Mind the Safety Gap: Reclaiming the role of the RN

Will you support improving patient health outcomes and safety by mandating that:

- **Any new nursing hires in tertiary, quaternary, and cancer care hospitals be RNs**
- **All first home care assessments be conducted by an RN**

Will you demand that health-care organizations use professional nursing care models?

Will you support increasing access to health services by implementing independent RN prescribing and allowing RNs to continue to initiate the controlled act of psychotherapy?

This is why

In May 2016, RNAO released a policy report entitled *Mind the safety gap in health system transformation: Reclaiming the role of the RN* which highlighted the health human resources necessary to achieve health system transformation.[1] The report concludes that trends in critical areas run counter to the Ontario government's goals for the health system transformation and putting "patients first," specifically:

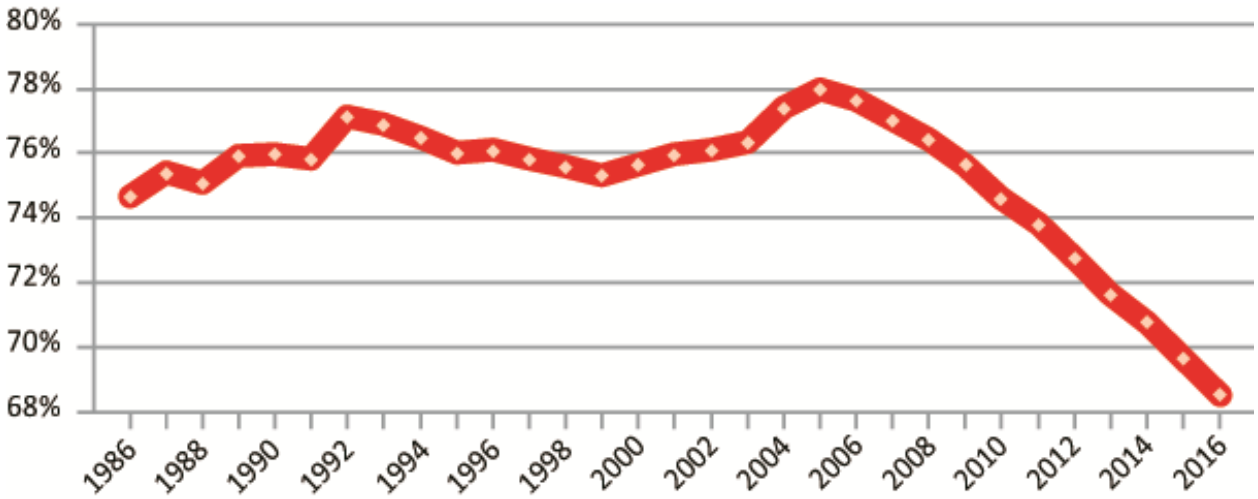
- Nursing skill mix (number of RNs, RPNs, and unregulated care providers) in acute care, home care and long-term care is being diluted
- Organizational models of nursing care delivery that are being used create fragmentation of care provision instead of care continuity

Ontario needs more RNs

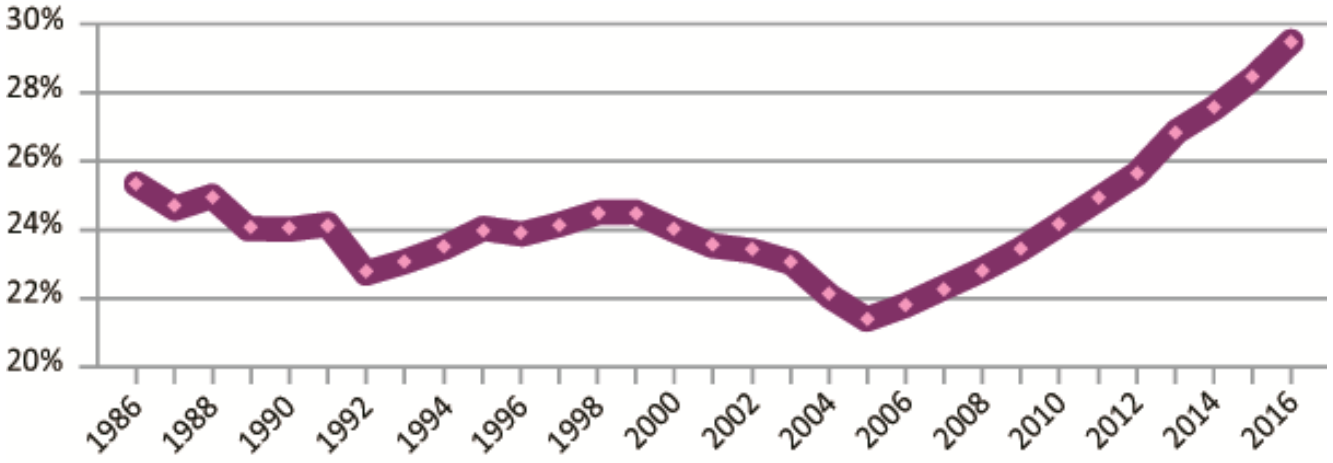
Ontario has the lowest RN-to-population ratio in Canada.[2] The Canadian Institute for Health Information (CIHI) figures show the province has only 703 RNs per 100,000 people compared to an average of 839 per 100,000 people in the rest of Canada.[3] At the same time, the ratio of RPNs-to-population continues to increase.

RNs are often a patient's first point of contact with the health system and they are present in most health service delivery settings. Poll after poll shows that RNs enjoy the highest public trust compared to other occupations.[4] In addition, studies conclusively show that employing RNs improves health and financial outcomes.[5] And yet the Ontario government continues to enable the replacement of RNs with lesser qualified health-care workers. Often the result of budget constraints combined with rising salaries, this practice puts patient safety and outcomes at risk, especially at a time when patient complexity is increasing.

RN SHARE OF ONTARIO NURSING EMPLOYMENT



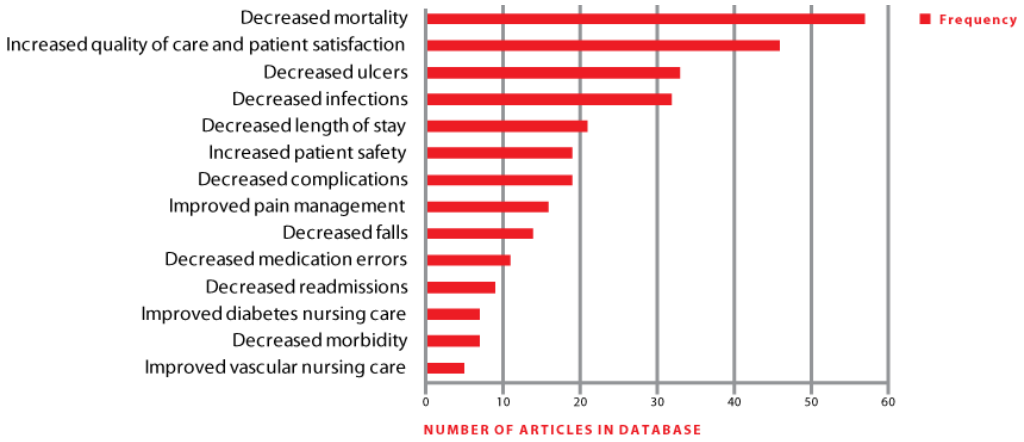
RPN SHARE OF ONTARIO NURSING EMPLOYMENT



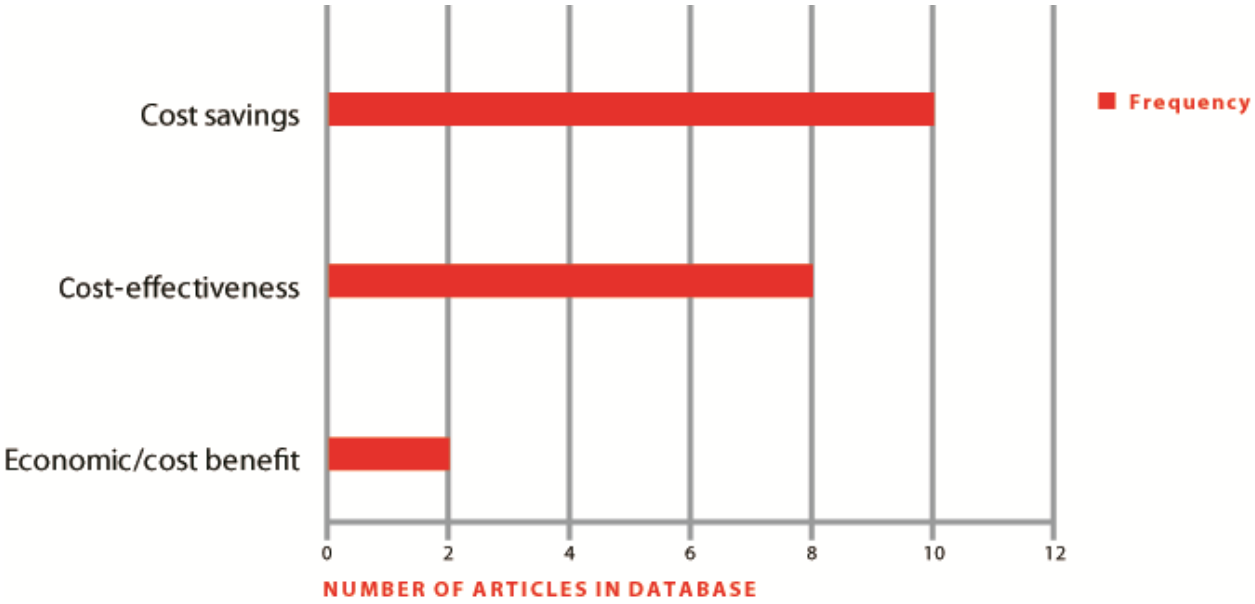
RN effectiveness

The largest ever publically available database of 70 years of research into RN effectiveness, released in 2017, shows that using RNs results in improved clinical and financial outcomes.[6] Higher levels of care from RNs result in fewer deaths, pressure ulcers, pneumonia and other pulmonary events, sepsis and infections, upper gastrointestinal bleeds, cardiac arrests, falls, and medication errors.[7 8 9 10 11 12 13 14 15 16]

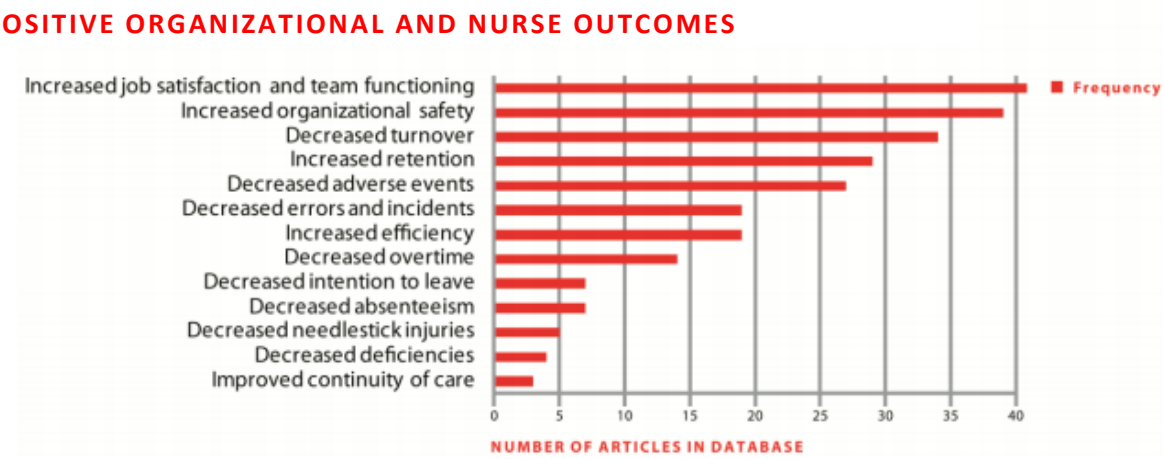
POSITIVE CLINICAL/PATIENT OUTCOMES



POSITIVE FINANCIAL OUTCOMES



In addition, patient outcomes improve when RNs provide direct care instead of assuming only a supervisory role.[17] A higher proportion of RNs is also linked to shorter lengths of stay in hospital and improved organizational effectiveness.[18 19 20]



We need to have the right nurse in the right place

The College of Nurses of Ontario (CNO) is clear that nursing skill mix should be determined based on three factors: the client, the nurse, and the environment. These factors should impact care provider assignment, or which category of nurse to match with patients, clients or residents based on their complexity, predictability, and risk of negative outcomes. More complex patients with less predictability and less stable environments should be cared for by RNs. Less complex patients, with predictability and a stable environment may be cared for by RPNs.[21] Despite our warnings of the negative impact of RN replacement and risky assignments, RNAO continues to hear of these trends across the province in various health-care settings and sectors. RNAO is not sitting idly by as RN replacement is occurring and functional models[22] of nursing care delivery are re-emerging. We have issued multiple *action alerts* calling on nurses, other health professionals and the public to respond. Despite over 28,000 responses, no action has been taken by government.

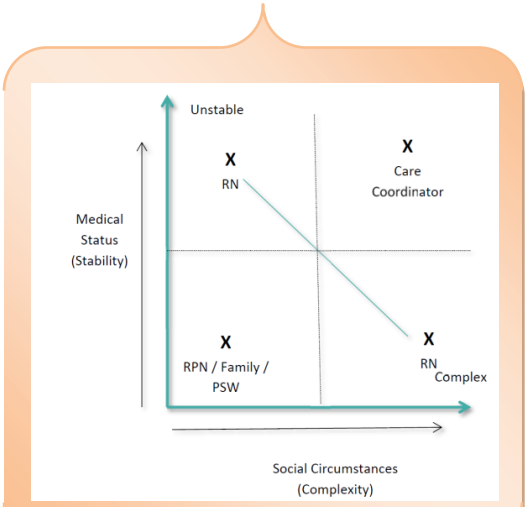


Fig. 1. Optimizing Ontario's Nursing Workforce [34]

RNAO is calling on the Ontario government to mandate that any new nursing hires in tertiary, quaternary and cancer care hospitals be RNs with a long-term goal of having an all RN-workforce in these settings within three years and in large community hospitals within five years.

These centres are designed to provide care specifically to persons with high degrees of complexity and instability. Diluting RN care in these settings is risky to patient safety and outcomes.

The complexity and prevalence of patients receiving home care have also increased as patients are being discharged earlier from hospital.[23] The practice of home care nursing is complex, requiring a diverse knowledge base to manage patient care across the lifespan.[24] During the initial visit, the complexity and stability of the patient is often unknown.[25] It is critical that all initial home health-care visits be provided by an RN because they have the advanced knowledge, skill, and judgment required to perform a comprehensive assessment and develop a care plan that ensures a patient's complex needs are met safely in their homes.[26]

Models of nursing care

RNAO believes that a nursing human resources strategy is not as simple as increasing the number of staff. It is about effectively matching human resources with the needs of patients.[27] It is imperative that nurses are fully engaged in the evolution of the health system to ensure service delivery remains person-and family-centred and of high quality.[28] This can only be accomplished through evidence-based practice and policy that includes: the appropriate number of RN staff; full and expanded scope of practice utilization; robust interprofessional practice; effective organizational models of nursing care delivery; the appropriate skill mix; and evidence based clinical practice.

The replacement of RNs with less qualified providers often goes hand-in-hand with implementing organizational models of nursing care delivery that fragment patient care. These models focus on parceling out patient care into a series of tasks to be completed. This practice, known as "functional nursing," was abandoned in the 1970s due to its detrimental impact on patient experience and outcomes, and it has now reemerged as "team nursing." Functional models of nursing care view nursing as a broad set of tasks (e.g. medication administration, dressing changes, baths, and vital signs) that can a be carried out by a variety of workers (e.g. RNs developing care plans, RPNs performing vital signs, and PSWs giving baths).[29] Fragmenting patient care based on tasks results in miscommunication and errors. With the care provider focused on the task at hand rather than connecting all aspects of care to form a complete picture of the person's health, they are not able to intervene in a timely manner when necessary. Implementation of these models is often motivated by budgetary restraints combined with rising salaries. This is a misguided attempt to save money and control local health-care spending by placing greater reliance on cheaper staff to deliver nursing services. Functional (or task-oriented nursing) is criticized for not recognizing clients as individuals and devaluing aspects of psychosocial care.[30]

In contrast, primary nursing (or total patient care models) assign individual patients to the most appropriate nurse (RN or RPN) who acts as their primary nurse throughout the entire care

process, providing all aspects of nursing care. This model facilitates comprehensive care of clients and is linked to improved patient outcomes as the nurse is better able to detect threats to patient safety and intervene promptly to avoid adverse events.[31]

Primary nursing is associated with improved outcomes for patients, nurses, and work environments when implemented through a supportive culture.[32] When nurses practise in primary nursing models, they have more autonomy, increased accountability for the care they provide, and improved clinical decision-making skills.[33] Evidence indicates that models of primary nursing are less costly for organizations than team-based models due to the decrease in administrative and supervisory activities.[34] [35]

Increase access to care by RNs

RNs are autonomous health professionals who practice independently and collaboratively within interprofessional teams. With 104,483 RNs registered to practice with the College of Nurses of Ontario, [36] expanding their scope of practice will secure timely access to quality health services across Ontario, and lead to a more efficient and effective health system. Unfortunately, Ontario has stagnated in achieving scope expansion for RNs. Despite the move to a mandatory BScN entry requirement for RNs in 2005 – which involved a curricula change from three years to four years – there has been no recent scope expansion for RNs. The time has come to make transformative changes.

<u>RN prescribing</u>

The *Primary Solutions for Primary Care* report released in 2012 recommends expanding the scope of practice for RNs to include prescribing.[37] The report was fully endorsed by all political parties and other key stakeholders.[38]

On May 17, 2017, Bill 127, *Stronger, Healthier Ontario Act (Budget Measures) Act,* received royal assent. This bill amended the *Nursing Act, 1991* to "...permit registered nurses who are not nurse practitioners to prescribe drugs that are designated in the regulations."[39] Amendments to the *Nursing Act* also give RNs authority to communicate a diagnosis for the purpose of prescribing a medication, yet they do not enable RNs to perform diagnostic tests, which is a necessary aspect of formulating a diagnosis. On June 28, 2017, the CNO received a letter from Minister of Health and Long-Term Care Dr. Eric Hoskins directing CNO to do the necessary work to enable RN prescribing. RNAO is urging the CNO to move forward with drafting regulations to allow RNs to independently prescribe medications.

Once regulations are passed, Ontario will become the first Canadian jurisdiction where RNs can prescribe medications and communicate diagnoses for the purpose of prescribing medications. RNAO continues to push for the necessary legislative changes to the *Laboratory and Specimen Collection Centre Licensing Act* to allow RNs to perform point-of-care tests which will expand their ability to diagnose and prescribe medications accordingly.

Independent prescribing will allow RNs to prescribe medications under their own authority within a regulated scope of practice and within their clinical competency area, without restricting them to a limited or pre-defined formulary. This model has been successfully used in the United Kingdom for the past 15 years and for the past 10 years in Northern Ireland, Australia, and New Zealand.

RNAO recommends two phases to the implementation of independent RN prescribing. The first phase would be to expand the scope of currently practising RNs who choose to integrate prescribing into their practice. These RNs would be required to complete a 300-hour postgraduate course and pass the final evaluative component. Once they have successfully passed, they will be granted a designation on their registration enabling them to practice to an expanded scope. RNAO expects this phase to come into effect in 2018.

The second phase would incorporate the curriculum from the course into undergraduate nursing programs within three years. The new competencies would be reflected in RNs' entry-to-practice exam and become part of entry-to-practice requirements. The efficacy of Ontario's health system depends largely on advancing access to care through innovative and evidence-informed enhancements, and independent RN prescribing will be an effective example of that. RNAO expects this phase to come into effect in 2021.

Psychotherapy

On Dec. 30, 2017, the Ontario government proclaimed psychotherapy as a controlled act. RNs, along with five other regulated professions (social workers, occupational therapists, physicians, psychologists, psychotherapists), are authorized to continue to treat patients using psychotherapy techniques during a two-year exemption period before the controlled act will be enforced.

A large number of nurses, including nurses working in mental health, are already performing and initiating psychotherapy and have been doing so for many years. RNAO has strongly advocated that RNs who have the appropriate education and training be able to continue initiating the controlled act of psychotherapy. However, unlike other regulatory colleges for the professions authorized to use psychotherapy, CNO wants RNs to obtain an order to perform the controlled act of psychotherapy from a prescriber (a nurse practitioner or physician). This decision was made despite recommendations from HPRAC that each of the colleges should outline appropriate guidelines and standards for their members and avoid dual memberships,[40] and despite the fact that some RNs have long been able to independently initiate and deliver psychotherapy. Many RNs have more extensive experience and training in psychotherapy than some other members of the five professions.

RNs who meet the conditions for initiating a controlled act, as with others who have the authority to practice psychotherapy, are best situated to assess their own knowledge, skill, and

judgment; a specific client's condition; and the appropriateness of intervention. They are more than capable of accepting sole responsibility for initiation.

On Dec. 21, 2017, the CNO Council received a letter from Minister Hoskins asking that the CNO revisit its requirement that RNs obtain an order to perform the controlled act of psychotherapy. If CNO does not reverse its decision, it will create a barrier for Ontarians to access valuable mental health services. There is a large body of evidence which supports the need for mental health services, especially in primary care settings, and a need for professionals who have the adequate skills, training and knowledge to deliver them.[41] [42] Furthermore, establishing direct accountability for initiating and performing psychotherapy as a controlled act will best protect the public. RNAO has repeatedly urged CNO to reconsider its approach to psychotherapy initiation since 2014.[43] [44] [45] [46]

RNAO's RECLAIMING THE ROLE OF THE RN ASKS

- Require that all new nursing hires in tertiary, quaternary, and cancer care hospitals be RNs
- All initial home health care visits be provided by an RN
- Require professional models of nursing care that advance care continuity and avoid care fragmentation (primary or total patient care) across all sectors of the health system
- Ensure RNs can order lab tests and prescribe medications for common ailments
- Integrate RN prescribing into the baccalaureate nursing curriculum by 2021
- Allow RNs to continue to initiate the controlled act of psychotherapy

NOTES FOR RNAO LEADERS

They say, we say

RNs are being self-serving. Why else are they asking for RPNs to be eliminated and replaced by RNs?

RNAO respects and values all nurses, including RNs, NPs, and RPNs. We believe that each nurse has an important role to play in our health system. Backed by evidence, the College of Nurses of Ontario (CNO) indicates that the determination of nursing skill mix must focus on three factors: the client, the nurse, and the environment. These factors should impact care provider assignment, or which category of nurse to match with patients, clients or residents based on their complexity, predictability, and risk of negative outcomes. More complex patients with less predictability and less stable environments should be cared for by RNs, whereas a less complex patient, with predictability and a stable environment may be cared for by RPNs (CNO, 2016).

RNAO is calling for the government to mandate that any new nursing hires in in tertiary, quaternary and cancer care hospitals be RNs with a long-term goal of having an all RN-workforce within these settings and within three years and in large community hospitals within five years.

RNAO is also calling for all first home health-care visits to be provided by an RN.

What an RN does is no different than what RPNs can do. It's the same job. In fact, RPNs are training now as RNs were 15 years ago.

Nursing has come a long way in recognizing the complexities of patient care and making changes to address the needs of increasingly complex patients. Today, patients are sicker and have more complex needs than ever before. Many experience multiple co-morbid conditions. While it is true that RPN training has been expanded from 18 months to two years, the old diploma RN position required three years, and the requirement that a four-year bachelor's degree (BScN) be deemed mandatory by the CNO in 2005 is necessary, because of the increased acuity of the patient population. Our complex patients must be cared for by an RN with the educational background and in-depth knowledge and critical thinking to do so. Matching nursing care to patient complexity will only enhance clinical and financial outcomes.

What is the difference between the various models of care – and why does it matter?

Patient safety is of utmost importance in choosing the appropriate organizational model of nursing care delivery. Functional nursing models fragment care based on tasks which results in miscommunication and errors. When the care provider is focused on the task at hand rather than connecting all aspects of care to form a complete picture of the person's health, they are unable to intervene in a timely manner when necessary. This practice puts patients at risk for negative outcomes.

Conversely, professional models of nursing care assign individual patients to the most appropriate nurse (RN or RPN) who acts as their primary nurse throughout the entire care process, providing all aspects of nursing care. Employing this model of nursing care is linked to improved patient outcomes and increased patient safety, as the nurse is better able to detect threats to patient safety when practising in a holistic manner.

An expanded scope for RNs is dangerous.

What is dangerous are the wait times to receive care, insufficient access to health services for vulnerable populations, lack of focused care for chronic disease management, and underutilization of health human resources as the need for health care increases.

RNs are autonomous health-care professionals that practice independently and are closely regulated by the CNO. RNs are currently involved in prescribing in Ontario through delegation, for example in public health units, nurse practitioner-led clinics and in rural, remote and northern communities.[47] Based on their assessments, RNs in some sectors are equipped with medical directives to respond to clients' needs with medications. Moreover, RNs are highly involved in recommending medications for clients to physicians and NPs based on their health assessments. While these activities are currently happening, RNs would still be expected to complete a mandatory course of approximately 300 hours, cumulating with an evaluation component in order to safely adopt an expanded scope of practice. All RNs will be eligible to take the course, however only those that successfully pass the evaluation component will be enabled to practice to an expanded scope. This will ensure that RNs practicing to an expanded scope will have the necessary competencies to engage in the practice safely. RNs in the UK that have undergone this process feel that autonomously prescribing is safer than prescribing by proxy and felt well prepared to prescribe by the post graduate course.[48] Furthermore, a systematic review of RN prescribing internationally found that RNs prescribe similarly to physicians in terms of dose and type of medication and had produced similar clinical outcomes to physicians.

An expanded role of the RN conflicts with the NP role.

NPs are transforming access to care. These nurses have seen an expansion in their scope of practice and Ontarians are the real winners of this added health system capacity. An expanded RN scope of practice does not substitute the role of the NP. Rather, it is about fully utilizing the competencies, knowledge and skills of RNs to improve timely access to quality care for the public. Currently, the inability to prescribe medications, order diagnostic testing and communicate a diagnosis limits the full potential of RNs towards facilitating timely access to care. Given educational and role distinctions between RNs and NPs, CNO describes: "NP competencies build and expand upon RN competencies"[49] and therefore, the NP role covers a much broader range of services. Specific services that NPs provide and RNs will not include prescribing controlled drugs, setting fractures, admitting clients to inpatient hospital units and making specialist referrals. A result of an expanded RN role is that NPs will be able to practise to their full scope and focus on clients with more complex care requirements. Lastly, not unlike the distinctions between RNs and RPNs, tools can be created to identify the appropriate care provider to the appropriate person at the appropriate time.

References:

[1] Registered Nurses' Association of Ontario (RNAO). (2016). *Mind the safety gap in health system transformation: Reclaiming the role of the RN*. Retrieved from http://rnao.ca/sites/rnao-ca/files/HR_REPORT_May11.pdf.

[2] RNAO. (2017). RNAO says latest nursing stats reveal Ontario's RN workforce continues to decline. Retrieved from http://rnao.ca/news/media-releases/2017/06/01/RN-workforce-decline.

[3] RNAO. (2017). RNAO says latest nursing stats reveal Ontario's RN workforce continues to decline. Retrieved from http://rnao.ca/news/media-releases/2017/06/01/RN-workforce-decline.

[4] Gallup. (2015). Honesty/ethics in professions. Retrieved from http://www.gallup.com/poll/1654/honesty-ethics-professions.aspx.

[5] RNAO. (2017). *70 years of RN effectiveness*. Retrieved from http://rnao.ca/bpg/initiatives/RNEffectiveness.

[6] RNAO. (2017). *70 years of RN effectiveness*. Retrieved from http://rnao.ca/bpg/initiatives/RNEffectiveness.

[7] West, G., Patrician, PA. & Loan, L. (2012). Staffing matters – every shift. *American Journal of Nursing, 112(12),* 22-27.

[8] Needleman, J., Buerhaus, P., Mattke, S., Stewart, M. & Zelevinsky, K. (2002). Nurse-staffing levels and the quality of care in hospitals. *The New England Journal of Medicine, 346*(*22*), 1715-1722.

[9] Glance, LG., Dick, AW., Osler, TM., Mukamel, DB., Li, Y. & Stone, PW. (2012). The association between nurse staffing and hospital outcomes in injured patients. *BMC Health Services Research, 12*, 247.

[10] Kane, RL., Shamliyan, TA., Mueller, C., Duval, S. & Wilt, TJ. (2007). The association of registered nurse staffing levels and patient outcomes: Systematic review and meta-analysis. *Medical Care, 45*(*12),* 1195-1204.

[11] Twigg, D., Duffield, C., Bremner, A., Rapley, P. & Finn, J. (2012). Impact of skill mix variations on patient outcomes following implementation of nursing hours per patient day staffing: A retrospective study. *Journal of Advanced Nursing, 68(12*), 2710-2718.

[12] Aiken, LH., Sloane, DM., Bruyneel, L., Van den Heede, K., Griffiths, P., Busse, R., Diomidous, M., Kinnunen, J., Kozka, M., Lesaffre, E., McHugh, MD., Moreno-Casbas, MT., Rafferty, AM., Schwendimann, R., Scott, RA., TIshelman, C., van Achterberg, T. & Sermeus, W. (2014). Nurse staffing and education and hospital mortality in nine European countries: A retrospective observational study. *The Lancet, 383*(*9931*), 1824-1830.

[13] Cho, E., Sloane, DM., Kim, E., Kim, S., Choi, M., Yoo, IY., Lee, HS. & Aiken, LH. (2015). Effects of nurse staffing, work environments, and education on patient mortality: An observational study. *International Journal of Nursing Studies, 52*(*2*), 535-542.

[14] Estabrooks, CA., Midodzi, WK., Cummings, GG., Ricker, KL. & Giovannetti, P. (2005). The impact of hospital nursing characteristics on 30-day mortality. *Nursing Research, 54*(*2*), 74-84.

[15] Kutney-Lee, A., Sloane, DM. & Aiken, LH. (2013). An increase in the number of nurses with baccalaureate degrees is linked to lower rates of postsurgery mortality. *Health Affairs, 32(3*), 579-586.

[16] Frith, K., Anderson, EF., Fan, T. & Fong, E. (2012). Nurse staffing is an important strategy to prevent medication errors in community hospitals. *Nursing Economic$, 30,* 288-294.

[17] Alenius, LS., Tishelman, C., Runesdotter, S. & Lindqvist, R. (2014). Staffing and resource adequacy strongly related to RNs' assessment of patient safety: A national study of RNs working in acute-care hospitals in Sweden. *BMJ Quality and Safety, 23 (3),* epub.

[18] Harless, DW. & Mark, BA. (2010). Nurse staffing and quality of care with direct measurement of inpatient staffing. *Medical Care, 48*(7), 659-663.

[19] Dubois, C., D'amour, D., Tchouaket, E., Clarke, S., Rivard, M. & Blais, R. (2013). Associations of patient safety outcomes with models of nursing care organization at unit level in hospitals. *International Journal for Quality in Health Care, 25*(*2*), 110-117.

[20] Patrician, PA., Pryor, E., Fridman, M. & Loan, L. (2011). Needlestick injuries among nursing staff: Association with shift-level staffing. *American Journal of Infection Control, 39*(6), 477-482.

[21] College of Nurses of Ontario (CNO). (2014). *RN and RPN practice: The client, the nurse and the environment. Practice guideline*. Retrieved from http://www.cno.org/globalassets/docs/prac/41062.pdf.

[22] Functional models of nursing care view nursing as a broad set of tasks (e.g. medication administration, dressing changes, baths, and vital signs) that can a be carried out by a variety of workers (e.g. RNs developing care plans, RPNs performing vital signs, and PSWs giving baths)[28]

[23] Home Care Ontario & OCSA Nursing Practice Council. (2017). *Optimizing nursing in Ontario's renewed home care system*. Retrieved from http://homecareontario.ca/docs/default-source/position-papers/optimizing-nursing-in-ontario-home-care-ontario-ocsa-final-july-2017.pdf?sfvrsn=4.

[24] Home Care Ontario & OCSA Nursing Practice Council. (2017). *Optimizing nursing in Ontario's renewed home care system*. Retrieved from http://homecareontario.ca/docs/default-source/position-papers/optimizing-nursing-in-ontario-home-care-ontario-ocsa-final-july-2017.pdf?sfvrsn=4.

[25] RNAO. (2016). *Mind the safety gap in health system transformation: Reclaiming the role of the RN*. Retrieved from http://rnao.ca/sites/rnao-ca/files/HR_REPORT_May11.pdf.

[26] RNAO. (2016). *Mind the safety gap in health system transformation: Reclaiming the role of the RN*. Retrieved from http://rnao.ca/sites/rnao-ca/files/HR_REPORT_May11.pdf.

[27] Bylone, M. (2010). Appropriate staffing: more than just numbers. *AACN Advanced Critical Care, 21(1),* 21-3.

[28] McBride, S., Delaney, JM. & Tietze, M. (2012). Health information technology and nursing. *American Journal of Nursing, 112(8),* 36-42.

[29] Dubois, C., D'Amour, D., Tchouaket, E., Clarke, S., Rivard, M. & Blais, R. (2013). Associations of patient safety outcomes with models of nursing care organization at unit level in hospitals. *International Journal for Quality in Health Care. 25(2),* 110-117.

[30] Duffield, C., Roche, M., Diers, D., Catling-Paull, C. & Blay, N. (2010). Staffing, skill mix and the model of care. *Journal of Clinical Nursing, 19*(*15-16),* 2242-2251.

[31] Dubois, C., D'Amour, D., Tchouaket, E., Clarke, S., Rivard, M. & Blais, R. (2013). Associations of patient safety outcomes with models of nursing care organization at unit level in hospitals. *International Journal for Quality in Health Care. 25(2),* 110-117.

[32] Matila, E., Pitkanen, A., Alanen, S., Lino, K., Luojus, K., Rantanen, A. & Aalto, P. (2014). The effects of the primary nursing care model: A systematic review. *Journal of Nursing Care*, *3(6),* epub.

[33] Wolf, GA. & Greenhouse, PK. (2007). Blueprint for design: Creating models that direct change. *Journal of Nursing Administration, 37(9),* 381-387.

[34] Wolf, GA. & Greenhouse, PK. (2007). Blueprint for design: Creating models that direct change. *Journal of Nursing Administration, 37(9),* 381-387.

[35] Dubois, C., D'Amour, D., Tchouaket, E., Clarke, S., Rivard, M. & Blais, R. (2013). Associations of patient safety outcomes with models of nursing care organization at unit level in hospitals. *International Journal for Quality in Health Care. 25(2),* 110-117.

[36] CNO. (2017). Membership statistics report. Author: Toronto http://www.cno.org/globalassets/docs/general/43069_stats/2017-membership-statistics-report.pdf.

[37] RNAO. (2012). Primary Solutions for Primary Care. http://rnao.ca/sites/rnaoca/files/Primary__Care_Report_2012_0.pdf.

[38] RNAO. (2012). Provincial task force action plan will ensure same day access for patients, system effectiveness, and cost savings. Media Release: June http://rnao.ca/news/media-releases/2012/06/28/provincial-task-force-action-plan-will-ensure-same-day-access-patient

[39] Bill 127 – Stronger, Healthier Ontario Act (Budget Measures), 2017 http://www.ontla.on.ca/bills/bills-files/41_Parliament/Session2/b127ra_e.pdf.

[40] Health Professions Regulatory Advisory Council (HPRAC). (2006). Regulation of health professionals in Ontario: New directions. Toronto: Author. http://www.hprac.org/en/reports/resources/englishtcmfinalreport.pdf

[41] Carter, R. (2015). Delivering cognitive behaviour therapy in a secure setting. *Mental Health Practice.* 19(3), 23-26.

[42] McLeod, K. & Simpson, A. (2017). Exploring the value of mental health nurse working in primary care in England: A qualitative study. *Journal of Psychiatric Mental Health Nursing.* 24, 387-395

[43] RNAO. (2014). Letter to CNO: Requiring an order to perform psychotherapy. Retrieved from http://rnao.ca/policy/letters/cno-re-requiring-order-perform-psychotherapy.

[44] RNAO. (2014). Letter to CNO: Recommendation to rescind requirement to perform psychotherapy. Retrieved from http://rnao.ca/policy/letters/cno-rnao-recommendation-rescind-requirement-order-perform-psychotherapy.

[45] RNAO. (2015). Letter to CNO: Initiation of RN psychotherapy. Retrieved from http://rnao.ca/policy/letters/cno-initiation-rn-psychotherapy.

[46] RNAO. (2017). Letter to CNO: Request that CNO pursue a regulation to enable RN initiation of psychotherapy. Retrieved from http://rnao.ca/policy/letters/pursue-regulation-rn-psychotherapy.

[47] Gielen, S.C., Dekker, J., Francke, A.L., Mistiaen, P. & Kroezen, M. (2014). The effects of nurse prescribing: A systematic review. *International Journal of Nursing Studies, 51*(7), 1048-1061.

[48] Bradley, E., B. Hynam, and P. Nolan, *Nurse prescribing: reflections on safety in practice.* Social Science & Medicine. 65(3): p. 599-609.

[49] CNO. (2011). Nurse practitioner. Retrieved from: http://www.cno.org/Global/docs/prac/41038_StrdRnec.pdf.