NURSE PRACTITIONERS'
ASSOCIATION OF ONTARIO

Submission to
Health Professions Regulatory Advisory Council

Critical Legislative and Regulatory Steps to Improve Access to Care for Patients and Facilitate Integration of Nurse Practitioners in Ontario

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An Interest Group of the Registered Nurses' Association of Ontario

Critical Legislative and Regulatory Steps to Improve Access to Care and Facilitate Integration of Nurse Practitioners in Ontario

NPAO Submission to HPRAC: Referral on Extended Class Nurses

Introduction

The Nurse Practitioners' Association of Ontario (NPAO), an interest group of the Registered Nurses' Association of Ontario (RNAO), represents the professional interests of all nurse practitioners in Ontario. NPAO advocates for accessible, high quality health care for Ontarians through the integration of nurse practitioners across the health care system. NPAO membership affords the benefits of advocacy services, professional support and educational opportunities. It is with this mission in mind that NPAO is pleased to provide this response to the Health Professions Regulatory Advisory Council's (HPRAC) consultation on the referral from Minister Smitherman related to Registered Nurses in the Extended Class [RN(EC)s; more commonly referred to as NPs].

NPAO's membership is comprised of over 1100 members. The majority (about 65%) are primary health care nurse practitioners (NPs-PHC). Another 30% are academically prepared as adult or paediatric nurse practitioners and are expected to write the Extended Class examinations within the next two or three years. Students in nurse practitioner programs and registered nurses with an interest in the nurse practitioner role comprise the remainder of the membership.

Recent changes to the Nursing Act (1991), effective August 29, 2007, protected use of the title nurse practitioner and established four specialty certificates within the Extended Class. The three new specialties, NP-Adult; NP-Paediatric; and NP-Anaesthesia join the NP-Primary Health Care specialty that was established in 1998 with the designation RN(EC). At present, there are 814 registered nurses in the extended class with the NP-PHC specialty certificate. Throughout this paper, this group will be referred to as NPs. There are more than 300 other registered nurses who previously used the title Acute Care Nurse Practitioner. They work in advance practice roles under medical directives[1] and meet the requirements for one or more of the other nurse practitioner extended class specialty certificates. For purposes of this paper, this group will be referred to as Advanced Practice Nurses (APNs).

[1] Medical directives are used to provide legal authority primarily through physician delegation to perform controlled acts that are not currently authorized to a health professional or that are authorized but cannot be implemented due to other legislative restrictions. The Nursing Act (1991), the Hospitals Management Regulation 965 under the PHA (1990), the HARP Act (1990) and Regulation 552 under the HIA (1990) are just a few examples of legislation which limit or prevent nurse practitioners from practicing to their full scope and necessitate the use of medical directives across all streams of nurse practitioner practice.

Overview and Support for CNO Proposals

NPAO enthusiastically supports the recommendations to expand scope of practice as outlined in CNO's submission. NPAO agrees with CNO's view that "legislative evolution of the nurse practitioner role in Ontario has failed to keep pace with practice realities, health system developments, technological advancements and population health needs." We also believe that the time has come to make the appropriate adjustments to legislation impacting nurse practitioner practice in order to increase access to safe and appropriate care from nurse practitioners thereby better meeting the health care needs of the public. This is particularly timely with the recent changes to establish the three new nurse practitioner specialty certificates. In these proposals, CNO has moved to align legislation and regulations for nurses in the extended class with the original vision for the role and current practices that have been underway for over ten years using a variety of methods to manage within the restrictive legislative barriers to bridge the care gaps.

Historical Context

Together with RNAO, NPAO has a long history of advocating for a regulated role for nurse practitioners in Ontario. Education programs began in the seventies but in 1982 the last primary health care nurse practitioner education program at McMaster University closed because nurses were deterred from entering the role; no legislative framework existed to support role implementation and government funding for nurse practitioner positions was not forthcoming. Over the next decade the need for the nurse practitioner role was repeatedly identified in provincial health system and health human resources studies.

Since the early 1990's, all political parties have supported the nurse practitioner role. At that time, work began in earnest on a legislative framework to establish the nurse practitioner role. Ontario was the first jurisdiction in Canada to develop a regulated role and throughout the discussions many compromises were made in order to move the vision forward. Two critical decisions were made: 1) to limit the role to primary health care and 2) to use a list-based approach to both prescribing medications and ordering laboratory and diagnostic tests.

On February 18, 1998, Bill 127, the Expansion of Nursing Services for Patients Act was proclaimed and later that year the College of Nurses admitted the first registrants into the Extended Class. Unlike earlier attempts to implement and integrate the role, over the next decade, successive governments directed resources to support the development of the nurse practitioner role in primary health care through education, legislation and funding.

Understanding the history is important context for this referral process. The role is not new; it has existed, in both unregulated and regulated roles in North America for over fifty years and in Ontario for over forty years. As Dr. Alba DiCenso noted in her presentation to HPRAC earlier this month, nurse practitioners are the most researched

health profession and have a strong track record as a health profession that provides safe and effective care.

Other Canadian jurisdictions followed Ontario's lead. More importantly, they learned from Ontario's experience and avoided many of the legislative and regulatory challenges that have been identified as barriers to practice in this province. This referral is a unique opportunity to direct the legislative and regulatory framework for nurse practitioners in Ontario and to enable the role to be implemented across all sectors of health care and in all practice settings. The proposals from CNO will establish a regulatory and legislative framework that will enable the four streams of nurse practitioner practice to be safely, fully and effectively integrated into Ontario's health care system.

In the past decade, much has been accomplished to support implementation of the role from both regulatory and legislative perspectives. Examples include changes to regulations under the Public Hospitals Act (1990) and various long term care legislation to enable the role in hospital outpatient and emergency departments and in long term care homes, respectively. Health care provider organizations (e.g., hospitals, mental health and social service agencies, Community Care Access Centres, long term care homes, correctional facilities, Family Health Teams, solo physician practices) have embraced the role and demand exceeds supply. Numerous health human resources and health system reports, both federal and provincial, called for the expansion of the role, including:

- Report of the Special Advisor "Integrated Service Plan for Northwestern Ontario. Vision for the Restructuring of Health Services in Northwestern Ontario" (2005);
- Report from Monique Smith, Parliamentary Assistant, Ministry of Health and Long-Term Care "Commitment to Care: A Plan for Long-Term Care in Ontario" (2004);
- The Health of Canadians – The Federal Role (Final Report) (2002)
- Commission on the Future of Health Care in Canada, Hon. Roy Romanow Commissioner. "Building on Values: The Future of Health Care in Canada – Final Report" (2002);
- Expert Panel on Health Professional Human Resources "Shaping Ontario's Physician Workforce: Building Ontario's Capacity to Plan, Education, Recruit and Retain Physicians to Meet Health Needs" (The George Report) (2001);
- Health Services Restructuring Commission "Primary Health Care Strategy: Advice and Recommendations to the Hon. Elizabeth Witmer, Minister of Health" (1999);
- A report from Dr. Robert McKendry, "Physicians for Ontario: Too Many? Too Few? For 2000 and Beyond" (1999);
- The Report of the Nursing Task Force "Good Nursing, Good Health: An Investment for the 21st Century" (1999).

Since 2000, there have been seven Ontario reports released that have analyzed and/or commented on both the contributions that nurse practitioners have made to achieving provincial objectives such as improving access to care for Ontarians and supporting the development of interprofessional teams and the many barriers that limit the system from benefiting from the full potential of the role. These include:

- PHCNP Integration Task Team Report (2007, not released);
- Living in our Vision World: A Roadmap for the Future Role of NPs in Ontario (2006) from the Accord Project, Primary Health Care Transition Fund Project;
- Supporting Interdisciplinary Practice: The Family Physician/Nurse Practitioner Educational and Mentoring Program. The Final Report from RNAO, OCFP, OMA, Jones Way and Associates and the University of Ottawa, Primary Health Care Transition Fund Project. (2006);
- The Ontario Nurse Practitioner in Long-Term Care Facilities Pilot Project in Ontario. Interim Evaluation, Final Report, aestima research (2005);
- IBM McMaster University Report on the Integration of Primary Health Care Nurses Practitioners in Ontario (2005);
- The RN(EC)-GP Relationship: A Good Beginning, Ontario Medical Association and the Registered Nurses' Association of Ontario (2003);
- PriceWaterhouseCoopers reports on Evaluation of Primary Care Reform Pilots in Ontario Phase 1 – Final Report and Phase 2 – Interim Report (2001).

More recently, Local Health Integration Networks are facilitating the development of new and innovative models of care using interprofessional teams that incorporate the nurse practitioner role.

Although advances have been made in legislation to enable the nurse practitioner role in Ontario, NPAO believes the legislative changes have not gone far enough. The legal scope of practice for Ontario nurse practitioners lags behind similar legislation in other Canadian jurisdictions including Nova Scotia, Manitoba, Saskatchewan, Alberta, British Columbia, and the North West Territories (HPRAC, 2007; CNO, 2007, Appendices F & G)[2]. Lists of diagnostic tests and medications to define scope are far less common in other jurisdictions in both Canada and the United States where the role has a long history. Where lists do exist they tend to be set in standards, are far less restrictive, and can be more easily updated in response to emerging new evidence-based practices and evolving roles. For practicing nurse practitioners and advance practice nurses, the current legislative scope of practice in Ontario is far too limiting and stymies practice with its over reliance on medical directives. This approach interferes with the integration of timely evidence-based best practices.

This referral to HPRAC presents an opportunity to build on the knowledge and experience of the first decade of the regulated nurse practitioner role to enable the role to meet the future health care needs of Ontarians.

[2] http://www.hprac.org/en/projects/resources/hprac-nursing.jurisdictionalreview.november2007.final.pdf

Expanding Nurse Practitioner Scope of Practice: Controlled Acts and New Authorities[3]

NPAO believes that CNO's proposal to add new controlled acts and to expand existing acts and authorities governed by other legislation are consistent with the scope of practice required by nurse practitioners and are essential to the practice of nurse practitioners regulated under the four new specialty certificates. Nurse practitioners, both present and future, practice across a broad range of practice settings, with diverse patient populations who have varying levels of care needs across the spectrum ranging from preventative / wellness care through to acute care and palliative care. Nurse practitioners specialize not only in terms of broad categories of practice such as those reflected by the CNO's four specialty areas of practice, but also in terms of clinical specialty including neonatal, adult and paediatric oncology, women's health, seniors health, pain management, adult and paediatric cardiology to name only a few. Providing access to a broad range of controlled acts is essential for nurse practitioners to individualize care in a timely manner, to address the clinical nuances of each clinical case, and to use health care resources wisely.

NPAO believes that given the variability in contexts and diversity of nurse practitioner practice, granting access to all acts proposed by CNO is the best way forward. This would not only ensure greater access to timely care, but also be more responsive to changing population health needs and evolving nurse practitioner experience. For instance, as nurse practitioners gain knowledge over time, through education and practice, they will collaborate and provide consultation on different issues with physicians and other health providers by virtue of integrating their experiential knowledge into practice. In order to ensure competent practice and support the safe performance of the expanded scope of practice proposed by CNO, nurse practitioners are committed to life-long learning. Ongoing learning can take many forms and may include attending interprofessional conferences on best clinical practices and collaborative care, participating in mandatory quality assurance and continuing competence programs set by CNO, and through completion of formalized education such as those available through the Council of Ontario University Programs in Nursing (COUPN) and the University of Toronto, Faculty of Nursing continuing education programs.

Nurse practitioners have the cognitive and technical skills required to safely implement their current role and the proposed expanded scope of practice based on their

[3] The additional controlled acts are:
1) setting or casting a fracture of a bone or a dislocation of a joint;
2) dispensing, selling or compounding a drug; and
3) applying a form of energy prescribed in regulation.
4) Expanded acts involve removing limitations on existing controlled acts authorized to NPs including communicating a diagnosis, administering a substance by injection or inhalation; and prescribing (see pages 5 & 6 of CNO submission). CNO has also recommended amendments to Healing Arts Radiation Protection Act (1990) or HARP, Regulation 682 under the Laboratory and Specimen Licensing Collection Act (1990), Regulation 965 under the Public Hospitals Act (1990), Regulation 552 under the Health Insurance Act (1990), and Regulation 107 under the RHPA (1990) to broaden authorities and or remove barriers to existing authorities.

foundational nursing and advanced practice education, experience in a nursing role, and commitment to ongoing learning. The nurse practitioner role is grounded in nursing knowledge which is patient centred care. Nurse practitioners are highly skilled nurses with additional education who do not envision their role as physician replacements. While physician shortages may have been part of the rationale for implementing the role, the vision for the future of the role is to fill gaps in meeting the evolving health care needs for the citizens of Ontario. One of the key roles that nurse practitioners can play is to offer an additional point of entry into the health care system as an effective clinical care provider.

Further, the impact of ever-changing technology and the demand for integration of evidence into practice requires a responsive system that enables nurse practitioners to act on current and available research and scientific data in a timely manner rather than rely on medical directives and subsequent legislative change which can take years to occur, if ever. A good example of the potential impact of technology in support of CNO's proposal is the implementation of new electronic "order sets." Order sets are electronic versions of preprinted orders and protocols frequently developed under the leadership of advance practice nurses in the hospital setting to bring evidence based care to team based practices. Electronic evolution of preprinted orders into "order sets" will greatly impact patient safety through intentionally designed system checks and balances to support interprofessional teams of health practitioners ordering drugs and diagnostic tests. Nurse practitioners and advance practice nurses at sites such Trillium Health Centre, Chatham Kent Health Alliance and the London hospitals are currently working with physicians, pharmacists and others to establish such systems. Nurse practitioners will need to have full access to a variety of "order sets" that is reflective of best available evidence. Therefore, nurse practitioners will need broad access to controlled acts and additional authorities to be able to integrate best evidence into practice as it becomes available.

It should be noted that granting access of a controlled act to any health professional group does not mean that all members of the profession will actually perform the controlled act nor does it jeopardize public safety as some have argued. Physicians for example have access to the majority of controlled acts listed under the Regulated Health Professions Act (RHPA) (1991), yet, like nurse practitioners only perform those acts pertinent to their practice area. Nurse practitioners, not unlike physicians, are extremely aware of their professional accountabilities and obligations, and as self-regulating professionals perform only those acts for which they possess the requisite knowledge, skill and judgment to competently perform safely.

Furthermore, nurse practitioners know they must also perform controlled acts in conjunction with current clinical practice guidelines, related practice standards and legislative requirements. NPAO recognizes that to ensure patient safety for some aspects of the proposed controlled acts, restrictions may be placed by the College on those acts in nurse practitioner practice standards (p. 15 CNO submission). While NPAO accepts the need for limitations in certain situations, as outlined in the draft CNO practice standard, it cautions that limitations should only be used to protect public

safety. NPAO strongly recommends, based on the experience of the past decade that limitations should not be used as a point for negotiation or compromise as occurred when nurse practitioners were first regulated (See page 2 of this paper for detail).

Clinical Practice Examples

Throughout the public hearings and roundtable discussions and in written submissions, nurse practitioners and advance practice nurses have provided numerous anecdotes of the strategies that have been implemented in current practice to address some of the legislative and regulatory barriers. They have also described how access to the new controlled acts or expanding existing controlled acts by removing limitations would improve patient care. Based on the experiences of nurse practitioners and advance practice nurses, NPAO also supports the position taken by CNO that maintaining access through delegation is inappropriate because it blurs professional accountability and fails to acknowledge the depth and breadth of education nurse practitioners possess to ensure the mastery of the cognitive and technical aspects required to competently perform a controlled act.

As one nurse practitioner stated:

> *As a nurse practitioner, and like all professional nurses, I know it is my responsibility to provide safe, effective and ethical care to my patients. I am accountable to my funder, my colleagues, myself and my patients. The concept of safety is embedded in all nursing education and demonstrated in the competencies required to complete the NP program and to be certified by our College. They include advanced nursing knowledge, clinical skill and clinical decision-making and most importantly, the good judgment to know when I am and when I am not capable of providing care safely. Whether I am able to prescribe from a very short list of drugs or from the complete array of drugs in the Compendium of Pharmaceuticals, I am competent in knowing when to prescribe safely and when to ask a physician colleague to do so. At no time would I consider putting my patient in jeopardy by prescribing a treatment of which I am uncertain*. (Mary Woodman, NP-PHC)

There are numerous examples of fragmentation that result due to restrictions placed on nurse practitioner practice when nurse practitioners have the knowledge, skill and judgment but the needed medications or tests are not on "the list."

- In busy emergency departments, patients seen by a nurse practitioner can wait hours when physicians are unavailable for signatures.
- Physicians working in locations with nurse practitioners on-site frequently interrupted during their daily schedules to sign requisitions or prescriptions.
- Patients may wait hours on busy hospital units for physicians to sign discharge prescriptions, negatively impacting both the flow of patients through the system from the emergency room and wait times in emergency departments.
- When physicians are off-site from the nurse practitioner, patients may have to undergo a repeat visit with a physician with whom they may not have an existing relationship.

- Orphan patients who may need to visit an emergency department or urgent care centre for a new prescription or renewal of existing medication often refuse to undertake this laborious process.

This story from a nurse practitioner working in an isolated, remote northern community is an illustration of a key legislative barrier to patient access to safe and effective care:

> *I recently saw a patient who required birth control. She had experienced side effects from other prescriptions and there was a new product that based on best evidence would be indicated as appropriate. However, it was not on my "approved list". The patient had to travel 250 kms down a dangerous logging road to the nearest physician for something that was clearly within my scope.* (Aaron Medd, NP-PHC)

Even in urban areas the limitations of the list-based approach can cause significant delays in access to care for patients as explained in this story:

> *A patient presented with abdominal pain and symptoms consistent with an infection from Helicobacter pylori. I ordered the appropriate laboratory test and the infection was confirmed. The gold standard treatment plan for this condition includes a proton pump inhibitor (PPI) medication, and is well within my scope of practice to prescribe. Because he was not on the medication at the time, I did not have the authority to order this combination of drugs. There were two alternatives. The patient could wait for his physician to return from vacation or I could send him to the local emergency department where he would have had to endure additional hours of waiting, only to be reassessed and re-examined unnecessarily by another physician or NP who was not familiar with his case.* (Sonja Mast, NP-PHC)

While the recent legislative change to the Nursing Act (1991) to allow categories of drugs to be authorized for nurse practitioners rather than specific individual drugs may address some of these issues, NPAO does not believe that drug categories will be broad enough to address the significant diversity of nurse practitioner practice and is concerned that significant limitations will be placed on practice through the use of "exceptions."

Many "exceptions" already exist. For example, although most of the common vaccines are included in the nurse practitioner authorized list, some important and emerging vaccines are not included.

> *As an NP working in an emergency department, I regularly prescribe vaccines. For patients who have been exposed to an animal that may be carrying rabies. I assess and identify the risk and can contact the Public Officer of Health, but can't administer this vaccine without an order from a physician colleague. As another example, the government recently decided to provide free immunization for HPV. Because we are the only facility that is open 24 hours, those who need varicella immune globulin are sent to the ED for care. I'm not authorized to prescribe it and would have to seek physician authorization.* (Willi Kirenko, NP-PHC, APN)

Additionally, as experience has demonstrated, regulations are difficult to change. As new scientific evidence respecting best prescribing practices emerge in each of the specialty certificate areas and the multiple subspecialties which are subsumed under these certificates, it is likely that requests for regulation change will be a common occurrence if drug categories are used. Consequently, nurse practitioners will face the same delays in implementing best evidence into practice that they currently face with the drug list.

Expanding access to controlled acts and authorities will also have a positive effect on in-patient hospital services and improve efficiencies within the system. This is particularly appropriate with the recent regulation change to include adult, paediatric and anaesthesia specialties within the extended class. As one advance practice nurse working in an acute rheumatology service stated:

> …*having the ability to sign these prescriptions and requisitions would have provided more timely and safer care to patients and would have acknowledged the accountability where the accountability for the orders originated. As well, patients could have been discharged without delay, instead of waiting with their families for a physician signature to leave the hospital. New patients could then be brought in and not cancelled due to lack of beds.* (Robert Harris, APN)

Nurse practitioners and advanced practice nurses working in varied practice settings speak in support of CNO's proposal to remove from the Nursing Act (1991) the requirement to consult prior to communicating a diagnosis. Nurse practitioners frequently have the knowledge regarding the appropriate treatment or diagnostic but cannot legally complete the process. NPAO recommends that valuable consultation time with physicians be used to address issues that fall outside of nurse practitioner competence rather than to validate diagnoses, prescriptions and treatments that nurse practitioners have the knowledge, skills and judgment to competently perform autonomously. Two nurse practitioners commented on this issue:

> *… limitations on the communication of diagnoses reduce access to primary health care for patients in my community. Currently with a diagnosis "beyond the RN(EC) scope of practice" patients are required to wait for an appointment with a physician to hear their diagnosis even if the diagnosis is the result of a test that I have ordered and from a visit that I have conducted with the patient. The delay between test and diagnosis can be stressful for the patient and is unnecessary when I am available to see them and educate them on the results. As a trained and regulated health care professional I am well aware of my professional limitations and know when to refer a patient on to another provider if an identified diagnosis and related treatments are beyond my knowledge, skill, or experience. In my opinion, this is similar to the way that Physician General Practitioners work in collaboration with specialists."* (Samanatha Dalby, NP-PHC).
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> *NPs are committed to interprofessional care. This model of care recognizes the autonomy of all providers and seeks to respect and utilize the full knowledge and skill base of all team members for the purpose of comprehensive care. Consultation among autonomous, self regulated professionals must not be a*

process of asking permission but rather of sharing information and consulting regarding plan of care. (Jennie Humbert, NP-PHC)

In written submissions to HPRAC, physicians have also articulated their frustration with the requirement for consultation, validating that in their experience nurse practitioners in many cases are well aware of the appropriate treatment but must delay care to complete a consultation. This experience was also cited in physician feedback as part of the IBM McMaster Report on the Integration of PHCNPs in Ontario[4] and the Supporting Interdisciplinary Practice project[5].

NPAO also supports the need for the additional controlled acts of dispensing, selling, and compounding drugs and to changes to the Drug and Pharmacies Regulation Act (1990) where required to support those changes. Nurse practitioners in rural areas and those who work with low-income communities often cite experiences on how the ability to dispense and sell some medications would be a huge asset to their patients. For example, one nurse practitioner described the advantage of being able to offer inexpensive contraceptive medications to women in the community who do not have health insurance as a means to ensure both access to care and consistency in the use of oral contraceptives. Access through a nurse practitioner to low cost emergency contraception (Plan B) is also very important in some of the rural and remote communities where the ability to travel to an area pharmacy or Public Health Unit is often limited.

Two nurse practitioners shared the following story of the difference that the controlled act of dispensing would have for their patients to ensure the best possible outcomes for their clients with diabetes.

> *A newly diagnosed patient with Type 2 Diabetes can easily need up to five medications at a cost of hundreds of dollars per month. The ability to dispense samples for a trial of a medication before investing in a particular medication that may have intolerable side effects is an important aspect of care that can increase a patients confidence in a prescribed treatment before investing large amounts in medications that may need to be changed.* (Susan Allen, NP-PHC and Bonny Johnson, NP-PHC)

NPAO recognizes in the above example that the ability to dispense samples would also require authorization through amendments to federal legislation (Food and Drug Act) and is working with CNO, RNAO and the Canadian Nurses Association to effect that change.

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[4] Ontario Ministry of Health and Long Term Care Nursing Secretariat, IBM Business Consulting Services and McMaster University. Report on the integration of primary health care nurse practitioners into the province of Ontario. MOHLTC Nursing Secretariat: McMaster University (2005)

[5] RNAO, OCFP, OMA, University of Ottawa and Jones Way and Associates. Supporting Interdisciplinary Practice: The Family Physician/Nurse Practitioner Educational and Mentoring Program. The Final Report Toronto. (2006)

Casting and setting simple fractures have also been identified as common practice, under medical directives, among nurse practitioners working in emergency departments especially in northern, rural and remote settings. In authorizing these acts to nurse practitioners, there will be a positive impact on the system by improving timely access to care. Standards and processes set by the CNO would ensure the necessary quality of practice while granting access to patients who require this service.

Addressing Restrictions in Related Legislation

In addition to adding and expanding controlled acts under the Nursing Act (1991), as noted previously, NPAO also strongly supports CNO's recommendations to amend other legislation that defines and/or limits nurse practitioner scope of practice.

NPAO strongly supports amendments to the Public Hospitals Act (PHA) (1990) Regulation 965 and the Health Insurance Act (HIA) (1990) Regulation 552 to enable nurse practitioners to provide care for in-patients as autonomous health care professionals. For example, as one nurse practitioner indicated changes to the PHA would increase efficiencies in the system and facilitate patient-centered care:

> *I work with hospitalists and family medicine physicians to manage the care of patients who are medically stable but awaiting long term care placement. Under current regulations, I am unable to directly discharge these patients even though I am fully aware of the comprehensive discharge plan and also participated with the patient, family and health care team to develop the detailed plan. This can result in delays if the physician is not available. Many of my patients are palliative and I co-manage their care daily. I am not able to complete a medical certificate of death due to the Public Hospital Act and the Vital Statistics Act.* (Michelle Acorn, NP-PHC and APN)

Amendments to the Healing Arts Radiation Protection Act (1990) (HARP) and Regulation 107 (Forms of Energy) under the RHPA would facilitate wellness and preventative care. This is an important aspect of nurse practitioner scope of practice and has the potential to significantly contribute to achieving government goals for improving the health of Ontarians. The following are some examples:

- Providing nurse practitioners with the authority to order screening and prevention tests. Bone mineral density tests are considered best practice for patients with high risk scores on assessment tools for osteoporosis. Nurse practitioners need to be able to incorporate this screening into their practice to avoid unnecessary duplication of services.
- Providing nurse practitioners with the ability to order x-rays of the spine, shoulder or hip. Shoulder injuries are common in active people yet nurse practitioners are not able to order this diagnostic test. This lack of authority often results in the patient unnecessarily seeing another health care professional or visiting an emergency department or urgent care centre for reassessment and care.

A quote from a Diagnostic Imaging Manager in northern Ontario is supportive of broader access to diagnostic tests for nurse practitioners:

Under current regulations, nurse practitioners do not have the authority to order many simple tests such as spinal, shoulder or hip x-rays and renal ultrasounds. These are hardly special procedures. (Phil Smith, Manager, Diagnostic Imaging)

In addition to screening tests, changes to the forms of energy regulation also reflect current practice of nurse practitioners working in institutional settings In an Emergency Department, Willi Kirenko, NP-PHC and APN is an Advanced Cardiac Life Support (ACLS) instructor and is responsible for teaching both nurses and physicians how to safely and effectively apply life-saving energy in the forms of defibrillation, cardioversion and the application and adjustment of transthoracic pace-makers. Even though she teaches residents and physicians on the indications and procedures, she does not hold the authority to perform these procedures autonomously.

I am frequently called on to provide advanced cardiac care to those arriving in our emergency department when the physician is also busy with a critical case. It makes no sense to my physician colleagues, that I can teach and direct others in these procedures but I don't have the authority to perform them myself. (Willi Kirenko NP-PHC, APN)

Similar reports have been received from advance practice nurses working in critical care units such as Tina Hurlock-Chorostecki, APN at London Health Sciences Centre. With the introduction of the NP- Anaesthesia role, a broader range of access to controlled acts, building upon the experiences of advance practice nurses and nurse practitioners who practice in critical care areas, will be critical to enable the role to work effectively in anesthesia care teams.

Implications of Medical Directives on Professional Practice

The purpose of a medical directive is to provide, in advance, authority to the nurse practitioner or advanced practice nurse to decide to perform or ask other providers to perform actions listed in the document under specific conditions without direct initial assessment by the physician.[6] It is the responsibility of the physician to ensure the delegated person has the knowledge, skills and judgment to perform the delegated act. The process of developing a medical directive usually rests with the advance practice nurse or nurse practitioner, while the collaborating physician(s), and in certain settings (e.g., hospital), other professionals impacted by the medical directive and the Medical Advisory Committee, sign an agreement approving medical directives. In an effort to keep medical directives evidence-based and current, the advance practice nurse or nurse practitioner is responsible to initiate and complete ongoing reviews and frequent updates which require collaborating physicians to re-sign the directives. The amount of time spent developing, reviewing and updating medical directives as well as taking them through physician and administrative approval processes is very labour intense and time consuming. Additionally, nurse practitioners in different settings report that there is poor understanding about medical directives among administrators and physicians. Nurse practitioners are frequently called upon to provide clarification.

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[6] http://www.medicaldirectives-delegation.com/orders/what/default.asp

The following are examples of how medical directives do not support timely integration of evidence-based practice and indicate poor utilization of time and processes to ensure quality care and patient safety:

- An NP-PHC who also holds a specialty APN certification reported requiring 27 drafts before her hospital-based medical directives were approved.
- An APN who had worked successfully with six collaborating physicians in one practice site for many years, moved to another site as a result of hospital program restructuring. After two years of successful collaboration at the new site, the APN is still waiting to have medical directives approved.
- Medical directives require a specific format. For one nurse practitioner collaborating with four physicians, the directives were initially 200 pages. By the time they were approved by the Medical Advisory Committee (MAC), the format requirements changed and the nurse practitioner had to rewrite all of the medical directives.
- New guidelines have been developed by the Federation of Health Regulatory Colleges of Ontario to enable the utilization of medical directives for community pharmacies. Health professionals are still largely unaware of these guidelines and there are still concerns that the process will not be sustainable or viable.[7]
- Nurse practitioners or advance practice nurses have reported that medical directives may cause confusion and distrust within interprofessional teams. Other professionals (e.g., respiratory therapists, physiotherapists and radiology technicians) often question nurse practitioner authority to direct patient care through a medical directive.
- Advance practice nurses report that medical directives rarely cover all the situations that can happen in an acute care setting, especially in complex care practices.

The complexity of the process to develop and approve medical directives is illustrated in the following description of the experience of one advanced practice nurse at an academic teaching hospital:

> *I was requesting a renewal of my medical directives. Each time it was presented, a different aspect within the medical directive was questioned. I finally asked to attend MAC to answer the questions directly. My responses were not respected until one member of MAC spoke up. This member was a physician who visited the ICU where I worked fairly regularly and we had worked together navigating patients into and out of the ICU. He said to the MAC "Stop. We let medical residents and clerks do these things all the time and they don't have near the knowledge, skill and expertise as she does. Who are we to say she can't continue to do this? I support we accept the document as it is". Discussion ended and the medical directive was approved.* (Tina Hurlock-Chorostecki, APN)

The use of medical directives has allowed for the demonstration of the value of the advance practice nurse and nurse practitioner role in hospital and other settings. However, the cumbersome nature of developing and maintaining medical directives prevents this from being a reasonable solution for a prolonged period of time. If we accept that health care is evolving to better meet the needs of patients and families, then we need to accept that health care provider roles and the legislation that governs

[7] http://mdguide.regulatedhealthprofessions.on.ca/pdf/MedicalTemplatesInstructions.pdf

their practice must evolve to meet those needs. The CNO proposal realizes that evolution in the regulation of nurse practitioner practice within the professional body allows for flexibility in meeting patient needs.

It is also critical to note that not all nurse practitioners are expected or required to perform each of the new or expanded acts or authorities in their specialty practice. This does not however, in NPAO's view, justify in any way the continual reliance on medical directives to enable practice. NPAO recognizes that medical directives and delegation will still play a role for nurse practitioner practice, but this should be the exception rather than the rule. As already noted, developing medical directives to enable nurse practitioner practice is an extremely time consuming and cumbersome process with the bulk of the work completed by the nurse practitioner and final approval by physicians and others depending on the setting. There are situations where physicians have left a service or community. As a result, the nurse practitioner is left in a difficult situation without valid current medical directives. Patients become confused when informed that the nurse practitioner can no longer provide certain services that they are accustomed to receiving from the nurse practitioner through authorized medical directives.

As one APN practicing in geriatrics recently stated:

> *The proposed changes are reflective of the work that APNs are doing daily in our acute care hospitals. We have the education, competencies, and experience to facilitate access to care, ensure efficient and safe patient flow through the system, and provide liaison with community resources for patients being discharged. I believe that the proposed regulatory changes will also promote accountability for the role. Medical directives are cumbersome, and do not reflect the independent cognitive appraisals that I conduct on the condition of the patients that I care for on a daily basis.* (Heather Whittle, APN)

Conundrums Arising from the Interface of Legislation and Practice Realities

NPAO believes that patients would be better served if processes were in place where the onus of responsibility for regulating the scope of practice of the profession lies completely within the legislative responsibility of the College established through a broad legislative framework, regulations, and practice standards rather than be extended through medical directives based on individual practitioner, team or facility needs. This concept of a broad approach to nurse practitioner regulation has been successfully implemented in many other jurisdictions as outlined in the recent HPRAC Jurisdictional Review (2007).

Lahey and Currie[8] for example, identified and addressed issues related to some of the inconsistencies in legislative scope of practice identified by the Kirby Commission (2002). The report noted the inconsistency in legislation for nurse practitioner practice across Canada is arbitrary and is not based on patient safety issues. In Nova Scotia, nurse practitioners are able to perform safely yet Ontario restricts their practice without

[8] Lahey and Currie, 2005. J of Interprofesional Care. Suppl 1:197-223, p. 202.

sound rationale. Using the experiential data from other jurisdictions, changes in Ontario are in the public interest and support the recommendation that the same standard of practice exist across Canada because it is actually safe and desirable for patient access.

Self-regulation is a key concept underpinning the Regulated Health Professions Act (1991). While physicians in all areas of specialty can prescribe most medications and perform many types of procedures, lack of familiarity with specific conditions and/or the use of specific drugs or procedures results in physicians referring patients to other physicians with specific knowledge to address patients needs as appropriate. Why would nurse practitioners not be given the same level of self-regulation? Referral among health care professionals is the true essence of interprofessional collaboration. Further, intraprofessional and interprofessional collaborative practice patterns are necessary to maximize the use of clinician knowledge and skills as well as available human health resources. It is also critical to avoid unnecessary restrictions to nurse practitioner practice that impact their ability to perform their role and the patient's ability to receive appropriate care. The collaborating physician's time must be integrated wisely into interprofessional practice patterns to ensure unnecessary duplication. Education for all practitioners about collaboration and achieving an understanding of the distinction between collaboration and supervision is needed.

In the recent Canadian review of interprofessional practice Lahey and Currie[9] state:

> *Interprofessional practice, professional regulation and professional malpractice law are all directed toward putting patient interest ahead of provider or system interests. They are each directed at maintaining and improving the quality of clinical practice.*
>
> *Our premise is that there must therefore be ways to ensure that they function in general harmony. Our argument on professional regulation is that the essential integrity of the system of professional self-regulation must be protected in programs of reform that seem to create space for interprofessional practice. Our reasoning is partly that self-regulation has become a core institution of the Canadian health care system and partly that it is not currently possible to definitively conclude that it is incompatible with the still evolving development of interprofessional practice. Our further argument is that law reform efforts should therefore concentrate on two objectives. The first is reducing the restrictiveness of individual scopes of practice and the regulatory framework within which specific scopes of practice operate. The second is the need for a transformation of regulatory culture comparable to the change in practice that is needed to make interprofessional practice possible.*

Further these authors quote the Hon. Roy Romanow: "Despite much rhetoric about interprofessional co-operation in reality, the professions tend to protect their scopes of practice." Romanow proposed that a fundamental rethinking of

[9] Lahey and Currie, 2005. J of Interprofesional Care. Suppl 1:197-223, p. 198.

"core assumptions" was required because "tinkering with the boundaries" is insufficient (p. 201). Some of the "core assumptions" described by Romanow, none of which were found to be evident, include the suggestion that without oversight by medicine, nurses and particularly nurses practitioners will:

- practice without regard for their limitations in knowledge and skill;
- be unaware, unable and uninterested in gaining additional skills and knowledge as practitioners when needed in the practice setting; and
- immediately stop collaborating when physicians are not required do to so by law.

Changes requested in the CNO submission do not suggest that nurse practitioners are seeking to diminish or limit collaboration. In actual fact, nurse practitioners actively seek out opportunities to develop and reinforce collaborative practice relationships with physicians and other professional groups to ensure that patients have access to high quality care based on their needs and available resources. This has been evidenced through their participation and leadership in many of the Primary Health Care Transition Fund and the Interprofessional Mentorship, Preceptorship, Leadership and Coaching Fund projects. The following summarizes the overarching philosophy of nurse practitioners:

> *Allowing NPs to work to their full scope of practice does not diminish the work of other health care providers. I rely on many physician partners to collaborate with me when I find myself beyond my scope of practice. I also find that they often approach me for my expertise in specific areas of care for our patients. Collaboration and consultation are core competencies for NPs. We rely on interprofessional relationships to optimize the care we provide to patients. Overlapping scopes of practice build capacity into our system and allow Ontarians better access to care*. (Maureen Loft, APN)

Collaborative solutions to addressing patient care needs are required. NPAO supports the CNO vision for the regulation of nurse practitioners articulated in its submission. NPAO views this vision as a significant step forward to improving patient access to quality care, through enabling nurse practitioner roles. With the limited experience of legal claims or malpractice for nurse practitioners in Canada since inception of the role, it is highly unlikely that nurse practitioners will suddenly refuse boundaries imposed by self-regulation and/or ignore the collaborative relationships that have been established with physicians in all practice settings. If, as a result of this review process, it is determined by HPRAC or by the Ministry of Health and Long-Term Care, that the best strategy for ensuring both intraprofessional and interprofessional collaborative relationships is through legislation, then this requirement must be applied in the same manner to all health professionals, not only to one profession as it currently is with Registered Nurses, Extended Class.

The safety of patients within the context of this proposal has been demonstrated in the past decade. However, many of the things nurse practitioners and advanced practice nurses in primary health care and hospital settings do to improve patient care are

hidden within current legislative frameworks and policy implementation. For example, the *NP Integration Report* identified that over 90% of nurse practitioners refer their clients to specialists. Furthermore, of those who do refer, 88% reported that they write the consultation note and the collaborating family physician allocates their billing number and signs the note. Less than 10% of nurse practitioners reported that they either refer the patient to the family physician (who sees the patient and writes the consultation note) or have the family physician write the consult note after discussing the matter with the nurse practitioner (p. 92). While the issue of referral to specialists is not a regulatory issue related to the mandate of the HPRAC review, this example illustrates how nurse practitioner practice is now masked by the ways that both practicing nurse practitioners and their physician colleagues navigate solutions to barriers.

When nurse practitioners facilitate and navigate their patients through the barriers imposed by the overly restrictive current legislation, this is not captured. Therefore the proof that nurse practitioners can successfully and safely perform many of the functions requested by the CNO is not transparent within the current system. We have attempted in this document to provide sufficient examples from a broad range of practices to demonstrate that nurse practitioners can and do meet the burden of providing safe care and will continue to do so with an expansion of their scope of practice.

Concluding Remarks

Implementation and integration of the nurse practitioner role should be informed by discussion and debate of issues in several dimensions. The fundamental question of what patients need, how they want their care delivered and what their expectations will be, remains unclear as new social trends collide with traditional health care delivery. Health care legislation and regulations needs to be structured to meet patients' needs so the system reflects both environmental and patient dimensions rather than trying to meet provider needs. Nurse practitioners have demonstrated through reports, research and experience, their ability to work within their scope of practice without medical oversight, to work collaboratively without this being imbedded in law and to manage evidence-based practice through continuing education, self- regulation and professional accountability.

We must effectively challenge the historical comparison of the nurse practitioner role to that of physicians and the alignment of the role as an augmentation or replacement for physicians during times of shortages. It will become increasingly clear in the new health care world that this misconception is based on a focus of tasks that nurse practitioners and physicians perform (e.g., prescribing treatment and diagnosing disease). This role overlap merely reflects overlap of some competencies necessary to deliver care, but the core education, in this case medicine versus nursing, indicates different approaches in care delivery will be used. Each approach uniquely reflects what the discipline brings to the interaction. Therefore, inherent in all discussions about the nurse practitioner role, it is assumed that it is imbedded in a nursing focus and background and in no way seeks to replace physician practice. The use of comparisons serves to create a competitive

approach that undermines the ability to create interactive teams in the new world that will deliver future health care.

In 2006, during the NPAO Accord project, nurse practitioners advanced that the new model that would help transform health care (i.e. the second curve of health care in the 21st century) focused on person-centred care that supports Ontarians to live intact meaningful lives using strong interprofessional collaboration as a key success factor in the delivery of health care services. Equipped with that perspective on health care in the future, nurse practitioners will continue their efforts to be leaders within a transformed health care system. Nurse practitioners have traditionally worked in areas of practice where care delivery is needed (i.e., under serviced and rural and remote areas) and it is reasonable to assume that they will continue to play a significant role within teams to identify and meet patients' needs. However, without the support of legislative change this role will continue to require justification to both nursing and medicine which limits the potential and diverts energy from the goal of improved patient care within the 21st century.

The College of Nurses' proposal to expand the scope of practice of nurse practitioners is consistent with changes that our health care system needs and is necessary to improve the utilization of nurse practitioners in Ontario. It is both appropriate and timely that HPRAC is reviewing these proposals as Ontario's health care system truly begins to shift to the second stage of Medicare to focus on effectively and efficiently meeting the needs of the people of Ontario.

As indicated earlier in this submission and as has been repeated throughout the stories that are shared in this document, NPAO strongly supports that HPRAC approve the proposals presented by the College of Nurses of Ontario. Put concisely, in words from the 35 members of the Huronia Nurse Practitioner Network:

> *Patients are caught in the legislative queue. It is time to seriously review the impact current legislative processes have on those most in need. Changes would offer more timely access to care for patients, improving quality of care and reducing duplication of services. The evidence demonstrates that nurse practitioners are able to provide care safely and effectively based on knowledge, skill and judgment.*

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