



**NURSE PRACTITIONERS'  
ASSOCIATION OF ONTARIO**

**Submission to  
Health Professions Regulatory Advisory Council**

**Non-Physician Prescribing**

**November 2008**

**Nurse Practitioners' Association of Ontario  
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**An Interest Group of the Registered Nurses' Association of Ontario**

## **INTRODUCTION**

The Nurse Practitioners' Association of Ontario (NPAO) is pleased to respond to the Health Professional Regulatory Advisory Committee's (HPRAC's) referral respecting non-physician prescribers. NPAO, an interest group of the Registered Nurses' Association of Ontario (RNAO), represents the professional interests of all nurse practitioners (NPs) in Ontario. Our mission is to achieve full integration of Nurse Practitioners to ensure accessible high quality health care for Ontarians.

As of November 1, 2008, there are 1106 NPs or Registered Nurses in the Extended Class including 964 Primary Health Care NPs, 42 Paediatric NPs, and 104 Adult NPs<sup>1</sup>. This fall, over 200 registered nurses wrote the primary health care, adult and paediatric examinations and results are expected by the beginning of the new year. When regulations for the new specialty certificates were approved in 2007, CNO estimated that 350 advanced practice nurses were eligible to write the NP examinations. It is estimated that another 100-150 advanced practice nurses are eligible but have not yet written the adult or paediatric examinations.

## **NPAO APPROACH TO NON-PHYSICIAN PRESCRIBER REFERRAL**

In 2007, NPAO responded to HPRAC's *Extended Class Referral* and provided extensive feedback including numerous examples supporting expanding access to controlled acts for nurse practitioners (NPs) (See Appendix A). In particular, the need to expand prescriptive authority of NPs using a broad open prescribing approach was emphasized. In December 2007, NPAO provided HPRAC with a supplementary submission which focused on ensuring Quality Assurance with expanded authorities (See Appendix B). HPRAC has requested that NPAO in its response to the *Non-Physician Prescriber* referral provide only new information and refer to its previous submission as required. HPRAC has assured NPAO that information already provided relevant to the new referral will be reviewed.

NPAO will endeavour to meet this request by cross-referencing responses to the two submissions made in 2007 and where appropriate may reiterate key points or examples. NPAO will not respond to every question posed by HPRAC. In some sections, information will be provided related to the general theme of questions. In addition, where questions are deemed to be more regulatory in nature, NPAO will defer to the College of Nurses of Ontario (CNO) submissions on the 2007 RN(EC) and their *Non-Physician Prescriber* response. If further clarification is required following review of CNO's current submission, NPAO will provide additional information at that time.

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<sup>1</sup> CNO Membership Total at a glance – NP Breakdown by Specialty retrieved November 9, 2008 from <http://www.cno.org/about/stats/totalcurrent.htm>. NOTE: Four NPs hold more than one certificate.

**PROFESSION INFORMATION** - Insert general contact information here (Questions # 1-8)

**1. Name of Organization**

Nurse Practitioners' Association of Ontario

**2. Address/website:**

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5. List other professions, organizations or individuals who could provide relevant information. Please provide contact names, addresses and contact numbers where possible.

College of Nurses of Ontario

Registered Nurses' Association of Ontario

Canadian Nurses Association

Canadian Association of Advanced Practice Nurses

**FOR PROFESSIONAL ASSOCIATIONS**

6. Names and positions of the senior directors and officers.

President - Tina Hurlock-Chorostecki RN(EC), NP-Adult, MSc(N), CNCC(C)

Past President - Pamela Pogue RN, BAAN, MSc(N)

President Elect - Paula Carere RN(EC), MEd

Secretary - Maureen Loft RN(EC), NP-Adult, MSc(N)

Executive Director - Jane Sanders BBA, MHSc

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

The Nurse Practitioners' Association of Ontario (NPAO) was founded in 1973 by a group of Nurse Practitioner (NP) graduates from the two newly established NP education programs in Ontario: McMaster University and the University of Toronto. NPAO was founded to represent nurse practitioners primarily functioning in primary care in Ontario.

In 1985, NPAO became an expert group of the Registered Nurses' Association of Ontario (RNAO). In 1998 NPAO changed its mandate to include NPs in all levels of health care: primary, secondary and tertiary care.

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

Refer to Question #5

## **CURRENT AUTHORIZED ACTS AND REGULATIONS**

9. Do current authorized acts and regulations reflect best practices for the prescribing or administration of drugs in the course of practice of members of your profession?

The current authorized acts and regulations do not reflect Nurse Practitioner (NP) best practices for prescribing of drugs or for administering drugs<sup>2</sup>. NPAO has consistently and repeatedly advocated for open prescribing and for the removal of unnecessary restrictions on NP practice since the role was first regulated in 1998. NPs, like physicians provide care to a wide variety of patient populations, and therefore require a broader approach to prescribing rather than limiting authority to lists of individual or categories of drugs in regulations.

NPAO does not view a 'one size fits all approach' for all non-physician prescribers as the appropriate course of action to meet the diverse prescribing requirements of NPs and their patients.

Although outside the scope of this specific referral, but in a closely related area, NPAO suggests that NPs under certain conditions be granted authority to perform the controlled acts of dispensing, selling, and compounding drugs<sup>3</sup>. NPs who work in rural areas and those who work with low-income families and communities where access to pharmacists or affordable drugs are issues often provide examples of how access to these controlled acts in certain circumstances would enhance patient access and improve overall care and health outcomes (NPAO, 2007, pp. 11-12).

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<sup>2</sup> Removal of restrictions on the controlled act of administering drugs for injection and inhalation, i.e., limiting to only drugs NPs may prescribe becomes an ancillary change should open prescribing be permitted.

<sup>3</sup> NPAO recognizes as noted in its 2007 submission, that other legislation at the provincial (Drug and Pharmacies Regulation Act) and federal levels (e.g. Food and Drugs Act) would require amendment to enable enactment of these controlled acts.

The *Health Systems Improvement Act* (2007) amended the *Nurses Act* (1991) to broaden NP prescriptive authority by permitting NPs to prescribe drugs from categories or classes of drugs listed in regulation rather than limiting prescriptive authority to lists of drugs.<sup>4</sup> This amendment was intended to broaden NP prescriptive authority to address the breadth and depth of NP practice, particularly with the regulation of the three new NP specialty certificates (Adult, Paediatric, and Anaesthesia) alongside primary health care NPs. In addition, the categories of drugs approach was intended to minimize the need for regulatory change and be more responsive to changes in best practice resulting from advances in science and technology and the emergence of new and more effective drugs on the market.

While authority to prescribe from categories of drugs may improve patient access and be more responsive than the list-based approach, NPAO does not believe it is the best approach to enable NP prescribing and reflect current best practices. It is unlikely that the drug categories will be broad enough to address the depth and breadth of nurse practitioner practice. Additionally, NPAO is concerned that significant limitations may be imposed on practice through the use of “exceptions” from the drug categories listed in regulation. This concern is amplified by recent drug category regulations drafted by another group of non-physician prescribers. Chiropractors drafted a regulation that identifies categories of drugs and in some case lists specific drugs under each category with specific conditions and limitations (CNO, 2008a, p. 4). While this approach may be appropriate for chiropractors whose scope of practice is limited to “diseases, disorders, and dysfunctions of the foot<sup>5</sup>”, NPAO is concerned that, if accepted by government, this may set a precedent of placing limitations for non-physician prescribers in regulations. NPAO asserts that a ‘one size fits all approach’ does not acknowledge the depth, breadth and diversity of NP scope of practice nor does it address the long-standing and significant prescriptive barriers that have impacted NP practice since their initial regulation in 1998.

As discussed in NPAO’s response to HPRAC’s *Extended Class Nursing* referral (November 2007), experience has demonstrated that regulations are extremely difficult to change and that the process is cumbersome, costly and at times politically charged. Lists are also neither patient-centred nor evidence-based. As new scientific evidence emerges respecting best prescribing practices and with greater usage of information technology (e.g. electronic order sets, online best practice guidelines, ISMP tools and resources, etc.) keeping categories up to date for each of the four specialty certificates and the multiple subspecialties subsumed under these certificates will be difficult and likely impractical, if not impossible to achieve. In fact, it is likely that requests for regulation change would become an even more common occurrence if drug categories and exceptions are placed in regulation. Consequently, nurse practitioners will likely face the same delays in implementing best evidence into practice and perhaps more than what they currently face today with the drug list.

Since the NP role was regulated ten years, there has only been one brief period, a few months in 2007, when no drug list regulations were pending government approval. Today, however, NPs are once again waiting for a revised drug list to be approved (submitted over a year ago). This process takes on average a minimum of two years to complete from the initial request for submissions by CNO to the publication of the regulatory change.

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<sup>4</sup> Excerpt from Ontario *Nurses Act* (1991): Individual drugs or categories under section 14. (1.1) A regulation made under clause (1) (d) may designate individual drugs or categories of drugs. 2007, c. 10, Sched. B, s. 14 (4).

<sup>5</sup> Excerpt from ON Chiropractic Act (1991), Scope of Practice, Section 4 retrieved November 1, 2008 from [http://www.e-laws.gov.on.ca/html/statutes/english/elaws\\_statutes\\_91c20\\_e.htm](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91c20_e.htm)

The current approved drug list regulation was created for primary health care nurse practitioners and thus does not necessarily reflect the practice requirements of the recently registered NPs in the adult and paediatric specialties. As outlined by both NPAO and CNO in the 2007 submissions, the need for changes to other regulations such as Regulations 965 and 552 under the *Public Hospitals Act* (PHA) (1990) and the *Health Insurance Act* (HIA) (1990), respectively are imperative to permit prescribing by NPs for inpatients.

## PROPOSED CHANGES TO AUTHORIZED ACTS AND REGULATIONS

10. Please describe in detail any proposed changes to current authorized acts and regulations that would reflect best practices for:

- a) prescribing of drugs by members of your profession, or
- b) administration of drugs by members of your profession.

### ***Prescribing of Drugs***

NPAO is requesting that restrictions be removed from the list of controlled acts in Subsection 5.1 (1) paragraphs 3 and 4 of the *Nursing Act* (1991) pertaining to prescribing and administering drugs. In regard to prescribing, to reflect best practices for the profession, paragraph 3 should refer to the controlled act of prescribing a drug only and not be restricted to drugs or categories of drugs listed in regulation. References to regulation making authority in Section 14 of the Act may also be deleted as the need for this authority would not be required if open prescribing is granted. Further, other legislation which impedes NP prescribing would need to be changed to fully enable prescribing practices (e.g. PHA Regulation 965). These recommended changes are fully described in CNO's Extended Class Referral (2007) submission.

NPAO acknowledged in its previous submission that limitations may be imposed on NP prescribing and agrees with CNO "*that any conditions necessary to protect the public be placed in the RN(EC) Practice Standard rather than in legislation*" (CNO, 2007, p. 13). Limits and conditions, if used appropriately, would acknowledge scope differences among the four NP specialty certificate holders as well as the impact that other legislation has on restricting prescribing authority (e.g. narcotic control regulations<sup>6</sup>). It is imperative that limits and conditions be placed in standards rather than legislation so that changes in best practice or other legislation can be incorporated into practice standards in a timely fashion rather than waiting for a regulation change.

In broadening prescriptive authority NPAO also recommends that authority also include prescribing blood and blood products and oxygen. NPs prescribe both oxygen and blood, but do so under delegation and medical directives authorized by physicians. It is unclear at this time where these items fit in the controlled acts model, i.e., are they classified as a drug or substance? Therapeutic oxygen has been classified as a drug that midwives may order and administer under the Midwifery Act (1991) Designated Drugs Regulation.<sup>7</sup> Despite this classification, efforts to provide NPs with the authority to prescribe oxygen under the NP drug regulations have been unsuccessful. NPAO has raised this issue with government since early

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<sup>6</sup> The Narcotic Control Regulations under the Controlled Drugs and Substances Act (1996) fall under federal government authority. Work has been underway since 2004 to amend these regulations to provide for non-physician prescriber authority including NPs. Once amendments are made to these Regulations, provincial regulations, i.e., drug lists or categories of drugs regulations would need to be amended to grant Ontario NPs the authority to prescribe narcotics.

<sup>7</sup> ON Midwifery Act (1991) Designated Drug Regulation retrieved November 11, 2008 from [http://www.e-laws.gov.on.ca/html/regs/english/elaws\\_regs\\_930884\\_e.htm](http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_930884_e.htm)

2002<sup>8</sup>. With respect to prescribing blood and blood products NPAO appreciates both federal and provincial policy or regulations may need to be changed to grant authority, however NPs in other jurisdictions in Canada such as Alberta already have the authority to prescribe blood / products (CARNA, 2004). In Nova Scotia, proposed regulations will provide NPs with the authority to prescribe blood and blood products (CNO, 2008a, p. 17).

### **Administration of Drugs**

In terms of changes to the controlled act of administration of a substance by injection or inhalation under paragraph 4 of the *Nursing Act* (1991), NPAO recommends this paragraph be deleted. This paragraph becomes redundant if full prescribing privileges are granted. In other words, no restrictions in regulations should be placed on NP authority to administer drugs or substances by any route if authority for open prescribing is granted. This issue was described by NPAO in its previous referral respecting the administration of vaccines (2007, p. 9). As stated, NPs are provided the authority to prescribe numerous vaccines. However, if a vaccine is not on the list even though the NP has the competence to prescribe it (e.g. rabies vaccine or varicella immune globulin for HPV) a physician must authorize it before the NP is permitted to administer it.

11. Why are these changes necessary? What regulatory or clinical practice purposes would be served by such changes? How would they advance patient care and patient safety?

Refer to NPAO (2007) and CNO (2007) Extended Class Referral HPRAC.

12. Are the proposed changes considered part of current routine practice of the profession, and authorized to members by medical directives, orders or delegation? Please describe. If authorized by medical directives, orders or delegation, is this approach inadequate or insufficient? Please explain.

Yes, the proposed changes are considered part of current routine practice of NPs. This is because NPs practice in a vast array of settings and serve diverse populations, often with multiple co-morbidities. Authority to prescribe drugs is enabled in two ways; through the individual drug list or categories as found in Regulation 275 of the *Nursing Act* (1991) and through the use of delegation and medical directives.

For NPs who practice exclusively with inpatients in public hospitals, medical directives are the tool used to enable prescribing because of restrictions placed on practice by the Hospital Management Regulation (PHA, Reg 965). In other words NPs are authorized to enact their controlled acts for out-patient populations only. Therefore, NPs who are RN(EC)s, despite having the legal authority under the *Nurses Act* to perform controlled acts are prevented from implementing those acts with inpatients and thus must rely on medical directives to authorize their performance in public hospitals. Although it is the Adult and Paediatric specialty certificate holders who are most impacted by this limitation, it is noteworthy that an increasing number of primary health care NPs are practicing in hospitals caring for inpatients and their scope of practice is also limited because of this legislative limitation. For advanced practice nurses who have not yet become members of the RN(EC), both delegation and medical directives are required to enable practice regardless of practice setting.

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<sup>8</sup> NPAO letter to Chief Nursing Officer, Nursing Secretariat, Ministry of Health and Long-Term Care, February 2002.

As discussed in detail in NPAO's 2007 *Extended Class Referral* submission and as was heard time and time again at the public consultations on the referral, the over-reliance on medical directives to authorize practice is inadequate and insufficient. Although, medical directives and delegation are mechanisms utilized by many professions to address legislative and regulatory limitations, they unduly limit the practice of the profession and interfere with the integration of timely evidence-based best practices. In addition, medical directives undermine NP practice authority as well as interprofessional collaboration by establishing and perpetuating an environment of mistrust in relation to scope of practice. In effect, the current process contradicts the true essence of interprofessional practice and does not recognize current competencies or acknowledge that scope of practice and roles evolve. The World Health Professions Alliance<sup>9</sup> states "roles and job descriptions should be described on the basis of the competencies required for service delivery and constitute part of a coherent, competency-based career framework that encourages progression through lifelong learning and recognition of existing and changing competence" (2008).

The following is an excerpt from NPAO's previous submission which explains the medical directives process and outlines NPAO's key concerns:

*"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. 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"* (NPAO, 2007, p. 13).

Further, when physicians change, NPs can be left without the authorization to practice. 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 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

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<sup>9</sup> The World Health Professions Alliance is a consortium of international organizations representing practitioners including the International Council of Nurses and the World Medical Association.

or community. As a result, the nurse practitioner is left in a difficult situation without valid current medical directives. Patients can become confused and frustrated when informed that the NP can no longer provide services they are accustomed to receiving from the NP. This undermines NP practice, duplicates care, and sometimes leaves the patient without care when a physician is not available to write the prescription.

13. Would the proposed changes result in an enhanced or changed scope of practice for the profession?

Yes the proposed changes to controlled acts would enhance the scope of practice of NPs by removing restrictions on their current practice authority. Complementary changes to auxiliary legislation impacting NP practice are also essential to provide NPs with the authority to practice unfettered in most practice settings.

If simultaneous changes are made to the PHA Regulation 965 and HIA Regulation 552, the necessity for delegation and medical directives would be virtually eliminated for NPs. Thereby freeing up valuable time for both NPs and physicians to spend in the clinical setting with patients rather than wasting valuable clinician time on administrative work.

14. Please describe in detail any changes or additions that would be required to the controlled acts that are now authorized to the profession and what, if any, limitations or conditions should be attached to the authorized act.

The College of Nurses of Ontario, as the regulatory body for NPs, is the most appropriate organization to determine what if any limitations be attached to authorized acts. In developing changes, it is anticipated that CNO would continue to use a consultative process with key stakeholders such as NPAO and practising NPs to determine appropriate limitations.

As noted in Questions #9 and #10, and in NPAO's earlier submission to HPRAC, NPAO is concerned that categories of drugs may not be broad enough to address the "significant diversity of nurse practitioner" and that significant limitations may be placed on practice through regulation (2007, p. 9). NPAO understands that conditions and limitations may be necessary, but cautions against using approaches that unduly restrict practice such as the one proposed by the College for Chiropractors where limitations are placed in regulation (CNO 2008a).

Instead NPAO suggests that if limitations are used Ontario should look to other provinces in Canada who have successfully enabled safe, evidence-based, broad prescriptive authority for NPs. For example, in BC the American Hospital Formulary Service (AHFS) is the framework used for NP prescribing. This framework provides for placing restrictions on prescribing classes, subclasses, or specific drugs as necessary. In BC limits and conditions for NP prescribing are listed for each specialty in NP standards and not in regulation. Newfoundland and Labrador has also proposed using this framework for their NPs (CNO, 2008a).

15. (a) Has the profession submitted a request to the Ministry of Health and Long-Term Care for changes or additions to the list of drugs that are included in the regulation under the profession-specific act? If yes, please attach copies of the submissions, and indicate when the request was made.

To date a drug category list regulation has not been submitted by CNO to the Ministry of Health and Long-Term Care under the new category. CNO is currently consulting with members, professional associations and other regulatory bodies in regard to implementation of the drug category process for prescribing lists.

It is noteworthy that the “Report of the NP Integration Task Team,” submitted to the Ministry of Health and Long-Term Care in March 2007, recommends that regulated health professionals are accountable to practice within their individual scope and area of competence. The Task Team recommended that legislation be drafted to provide members of the Extended Class the authority to:

- i) order diagnostic or laboratory tests available in Ontario; and
- ii) prescribe drugs approved in Ontario.

While government has not responded to this report, this recommendation may be interpreted as a step toward supporting broadening prescriptive authority for NPs.

15. (b) Are there additions or changes, since the submission was made, that HPRAC should now consider? Please describe in detail.

15. (c) If a formal submission has not been made at this time, what are the exact changes you now propose to current legislation and regulations?

For 15. (b) and (c) refer to CNO’s Non-Physician Prescriber response.

## **RISK OF HARM**

16. What additional risk of harm to the patient or client might result from the proposed changes? How would your profession manage this risk?

It might be argued that the elimination of individual drugs or categories of drugs from NP regulations and implementing open prescribing may lead to unsafe care by some practitioners. As self-regulating professionals NPs are well aware of their professional responsibility to ensure they provide safe, competent, and ethical care to their patients by adhering to practice standards and guidelines as set by CNO and their relevant specialty and subspecialty area (e.g. Canadian Cardiovascular Society, Canadian Paediatric Society Canadian Anesthesiologists’ Society, Canadian Respiratory Health Professionals, Canadian Society of Endocrinology and Metabolism, and Canadian Orthopaedic Association). If granted broad prescriptive authority, NPs will continue to adhere to practice standards and guidelines, etc., and to exercise that authority within their own level of competence, thereby reducing overall risk of harm. As identified by CNO *“it is not the regulated list of drugs or tests that ensures appropriate prescribing, ordering and monitoring by the RN(EC). Rather, it is the RN(EC)’s competencies in: health assessment and diagnosis; health-care management and therapeutic intervention; health promotion and prevention of illness, injury and complications; and professional role and responsibility that promote safe practice”* (CNO, 2007, p. 29)

Regulatory expectations for performing controlled acts in Ontario are generally consistent for all regulated health professionals regardless of the controlled acts the profession may access. For example, physicians have no restrictions on the controlled act of prescribing under the *Medicine Act* (1991), yet physicians are expected to only prescribe drugs in situations where they possess the requisite knowledge, skill and judgment to competently and safely prescribe and to consult and refer patients as necessary. This expectation would be no different for NPs should they be granted broad authority. NPAO acknowledges that limitations may be used to reduce

risk of harm and that, if used, they be placed in standards and not in regulation. This is essential to ensure timely updates consistent with changes in best practice evidence and the use of information technology (See also question # 29).

Risk of harm is further minimized because NPs are recognized as interprofessional collaborative practice leaders demonstrated by numerous reports (CNPI 2006). NPs *“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”* (NPAO, 2007, p. 17). The NP Practice Standards also set out expectations for collaboration and consultation with physicians and other health care professionals (CNO, 2008b, pp. 10-11).

In addition to compliance with practice standards and guidelines, another means to reduce the risk of harm is adherence with CNO’s Quality Assurance (QA) programme<sup>10</sup>. NPs are currently required under ON Nursing Regulation 275/94 (1991) to engage in a mandatory practice review to assess their knowledge, skills and judgment to ensure competence to practice as an NP in Ontario. Currently this programme requires NPs to engage in a College-led peer review process *“at the end of his or her first three years or first 1800 hours of practice as a registered nurse in the extended class, whichever occurs first.”*<sup>11</sup>

CNO’s programme is undergoing revision, and new regulations have been proposed to monitor member participation or compliance with the QA programme (CNO, 2008c). Changes for NPs will include a cyclical practice review and assessment of knowledge in relation to the NP Practice Standard which includes standards for prescribing and administering drugs<sup>12</sup>. Risk of harm will be reduced by requiring NPs to demonstrate competence in prescribing to ensure the practice standard is being met.

Another way to reduce risk of harm should broad prescriptive authority be granted to NPs is through greater integration of information technology into NP practice, such as accessing online resources and electronic patient medication ordering systems. For example, NPs currently utilize reliable and trusted web-based resources to modify best practices respecting prescribing by rapidly acquiring up-to-date information. The Institute for Safe Medication Practices or ISMP hosts one such website that provides numerous tools and resources to assist practitioners at the individual patient level through to the system level to ensure safe prescribing and medication practices<sup>13</sup>. Examples include *Improving Medication Safety with Anticoagulant Therapy*<sup>14</sup> and *Guidelines for Preventing Medication Errors in Pediatrics*.<sup>15</sup> NPs are aware of medication safety concerns broadly and specifically in relation to their specialty areas of practice as referenced in these documents. With this knowledge, NPs are well-positioned to champion best practices and integrate changes into practice as members of inter-professional collaborative practice teams and at the system level.

Similarly, safe broad prescriptive authority is further enhanced by the use of electronic “order sets”.<sup>16</sup> Order sets also reduce risk of harm and positively impact patient safety as they provide “intentionally designed system checks and balances to support inter-professional teams of

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<sup>10</sup> Quality Assurance Extended Class Practice Review requirements at [http://www.cno.org/for/rnec/pdf/PracticeReview\\_%20Jan2005.pdf](http://www.cno.org/for/rnec/pdf/PracticeReview_%20Jan2005.pdf)

<sup>11</sup> Ontario Regulation 275/94, Section 27 (1)

<sup>12</sup> NP Standard (2008) #4 - Prescribing a drug, or category of drugs, designated in the regulations and Standard #5 - Administering a substance by injection or inhalation

<sup>13</sup> ISMP Tool and Resources retrieved from <http://www.ismp.org/Tools/default.asp>

<sup>14</sup> <http://www.ismp.org/Tools/anticoagulantTherapy.asp>

<sup>15</sup> <http://www.ismp.org/Newsletters/acutecare/articles/20020601.asp>

<sup>16</sup> See NPAO 2007 submission for overview on page

health practitioners ordering drugs and diagnostic tests”. These electronic “order sets” are already being used in a number of facilities in Ontario. However, to ensure that NPs can fully engage in the inter-professional team broader prescriptive authority is essential so that NPs too are able to integrate best evidence into practice as it becomes available.

Finally, it should also be considered that without broadening NP prescriptive authority there is potential for a greater risk of harm to befall patients because access to timely care and treatment may be delayed with a subsequent negative outcome on health. This also has implications on scarce health care resources. Time and time again, NPs have provided examples illustrating where the drug list in regulation approach has hampered care and placed strain on precious health care resources (NPAO, 2007a).

## **EDUCATION AND CONTINUING COMPETENCY**

17. How does your profession require demonstration of competencies for pharmacotherapy?

NPs in Ontario must successfully complete a comprehensive pharmacotherapy course coupled with advanced pathophysiology course as part of their entry-to-practice educational programme. NP educational programmes incorporate the *Canadian Nurse Practitioner Core Competency Framework (2005)*<sup>17</sup> which outlines competencies which are core to the practice of all NPs in Canada. The Health Care Management and Therapeutic Intervention competency indicators specific to the practice of NP prescribing include:

- *determines treatments and prescribes them based on theory and evidence-based practice for the specific client population, while considering active participation of clients, best outcomes and cost-effectiveness; and*
- *applies knowledge of pharmacology in selecting, prescribing, monitoring and dispensing drugs and performs these competencies as appropriate for the NP's scope of practice, level of competency and clinical practice setting by selecting drug therapy based on knowledge of pharmacology, including pharmacokinetics, pharmacodynamics and evidence-based practice, as well as drug interactions and client health history, disease, disorder or condition, and consulting, collaborating with and/or referring to physicians and pharmacists when appropriate.*

To become a member of the extended class the NP must meet competency requirements pertaining to the controlled act of prescribing. This is achieved in part by meeting NP entry-to-practice educational programme requirements and by passing the respective national specialty registration examination as approved by CNO Council.

Like any self-regulating professional new to practice, the recently-graduated NP is expected to prescribe within the limits of their knowledge and experience. There was a desire expressed by novice NPs to increase the number of independent clinical practice hours during their educational programme to facilitate integration of knowledge into practice (IBM study). The Council of Ontario University Programs in Nursing (COUPN) increased the number of clinical practice hours to enhance advanced clinical decision-making and problem solving techniques. Additionally, projects that examined the role of mentorship in enhancing NP clinical knowledge, such as Supporting Interdisciplinary Practice (a PHC Transition Fund project) and Cancer Care Ontario's palliative care mentorship funded through the ICEF, MOHLTC, suggest the use of e-

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<sup>17</sup> Core competency document located at: [http://206.191.29.104/documents/pdf/CNPE\\_Core\\_Competency\\_Framework\\_e.pdf](http://206.191.29.104/documents/pdf/CNPE_Core_Competency_Framework_e.pdf)

mentorship as a viable and effective model for transition of new NPs into independent practice (NPAO, Supplemental Submission, December 2007 – Appendix B).]

For all practitioners as they advance from novice to expert, it is important to ensure ongoing competent practice and support the safe performance of the expanded scope of practice by engaging in 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 foundational nursing and advanced practice education, experience in a nursing role, and commitment to ongoing learning” (NPAO, 2007, pp. 6-7).*

18. Please provide pharmacotherapy course content in the current educational curriculum and demonstrate how it ensures the minimum qualifications for the prescribing or administration of drugs by members of your profession.

Refer to CNO's Non-Physician Prescriber submission.

19. Does the health professional college require continuing education and training for members to ensure competency in the prescribing or administration of drugs? Please be specific and provide documentation to the extent possible. Please describe how the college ensures its members keep pace with advancements in pharmacotherapy, pharmacology and patient safety.

Yes the College of Nurses of Ontario requires NPs to engage in life long learning to ensure competent practice as outlined in NP Practice standards and guidelines. In addition, to meet the requirements of the College's QA programme it is essential for NPs to engage in continuing education and training to ensure ongoing competency in prescribing (See Questions #16 for more detail of QA requirements).

As discussed in Question #17, numerous methods are used by NPs to maintain currency. For example, NPs in the clinical practice setting engage in ongoing learning by participating in educational sessions sponsored by pharmaceutical companies, and by engaging with pharmaceutical company representatives to gather relevant information,. It is interesting to note, that some pharmaceutical companies now have dedicated representatives engaging solely with NPs. NPs also collaborate with physicians by participating in rounds and ongoing educational opportunities such as those sponsored by schools of medicine.

NPAO has also taken on an active role of facilitating ongoing learning by providing links to relevant and credible resources on the NPAO website (e.g., specialty practice and physician websites such as Ontario MD, MD Brief, McMaster's Small Group Problem Based Learning program). NPAO is also sought out by educational bodies and stakeholder groups to circulate and post information on CHE events (CCO and OCFP Education Sessions on Colorectal

Cancer and Screening) and has sponsored continuing education conferences such as the recent Tri-Professional Conference.

20. Please indicate what college documents are available to members on the prescribing or administration of drugs, including relevant standards of practice, rules and guidelines. Are these documents current? Please include the documents with the submission.

NPAO members follow the relevant standards, rules and guidelines as set by the College of Nurses of Ontario. These standards and documents are constantly being updated by CNO to ensure currency for safe practice and are available electronically on NP dedicated web pages on CNO's website<sup>18</sup>. In addition to QA requirements (See Question #16), other CNO resources direct and guide NP practice particularly in relation to prescriptive authority<sup>19</sup>. For example as noted previously, the *Practice Standard: Nurse Practitioner (2008)* includes specific expectations that pertain to prescribing.

As a registered nurse, and as a medication prescriber, an NP is also expected to follow other relevant standards and guidelines such as the new medication standard published this year. This standard outlines expectations for safe medication administration practices and includes a new section developed in consultation with the ISMP to enhance patient safety respecting "safe medication practices, medication reconciliation and adverse drug reactions" (CNO 2008d, p. 14).

21. Please describe current competencies, education and training of members of the profession to perform any of the proposed changes.

See Questions #17 and #19.

22. Do all members of the profession have the competencies to perform any proposed activity related to the prescribing and/or administration of drugs?

See Question #17

23. What effect would the proposed change in the prescribing or administration of drugs have on members of your profession who are already in practice?

a) What additional competencies, education and training would be required for all (or some additional) members of the profession to perform any proposed activity?

See Questions #17 and #19

b) How will the members become current with the changes, and how will their competency be assessed? and c) What quality improvement or quality measurement programs do you have in place and what additional programs would be put into place?

See Question # 16 for QA discussion.

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<sup>18</sup> Comprehensive College NP practice resources located at [http://www.cno.org/for/rnec/np\\_pracRes.html](http://www.cno.org/for/rnec/np_pracRes.html)

<sup>19</sup> NP Practice Standard at [http://www.cno.org/docs/prac/41038\\_StrdRnec.pdf](http://www.cno.org/docs/prac/41038_StrdRnec.pdf)

d) What educational bridging programs will be necessary for current members?

See Question #17

### **PUBLIC INTEREST (Questions 24 – 26)**

In 2007, CNO provided a comprehensive response respecting the positive impact that expanding NP scope of practice, including expanded prescribing authority, would have on the public (CNO, 2007, pp. 19 – 34). NPAO strongly supports this overview and maintains that it well represents its views and the views of its members.

### **PRESCRIBING: DRUG REGULATIONS UNDER PROFESSIONAL ACTS (Questions 27 – 31)**

27. Please describe challenges faced by members of the profession as a result of listing specific drugs in regulation schedules made under the profession-specific act.

NPs have experienced numerous challenges in relation to the listing of drugs in regulation, including experiencing long delays – normally years – before lists are updated, if ever, and the inability to prescribe new best practice drugs because they are not on the list. Lists may also contain drugs which have become obsolete or contraindicated for certain conditions, leaving the NP with no drug to prescribe in certain cases. NPAO does not agree that the shift to categories in regulation will fully address these issues as it is unlikely that drug categories will be broad enough to address the depth and breadth of nurse practitioner practice and, with possible “exceptions” in regulation, will require frequent regulatory change to keep pace with practice of the four specialty NP certificates (See Question # 9).

As a result of these long delays in regulation change and the impact of other legislative frameworks on limiting NP practice (PHA Reg 965, HIA Reg 552), medical directives have been used as a means to grant necessary authority. While medical directives are intended to provide a vehicle to enable practice in the absence of regulation change, they are becoming more and more difficult to approve and in general there appears to be an over-reliance on them (See Question #12). This is despite the efforts of the Federation of Health Regulatory Colleges of Ontario to enable the more effective utilization of medical directives (See NPAO, 2007a, p. 14). Medical directives do not support timely integration of evidence-based practice, take a significant amount of time to develop, diminish NP accountability for patient care, undermines the authority of the NP, and do not always ensure quality care and patient safety. Numerous examples were provided to HPRAC by NPAO in its 2007 submission demonstrating these issues (pp. 13-15). Today, NPAO continues to be informed by its members of the constant day-to-day struggle they endure in getting medical directives approved and which sometimes border on abusive situations. It is a frustrating and demeaning experience for NPs who have been deemed by the College as competent to prescribe.

29. If classes of drugs, rather than a list of specific drugs were included in the regulation, what conditions should be attached, if any, to the classes? Should the broad purpose, indications, or some other reference be specified (e.g. for pain relief in labour; for smoking cessation; for treatment of sexually transmitted diseases; in emergency; refill). Please comment in detail.

In 2007 an amendment was made to the *Nursing Act* (1991) to provide for NPs to prescribe from classes of drugs included in regulation. As part of consultations with CNO, NPAO has asserted that if classes are used they should not be tied to specific indications for use as indications are multiple and change over time. This would be confusing for both NPs and other team members. NPs need flexibility to enable prescribing based on evidence for variable indications and patient populations being served.

As noted in NPAO's 2007 response and as part of this response to Questions # 9 and # 27, NPAO asserts that categories of drugs in regulation is not the best approach to enable broader NP prescribing. It is unlikely that the drug categories will be broad enough to address the depth and breadth of nurse practitioner specialty practice. Also, past experience shows that requiring a regulation change to keep pace with rapid changes in best practice is ineffective and inefficient. Additionally, NPAO is concerned that significant limitations may be imposed on practice through the use of "exceptions" from the drug categories listed in regulation thereby reducing the NP ability to provide the care that their patients require.

NP diversity in practice, along with managing patients with multiple co-morbidities makes the use of limitations in regulation an unworkable option. For example, unlike midwives, NPs would potentially prescribe pain medication for a wide-range of health problems. Limiting to a broad purpose or specific reference in regulation would unduly hamper scope by potentially preventing NPs from prescribing drugs relevant to the practitioner's area of specialty and needs of their patients.

This issue is illustrated by the following example:

*For example the drug sildenafil (Viagra) is commonly prescribed for erectile dysfunction. In critical care and acute care respirology this drug is commonly used in patients with pulmonary hypertension to reduce the hypertension and reduce cardiac/respiratory effects and enable weaning people from mechanical ventilation. As a fact, pulmonary hypertension was the original research for the drug, the effect on erectile dysfunction was a serendipitous finding from that research. Tina Hurlock-Chorostecki, RN(EC), NP Adult*

Similarly, issues may arise with respect to prescribing combinations of drugs. For example, with lists the NP can prescribe one or both of the drugs, but if the drugs are combined then the NP is not authorized to prescribe. It is unclear how this situation would be resolved with the use of categories of drugs with related restrictions.

30. If classes of drugs, rather than a list of specific drugs were included in the regulation, how would you classify the drugs for your profession? Are there circumstances where a drug class would not be appropriate in a regulation schedule for the profession? Are there situations where a combination of class and list of specific drugs would better respond to the competencies of the profession?

See Question #9 and 29 and NPAO (2007a)

31. If applicable, please describe in general your profession's experience with requests for changes to drug regulations, including specifics of the requests made, regulation changes that followed, if possible the time required for changes to regulations, and what, if any, proposed changes were, or were not, approved by government.

As discussed in Question #9, and as outlined in its 2007 submission NPAO's experience with the regulation change process has overall not been a positive one. It is a cumbersome process that is time consuming (at a minimum a two year process) and costly<sup>20</sup> and often subject to the scrutiny of multiple stakeholders who may not fully understand the scope of practice of NPs. The list when finally approved sometimes results in approved drugs which are out of date making the approved drugs neither patient-centred nor evidence-based based on current practice.

Refer to CNO (2007) submission page 29-30 for examples of specific regulatory requests.

32. Do members of your profession practice in a collaborative or team environment where a change in drug regulations or legislation would contribute to multidisciplinary health care delivery? How would relations between professionals working in a team be impacted? What additional standards would be required (e.g., record-keeping, referral protocols)? Please describe any consultation process, agreements or other arrangements that have occurred with other professions.

One of the core components of NPs practice is collaboration. NPs collaborate with all members of the health care team and adhere to practice standards respecting collaboration and consultation. Intra-professional and inter-professional collaborative practice is essential to "maximize the use of clinician knowledge and skills as well as available human health resources" (NPAO, 2007, p. 17). NPAO believes that recent changes to RHPA College Objects resulting from the HSIA (2007) amendments is a positive step forward to improving intra- and inter-professional collaboration among health professionals.

In terms of defining inter-professional practice, one NP aptly summarized the meaning of collaboration for NPs within health care teams and which is worth repeating:

*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) (NPAO, 2007, pp. 11-12).*

NPAO maintains that a change in drug regulations, that is, moving to open prescribing for NPs would have a positive impact on multidisciplinary team health care delivery and ultimately patient care. For example, by removing the limitation on prescriptive authority, NPs would be able to use clinical skills and knowledge to their fullest and prescribe appropriate medications for their patients. This helps to minimize unnecessary utilization of physician consultation time, and duplication in care, and improves timely access to best-evidence-based care for patients. Further a change of this nature validates the value or contribution NPs make to the team in being able to provide timely care to patients in conjunction with other team members, particularly when delays in treatment can have a profound negative effect on patient outcomes. The change would lead to role clarity and help promote trust and understanding of among team members.

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<sup>20</sup> For several years, NPAO contracted the Drug Information and Research Centre, at significant cost, to provide detailed drug submissions to CNO.

Additionally, the need for medical directives would be significantly reduced should regulatory changes also be made to allow autonomous practice with in-patients. NPAO asserts that medical directives create barriers to true interprofessional practice (See Questions #13 and #27). From a system perspective, expanding access to the controlled act of prescribing would have a positive effect on in-patient hospital services and improve efficiencies within the system, for example by eliminating administrative time required to prepare and approve medical directives. Additional standards and record keeping requirements would not be necessary nor would time need to be spent on agreements or arrangements among professionals. It would be prudent, however, to provide standardized education among teams respecting NP prescribing standards to facilitate understanding of roles and team accountabilities and responsibilities.

### **OTHER JURISDICTIONS**

33. Describe any obligations or agreements on trade and mobility that may be affected by the proposed changes for the profession. What are your plans to address any trade/mobility issues?

Refer to CNO (2007) submission Question #30 (pp 53-54).

34. What is the experience in other Canadian jurisdictions? What is the experience in international jurisdictions?

Refer to CNO (2007) submission Questions #32 and #33 (pp. 55-57), RNAO response to Extended Practice Referral (2007), and HPRAC jurisdictional review (2007).

### **COSTS AND BENEFITS**

35. What are the potential costs and benefits to the public and the profession of the proposed changes? Please consider and describe the economic impact, costs and benefits to:

- a) patients,
- b) broader health care service delivery system,
- c) educational sector,
- d) regulatory sector, and
- e) the profession.

Refer to CNO (2007) submission for description of costs and benefits (pp. 57-60)

### **ADDITIONAL INFORMATION**

36. Is there any other relevant information that HPRAC should consider when reviewing your submission?

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## Appendix A

### Critical Legislative and Regulatory Steps to Improve Access to Care for Patients 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<sup>21</sup> 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).

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<sup>21</sup> 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 21<sup>st</sup> 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)<sup>22</sup>. 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.

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<sup>22</sup> <http://www.hprac.org/en/projects/resources/hprac-nursing.jurisdictionalreview.november2007.final.pdf>

## **Expanding Nurse Practitioner Scope of Practice: Controlled Acts and New Authorities<sup>23</sup>**

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

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<sup>23</sup> 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).*

*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<sup>24</sup> and the Supporting Interdisciplinary Practice project<sup>25</sup>.

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 patient's 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, RAO and the Canadian Nurses Association to effect that change.

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<sup>24</sup> 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)

<sup>25</sup> RAO, 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.<sup>26</sup> 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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<sup>26</sup> <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.<sup>27</sup>
- 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

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<sup>27</sup> <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<sup>28</sup> 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

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<sup>28</sup> 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<sup>29</sup> 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

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<sup>29</sup> 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 21<sup>st</sup> 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 21<sup>st</sup> 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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## Appendix B

### Supplemental Submission From NPAO - Requested by Charles Beer following roundtable meetings. Key Points from Discussion re Outstanding HPRAC Issues

#### Key messages from nursing in regard to the need for these changes

- Improving access to care for patients
- Provide quality patient care
- Patient safety is of paramount importance
- Mobility of NP service across sectors and settings is necessary
- College of Nurses is the appropriate body to set and monitor the standards of practice; currently hospitals and sometimes unions are setting standards; remove requirements for oversight by other professions as this should be at the discretion of CNO consistent with their mandate to protect public safety
- Contributions of NPs are often buried/invisible

#### Short forms:

NONPF – National Organization of NP Faculties (US based)

CNO – College of Nurses of Ontario

OCGS – Ontario Council on Graduate Studies

MOHLTC – Ministry of Health and Long-term Care

COUPN – Council of Ontario University Programs in Nursing

HPRAC – Health Professions Regulatory Advisory Council

SIP – Supporting Interdisciplinary Practice (a PHC Transition Fund project)

CCO – Cancer Care Ontario

Issue - HPRAC Question	Discussion	Proposal
<b>Education</b> programs not currently accredited.	<ul style="list-style-type: none"> <li>• Task team report (still not released by MOHLTC) apparently recommends that an accreditation process should be in place for NP education programs.</li> <li>• NONPF has reviewed COUPN program as part of the preparation for federal entry to practice review to</li> </ul>	HPRAC request that CNO provide a detailed brief on the OCGS review of NP education programs to assess if this process is equivalent to an expert nursing third party review.

	<p>move the program to Masters; understanding is that it is a positive report. COUPN has not circulated the report.</p>	<p>If it is determined that additional expert review is required by an external accreditation process, HPRAC should recommend that CNO revise the criteria for approving educational programs to include a requirement that they are accredited.</p>
<p><b>Clinical preparation for practice</b> Physicians have several years of practice before working independently. Are NPs prepared for practice out of education programs?</p>	<ul style="list-style-type: none"> <li>• IBM McMaster report provides rationale for a transitional, mentored type of initiative as NPs enter practice.</li> <li>• NPAO has a proposal already developed that is interprofessional and focuses on ongoing support rather than “supervision”.</li> <li>• There should be specific strategies for implementation outlined in the Task Team report (not released).</li> <li>• COUPN is moving to increase number of hours of clinical placement and will exceed minimum requirement to meet national competencies as part of move to Masters (contact COUPN for more information on this process)</li> <li>• Learned from various projects (SIP, CCO palliative mentorship) that e-mentorship is a viable and effective model for transition to independent practice.</li> </ul>	<p><b>Proposal: mentorship for first year of clinical practice</b></p> <ul style="list-style-type: none"> <li>• NPAO (partners to be determined) should be assigned leadership role to develop and implement a mentoring program</li> <li>• Program should build on experience of other projects: largely e-mentoring approach but likely some face to face required.</li> <li>• Successful similar strategies that could provide templates for this type of mentorship include SIP PHC transition fund project and the CCO Collaborative NP/MD dyad mentorship in palliative care program.</li> </ul>
<p><b>Continuing education</b> How can HPRAC ensure that NPs maintain competency?</p>	<ul style="list-style-type: none"> <li>• Strategies related to regulatory QA is required. CNO is already working to update their QA program</li> </ul>	<p><b>Proposal: Annual QA</b></p> <ul style="list-style-type: none"> <li>• NPs should be required to participate in regular case review process - interprofessional and across the breadth of their practice for example cases.</li> </ul> <p><b>Proposal: Intensive education/practice update – QA requirement</b></p> <ul style="list-style-type: none"> <li>• Requirement to have intensive one or two continuing education days; requirement to attend every 2 years.</li> <li>• Content should be intensive clinical focus – best practices, patient safety especially around</li> </ul>

		<p>prescribing and ordering labs/diagnostics.</p> <ul style="list-style-type: none"> <li>• Could be linked to pre/post NPAO conference based on rationale that this conference has very high professional participation (400+ out of 1000+ members).</li> <li>• Need to ensure that employers are required to provide a minimum number of CE days annually (10).</li> </ul>
	<ul style="list-style-type: none"> <li>• Strategies related to workplace could be proposed.</li> </ul>	<p><b>Proposal: Workplace strategies</b></p> <ul style="list-style-type: none"> <li>• Interprofessional Practice Councils could be established in hospitals to undertake a credentialing process for nursing and perhaps other professionals.</li> <li>• Rationale - independent of Medical process, tailored to nursing or interprofessional needs.</li> </ul>
	<ul style="list-style-type: none"> <li>• External objective 3<sup>rd</sup> party strategies could be proposed.</li> </ul>	<p><b>Proposal: Recognize a nursing organization to accredit continuing education</b></p> <p>RNAO should be recognized as an organization that could accredit educational programs for NP continuing education.</p>
<p><b>Specific Controlled Act</b> Should NPs have full access? Should there be specific “limitations” for any of the controlled acts?</p>	<p><b>Casting</b></p> <ul style="list-style-type: none"> <li>• agree there should be specific requirements met in order to use this controlled act.</li> <li>• some of these are included in the appendices of the CNO submission.</li> </ul>	<p><b>Proposal for requirements for performing the act and maintaining competency:</b></p> <ul style="list-style-type: none"> <li>• Propose that NPs who set or cast a fracture apply to request authority for this act from CNO and be required to demonstrate specific additional education from a recognized/accredited program.</li> <li>• Initial practice (ie for the first # of casts) should be reviewed by an orthoped or other qualified physician.</li> <li>• There should be a minimal performance standard established to maintain competency.</li> <li>• Annual requirement for 3 case reviews and a practice review by an orthoped or other qualified</li> </ul>

		physician
	<b>Communicating a diagnosis</b>	<ul style="list-style-type: none"> <li>• Comparisons with other jurisdictions suggest the practice is variable.</li> <li>• Therefore the logical question is why can NPs in Manitoba convey a diagnosis, yet NPs in Ontario cannot.</li> <li>• What possible restrictions are there beyond “does the NP have the knowledge, skills and judgment to convey the diagnosis and explain the treatment plan in sufficient detail to allow the patient informed choice and realistic expectation of accuracy” If that isn’t the case, then refer.</li> </ul>
	<b>Prescribing energy</b> <ul style="list-style-type: none"> <li>• Need to have full and open access</li> <li>• Recognize the issue of rapid expansion of technology; similar to pharmaceuticals (old drugs used as part of new treatment modes; evolving drugs)</li> <li>• Technology is used to increase access to patient care and ensure patient safety</li> <li>• some of these are included in the appendices of the CNO submission</li> </ul>	<ul style="list-style-type: none"> <li>• Propose that NPs who apply energy, apply to CNO to request authority for this act and have specific additional education from some accredited program.</li> <li>• Initial practice should be reviewed by a radiologist or a qualified physician.</li> <li>• There should be a minimal performance standard established to maintain competency.</li> <li>• Annual requirement for 3 case reviews and a practice review.</li> </ul>
	<b>Dispensing and compounding</b> <ul style="list-style-type: none"> <li>• some of these are included in the appendices of the CNO submission</li> </ul>	<ul style="list-style-type: none"> <li>• Limits on dispensing and compounding may be appropriate and should be developed with consideration of a number of factors (e.g. patient income, potential to ensure compliance, etc.).</li> </ul>