RNAO Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Nursing Human Resources

1. **RNAO is calling for the province to develop an interprofessional health human resource plan to align population health needs and the full scope of practice of all regulated health professionals with system policy priorities. Will you join our call?**
    a. **In the absence of such a plan today and in the face of conclusive research on the impact of RNs on health outcomes, will you support an immediate moratorium on the replacement of RNs with less qualified providers?**
    b. **Will you protect the health of Ontarians by halting fragmented organizational models of nursing care?**

Putting patients first:

In 2015, three major policy reports were released by the Ministry of Health and Long-Term Care to direct health system evolution and restructuring to put patients first.[1,2,3]

Health human resources are the fuel necessary to drive the engine of change in Ontario's health system. However, RNAO is deeply concerned that there is no substantive health human resource plan for the province.[4] Ontario is in urgent need of an evidence-based interprofessional health human resource plan that incorporates: population health needs, policy priorities for the system, and that ensures all health-care providers are working to their full scope of practice.

The need for such a plan is especially urgent, given that in some parts of Ontario RNs are being replaced with less qualified providers and organizations are fragmenting nursing care delivery into tasks delegated to practical nurses and unregulated providers. This practice, known as "functional nursing" was abandoned in the 1970's due to its detrimental impact on patient outcomes and is being rebranded today as "team nursing." It is often motivated by short-sighted attempts to control local health-care spending. But history clearly tells us that they cost the system much more in the long run, while putting people's health at risk.

RNAO's advocacy on this issue has prompted 16,000 respondents, of which over 2,000 members of the public, to write to Minister Hoskins and urge him to stop the replacement of RNs with less qualified providers. RNAO reaffirms this call and urges the minister to step in by issuing a moratorium on the replacement of RNs with less qualified providers, pending the development of a comprehensive evidence-based interprofessional health human resource plan. RNAO is also calling on the ministry to put a stop to fragmented organizational models of nursing care delivery, because the evidence is conclusive that such models disrupt continuity of care and continuity of care-giver, which in turns compromises quality, safety and patient outcomes.

RNAO is examining health system trends, nursing human resource data and evidence on skill-mix, staffing and care-delivery models and plans to release a report this spring. Our preliminary analysis of

membership data from the College of Nurses of Ontario (CNO) shows that despite commitments from both the current and past health minister to expand community care and realign resources, the annual rate of change in RN employment in the community has been +4.8 per cent between 2011-14. And yet, RPN employment sits at +15.9 per cent. The shares of the community nursing workforce in 2005 were 82 per cent RN and 16 per cent RPN respectively. This dropped to 70 per cent RN and 26 per cent RPN by 2014. The situation is similar in hospitals where the annual rate of change for RNs has been +1.6 per cent versus +5.2 per cent for RPNs between 2011-14. The shares of the hospital nursing workforce in 2005 were 83 per cent RN and 17 per cent RPN. This dropped to 79 per cent RN and 20 per cent RPN by 2014.

For the workforce as a whole, the RPN share of nursing employment in Ontario jumped from 21.5 per cent to 28.4 per cent between 2005 and 2015. Correspondingly, the RN/population ratio declined in 2015, to 71.4 per 10,000 Ontarians, 11.3 per cent below its 1986 level. The gap with the rest of Canada is as wide as ever (83.6 vs. 71.4 per 10,000 in 2014), meaning that Ontario would have to add 16,659 more RNs to catch up with the rest of the country. The result is that people in Ontario have less access to RNs, while the workloads of RNs are higher. When you examine Ontario's RPN/population ratio, it is close to that of the rest of the country (27.2/10,000 vs. 27.8/10,000), so the nurse/population gap is almost entirely on the RN side.[5] Shifting more RN positions to RPN positions just pushes Ontario even more out of line with the rest of the country.

These figures are concerning because the CNO requires that RNs deliver care for complex and unstable patients and the complexity of care requirements and instability in the community and hospital sectors have increased dramatically. Hospitals are increasingly being positioned as centres to treat those who are acutely ill and have complex needs. The CCACs have also identified that "... the number of patients with higher needs has increased by 73 per cent over the last five years."[6] Therefore, it is concerning to observe such significant increases in the RPN workforce, with minimal increases in the RN workforce. RNAO acknowledges that there is a role for practical nurses and unregulated care providers in the community. However, it is critical to ensure the appropriate care resources are matched with the needs of patients. These needs demand a highly knowledgeable and skilled workforce that includes a substantive proportion of RNs and NPs.

Evidence shows that the amount of direct patient care provided by RNs is directly linked to reduced mortality and morbidity rates. This means higher levels of care from RNs result in fewer deaths,[7,8] readmissions,[9] pressure ulcers,[10] pneumonia and other pulmonary events,[11,12] post-operative infections,[13,14] upper gastrointestinal bleeds,[15] cardiac arrests,[16] and medication errors.[17,18]

Continuity of care and continuity of care giver are proven to be strongest when RNs provide total nursing care for unstable patients with unpredictable outcomes, RPNs provide care for stable patients with predictable outcomes, and PSWs provide support where appropriate as delegated by a nurse. RNs must also care for those patients whose condition is uncertain, to avoid shifting between providers. This model is known as 'primary nursing' and is associated with improved outcomes for patients, nurses, and work environments when implemented through a supportive culture.[19,20] This organizational model of care provides nurses with the time to understand clients' unique needs and intervene early when signs

of disease progression appear.[21] When nurses practise in primary nursing models they have more autonomy, increased accountability for the care they provide, and improved clinical decision-making skills.[22] Evidence indicates that models of primary nursing are less costly for organizations than fragmented models due to the decrease in administration staff, time spend supervising use of agency nurses.[23,24]

They Say, We Say

"Using RPNs to full scope of practice is a part of interprofessional practice. Doesn't RNAO support interprofessional collaboration?"

RNAO fully supports interprofessional collaboration and the full scope of practice utilization of all regulated health professionals. However, it is imperative that the right professional is providing care to the right patient. At a time when the health system is evolving and care needs are becoming more complex, organizations and health planners must ensure that they have a nursing workforce with the knowledge and skill to effectively respond to current and future needs.

From a regulatory perspective, RNs are most effectively utilized to provide care for unstable patients with unpredictable outcomes, RPNs provide care for stable patients with predictable outcomes, and PSWs for support where appropriate as delegated by a nurse. RNAO believes that RNs must also care for patients whose condition is uncertain, to avoid shifting between providers.

"Team based models of nursing care are cost effective and can appropriately respond to patient needs. Why should we invest in primary nursing?"

While team-based models appear cost effective in the short term, they actually increase costs over time and result in poor patient and work environment outcomes. There are many challenges with team-based nursing including: decreased continuity of care, lack of clarity with accountability and responsibility, and liability concerns.[25] RNs face increased responsibility as they have to supervise less skilled and experienced staff, leading to communication gaps and challenges to effective interprofessional collaboration.[26] Most importantly, these changes affect the health and wellness of human lives. Society cannot put a cost on the life of a human being.

With primary models of nursing, patient and nurse outcomes are improved, which decreases cost. The amount of direct patient care RNs provide is linked to mortality and morbidity rates and recent evidence shows that client outcomes improve when RNs provide direct care.[27] When nurses practise in primary nursing models they utilize more of their autonomy and clinical decision-making skills compared to when they work in team-based models of care.[28,29,30,31,32] For example, primary nursing has proven to be invaluable in critical care settings where clients are highly complex and/or uncommunicative. Primary nursing enables nurses with the time to understand clients' non verbal cues and intervene early when signs of disease progression appear.[33] Furthermore, primary nursing facilitates client- and family-centred care as nurses focus on conserving the wholeness (or health) of the client and their family.[34]

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[4] See Home and Community Care Expert Panel Report; Patient's First Documents and Primary Health Care Expert Advisory Committee.
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