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

QPOR QUEEN's PARK ON THE ROAD

Fully Utilizing Registered Nurses (RN)

Will you join RNAO's call to develop a provincial 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 support the implementation of the recommendations from RNAO's *Mind the Safety Gap in Health System Transformation: Reclaiming the Role of the RN*, beginning by mandating an all RN-workforce in tertiary, quaternary, and cancer care hospitals?

Can we count on you to urge the government to deliver its promise to implement independent RN prescribing by making the necessary legislative/regulatory amendments this year and launching the voluntary education course for current RNs in 2017?

RNs represent the largest group of regulated health professionals in Ontario.[1] RNs are present in virtually every health service delivery setting. The public has ready access to RNs and poll after poll shows that RNs are privileged with the highest public trust compared to any other occupation. RNs are often the first point of contact with the health system. Key features of health system effectiveness involve appropriately utilizing all health professionals to their full competencies, knowledge and skills. This includes making appropriate decisions pertaining to nurse staffing and organizational models of nursing care delivery.

Health human resources are the fuel necessary to drive the engine of change in Ontario's health system. Exciting transformation efforts are underway. However, 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. In absence of this plan and corresponding policy, some organizations are replacing RNs with less qualified providers and/or fragmenting nursing care delivery into tasks delegated to practical nurses and unregulated providers. This practice, known as "functional nursing" was abandoned in the 1970s 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.

This is occurring at a time when Ontario has the worst RN-to-population ratio. RNAO calculations based on CIHI figures show the province has only 711 RNs per 100,000 people compared to an average of 841 per 100,000 people in the rest of Canada.[2] A lack of effort to adequately address population health needs, combined with an increased emphasis on community-based care means that complexity is rising across sectors. How can we put patients first while replacing RNs with less qualified health-care providers?

The evidence conclusively shows that using RNs results in improved clinical and financial outcomes. 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. [3,4,5, 6,7, 8,9,10,11,12] Recent evidence also demonstrates that patient outcomes improve when RNs provide direct care instead of assuming a supervisory role in functional nursing.[13] A higher proportion of RNs is also linked to shorter lengths of stay and improvements in failure to rescue, as well as superior organizational effectiveness (fewer adverse events and staff injuries). [3,14,15,16] Adding full time equivalent RNs to increase the number of hours per patient day to 9 would save 5900 lives per year, reduce hospital days by 3.6 million and increase productivity by $1.3 billion per year.[17] Another study demonstrated an investment in RNs at a cost of $1.36 million resulted in a savings on units from $2.2 million to $13.2 million in prevented adverse events.[18] The evidence is clear, increasing the number of RNs will benefit the public, improve organizational outcomes and save money for the health system.

In May, RNAO released a policy report outlining what must happen if Health Minister Eric Hoskins wants to achieve his goal of putting patients first. The report makes the following eight recommendations:

1. MOHLTC develop a provincial evidence-based interprofessional HHR plan to align population health needs and the full and expanded scopes of practice of all regulated health professions with system priorities.
2. MOHLTC and Local Health Integration Networks (LHIN) issue a moratorium on nursing skill mix changes until a comprehensive interprofessional HHR plan is completed.
3. Mandate LHINs to use organizational models of nursing care delivery that advance care continuity and avoid fragmented care.
4. MOHLTC legislate an all-RN nursing workforce in acute care within two years for tertiary, quaternary and cancer centres (Group A and D hospitals) and within five years for large community hospitals (Group B).
5. LHINs to require that all first home health-care visits be completed by an RN.
6. MOHLTC, LHINs and employers eliminate all barriers, and enable NPs to practise to full scope, including: prescribing controlled substances; acting as most responsible provider (MPP) in all sectors; implementing their legislated authority to admit, treat, transfer and discharge hospital in-patients; and utilizing fully the NP-anaesthesia role inclusive of intra-operative care.
7. MOHLTC legislate minimum staffing standards in LTC homes: one attending NP per 120 residents, 20 per cent RNs, 25 per cent RPNs and 55 per cent personal support workers.
8. LHINs locate the 3,500 CCAC care co-ordinators within primary care to provide health system care co-ordination and navigation, which are core functions of interprofessional primary care.

RNAO is not sitting idly by as RN replacement is occurring and functional models of nursing care delivery are re-emerging. We have issued *Action Alerts*, calling on nurses, other health professionals and the public to respond and 21,500 have done so. As a start, RNAO is calling for a focus to mandate an all RN-workforce in tertiary, quaternary, and cancer care centres. These centres are designed to provide care specifically to persons with high degrees of complexity and instability. Any attempt to replace RNs in these settings is unconscionable.

Independent RN Prescribing

A task force convened by RNAO in 2012 to examine the utilization of nurses in primary care, resulted in a recommendation to expand the scope of practice of the RN to include prescribing.[19] The government listened and committed to RN prescribing in 2013. Most recently, RN prescribing was included in the 2016 budget and at RNAO's 91st Annual General Meeting Minister Hoskins announced his support for independent RN prescribing.[20] RNAO is proposing that RNs be responsible and accountable for the entire nursing process (assessment, planning, intervention, evaluation) where it is appropriate within their scope. This will be the key to unlocking timely access to quality health services across the system. As part of their assessments they should be able to order diagnostic testing/imaging and communicate a diagnosis. They should also be able to independently provide the appropriate treatment within their scope, which may include prescribing a medication. For this to be realized, legislative/regulatory amendments are needed to the *Nursing Act* and sector specific legislation (e.g. *Public Hospitals Act).*

In Ontario, RNs are required to complete a four year baccalaureate degree, which results in one of the highest entry-to-practice nursing education standards in the world. However, RNAO recognizes that independent prescribing is not currently within the nursing education curriculum for RNs. Therefore, a two-phased approach is proposed. First, RNAO proposes the development of a voluntary 300 hour continuing education course for current RNs, to launch in 2017. This mimics the process in the United Kingdom where RNs who complete the course are able to independently prescribe. RNAO is calling for the course to include classroom learning, however, the bulk of the learning will involve clinical experience and mentorship within workplaces. Then, by 2020, RNAO calls for the expanded RN scope to be included in the undergraduate nursing curriculum, so that all RNs graduating are optimally equipped to facilitate timely access to health services.

RNAO provided a comprehensive analysis of independent RN prescribing in its submission to the Health Professions Regulatory Advisory Council in 2015.[21] Both the International Council of Nurses (ICN) and Sigma Theta Tau International (STTI) have joined RNAO in endorsing independent RN prescribing in Ontario.[22]

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