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

QPD QUEEN's PARK DAY

Reclaiming the role of the RN

Ontario has the lowest RN-to-population ratio in the country. Will you support improving patient safety and health outcomes by ensuring that:

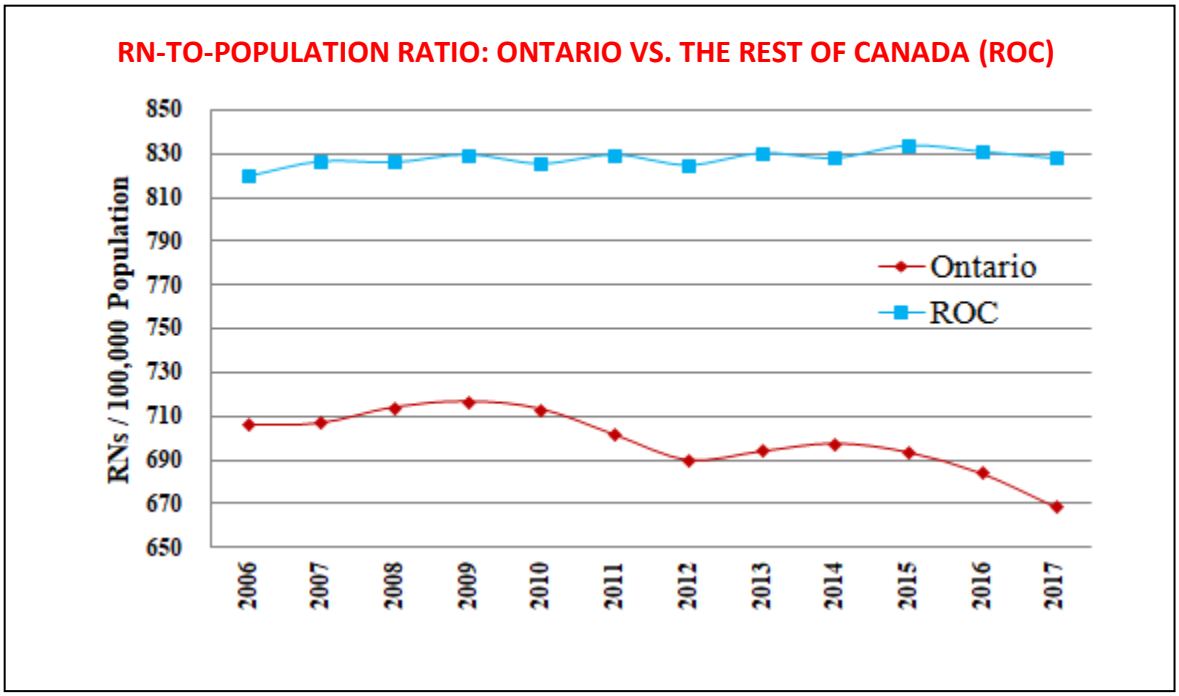
- **Hospitals are funded to immediately fill the 10,000 RN vacancies**
- **All new nursing hires in acute care and cancer care hospitals are RNs**
- **All first home care assessments are conducted by an RN**

Will you support increasing access to health services by ensuring that:

- **Independent RN prescribing is implemented in all practice settings, inclusive of diagnostics**
- **RNs are allowed to continue to initiate and perform the controlled act of psychotherapy**

Ontario needs more RN positions

Ontario has a shortage of RN positions. Despite evidence that RNs deliver better results for lower cost,[1] this year – for the third year in a row – the RN-to-population ratio in our province is the lowest in Canada.[2] A huge and widening gap has opened up between the province and the rest of the country, as the graph below shows.[3] Ontario has only 669 RNs per 100,000 people compared to an average of 828 RNs per 100,000 people in the rest of Canada.[4]



This compares poorly with the employment of our RPN colleagues, whose per capita employment (297 per 100,000) is much higher than that of the rest of Canada (285). As the Registered Practical Nurses Association of Ontario (RPNAO) notes, "Ontario has an adequate and stable supply of RPNs."[5]

The RN numbers are a wake-up call for people concerned with the state of our health-care system. Patients and families are all too familiar with the phenomenon of hallway nursing. This problem exacerbates and highlights the RN deficit. Calculations by the Ontario Nurses' Association show there are more than 10,000 vacant RN positions in hospitals across the province.[6]

> RNAO calls on the Ontario government to provide hospitals with funding earmarked to immediately fill the 10,000 RN vacancies.

Enhancing RN supply

To fill that RN gap, start with RNs who are registered in Ontario but not working here in that capacity. In 2017, 4,541 RNs registered as nurses who did not have nursing employment in Ontario, and 2,564 of them were seeking such employment. There were 1,910 other Ontario-registered RNs working outside of Ontario who might be candidates to return; otherwise, why would they maintain their Ontario registration?[7]

Also, if all RNs had their preferred work status (full-time, part-time or casual), 6,578 more RNs would have had full-time employment in 2017. Enabling them to work full-time would increase the number of full-time equivalent RNs by several thousand.[8] The big winners will be Ontario patients who will get enhanced care continuity.

Other sources of RN supply are readily available. The first is RPNs transitioning to RNs. As the Registered Practical Nurses Association of Ontario (RPNAO) notes in its pre-budget submission "hundreds of RPNs across the province want to make that change."[9]

> RNAO supports the call by RPNAO to help address Ontario's growing RN shortage by advancing RPNs through bridging programs to complete BScN degrees. That can be achieved by maintaining and increasing funding for the *Nursing Education Initiative* (NEI). RNAO would be pleased to integrate this additional RPN-to-BScN bridging funding to our existing *NEI* program.

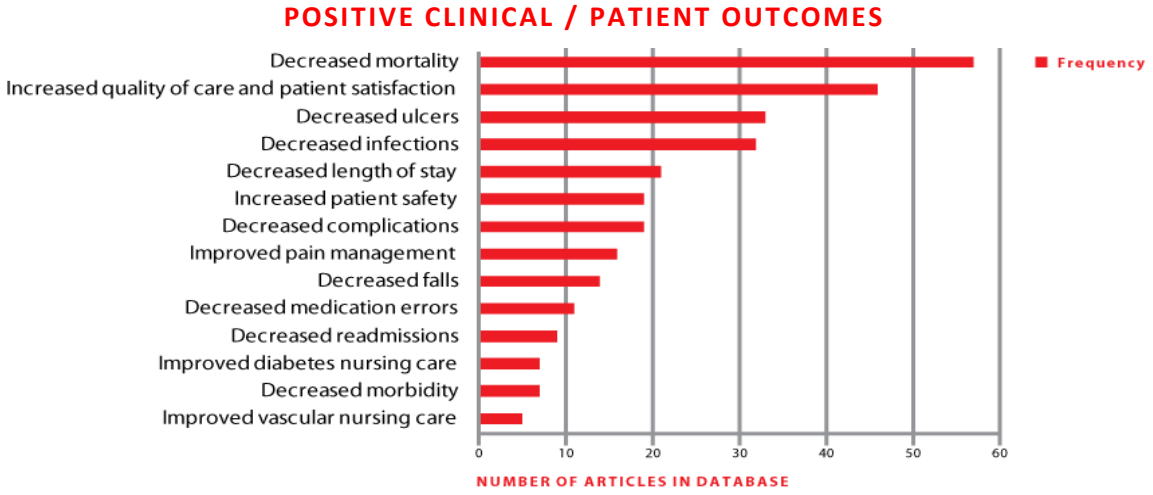
Secondly, Ontario attracts hundreds of internationally educated RNs (IENs) who must work as unregulated care providers or worse, must leaving Canada due to the lengthy regulatory process. This is an underutilized resource.

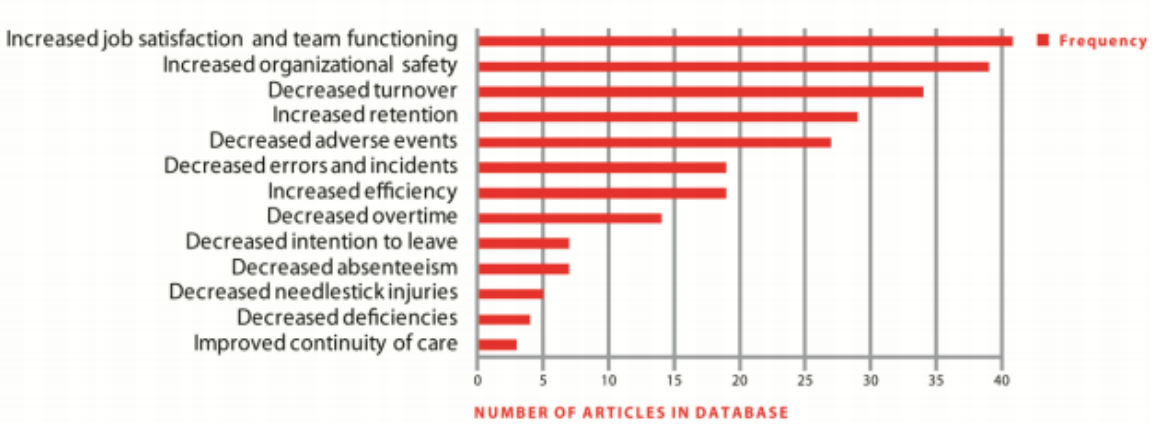
> RNAO supports IENs who have made Ontario their home. RNAO urges the College of Nurses of Ontario to streamline its processes so that these IENs may know their fates within one year of application. RNAO opposes the active recruitment ("poaching") of IENs from other jurisdictions – particularly from jurisdictions that have RN shortages.

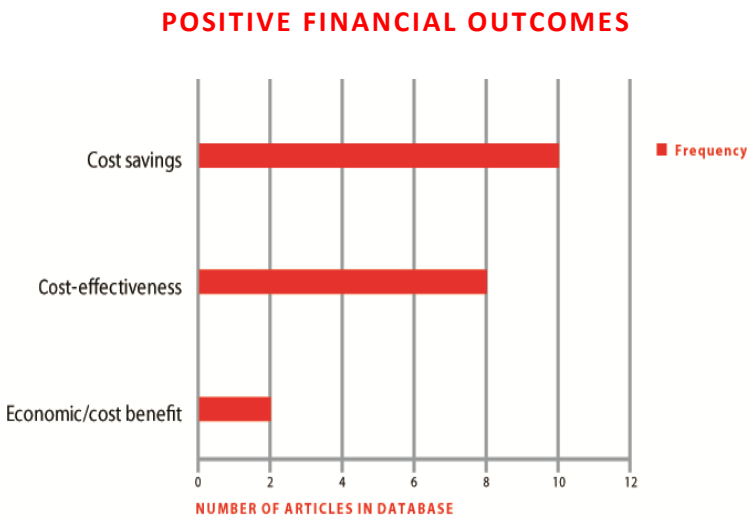
RN care results in a more effective and efficient health system

Decades of studies conclusively show that RNs are essential for better clinical, organizational, and financial outcomes in our health system.[10] The largest publicly available database of research on RN effectiveness released in 2017 – comprised of 626 studies – shows that when RNs provide care, there is higher patient satisfaction and that those patients are less likely to experience infections, falls, pressure sore injuries, pneumonia, cardiac arrests, and death.[11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30] As well, patient outcomes improve when RNs provide direct care instead of assuming primarily a supervisory role.[31] RN care is linked to shorter lengths of hospital stays, fewer medication errors, lower readmission rates, and improved organizational effectiveness.[32 33 34 35 36 37 38 39 40 41 42 43] A greater proportion of RNs also results in greater costs savings to our health system.[44 45 46 47]

Overall the result of RN care is a more effective and efficient health system.[48] Given this overwhelming evidence, it is imperative that Ontario reverse the damaging trend of the declining RN-to-population ratio. Ontarians can't afford the consequences.







The right nurse in the right place

For patients to have the best possible outcomes, it is essential to match the appropriate nurse with the needs of the patient.[49] The College of Nurses of Ontario (CNO) outlines three factors that should guide decision-making in determining the appropriate care provider assignment: the client, the nurse, and the environment.[50] These factors inform which category of nurse to match with which patients based on patient 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 more predictability and a stable environment may be cared for by RPNs.[51]

Nursing workforce distribution is also known as nursing skill mix. Effective nursing skill mix decisions are essential to ensure timely access to safe and quality care, and to improve outcomes for patients, organizations, and the health system. In the landmark 2016 report, *Mind the safety gap in health system transformation: Reclaiming the role of the RN*, RNAO highlighted how nursing skill mix is being diluted.[52] The RN share of Ontario's nursing workforce is plummeting, in part because of the troubling trend of replacing RNs with less appropriate health-care providers for patient complexity. This practice puts patient outcomes and safety at risk, and is especially concerning at a time when patient complexity is increasing across all health-care sectors. Yet RNAO continues to hear of these trends across the province in various health-care settings and sectors.

In acute care and cancer care hospitals, nearly all patients require the advanced knowledge, competencies, and judgment of RNs. These centres are designed to provide care specifically to persons with high degrees of complexity and instability. Diluting RN care in these settings is a risk for patients and the system that Ontarians can't afford to take.

> RNAO calls on the Ontario government to require all new nursing hires in acute care and cancer care hospitals be RNs.

The complexity and prevalence of patients receiving home care has also increased as patients are being discharged from hospital much earlier than ever before.[53] The practice of home care nursing requires a diverse knowledge base to manage patient care across the lifespan.[54] During the initial visit, the complexity and stability of the patient is often unknown.[55] It is critical that all initial home health-care visits be provided by an RN because they have the expert 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.[56]

> RNAO calls on the Ontario government to require all first home care assessments be conducted by an RN.

Models of nursing care

Patient safety is of the utmost importance in choosing the appropriate organizational model of nursing care delivery.

Functional models of nursing care fragment care based on tasks, which results in miscommunication and errors. This practice, also known as "functional nursing", was abandoned in the 1970s due to its detrimental impact on patient experience and outcomes. It has now re-emerged as "team nursing." Functional models view nursing as a broad set of tasks (e.g.: medication administration, dressing changes, and baths) that can be carried out by a variety of workers (e.g.: RNs developing care plans, RPNs performing vital signs, and PSWs giving baths).[57] 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. This practice puts patients at risk for negative outcomes.

Implementation of functional nursing models often goes hand-in-hand with replacement of RNs by other providers, and is often motivated by budgetary restraints. 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 to the detriment to patients, nurses, and the system.

In contrast, professional models of nursing care, also known as "primary nursing", assign individual patients to the most appropriate nurse, RN or RPN, who acts as their primary nurse throughout the entire care process. The primary nurse provides all aspects of nursing care, ensuring care continuity. Employing this model of nursing care 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.[58]

Primary nursing is associated with improved outcomes for patients, nurses, and work environments when implemented through a supportive culture.[59] When nurses practise in primary nursing models, they have more autonomy, increased accountability for the care they provide, and improved clinical decision-making skills.[60] 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.[61] [62]

> RNAO urges the government to enable health care organizations to implement models of care that advance care continuity and avoid care fragmentation.

Increase access to care by increasing RN scope of practice

RNs are autonomous health professionals who practise independently and collaboratively within interprofessional teams. With more than 100,000 RNs registered to practise with the College of Nurses of Ontario, [63] expanding their scope will secure timely access to quality health services across Ontario, and lead to a more effective and efficient health system.

RN prescribing

RN prescribing has huge potential to open same day access to timely care across the province. RNAO has been advocating for this to happen since 2012.[64] Amendments to the *Nursing Act* in 2017 gave RNs the authority to prescribe a medication and communicate a diagnosis for the purpose of prescribing a medication.[65] This marked an important milestone in moving this expanded scope of practice forward, building on years of work by RNAO.[66] [67] [68]

Following legislative changes, the Ministry of Health and Long-Term Care directed CNO to do the necessary work to enable RN prescribing. Of grave concern, the CNO has taken a restrictive approach to developing the framework to enable RN prescribing. In Dec. 2018, CNO released proposed regulations that restrict RN prescribing to a limited list of drugs and drug categories.[69] CNO's proposed regulation changes will do little to increase timely access to care or to increase efficiencies in our health system.

RNAO supports independent RN prescribing in all settings and inclusive of diagnostics as the best model to implement this expanded scope of practice.[70] In the independent RN prescribing model, a nurse may prescribe medications under their own authority within a regulated scope of practice, without restrictions from a limited list of drugs. Independent prescribers are allowed to prescribe any medication that is within their clinical competency area, with the exception of controlled drugs and substances. As an independent prescriber, an RN would be fully responsible for the assessment of a patient's needs and prescription of the appropriate medication. The independent prescribing model recognizes the broad depth of RN expertise, and ensures RNs are fully accountable for their own practice. This model has been successfully used in the United Kingdom for over 10 years,[71] and many other countries.[72] [73] [74]

Based on updates RNAO has received from CNO, a main reason for their restrictive approach to RN prescribing is that the legislation as currently written does not give RNs the authority to order diagnostic testing. The ability to order diagnostic tests is an important aspect of formulating a diagnosis, part of the continuum of care necessary for safe prescribing. RNs need the authority to order and perform diagnostic tests to inform their diagnoses and appropriately prescribe medications. RNAO calls on the Ontario government to amend the necessary legislation to allow RNs to order and where appropriate perform diagnostic testing, inclusive of laboratory testing and point-of-care testing.

Furthermore, independent RN prescribing must include RNs in all practice settings. While the greatest impact for this expanded scope is likely to be realized in primary care, home and community care, and long-term care settings, to truly increase access to all Ontarians it is imperative to include all practice settings. Currently, RNs working in Ontario hospitals will be barred from this expanded scope. This is significant as RNs working in remote outpost nursing stations that are governed by a provincial hospital will not be authorized to prescribe

medications. To reach patients in the most rural and remote areas of Ontario, it is necessary to amend the *Public Hospitals Act, 1990.*[75] In addition, amendments to the *Health Promotion and Protection Act, 1990* are necessary to ensure RNs working in public health are able to prescribing medication for the purpose of treating sexually transmitted diseases.[76]

RNAO urges a phased approach to the implementation of independent RN prescribing to support adequate preparation of the nursing workforce. The first phase would expand the scope of currently practising RNs who choose to integrate prescribing into their practice. These RNs would be required to complete and pass an approved postgraduate course. Upon successful completion, a notification on their registration will indicate they are authorized to practice to an expanded scope. The second phase would incorporate the course curriculum into undergraduate nursing programs by 2020. The new competencies would be reflected in RNs' entry-to-practice exam and become part of entry-to-practice requirements.

> RNAO calls on the government to ensure the implementation of independent RN prescribing in all practice settings and inclusive of diagnostics by 2019, and the incorporation of RN prescribing into baccalaureate entry-to-practice by 2020.

Psychotherapy

In December 2017, the Ontario government proclaimed psychotherapy as a controlled act.[77] A two-year exemption period was then put in place enabling anybody to continue to treat patients using psychotherapy techniques before the controlled act will be enforced in Jan. 2020.[78]

At the end of the exemption period, nurses – along with five other regulated professions (social workers, occupational therapists, physicians, psychologists, psychotherapists – must have regulations in place to be allowed to continue to initiate and perform the controlled act of psychotherapy. RNAO welcomes the CNO Council's decision at their Dec. 2018 meeting to circulate for feedback a draft regulation that would, if approved by government, enable RNs to independently initiate and perform the controlled act of psychotherapy.[79] RNAO strongly supports the proposed amendments to Part III (Psychotherapy) of Ontario Regulation 275/94 (General) under the *Nursing Act, 1991*.[80] [81]

As far back as 2014, RNAO has urged CNO to include initiation in the regulation of psychotherapy now that it is a controlled act.[82] [83] [84] [85] There is a large body of evidence supporting 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.[86] [87] The reality is a large number of qualified RNs, including nurses working in mental health, are already initiating and performing psychotherapy, and have been doing so for many years. RNAO believes RNs who have the appropriate education and training should be able to continue to initiate and perform the controlled act of psychotherapy. Ensuring that RNs who have the knowledge and training to practise psychotherapy are authorized to initiate and perform the controlled act will improve access to vital mental health services for Ontario's most marginalized populations.

RNAO calls on the Ontario government to ensure regulation is in place before the end of the exemption period to authorize RNs to continue to initiate and perform the controlled act of psychotherapy**.**

RNAO's RECLAIMING THE ROLE OF THE RN ASKS

- Provide hospitals with funding earmarked to immediately post and fill 10,000 RN vacancies.
- Support advancing RPNs through bridging programs to complete BScN degrees. That can be supported by maintaining and strengthening funding for the *Nursing Education Initiative* (NEI). RNAO would be pleased to integrate this additional RPN-to-BScN bridging funding to our existing *NEI* program.
- Urge the College of Nurses of Ontario to streamline its processes to ensure IENs who have chosen to make Ontario their home, know their fates within one year of application.
- Oppose the active recruitment of nurses from other jurisdictions – particularly from jurisdictions that have RN shortages.
- Require that all new nursing hires in acute care and cancer care hospitals be RNs.
- Require that all first home care assessments be conducted by an RN.
- Enable health care organizations to implement models of care that advance continuity and avoid fragmentation.
- Ensure the implementation of independent RN prescribing in all sectors, inclusive of diagnostic testing by 2019, and integrate RN prescribing into the baccalaureate nursing curriculum by 2020.
- Ensure regulation is in place by Jan. 2020 authorizing RNs to continue to initiate and perform the controlled act of psychotherapy.

NOTES FOR RNAO LEADERS

They say, we say
This section is for RNAO leaders only. It provides additional information and suggested responses for statements we may receive about this issue.

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

RNAO has never advocated for the elimination of the RPN role, or for RPNs currently working to lose their jobs. 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.

RNAO's asks are informed by the reality that there is a severe RN shortage in our health system. The RN-to-population ratio in Ontario is the lowest in Canada. Calculations by the Ontario Nurses' Association show there are more than 10,000 vacant RN positions in hospitals across the province.[88]

Backed by evidence, the CNO's Practice Guideline, *RN and RPN practice,* outlines that the determination of nursing skill mix must focus on three factors: the client, the nurse, and the environment.[89] These factors should determine care provider assignment, or which category of nurse to match with patients 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 patient, with predictability and a stable environment may be cared for by RPNs.[90]

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 of training. In 2005, the requirement for RNs to obtain a four-year bachelor degree (BScN) was deemed necessary by the CNO because of the increasing acuity of the patient population. Complex patients can only be cared for effectively if that care is delivered by an RN with the educational background and in-depth knowledge and critical thinking they bring to their role.

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 a person's health, they are unable to intervene in a timely manner when necessary. This practice puts patients at risk.

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 because 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 practise 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.[91] 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 practise 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 who 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.[92] 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.

References:

[1] Registered Nurses' Association of Ontario (RNAO). (2017). *70 years of RN effectiveness.* Retrieved from http://rnao.ca/bpg/initiatives/RNEffectiveness.

[2] RNAO. (2018). *Ontario has the worst RN-to-population ratio in Canada: Province must hire more RNs to end hallway nursing* [Media Release]. Retrieved from https://rnao.ca/news/media-releases/2018/06/14/ontario-has-worst-rn-population-ratio-canada-province-must-hire-more-.

[3] RNAO. (2018). *RN/NP Workforce Backgrounder.* Retrieved from https://rnao.ca/sites/rnao-ca/files/RNAO_RN_NP_HR_Backgrounder_April_2018.pdf.

[4] RNAO. (2018). *Ontario has the worst RN-to-population ratio in Canada: Province must hire more RNs to end hallway nursing* [Media Release]. Retrieved from https://rnao.ca/news/media-releases/2018/06/14/ontario-has-worst-rn-population-ratio-canada-province-must-hire-more-.

[5] Registered Practical Nurses Association of Ontario (RPNAO). (2019). *Strengthening the Front Lines of Care - Registered Practical Nurses Association of Ontario Pre-Budget Submission 2019*. P.3.

[6] RNAO & ONA. (2018). *Ontarians need more registered nurses*. Retrieved from http://rnao.ca/sites/rnao-ca/files/RNAO_ONA_Backgrounder_May72018.pdf.

[7] RNAO. (2018). *RN/NP Workforce Backgrounder.* P. 33. Retrieved from https://rnao.ca/sites/rnao-ca/files/RNAO_RN_NP_HR_Backgrounder_April_2018.pdf.

[8] RNAO. (2018). *RN/NP Workforce Backgrounder.* P. 38. Retrieved from https://rnao.ca/sites/rnao-ca/files/RNAO_RN_NP_HR_Backgrounder_April_2018.pdf.

[9] RPNAO. (2019). *Strengthening the Front Lines of Care - Registered Practical Nurses Association of Ontario Pre-Budget Submission 2019*. P.3.

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

[11] 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.

[12] Blegen, M. A., Goode, C. J., & Reed, L. (1998). Nurse staffing and patient outcomes. *Nursing Research, 47*(1), 43-50

[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] Clark, P. A., Leddy, K., Drain, M., & Kaldenberg, D. (2007). State nursing shortages and patient satisfaction: more RNs--better patient experiences. *Journal of Nursing Care Quality, 22*(2), 119-127.

[15] 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.

[16] 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.

[17] 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.

[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] 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.

[20] 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.

[21] McCloskey, J. M. (1998). Nurse staffing and patient outcomes. *Nursing Outlook, 46*(5), 199-200.

[22] McGillis Hall, L., Doran, D., & Pink, G. H. (2004). Nurse staffing models, nursing hours, and patient safety outcomes. *Journal of Nursing Administration, 34*(1), 41-45.

[23] 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.

[24] Seago, J. A., Williamson, A., & Atwood, C. (2006). Longitudinal analyses of nurse staffing and patient outcomes: more about failure to rescue. *Journal of Nursing Administration, 36*(1), 13-21.

[25] Stratton, K. M. (2008). Pediatric nurse staffing and quality of care in the hospital setting. *Journal of Nursing Care Quality, 23*(2), 105-114.

[26] Sovie, M. D., & Jawad, A. F. (2001). Hospital restructuring and its impact on outcomes: nursing staff regulations are premature. *Journal of Nursing Administration, 31*(12), 588-600.

[27] Tervo-Heikkinen, T., Kvist, T., Partanen, P., Vehvilainen-Julkunen, K., & Aalto, P. (2008). Patient satisfaction as a positive nursing outcome. *Journal of Nursing Care Quality, 23*(1), 58-65.

[28] 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.

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

[30] Woodward, J. L. (2009). Effects of rounding on patient satisfaction and patient safety on a medical-surgical unit. *Clinical Nurse Specialist: The Journal for Advanced Nursing Practice, 23*(4), 200-206.

[31] 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). 242-249.

[32] Blegen, M. A., & Vaughn, T. (1998). A multisite study of nurse staffing and patient occurrences. *Nursing Economics, 16*(4), 196-203.

[33] 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.

[34] Flanagan, J., Stamp, K. D., Gregas, M., & Shindul-Rothschild, J. (2016). Predictors of 30-Day Readmission for Pneumonia. *Journal of Nursing Administration, 46*(2), 69-74.

[35] Frith, K. H., Anderson, E. F., Tseng, F., & Fong, E. A. (2012). Nurse staffing is an important strategy to prevent medication error in community hospitals. *Nursing Economics, 30*(5), 288-294.

[36] Han, K. T., Kim, S. J., Jang, S. I., Kim, S. J., Lee, S. Y., Lee, H. J., & Park, E. C. (2015). Positive correlation between care given by specialists and registered nurses and improved outcomes for stroke patients. *Journal of the Neurological Sciences, 353*(1-2), 137-142.

[37] Kim, S. J., Park, E.-C., Han, K.-T., Kim, S. J., & Kim, T. H. (2016). Nurse Staffing and 30-day Readmission of Chronic Obstructive Pulmonary Disease Patients: A 10-year Retrospective Study of Patient Hospitalization. *Asian Nursing Research, 10*(4), 283-288.

[38] Lasater, K. B., & McHugh, M. D. (2016). Nurse staffing and the work environment linked to readmissions among older adults following elective total hip and knee replacement. *International Journal for Quality in Health Care, 28*(2), 253-258.

[39] Ma, C., McHugh, M. D., & Aiken, L. H. (2015). Organization of Hospital Nursing and 30-Day Readmissions in Medicare Patients Undergoing Surgery. *Medical Care, 53*(1), 65-70.

[40] McCloskey, J. M. (1998). Nurse staffing and patient outcomes. *Nursing Outlook, 46*(5), 199-200.

[41] McGillis Hall, L., Doran, D., & Pink, G. H. (2004). Nurse staffing models, nursing hours, and patient safety outcomes. *Journal of Nursing Administration, 34*(1), 41-45.

[42] Patrician, P. A., Loan, L., McCarthy, M., Fridman, M., Donaldson, N., Bingham, M., & Brosch, L. R. (2011). The association of shift-level nurse staffing with adverse patient events. *Journal of Nursing Administration, 41*(2), 64-70.

[43] Seago, J. A., Williamson, A., & Atwood, C. (2006). Longitudinal analyses of nurse staffing and patient outcomes: more about failure to rescue. *Journal of Nursing Administration, 36*(1), 13-21.

[44] Dall, T. M., Chen, Y. J., Seifert, R. F., Maddox, P. J., & Hogan, P. F. (2009). The economic value of professional nursing. *Medical Care, 47*(1), 97-104.

[45] Horn, S. D. (2008). The business case for nursing in long-term care. *Policy, Politics, & Nursing Practice, 9*(2), 88-93. doi: 10.1177/1527154408320420.

[46] McKenna, E., Clement, K., Thompson, E., Haas, K., Weber, W., Wallace, M., . . . Roda, P. I. (2011). Using a nursing productivity committee to achieve cost savings and improve staffing levels and staff satisfaction. *Critical Care Nurse, 31*(6), 55-65.

[47] Shamliyan, T. A., Kane, R. L., Mueller, C., Duval, S., & Wilt, T. J. (2009). Cost savings associated with increased RN staffing in acute care hospitals: simulation exercise. *Nursing Economics, 27*(5), 302-314, 331.

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

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

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

[51] CNO. (2014). *RN and RPN practice: The client, the nurse and the environment*. Retrieved from http://www.cno.org/globalassets/docs/prac/41062.pdf.

[52] 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.

[53] 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.

[54] 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.

[55] 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.
[56] 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.

[57] 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.

[58] 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.

[59] 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). doi:10.4172/2167-1168.1000205.

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

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

[62] 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.

[63] CNO. (2017). *Membership statistics report 2017*. Retrieved from http://www.cno.org/globalassets/docs/general/43069_stats/2017-membership-statistics-report.pdf.

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

[65] Stronger, Healthier Ontario Act (Budget Measures), 2017 (S.O. 2017, c. 8 - Bill 127). Retrieved from https://www.ontario.ca/laws/statute/S17008.

[66] RNAO. (2016). *Registered Nurse Prescribing Referral – Submission to the Health Professions Regulatory Advisory Council*. Retrieved from https://rnao.ca/sites/rnao-ca/files/RNAO_RN_Prescribing_HPRAC_-_Jan_15_2016_Submission-Final.pdf

[67] RNAO. (2018). RNAO Submission on RN Prescribing Competencies Submission to the College of Nurses of Ontario. Retrieved from https://rnao.ca/sites/rnao-ca/files/RNAO_Submission_to_CNO_on_RN_Prescribing_Competencies_Nov_2018.pdf

[68] RNAO. (2019*). RNAO Submission on RN Prescribing – Proposed Regulation Change to the College of Nurses of Ontario.* Retrieved from https://rnao.ca/sites/rnao-ca/files/RNAO_Submission_RN_prescribing_Jan_28_2019.pdf

[69] College of Nurses of Ontario. (2018). *Clause by clause overview of draft regulation under the Nursing Act, 1991*. Retrieved from http://www.cno.org/globalassets/1-whatiscno/legislation/clause-by-clause-regulation-overview.pdf.

[70] RNAO. (2019*). RNAO Submission on RN Prescribing – Proposed Regulation Change: Submission to the College of Nurses of Ontario.* Retrieved from https://rnao.ca/sites/rnao-ca/files/RNAO_Submission_RN_prescribing_Jan_28_2019.pdf

[71] Royal College of Nursing. (2012). *RCN Fact Sheet: Nurse Prescribing in the UK.* Retrieved from https://www.rcn.org.uk/about-us/policy-briefings/pol-1512.

[72] RNAO. (2019*). RNAO Submission on RN Prescribing – Proposed Regulation Change: Submission to the College of Nurses of Ontario.* Retrieved from https://rnao.ca/sites/rnao-ca/files/RNAO_Submission_RN_prescribing_Jan_28_2019.pdf

[73] RNAO. (2016). *Registered Nurse Prescribing Referral – Submission to the Health Professions Regulatory Advisory Council*. Retrieved from https://rnao.ca/sites/rnao-ca/files/RNAO_RN_Prescribing_HPRAC_-_Jan_15_2016_Submission-Final.pdf

[74] Health Professionals Regulatory Advisory Council. (2015). *Registered Nurse Prescribing: Putting Patients First - Volume 2*. Retrieved from https://www.hprac.org/fr/reports/resources/RN-Prescribing-Vol-2-Final-2016-03-21-FINAL-s.pdf

[75] Public Hospitals Act: Regulation 965 Hospital Management. (1990, c. P.40). Retrieved from https://www.ontario.ca/laws/regulation/900965

[76] Health Protection and Promotion Act (1990, c. H.7). Retrieved from https://www.ontario.ca/laws/statute/90h07

[77] Psychotherapy Act, 2007 (S.O. 2007, c. 10, Sched. R). Retrieved from https://www.ontario.ca/laws/statute/07p10.

[78] CNO. (2018). *Psychotherapy and the controlled act component of psychotherapy*. Retrieved from http://www.cno.org/en/learn-about-standards-guidelines/educational-tools/ask-practice/answers-to-your-questions-about-psychotherapy/

[79] CNO. (2018). *Council decides – December 2018*. Retrieved from http://www.cno.org/globalassets/1-whatiscno/council/meetings/2018/council-decides-dec-vfinal.pdf

[80] CNO. (2018). *Proposed amendments to Part III (Psychotherapy) of Ontario Regulation 275/94 (General) under the Nursing Act, 1991*. Retrieved from http://www.cno.org/globalassets/1-whatiscno/legislation/draft-regulation---psychotherapy.pdf

[81] RNAO. (2019). Letter to CNO: RNAO support of independent initiation of the controlled act of psychotherapy. Retrieved from https://rnao.ca/sites/rnao-ca/files/RNAO_feedback_to_CNO_psychotherapy_feb_11_2019.pdf

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

[83] 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.

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

[85] 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.

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

[87] 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.

[88] RNAO & ONA. (2018). *Ontarians need more registered nurses*. Retrieved from http://rnao.ca/sites/rnao-ca/files/RNAO_ONA_Backgrounder_May72018.pdf.

[89] CNO. (2018). *RN and RPN practice: The client, the nurse and the environment*. Retrieved from http://www.cno.org/globalassets/docs/prac/41062.pdf.

[90] CNO. (2018). *RN and RPN practice: The client, the nurse and the environment*. Retrieved from http://www.cno.org/globalassets/docs/prac/41062.pdf.

[91] 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.

[92] Bradley, E., Hynam, B., & Nolan, P. (2007). Nurse prescribing: reflections on safety in practice. *Social Science & Medicine. 65*(3), 599-609.