of the Different Models of RN Prescribing

For the purposes of this referral, HPRAC developed high-level definitions of the models the Minister asked HPRAC to assess. HPRAC developed these definitions based on the evidence and literature available at the time of the referral. These definitions were used to consult with stakeholders.

The following sections provide an analysis of each of the models HPRAC was requested to assess. Each model was assessed against HPRAC's criteria, *Registered Nurse Prescribing Referral: Criteria for Assessment of Prescribing Models*.¹⁹⁹ Certain categories of the criteria have been collapsed to facilitate evaluation.²⁰⁰

¹⁹⁵ Wilkinson, J., Carryer, J., Adams, J., & Channing-Pearce, S., *Evaluation of the Diabetes Nurse Specialist Prescribing project*, 2011, New Zealand Society for the Study of Diabetes, <http://www.nzssd.org.nz/documents/dnss/DNS%20prescribing%20%20project%20final%20report%202011.pdf>.

¹⁹⁶ Nursing Council of New Zealand, *Consultation on two proposals for registered nurse prescribing: Community nurse prescribing, specialist nurse prescribing*, consultation document, February 2013, <http://www.nzssd.org.nz/documents/dnss/DNS%20prescribing%20%20project%20final%20report%202011.pdf>.

¹⁹⁷ Ibid.

¹⁹⁸ Nursing Council of New Zealand, *Consultation: Two proposals for registered nurse prescribing*, 2013, <http://www.nursingcouncil.org.nz/content/download/984/3782/file/Executive%20summary%20RN%20prescribing%20analysis%20of%20submissions%20October%202013.pdf>.

¹⁹⁹ HPRAC, *Registered Nurse Prescribing Referral: Criteria for Assessment of Prescribing Models*, 2016, <http://www.hprac.org/en/resources/Criteria-RN-Prescribing-2015-11-23.pdf>, accessed March 2, 2016.

²⁰⁰ For example, the body of knowledge and education and accreditation categories were combined into a single criterion.

Independent Prescriber

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

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

Analysis of the Independent Prescriber Model

Risk of Harm

In a 2005 evidence review of the safety and quality of independent prescribing in the UK, it was found that observed consultations between nurses and patients were clinically appropriate. In consultations, nurses provided the correct dosage 87% of the time, effective medication was prescribed 83% of the time and 96% of consultations yielded no apparent unnecessary duplication of medication. However, in this same study, it was found that 18% of consultations provided incorrect direction and 12% of directions by the nurse were not practical. Furthermore, of the consultations reviewed, 12% of prescription durations were not acceptable and 10% of prescriptions had significant interaction with other medications.²⁰¹ Literature reviews available to HPRAC did not produce any comparators to other independent prescribers (i.e., physicians).

RNAO, which advocates for RNs, notes that the risk of harm to patients from RNs prescribing independently would be minimal. The organization states that “RNs are required to be aware of their level of competency and practice within it,”²⁰² and explains that if an RN feels a situation is beyond her or his competency, the RN would refer to another regulated health professional.²⁰³

It was noted by the College of Physiotherapists of Ontario (CPO) that while independent prescribing may have a “marginally” higher risk of harm, the risk of harm from not receiving adequate care would be substantially higher.²⁰⁴

Both the NPAO and CPSO raised concerns about the potential confusion that could result from RNs being given the ability to independently prescribe. Both organizations noted that the addition of another prescriber could confuse patients about “whom they should seek a prescription from,”²⁰⁵ and that this could result in “uncertainty as to which health care professional is ultimately responsible for the patient.”²⁰⁶

²⁰¹ Latter, S., et al., *An evaluation of extended formulary independent nurse prescribing. Final Report*, School of Nursing and Midwifery, University of Southampton, 2005, cited in Latter, S., Safety and quality in independent prescribing: an evidence review, *Nurse Prescribing* 2008;6(2):59-66, <http://eprints.soton.ac.uk/50386/>.

²⁰² HPRAC, *Stakeholder Feedback on the Registered Nurse Prescribing Referral: Stakeholder Submissions*, p. 165.

²⁰³ Ibid., p. 166.

²⁰⁴ Ibid., pp. 68-69.

²⁰⁵ Ibid., p. 104.

²⁰⁶ Ibid., p. 63.

NPAO also noted that the most effective and safest method of becoming an independent prescriber is to become an NP.²⁰⁷ A number of comments were made by stakeholders related to RNs' preparedness to prescribe based on their competency and knowledge, skills, education and judgment. While comments to this effect are also listed under "Body of Knowledge, Education and Accreditation," below, they inform and are informed by the risk of harm and should be considered as such when evaluating the model as a whole.

ISMP, however, raised concerns about prescribing in general, noting that prescribing errors can cause harm and death, and are, in fact, common. The organization notes that "of 92 harmful incidents reported to the Ontario Critical Incident Reporting Program between Oct 2011 and Dec 2014, 18 incidents (20%) were associated with prescribing. Of these 16 resulted in harm and 2 resulted in death."²⁰⁸ ISMP goes on to explain that the incidents described above happened in hospital settings, where safeguards and systems exist to prevent prescribing errors.²⁰⁹

During HPRAC's consultation, stakeholders were asked what impact independent prescribing would have on risk of harm to patients:²¹⁰

- 65.5% of survey responses identified that there would be an increase in the risk of harm
- 11.5% of survey responses identified that there would be a decrease in the risk of harm
- 23% of survey responses identified that there would be no change to the risk of harm²¹¹

Public Need

An evidence review from the UK in 2005 provided a number of observations related to patient-centred care, specifically that, in interactions observed, almost 90% of nurses provided patients with a range of information, including instructions related to dose, duration and use. Nurses also checked the patient's comprehension and commitment to the medication regime 73% of the time. However, areas of concerns were also present: The study noted that in almost half of interactions observed, nurses required improvement when instructing patients about a medication's potential side effects and actions to take in the event of a side effect. The study also described how information related to the risks and benefits of treatment options was not given to patients almost 40% of the time.²¹² Literature reviews available to HPRAC did not produce any comparators to other independent prescribers (i.e., physicians).

Independent prescribing was viewed by certain stakeholders as a way to improve access to care in different communities. One group told HPRAC that rural and remote communities would experience enhanced access to care as a result of RN independent prescribing,²¹³ whereas another group suggested that the model would support the aging community.²¹⁴ It was also explained to

²⁰⁷ Ibid., p. 96.

²⁰⁸ Ibid., p. 94.

²⁰⁹ Ibid.

²¹⁰ Ibid., p. 8.

²¹¹ As noted earlier in the report, the data collected should not be interpreted as empirical evidence of, or opposition to, a particular topic. Respondents self-selected (i.e., sought out participation) in the consultation process and may not be representative of a larger group.

²¹² Latter et al.

²¹³ HPRAC, *Stakeholder Feedback on the Registered Nurse Prescribing Referral: Stakeholder Submissions*, pp. 123, 131.

²¹⁴ Ibid., p. 131.

HPRAC that this model could provide flexibility to patients by decreasing the need for the involvement of other regulated health professionals with prescribing authority, resulting in more timely care and convenience.²¹⁵

Body of Knowledge, Education and Accreditation

HPRAC heard from many stakeholders about the need for additional education and experience for current RNs to independently prescribe. Numerous stakeholders noted that “the current practice does not support RNs in the general class to diagnose patients with a medical condition or prescribe a medication to a patient independent of a physician/NP.”²¹⁶ It was explained to HPRAC that a “substantive training program” would be required, including proper assessment, to prepare RNs for the responsibility and accountability associated with prescribing.²¹⁷

COUPN and CAAT, who are uniquely situated to provide insights on the education of nurses in Ontario, explained in their submission that RN prescribing is not appropriate at the current entry to practice level.²¹⁸ The two bodies submit that RNs require significant clinical experience in the area they would be prescribing in, in order to develop the necessary knowledge and clinical reasoning skills,²¹⁹ and that they would be required to complete additional education to attain the knowledge, skill and judgment to safely prescribe independently.²²⁰ Examples of additional education required include training in the areas of pharmacotherapeutics and health assessment, as well as the appropriate use of diagnostics.²²¹

COUPN and CAAT identified the following competency requirements for independent prescribers: diagnostic reasoning, differential diagnosis, formulation and initiation of a treatment plan, and knowledge, communication and critical analysis skills related to each of the competencies mentioned. It was explained to HPRAC that “these are competencies of NPs and thus require the full NP education.”²²²

When asked to evaluate a potential program of 300 hours of additional education for RNs to prescribe independently, COUPN and CAAT noted in their submission that this type of program would be “appropriate for supplemental prescribing, but not for independent prescribing.”²²³ The submission goes on to explain that “such prescribing authority [RN independent prescribing] would require significant clinical experience in the area in which the prescribing will occur, in order to develop the knowledge and clinical reasoning skills. Such prescribing authority is not appropriate at the entry-to-practice level.”²²⁴

²¹⁵ Ibid., p. 47.

²¹⁶ Ibid., p. 128.

²¹⁷ Ibid., p. 152.

²¹⁸ Ibid., p. 84.

²¹⁹ Ibid., p. 84.

²²⁰ Ibid., p. 55.

²²¹ Ibid., p. 89.

²²² Ibid., pp. 81-82.

²²³ Ibid., p. 84.

²²⁴ Ibid., p. 84.

CNO, the regulator of the profession, explained in its submission to HPRAC that RNs would require education corresponding to new authorities, such as communicating a diagnosis or ordering diagnostic tests, depending on the model recommended.²²⁵

Economic Impact

HPRAC learned that, in a review of NP prescribing patterns in Ontario, with the introduction of prescribing for this class of nurses, prescribing habits after a period of time ended up closely matching those of physicians.²²⁶ Although determining the exact cost implications of the addition of RNs as prescribers was beyond HPRAC's scope, the evaluation of NP prescribing in Ontario could be informative in terms of increases in prescribing and the cost associated with this to the Ontario health care system.

Other economic considerations include resource requirements to develop the necessary curriculum, and increased membership fees.²²⁷ Many stakeholders raised the concern that current malpractice coverage would not be sufficient, that there would be increased costs related to lawsuits and settlements, noting that the "premiums for NPs are three times that of an RN."²²⁸

Relevance to the Profession, Health Care System and Relationship to Other Professions

A limited number of stakeholders told HPRAC that RN prescribing would result in greater autonomy while also increasing collaboration within health care teams,²²⁹ and that it would enable the improvement of inter-professional teamwork.²³⁰

One stakeholder group told HPRAC that as prescribers, physicians have been heavily influenced by the bio-medical practice model, while nurses practise in a more holistic manner, and that "moving towards RN prescribing may have an impact on nursing's theoretical philosophy of practice."²³¹

Other Considerations

Implementation

In an evaluation of independent prescribers in the UK, HPRAC learned that almost a quarter of independent prescribers practise in a supplementary capacity, and that some hospitals in the UK "require newly qualified nurse independent prescribers to practice under a supplementary prescriber capacity for six months before they take on full prescribing responsibilities."²³² HPRAC also learned that NHS policies restrict nurse prescribing based on setting, or that an NHS health trust may have a limited prescribing formulary.²³³

The limited availability of development and continued training resources that would enable nurse prescribers to refresh their knowledge and skills was also found to be an issue in the UK.²³⁴ This

²²⁵ Ibid., p. 55.

²²⁶ Sangster-Gormley, E., Prescribing Patterns of Nurse Practitioners in Canada, *CMAJ*, 2016;188(3):173-4, <http://www.cmaj.ca/content/early/2015/09/21/cmaj.150913.extract>, accessed March 16, 2016.

²²⁷ HPRAC, *Stakeholder Feedback on the Registered Nurse Prescribing Referral: Stakeholder Submissions*, p. 58.

²²⁸ Ibid., p. 111.

²²⁹ Ibid., p. 123.

²³⁰ Ibid., p. 38.

²³¹ Ibid., p. 133.

²³² Royal College of Nursing, "RCN Fact Sheet, Nurse Prescribing in the UK."

²³³ Ibid.

²³⁴ Ibid.

issue has the potential to be particularly acute in Ontario; one stakeholder noted that there are “no educational institutions in Ontario offering additional training/courses for RNs in the general class to obtain the knowledge, skill and judgment required for an RN to independently prescribe medications.”²³⁵

Available Evidence

Close examination of the literature review, *A Preliminary Literature Review on the Effectiveness of Registered Nurse Prescribing*, indicates that evidence related to the effectiveness of RN prescribing is very limited. The evidence presented in the literature review was often attributed to “prescribing by NPs or Advanced Practice Nurses (APNs) with graduate preparation.”²³⁶

Supplementary Prescriber

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

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

Analysis of the Supplementary Prescriber Model

Risk of Harm

The nature of the model, which requires collaboration between the nurse and physician/NP, could result, as one organization noted, in blurred accountabilities, creating “significant patient safety concerns.”²³⁷

As explained in the independent prescriber model analysis, risk of harm informs and is informed by a nurse’s body of knowledge, education and accreditation, and should be considered as such when evaluating the model as a whole.

Public Need

HPRAC learned that, in an evaluation of patients receiving health care for mental health-related issues, users reported that supplementary prescribing was beneficial, because mental health nurse

²³⁵ HPRAC, *Stakeholder Feedback on the Registered Nurse Prescribing Referral: Stakeholder Submissions*, p. 132.

²³⁶ *Ibid.*, p. 99.

²³⁷ *Ibid.*, p. 166.

prescribers listened to patients and gave information on medications. As well, the model allowed for a focus on collaboration.²³⁸

It was noted by one stakeholder organization that a supplementary prescribing model is not appropriate in LTC homes or in-patient units,²³⁹ however, which limits the applicability and potential impact that RNs as supplementary prescribers could have on access to care.

HPRAC heard through stakeholder responses to the consultation that this model requires RNs to enter into a collaborative relationship with a physician or NP. This relationship therefore requires that any change in a patient's health status be assessed and diagnosed by a NP or physician,²⁴⁰ potentially delaying care.

Body of Knowledge, Education and Accreditation

In their submission to HPRAC, COUPN and CAAT recommend two to three years of clinical experience with the client population or in the specialty clinical area in which they intend to practise, "in addition to Masters-level courses in pathophysiology, advanced health assessment and diagnosis, and therapeutics."²⁴¹ It was noted to HPRAC that these particular courses were part of NP training and specifically focus on "developing the competencies surrounding mechanisms of disease, history taking, physical assessment, pharmacological and non-pharmacological therapies."²⁴²

Economic Impact

In a 2008 evaluation of supplementary prescribing in the UK, researchers found that this model of prescribing, while considered cost effective, was, for the nurse, twice as time-consuming per patient as a physician consultation.²⁴³ The authors note, however, that while this may have an impact on patient wait times, nurses used these consultations as an opportunity to "conduct health checks, measure blood pressure, take blood samples and conduct medicine use reviews, making direct comparisons with physicians difficult."²⁴⁴ The authors of the study further qualified the findings of their research, noting that "the costs reported in this research consider all areas of supplementary care provided by nurses, whereas the cost measurements of physician prescribing consider primary care only."²⁴⁵

²³⁸ Cooper, R.J., et al., Nurse and pharmacist supplementary prescribing in the UK – A thematic review of the literature, *Health Policy* 2008;85(3):277-292, https://www.researchgate.net/profile/Richard_Cooper12/publication/5943515_Nurse_and_pharmacist_supplementary_prescribing_in_the_UK--a_thematic_review_of_the_literature/links/00b49529703a7c41a1000000.pdf.

²³⁹ HPRAC, *Stakeholder Feedback on the Registered Nurse Prescribing Referral: Stakeholder Submissions*, p. 102.

²⁴⁰ Ibid., p. 166.

²⁴¹ Ibid., p. 81.

²⁴² Ibid., p. 81.

²⁴³ Bissell et al. identified that the supplementary prescribing consultations cost £6.50 (\$13.91 Cdn) for nurses and took an average of 21 minutes, whereas physician consultations last 12 minutes and cost £34 (\$72.76 Cdn) (in 2007, £1 UK = \$2.14 UK; see Bank of Canada, "Financial Markets Department, Year Average of Exchange Rates," 2007, <http://www.bankofcanada.ca/stats/assets/pdf/nraa-2007-en.pdf>).

²⁴⁴ Bissell et al.

²⁴⁵ Ibid.

Relevance to the Profession, Health Care System and Relationship to Other Professions

The supplementary prescriber model was viewed by HPRAC as a method of prescribing that was characterized by significant requirements for inter-professional collaboration, which was viewed as beneficial to patient-centred care.

Other Considerations

Implementation

Evaluations of supplementary prescribing in the UK identified a number of challenges related to the implementation of supplementary prescribing, specifically that this model can result in the nurse having difficulty accessing patients' medical records and/or experiencing a lack of access to prescribing pads.^{246,247,248}

Other difficulties with supplementary prescribing identified focused on the CMP, which was found to be a challenge given the time it would take to establish a CMP,^{249,250,251,252} the difficulty associated with finding a physician to sign off on the CMP²⁵³ and the fact that a CMP may not be suitable for individuals with multiple co-morbidities because of the lack of flexibility within the CMP, which could ultimately inconvenience the patient.²⁵⁴

Other concerns identified to HPRAC ranged from IT infrastructure barriers, which could not accommodate supplementary prescribing due to an inability to print prescriptions,^{255,256,257,258,259} and a lack of awareness of the role of the supplementary prescriber amongst peers, physicians, patients and other health care professionals. It was acknowledged in the literature that these challenges could be overcome if a top-down commitment to the model was embedded in the organization.²⁶⁰ Other concerns highlighted the fact that supplementary prescribing formalizes

²⁴⁶ Carey, N., & Courtenay, M., Nurse supplementary prescribing for patients with diabetes: A national questionnaire survey, *Journal of Clinical Nursing*, 2008;17(16):2185-2193, http://www.scele.org/web_scele/archivos/Cuestionario_prescripcion_DM_08.pdf.

²⁴⁷ Bissell et al.

²⁴⁸ Cooper et al.

²⁴⁹ Ibid.

²⁵⁰ Stenner, K., Carey, N., & Courtenay, M. Implementing nurse prescribing: a case study in diabetes, *Journal of Advanced Nursing*, 2010;66(3):522-531, <http://www.ncbi.nlm.nih.gov/pubmed/20423387>.

²⁵¹ Courtenay, M., Carey, N., Burke, J., Independent extended and supplementary nurse prescribing practice in the UK: A national questionnaire survey, *International Journal of Nursing Studies*, 2007;44(7):1093-1101, http://scele.org/web_scele/archivos/Prescripcion%20enfermera_2007.pdf.

²⁵² Bissell et al.

²⁵³ Ibid.

²⁵⁴ Cooper, R., et al., Stakeholders' views of UK nurse and pharmacist supplementary prescribing, *Journal of Health Services Research & Policy*, 2008;13(4):215-221, https://www.researchgate.net/profile/Richard_Cooper12/publication/23269979_Stakeholders'_views_of_UK_nurse_and_pharmacist_supplementary_prescribing/links/0c960529705a0e467e000000.pdf.

²⁵⁵ Bissell et al.

²⁵⁶ Cooper et al., Stakeholders' views of UK nurse and pharmacist supplementary prescribing.

²⁵⁷ Courtenay, M., & Carey, N., Nurse independent prescribing and nurse supplementary prescribing practice: A national survey, *Journal of Advanced Nursing*, 2008;61(3):291-299.

²⁵⁸ Carey & Courtenay, Nurse supplementary prescribing for patients with diabetes: A national questionnaire survey.

²⁵⁹ Cooper, R.J., et al., Nurse and pharmacist supplementary prescribing in the UK – A thematic review of the literature.

²⁶⁰ Cooper et al., Stakeholders' views of UK nurse and pharmacist supplementary prescribing.

existing practices, might negatively affect colleague workloads and could cause confusion about the role of the supplementary prescriber on the care team.²⁶¹

Certain elements of these findings were reflected in comments made by organizations during the consultation, which suggested that this model of prescribing would be time-intensive for NPs and physicians, because a CMP takes time to develop.²⁶²

Use of Protocols

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

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

As described in Chapter II, the use of protocols, through delegation, orders and medical directives, is currently in use in many health care settings in Ontario.

Analysis of the Use of Protocols Model

Risk of Harm

Although one organization underscored that this model requires up-to-date and regularly evaluated protocols and directives to ensure the mitigation of risk of harm, HPRAC also heard from a stakeholder that the use of protocols “has demonstrated consistency in practice, is explicit and least likely to result in medical errors.”²⁶³

As explained in the other two models, risk of harm informs and is informed by a nurse's body of knowledge, education and accreditation, and should be considered as such when evaluating the model as a whole.

Public Need

A number of stakeholder groups told HPRAC during its consultation that the use of protocols, through delegation and medical directives, “can and does work effectively,”²⁶⁴ can be effective in providing care in rural and remote communities and can resolve certain access issues in these communities,²⁶⁵ and that the use of this model of prescribing may be the most optimal.²⁶⁶

²⁶¹ Cooper et al., Nurse and pharmacist supplementary prescribing in the UK – A thematic review of the literature.

²⁶² HPRAC, *Stakeholder Feedback on the Registered Nurse Prescribing Referral: Stakeholder Submissions*, p. 166.

²⁶³ Ibid., pp. 123-124.

²⁶⁴ Ibid., p. 64.

²⁶⁵ Ibid., p. 63.

²⁶⁶ Ibid., p. 153.

Other stakeholders suggested that the use of protocols may not best address public need; as one organization noted, “protocols will be cumbersome to complete, require regular updating to reflect best practices, fail to address the unique needs of clients, blur professional accountability and become void when the signing practitioner with prescribing authority leaves the organization”²⁶⁷

Body of Knowledge, Education and Accreditation

COUPN and CAAT describe in their submission to HPRAC the key competencies required to safely prescribe through the use of protocols. These include the ability to safely administer medications and therapies, having a clear understanding of accountability and responsibility related to prescribing and administering of drugs, and understanding the role of the health care team to consult when necessary. All three of these competencies are identified by COUPN and CAAT as acquired through RN education. The remaining competency identified to safely engage in the use of protocols is having familiarity with, and knowledge of, the patient population, which, according to COUPN and CAAT, is acquired after attaining some experience within a given clinical area.²⁶⁸

Economic Impact

It was noted that this model is, largely, currently being used in Ontario²⁶⁹ and would likely have minimal economic impact on the health care system, providers and patients.

Relevance to the Profession and the Health Care System, and Relationship to Other Professions

It was explained by NPAO that resources and tools developed by the Federation of Health Regulatory Colleges of Ontario currently exists. These tools support the development of directives and the delegation process. NPAO also explained that CNO currently has standards for directives that specify requirements for safe use²⁷⁰ and, as noted by CPSO, can promote the optimal use of health care resources and personnel.²⁷¹

Summary of Analysis

After conducting its analysis of the three models of RN prescribing identified by the Minister, as well as those found in other jurisdictions, HPRAC recognized that elements from a variety of models would best address the requirements of the referral and improve access to patient-centred care while also minimizing the risk of harm.

²⁶⁷ Ibid., p. 166.

²⁶⁸ Ibid., p. 82.

²⁶⁹ Ibid., p. 123.

²⁷⁰ Ibid., p. 18.

²⁷¹ Ibid., p. 64.

Chapter VI: Recommendations

In his letter to HPRAC, the Minister of Health and Long-Term Care outlined his and the Premier's commitment to RN prescribing.

During its review and analysis of the three different models of RN prescribing provided by the Minister, HPRAC examined which model of prescribing would most effectively meet public need (i.e., improve access to patient-centred care) while simultaneously ensuring that risk of harm can and would be properly minimized and mitigated.

Throughout its deliberations, HPRAC found it difficult to reconcile the benefits associated with the variety of models of RN prescribing found in other jurisdictions with the three models provided by the Minister. If the models given were defined and followed in rigid terms, HPRAC determined that they would omit the possibility of a model of RN prescribing that would, in HPRAC's opinion, most effectively meet patient-centred care access needs while minimizing risk of harm.

Upon concluding its assessment, HPRAC determined that two models of RN prescribing would best serve the people of Ontario at this time. These models contain foundational elements of those provided by the Minister, but build in a certain degree of variation found in other jurisdictions, to help maximize the positive impact on Ontarians.

Registered Nurse Specialist Practice

HPRAC recommends that a registered nurse specialist practice (RNSP) certificate of registration be established by the College of Nurses of Ontario (CNO).

The RNSP has been recommended as a means to address the needs of many of the patients in Ontario who have chronic care needs. This recommendation of RN prescribing most closely resembles the supplementary prescriber model.

In this proposed model, the diagnosis of a patient's disease or disorder is made by a physician or NP, who would have full responsibility for the diagnosis of the patient. The RNSP and physician/NP would share the responsibility of prescribing, however. A CMP would be developed by the RNSP in conjunction with the physician or NP, and would be agreed to by all parties, including the patient. The CMP would be patient specific, designed to be long term and would focus on specific disease clusters (e.g., diabetes, wound care, pulmonary disorders, etc.).²⁷² The CMP would set out categories of drugs that could be prescribed to the patient as well as the diagnostic tests that could be ordered and interpreted by the RNSP.

This class of nurse would be permitted to assess, prescribe and treat for a variety of patient diseases and disorders as long as they were within the RNSP's clinical competency and set out in the CMP.

Post-graduate courses following a baccalaureate degree in nursing (or equivalent), and clinical experience in nursing in general, and the area of specialty specifically, would be required. RNSPs will require rigorous and continuous education in their field of specialty. The exact amount of clinical experience and specific educational requirements would likely vary, depending on the

²⁷² HPRAC suggests that MOHLTC determine which diseases and disorders RNSPs could specialize in, to maximize the benefits to Ontarians.

disease cluster the RNSP would practise in. These specific requirements would be determined by the CNO after extensive consultation with MOHLTC, health regulatory colleges, educational institutions and stakeholders. However, the educational requirements should be less than that of an NP.

HPRAC has recommended the RNSP class of registration for its potential to provide specific benefits to Ontarians, such as:

- a focus on inclusive, patient-based care that is collaborative and requires inter-professional collaboration;
- increased amounts of “face time” between a care provider and the patient;
- a greater focus on preventative care;
- reduced wait times and greater frequency (where needed) of patient interactions with RNSPs;
- reduced wait times for other patients waiting to see a physician or NP. Reduced wait times for primary care would likely result from patients being diverted to the RNSP and away from the primary care provider; and
- being well suited to serve patients in a variety of settings, including home and community care.

While the introduction of the RNSP class does not guarantee the aforementioned benefits, if this specific recommendation is accepted, HPRAC encourages that these outcomes be considered as a measure of performance when designing the details of the RNSP class of registration.

Registered Nurse Advanced Practice

HPRAC recommends that a registered nurse advanced practice (RNAP) certificate of registration be established by CNO.

The RNAP has been recommended as a means to provide care to patients presenting with common, non-complex diseases and/or disorders that require access to a primary care provider for treatment.

This recommendation of RN prescribing most closely resembles the use of protocols. Although not exercising independent decision-making like a physician or NP, the RNAP would be authorized to determine treatment individually.

In this proposed model, the RNAP would assess, order diagnostic tests and prescribe drugs with the assistance of a decision support tool (DST). The tests that could be ordered and the drugs that could be prescribed would be limited to what is identified in the DST. The RNAP would only provide care if and when a DST exists to guide the actions of the RNAP.

The DSTs would be developed and maintained by CNO after extensive consultation with MOHLTC, other health regulatory colleges, employers, educational institutions and stakeholders. The DSTs would be non-patient specific, covering a range of common non-complex conditions; limited to short-term diseases and disorders; and require that any disease or disorder beyond the DST and competency of the RNAP be referred to a physician or NP. The DSTs would be developed by the regulatory body but implemented at the community level (e.g., hospital, nursing station, family health team, CHC, CCAC).

Post-graduate courses following a baccalaureate degree in nursing (or equivalent) and clinical experience in nursing would be required. The exact amount of clinical experience and specific

educational requirements would be determined by CNO after extensive consultation with the MOHLTC, educational institutions and stakeholders. However, the educational requirements should be less than that of an NP.

HPRAC has recommended the RNAP class of registration for its potential to provide specific benefits to Ontarians, such as:

- patients with common non-complex conditions being seen in higher volumes, thereby reducing wait times for access to care;
- better service for those in rural and remote communities;
- assisting with preventative care by treating non-complex conditions before they become complex;
- reduced wait times for other patients to see a physician or NP, since certain patients could be diverted to the RNAP and away from the primary care provider; and
- patients being treated in the home and community by the RNAP.

While the introduction of the RNAP class of registration does not guarantee the aforementioned benefits, if this specific recommendation is accepted, HPRAC encourages that these outcomes be considered as a measure of performance when designing the specific details of the RNAP class of registration.

Prescribing and Rural and Remote Communities

HPRAC recommends that MOHLTC increase the number of NPs and physicians in rural and remote locations, consider measures to improve the use of protocols in these communities and continue to reduce barriers to the use of telemedicine.

During its research, HPRAC identified critical challenges to access to care in rural and remote communities, including a lack of primary care providers and a system of protocols that ties medical directives to a single physician, which are voided when the physician no longer provides care in that particular community, resulting in patients not receiving the care they need.

To help address the lack of primary care providers, HPRAC recommends that MOHLTC work with stakeholders to increase the number of NPs and physicians in rural and remote communities. HPRAC is fully aware that the implementation of this recommendation is likely complex and could face significant challenges in terms of human resource deployment. NPAO suggested to HPRAC a number of approaches that could help in addressing this issue, including increasing the number of NP graduates per year and finding ways that NPs can work more closely with RNs in these communities, potentially through increasing the use of directives authorizing RNs to perform specific procedures in consultation with an NP.²⁷³

Steps should also be taken to alleviate access-to-care barriers that are related to medical directives/standing orders being tied to a single physician. MOHLTC should consider different approaches to medical directives and standing orders that remove this barrier. This new approach to protocols could see health regulatory colleges or the employer be responsible for the delegated authority, rather than a particular physician or NP.

²⁷³ HPRAC, *Stakeholder Feedback on the Registered Nurse Prescribing Referral: Stakeholder Submissions*, p. 100.

This proposed approach would be a departure from the current legislative scheme, which enables the use of protocols; therefore, HPRAC recommends that MOHLTC consult with stakeholders in the nursing and medical community, to ensure that any proposed model adequately mitigates risk while simultaneously increasing access to care.

Finally, HPRAC saw the use of telemedicine as a potential mechanism that could further assist with increasing access to care in rural and remote communities. While the Ontario Telemedicine Network, for example, has seen significant growth since its inception, approximately a 30% year-over-year increase,²⁷⁴ HPRAC learned that barriers that limit the potential of telemedicine in Ontario persist. HPRAC recommends that MOHLTC work with relevant stakeholders to properly provide incentives for and reduce barriers to the fuller adoption of telemedicine. These measures could include developing incentives for telemedicine sites to attract greater numbers of patients to use their services, providing supports for specialists who treat patients via telemedicine to reduce workloads, providing support for hospitals to upgrade and pay for networks that support specialist use of videoconferencing and, finally, facilitating eHealth Ontario's onboarding of new clinicians into telemedicine, so that they may quickly and easily use telemedicine services.

Independent Prescribing

The MOHLTC consider whether, in the future, Ontario should move toward a model of RN independent prescribing similar to that used in the UK.

In the event that HPRAC's three recommendations are accepted as outlined above, and concerns persist that there is a need for greater access to patient-centred care that could be addressed directly by RN prescribing, the Minister may, at that time, wish to consider a model of RN independent prescribing in Ontario that is based on the UK experience and that replicates many of the elements that defined the evolution of RN independent prescribing in the UK.

The RN independent prescriber model in Ontario could begin with a pilot program. This pilot would allow for the gradual introduction of an RN prescriber model that would consist of a defined list of medications, and a select list of disease clusters the nurse could treat, that would assist the RN in treating the patient and would be based on a model of collaborative, inter-disciplinary care. Any RN choosing to participate in the pilot program would be required to demonstrate clinical experience in a specific area of care (e.g., adult, child, mental health, etc.), and be required to demonstrate proper knowledge, skill and judgment related to the conditions being treated, and the pharmacological options for treatment and patient status.

HPRAC has recommended the RN independent prescribing model because it has the potential to provide specific benefits to Ontarians, such as:

- reduced wait times for patients to access care for specific conditions;
- better service for those in rural and remote communities;
- the promotion of inter-professional care; and
- reduced wait times for other patients to see a physician or NP, since certain patients will be diverted to the RN independent prescriber and away from the primary care provider.

²⁷⁴ Email to HPRAC Secretariat from Karen Waite, Ontario Telemedicine Network, March 1, 2016.

Chapter VII: Conclusion and Other Considerations

The request referred to HPRAC was unlike a number of previous HPRAC referrals. Rather than requesting that HPRAC make recommendations on whether or not a profession should be regulated or have an expanded scope of practice, the Minister requested that HPRAC determine how a particular scope of practice increase could be realized.

After having conducted research, a comprehensive stakeholder consultation and engaging in significant deliberations related to the referral request, HPRAC recognizes that the recommendations it has made will not fully solve the patient-centred care and access-to-care issues that face Ontarians. The recommendations that HPRAC has made are clearly just one policy lever available to MOHLTC to help increase patient-centred care and access to care.

HPRAC maintains that, with the introduction of two new certificates of registration in Ontario, the RNSP and RNAP, tangible gains could be made to increase patient-centred access to care. These two new certificates of registration of nurses, in conjunction with the recommendation that MOHLTC continue to work with stakeholders to continue to increase the number of NPs and physicians in rural and remote communities, improve the use of protocols and continue to support telemedicine, could have a substantive, recognizable and positive impact on patients in Ontario.

It is important to note that while HPRAC has recommended the introduction of two new classes of nurses who will have increased access to prescribing, HPRAC envisions a model of care that focuses on greater frequency of patient and provider interactions, faster access to care and a greater emphasis on preventative care, not necessarily an increase in prescribing to patients.

Should these recommendations be accepted, a rigorous model of evaluation should be established. This evaluation would focus on patient outcomes rather than simply the number of prescriptions made. Indeed, given that Canadians, including Ontarians, are amongst the heaviest users of prescription drugs, compared with other countries,²⁷⁵ the Minister may wish to include efforts to de-prescribe²⁷⁶ as part of the evaluation of these models.

In addition to the aforementioned recommendations, HPRAC has also recommended that consideration be given to whether, in the future, Ontario should move toward an RN independent prescriber model similar to that which currently exists in the UK. The UK has a rich experience of implementing independent prescribing, which HPRAC feels Ontario could learn from. This, however, would be dependent on demonstrating that any future model mitigates risk and ensures that independent RN prescribers have the knowledge, skills, judgment, education and competency to safely prescribe independently.

²⁷⁵ Health Council of Canada.

²⁷⁶ HPRAC, *Stakeholder Feedback on the Registered Nurse Prescribing Referral: Stakeholder Submissions*, p. 94.

Other Considerations

During its consultation, HPRAC heard from stakeholders that the introduction of new models of RN prescribing could cause confusion amongst patients and regulated health professionals related to the roles and responsibilities of any new RN prescriber. In that HPRAC has recommended the introduction of two new models of RN prescribing, should these recommendations be accepted, MOHLTC, CNO, RNAO and other relevant stakeholder groups will need to engage in significant communication exercises to ensure that patients, health care providers and professionals are acutely aware of the roles and responsibilities of these new classes of RNs.

Although HPRAC has made a number of recommendations which it views can increase patient-centred access to care, it understands that these recommendations have limitations and obstacles that will need to be overcome if they are to succeed in their objective: increasing Ontarians' access to patient-centred care. For example, HPRAC learned that supplementary models of prescribing have faced implementation challenges in other jurisdictions. HPRAC advises that MOHLTC closely examine these issues and learn from them, in order to help ensure efficient and effective rollout of this new model of RN prescribing. HPRAC suggests that MOHLTC consult with and learn from other jurisdictions that use or are in the process of developing DSTs. HPRAC is also aware that maximizing the use of protocols and increasing the number of NPs and physicians in rural and remote regions are longstanding issues. Overcoming these challenges will require new ways of thinking that are potentially innovative and unconventional.

Finally, HPRAC learned that Ontarians currently face very real challenges in receiving conflicting information from different health care professionals and care providers being unaware of care that a patient has recently received, and that physicians and other health care providers are sometimes unaware of critical aspects of a patient's medical history. Should HPRAC's recommendations be accepted and these new models of RN prescribing be introduced, these concerns could be further exacerbated, resulting in a degradation of patient care. However, the introduction of these models could also provide an opportunity to further improve inter-professional care and significantly ameliorate those instances in which a patient transitions from one health care service provider or care professional to another.

Appendix A: Minister's Letter

**Ministry of Health
and Long-Term Care**

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HLTC2968IT-2015-362

NOV 04 2015

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

Dear Mr. Corcoran:

On February 26, 2015, Premier Kathleen Wynne and I affirmed our government's commitment to authorize registered nurses (RNs) to prescribe drugs. This proposed change in the scope of practice of RNs aligns with our vision of a health care system that puts patients first by providing increased access to care.

As the decision has been made that this change in scope will occur, this referral to the Health Professions Regulatory Advisory Council (HPRAC) is not seeking advice on whether the scope of practice of RNs should be expanded to include prescribing drugs, but rather, I am asking the Council to conduct broad consultations with key partners within the nursing and health care community to assess the following three models of RN Prescribing:

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

I am requesting that HPRAC provide me with the results of its consultation along with its recommendations related to which model is most appropriate for Ontario. I would like this report no later than March 31, 2016.

I recognize that this referral is a departure from the typical referrals that HPRAC has received in the past; however, given your extensive expertise in broad-based consultations, your undertaking this work will be of tremendous value to the policy development required to implement this change in the scope of practice of RNs.

.../2

- 2 -

Please extend my appreciation to the Council for supporting this important initiative. If you have any questions, please contact Denise Cole, Assistant Deputy Minister, Health Human Resources Strategy Division (HHRSD) at denise.cole@ontario.ca or at 416-212-7688.

Yours sincerely,



Dr. Eric Hoskins
Minister

c: Denise Cole, Assistant Deputy Minister, HHRSD
Presidents and Registrars of the Regulated Health Professional Colleges

Health Professions Regulatory Advisory Council

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