



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

THE STANDARD OF CARE.

The College of Nurses of Ontario

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

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

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EXECUTIVE SUMMARY

Bill 179 is a positive step towards enabling the public to receive services that health professionals are competent to perform. The College of Nurses of Ontario (CNO) is supportive of many of the proposed changes in the Bill, including amendments to the *Healing Arts Radiation Protection Act* and some of the changes to the *Nursing Act, 1991*.

This submission describes five proposed amendments to Bill 179 where CNO feels that the public interest could be better met:

1. removing restrictions on Nurse Practitioner (NP) access to the controlled act of “prescribing a drug”;
2. authorizing Registered Practical Nurses (RPNs) and Registered Nurses (RNs) to perform the controlled act of “dispensing a drug”;
3. removing provisions related to “College Supervisor”, and consult Colleges about the desired objectives and how to best achieve those objectives;
4. replacing reference to “standards of knowledge, skill and judgement relating to the performance of controlled acts common among health professions” with “common principle-based standards”; and,
5. requiring employers to provide statements of liability coverage to employees who are regulated health professionals.

We look forward to the changes resulting from Bill 179, with the proposed amendments to Bill 179 that are described in the submission below.

INTRODUCTION

The College of Nurses of Ontario (CNO) is the regulatory body for approximately 150,000 Ontario nurses¹. CNO regulates nursing to protect the public. This is done by: setting requirements to enter the profession, establishing and enforcing standards of nursing practice, and assuring the quality of practice and continuing competence of nurses.

CNO is pleased to submit recommendations regarding Bill 179, the *Regulated Health Professions Law Statute Amendment Act, 2009*. Many of the nursing related amendments proposed in Bill 179 were recommended by CNO as changes that enhance public access to safe care. The College supports that Nurse Practitioners (NPs) be granted access to: dispense, sell and compound drugs; apply forms of energy; order x-rays and CT scans that they deem appropriate for patient care; and, set or cast a joint dislocation or bone fracture.

In addition to the many positive changes proposed in the Bill, there are some provisions that concern CNO. This submission outlines five areas where the College feels that the public interest could be better met.

¹ Nurse Practitioners, Registered Nurses and Registered Practical Nurses.

NURSING ACT, 1991

Nurse Practitioner Prescriptive Authority

Recommendation: That revisions be made to section 18 of Bill 179, which amends various sections of the *Nursing Act, 1991* to remove restrictions on NP prescribing:

- i. **Revise subsection 18(2) of Bill 179 to amend subsection 5.1(1), paragraph 6 of the *Nursing Act, 1991* by removing the requirement that a substance be “designated in the regulations”.**
- ii. **Revise subsection 18(2) of Bill 179 to remove subsection 5.1(1), paragraph 7 and subsection 5.1(2) of the *Nursing Act, 1991*, which are both consequential to the change recommended in item (i) above.**
- iii. **Revise subsection 18(2) of Bill 179 to amend subsection 5.1(1), paragraph 8 of the *Nursing Act, 1991* to remove the requirement that a drug be “designated in the regulations”.**
- iv. **Revise subsection 18(6) to remove clauses 14(1)(c), (d) and (e), and subsections 14(2) through to and including 14(6) of the *Nursing Act, 1991*.**

CNO does not support a list of drugs or substances² for NPs. There are approximately 1400 NPs in Ontario providing a wide range of health services to a diverse population in a variety of practice settings. They provide services to people of all ages, in all parts of the province, in every sector of the health system and throughout various stages of wellness to illness. Because of this broad and varied patient population, the NP drug and substance list will consist of several hundred drugs and substances in order to meet effective treatment

² An example of a substance may be a gas, such as oxygen, which is commonly required for treatment purposes by NPs.

needs. It is not possible to create a comprehensive and up-to-date list of drugs and substances necessary to provide care for all the patient populations that NPs currently service in Ontario.

Recent consultation with healthcare providers³ made it clear to CNO that NPs require access to drugs relevant to countless clinical situations - beyond what can be predicted by a list of drugs and substances. Removing restrictions on NP access to the controlled act of “prescribing a drug” is in the public interest. Below are examples⁴ of the potential positive impact of eliminating a drug list.

- NPs who provide primary care to patients could have immediate access to appropriate drug therapy (e.g., clients with drug allergies could have immediate access to appropriate, alternate drug therapy).
- System resources currently used to “work around”⁵ the legislative restrictions could be re-directed to other patient care priorities. Also, costs to the system as a result of “work arounds” (e.g., costs to clients) could be directed back into the healthcare system.
- Patients could have earlier access to new drugs and immunizations approved for use in Canada that are appropriate for their treatment.
- NPs could offer their patients combined immunizations, such as *Twinrix* (a combined Hepatitis A/B vaccine), which is currently not permitted because the vaccines are listed as “single entity” on the drug list, which prohibits the NP from prescribing them in their combined form.

³ CNO consulted with physicians, pharmacists and NPs (NP-Adult, NP-Paediatrics and NP-Primary Health Care).

⁴ Based on actual practice scenarios.

⁵ Two examples of “work arounds” include the use of medical directives (i.e., a physician order for a drug that is not on the NP drug and substance list that may be implemented for any patient who meets specified conditions – that the NP is competent to prescribe) and duplication of care (i.e., a patient required to see another care provider because the NP is unable to prescribe the drug that is needed for treatment).

- The overall management of chronic diseases, such as diabetes and hypertension, could be improved – NPs would be able to initiate the necessary drug therapies and make adjustments based on the patient’s response.
- Patients with limited access to resources (e.g., rural areas, vulnerable populations, etc.) could receive more timely and equitable access to drug therapies.

CNO’s proposal for broad prescriptive authority would facilitate more timely and direct access to preventative primary healthcare and urgent care. It may help to reduce the risk of complications, prevent patient deterioration and contribute to earlier treatment of illness. The drug and substance list blocks public access to appropriate and timely healthcare services. Patient choice of healthcare provider may be threatened should Ontario’s legislative framework impede an NP’s ability to support patient choice in situations where the NP is competent to provide patient care. Patients who receive healthcare services from NPs are being disadvantaged by having restricted access to drug therapy on the basis of a list. Enabling NPs to prescribe according to their competencies would reduce the overall fragmentation of care and improve their patients’ confidence that the system is equipped to meet their needs. Each and every time NPs encounter a clinical situation in which they are competent to prescribe a drug, but are prevented from doing so because of an externally imposed process, patient care is potentially undermined and patients are disadvantaged.

NPs are knowledgeable, safe prescribers who are accountable for their own clinical decisions. At entry-to-practice, NPs are competent to prescribe⁶. Throughout their practice, NPs are accountable for working within their legal scope of practice and to their individual level of competence, including the controlled act of prescribing a drug. The legislative framework should reflect this accountability. A list imposes an artificial barrier between the

NP's competency (i.e., knowledge, skill and judgement) to safely prescribe a particular drug and the patient's right to timely access to treatment.

There is no public interest rationale for restricting NP prescribing to a list of drugs and substances, especially given the more progressive alternatives that have been implemented in other jurisdictions. For example, Alberta and British Columbia have legislative frameworks enabling broader prescriptive authorities for NPs. Also, the United Kingdom and a number of states in the United States also have broad prescriptive authority in place for NPs. In 2006, in preparation for anticipated changes in NP legislated scope of practice, CNO held a number of stakeholder consultation sessions. In relation to broad prescriptive authority, CNO had support from the College of Medical Radiation Technologists of Ontario, the College of Physicians and Surgeons of Ontario, the College of Respiratory Therapists of Ontario and the Ontario College of Pharmacists.

Although the new drug approval process envisioned by the government may or may not improve timelines for adding drugs to the list, there will always be an unnecessary delay from when an NP may need to prescribe a particular drug to when that drug is added to the list. In the meantime, the “work-arounds” will continue: costly medical directives, costly duplication of care⁷, or the costly waste of the NP's, the physician's and the patient's time to obtain a physician signature on a prescription the NP has written. The most common “work-around” example in Ontario is the use of medical directives (see footnote #6). NPs are writing their own directives that are signed off by physicians. Although the directive is developed and implemented by the NP⁸, in reality the physician is ultimately accountable for

⁶ To become registered, NPs must complete a CNO approved education program, a regulatory examination, and demonstrate evidence of safe practice. Each of these requirements involves an assessment of the prospective NP's competencies, including those related to prescribing.

⁷ Patients are required to see a physician to obtain a prescription although the NP is competent, but not permitted, to provide.

⁸ Most often, the physician will not have any interaction with the individual patient for which the directive is being used.

the order. This blurs the lines of accountability. CNO's proposal for removing restrictions on NP access to prescribing a drug will provide clarity that the NP is solely responsible for the prescription.

Though the government has not provided details about the new drug approval process, our understanding is that there may be a need to develop five lists for: prescribing, dispensing, compounding and selling drugs, as well as substances for injection and inhalation. What the Bill proposes in terms of the creation of an expert panel to decide upon the appropriateness of the content of five lists is potentially far more cumbersome and confusing than the current drug approval process and would be very resource intensive for all parties involved.

CNO is committed to monitoring the expanded scope of practice of its members and holding its members accountable to their respective competencies, as evidenced in the revised Quality Assurance (QA) Program. The new QA Program will involve a self assessment for all members, focusing on the application of CNO's practice standards⁹ and the development of a learning plan. NPs are expected to apply knowledge of pharmacology in selecting, prescribing, monitoring and dispensing drugs, and performing these competencies as appropriate for the NP's scope of practice, level of competency and clinical practice setting. A practice assessment will be conducted on a cyclical basis for all NPs and will involve multiple components in order to address the controlled acts that NPs have access to, including prescribing¹⁰.

⁹ NPs will be expected to demonstrate practice in accordance with the NP Practice Standard, which addresses safe medication practices, as well as other standards selected by CNO.

¹⁰ The practice assessment for NPs will involve an objective test, a Chart Review and/or a Practice Simulation.

The QA Program will assess prescriptive authority for NPs through an objective test that measures NPs' knowledge of pharmacology in selecting, prescribing, monitoring and dispensing drugs. NPs may also be required to participate in additional assessment options that may include a Chart Review¹¹ or a Practice Simulation¹². The Chart Review involves reviewing patient charts to assess clinical decision making, interpretation of clinical findings and the identified treatment plan related to drug therapy. The Practice Simulation will involve using standardized patients to assess NPs' knowledge, skill and judgement when prescribing medication. The new QA Program will support the expanded scope of practice by promoting nurses' continuing competence and by applying increased rigour to ensure public protection.

Patient safety is best ensured through regulatory mechanisms that promote safe practice. Ultimately, safe practice is promoted by NPs' completion of a rigorous CNO approved NP program, demonstration of safe practice, their compliance with CNO Practice Standards, and their ongoing participation in CNO's QA Program. Granting NPs the authority to broadly prescribe better meets the public interest rather than relying on a list of drugs and substances as approved from time to time by the government. This authority will result in increased access to timely and appropriate care for Ontarians, which will ultimately enhance the quality and efficiency of patient care.

¹¹ Chart Review is an assessment which combines chart audit and clinician interview. This assessment is typically used to assess clinical decision making and application of knowledge with actual patients.

¹² Practice Simulation is an assessment made up of a series of stations through which the NP would rotate, oftentimes using standardized patients, to assess physical examination, history taking skills, communications skills, ability to make a diagnosis and plan a treatment of care.

Registered Nurse and Registered Practical Nurse Dispensing Authority

Recommendation:

Revise section 18 of Bill 179 to amend section 4 of the *Nursing Act, 1991* to authorize nurses to perform the controlled act of dispensing a drug.

In September 2005, CNO's Council passed a motion supporting that all nurses¹³ be granted access to the controlled act of dispensing a drug that is prescribed by an authorized prescriber. The Health Professions Regulatory Advisory Council (HPRAC) also made this recommendation in their *Critical Links* report (January 2009). Dispensing drugs was, under the *Health Disciplines Act*, a routine part of all nursing practice. Following the introduction of the *Regulated Health Professions Act (RHPA), 1991*, nurses continued to dispense drugs but could only do so under delegation, a process for enabling an authorized profession to transfer to nurses an activity beyond their legislated scope of practice.

Given that dispensing is not defined in the *RHPA*, CNO has interpreted the definition of dispensing to relate specifically to providing medication to patients for their *self-administration*. In other words, if a nurse takes one or multiple doses from a medication stock (e.g., a ward stock), pursuant to an authorized prescriber's order, repackages the medication and gives this to the patient or patient's representative for the patient to take at a later time, this is considered dispensing. Although dispensing and administering drugs involve many of the same principles, CNO does not consider dispensing to refer to a nurse taking one or multiple doses from a medication stock (e.g., a ward stock) and immediately administering the medication to a patient (e.g., a pill by mouth).

¹³ Nurse Practitioners, Registered Nurses and Registered Practical Nurses.

CNO's *Medication* practice standard¹⁴ states that dispensing involves the following phases:

- receiving/reading the prescription;
- adjusting the order according to approved policy (e.g., substitution), if appropriate;
- selecting the drug to dispense;
- checking the expiry date;
- reconstituting the product, if needed;
- repackaging the drug;
- labelling the product; and,
- completing a final physical check to ensure the accuracy of the finished product.

Of the phases listed above, the only two phases that CNO does not consider to be a part of routine medication administration are repackaging the drug and labelling the product. In fact, the document *Delegation of Dispensing*¹⁵, developed jointly by CNO and the Ontario College of Pharmacists, states that there is “considerable overlap” between the technical and cognitive components of dispensing a drug and preparing a drug for administration.

The knowledge, skill and judgement (i.e., competencies) required to administer drugs has many similarities to the competencies required to dispense drugs. The performance of dispensing a drug is reflected in nursing education and entry-to-practice competencies. The QA Program promotes nurses' continuing competence in all aspects of their practice, including dispensing a drug.

¹⁴ Please refer to the following link for CNO's *Medication* practice standard:
http://www.cno.org/docs/prac/41007_Medication.pdf

¹⁵ The Ontario College of Pharmacists. (1996). *Delegation of Dispensing*. Retrieved June 1, 2009 from <http://www.ocpinfo.com/client/ocp/OCPHome.nsf/web/Delegation+of+Dispensing>

There are a wide variety of practice settings in which no authorized provider (e.g., pharmacist) is readily available and nurses routinely dispense medications to meet patient needs. These settings include, but are not limited to, acute care units, long-term care facilities, Northern outposts, community clinics and public health clinics. Some examples are listed below:

- Registered Practical Nurses (RPNs) and Registered Nurses (RNs) dispense to hospitalized patients or long-term care residents who have been granted a leave of absence but who must continue with their medication treatment regime.
- Patients who present to an Emergency Department in the middle of the night may be given sufficient doses of a medication upon their discharge in order to initiate timely treatment, until a community pharmacist is available to fill a prescription (e.g., antibiotics).
- RPNs and RNs frequently dispense prophylactic medications in travel clinics.
- RPNs and RNs often dispense medication in sexual health clinics in response to patient need, especially for marginalized populations (e.g., an individual who could not otherwise afford birth control).
- RPNs and RNs in correctional facilities repackage and label stock medications for inmates.
- RPNs and RNs working in isolated areas routinely dispense medications to patients from the nursing station medication stock.

- RPNs and RNs who work in community health clinics or public health clinics routinely dispense medications to patients who are financially disadvantaged and in need of immediate treatment. They also dispense to patients whose compliance is in question (e.g., patients who leave with a prescription but there is no assurance that they will fill the prescription and begin necessary treatment).

Granting nurses access to the controlled act of dispensing when the drug is prescribed by an authorized prescriber, rather than relying on the delegation process, will enable CNO to address the activity comprehensively in its standards of practice and through its QA Program in order to better fulfil its public protection mandate. Furthermore, eliminating the need for delegation of a procedure that is common to nursing practice clarifies the lines of accountability and facilitates CNO's ability to hold nurses accountable for their practice. Nurses would continue to collaborate with the interdisciplinary team, including (but not limited to) situations beyond their knowledge, skill and judgement.

REGULATED HEALTH PROFESSIONS ACT, 1991

College Supervisor

Recommendation:

Revise Bill 179 to remove subsections 24(2) and 24(8), which introduce the concept of a College Supervisor.

CNO considers the concept of a College Supervisor to be an unnecessary erosion of self-regulation. These proposed changes come with no explanatory rationale from the government; therefore, the objectives of this addition are unclear. Under subsection 5(1) of the *RHPA*, the Minister already has powers to oversee and direct the activities of regulatory Councils: “The Minister may, (a) inquire into or require a Council to inquire into the state of practice of a health profession in a locality or institution; (b) review a Council’s activities and require the Council to provide reports and information; (c) require a Council to make, amend or revoke a regulation under a health profession Act or the *Drug and Pharmacies Regulation Act*; (d) require a Council to do anything that, in the opinion of the Minister, is necessary or advisable to carry out the intent of this Act, the health profession Acts or the *Drug and Pharmacies Regulation Act*”.

The College believes that the proposed provisions are premature and that there needs to be dialogue with the Minister regarding appropriate mechanisms to further enhance the accountability of all Colleges. CNO requests that the provisions related to the College Supervisor be removed from the Bill entirely and that the Minister engage in consultation with Colleges about the desired objectives and how to best achieve those objectives. Should the government feel strongly that a supervisory appointment is essential, CNO suggests that its inclusion be captured in section 5 of the *Regulated Health Professions Act, 1991*, “Powers

of Minister”. Specifically, if a Council does not comply with a request under subsection 5(1)(d), the Lieutenant Governor in Council may appoint a person as a College Supervisor for the limited purpose of fulfilling the Minister’s request. This section could also be expanded to include a public safety rationale and additional procedural requirements.

Collaborative Standards

Recommendation:

Amend subsection 24(11) of Bill 179 to remove reference to “standards of knowledge, skill and judgement relating to the performance of controlled acts common among health professions”, replacing it with “common principle-based standards”.

Bill 179 includes provisions requiring Colleges to develop “standards of knowledge, skill and judgement” relating to common controlled acts. CNO supports the principle of collaborative standards; however, the focus on controlled acts has the potential to result in standards specific to procedures, skills and tasks (e.g., suctioning). This is a narrow interpretation of the collaborative development of common standards. Rather than focus on procedures, skills and tasks, CNO is supportive of developing collaborative standards that focus on common *principles* of practice that are applicable to all professions (e.g., infection control, ethics, communication, documentation, etc.). CNO believes that this approach would have a more meaningful effect on the way health professionals work together to provide health services and would result in a positive impact on patient care.

Liability

Recommendation:

Amend subsection 24(13) of Bill 179 to require employers to provide statements of liability coverage to employees who are regulated health professionals.

A majority of CNO members have liability coverage through their employers. In light of this, CNO will not require nurses to obtain individual professional liability protection coverage where adequate insurance coverage exists through the employer. We anticipate that many nurses will rely on their employer coverage to meet CNO's requirements. To facilitate a member's ability to respond to the College's request for proof of coverage, CNO recommends that an obligation be placed on employers to provide regulated health professionals, who are employees, with a statement of coverage applicable to their employment, when requested.

CONCLUSION

The changes resulting from Bill 179, along with the changes recommended by CNO in this submission, are a positive step toward enabling the public to receive services that healthcare professionals are competent to perform. The healthcare system will benefit as fewer resources will be wasted on authorizing mechanisms currently used to “work around” antiquated legislation. In summary, CNO recommends:

- 1. That revisions be made to section 18 of Bill 179, which amends various sections of the *Nursing Act, 1991* to remove restrictions on NP prescribing:**
 - a. Revise subsection 18(2) of Bill 179 to amend subsection 5.1(1), paragraph 6 of the *Nursing Act, 1991* by removing the requirement that a substance be “designated in the regulations”.**
 - b. Revise subsection 18(2) of Bill 179 to remove subsection 5.1(1), paragraph 7 and subsection 5.1(2) of the *Nursing Act, 1991*, which are both consequential to the change recommended in item (i) above.**
 - c. Revise subsection 18(2) of Bill 179 to amend subsection 5.1(1), paragraph 8 of the *Nursing Act, 1991* to remove the requirement that a drug be “designated in the regulations”.**
 - d. Revise subsection 18(6) to remove clauses 14(1)(c), (d) and (e), and subsections 14(2) through to and including 14(6) of the *Nursing Act, 1991*.**
- 2. Revise section 18 of Bill 179 to amend section 4 of the *Nursing Act, 1991* to authorize nurses to perform the controlled act of dispensing a drug.**
- 3. Revise Bill 179 to remove subsections 24(2) and 24(8), which introduce the concept of a College Supervisor.**
- 4. Amend subsection 24(11) of Bill 179 to remove reference to “standards of knowledge, skill and judgement relating to the performance of controlled acts**

- 5. Amend subsection 24(13) of Bill 179 to require employers to provide statements of liability coverage to employees who are regulated health professionals.**