



COLLEGE OF NURSES
OF ONTARIO
ORDRE DES INFIRMIÈRES
ET INFIRMIERS DE L'ONTARIO

THE STANDARD OF CARE.

The College of Nurses of Ontario

**Oral Submission to:
The Standing Committee on Social Policy**

***BILL 179, REGULATED HEALTH PROFESSIONS
LAW STATUTE AMENDMENT ACT, 2009***

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Standing Committee on Social Policy
Bill 179 Speaking Notes: College of Nurses of Ontario

Hello, my name is George Fieber. I am a Registered Nurse, Director of Professional Practice at Thunder Bay Regional Health Sciences Centre and President of the College of Nurses of Ontario.

With me today is: Anne Coghlan, Executive Director of the College of Nurses.

I am pleased to be speaking to you today on behalf of the College, which is the regulatory body for the nursing profession in Ontario.

We are pleased to see that many of the changes related to nursing practice that were recommended by the College in 2006 are included in Bill 179.

We recommended the changes to improve public access to quality health services, and to improve transparency regarding “who is accountable for what” in Ontario’s health system.

The College has provided a written submission to the Standing Committee, which outlines five areas of concern with the Bill.

My comments today will elaborate on one issue: nurse practitioner prescribing.

There are about 1400 nurse practitioners, also known as “NPs”, registered in Ontario. They work in every corner of this province: large urban cities, rural communities and in remote areas.

They provide health services to people of all ages, from all walks of life, with all sorts of health care needs: from those who are healthy and well - - to those who are terminally ill -- and everyone in between.

This means people with living diabetes, cancer, heart disease and dementia to name just a few.

Nurse practitioners work in every imaginable setting: emergency rooms, intensive care units, long term care homes, public health units, hospital wards and community health centres -- this list could easily go on .

I could probably find you an NP who works with just about any patient population that you could think of.

This diversity in NP practice is the reason why the College of Nurses does **not** support a list of drugs for nurse practitioner prescribing and why we believe the drug list is **not** in the public interest.

We would like Bill 179 amended to enable broad prescriptive authority for nurse practitioners.

I don't think anyone is challenging that NPs are competent to prescribe drugs: it is part of their education, it is well reflected in their core competencies and it is a common part of their practice.

The College sets practice standards for safe and ethical NP practice, including standards for prescribing.

Nurse practitioners currently have access to the controlled act of prescribing, *because* they are competent to prescribe drugs.

Let me expand on what I mean when I say NPs are competent.

Prescribing is not a discrete and isolated event. It is an integrated part of a process of providing health services to patients.

For example:

Before prescribing a drug, the nurse practitioner conducts a health assessment, a history and a physical exam.

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The nurse practitioner formulates a differential diagnosis, which is a systematic process of elimination through which the NP analyzes clinical findings and symptoms to narrow down the list of potential diagnoses.

The NP takes inventory of all medications the patient is taking to reduce the risk of interactions and potential errors.

After writing the prescription, the nurse practitioner documents it in the patient's health record and monitors the patient's response to treatment.

These are just a few highlights to illustrate to you that prescribing is part of a continuum.

You can see how critical that entire process is. Patients are at risk if something goes wrong at any step of the process.

Nurse practitioner education covers that entire continuum: health assessment, diagnosis and therapeutics.

The College's registration exams, practice standards and quality assurance program also cover that continuum.

So, now let me talk about the list and some issues.

First and foremost there is absolutely **no** connection between a list of drugs and safe prescribing.

There are currently close to 300 drugs on the NP drug list. Any one of those can cause harm if prescribed incorrectly.

There is nothing magical about the list that prompts a nurse practitioner to select the right drug, or choose the right dose to treat the right condition.

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Rather, it is nurse practitioner competencies and the College's practice standards in the areas of health assessment, diagnosis and treatment that promote and guide safe prescribing.

Second: given the diversity in NP practice, and the variety of patient populations, it would be impossible to predict and list every drug that an NP may be required to prescribe to meet patient care needs.

An NP **only** prescribes those drugs that she or he is competent to prescribe and that are relevant to the patient population with whom she or he works. This is a standard of practice set by the College.

What this means is that the individual NP is familiar with the *specific* drug and understands the *particular* patient's condition and symptoms.

The NP understands how and why the specific drug is used to treat this patient's condition and whether there are any specific patient factors that may alter the medication's desired effect.

This means the NP understands the potential side effects and interactions the drug may cause, and whether this patient may be at increased risk for such effects.

It means promoting optimal therapy for the patient, including education to encourage compliance.

And, it means the NP understands how to monitor the patient taking the medication to ensure it is having the desired effect – and taking the necessary steps to follow up if treatment is not working.

So....knowing this I ask -- what added value is there for the patient in requiring the NP to check a list of drugs?

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A list of drugs is **not** in the public interest because there will always be an unnecessary delay from when a nurse practitioner may need to prescribe a particular drug, to when that drug is added to the list.

I can't tell you how many times this happens with the drug list, and each and every time it does -- patient care in Ontario is undermined.

The list imposes an artificial barrier between the NP's competency to prescribe a drug, and the patient's right to timely access to treatment.

Finally, we'd like to share our experience with the list over the past 10 years.

The list is rigid – a drug is either on it, or its not.

If the drug is not on the list, then the NP cannot prescribe it.

While the list is rigid, patient care needs are not.

So, I will close with a few real life examples of the negative affect this list has on patient care.

Twinrix is a combination vaccine that offers dual protection for both Hepatitis A and Hepatitis B. According to the drug list, NPs can prescribe both the Hepatitis A and B vaccines, but not the *combined* agent because it is not listed.

Does that make sense to you?

Here's another example. Ciprofloxacin HC ear drops were used to treat certain ear infections.

The College first asked for this drug to be added to the list in 2002. It was finally added in 2004.

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Then, in 2007, this drug was discontinued – it is no longer available in Canada. Although there are suitable alternatives, NPs cannot prescribe them until they are added to the list.

A nurse practitioner in Thunder Bay recently told me that she needed to provide ventolin to a patient who is homeless. However, the list only allows her to “renew” ventolin. This means, it must first be prescribed by a physician, and then the list permits her to order the “repeats”.

This patient is homeless. He does not have a physician. Although she is perfectly capable of prescribing ventolin – her best available option that day was to send him to an emergency department to get treatment.

My last example will be quick. As I said, the drug list is rigid. A drug is either on it, or not.

Seasonal influenza vaccine is on the NP drug list. However, the pandemic H1N1 vaccine is not.

These are just a few of the multitude of problems faced by nurse practitioners and their patients every day.

This is why the College’s position is that the list of drugs is more harmful to patient care than helpful.

This concludes my remarks.

We have provided more information in the College’s written submission.

I will leave copies of my oral submission.

We would be pleased to respond to any questions you may have.

Thank you.