College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario

THE STANDARD OF CARE.

**Agenda Item 3.2**

# Discussion Note – June 2020 Council
# RPN Scope of Practice: revised Controlled Acts Regulation for submission to Government

## Contact for Questions

Kevin McCarthy, Director of Strategy

## For Discussion

That Council approve proposed changes, as shown in Attachment 1 to the briefing note, to Part III, Controlled Acts of Ontario Regulation 275/94: General, as amended, made under the *Nursing Act, 1991* for submission to the Minister of Health.

## Public Interest Rationale

The implementation of these regulations will allow patients, in community settings, to receive more timely care by eliminating the need for an RPN to obtain an order before providing these aspects of care.

## Question for Council

In March 2020 Council approved draft regulation changes for notice and circulation (60-day consultation).[1] Does the feedback received change Council's perspective that the proposed regulation is in the public interest?

## Background

In June 2019, CNO received a letter from Ontario's Minister of Health requesting that CNO make the necessary regulatory amendments to authorize RPNs to perform the following procedures without first obtaining an order:

- irrigating, probing, debriding and packing a wound

[1] Subsection 95(1.4) of the Health Professions Procedural Code under the *Regulated Health Professions Act, 1991* requires all regulations made by Council to be circulated for at least 60-days.

- venipuncture to establish peripheral intravenous access and maintain patency using a solution of normal saline (0.9 per cent), in circumstances in which the individual requires medical attention and delaying the venipuncture is likely to be harmful to the individual
- assisting with health management activities that require putting an instrument beyond the labia majora and, assessment that requires putting an instrument, hand or finger beyond the labia majora
- assessing an individual or assisting an individual with health management activities that requires putting an instrument or finger beyond an artificial opening into the patient's body

All nurses are accountable for their own practice, for being aware of the limits of their competence and from refraining from providing care when not competent. Currently, RPNs are providing these aspects of care when an order is provided. This means that this regulation, once implemented, will result in a change in RPN authority rather than a change in RPN practice.

Should this regulation move forward, the need for an order will remain unchanged in a hospital setting. The *Public Hospitals Act* requires that there be an order for any treatment by an RN or RPN. Thus, this change will only occur in community settings.

The timeline below outlines the key activities that have led to development of the draft regulation that you are considering today.

**Summary of Literature Review:**
Council reviewed the results of a comprehensive literature review in June 2018. While there were limitations to this review (e.g. most of the literature referenced is about nurses in general, difficult to find studies that fully reflect the RPN role in Ontario), the literature suggests there are relevant roles for RPNs related to the proposed activities. In addition, the literature referred to factors that support safe nursing practice. This information was instrumental in Council moving forward with developing regulation amendments that were based on evidence.

**Stakeholder Consultations, 2019:**

A key focus of the work conducted to date has been to determine if existing regulatory mechanisms are sufficient to ensure public protection or if additional requirements are necessary. In the Fall of 2019, CNO engaged in stakeholder consultations to explore this issue with those who would be most impacted by the changes. Stakeholders included community employers, clinical experts, CNO's Employer Reference Groups (Multi-Sector and Long-Term Care), educators, including CNO's Academic Reference Group, unions and associations (RPNAO, RNAO, NPAO, Ontario Personal Support Workers Association, Ontario Hospital Association, Retirement Home Regulatory Authority, and Home Care Ontario).

These stakeholder consultations confirmed that existing regulatory mechanisms do support safe care and will support the safe implementation of these changes. However, a need to raise awareness of these existing resources was identified. CNO's current standards, guidelines and resources articulate the requirements of all nurses to ensure competence before providing care and accountabilities for assessment and follow-up once care has been provided.

A comprehensive communications plan will be developed to draw nurses and other key stakeholders to our existing resources. A focus will be on raising awareness of the document 'RN and RPN Practice: The Client, The Nurse and The Environment' to assist employers and nurses in establishing role clarity within their practice settings. The information shared in this document identifies accountabilities for RNs and RPNs and outlines factors to be considered when assigning the appropriate care.

**Circulation and summary of feedback**

Attachment 1 shows relevant sections of the current Controlled Acts Regulation (Ontario Regulation 275/94, s. 15 & 15.1), with proposed additions highlighted in yellow. These revisions were circulated to nurses and key stakeholders on March 13, 2020 with a request for feedback by May 11, 2020.

CNO received 3,150 survey responses:

- 174 NP
- 1,399 RN
- 1,273 RPN
- 151 members of the public, and
- 153 other

When asked, “Do you support the regulation change?”

- 50.9% responded no (1,607)
- 43.2 %responded yes (1,364)
- 5.8% (184) were unsure

84.1% of RPNs who responded supported the regulation change.

79.5% of RNs who responded did not support the change.

When asked, “Is the proposed regulation change in the public interest?”

- 46% of respondents said no (1,470)
- 43.2 % of respondents said yes (1,363)
- 10.2% of respondents were unsure (322)

77.3% of RPNs who responded indicated that the proposed regulation change is in the public interest.

72.4% of RNs who responded stated that it is not in the public interest.

151 members of the public responded to the survey. Of those, 86% of the members of the public who responded did not support the change. However, when these changes were shared with Council’s Public Advisory Group in the fall of 2019 there was broad support. The members of the group are well versed in the regulatory role and CNO council consults with them frequently. The advisory group’s November 2019 Report includes feedback on the RPN scope changes.

**Thematic Analysis**

A thematic analysis of the survey feedback was conducted by two CNO staff who independently reviewed feedback to identify common themes and conferred to ensure consistency of themes identified. Themes are summarized in attachment 3 and fall into the following categories:

Themes in support of the regulation:

- More timely access to patient care and continuity of patient care
- RPNs’ ability - with the right supports, they can attain the necessary competence to initiate these procedures
- RPNs are already competently providing this care under the authority of an order

Themes in opposition to the regulation:

- RPNs lack knowledge, skill and judgment to perform these procedures

- Risk to patient safety related to certain procedures (e.g. wound care, specifically debriding, and venipuncture)
- Cost-savings is the motivator for this change

To date, we have received two letters from key stakeholders – the Ontario Nurses Association (Attachment 4) and the Registered Nurses' Association of Ontario (Attachment 5). However several key stakeholders provided feedback through the survey, including RPNAO (weRPN) (Attachment 6)

## Next Steps:

- Should Council approve the proposed regulation, it will be submitted to the Minister of Health by the end of June 2020.
- After submission to the Minister, the regulation undergoes the Ministry's internal review. The Minister has the power to alter Council's proposed regulation before it is approved by the government. The regulation will not take effect until it is approved by the Ontario government.
- CNO will move forward with a communications plan that will focus on raising awareness among all nurses and stakeholders about regulatory mechanisms that support safe nursing practice (e.g. RN and RPN Practice: The Client, The Nurse and The Environment, Authorizing Mechanisms, Decisions About Procedures and Authority).

## Attachments:

1. Draft Proposed Controlled Acts amendments
2. Practice Background
3. Summary of key themes in response to circulation of the proposed regulation
4. Letter from Ontario Nurses Association
5. Letter from Registered Nurses' Association of Ontario
6. Feedback from the Registered Practical Nurses' Association of Ontario (weRPN)

## Attachment 1

Below is the proposed regulation change that will enable RPNs to initiate these activities in the absence of an order. Changes are highlighted in yellow:

**Nursing Act, 1991**

**ONTARIO REGULATION 275/94**

**GENERAL**

**Consolidation Period:** From January 1, 2020 to the e-Laws currency date.

Last amendment: 473/19.

***This is the English version of a bilingual regulation.***

**15.1** (1) For the purposes of clause 5 (1) (a) of the Act, a registered practical nurse in the general class may perform a procedure set out in subsection (2) if he or she meets all of the conditions set out in subsection (3). O. Reg. 387/11, s. 1.

(2) The following are the procedures referred to in subsection (1):

1. With respect to the care of a wound below the dermis or below a mucous membrane, any of the following procedures:
   i. cleansing,
   ii. soaking,
   iii. irrigating,
   iv. probing,
   v. debriding,
   vi. packing,
   vii. dressing.

2. Venipuncture to establish peripheral intravenous access and maintain patency, using a solution of normal saline (0.9 per cent), in circumstances in which,
   i. the individual requires medical attention, and
   ii. delaying venipuncture is likely to be harmful to the individual.

3. A procedure that, for the purpose of assisting an individual with health management activities, requires putting an instrument,
   i. beyond the point in the individual's nasal passages where they normally narrow,

ii. beyond the individual's larynx, or
iii. beyond the opening of the individual's urethra.

4. A procedure that, for the purpose of assessing an individual or assisting an individual with health management activities, requires putting an instrument or finger,

i. beyond the individual's anal verge, or
ii. into an artificial opening into the individual's body.

5. A procedure that, for the purpose of assessing an individual or assisting an individual with health management activities, requires putting an instrument, hand or finger beyond the individual's labia majora.

6. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgment, insight, behaviour, communication or social functioning. O. Reg. 387/11, s. 1; O. Reg. 473/19, s. 2.

## Attachment 2

### What is a controlled act?

- A controlled act is a procedure that poses a significant risk to the public if performed by an unqualified person. All of the controlled acts are set out in Section 36 of the Regulated Health Professions Act. The controlled acts that nurses can perform are set out in the Nursing Act.

### What is an order?

- An order is a prescription made by a regulated health professional for a procedure, treatment, drug or intervention for a particular client. A RN or RPN requires an order when: a procedure falls under a controlled act authorized to nursing or when required by other legislation such as the Public Hospitals Act. Or, orders may be required by organizational policy.

### What is initiation?

- Initiation allows RNs and RPNs to independently decide to perform certain controlled acts in the absence of an order when conditions are met. In order for nurses to be able to initiate controlled acts, they need to be specific in regulations.

### What do these changes mean?

The changes will enable RPNs to initiate components of certain controlled acts which they currently are able to perform with an order, as follows.

Authorizing RPNs to initiate irrigation, probing, debriding and packing a wound

- What is this?
  - Irrigation, probing, debriding and packing are activities associated with complex wound care
- What is the current situation?
  - RPNs are authorized to initiate cleansing, soaking and dressing a wound – they need an order for irrigation, probing, debriding and packing a wound
- What is the Minister proposing?
  - That CNO amend regulation 275/94 under the *Nursing Act, 1991* to allow RPNs to initiate irrigation, probing, debriding and packing a wound

Authorizing RPNs to initiate venipuncture to establish peripheral intravenous access and maintain patency using a solution of normal saline (0.9 per cent), in circumstances in which the individual requires medical attention and delaying the venipuncture is likely to be harmful to the individual.

- What is this?
    - Venipuncture establishes access to a vein (for example, for fast fluid replacement)
- What is the current situation?
    - Currently, RPNs can perform venipuncture with an order
- What is the Minister proposing?
    - That CNO amend regulation 275/94 under the *Nursing Act, 1991* to allow RPNs to initiate venipuncture to establish peripheral intravenous access and maintain patency, in certain circumstances

Authorizing RPNs to initiate assistance with health management activities that require putting an instrument beyond the labia majora and, initiate activities that for the purpose of assessing an individual, require putting an instrument, hand or finger beyond the labia majora.

- What is this?
    - This relates to RPNs initiating a procedure that, for the purpose of assisting or assessing an individual, requires putting an instrument, hand or finger beyond the individual's labia majora
- What is the current situation?
    - For the purpose of assisting an individual with health management activities, RPNs can initiate putting a hand or finger beyond the labia majora, but they must have an order to put an instrument beyond the labia majora.
    - For an RPN to perform any of the above activities for *assessment* purposes they currently require an order.
- What is the Minister proposing?
    - That CNO amend the regulation 275/94 under the *Nursing Act, 1991* to allow RPNs to initiate putting an instrument beyond a client's labia majora for assistance or putting an instrument, hand or finger beyond a client's labia majora for assessment purposes

Authorizing RPNs to initiate assessing an individual or assisting an individual with health management activities that requires putting an instrument or finger beyond an artificial opening into the client's body

- What is this?
    - Examples of procedures that involve putting an instrument or finger beyond an artificial opening into the client's body are cleaning a colonoscopy stoma or suctioning an established tracheostomy site
- What is the current situation?
    - Currently, RPNs can initiate activities related to openings in the client's body (for example, beyond the anal verge) – but not an artificial opening. They can perform procedures that require putting and instrument or finger beyond an artificial opening into the client's body when an order is provided.
- What is the Minister proposing?
    - That CNO amend the regulation 275/94 under the *Nursing Act, 1991* to allow RPNs to initiate putting an instrument or finger beyond an artificial opening into the client's body

## How will the public be protected?

RPNs already have the authority to initiate components of some controlled acts, as described above. Regulatory mechanisms are in place to support protection of the public. Before initiating any controlled act, regulations under the *Nursing Act, 1991* require all RPNs and RNs to:

- have the knowledge, skill and judgment to perform the procedure safely, effectively and ethically
- have the knowledge, skill and judgment to determine whether the individual's condition warrants performance of the procedure
- determine that the individual's condition warrants performance of the procedure, having considered:
    - the known risks and benefits to the individual of performing the procedure
    - the predictability of the outcome of performing the procedure
    - the safeguards and resources available in the circumstances to safely manage the outcome of performing the procedure
    - other relevant factors specific to the situation
- accept accountability for determining that the individual's condition warrants performance of the procedure

## Attachment 3 – Summary of key themes

The following summarizes key themes from qualitative feedback submitted via the survey as well as written responses from organizations.

### Themes in support of the regulation:

- **More timely access to patient care and continuity of patient care**

Stakeholders noted that the proposed changes would reduce wait times and improve access to care. The changes would also contribute to continuity of care, allow for more timely access to procedures and better patient care in community settings. For example, it was noted that delays in obtaining an order to initiate treatment negatively impacts patient care:

> *"I work in the community and have the knowledge, skills and judgement to complete these tasks and determine when certain procedures should be initiated. However, awaiting an order delays the treatment, sometimes for days!! This is often detrimental to the patient- ask anyone who's ever tried to get an order on a Saturday afternoon."*

- **RPNs' ability - with the right supports, they can attain necessary competence**

The feedback suggested that RPN education provides the foundational knowledge, skill and judgement for RPNs upon which competence to initiate these procedures can be built. Stakeholders emphasized that as long as RPNs have the necessary competence and with the right supports such as education and mentorship, an order is not needed to perform these procedures safely.

> *"With increased education and training I, as an NP, have no concerns in enabling RPN's to perform these controlled acts in the establishment of practicing to one's full scope."*

> *"It's my belief RPN's can develop the competence for those particular tasks listed in this article. RPN's know their limits and will consult when necessary. RPN's have the ability to manage outcomes to those tasks as well. Therefore I believe it's reasonable to have the RPN scope expand to add the medical procedures listed."*

- **RPNs are already competently providing this care under the authority of an order**

Stakeholders stated that RPNs are currently performing these procedures competently in practice. As noted below, depending on the practice setting, many of these procedures are already being performed safely under the authority of an order or medical directive:

*"In many instances where "standing orders" are already in place RPNs perform these tasks without consulting a physician or advanced practitioner."*

### Themes in opposition to the regulation:

- **RPNs lack knowledge, skill and judgment to perform these procedures**

The majority of stakeholders who did not support the proposed regulation were concerned with the proposed changes due to RPNs' lack of foundational education as well as not having the necessary knowledge, skill and judgement, particularly critical thinking skills which can jeopradize patient safety. Furthermore, it was noted that due to complexity of these procedures, they should remain within the RN scope of practice.

*"The RPN does not have the ability to act on his/her judgment alone related to lack of education skill and abilities."*

*"RPNs may be taught how to complete the task but do they have the required judgement skill and knowledge to troubleshoot and determine when such tasks are appropriate."*

- **Risk to patient safety related to certain procedures (e.g. wound care, specifically debriding, and venipuncture)**

Stakeholders expressed concern with certain procedures that could cause risk to patient safety. Concern was raised in particular related to debridement of a wound and venipuncture. It was emphasized that additional advance training and, possibly, certification is required in these areas. They stated that RPNs do not have the advance knowledge to properly make an informed decision on how to treat and debride a wound. Many suggested that debridement should be left to RNs and other practitioners who are specialized and certified in wound care.

*"Debridement is a skill that requires education, mentorship, validation of skill and ongoing practice to achieve and maintain competency; probing a wound can cause serious, irreparable harm to patients without understanding the anatomy and structures adjacent to wound openings - puncturing a lung or bowel is serious."*

- **Cost-savings is the motivator for this change**

Stakeholders stated that these changes were motivated by cost-savings to the healthcare system and not in the interest of the public. They commented that it is a way to add more responsibility to RPNs for less pay and ultimately to replace RNs with RPNs for cost-savings reasons:

*"Patient safety should come before cost savings. These proposed changes feel like they are a way to get RN work from RPNs at a savings to the employer but a huge risk to the population."*

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May 7, 2020

**VIA EMAIL**

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Dear Ms. Coghlan, Mr. McCarthy & Ms. Evans,

**Re: Proposed Regulation Changes Expanding the Scope of Practice for Registered Practical Nurses (RPNs)**

I am writing to express ONA's position regarding the College of Nurses of Ontario's (CNO) proposed Regulation expanding the scope of practice for Registered Practical Nurses (RPNs). ONA is concerned that the draft Regulation is not evidence-based and that approving the Regulation without comprehensive consultation may lead to reduced patient outcomes.

ONA strongly believes that both RNs and RPNs have a legitimate place in our health care system. Both contribute a great deal to the needs of their patients. However, RPNs practice appropriately with patients with less complex health needs and stable and predictable outcomes. A proposal that may force RPNs to care for unstable patients with unpredictable outcomes poses a risk to patient safety. As CNO itself points out in its three factor framework guideline, while RNs and RPNs study from the same body of nursing knowledge, RNs study for a longer period of time, which equips them with greater foundational knowledge in clinical practice, decision-making, critical thinking and leadership. As a result, the level of autonomous practice of RNs is greater than that of RPNs.

The proposed Regulation will primarily affect the care of patients in long-term care and community settings. We know that patients in these settings are more complex and have greater acuity levels than in the past. In addition, these practice settings are relatively unsupported, often short staffed and face challenges ensuring continuity of care. Therefore, it is essential that the scope of practice for RNs and RPNs is accurate and appropriate for these patients.

Allowing an RPN to make decisions about a newly authorized procedure, without the critical thinking skills and guidance of an RN, could result in negative outcomes for patients. RPNs rely on the enhanced critical thinking and leadership of RNs. An RN assesses a patient's complexity and the individual RPN's level of knowledge, skill and judgment, to determine whether it is appropriate to delegate an intervention to the RPN. Allowing RPNs to initiate controlled acts independently assumes not only that they have the practical skills and knowledge to ensure competency but that they possess the analytical and critical thinking skills to determine when an intervention is necessary and within their scope.

We are specifically opposed to RPNs independently initiating venipuncture in order to establish a peripheral intravenous line. If a patient's condition has deteriorated to the point they are in need of this procedure, that patient is, by definition, unstable. According the three factor framework, a client who is unstable is more likely to fall within the scope of an RN. Similarly, extending an RPN's scope to include packing and debridement of wounds also raises concerns for patient safety. RPNs do not have the critical thinking skills and training to provide this type of intensive wound care. These are only two examples of the proposed expanded scope for RPNs that raise issues of patient safety.

Any proposal to expand RPN scope of practice into traditional RN scope must be informed by the best available evidence, including peer-reviewed research and advice from clinicians and experts. ONA has reviewed the Briefing Notes presented to CNO Council in June 2018, September 2019 and December 2019. This material makes it clear that the expanded RPN scope is not supported by strong research. In fact, the opposite is true. The summary of the literature review states, **"It is important to note that there is <u>not</u> a significant amount of literature related to RPNs."** (June 2018 Council Briefing Notes, p. 152). A decision as important and as risky as expanding RPN scope cannot be based on incomplete research.

A review of the role of RPNs (or "Licensed Practical Nurses") in other provinces shows that no other province except British Columbia allows RPNs to perform any of the proposed procedures without an order.

It is essential not only that any proposed RPN scope be evidence-based but that it be undertaken based on a comprehensive consultation process. However, the Council Briefing Notes demonstrate that ONA and the Registered Nurses Association of Ontario expressed strong opposition to the proposal because of concerns regarding patient safety. These concerns were not closely examined or discussed in any detail. In addition, clinical experts expressed specific worries with allowing wound debridement and more general concerns regarding role confusion. Again, these concerns were not thoroughly explored or resolved.

It is clear to ONA that CNO's proposal to expand RPN scope is not evidence-based and does not include a careful and measured consultation with nursing experts and stakeholders, including ONA. This consultation must not be rushed or completed during a time when nursing stakeholders are preoccupied with an unprecedented pandemic. Patient safety requires no less.

Sincerely,

**ONTARIO NURSES' ASSOCIATION**

Vicki McKenna, RN
President

C: ONA Board of Directors

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

May 25, 2020

Cheryl Evans, Council President
Anne Coghlan, Executive Director and Chief Executive Officer
College of Nurses of Ontario
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Dear Cheryl and Anne,

**Re: Expanding RPN scope of practice and RN prescribing**

The Registered Nurses' Association of Ontario (RNAO) welcomes the opportunity to provide feedback to the College of Nurses of Ontario (CNO) on its proposed new regulation to expand the Registered Practical Nurse (RPN) scope of practice to include independent initiation of the following controlled acts:

- Irrigate, probe, debride and pack a wound below the dermis or below a mucous membrane;
- Venipuncture to establish peripheral intravenous access and maintain patency using a normal saline solution when the client requires medical attention and delaying venipuncture is likely harmful to the client;
- Put an instrument, hand or finger beyond the labia majora when assessing or assisting with health management activities; and
- Put an instrument or finger beyond an artificial opening into the client's body for the purpose of assessing or assisting with health management activities.[1] [2]

As we have already expressed to the CNO, RNAO does not support the proposed regulation summarized above and believes the proposed changes to the RPN scope will result in damaging shortfalls related to:

1. Protection of patient safety
2. Requisite knowledge, skills and judgment required for procedures not in the RPN skill set
3. Decision-making influenced by client factors under CNO's three-factor framework (complexity, predictability and risk of negative outcomes).[3]

RNAO's concern regarding substantial scope of practice expansion for RPNs to initiate these controlled acts was echoed in 2018 by Helena Jaczek, then minister of health, when she requested a hold on CNO's advancement on this matter until comprehensive, evidence-based, and expert-advised consultation was complete.[4] [5] Once again, two years later, these same four controlled acts are being proposed by CNO for RPN initiation in this regulation change, after so recently being disallowed by government.[6]

It is important to note that the current scope of RPN practice, based on a previous regulation change, allows for RPNs to perform the above intrusive procedures with an order from an appropriate provider.[7] Moreover, the RPN scope has consistently been expanded in particular, over the past three to four years, to include performance of controlled acts, and now initiation of these acts, whereas there has been complete stagnation in scope expansion for RNs evident in the *Nursing Act, 1991* and regulation,[8] [9] since the move to the BScN entry requirement for RNs in 2005, when RN education moved from three to four years.[10] [11] [12]

Of critical concern is that expanding the RPN scope to authorize independent initiation of these controlled acts effectively renders the Registered Nurse (RN) and RPN scope identical. That the CNO takes this move is objectionable considering that RPNs have a two year college degree and RNs a four year baccalaureate. As we have discussed in repeated occasions with CNO staff, RNAO insists that these changes jeopardize the safety of Ontarians, will add to already existing role confusion and tensions, and grossly undermine the enhanced knowledge and critical thinking of RNs.

According to the CNO three-factor framework referenced in *RN and RPN Practice: The client, the nurse, and the environment*, complex patients with less predictability and less stable environments are cared for by RNs.[13] CNO further explains:[14]

> RNs and RPNs study from the same body of nursing knowledge. RNs study for a longer period of time, allowing for greater foundational knowledge in clinical practice, decision-making, critical thinking, leadership, research utilization and resource management. As a result of these differences, the level of autonomous practice of RNs differs from that of RPNs.
>
> The complexity of a client's condition influences the nursing knowledge required to provide the level of care the client needs. A more complex client situation and less stable environment create an increased need for consultation and/or the need for an RN to provide the full range of care requirements.

Based on this framework, RPNs should not care for highly complex, unstable clients who are at risk for deterioration – therefore, initiation of the proposed procedures such as venipuncture and wound debridement should never be required of an RPN. Furthermore, RPN initiation of these controlled acts also implies urgency when an RN is not available which would rarely if ever be the case.

As RNAO strongly expressed in the May 8, 2020 meeting requested by CNO to discuss our concerns, it is RNAO's perception that CNO is skewing their regulatory decision making in favour of expanding RPN scope, without clear evidence of population health needs nor the requisite RPN knowledge, judgment and skills. Indeed, CNO is doing so contradicting its own framework mentioned above. Simultaneously, RNAO is keenly aware that CNO has actively attempted to contract RN scope of practice in spite of solid evidence of population need and high

capacity of RNs, (i.e., initiation of RN psychotherapy), and also has proceeded extremely slowly with RN scope expansion (i.e., RN prescribing).[15] [16]

As evidence for this perception, in 2014 the CNO acted to remove initiation of psychotherapy from the RN scope of practice despite the facts that: RNs had been consistently and ably carrying out this practice for approximately ten years, there is high population need, and it is clearly within the knowledge, skill and judgment of the RN. Furthermore, while, five regulatory bodies immediately enabled their professionals to initiate psychotherapy (occupational therapists, physicians, psychologists, registered psychotherapists, and social workers), CNO was the only regulatory body attempting to take away from RNs a long standing practice[17] This act of initiation for RNs was only fully reinstated without barriers in 2019 following a two year exemption period and considerable evidence-based advocacy on the part of RNAO that triggered a letter to CNO by Eric Hoskins, then minister of health.[18] [19] [20]

Further adding to this view, in the case of RN prescribing, the CNO has deliberated this scope change for the last eight years.[21] Once again in 2020, RNAO is providing feedback for how to proceed with this expanded scope in a timely way. At this time, we note that CNO is still not prepared to embrace the expansion of RN practice through continuing education for practicing RNs, as well as through the basic undergraduate nursing curriculum to be fully incorporated as part of the RN scope of practice for all graduating RNs.[22] CNO's stubbornness in regards to RN prescribing despite the robust evidence from other countries – such as United Kingdom and New Zealand – is difficult to comprehend. This position contradicts the evidence gathered by CNO itself and it is not good for patients, health organizations and the public.

This grave imbalance in CNO's approach to proposed regulatory changes related to RN and RPN scope is disheartening and shocking. RNAO would like to address this matter as a major concern directly with the CNO Council, and is asking for an urgent meeting to that effect. CNO's actions – favouring scope expansion for RPNs while presenting barriers to enhancing the RN role or even taking steps to narrow it – creates an unclear distinction between the two roles. Any blurring of the roles makes it difficult for employers and the public to understand and adequately utilize these two categories of nurses, and leads to tensions between RNs and RPNs. On the contrary, it is RNAO's view that both RN and RPN categories should be respected and fully utilized within their scopes of practice and both types of nursing education should be valued.

Such role confusion already leads to inappropriate utilization of regulated professionals, imbalanced workload and missed opportunities for expanded service delivery.[23] Furthermore, the role blurring may also discourage each category from practicing to their full extent and hinder the retention of RNs in practice settings that employ RPNs.[24]

RN and RPN category role confusion and blurring also raises the troubling question in the minds of students, the public and policymakers as to why a four-year university degree is required in the first place, when a two-year college graduate can perform almost at the same level of acuity,

complexity and initiation. Since there are substantial personal and societal costs to have a four year baccalaureate program, as compared to a two year program, this undervaluing of the baccalaureate degree is deeply worrisome. Indeed, the quality and level of RN undergraduate education must in no way be diminished and in fact must be enhanced to ensure sustained expanded RN scope, for example, by including RN prescribing in undergraduate nursing education. Having RNs graduate with this competency will enhance access to health services for Ontarians.

It should be noted that these moves by the CNO constitute a process of de-skilling of nursing care, as the requirement to perform complex procedures is approved for professionals with half the years of education that were previously required. There is a broad literature providing evidence of the harm to patients and society resulting from deskilling of nurses' work.[25] [26] [27]

Finally, the trends we have reviewed in this letter beg the question of what is CNO's understanding of its role regulating three different categories of nurses and how it intends to perform that role in the go forward. It should be clear from this letter that the professional association representing RNs and NPs in Ontario has serious concerns about how the College is performing its regulatory role.

In conclusion, RNAO is strongly opposed to the proposed RPN scope regulation change and maintains it is not in the public's best interest. We therefore recommend that CNO *does not* move forward to the Ministry of Health in June 2020 with the proposed new changes to RPN scope of practice.

We reiterate our request to meet with the CNO Council on our growing concerns about the imbalance in CNO's approach to proposed regulatory changes related to RN and RPN scope. Please let us know if you are open to such a meeting.

We thank you for the opportunity to provide feedback and trust you will continue to seek consultation with RNAO in regards to this matter.

Warm regards,

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President, RNAO

CC: CNO Council
Hon. Doug Ford, Premier of Ontario
Hon. Christine Elliott, Minister of Health
Helen Angus, Deputy Minister of Health
Sean Court, ADM, Strategic Policy and Planning Division, MOH
Allison Henry, Director, Health Workforce Regulatory Oversight Branch, MOH
Michelle Acorn, Provincial Chief Nursing Officer, MOH

## Endnotes

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## Attachment 6 – RPNAO (WeRPN) - Survey Feedback.

1. Wound Care: Currently many RPNs have the knowledge, skill and judgement to perform wound care procedures with an order. Some are wound care experts. However, when clients require wound care beyond cleansing, soaking, and dressing, the RPN, in community settings, is required to contact an RN for an order to initiate these procedures. In many cases the RN provides the order without personally assessing the wound, whereby the RPN is in effect initiating the additional procedures based on his or her own knowledge, skill, and judgement. In this situation, the RN "initiation" is substantively administrative in nature, rather than clinically based. In other cases, the RPN may not be able to contact the RN for an order because the RN is not able to personally assess the wound or is unavailable, potentially denying the client the care that he or she needs, or resulting in a deterioration of the client's wound that can lead to additional treatment that might include hospital admission. In practice, when RPNs are unable to access another health professional (MD, NP, RN) to obtain an order in a timely fashion, it can impact patient outcomes and the proposed changes will help address this issue.

2. Venipuncture: Initially when this regulation was enacted RPNs did not initiate venipuncture. Currently Ontario's RPNs routinely initiate venipuncture with an order and have the knowledge, skill, and judgement to initiate venipuncture when a client's condition rapidly deteriorates and the patient requires immediate access to IV fluids. The proposed amendment would ensure equitable and timely access to this essential emergency care in particular in rural and remote areas where RPNs may be the only available nurse and the client may not have timely access to a physician or NP to obtain an order

3. Assessing (Labia Majora): For the purpose of assisting an individual with health management activities, the current regulation permits an RPN to initiate a procedure that requires putting a hand or finger beyond the individual's labia majora. The regulation does not permit an RPN to initiate a procedure that, for the purpose of assessing an individual, requires putting a hand or finger beyond the individual's labia majora. The act of assessing precedes the actions of implementation in the nursing process. To permit implementation without permitting assessment is counterintuitive in many circumstances.

4. Assessing (Artificial Opening): For the purpose of assisting an individual with health management activities, the current regulation permits an RPN to initiate a procedure that requires putting a hand or finger beyond the individual's labia majora or anal verge. The regulation does not allow an RPN to initiate a procedure that requires putting an instrument or a finger beyond an artificial opening into a client's body. This restriction prohibits RPNs from initiating a number of procedures for the purpose of assisting an individual with health