



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

PRIMARY SOLUTIONS *for* PRIMARY CARE

**MAXIMIZING and
EXPANDING the
ROLE of the
PRIMARY CARE
NURSE in
ONTARIO**

PRIMARY CARE
NURSE
TASK FORCE
REPORT

PRIMARY CARE NURSE TASK FORCE MEMBERS

Doris Grinspan	Registered Nurses' Association of Ontario (co-chair)
Judie Surridge	Ontario Family Practice Nurses (co-chair)
Ann Alsaffar	Canadian Family Practice Nurses Association
Lisa Ashley	Canadian Nurses Association
Peter Brown	Ontario Medical Association
Sheilagh Callahan	George Brown College
Merry Cardinal	Association of Ontario Health Centres
Michelle Clifford-Middel	Georgian Nurse Practitioner-Led Clinic
Beth Cowper-Fung	Nurse Practitioners' Association of Ontario
Gwen Devereaux	Association of Family Health Teams of Ontario
Scott Downs	Gizhewaadiziwin Health Access Centre
Jan Kasperski	Ontario College of Family Physicians
Judith Manson	Association of Family Health Teams of Ontario
Claudia Mariano	Nurse Practitioners' Association of Ontario
Mariana Markovic	Ontario Nurses' Association
Dianne Martin	Registered Practical Nurses Association
Tammy O'Rourke	Nurse Practitioners' Association of Ontario
Kelly Pensom	Ontario Family Practice Nurses
Colleen Snyder	Association of Family Health Teams of Ontario
Adrianna Tetley	Association of Ontario Health Centres
Karen Thompson	Community Health Nurses' Initiatives Group
Tim Lenartowych	Registered Nurses' Association of Ontario (staff support)
Kayla Scott	Registered Nurses' Association of Ontario (staff support)

Please direct correspondence regarding this report to
Tim Lenartowych, RNAO Nursing Policy Analyst:

tlenartowych@rnao.ca

This document may be produced, reproduced or published in its entirety or in part, without modification, in any form, including in electronic form, for policy, educational and any other non-commercial purpose. Should any adaptation of the content contained in this document be required, for any reason, written permission must be obtained from RNAO. Appropriate credit or citation must appear on all copied materials in the following manner:

Registered Nurses' Association of Ontario (2012). *Primary Solutions for Primary Care: Maximizing and Expanding the Role of the Primary Care Nurse in Ontario*. Toronto, Ontario: Registered Nurses' Association of Ontario (RNAO).

Editors: Melissa Di Costanzo, Kimberley Kearsey, Marion Zych – RNAO

Designer: Olga Gabrieleva – RNAO

**PRIMARY
SOLUTIONS
for
PRIMARY
CARE**

**MAXIMIZING and
EXPANDING the
ROLE of the**

**PRIMARY CARE
NURSE in
ONTARIO**

PRIMARY CARE
NURSE
TASK FORCE
REPORT

TABLE OF CONTENTS:

Executive Summary.....	4
Introduction.....	11
Task Force Background.....	18
Literature Review.....	20
Historical Evolution.....	24
Nursing Human Resource Analysis.....	26
Primary Care Nurse Role Descriptions.....	29
Making It Happen.....	36
Evaluation.....	48
Recommendations.....	50
Next Steps.....	54
Conclusion.....	55
Appendix A . Primary Care Nurse Task Force Terms of Reference.....	56
Appendix B . Phase One Role Descriptions.....	58
Appendix C . Phase Two Role Descriptions.....	66
Appendix D . Primary Care Nurse Task Force Literature Synthesis.....	76
References.....	105

Dear Stakeholder,

The Primary Care Nurse Task Force was launched by the Registered Nurses' Association of Ontario (RNAO) in response to the gross under-utilization of thousands of primary care nurses – Registered Nurses (RNs) and Registered Practical Nurses (RPNs) – in Ontario's health system. Bringing together key stakeholders from across the health system, we engaged in factual and evidence-based discussions that were open, thoughtful, and respectful. The result is a report that offers a fair and balanced analysis and practical solutions to improve primary care. The goal is simple: improve access to timely, quality, and person-centred care for the public.

The sustainability of Ontario's health system depends largely on the success of primary care; success that can and must be advanced through innovative, evidence-based enhancements like the ones contained in this report. The nursing profession, as the largest group of regulated health professionals in Ontario, upholds its strong responsibility to study and recommend health system improvements that will optimize patient outcomes and system cost-effectiveness. The recommendations in this report are solution-focused and build on the tremendous potential that already exists within our health system.

This report is a blueprint to maximize and expand the role of primary care nurses, paving the path for other health professionals in Ontario. To benefit the public, we call on government and its agencies, professional associations, trade unions, regulatory bodies, educators, clinicians and employers to embrace and promptly implement the recommendations in this report.

We express our endless appreciation to all the Task Force members for their invaluable expertise. Their generous contribution of time illustrates an unwavering commitment to strengthen primary care for all Ontarians. Our gratitude also goes to the many voices from the field that grounded our work. Lastly, we extend a very special thanks to our RNAO staff Kayla Scott, for helping us launch this Task Force, and Tim Lenartowych, for his support in drafting this report.

Dr. Doris Grinspun RN, MSN, PhD, LLD(hon), O.ONT.

Judie Surridge RN, BA

Co-Chair

Chief Executive Officer

Registered Nurses' Association of Ontario

Co-Chair

President

Ontario Family Practice Nurses

Executive Summary

Overview

Nurses and other health professionals practise to their full scope when they are in a practice environment that enables them to fully utilize their competencies, knowledge, and skills to provide high quality, evidence-based and patient-centred care. The Commission on the Reform of Ontario's Public Services is calling for an expansion to the scope of practice of nurses and other health professionals as a sustainability strategy for Ontario's publicly-funded, not-for-profit health system.¹ College of Nurses of Ontario data estimates there are approximately 2,873 Registered Nurses (RNs) and 1,412 Registered Practical Nurses (RPNs) who practise in Ontario's primary care system, totaling 4,285 nurses.² Primary care can be defined as "...that level of a health service system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and co-ordinates or integrates care provided elsewhere by others."³ The Registered Nurses' Association of Ontario (RNAO), the professional association representing RNs working in all roles and sectors in Ontario, regularly receives anecdotal reports from the field suggesting that while nurses in all settings are working very hard and provide long hours of care, the roles of the RN and RPN in primary care are misaligned to the competencies, knowledge, and skills of these professionals. These reports are validated in a study that found only 61 per cent of Canadian RN respondents report practising to their full scope of practice in primary care.⁴ Clearly there is untapped potential in Ontario's primary care system with a significant nursing workforce waiting and eager to be fully utilized and take on expanded roles.

The Primary Care Nurse Task Force (hereafter referred to as the Task Force) was launched by

RNAO to explore the unique role of the RN and RPN in primary care, and to develop recommendations that optimize the full utilization of these nurses to strengthen patient outcomes and health system cost-effectiveness. The Task Force focused on the role of both RNs and RPNs to provide differential role clarity in primary care and optimize both roles within patient-centred interprofessional teams, while strengthening continuity of care.

While the scope of this Task Force was on RNs and RPNs practising in Ontario's primary care setting, the recommendations hold tremendous potential for nurses practising in other health sectors and jurisdictions. This report represents a first step towards ensuring the full utilization of all health professionals in Ontario, which is a part of Ontario's blueprint for action on interprofessional care.⁵ Future policy must strengthen the interprofessional team's ability to provide the highest quality of care for patients, while ensuring the most appropriate use of all health professionals and resources.

The Task Force focused on two progressive phases of outcomes. The first phase identifies the highest level of RN and RPN scope of practice utilization already present in selected primary care settings in Ontario and recommends an upward harmonization of scope of practice utilization for all primary care nurses, across all sites in Ontario. The second phase involves identifying needed expansions to the existing scope of practice of the primary care RN and RPN that would serve to further improve access to primary care for the public. The recommendations for the second phase focus on the mechanisms required to achieve the proposed scope of practice expansions.

1

Phase One

The Task Force collected current primary care RN and RPN role descriptions in Ontario and analyzed them to identify key elements of practice (i.e. health assessment, education, counseling, etc.). Following this initial analysis, the highest scope of practice utilization was identified within each practice element and this led to the development of prototype RN and RPN role descriptions. These role descriptions enable Ontarians and the health system to benefit from the full scope of practice utilization of RNs and RPNs.

Phase one recommendations from the Task Force centre on securing province-wide uptake of these prototype role descriptions, emphasizing that there is nothing contained in these that was not taken from an existing primary care nurse role description in Ontario. This analytical approach provides the necessary evidence that primary care RNs and RPNs are capable of providing a broad range of care to Ontarians, with the potential of providing much more substantial and comprehensive service to the public. The resulting role descriptions set the bar at a high and realistic level for an immediate upward harmonization of RN and RPN scope of practice utilization across all primary care settings in Ontario.

It is understood that in order to ensure a consistent utilization and implementation of the phase one role descriptions, a number of complementary system enhancements are required, including:

- ensuring role direction and clarity;
- leveraging existing primary care nursing educational programs and developing new ones as necessary. This includes learning institutes and online resources;
- enhancing current primary care models to include more time for on-site education, mentorship and research;
- leveraging the expertise of experienced primary care nurses already practising at full scope, nurse practitioners (NPs), family physicians, and clinical nurse specialists, to mentor and support primary care RNs and RPNs;

- expanding primary care nursing placements in entry level nursing education programs and supporting primary care nurses to take on teaching/mentoring roles;

- continuing to reform primary care funding models to ensure the most appropriate use of all health professionals and maximizing interprofessional care delivery; and
- supporting opportunities to build nursing leadership in primary care organizations.

2

Phase Two

There is significant potential for the roles of RNs and RPNs in primary care to be expanded to optimize patient care outcomes and achieve system efficiency and cost-effectiveness. Phase two RN and RPN role descriptions were developed to articulate expanded nursing roles in Ontario's primary care system.

The expanded role of the RN focuses on authorizing access to the following three controlled acts under the *Regulated Health Professions Act, 1991* through amendments to the *Nursing Act, 1991* and associated regulations:

- "Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis;"⁶
- "Prescribing, dispensing, selling or compounding a drug as defined in the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept;"⁷ and
- "Applying or ordering the application of a form of energy prescribed by the regulations under this Act."⁸

In addition, amendments would need to be made to the *Laboratory and Specimen Collection Centre Licensing Act, 1990* and associated regulations to permit RNs to order laboratory tests.

Practical examples where an expanded role of the RN would be appropriate include:

- The identification and treatment of Otitis Media (ear infection) or an infection of the throat which are common encounters in primary care;
- The initiation and maintenance of a comprehensive contraception program, which would involve prescribing birth control pills to patients. Currently, many public health nurses are assuming this function through delegation and medical directives; and
- The management of chronic illnesses where nurses have developed long-term therapeutic relationships with patients.

Given the overwhelming evidence identifying RNs' clinical expertise and its impact on patient and system outcomes, the significant international benefits of RNs prescribing medications in the United Kingdom (UK) and abroad, and the need for Ontarians to obtain timely access to quality primary care, the time is right to authorize RN prescribing in Ontario. In the context of this report, RN prescribing is defined as authorizing RNs to: initiate, renew, dispense, compound and sell medication to prevent or treat health conditions, chronic disease and episodic illness in accordance with an individual RN's level of competencies, knowledge, and skills. In many instances, RNs have already been engaged in prescribing medication through delegation (i.e. public health nurses in sexual health clinics and RNs in remote northern communities). RNs, as autonomous health professionals, are required to understand their competencies and practice limits based on: evidence, policy, regulations, practice standards and the degree of personal knowledge, skills, and experience. RNs, working in interprofessional teams, are well-positioned to effectively and safely expand their scope of practice to include prescribing.

Building upon international experience, requirements will need to be fulfilled before current RNs are able to prescribe medications, such as completion of a focused pharmacology course (300 hours) that expands existing pharmacology education

and experience. Requirements will also need to be established to maintain competency through continuing education. This approach is similar to current requirements in the UK. Caution must be exercised to avoid the use of restrictive 'prescribing lists' for RNs, which have been historically troublesome in both the UK and in Ontario with respect to previous NP prescribing lists. The independent nurse prescriber program, originating in the UK, is the model of prescribing that this report recommends be adopted in Ontario.

In order to be the most effective prescribers, RNs would also require authorization to order, interpret and communicate the outcomes of diagnostic/laboratory testing. It would be hazardous for any practitioner to prescribe medication without the ability to access and interpret all of the required patient information. Furthermore, in order to facilitate appropriate treatment and follow-up, RNs must be authorized to identify and communicate a diagnosis to their patients. Access to all of these new controlled acts for RNs would be framed within the context of diagnosing, treating or preventing health conditions, chronic disease and episodic illness within the individual RN's level of competencies, knowledge, and skills.

In situations where the care requirements are outside of the RN's expanded scope of practice, the RN would be required to consult with, or transition care to, the most appropriate member of the interprofessional team (i.e. more experienced primary care RN, NP, family physician, or clinical nurse specialist) to determine the most appropriate course of action. This is not unlike what occurs now in the health system. Consultation and collaboration are key components of interprofessional team work.

A second area for role expansion of the RN that is part of the Task Force's phase two recommendations is care co-ordination. At present, attempts to co-ordinate care are taking place outside the primary care setting in Community Care Access Centres (CCACs). A working definition of care co-ordination has been developed, through the analysis of over 40 definitions within the literature, as: "the deliberate organization of patient care activities between two or more participants

Task Force Outcomes

(including the patient) involved in a patient's care to facilitate the appropriate delivery of health services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.⁹ The Task Force unanimously concludes that care co-ordination is a role function that belongs fully within primary care. Given the rich supply of primary care RNs and the need for full human resource utilization, care co-ordination is a natural fit to the evolving role of the primary care RN.

An important facet of care co-ordination is system navigation, which can be defined as: "[offering assistance] to patients in "navigating" through the complex health system to overcome barriers in accessing quality care and treatment."¹⁰ *Ontario's Action Plan for Health Care* identifies the need for system navigation and care co-ordination, especially for seniors who are living with multiple chronic health conditions.¹¹ Primary care RNs are best situated with the clinical background and system knowledge, to support Ontarians and co-ordinate with patients through all transitions from 'womb to tomb.' RNAO is developing a model titled 'Enhancing Community Care for Ontarians (ECCO)' that places primary care RNs at the centre of care co-ordination, advances system integration and removes the costly structural duplication currently in Ontario, central features for health system transformation.

Recognizing the valuable role that RPNs play in primary care settings, there is potential for RPNs to assume an important role in executing evidence-based clinical and education programs that advance health promotion and disease prevention in primary care. For example, an RPN with a foot care certificate could excel in leading evidence-based foot care programming in primary care. Similarly, RPNs in primary care are well positioned to deliver immunization programs. The RPN would also assume an important role in supporting the identification, planning and evaluation of these programs. This approach to role expansion will support RPNs in developing knowledge and skills in areas of clinical interest.

Literature synthesis matrix

Historical review

Human resource analysis

Inventory matrix of current roles of RNs and RPNs across primary care settings*

Phase one RN and RPN role descriptions

Phase two RN and RPN role descriptions

Barrier/solution/lead matrix

Final report with recommendations and accountabilities

*Available on RNAO's website: www.RNAO.ca

Summary of Recommendations

Phase One

Recommendations	Accountability	Proposed Timeline
Implementation and Evaluation	Ministry of Health and Long-Term Care Registered Nurses' Association of Ontario	Immediately
1. Appoint a six month government committee, co-sponsored by RNAO and the Ministry of Health and Long-Term Care, with representation from professional associations, regulatory bodies and primary care associations, to roll-out the timely and effective implementation and evaluation of the recommendations in this report.		
Role Direction Phase I	Ministry of Health and Long-Term Care Local Health Integration Networks	Immediate directive provided, with role maximization compliance required by December 31, 2013
2. Issue directives, with specific timelines, for the upward harmonization of RN and RPN scope of practice across all primary care settings, as a first step to maximize all roles within the interprofessional team.		
3. Issue a directive to primary care organizations to formally designate a nurse lead to spend a portion of her/his role advising the management team and board of directors from a nursing perspective.	Ministry of Health and Long-Term Care Local Health Integration Networks	Immediate directive provided, with designated nurse lead compliance required by December 31, 2013
Education and Support Phase I		
4. RNs and RPNs, currently working in primary care, self-assess their educational needs and engage in educational programs to meet the requirements of the phase one role description.	Primary Care Organizations Primary care RNs/RPNs	Immediate directive to self-assess, with role maximization compliance required by December 31, 2013
5. Support primary care nurses to practise to full scope within interprofessional teams, using the phase one role description developed by the Task Force as a resource. This includes providing the necessary mentorship, team building, team roles clarification, and acknowledgment of local support needs.	Primary Care Organizations	Immediate, with role maximization compliance required by December 31, 2013
6. Fund RNAO to develop a primary care nursing-focused learning institute for RNs and RPNs to strengthen the knowledge, skills and confidence of primary care nurses.	Ministry of Health and Long-Term Care	Immediate funding provided with first learning institute by December 31, 2012
7. Secure clinical placements in primary care practice for RN and RPN students.	Schools of Nursing Primary Care Organizations	Immediate initiation with full compliance by December 31, 2013
Primary Care Funding		
8. Work to further reform physician compensation models in a way that advances full utilization of nurses and all other health professionals, while ensuring fair compensation for physicians.	Ministry of Health and Long-Term Care Ontario Medical Association	Immediate as part of current (2012) negotiations with the Ontario Medical Association
9. Develop a uniform and streamlined process to apply for additional funding to increase health human resources for primary care organizations when patient enrollment targets are met, and infrastructure capacity exists.	Ministry of Health and Long-Term Care	Immediate with uniform and streamlined application process in place by December 31, 2012

Recommendations	Accountability	Proposed Timeline
Legislation <p>10. Amend the <i>Nursing Act, 1991</i> and associated regulations to authorize RNs in the general class to:</p> <ul style="list-style-type: none"> • prescribe medication to prevent and/or treat health conditions, chronic disease and episodic illness within their level of competency; • compound and sell medication; • identify and communicate a diagnosis within their level of competency; and • order diagnostic imaging. 	Legislation Government of Ontario College of Nurses of Ontario	Achieved by January 1, 2014
<p>11. Amend the <i>Laboratory and Specimen Collection Centre Licensing Act</i> and associated regulations to authorize RNs in the general class to order laboratory tests.</p>	Government of Ontario College of Nurses of Ontario	Achieved by January 1, 2014
<p>12. Implement regulations under the <i>Regulated Health Professions Statute Law Amendment Act, 2009</i> to authorize RNs in the general class and RPNs to dispense medication.</p>	College of Nurses of Ontario	Achieved by January 1, 2013
Role Direction Phase II		
<p>13. Issue directives with specific timelines for the expanded scope of practice utilization of RNs, to include RN prescribing and care co-ordination, for all primary care organizations.</p>	Ministry of Health and Long-Term Care Local Health Integration Networks	Directive issued in January, 2014, with expanded scope of practice role compliance by December 31, 2015
<p>14. Support RPNs in executing clinical and educational programs to advance health promotion and disease prevention.</p>	Primary Care Organizations	Expanded scope of practice role compliance by December 31, 2015
Education and Support Phase II		
<p>15. Fund and develop focused pharmacology/diagnostic courses (i.e. 300 hour nurse prescribing course offered in the UK) that expand on the experiences and competencies of current RNs to prepare them for an expanded role, while enhancing current nursing education programs and supporting nursing faculty to incorporate an expanded RN role into nursing curricula.</p>	Ministry of Training, Colleges and Universities (funder) Educational Institutions	Funds made available in February 2014. Course developed and offered by September 2014
<p>16. Establish a certification program to promote professional development and knowledge advancement and acknowledge the unique competencies of primary care nurses.</p>	Canadian Nurses Association	By January 1, 2015
Health System Enhancement		
<p>17. Identify areas of structural duplication and work toward better system integration by improving linkages across all sectors and moving care co-ordination to primary care.</p>	Ministry of Health and Long-Term Care	Process and transition completed by January 1, 2015
<p>18. Establish tripartite leadership councils within Local Health Integration Networks, including one representative from: nursing, medicine, and another health profession that is not medicine or nursing (i.e. pharmacist, physiotherapist, occupational therapist, etc.) to provide clinical and human resources advice to LHINs.</p>	Ministry of Health and Long-Term Care Local Health Integration Networks	Model and selection process developed by January 1, 2013. Councils in place on each LHIN by January 1, 2014

Phase Two

Recommendations

Accountability

Proposed Timeline

Nursing Human Resources

19. Provide primary care organizations with the funding required to offer competitive compensation and benefits to primary care nurses and other health professionals, eliminating inequities with other sectors of the health system.

Ministry of Health and Long-Term Care

By January 1, 2015

Local Health Integration Networks

20. Support and fund strategies that will ensure at least 70 per cent of primary care nurses are working full-time.

Ministry of Health and Long-Term Care

Directive issued by January 2014, with 70 per cent full-time employment target in all primary care settings achieved by December 31, 2015

Local Health Integration Networks

Primary Care Organizations

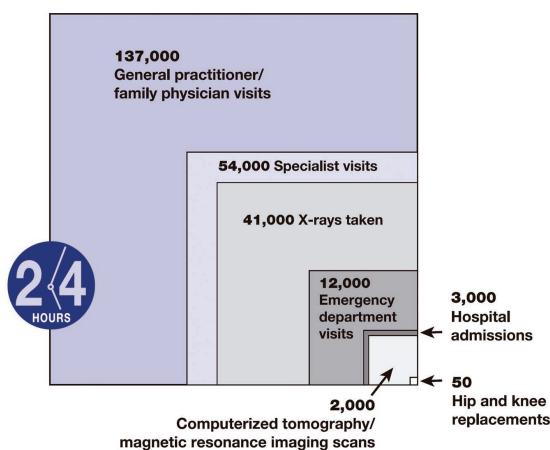
Introduction

"There seems to be a lack of understanding around primary care and the important role that nurses play in Ontario's primary care system. We often find ourselves practising within a medical model that fragments patient care. This is not rewarding for us and does not use our full knowledge and skill. My vision for primary care nursing in Ontario involves honouring the nursing care model and enhancing the identity of nurses. We need to see a shift in both attitudes and the practice environment in order to demonstrate our full potential."

Primary Care Nurse

Ontario's primary care system frequently represents an individual's first point of contact with the health system and is often regarded as the foundation for health care in this province. Yet, the political emphasis has historically been misaligned, placing emphasis on strategies that optimize acute care hospitals and wait times for key surgeries identified by government, such as joint replacements. As demonstrated in Figure One, generated by the Institute for Clinical Evaluative Sciences (2006), this emphasis represents a small fraction of health care being provided to Ontarians each day. Similar research from the United States estimates that approximately 11 per cent of Americans visit a primary care physician's office in a month, while 1.2 per cent visit an emergency department and less than 0.1 per cent of the population is hospitalized during the same time period.¹²

Figure One: **AVERAGE NUMBER OF VARIOUS HEALTH-CARE SERVICES ACCESSED EACH DAY, IN ONTARIO, 2002/03¹³**



"My vision for primary care nursing in Ontario involves honouring the nursing care model and enhancing the identity of nurses. We need to see a shift in both attitudes and the practice environment in order to demonstrate our full potential."

Primary Care Nurse

*Values rounded to the nearest thousand with the exception of hip and knee replacements, which were rounded to the nearest 10.

...only 61 per cent of Canadian RN respondents report practising to their full scope of practice in primary care.

College of Nurses of Ontario data estimates there are approximately 2,873 RNs and 1,412 RPNs who practise in Ontario's primary care system, totaling 4,285 nurses.¹⁴ The Registered Nurses' Association of Ontario (RNAO), the professional association representing RNs working in all roles and sectors in Ontario, regularly receives anecdotal reports from the field suggesting that while nurses in all settings are working hard and providing long hours of care, the roles of the RN and RPN in primary care are misaligned to the competencies, knowledge, and skills of these professionals. These reports are validated in a study that found only 61 per cent of Canadian RN respondents report practising to their full scope of practice in primary care.¹⁵ Nurses and other health professionals practise to their full scope of practice when they are in an environment that enables them to fully utilize their competencies, knowledge, and skills to provide high quality, evidence-based, and patient-centred care. The Commission on the Reform of Ontario's Public Services (Drummond commission) is calling for an expansion to the scope of practice of nurses and other health professionals as a sustainability strategy for Ontario's publicly-funded, not-for-profit health system.¹⁶

The term 'primary care' is frequently used without a common understanding of its definition and

meaning. Health Canada identifies primary care as being "... the element within primary health care that focuses on health-care services, including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury."¹⁷ Building upon this definition, primary care can also be defined as "... that level of a health service system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and co-ordinates or integrates care provided elsewhere by others."¹⁸ There are a number of models used in Ontario to deliver primary care which are summarized in Table One. Increasingly, there has been a shift towards interprofessional care delivery in the primary care setting. A report from the Health Council of Canada identified that when Canadians have additional access to a nurse and/or other health professionals in primary care, they are 2.5 times more likely to report receiving a range of care that meets most of their needs.¹⁹ In 2007, the Canadian Nurses Association (CNA) and the College of Family Physicians of Canada (CFPC), jointly released a vision statement on interprofessional care that puts patients at the centre of health care and calls for every Canadian to have access to a family doctor, a RN and/or a nurse practitioner (NP), and other complementary health professionals.²⁰ While this national vision advances the concept of interprofessional teams, it does not address the optimal ratio and skill mix of RNs, RPNs, NPs, family physicians and other health professionals.

Primary care delivery is an important and integral approach to support the principles and values of primary health care,²¹ which can be defined as: "...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-

reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, families and communities with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.²² The primary care setting has the potential to serve as the central point of contact as patients transition through the health system, making it an ideal venue to advance the principles of primary health care, in collaboration with other areas of the health system. While the recommendations of this Task Force form important components that will support fostering a health system that embraces primary health care, the focus of this report is on enhancing the primary care system in Ontario. In particular, this report focuses on increasing access to quality primary care for Ontarians and facilitating system effectiveness through the full utilization of the 4,285 primary care nurses²³ who currently practise in inconsistent and underutilized roles within primary care organizations. The recommendations contained in this report represent a first step towards ensuring the full utilization of all health professionals in Ontario, which is consistent with Ontario's blueprint for action on interprofessional care that calls for all professions to be practising at their full scope.²⁴ Future policy must strengthen the interprofessional team's ability to provide the highest quality of care for patients, while ensuring the most appropriate use of health-care resources.

Overall, little to no attention has been given to the role of the primary care nurse (RN and RPN) by governments, employers and professional associations and as a result, this role is grossly under-utilized to the detriment of the public and the health system as a whole. This report and recommendations aim to close this gap through the optimal utilization of nursing human resources in Ontario's primary care setting.

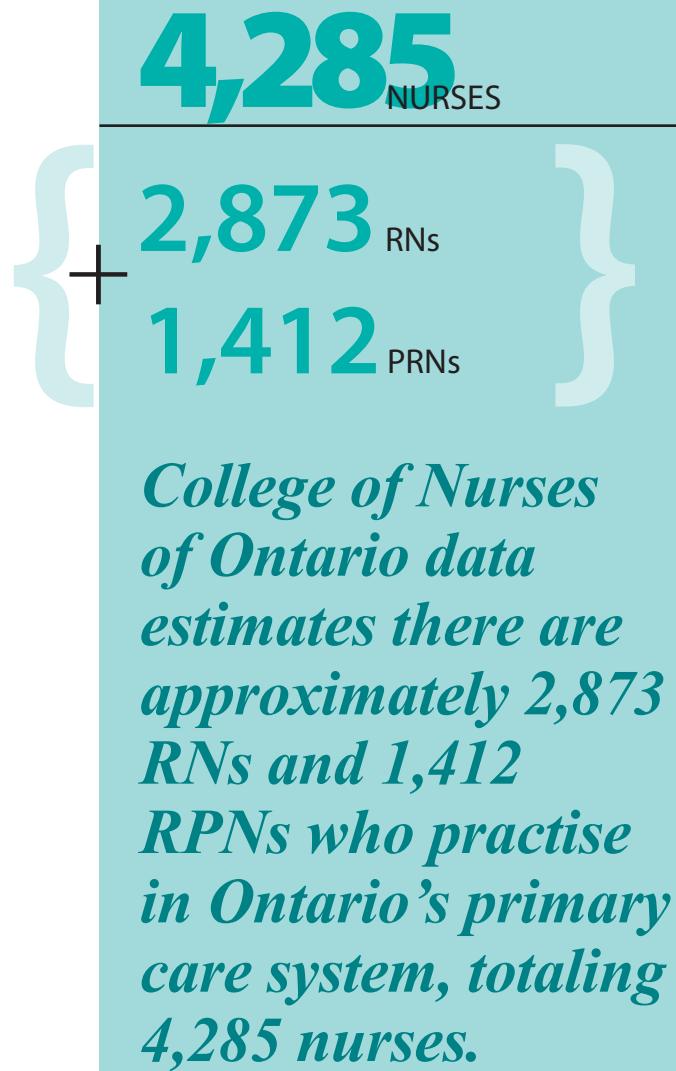


Table One: Overview of Primary Care Models in Ontario

	Number Operational	Governance Model	Patient Population	Current Health Professionals	Physician Compensation	After Hours Requirements
Aboriginal Health Access Centres ^{25,26}	10	Community	First Nations both off and on reserve, Inuit and Métis	Clinical Lead: Nurse Practitioner, Physician or other lead • Dietitians • Health Promoters • Occupational Therapists • Registered Nurses • Registered Practical Nurses • Social Workers • Traditional Healers	Salary	Yes
Community Health Centres ²⁷	73	Community	High risk communities and populations that may have trouble accessing health services due to language, culture, physical disabilities, socio-economic status or geographic isolation	Clinical Lead: Nurse Practitioner, Physician or other lead • Aboriginal Healers • Chiropodist • Community Development Workers • Counsellors • Dietitians • Health Promoters • Occupational Therapists • Physiotherapists • Registered Nurses • Registered Practical Nurses • Social workers	Salary	Yes
Comprehensive Care Model ²⁸	Unavailable	Physician-Led	General population	Clinical Lead: Physicians • Nurses (in some practices)	Fee-for-service with incentives	Yes
Family Health Teams ^{29,30}	200	Mixed Community & Professional	General population	Clinical Lead: Physicians • Dietitians • Health Promoters • Nurse Practitioners • Occupational Therapists • Pharmacists • Physicians • Physiotherapists • Registered Nurses • Registered Practical Nurses • Social workers	Blended capitation Complement-based Blended salary	Yes

	Number Operational	Governance Model	Patient Population	Current Health Professionals	Physician Compensation	After Hours Requirements
Family Health Networks ³¹	Unavailable	Physician-Led	General population	Clinical Lead: Physicians • Nurses (in some practices)	Blended capitation	Yes
Family Health Organizations ³²	Unavailable	Physician-Led	General population	Clinical Lead: Physicians • Nurses (in some practices)	Blended capitation	Yes
Family Health Groups ³³	Unavailable	Physician-Led	General population	Clinical Lead: Physicians • Nurses (in some practices)	Fee-for-service with incentives	Yes
Nurse Practitioner-Led Clinics ³⁴	24	Mixed –Community & Professional	General population with focus on high risk groups	Clinical Lead: Nurse Practitioners • Dietitians • Occupational Therapists • Pharmacists • Physicians • Registered Nurses • Registered Practical Nurses • Social workers	Salary	Yes
Rural-Northern Physician Group Agreement ³⁵	Unavailable	Physician-Led	Rural Ontarians	Clinical Lead: Physicians	Blended complement	Yes

*Note that while all models provide primary care services, the nature and depth of services is determined by a primary care organization's capacity, resources and mandate.

A primary care nurse is the term used for any nurse that focuses his or her practice within the primary care setting. A large proportion of these nurses are practising in the primary care models described previously and may use the title family practice nurse. A family practice nurse/primary care nurse "... holistically assesses the needs of individuals and families and facilitates the intervention process to assist patients in maintaining optimal health, while also minimizing health-care expenditures."³⁶ For the purposes of this report, the term primary care nurse will be used.

...to improve population health and jurisdictional economies, governments are increasingly placing attention on the role of primary care, and, in particular, how the nursing profession can transform care delivery.

Focusing attention on health promotion and disease prevention to improve population health and jurisdictional economies, governments are increasingly placing attention on the role of primary care, and, in particular, how the nursing profession can transform care delivery. Significant gains have been made in solidifying the role of the Nurse Practitioner (NP) in Ontario's primary care setting, both within expanded authorities and the creation of North America's first Nurse Practitioner-led clinics (NPLC). These clinics leverage the expertise of NPs working with an interprofessional team to: "... provide comprehensive, accessible and co-ordinated family health-care services to populations that do not have access to a primary care provider."³⁷ As of June 2012, 24 NPLCs are operational and providing thousands of Ontarians with high quality, evidence-based, and patient-centred primary care. An additional two clinics are already funded and they will be operational within the coming months.

As of June 2012, 24 NPLCs are operational and providing thousands of Ontarians with high quality, evidence-based, and patient-centred primary care.

In addition to doubling their presence in terms of working status,³⁸ NPs have seen significant enhancements to their ability to provide comprehensive patient care through the *Regulated Health Professions Statute Law Amendment Act, 2009* and amendments to the *Public Hospitals Act (Regulation 965)*. While nurses and patients alike have been celebrating these momentous improvements, increasing attention must be drawn towards RNs and RPNs currently practising in primary care.

RNs and RPNs represent a grossly under-utilized resource in Ontario's primary care system, and these nurses are waiting and eager to be fully utilized and to take on expanded roles. Table two provides a broad distinction between the RN, RPN and NP categories across the health system.

RNs and RPNs represent a grossly under-utilized resource in Ontario's primary care system, and these nurses are waiting and eager...to take on expanded roles.

Table Two: Overview of Nursing Categories in Ontario

	Registered Practical Nurse	Registered Nurse	Nurse Practitioner
Entry to Practice Education	Two-year Practical Nursing Diploma from a community college.	Four-year baccalaureate degree in nursing.	Four-year baccalaureate degree in nursing, minimum of two years of direct nursing experience as a RN, and completion of a one-year NP program or master's degree.
Broadly Defined Role	Practises nursing autonomously to meet identified nursing care needs of less-complex patients with predictable outcomes. ³⁹	Practises nursing autonomously to meet a wide range of nursing care needs of patients regardless of complexity and predictability. ⁴⁰	Practises nursing autonomously by expanding upon the competencies of the RN to use their legislated authority to diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform expanded procedures. ⁴¹ Authorized, through <i>Regulation 965 of the Public Hospitals Act</i> , to admit, treat, transfer and discharge patients to and from in-patient units in hospitals.

In January 2012, the Council of the Federation, which is made up of Premiers and Territorial Leaders, announced development of a Health Care Innovation Working Group to ensure sustainability of Canada's health system. The council agreed to focus on: scope of practice, human resources management and clinical practice guidelines.⁴² This work is coinciding with a number of reports that call for expanding the scope of practice for many health professionals, including nurses.^{43, 44, 45} RNAO has long advocated and spoken out on the pivotal role nurses play in ensuring the sustainability, quality and effectiveness of Ontario's publicly-funded and not-for-profit health

system. The time has come to seriously examine the role of the RN and RPN in primary care and propose changes that will enhance the patient experience and support health system quality and cost-effectiveness. RNAO recognizes the tremendous potential that primary care nurses bring to the health system in delivering optimal patient outcomes and quality-based care. Therefore, the Primary Care Nurse Task Force was launched by RNAO to explore the unique role of the RN and RPN in primary care, and to develop recommendations that optimize the full utilization of these nurses to strengthen Ontario's primary care system.

Task Force Background

Recognizing the need to expand the role and practice scope of nurses, as called for by the Drummond commission, the Primary Care Nurse Task Force (Task Force) was launched by RNAO and co-chaired by Dr. Doris Grinspun, Chief Executive Officer of RNAO, and Judie Surridge, President of the Ontario Family Practice Nurses (OFPN). The OFPN Interest Group is affiliated with RNAO and has a mandate to promote and support the professional role of the nurse in family practice.⁴⁶ The Terms of Reference for the Task Force, including the organizational membership, are attached as Appendix A.

The organizational membership of the Task Force was broad and included provincial and federal representation from: nursing associations, a trade union, medical associations, primary care associations and representation from nurses currently practising in primary care.

Task Force Responsibilities

Assess the range of roles currently played by RNs and RPNs in Ontario's primary care settings

Define the competencies, knowledge, and skills required in primary care nursing practice

Identify current and future health system needs in primary care

Recommend, as a first step, the full utilization of nurses in primary care by leveraging the potential that currently exists within the system

Recommend, as a second step, an expanded scope of practice that optimizes nurses' ability to deliver quality primary care and improve primary care access

Leverage the education, strength and position of primary care nurses to bring about a primary health-care system that promotes health equity and addresses root causes of health disparities, including addressing the social and environmental determinants of health

Task Force Outcomes

The Task Force focused on the role of RNs and RPNs to provide differential role clarity in primary care and to optimize both roles within patient-centred interprofessional teams, while strengthening continuity of patients' care. While the scope of this Task Force focused on RNs and RPNs practising in Ontario's primary care setting, the recommendations hold tremendous potential for nurses practising in other health sectors and jurisdictions.

The original term of the Task Force was one year, however, given the pressing nature of the issue at hand, the term was expedited. A series of four teleconferences were held between January and April 2012 with a wrap-up teleconference to review the draft report in May 2012. As a truly collaborative process, members were invited to provide and integrate feedback throughout the progression of the Task Force.

The Task Force is focusing its work on two phases of outcomes. The first phase (Appendix B) identifies the highest level of RN and RPN scope of practice utilization already present in selected primary care settings and recommends an upward harmonization of scope of practice utilization for all primary care nurses across all sites in Ontario. The second phase (Appendix C) involves identifying needed expansions to the existing scope of practice of the primary care RN and RPN that would serve to further improve access to primary care for the public.

While the Task Force strove to achieve consensus at all times, membership on the Task Force does not indicate a full endorsement of all its outcomes or recommendations. This report is the result of open, thoughtful and evidence-based discussions within the Task Force, ongoing Task Force feedback, literature synthesis and checking the pulse of nurses and other health professionals working at the point-of-care.

Literature synthesis matrix

Historical review

Human resource analysis

Inventory matrix of current roles of RNs and RPNs across primary care settings*

Phase one RN and RPN role descriptions

Phase two RN and RPN role descriptions

Barrier/solution matrix

Final report with recommendations

*Available on RNAO's website: www.RNAO.ca

Literature Review

Given the need to ground all recommendations in evidence, a decision was made to conduct a literature review to expand the Task Force's understanding of the current role of the primary care nurse and to identify areas for expansion.

This review incorporated both academic publications and reports from expert commissions/committees. Electronic databases were consulted including Google Scholar, Medline and CINAHL. Task Force members were also solicited to contribute relevant publications. While this review was thorough, it cannot be considered systematic. However, there was a considerable amount of information that was available to inform the recommendations within this report. Unfortunately, this review did not yield information specific to the RPN role and a research gap exists in this regard. A detailed table of the key documents reviewed can be found summarized as Appendix D. A number of themes were identified within the literature and are summarized below.

Current Role of the Primary Care Nurse

The current role of the primary care nurse within the context of the Canadian health system has not been clearly defined or studied extensively within the literature. The limited literature that does exist suggests an under-utilization of the nursing role in the delivery of primary care.^{48,49} One study that surveyed Canadian RNs in family practice identified that the current role of the RN often involves carrying out a number of clinic activities that could be completed by non-nursing support staff. Consequently, only 61 per cent of respondents feel they are working to full scope.⁵⁰ Examples of non-nursing duties performed regularly by RNs include: booking appointments, preparing clinic rooms and restocking supplies.⁵¹ In this same study, 88 per cent of respondents indicate a desire to develop their clinical skills.⁵² Results of this study parallel anecdotal reports received by RNAO from RNs practising in

primary care. The inefficient use of the established competencies, knowledge, and skills of primary care nurses is alarming because of the negative implications for the nursing profession, the health system and most importantly, for Ontarians.

To increase the sense of identity of primary care nurses, the Canadian Nurses Association developed a toolkit that profiles both the local and system-wide benefits that primary care nurses generate, including: enhanced access to care, cost-effectiveness, improved patient outcomes, improved preventative screening and a potential reduction in emergency department utilization.⁵³ In 2008/09, Toronto's University Health Network, in collaboration with the Ontario Family Practice Nurses, Canadian Family Practice Nurses Association, Ontario College of Family Physicians and George Brown College, identified and expanded upon seven thematic competencies of the primary care nurse.⁵⁴ These thematic competencies include: professional, expert, communicator, synergist, health educator and lifelong learner.⁵⁵ Such resources, alongside this report, serve to advance policy formulations that fully utilize primary care nurses and expand nurses' scope of practice to benefit the public.

As the Ontario government attempts to build a sustainable nursing workforce, it is important to note that there are significant nursing human resource implications associated with the limited utilization of primary care nurses. For example, an integrated literature review examining the role of practice nurses in the United Kingdom found that these nurses experience limited job satisfaction as their scope of practice is restricted.⁵⁶ Drawing upon a study from the acute care hospital sector, researchers found that workload, patient acuity, lack of time and ineffective teamwork are barriers preventing nurses from working to their full scope of practice.⁵⁷ As a result, close attention is needed to understand how under-utilization of a nursing workforce has impacts on the health system and vice versa.

The Shift Towards Full Utilization and Expanded Scope

There is tremendous potential within the health system to support nurse-driven, interprofessionally rooted enhancements to the delivery of primary care. A number of recent reports and articles have called for the full utilization and expansion of nursing practice to benefit patients and increase access to health services.^{58,59,60,61} In the report of the Commission on the Reform of Ontario's Public Services, the Commission calls on the system to specifically authorize nurses and other health professionals to "...do what they could competently do" and recommends a "...net shift in responsibilities from physicians to nurses."⁶² It is important to note that the full utilization of nurses and expanded scope of practice is meant to complement and not replace the role of other health professionals, including NPs and physicians. Dr. Dorothy Pringle, past editor-in-chief of *Canadian Journal of Nursing Leadership*, points out that there has been a consistent shift in the responsibilities of health professionals over time and the best rationale for expanding nurses' scope of practice is not that it will decrease burden on other providers, but that it will support continuity of care through expanded service provision.⁶³

Ontarians are ready for nurses to play an expanded role in the delivery of their care.

Ontarians are ready for nurses to play an expanded role in the delivery of their care. In 2002, the Commission on the Future of Health Care in Canada found that Canadians are comfortable with nurses providing their routine care.⁶⁴ It is important to note that this commission was occurring years before significant nurse-led innovations were being demonstrated as robust and effective solutions, such as establishing Nurse Practitioner-led clinics in Ontario. Furthermore, the public places significant trust in the nursing profession. This is demonstrated throughout public opinion polls such as the 2010 Gallup Honesty and Ethics Survey that ranked nurses at the highest level among professions for the 11th year in a row.⁶⁵ This work strongly suggests that the public would embrace the full and expanded utilization of nurses in primary care and across the health system.

A 2009 Cochrane Review suggests that appropriately educated nurses providing expanded care can generate comparable outcomes for patients relative to their physician colleagues.

The safety of expanded nursing roles has been studied within the literature. A 2009 Cochrane Review suggests that appropriately educated nurses providing expanded care can generate comparable outcomes for patients relative to their physician colleagues.⁶⁶ It is important to note that RNs and RPNs in Ontario are educated as autonomous practitioners who are capable of providing expanded care delivery, in alignment with their educational preparation, clinical knowledge base and professional skill set. While primary care nurses possess significant clinical expertise, the transition towards full utilization or expanded scope of practice may require a 'refresher' education session or other education strategies to refresh, update and/or upgrade competencies, knowledge and skills, especially in circumstances where significant time has lapsed since the nurse last used her or his full scope of practice. This educational need has been validated within the literature.⁶⁷ Current practical examples that enhance nurses' competencies, knowledge, and skills to embrace new roles include bridging programs that support RPNs who want to become RNs, and graduate programs that support RNs who want to become clinical nurse specialists.

Ontario can safely follow and expand upon the work that is being done to broaden nurses' scope of practice in other jurisdictions, such as the province of British Columbia. The College of Registered Nurses of British Columbia (CRNBC) recently expanded regulations impacting the scope of practice of the RN. For example, RNs may now perform expanded wound care services, order certain diagnostic images and compound/dispense/administer Schedule II medications without an order to treat certain conditions.⁶⁸ Ontario has always been recognized as a leader in health-care innovation and it is important for Ontario to continue to advance the role and scope of practice of nurses, both to benefit the public's timely access to quality health services, and to strengthen the recruitment and retention of nurses.

Cost-Effectiveness

Little quantitative research exists identifying the direct cost-effectiveness of the full and expanded utilization of nurses in primary care. It is important to note that total payments to Ontario's family physicians increased by \$1.3 billion or 54 per cent (after inflation) over a period of five years between 2003/04 and 2009/10.⁶⁹ In 2009/10, the mean payment per full-time equivalent family physician was \$300,100.⁷⁰ In 2011, the base salary of a full-time RN practising in a hospital with 25 years experience was \$82,758.⁷¹ Nurses in primary care typically earn significantly less than their hospital colleagues.⁷² Therefore, there is potential for nurses to improve cost-effectiveness in primary care. For example, a 2006 systematic review of nurse-led care in dermatology identifies research demonstrating a 25 per cent deferral in appointments with a family physician, while enhancing continuity of care.⁷³ A study from the United Kingdom found that nearly 75 per cent of dermatological issues are managed in primary care. The potential for cost savings in this circumstance and many others is clearly evident. It is also important to note that the greatest contribution provided by nurses in primary care is rooted within the quality care perspective, which is where more emphasis must be placed.

The intent of this report is not to advocate for a decrease in compensation for physicians. Like all health professionals, physicians must be compensated appropriately for the valuable care they provide. However, the health system must recognize the appropriate application of a family physician's competencies, knowledge, and skills so that nurses can effectively partner with physicians to expand access and increase the effectiveness of the primary care setting. While physicians will always have a key and extremely important role in primary care, a report from the Institute for Clinical Evaluative Sciences identifies that the highest earning physicians are actually in areas such as Diagnostic Radiology and Ophthalmology.⁷⁵ In these clinical areas, physicians are using their advanced medical knowledge and expertise to provide specialized care for highly complex health-care requirements. Similar applications of the physician's advanced medical knowledge and skill must be considered for the primary care setting.

New Roles for RNs

RN prescribing is a relatively new opportunity to Canada, however, it is a well-established practice in other jurisdictions such as the United Kingdom (UK).⁷⁶ There are three categories of nurse prescribers within the United Kingdom, including: independent nurse prescribers with full access to the British formulary; district nurses/health visitors who can prescribe from a defined list; and supplemental nurse prescribers who prescribe within an established framework developed in collaboration with the physician and patient.⁷⁷ A number of studies have identified non-medical prescribing as being well received by patients, creating a number of benefits including enhanced access and continuity of care.^{78,79,80,81} One study investigated the views of patients who never experienced nurse prescribing to determine their confidence in the practice. Over half of the participants hold the same or more confidence in a nurse's ability to prescribe compared to a physician. Fewer than 10 per cent would prefer to see a physician instead of a nurse.⁸² Nurse prescribing also has implications for optimizing nursing human resources as it is associated with enhanced self-esteem and improved job satisfaction.^{83,84,85} In order to develop prescribing competencies, knowledge, and skills, education programs that complement existing competencies were developed in the United Kingdom to support nurses in their prescriber role.⁸⁶ In one study, 95.2 per cent of respondents felt that the training they received is beneficial to their prescriber function.⁸⁷ It is also important to note that most nurse prescribers possess extensive clinical experience prior to pursuing the prescriber role. A large survey of nurse prescribers in the United Kingdom found 75 per cent of the sample had more than five years of clinical experience in their respective practice areas before pursuing the prescribing program. An important learning point identified through the UK experience is that list-based prescribing is too restrictive.^{88,89} This finding coincides with historical reports from the field in Ontario when NPs felt extremely limited in prescribing from a list. In Ontario, there is tremendous potential to implement RN prescribing in alignment with the perspective of an author who described prescribing as a natural extension for many nurses.⁹⁰

Over half of the participants hold the same or more confidence in a nurse's ability to prescribe compared to a physician.

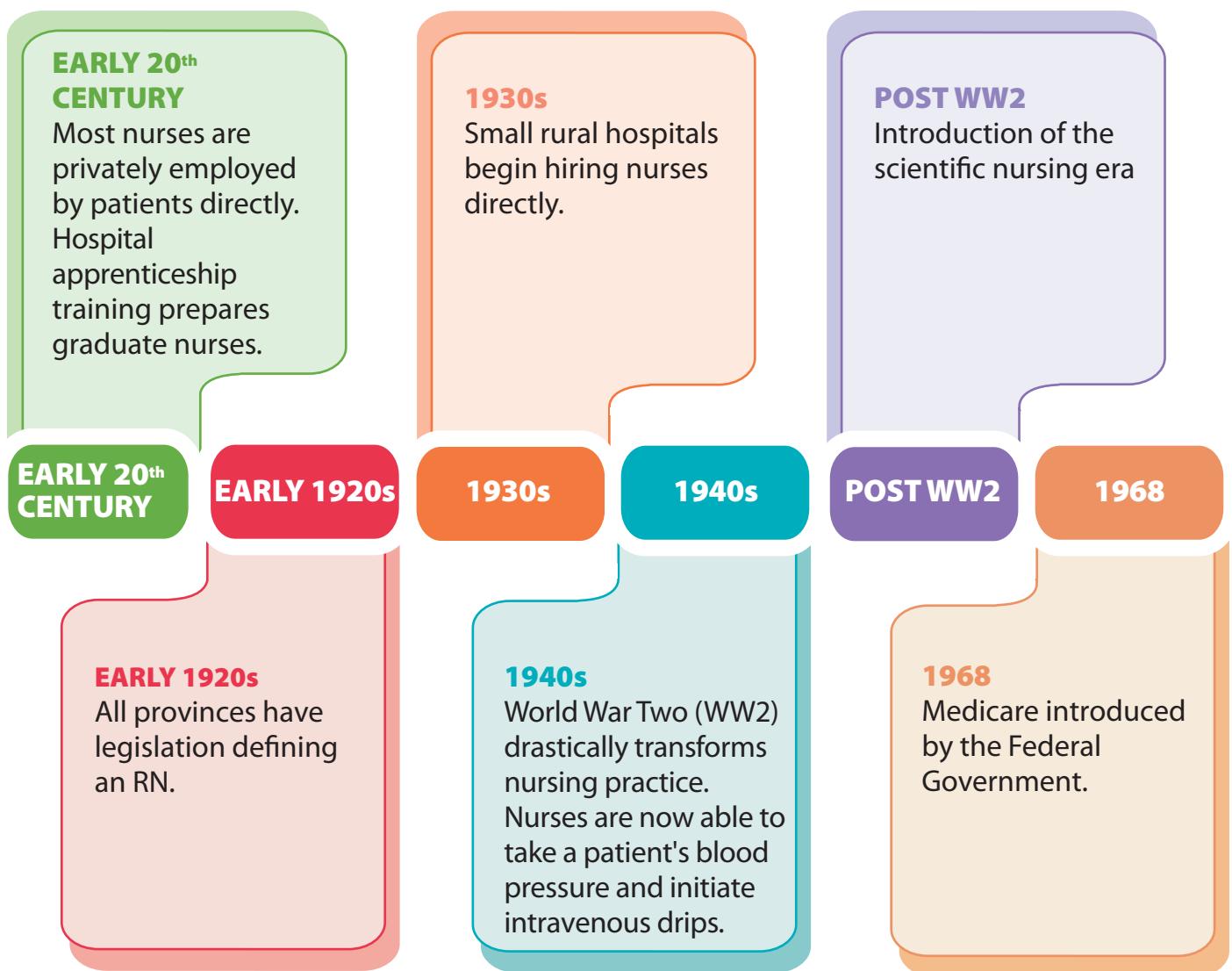
Care co-ordination is an essential next step for transforming Ontario's health system and has been identified as a priority within *Ontario's Action Plan for Health Care*.⁹¹ A working definition of care co-ordination has been developed, through the analysis of over 40 definitions within the literature, as: "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health-care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care."⁹² RNs have been identified as leaders with the competencies, knowledge, and skills to support care co-ordination in a number of ways, including assuming a health system navigator function, which is a component of care co-ordination.⁹³ System navigation can be defined as: "[offering assistance] to patients in "navigating" through the complex health-care system to overcome barriers in accessing quality care and treatment."⁹⁴ *Ontario's Action Plan for Health Care* identifies the need for system navigation and care co-ordination, especially for seniors who are living with multiple chronic health conditions.⁹⁵ It is the Task Force's unanimous view that the care co-ordination role must be located in primary care. A recent report from the Health Council of Canada on home care in Canada identified the need for integration between primary care and other areas of the health system, citing a study where 30 per cent of primary care physicians were unaware of their patient's recent hospitalization.⁹⁶ Furthermore, a cluster-randomized control trial that used RNs in primary care to implement a guided care model for multi-morbid older persons significantly improved self-reported quality of chronic health care.⁹⁷ This work is complemented by a qualitative study that identifies the success of nurse-led/primary care-based case management in the co-ordination of patient care.⁹⁸ Therefore, there is significant potential to develop this expanded role of the RN within the primary care system, fostering linkages with other areas of the health system.

A large survey of nurse prescribers in the United Kingdom found 75 per cent of the sample had more than five years of clinical experience in their respective practice areas before pursuing the prescribing program.

*Care co-ordination is an essential next step for transforming Ontario's health system and has been identified as a priority within *Ontario's Action Plan for Health Care*.*

Historical Evolution

Figure Two: HISTORICAL EVOLUTION OF NURSING IN ONTARIO AND CANADA^{101,102,103}

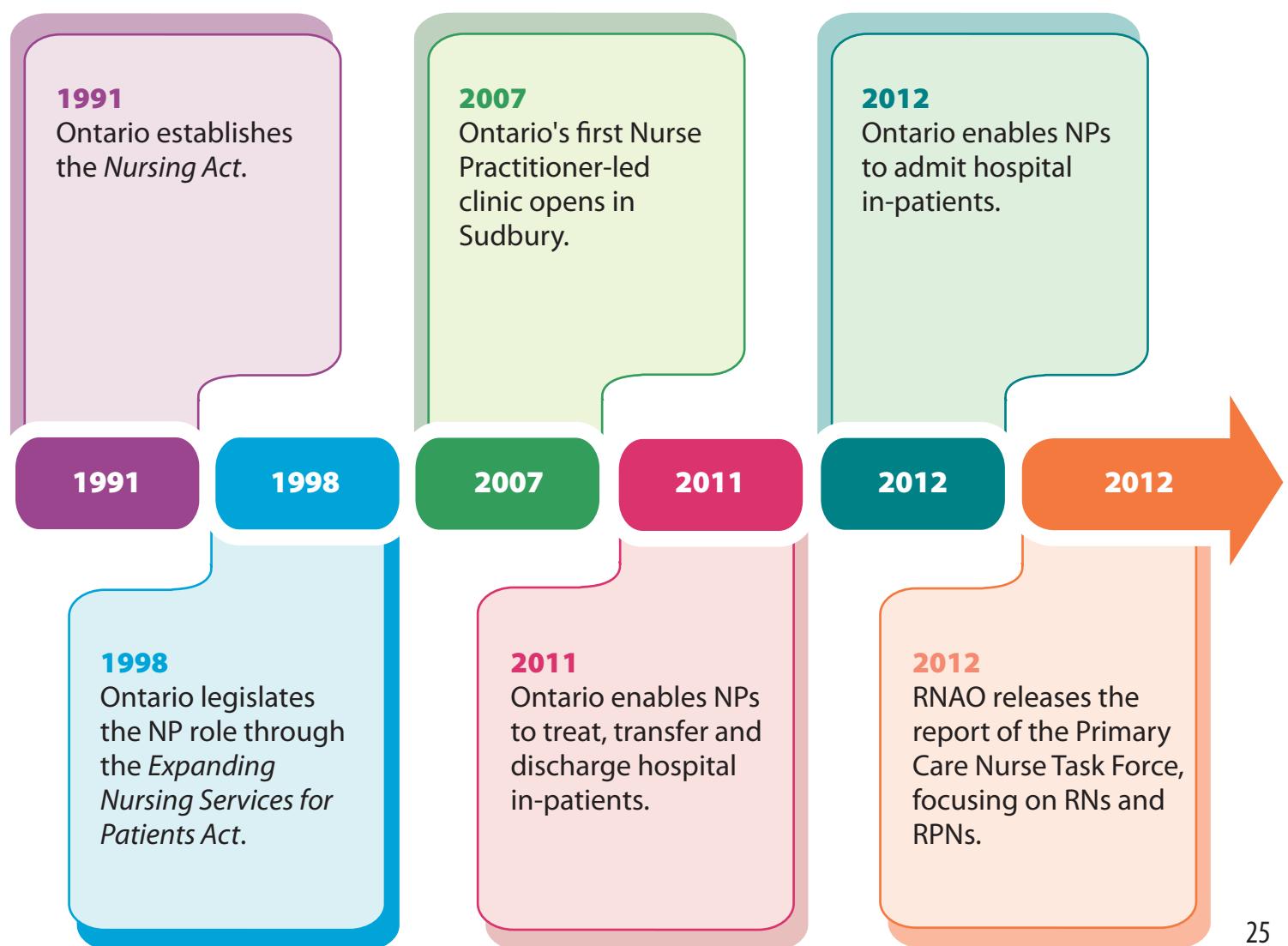


The nursing profession is continuously evolving and growing alongside the increasing demands of the health system. This rapid rate of change was particularly evident during and following World War Two, when, not unlike today, significant demands were placed on the health system. As a result, the scientific era of nursing practice was introduced.⁹⁹ Nurses began taking on new roles, such as the ability to assess a patient's blood pressure status and initiate an

intravenous line, which were previously functions exclusive to the role of the physician.¹⁰⁰

In the present day, we are seeing similar demands on our health system from a limited resource perspective. The provincial government is trying to ensure the greatest benefit for every dollar of health-care funding. Primary care nurses and nurses within other areas of the health system have an opportunity to once again rise and use their full

competencies, knowledge, and skills to create positive change for patients and the health system. Historical perspective can be very beneficial to guide and inform the solutions for the present. The high-level historical timeline that follows illustrates the evolving nature of the nursing profession, and provides evidence that the profession has always been both dynamic and forward-thinking (Figure Two).



Nursing Human Resource Analysis

To gain a better understanding of the status of the primary care nursing workforce, a high-level nursing human resource analysis was conducted. Self-reported membership data was obtained from the College of Nurses of Ontario capturing nurses who self-identify as practising in primary care. Table Three provides a historical overview of the number of nurses practising in primary care.

**Table Three:
Number of Primary Care
Nurses in Ontario By Year and
Nursing Category¹⁰⁴**

	2005	2006	2007	2008	2009	2010
RN	2,419	2,475	2,663	2,707	2,823	2,873
RPN	1,150	1,167	1,221	1,303	1,349	1,412
NP	381	411	465	576	656	741

Between 2005 and 2010, there had been an increase of approximately 16.7 per cent in the number of RNs practising in primary care.¹⁰⁵ The overall growth rate in the RN workforce in Ontario during this time period was 5.5 per cent,¹⁰⁶ which demonstrates that the primary care RN workforce is growing steadily. Further increases in RN employment in primary care are likely to be demonstrated in 2011 data given the Inter-Professional Shared Care – 500 Nurses Initiative negotiated through the Ontario Medical Association's collective agreement with the Ministry of Health and Long-Term Care, which sought to create 500 additional RN positions in family practice over several waves.¹⁰⁷ Similarly, there has been

an increase of approximately 17.3 per cent in the number of RPNs in primary care between 2005 and 2010.¹⁰⁸ This growth in RPNs is slightly below the overall growth rate for the RPN workforce in Ontario during the same time period, which was 24.3 per cent.¹⁰⁹ The sharpest increase in employment in primary care has been among NPs who have seen an increase of 94.5 per cent between 2005 and 2010.¹¹⁰ While this growth is significant, it is somewhat lower than the overall growth rate for NPs in Ontario during this time period, which was 150.2 per cent.¹¹¹

The role of the NP has transformed dramatically in recent years and this has been clearly evident in the delivery of primary care to Ontarians. The introduction of Nurse Practitioner-led clinics and an expanded scope of practice have cemented the role of NPs in the delivery of quality, timely and accessible primary care in Ontario. In order to expand access to primary care, the government realized that the number of NP positions had to be increased. Therefore, similar increases will be required when the role of the RN and RPN are maximized. These increases will not only improve access to quality care; they will also support sustainability of Ontario's primary care system.

Continuity of care and continuity of caregiver are essential to delivering quality patient care in all sectors.¹¹² This is particularly true in primary care, where long-term care therapeutic relationships must be established to promote health and well-being. Permanent, full-time nursing employment is a key factor in supporting continuity of care and continuity of caregiver.¹¹³ Table Four provides an overview of the employment status of primary care nurses compared with Ontario's overall nursing workforce.

When compared to the provincial average, the percentage of RNs and RPNs working full-time in primary care is lower. Many primary care RNs are hired by physicians who may not receive dedicated funding from the government for nursing care. Physicians may choose to employ nurses on a part-time basis in an effort to reduce cost, while inadvertently compromising continuity of care. Any enhancements made to nursing practice in the primary care setting must consider employment status. In all sectors, at least 70 per cent of nurses must work full-time.¹¹⁵ It is important to acknowledge that some primary care nurses choose to work on a part-time basis and nurses must never be forced to unwillingly change their employment status. However, surveys of part-time and casual nurses suggest that most nurses prefer full-time employment.¹¹⁶

Identifying the ratio of primary care nurses to the population of Ontario helped to generate a better sense of Ontarians' limited access to nurses in primary care. Table Five provides a historical overview of the ratio of RNs and RPNs to the population of Ontario, as calculated by RNAO.

The Government of Ontario projects an annual growth rate of 1.2 per cent in Ontario's population through 2035-36.¹¹⁹ In order to simply maintain the current population ratio of RNs/RPNs over the next 10 years, 500 additional primary care nurses would need to be added by 2020. Table Six provides the increase in primary care nurses, as calculated by RNAO, which would be required to simply maintain the current ratio.

However, the current population ratios are not sufficient to provide quality, timely and accessible care to Ontarians. For example, British Columbia, where enhancements have been made to the RN scope of practice,¹²² far exceeds Ontario with a primary care RN to population ratio of approximately 1:1277 residents.¹²³ In 2010, RNAO calculated the combined ratio of family physicians and NPs in primary care to Ontarians as being approximately

**Table Four:
Primary Care Nurse Employment Status by Nursing Category (2010)¹¹⁴**

	Primary Care Nurses		Ontario's Nursing Workforce	
	Full-Time	Part-Time/Casual	Full-Time	Part-Time/Casual
RN	56.2%	43.8%	65.5%	34.5%
RPN	57.2%	42.8%	57.9%	42.1%

**Table Five:
Primary Care Nurse Population Ratios By Year and Nursing Category^{117,118}**

	2007	2008	2009	2010
RN	1:4803	1:4778	1:4630	1:4604
RPN	1:10477	1:9927	1:9690	1:9368
RN/RPN combined	1:3294	1:3226	1:3133	1:3087

1:1150 residents.^{124,125,126} Therefore, this figure can be used as a target ratio for determining the optimal number of primary care RNs and RPNs in Ontario. Using 2010 CNO membership data¹²⁷ as a baseline and a projected population growth rate of 1.2 per cent,¹²⁸ RNAO calculated that, at minimum 8,000 nurses, an increase of approximately 3,700 nurses from 2010, would need to be working in primary care by 2016 to achieve this population target ratio. A five-year approach can be used to bring Ontario to this target, which would require an increase of 740 nurses each year in primary care beginning in 2012. Given the rising complexity in the health-care needs of Ontarians,¹²⁹ a 75/25 RN/RPN split is required, meaning that at least 75 per cent of the newly created nursing positions would be RN positions and up to 25 per cent would be RPN positions. Ontario can achieve this target by ensuring all current vacancies are filled, and through the creation of new

Table Six:
Additional Primary Care Nurses (RN/RPN Combined)
Required to Maintain Ratio^{120,121}

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Number of Positions (RN/RPN Combined)	51	52	53	53	54	55	55	56	57	57

*Calculated using Table Five and anticipated population growth data from the Government of Ontario

permanent full-time nursing positions. Increasing and retaining the nursing workforce is consistent with a recommendation from the Drummond commission that recognizes the significant need to align the supply of nurses in Ontario with the needs of Ontarians.¹³⁰

Obtaining comparable nursing human resource data for 2011 and beyond will be challenging as the College of Nurses of Ontario (CNO) recently changed the manner in which it reports membership information. Future data will be provided as job counts as opposed to the previous practice of providing head counts.¹³¹ The challenge in exclusively providing job counts is the data may be inflated in circumstances where the nurse has multiple employers. Therefore, this information does not provide an accurate profile of the primary care nursing workforce. It will be important for the CNO to continue to provide head count data, in addition to job counts, to sustain an important long-term nursing human resource analysis.

A joint report from the Association of Family Health Teams of Ontario, the Association of Ontario Health Centres and the Nurse Practitioners' Association of Ontario identifies compensation as the key challenge for recruiting and retaining nurses and other non-physician staff within primary care organizations.¹³² Significant inequities exist in the salary and benefits offered in primary care compared with other sectors of the health system.¹³³ As a result, there are extremely high turnover rates in primary care, with an annual loss of approximately 6.5 per cent of staff capacity.¹³⁴ Approximately 50 per cent of those leaving primary care organizations are also leaving the primary care

setting altogether and taking away a significant amount of clinical expertise.¹³⁵ This joint report also identifies a 10 per cent vacancy rate for RNs in primary care organizations.¹³⁶ Inequities that exist in compensation and benefits within the primary care setting are extremely alarming and the government must act promptly to ensure the sustainability of the primary care workforce.

RNAO has also received a number of anecdotal reports from primary care organizations expressing concern over accessing Ministry of Health and Long-Term Care (Ministry) funding such as through the Nursing Graduate Guarantee initiative and/or applying for additional human resources. Frequently, these organizations devote a considerable amount of time and effort to preparing proposals, submitting applications and following-up with the Ministry. This is time that could be devoted to delivering quality patient care, which is where primary care practitioners need to place their focus. A system must be implemented by the Ministry to facilitate accessibility of funding that will improve the delivery of primary care in Ontario.

In summary, this high-level nursing human resource analysis demonstrates the pressing need for the provincial government to take decisive action to support the primary care nursing workforce. While attention and resources are being directed toward the primary care setting, there has been little focus to date on the means required to strengthen the primary care nursing workforce. Additionally, there is considerable room for expanding the nursing workforce in primary care to create more equitable and accessible primary care across Ontario.

Primary Care Nurse Role Descriptions

“Our role is not fully understood and is often viewed as being an assistant to the physician. When a nurse is unable to work to his or her full scope, the patient misses out on a unique opportunity that can be created through the delivery of safe and effective nursing care. Nurses in family practice are at risk of losing their knowledge, skill and confidence unless something is done. My vision for primary care nursing in Ontario is one where nurses can practise to their full scope and focus on an upstream approach to primary care.”

Primary Care Nurse

“When a nurse is unable to work to his or her full scope, the patient misses out on a unique opportunity that can be created through the delivery of safe and effective nursing care.” Primary Care Nurse

“My vision for primary care nursing in Ontario is one where nurses can practise to their full scope and focus on an upstream approach to primary care.” Primary Care Nurse

1 Phase One

Primary care nurses possess a wealth of clinical competencies, knowledge and skills, which have the ability to positively transform primary care delivery in Ontario. To gain a better understanding of the role of the primary care nurse and how this role varies across settings and regions, current role descriptions of RNs and RPNs were collected from several primary

care organizations, including: Family Health Teams; a Community Health Centre; Nurse Practitioner-led clinics; and Aboriginal Health Access Centres. The content of these role descriptions was extracted and positioned within a matrix for each nursing category (RN and RPN), organized by key elements of practice (i.e. health assessment, treatment, management, planning, education, advocacy, referral, collaboration, co-ordination, skill, knowledge and professional requirements). These matrices are available through RNAO's website (www.RNAO.ca) and demonstrate inconsistent approaches in how the competencies of the primary care nurse are being utilized in Ontario. While attempts were made to ensure the matrices were representative of the diverse roles of primary care nurses across Ontario, given the large number of primary care organizations in Ontario and subsequently a large number of role descriptions, only role descriptions collected by Task Force members were analyzed and included in the matrices.

It is important to note that many of the RN role descriptions reviewed were adaptations of a Family Practice Nurse Role Description compiled by the Canadian Nurses Association and the Canadian Family Practice Nurses Association.¹³⁷ While appreciative of this excellent work, it was necessary to build upon this document to develop separate role descriptions specific to the Ontario context. While similar to other jurisdictions, the practice of nurses in Ontario is unique. For example, Ontario has very unique primary care models, such as Nurse Practitioner-led clinics. Ontario is also the only jurisdiction in Canada to have the RPN role, and RPNs are also included within the mandate of the Task Force. The RN and RPN role descriptions developed differ by recognizing the different foundational knowledge bases, educational requirements and critical thinking skills between the two nursing categories and the broader clinical expertise of the RN.

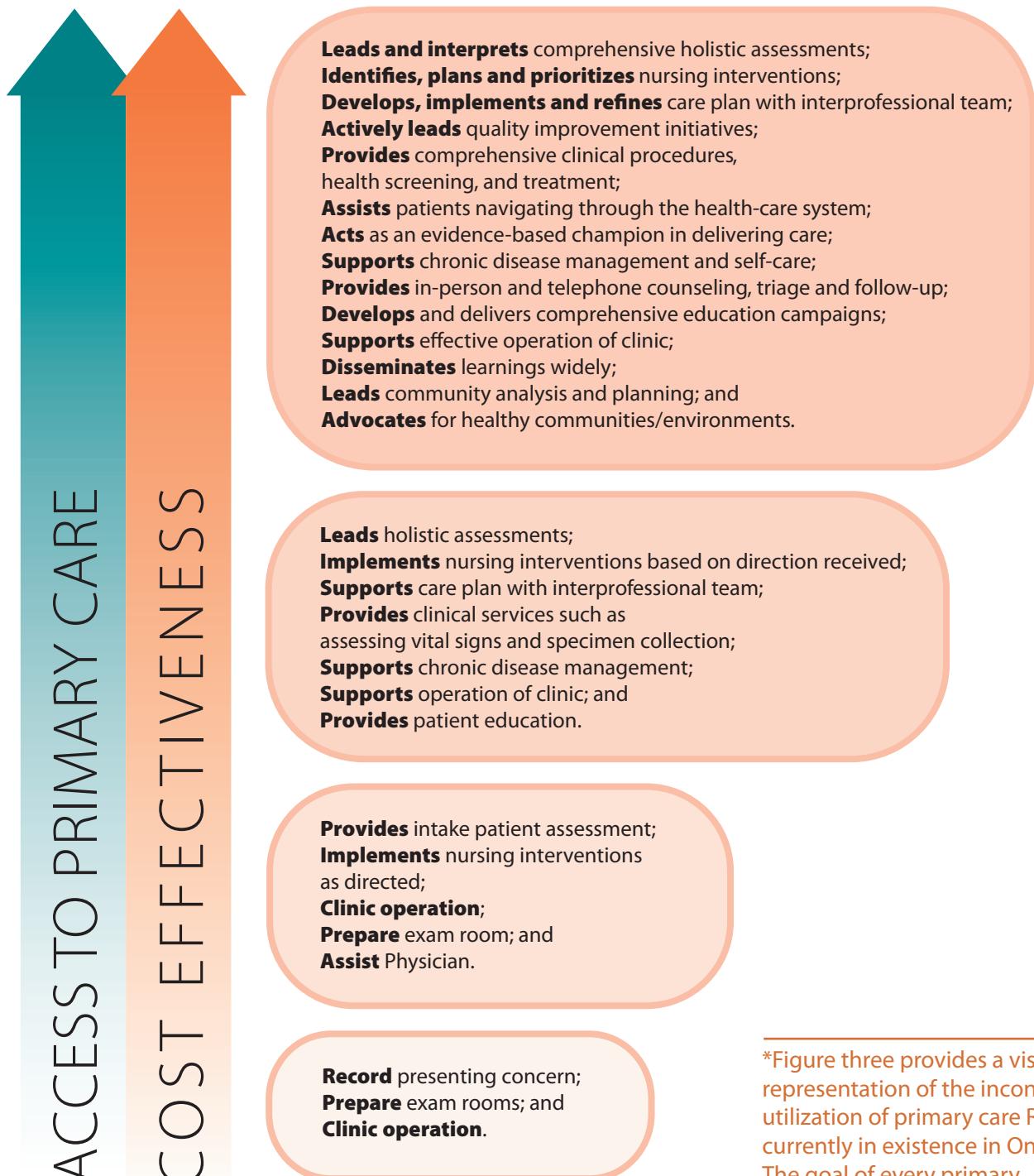
The role description matrices were analyzed and used to identify the highest scope of practice utilization within each practice element. This information led

to the development of prototype phase one RN and RPN role descriptions. There is nothing contained within these role descriptions that was not taken from an existing primary care nurse role description in Ontario. This analytical approach provides the necessary evidence that primary care RNs and RPNs are capable of providing a broad range of service to Ontarians, with the potential of providing a much more substantial and comprehensive range of care to the public. The resulting role descriptions set the bar high, but realistically, for the upward harmonization of RN and RPN scope of practice utilization across all primary care settings in the province, as illustrated in Figures Three and Four. The phase one role descriptions represent the minimum depth and scope of the RN and RPN role in primary care that is needed to strengthen primary care in Ontario.

The benefits of a consistent implementation of the phase one role description are plenty. Ensuring primary care nurses have the ability to practise to their maximal scope of practice will increase Ontarians' access to quality primary care. Moreover, it will extend the capacity of the interprofessional team, allowing for an increased patient volume. The consistent upward harmonization of primary care nurses' scope of practice across Ontario will also strengthen the ability of the health system to afford the public delivery of comprehensive chronic disease prevention and management programs, thus delaying complications and reducing unnecessary hospitalizations or emergency department visits. An upward harmonization of nurses' scope of practice serves to support primary care organizations in achieving targets established by government and its agencies (i.e., LHINs, Health Quality Ontario), advancing accountability requirements and outcomes.

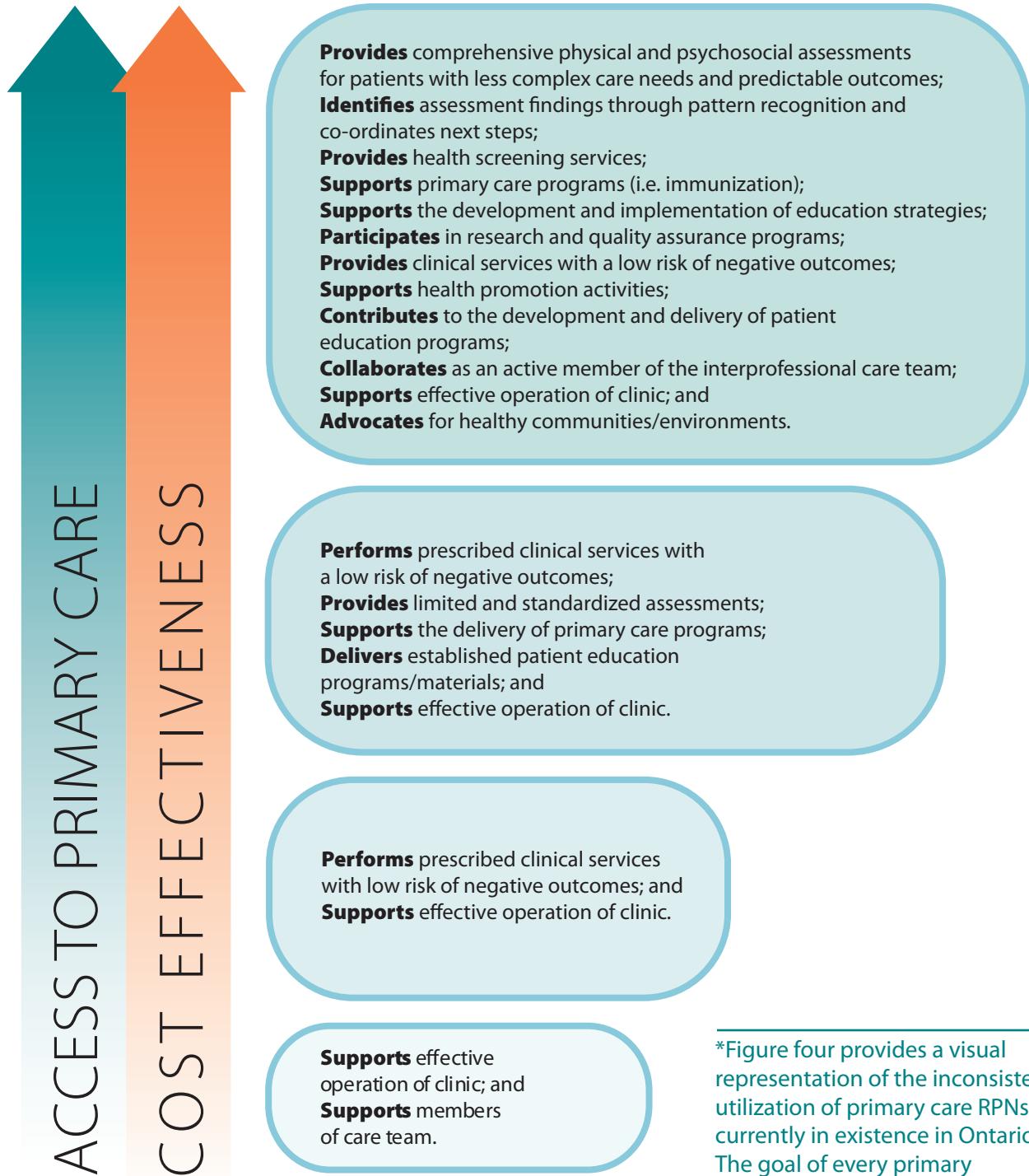
In order to ensure a consistent utilization and implementation of the phase one role descriptions, a number of complementary system enhancements will be required. These enhancements are discussed in greater detail in the next section of this report.

Figure Three: PHASE ONE RN ROLE DESCRIPTION UPWARD HARMONIZATION



*Figure three provides a visual representation of the inconsistent utilization of primary care RNs currently in existence in Ontario. The goal of every primary care organization/practice must be to reach the highest level of scope of practice utilization by December 31, 2013.

Figure Four: PHASE ONE RPN ROLE DESCRIPTION UPWARD HARMONIZATION



*Figure four provides a visual representation of the inconsistent utilization of primary care RPNs currently in existence in Ontario. The goal of every primary care organization/practice must be to reach the highest level of scope of practice utilization by December 31, 2013.

Phase Two

A thorough review of the phase one role descriptions was conducted against the knowledge, skill and expertise that primary care nurses hold, the content of the scientific literature and the context of interprofessional teams. There is significant potential for the roles of the RN and RPN in primary care to be expanded to optimize patient care and achieve system and cost-effectiveness. Phase Two RN and RPN role descriptions were developed to articulate expanded nursing roles in Ontario's primary care system.

The expanded role of the RN focuses on authorizing access to the following three controlled acts under the *Regulated Health Professions Act, 1991* through amendments to the *Nursing Act, 1991* and associated regulations:

- “Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis;”¹³⁸
- “Prescribing, dispensing, selling or compounding a drug as defined in the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept;”¹³⁹ and
- “Applying or ordering the application of a form of energy prescribed by the regulations under this Act.”¹⁴⁰

Practical examples where an expanded role of the RN would be appropriate include:

- The identification and treatment of Otitis Media (ear infection) or an infection of the throat, which are common encounters in primary care;

- The initiation and maintenance of a comprehensive contraception program which would involve prescribing birth control pills to patients. Currently many public health nurses are assuming this function through delegation and medical directives; and
- The management of chronic illness where nurses have developed long-term therapeutic relationships with patients.

In addition, amendments would need to be made to the *Laboratory and Specimen Collection Centre Licensing Act, 1990* and associated regulations to permit RNs to order laboratory tests.

Given the overwhelming evidence identifying RNs' clinical expertise and its impact on patient and system outcomes, significant international benefits of RNs prescribing medications in the United Kingdom (UK) and abroad, and the need for Ontarians to obtain timely access to primary care, the time is right to authorize RN prescribing. In the context of this report, RN prescribing is defined as authorizing RNs to: initiate, renew, dispense, compound and sell medication to prevent or treat health conditions, chronic disease and episodic illness in accordance with an individual RN's level of competencies, knowledge, and skills. In many instances, RNs have already been engaged in prescribing medication through delegation (i.e. public health nurses in sexual health clinics and RNs in remote northern communities). Nurses, as autonomous health professionals, are required to understand their competencies and practice limits based on: evidence, policy, regulations, practice standards and the degree of personal knowledge and experience. The environment in which an RN practises will also impact the capacity to prescribe certain medications. For example, an experienced

clinical nurse specialist practising in a highly specialized chronic disease management program would possess different prescribing practices compared to an RN in a general family practice setting where there is a broad array of care needs encountered. Therefore, RNs working in interprofessional teams are well-positioned to effectively and safely expand their scope of practice to include prescribing.

Anticipated benefits of implementing RN prescribing for Ontarians

- Increased access to required medications
- Enhanced medication management
- Improved continuity of care
- Improved continuity of caregiver
- Decreased wait times in primary care
- Improved patient outcomes
- Enhanced patient satisfaction

Anticipated benefits for primary care organizations

- Increased patient capacity and volume
- Decreased strain on physicians and NPs
- Improved chronic disease management
- Enhanced ability to achieve targets set by government and other funding agencies

Anticipated health system outcomes

- System cost-effectiveness
- Increased retention of nurses through improved role satisfaction
- Increased primary care system capacity

Requirements will need to be fulfilled by current RNs before being able to prescribe medication, such as completion of a focused pharmacology course (300 hours) that expands existing pharmacology education and experience, and completion of ongoing continuing education. For example, the University of Surrey in the UK offers a 300 hour Independent/Supplementary Nurse Prescribing course that is comprised of 162 hours of classroom teaching, 90 hours of practicum experience, and 48 hours of self-study.¹⁴¹ A similar approach can be used in Ontario for nurses currently in practice, and there is potential for collaboration between faculties of nursing, medicine and pharmacy. The expanded role of the RN would also need to be adapted within current nursing curricula, with support for faculty to incorporate an expanded RN role into teaching resources and course content. It is important to flag that caution must be exercised to avoid the use of restrictive ‘prescribing lists’ for RNs, which have historically been troublesome in both the UK and in Ontario with respect to previous NP lists. The independent nurse prescriber program originating in the UK is the model of prescribing that this report is recommending be adapted within Ontario.

In order to be the most effective prescribers, RNs would also require authorization to order, interpret and communicate the outcomes of diagnostic/laboratory testing. It would be hazardous for any practitioner to prescribe medications without the ability to access and interpret all of the required patient information. Furthermore, in order to facilitate appropriate treatment and follow-up, RNs must be authorized to communicate a diagnosis to their patients. Access to all of these new controlled acts for RNs would be framed within the context of diagnosing, treating or preventing health conditions, chronic disease and episodic illness in accordance with the individual RN’s level of competencies, knowledge, and skills.

In situations where the care requirements are outside of the RN’s expanded scope of practice, the RN would be required to consult with, or transition care to, the most appropriate member of the interprofessional team (i.e. experienced primary care RN, NP, family physician, or clinical nurse specialist) to determine the most appropriate course of action. This is not unlike what occurs now in the health system. Consultation and collaboration are key components of interprofessional teamwork.

It is important to highlight that in many areas of the health system, nurses are already performing these functions through the use of medical directives and delegation. However, the use of these authorization mechanisms can sometimes fragment or delay care

by being too restrictive or ambiguous. The nursing profession has grown and evolved significantly over the past decade and it is now time for nurses to take full responsibility for these functions, as articulated in an editorial in the Canadian Journal of Nursing Leadership.¹⁴² Ontario must maintain its reputation as a forward-thinking province and a leader in health-care delivery. Implementing RN prescribing, granting complementary access to diagnostic/laboratory testing, and supporting the ability to communicate a diagnosis will solidify Ontario as the national leader in evidence-based nursing practice.

The proposed phase two expansions to the RN scope of practice are meant to complement and support the role of other health professionals, including NPs and physicians, to strengthen interprofessional care delivery in Ontario. It is well acknowledged that the relationship that exists between primary care physicians, primary care NPs and primary care RNs/RPNs is strong. Moreover, collaboration in primary care can be defined as "... a way of working, organizing, and operating a practice group or network in a manner that effectively utilizes the provider resources to deliver comprehensive primary health care in a cost-efficient manner to best meet the needs of the specific practice population."¹⁴³ The proposed phase two role of the RN will not exist in isolation and will focus on utilizing the full potential of RNs to increase access to care, enhance capacity of primary care organizations, and contribute to the sustainability of Ontario's publicly-funded, not-for-profit health system.

To differentiate the role of the NP in Ontario with the proposed phase two role of the RN, it is important to consider the advanced education pursued by NPs that prepares them for a significant broadening of the scope of nursing practice. The proposed phase two expansions to the RN scope of practice are not meant to mimic or replace the NP role. These expansions are framed within the appropriate context of the care RNs have the competencies, knowledge, and skills to provide. Like all regulated health professionals, RNs will continue to be required to understand the limits of their practice and know when it would be appropriate to consult or transition care to a more appropriate member of the interprofessional team in certain circumstances. Moreover, the phase two expansions to the RN role represent a natural extension to the practice of an RN. They are not meant to replace any other professional within the interprofessional team. This work can lay the foundation for an upward harmonization of practice scopes across the interprofessional team to ensure the right professional is able to provide the right care, at the right time, for Ontarians.

A second area for role expansion of the RN that is part of the Task Force's phase two recommendations is care co-ordination. At present, attempts to co-ordinate care are occurring outside of the primary care setting in Community Care Access Centres (CCACs). The Task Force unanimously concludes that care co-ordination is a role function that belongs fully within primary care as the most appropriate setting to facilitate care co-ordination. Given the rich supply of primary care RNs and the need for full human resource utilization, care co-ordination is a natural fit to the evolving role of the primary care RN.

Primary care RNs are best situated with the clinical background and system knowledge to support Ontarians and co-ordinate with patients. Primary care nurses have the privilege of journeying with patients across all stages of their life and can function proactively, rather than the often reactive nature of current care co-ordination (i.e. discharge from hospital following a significant health event). Furthermore, primary care nurses are capable of delivering continuity of care and caregiver, thereby minimizing confusion and disruption to the care requirements of Ontarians. RNAO is developing a model titled 'Enhancing Community Care for Ontarians (ECCO)' that will place primary care RNs at the centre of transforming care co-ordination and removing duplication within the health system, a central point for health system transformation. This model, in conjunction with the recommendations in this report, will be pivotal in supporting the sustainability of Ontario's publicly-funded, not-for-profit health system.

Recognizing the valuable role that RPNs play in primary care settings, there is potential for RPNs to assume an important role in executing evidence-based clinical and education programs that advance health promotion and disease prevention in primary care. For example, an RPN with a foot care certificate could excel in leading evidence-based foot care programming in primary care. Similarly, RPNs in primary care are well-positioned to deliver immunization programs. The RPN would also assume an important role in supporting the identification, planning and evaluation of these programs. This approach to role expansion will support RPNs in developing knowledge and skill in areas of clinical interest, while improving patient care.

In summary, the phase two role descriptions recognize the tremendous potential that expansions to the scope of nursing practice can bring to Ontario's health system. The phase two role descriptions represent the minimum depth and scope of an expanded RN and RPN role in primary care that is needed to strengthen primary care in Ontario. Primary care nurses are ready and willing to adopt these new roles and improve patient outcomes through patient-centred, evidence-based nursing practice.

Making It Happen

In order to make the phase one and two role descriptions a reality, there is a need to address the barriers that limit the practice of primary care nurses. These are included in Table Seven and Table Eight below, alongside the most appropriate party to lead the identified solutions. Themes from this information were used to generate the recommendations contained later in this report.

Table Seven: Phase One Solutions Matrix

Barrier	Solution	Lead
Role Direction		
Many primary care nurses inherit historical role descriptions which may not be representative of current competencies, knowledge, and skills.	Develop a current role description that accurately aligns with a primary care nurse's competencies, knowledge, and skills. Issue directives for role maximization.	Primary Care Nurse Task Force Ministry of Health and Long-Term Care Local Health Integration Networks
The role differential between the primary care RN and RPN may be unclear.	Develop separate RN and RPN role descriptions that align with the competencies, knowledge, and skills in each nursing category.	Primary Care Nurse Task Force
The role of the primary care nurse is often directed by a decision-maker who may not fully understand the scope of practice and role of an RN or RPN in primary care.	Develop an education strategy targeted to primary care providers regarding the optimal role of the primary care nurse.	Registered Nurses' Association of Ontario in collaboration with the Ontario Family Practice Nurses Interest Group, Ontario Medical Association and Ontario College of Family Physicians Ministry of Health and Long-Term Care (Funder)
Limited experience or education on effective interprofessional team functioning can influence the role of health professionals.	Develop and fund interprofessional education programs and initiatives that support effective interprofessional team functioning.	Ministry of Health and Long-Term Care Primary Care Organizations

Barrier	Solution	Lead
Nurse Education	<p>Entry level nursing curricula provides limited information and experience with primary health care and primary care nursing, resulting in knowledge gaps among new graduates.</p> <p>Develop and integrate primary health care and primary care nursing content throughout nursing curricula.</p> <p>Increase student placement opportunities in primary care and community practice.</p> <p>Engage and support primary care nurses to mentor and teach students.</p>	<p>Schools of Nursing through the Council of Ontario University Programs in Nursing (COUPN) and Colleges of Applied Arts and Technology (CAATS)</p> <p>Ministry of Training, Colleges and Universities</p> <p>Primary Care Organizations</p>
Current primary care nurses practising at a lower scope for a number of years may have lost confidence in their competencies, knowledge, and skills.	<p>Develop and provide educational resources and supports that will be accessible to primary care nurses, including:</p> <ul style="list-style-type: none"> • Primary care nurse institute; • Primary care nurse toolkit; • Primary care nurse competencies, knowledge, and skills refinement programs. 	<p>Registered Nurses' Association of Ontario in collaboration with Task Force Member Organizations (Coordinator)</p> <p>Ministry of Health and Long-Term Care (Funder)</p> <p>George Brown College Family Practice Nursing Program</p>
	<p>Support evidence-based guideline implementation within the primary care setting.</p>	<p>Primary Care Organizations</p> <p>Registered Nurses' Association of Ontario</p> <p>Ministry of Health and Long-Term Care</p>
	<p>Develop linkages between public health and primary care, utilizing the competencies, knowledge, and skills of public health nurses.</p>	<p>Public Health Units</p> <p>Primary Care Organizations</p>
	<p>Develop linkages with other areas of the health system including the hospitals, home health and long-term care.</p>	<p>Primary Care Organizations</p> <p>Ministry of Health and Long-Term Care</p>
	<p>Leverage the expertise of experienced primary care nurses, clinical nurse specialists, nurse practitioners and physicians to mentor and support primary care RNs and RPNs</p>	<p>Primary Care Organizations</p> <p>Ministry of Health and Long-Term Care</p>

Barrier	Solution	Lead
Primary Care Models		
Current Primary Care models place emphasis on providing a high volume of patient care, limiting time spent on advancing care delivery through: research, quality improvement and professional innovation.	<p>Enhance primary care models to include time and funding for nursing research, quality improvement and professional innovation to support the timely and accessible delivery of quality primary care.</p> <p>Encourage application and commitment towards Best Practice Spotlight Organization (BPSO) status.</p>	Ministry of Health and Long-Term Care Local Health Integration Networks Registered Nurses' Association of Ontario Primary Care Organizations
Funding Models		
Current primary care funding models are physician-focused and compensate physicians for directly performing many aspects of a primary care nurses' capabilities (i.e. assessments), thus limiting the ability of nurses to practise to their full scope.	Work to further reform physician compensation models in a way that advances full utilization of nurses and all other health professionals, while ensuring fair compensation for physicians.	Ministry of Health and Long-Term Care Local Health Integration Networks Ontario Medical Association
Funding for primary care nursing positions is limited.	Place emphasis on primary care funding models that are interprofessional and patient-centred. Include dedicated funding to create permanent full-time nursing positions and support the social determinants of health by advancing the principles of primary health care.	Ministry of Health and Long-Term Care Local Health Integration Networks
Nursing Human Resources		
Recruiting and retaining primary care nurses can be a challenge as demonstrated by high turnover and vacancy rates in primary care organizations.	<p>Improve recruitment, retention and work environments in primary care by eliminating compensation and benefit inequities across the health system.</p> <p>Fill current vacancies by enhancing the profile of primary care nursing in Ontario.</p>	Ministry of Health and Long-Term Care Local Health Integration Networks

Barrier	Solution	Lead
Nursing Leadership		
Nursing leadership is missing or extremely limited within primary care organizations. As a result, the voice of nursing is not always heard.	Establish and formalize nursing leadership roles within all primary care organizations through dedicated support and establishing a clear role description.	Ministry of Health and Long-Term Care Local Health Integration Networks Registered Nurses' Association of Ontario Primary Care Organizations

Evaluation of Primary Care Nurse Role		
Limited research exists specific to the role of the primary care nurse in Ontario.	Develop and implement an evaluation framework for the Primary Care Nurse Task Force recommendations that will enhance an understanding of the primary care nurse role in Ontario.	Implementation Committee Independent Researchers

Role Direction

As this report shows, the role of the primary care nurse varies across the province, with no consistent understanding of the knowledge, skill and expertise of these nurses within Ontario's health system. Moreover, the role of the primary care nurse is frequently dictated by a decision-maker who may be unfamiliar with the competencies and capabilities of a primary care nurse. This misunderstanding is often aligned with historical context where primary care nurses were inappropriately viewed as assistants, rather than autonomous health professionals. In response to these concerns, it is anticipated that the phase one and two role descriptions will clearly articulate to all primary care decision-makers the important and valuable role of the primary care nurse. Moreover, the role descriptions provide clarity to differentiate the role of the RN and RPN in primary care and help to ensure the right patient is seen at the right time, by the right professional. Direction will need to be provided from the Ministry of Health and Long-Term Care and Local Health Integration Networks to ensure a consistent approach to role maximization within an established timeframe.

Trends in primary care are shifting away from truly independent practice and towards patient-centred, team-based care. There would be great benefit and interest in developing and strengthening interprofessional initiatives that target the unique needs of primary care professionals. These initiatives may involve education programs that identify the role and strengths of each team member and provide: strategies/applications that enable effective team-based care delivery, conflict management training, communication tools, and resources for evaluation.

Nursing Education

There is limited exposure to primary care nursing within initial nursing education programs. This creates significant challenges for new nursing graduates who may lack the required competency to thrive in this environment. Limited exposure to primary care nursing may also inhibit new nursing graduates' intentions to eventually pursue a career in this rewarding and dynamic setting. In addition, nursing students must appreciate the community context of their practice and not just their care with individuals. Therefore, there is a need to integrate and strengthen primary health-care principles and values within nursing curricula. Nursing students should also have the opportunity to engage in community practice placements as an invaluable learning experience. Primary care nurses must be engaged and supported to mentor and teach students in all primary care settings. Furthermore, primary care organizations need to be open to accepting nursing students for clinical placements.

The move towards having all primary care nurses practise to their full scope in Ontario will require educational support that considers local needs and self-assessment. In many circumstances, the competencies, knowledge, and skills of the primary care nurse have been suppressed from years of working below their full scope of practice. There is no 'one size fits all' approach, and the process to achieve full scope utilization will differ for each nurse. A key education strategy that can be implemented to support primary care nurses involves holding intensive week-long learning institutes that focus on practical skill and knowledge development. RNAO has been organizing and delivering successful learning institutes on a number of topics, for some time. RNAO describes a learning institute as: "[providing one] with knowledge and strategies to help [one] to transform nursing through knowledge. In addition, [one] will develop a network of support, and will leave highly motivated to take a leadership role in developing an evidence-based nursing culture in [one's] workplace."¹⁴⁴

This work may be complemented by e-learning modules, a tool-kit and workshops. Established education programs can also be strengthened to provide leadership in developing primary care nursing knowledge and expertise. For example, George Brown College offers Canada's first post-graduate certificate program in family practice nursing (Table Nine), which offers students an intensive learning experience to "... provide comprehensive care to individuals and families across the lifespan within family health team/

primary care contexts and settings."¹⁴⁵ In addition, there is tremendous value in leveraging the significant expertise of clinical nurse specialists as mentors to primary care RN and RPNs. Clinical nurse specialists are RNs with advanced education at the graduate level, who hold a higher level of clinical nursing specialty.¹⁴⁶ Clinical nurse specialists have tremendous potential to emerge as clinical leaders within the primary care setting and their expertise must be made available to all primary care organizations through system enhancements. The mentorship provided from clinical nurse specialists may be complemented with mentorship from experienced primary care nurses, NPs and physicians.

RNAO is known internationally for its Nursing Best Practice Guidelines Program, which has produced 50 systematic evidence-based guidelines, a broad range of implementation resources and hundreds of Best Practice Spotlight Organizations.¹⁴⁷ Guidelines are developed using a systematic process over a number of years with funding from the Ministry of Health and Long-Term Care and reviewed every three years and revised as necessary.¹⁴⁸ A number of the guidelines produced to date have direct relevance to primary care to support evidence-based nursing practice. However, the primary care setting can benefit from additional resources to support and optimize guideline implementation. Moreover, there may be opportunity to enhance existing guidelines, when reviewed in the future, to maximize relevance and uptake within non-institutionalized settings. For example, there is interest in implementing the *Prevention of Falls and Fall Injuries in the Older Adult* guideline in primary care to prevent falls in the community. Revising this guideline to include implications for primary care can strengthen the ability of primary care nurses and other health professionals to develop comprehensive falls prevention strategies with patients and caregivers.

Maximizing the role of nurses in primary care cannot occur without linkages between primary care and other areas of the health system, such as public health. Historically, public health units have assumed a number of functions meant to thrive within primary care. As a result, public health nurses are able to share a considerable amount of expertise to support colleagues within primary care. Furthermore, well-established relationships between primary care and other areas of the health system will support enhanced integration and a seamless experience for patients.

Table Nine:
Overview of George Brown College's Family Practice
Nursing Program Ontario Graduate Certificate

The Family Practice Nursing Program at George Brown College prepares the RN to provide comprehensive care to individuals and families across the lifespan within family health teams/primary care contexts and settings. Current research and theoretical perspectives provide the foundation of study for interprofessional family-centred care. Courses build on entry-to-practice nursing competencies and provide the RN opportunities to apply theory and advance practice within an interprofessional team environment. The program is based on a primary health-care model in which collaborative, patient-centred teamwork enables professionals to practise to their full capabilities, leading to better patient outcomes and higher job satisfaction.

Primary Care Models

Ontario's primary care organizations place an exclusive emphasis on delivering patient care, leaving little time to engage in nursing research, quality improvement and professional innovation. Given the provincial government's shift in emphasis to the community and primary care settings, it is critical for Ontario to possess a strong, innovative and evidence-based primary care system. Releasing time to allow nurses and other health professionals to fulfill professional obligations outside of delivering care will benefit the patient, community and health system over time. It is also crucial for primary care organizations to have a robust understanding of the communities they serve and the programs they deliver. Research, evaluation, needs assessments and community engagement are critical components that are missing in many primary care models. The role of the primary care nurse must include leading these very important functions to promote effective care delivery.

As part of the Nursing Best Practice Guidelines Program, RNAO partners with health-care and academic organizations interested in pursuing Best Practice Spotlight designation. A Best Practice Spotlight Organization (BPSO) is selected by RNAO, through a Request for Proposals process, to implement and evaluate RNAO's Nursing Best Practice Guidelines. To date there are over 250 BPSO sites around the world.¹⁴⁹ Primary care organizations are encouraged to apply for participation in this innovative opportunity. Doing so will represent a significant step forward in developing an evidence-based nursing culture in Ontario.

Funding Models

A consistent message being delivered by primary care nurses is concern over physician-focused funding models in primary care. In many circumstances, physicians are being compensated to provide care that is well within the scope of practice of a RN, RPN or other health professional. For example, nurses are thoroughly educated to provide comprehensive physical and psychosocial assessments of patients. In many circumstances, a primary care nurse's ability to perform routine assessments is limited given a significant source of compensation for a family physician is received by directly performing these assessments. Funding models must be adjusted to allow primary care nurses and all other health professionals to practise to their full scope, while ensuring fair compensation for physicians. Family physicians are invaluable members of the interprofessional care team and possess expert knowledge and skill. Family physicians possess the expertise needed to focus on more acute and specialized areas of family practice. The intent of this Task Force is not to replace or substitute physicians or other providers, but to complement their role by ensuring the right patient is seen by the right professional at the right time. This process will strengthen access, quality and effectiveness by ensuring the full knowledge and skill of each professional is maximized within primary care. There is a need to support patient-centred interprofessional primary care models with dedicated funding for permanent full-time nursing positions, and an emphasis on advancing primary health care through the social determinants of health. Primary care models must ensure that they are providing the

Primary care is an ideal setting to observe and influence the social environments that impact health status and access to health services.

A comprehensive compensation and benefit strategy is required for the sustainability of the primary care nursing workforce.

Ensuring that dedicated nursing leadership exists in primary care organizations will strengthen and develop the role of the primary care nurse.

accessible and culturally sensitive services required by all members of the communities in which they serve. Primary care is an ideal setting to observe and influence the social environments that impact health status and access to health services. Therefore, it is paramount for primary care models to incorporate the ‘big picture’ into the foundation of all services/programming in order to effectively account for the many social and environmental determinants of health. Primary care nurses are well-equipped with the knowledge and skill required to facilitate this process as part of practising to their full scope.

Nursing Human Resources

A comprehensive compensation and benefit strategy is required for the sustainability of the primary care nursing workforce. Inequities in compensation and benefits will continue to drive the required expertise in primary care away to other areas of the health system, at a cost to Ontarians and the health system. Lastly, streamlining government processes to receive funding in primary care must occur to ensure the best use of a primary care practitioner’s time. It is not efficient for primary care nurses and other professionals to devote precious time to drafting proposals and engaging in follow-up, when this time could be better spent providing care to Ontarians.

Nursing Leadership

The voice and identity of nursing and other health professions in many primary care organizations is either missing or extremely limited. As a result, the role of a nurse is often dictated based on assumptions of decision-makers, which may be inconsistent with the true potential of these nurses. Furthermore, it is incredibly valuable for primary care nurses to have access to professional nursing support within their organization. Ensuring that dedicated nursing leadership exists in primary care organizations will strengthen and develop the role of the primary care nurse. A practical example of enhancing nursing leadership in primary care organizations involves designating a nurse-lead to spend a portion of her/his time serving as a liaison and advising management and the board of directors from a nursing perspective.

Table Eight: Phase Two Solutions Matrix

Barrier	Solution	Lead
RN Prescribing		
RNs in the general class do not have the ability to prescribe or dispense medication.	Amend the <i>Nursing Act, 1991</i> and associated regulations to permit RNs in the general class to prescribe medication.	Ministry of Health and Long-Term Care The College of Nurses of Ontario
RNs in the general class do not have the ability to order diagnostic testing.	Implement regulations under the <i>Regulated Health Professions Statute Law Amendment Act, 2009</i> to permit RNs in the general class the ability to dispense medication.	Ministry of Health and Long-Term Care The College of Nurses of Ontario
	Amend the <i>Nursing Act, 1991</i> , the <i>Laboratory and Specimen Collection Centre Licensing Act, 1990</i> and associated regulations to permit RNs in the general class to order laboratory tests to support comprehensive patient assessments.	
	Amend the <i>Nursing Act, 1991</i> and associated regulations to permit RNs to order the application of a form of energy (i.e. x-rays) to support comprehensive patient assessments.	
RNs in the general class do not have the ability to identify and communicate a diagnosis to a patient.	Amend the <i>Nursing Act, 1991</i> and associated regulations to permit RNs in the general class to identify and communicate a diagnosis to initiate treatment in relation to their proposed prescriber role.	Ministry of Health and Long-Term Care The College of Nurses of Ontario
	Amend the <i>Nursing Act, 1991</i> and associated regulations to authorize RNs and RPNs to compound and sell medication.	
	Issue direction with specific timelines for the expanded scope of RN practice to be integrated within primary care organizations.	

Barrier	Solution	Lead
RNs in the general class will require educational/ orientation support to embrace their expanded roles.	Develop a comprehensive education program to support current RNs in the general class. Enhance current baccalaureate nursing curricula to accommodate the expanded RN role.	Registered Nurses' Association of Ontario in collaboration with education partners Ministry of Health and Long-Term Care (funder) Council of Ontario University Programs in Nursing Primary Care Organizations
Care Co-ordination		
Unnecessary and inefficient duplication currently exists across the health system.	Develop and implement a primary care based model that enhances the delivery of community care while eliminating duplication, with support from LHINs.	Registered Nurses' Association of Ontario (develop model) Ministry of Health and Long-Term Care (implement model)
RPN Program Management		
Some RPNs may not be prepared to execute evidence-based clinical and education programs in primary care.	Implement education strategies with a focus on specializing in a particular area of practice (i.e. foot care certification).	Registered Practical Nurses Association of Ontario Registered Nurses' Association of Ontario Ministry of Health and Long-Term Care (funder)
Nursing Human Resources		
Recruiting and retaining primary care nurses can be a challenge as demonstrated by high turnover and vacancy rates in primary care organizations.	Improve recruitment, retention and work environments in primary care by eliminating compensation and benefit inequities across the health system. Fill current vacancies by enhancing the profile of primary care nursing in Ontario.	Ministry of Health and Long-Term Care Local Health Integration Networks

Barrier	Solution	Lead
Primary care nurse to population ratios are too low, impacting access to the delivery of quality nursing care.	<p>Invest in the creation of 3,700 new permanent full-time primary care nursing positions (75 per cent RN and 25 per cent RPN) over five years to establish a ratio of at least one primary care nurse per 1,150 Ontarians, while continuing to steadily increase the number of primary care NPs.</p> <p>Implement recruitment strategies that eliminate the 10 per cent vacancy rate for nurses in primary care.</p> <p>Remove barriers to accessing Ministry of Health and Long-Term Care funding that will support the delivery of accessible primary care.</p>	Ministry of Health and Long-Term Care Local Health Integration Networks
Primary care nurse full-time employment rates average 57 per cent ¹⁵⁰ which limits the ability to ensure continuity of care and caregiver.	Support strategies that increase full-time nursing employment to ensure 70 per cent of primary care nurses are employed full-time. Strategies may include: creative scheduling, combining part-time lines and providing funding to convert part-time to full-time positions.	Ministry of Health and Long-Term Care Local Health Integration Networks

Nursing Leadership

Nursing leadership is missing at the Local Health Integration Network level. Current primary care leads are all physicians.	Establish a tripartite leadership model within each Local Health Integration Network that includes a physician, an RN and one other health professional (i.e pharmacist, physiotherapist, occupational therapist, etc.).	Local Health Integration Networks
-----------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------

Professional Development

At present, there is limited opportunity to formally recognize the unique and valuable contributions that primary care RNs make to the primary care system.	Establish a certification program that promotes professionalism, knowledge advancement, and recognizes the tremendous expertise of primary care RNs.	Canadian Nurses Association
-------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------

RN Prescribing

Accepted and respected internationally, RN prescribing is a relatively new opportunity in Ontario. However, it is not a novel concept given RNs have possessed the knowledge, skill and expertise to become effective prescribers for many years. The single most effective outcome of RN prescribing will be improved continuity of care leading to enhanced patient outcomes. Significant legislative and regulatory amendments would be required to facilitate this enhancement, however, representatives of government, regulators, unions, educators, health-care organizations, interest groups, patient groups, professional associations and the public must unite to make this concept a reality. Educational courses will also need to be offered to RNs pursuing the prescriber function, however, these sessions will expand upon the accumulated expertise of RNs. A comprehensive education strategy will need to be implemented to support other health professionals (i.e. physicians and pharmacists) to learn how RN prescribing would operate. As previously identified in this report, in order to become effective prescribers, RNs would also require access to ordering diagnostic testing and the ability to communicate a diagnosis. Furthermore, RNs in many circumstances require the ability to compound, dispense and sell medications when access to a pharmacy is limited or unavailable. Direction will need to be provided from the Ministry of Health and Long-Term Care and Local Health Integration Networks, with specific timelines, to ensure the expanded scope of practice of the RN is integrated within primary care organizations. The benefits of RN prescribing would not be isolated to primary care and would be felt in all practice areas across Ontario. Whether one receives care in a primary care organization, hospital, long-term care home, residence or street-corner, all Ontarians deserve equitable access to the highest quality of care possible. RN prescribing is an important first step in achieving this desired outcome. A comprehensive evaluation of RN prescribing in Ontario would also be required to identify the impact at the patient, organizational, workforce and systems level. This important research will be critical to validating previously established international findings and shaping the ongoing evolution of the RN role.

Care Co-ordination

As previously identified in this report, primary care is the setting often regarded as the entry point to the health system. It is the interface where care can be co-

ordinated and delivered through a seamless transition across life stages from 'womb to tomb'. However, the current system established outside of primary care to support care co-ordination is proving to be ineffective from both a quality and financial perspective. Given the provincial government's demand for better value on health-care expenditures, now is the time to begin looking closely at how primary care RNs can support Ontarians navigate through the complexities of the health system, while co-ordinating the delivery of health-care/community services and supporting more effective /efficient interactions with the health system. Particular attention can be given to support those living in areas where access to health services may be limited, disenfranchised and marginalized groups, the elderly with multiple chronic conditions, and persons experiencing disabilities. There is a significant workforce of RNs in primary care that would excel in this function.

RPN Program Management

RPNs should be encouraged and supported to enhance their knowledge base by pursuing certification programs that would allow them to develop competency in a particular clinical area. RPNs could then use this knowledge to execute effective evidence-based programs within the primary care setting. RPNs should also have the opportunity to support planning, developing and evaluating these programs.

Nursing Human Resources

Additional investments must be made to develop, enhance and sustain the nursing workforce in primary care. Funding for nursing positions in primary care often varies with physicians frequently employing nurses as part of the practice's overhead. Stable and secure funding for permanent full-time nursing positions is essential to create access to nursing care in the primary care setting. Furthermore, the creation of 3,700 new primary care nursing positions (75 per cent RN and 25 per cent RPN) over the next five years, coupled with recruitment strategies to eliminate a 10 per cent vacancy rate, would ensure there is at least one primary care nurse per 1,150 Ontarians. Additional investments are also required to convert current part-time/casual positions into full-time positions to ensure at least 70 per cent of primary care nurses are working on a full-time basis.

Nursing Leadership

It is concerning that primary care nurses and other health professionals are not represented within Local Health Integration Networks (LHIN). Each of the 14 LHINs have exclusively appointed physicians to support primary care decision-making. Given the interprofessional nature of primary care, a tripartite model of leadership incorporating medicine, nursing and another health profession (that is neither from medicine or nursing) would be a much more appropriate and effective model to follow.

Professional Development

The Canadian Nurses Association identifies certification as a "...recognized credential for registered nurses who meet specific nursing practice criteria, continuous learning and exam-based testing requirements."¹⁵¹ Given the uniqueness and complexity of primary care nursing practice, certification in this area will promote continued education, knowledge advancement and will acknowledge the invaluable contributions of primary care RNs in delivering quality primary care. The anticipated outcomes of developing a certification program in primary care nursing include:

- enhanced competency through education and skill refinement;
- greater clarity on the role of the RN in primary care practice;
- increased role satisfaction;
- opportunities for career advancement; and
- ongoing capacity development through the certification renewal requirements.

enhanced competency through education and skill refinement

greater clarity on the role of the RN in primary care practice

increased role satisfaction

opportunities for career advancement

ongoing capacity development through the certification renewal requirements

Evaluation

In order to effectively measure the success of the recommendations presented in this report, and to monitor implementation, an evaluation should be conducted to assess the impact and outcomes at the local and system level. The following broad metrics can be used as a starting guide for an evaluation of phase one, and eventually phase two:

Table Ten: Evaluation Indicators and Anticipated Outcomes

Indicator	Anticipated Outcomes
Patient access to primary care	Increased access to primary care and attachment to primary care providers for Ontarians
Percentage of patients able to access same-day primary care	Increased percentage of patients able to access same-day primary care
Patient capacity and volume	Increased capacity of primary care organizations and subsequently increased patient volume
Patient satisfaction	Improved patient satisfaction
Patient outcomes	Improved patient outcomes
Role satisfaction amongst nurses	Improved role satisfaction
Emergency department utilization	Decreased emergency department utilization to access primary care services
Hospitalization	Decreased unnecessary hospitalization
Patient safety	Improved patient safety
Service to marginalized populations	Increased access to primary care for marginalized populations
Team effectiveness	Improved integration, collaboration, communication, consultation and overall team effectiveness
Therapeutic self-care	Empowered patients and increased self-efficacy
Number of primary care nurses and employment status	Increased number of primary care nurses employed full-time
Primary care investments	Maximized primary care investments

Systems would need to be established and refined to identify benchmarks and collect/interpret the data needed to effectively evaluate the recommendations in accordance with the proposed metrics. In addition, researchers would need to be engaged and funded to lead the evaluation process. This research could generate significant knowledge and evidence that would strengthen the primary care knowledge base in Ontario and abroad. Moreover, this work would also assist to better articulate the role of the primary care nurse in Ontario and close the gap in the literature that exists surrounding the role of the RPN in primary care.

strengthen the primary care knowledge base in Ontario and abroad

assist to better articulate the role of the primary care nurse in Ontario

close the gap in the literature that exists surrounding the role of the RPN in primary care

Recommendations

To maximize and expand the scope of practice of primary care nurses, the Task Force has the following recommendations



Recommendations

Recommendations	Accountability	Proposed Timeline	
Implementation and Evaluation			Phase One
<p>1. Appoint a six month government committee, co-sponsored by RNAO and the Ministry of Health and Long-Term Care, with representation from professional associations, regulatory bodies and primary care associations, to roll-out the timely and effective implementation and evaluation of the recommendations in this report.</p>	Ministry of Health and Long-Term Care	Immediately	
	Registered Nurses' Association of Ontario		
Role Direction Phase I			
<p>2. Issue directives, with specific timelines, for the upward harmonization of RN and RPN scope of practice across all primary care settings, as a first step to maximize all roles within the interprofessional team.</p>	Ministry of Health and Long-Term Care	Immediate directive provided, with role maximization compliance required by December 31, 2013	
	Local Health Integration Networks		
<p>3. Issue a directive to primary care organizations to formally designate a nurse lead to spend a portion of her/his role advising the management team and board of directors from a nursing perspective.</p>	Ministry of Health and Long-Term Care	Immediate directive provided, with designated nurse lead compliance required by December 31, 2013	
	Local Health Integration Networks		
Education and Support Phase I			
<p>4. RNs and RPNs, currently working in primary care, self-assess their educational needs and engage in educational programs to meet the requirements of the phase one role description.</p>	Primary Care Organizations	Immediate directive to self-assess, with role maximization compliance required by December 31, 2013	
	Primary care RNs/RPNs		
<p>5. Support primary care nurses to practise to full scope within interprofessional teams, using the phase one role description developed by the Task Force as a resource. This includes providing the necessary mentorship, team building, team roles clarification, and acknowledgment of local support needs.</p>	Primary Care Organizations	Immediate, with role maximization compliance required by December 31, 2013	
<p>6. Fund RNAO to develop a primary care nursing-focused learning institute for RNs and RPNs to strengthen the knowledge, skills and confidence of primary care nurses.</p>	Ministry of Health and Long-Term Care	Immediate funding provided with first learning institute by December 31, 2012	
<p>7. Secure clinical placements in primary care practice for RN and RPN students.</p>	Schools of Nursing	Immediate initiation with full compliance by December 31, 2013	
	Primary Care Organizations		
Primary Care Funding			
<p>8. Work to further reform physician compensation models in a way that advances full utilization of nurses and all other health professionals, while ensuring fair compensation for physicians.</p>	Ministry of Health and Long-Term Care	Immediate as part of current (2012) negotiations with the Ontario Medical Association	
	Ontario Medical Association		
<p>9. Develop a uniform and streamlined process to apply for additional funding to increase health human resources for primary care organizations when patient enrollment targets are met, and infrastructure capacity exists.</p>	Ministry of Health and Long-Term Care	Immediate with uniform and streamlined application process in place by December 31, 2012	

Recommendations	Accountability	Proposed Timeline
<p>Legislation</p> <p>10. Amend the <i>Nursing Act, 1991</i> and associated regulations to authorize RNs in the general class to:</p> <ul style="list-style-type: none"> • prescribe medication to prevent and/or treat health conditions, chronic disease and episodic illness within their level of competency; • compound and sell medication; • identify and communicate a diagnosis within their level of competency; and • order diagnostic imaging. 	<p>Legislation</p> <p>Government of Ontario College of Nurses of Ontario</p>	<p>Achieved by January 1, 2014</p>
<p>11. Amend the <i>Laboratory and Specimen Collection Centre Licensing Act</i> and associated regulations to authorize RNs in the general class to order laboratory tests.</p>	<p>Government of Ontario College of Nurses of Ontario</p>	<p>Achieved by January 1, 2014</p>
<p>12. Implement regulations under the <i>Regulated Health Professions Statute Law Amendment Act, 2009</i> to authorize RNs in the general class and RPNs to dispense medication.</p>	<p>College of Nurses of Ontario</p>	<p>Achieved by January 1, 2013</p>
<p>Role Direction Phase II</p>		
<p>13. Issue directives with specific timelines for the expanded scope of practice utilization of RNs, to include RN prescribing and care co-ordination, for all primary care organizations.</p>	<p>Ministry of Health and Long-Term Care Local Health Integration Networks</p>	<p>Directive issued in January, 2014, with expanded scope of practice role compliance by December 31, 2015</p>
<p>14. Support RPNs in executing clinical and educational programs to advance health promotion and disease prevention.</p>	<p>Primary Care Organizations</p>	<p>Expanded scope of practice role compliance by December 31, 2015</p>
<p>Education and Support Phase II</p>		
<p>15. Fund and develop focused pharmacology/diagnostic courses (i.e. 300 hour nurse prescribing course offered in the UK) that expand on the experiences and competencies of current RNs to prepare them for an expanded role, while enhancing current nursing education programs and supporting nursing faculty to incorporate an expanded RN role into nursing curricula.</p>	<p>Ministry of Training, Colleges and Universities (funder) Educational Institutions</p>	<p>Funds made available in February 2014. Course developed and offered by September 2014</p>
<p>16. Establish a certification program to promote professional development and knowledge advancement and acknowledge the unique competencies of primary care nurses.</p>	<p>Canadian Nurses Association</p>	<p>By January 1, 2015</p>
<p>Health System Enhancement</p>		
<p>17. Identify areas of structural duplication and work toward better system integration by improving linkages across all sectors and moving care co-ordination to primary care.</p>	<p>Ministry of Health and Long-Term Care</p>	<p>Process and transition completed by January 1, 2015</p>
<p>18. Establish tripartite leadership councils within Local Health Integration Networks, including one representative from: nursing, medicine, and another health profession that is not medicine or nursing (i.e. pharmacist, physiotherapist, occupational therapist, etc.) to provide clinical and human resources advice to LHINs.</p>	<p>Ministry of Health and Long-Term Care Local Health Integration Networks</p>	<p>Model and selection process developed by January 1, 2013. Councils in place on each LHIN by January 1, 2014</p>

Recommendations	Accountability	Proposed Timeline
Nursing Human Resources		
19. Provide primary care organizations with the funding required to offer competitive compensation and benefits to primary care nurses and other health professionals, eliminating inequities with other sectors of the health system.	Ministry of Health and Long-Term Care Local Health Integration Networks	By January 1, 2015
20. Support and fund strategies that will ensure at least 70 per cent of primary care nurses are working full-time.	Ministry of Health and Long-Term Care Local Health Integration Networks Primary Care Organizations	Directive issued by January 2014, with 70 per cent full-time employment target in all primary care settings achieved by December 31, 2015

Next Steps

In an effort to disseminate this report widely, the document will be made available online through RNAO's website (www.RNAO.ca) and Task Force members will be invited to post a link on their respective websites. To support implementation of the recommendations, a copy of the report will be sent to the identified leaders for each recommendation, including representatives of government, provincial agencies and other decision-makers. RNAO will use this report as an important policy tool to influence action and inform future policy directions per the direction of the Board of Directors.

Effective implementation of the Task Force's recommendations will require establishment of a committee, co-chaired by RNAO and the Ministry of Health and Long-Term Care, with broad external representation from all impacted parties. The purpose of this committee will be to provide strategic advice to promote effective implementation of the recommendations and to provide outcome monitoring. Considerations of this committee will include:

- reviewing how the recommendations will affect other primary care roles (clinical, administrative and clerical) and determining what action will be required to support role transitions;
- examining appropriate mixes of health professionals and providers in primary care, using an evidence/population-needs-based, equity-oriented planning approach to primary care;
- identifying effective implementation strategies;
- leading and developing the evaluation framework identified within this report;
- supporting legislative and regulatory changes affecting nursing practice through the provision of expert advice to government; and
- developing the care co-ordination role within primary care.

RNAO will also develop and issue a report on its Enhancing Community Care for Ontarians (ECCO) model later in 2012.

Conclusion

In conclusion, primary care nurses are not being utilized to their full potential within Ontario's health system. The effects of RN and RPN under-utilization in primary care, are significant, and felt by Ontarians both as patients and taxpayers. The time has come to address this important issue to ensure the public receives the right care from the right provider, and at the right time. The Primary Care Nurse Task Force has engaged in an evidence-based review of the role of the primary care nurse in Ontario and is offering reasonable, clear and effective solutions that will maximize and expand the role of nurses in primary care. There is no reasonable justification for not embracing all of the recommendations provided, particularly in the current economic climate. In fact, the recommendations provided in this report are likely to produce significant long-term cost savings for the health system as well as result in improved patient health outcomes. Prompt and effective implementation of the recommendations will enhance the delivery of quality, evidence-based, patient-centred primary care that Ontarians deserve.

In this report, the first phase of recommendations focus on maximizing the current scope of practice of primary care nurses. The second phase of recommendations focus on expanding scope of practice. RNAO is calling on government, regulators and other decision-makers to review this work and to act promptly on addressing the issues discussed in this report. The benefits of implementing these recommendations will not be isolated to the primary care setting, but will generate significant system-wide benefits. Given the government's shift in attention to primary care, and maximizing the use of all health professionals, RNAO feels this report is timely and will achieve the outcomes desired by the government. Finally, effective implementation of these recommendations will solidify Ontario's position as a world leader in advancing the nursing profession and the primary care setting through innovative, evidence-based and resourceful solutions.

The effects of RN and RPN under-utilization in primary care, are significant, and felt by Ontarians both as patients and taxpayers.

Appendix A:

Primary Care Nurse Task Force

Terms of Reference

Mandate

To bring together key stakeholders in primary care in Ontario to review and revise, as necessary, the role of registered nurses and registered practical nurses in primary care. The end goal of this task force is to adjust roles as needed to facilitate timely access to person-centred quality primary care and optimize patient and community outcomes.

Background

Ontario has a total of 4,285 primary care nurses. Of these, 2,873 are registered nurses (RNs) and 1,412 are registered practical nurses (RPNs). To bring about transformational change to our primary health-care system, the doors must be opened to utilize these health-care professionals to their full scope of practice and in a range of roles that optimize the nurses' impact on our health system performance and the health outcomes of individuals, families and communities.

Co-Chairs

Chief Executive Officer, RNAO
President, Ontario Family Practice Nurses

Membership

In order to achieve a range of expertise on primary care/family practice nursing, including both a rural and urban perspective, the following organizations are represented on this Task Force:

Association of Family Health Teams of Ontario (3)

Association of Ontario Health Centres (2)

Canadian Family Practice Nurses Association (1)

Canadian Nurses Association (1)

Community Health Nurses' Initiatives Group (1)

George Brown College Family Practice Nursing Program (1)

Nurse Practitioners' Association of Ontario (3)

Ontario College of Family Physicians (1)

Ontario Family Practice Nurses (1)

Ontario Medical Association (1)

Ontario Nurses' Association (1)

Primary Care Organizations (Determined by co-chair)

Registered Practical Nurses Association of Ontario (1)

Term of Task Force

One year (or shorter).

Frequency of Meetings

Four meetings face-to-face or via teleconference.

Responsibilities

- To assess the range of roles currently played by RNs and RPNs in Ontario's primary care settings.
- To define the competencies, knowledge and skills required in primary care nursing practice.
- To identify current and future health system needs in primary care.
- To recommend, as a first step, optimizing the full utilization of nurses in primary care by leveraging the potential currently existing within the system.
- To recommend, as a second step, an expanded scope of practice that optimizes nurses' ability to deliver quality primary care.
- To leverage the strength and position of primary care nurses to bring about a Canadian primary health-care system that promotes health equity and addresses root causes of health disparities, including addressing the social and environmental determinants of health.

Task Force Support

RNAO Health and Nursing Policy Department.

1

Appendix B:

Phase One

Role Descriptions

Registered Nurse

Role Description:

The primary care registered nurse (RN) practises primarily in the community setting, often in clinics and primary care organizations to provide a range of patient-centred health care services to individuals, families and communities at all life stages. The primary care RN practises autonomously to their full scope of practice and is an important member of the interprofessional care team. Frequently, the primary care RN is a patient's first point of contact with the health system and provides a broad spectrum of health promotion, chronic disease management, disease prevention, education, counseling, treatment and supportive care. The primary care RN maintains competencies based on in-depth knowledge and skills in clinical practice, and holds the expertise required to conduct comprehensive health assessments and implement appropriate nursing interventions. The primary care RN is active within the community, assessing health needs and advocating for change. The primary care RN aligns her/his practice with evidence-based strategies that maintain the highest level of quality and continuity for the patient.

- Provides health screening services, when required, including: assessing vital signs, monitoring height and weight, assessing vision, cervical screening, performing electrocardiograms, collecting specimens, administering and interpreting tuberculosis skin testing and conducting point-of-care testing (i.e. urine dips) using the appropriate authorization mechanisms.

Program Management:

- Identifies, plans, executes and evaluates clinical and education programs to advance health promotion and disease prevention within primary care.

Documentation:

- Maintains thorough and comprehensive documentation in alignment with the *Documentation Practice Standard* from the College of Nurses of Ontario, and the needs of the interprofessional team.
- Embraces e-Health and electronic documentation as a method to integrate care delivery.

Quality Improvement:

- Acts as an evidence-based champion, using evidence-based knowledge and best practices to guide clinical and work environment practices.
- Supports development of an evidence-based culture within her/his organization.
- Participates in and leads quality improvement initiatives by collecting, interpreting and reporting health data when required to support continuous quality improvement.

Domains of Practice

Assessment:

- Provides comprehensive physical and psychosocial patient assessments at regular intervals and when required. This assessment includes: collecting health history, identifying and presenting concerns, maintaining medication profiles, completing physical evaluations, conducting a complete mental health assessment, reviewing social factors and conducting a risk analysis.
- Interprets assessment findings and co-ordinates further action such as implementing nursing interventions or referral to a physician or other health professional within the team.

Treatment:

- Remains accessible via telephone and in-person to provide: triage services, health counseling and to arrange appropriate patient follow-up.
- Manages immunization programs, including: assessing records, identifying outstanding vaccinations required, and administering vaccine when appropriate.
- Provides medication management expertise in collaboration with physician and pharmacist.
- Provides clinical services with a higher degree of complexity.

Patient Self Management:

- Leads upstream health promotion activities, rooted in the social determinants of health that also emphasize accessibility, early detection/intervention, lifestyle counseling and disease prevention.
- Leads chronic disease management in collaboration with a nurse practitioner, physician and other health professionals.
- Develops, monitors and refines individualized care plans in collaboration with the interprofessional team.
- Supports patients in identifying and utilizing community resources.
- Involves the patient at the forefront of all care decisions.
- Ensures appropriate referrals and connections are made.

- Strives to co-ordinate services and care as much as possible to promote continuity and follow-up.

- Assists patients to interpret health-care findings.

Management/Administration:

- Participates in the effective day-to-day operation of the organization.
- Supports and maintains the goals and objectives of the team.
- Acts as a resource to the clinical practice team by providing knowledge and expertise.
- Supports staff development.
- Leads the review, implementation and planning of projects that support effective patient care.
- Contributes to the development of policies/procedures and medical directives.
- Supervises volunteers and staff as necessary.

Planning:

- Provides a nursing perspective to planning activities within the organization.
- Conducts patient and community needs assessments.
- Assesses strengths and opportunities within the community.
- Evaluates programs and practices, and revises as necessary.

Education:

- Assesses education needs amongst patients and within the community.
- Identifies readiness for education, and acts accordingly.
- Leads health education programs and strategies, using a variety of innovative and accessible approaches.
- Engages in one-to-one patient education regarding: health promotion, disease management, disease prevention, mental health, lifestyle, medication management, community supports and social considerations.
- Prepares patient education materials.
- Supports staff education.

Advocacy:

- Advocates for the patient.
- Advocates for healthy communities through social justice and equality.
- Advocates for an environment that supports the patient's learning, and maximizes their participation and control in meeting their health goals.
- Participates in community groups to address identified needs.

Collaboration:

- Collaborates, as an active member of the interprofessional team, with a number of health professionals to support quality patient care.
- Supports an environment that embraces communication and consultation.

- Liaises with community resources and community groups.
- Provides assistance to colleagues when required.
- Consults with more experienced RNs, NPs, physicians, or other members of the interprofessional team if an issue arises outside her/his scope, or if unclear.

Knowledge:

Holds expert knowledge and proficiency within the RN role regarding:

- Current evidence-based practices, leveraging best practice guidelines.
- Assessment, treatment, health promotion, chronic disease management, disease screening, population health concepts, community development and quality improvement.
- Effective delivery of primary health care and primary care nursing.
- Social determinants of health.
- Cultural competence.
- Relevant legislation, regulations and practice standards.

Professional Commitment:

- Maintains membership and involvement in the Registered Nurses' Association of Ontario and affiliated Interest Groups (Family Practice Nurses Interest Group).
- Exercises expert evidence-based clinical judgment.
- Practises within defined scope of practice in accordance to her/his competencies, knowledge and skills.

- Practises in accordance to organization policy, best practices, legislation, regulation and practice standards.
- Maintains a commitment to life-long learning, self reflection, and professional development.
- Assists in the orientation of new staff.
- Mentors students from a number of disciplines and professions.
- Maintains the highest level of patient confidentiality.
- Disseminates knowledge to peers and community through publications and presentations.
- Advances primary care through advocacy and scholarly work.
- Specialty certification encouraged. Examples include: CNA Certification; Diabetes Educator; Venipuncture course; Asthma Educator; and Foot Care Certificate.
- Primary care nurse focused education an asset.
- Valid drivers' license and access to reliable transportation (as appropriate).
- Complete WHIMIS training.

Experiential Requirements:

- Three to five years of previous clinical experience an asset.
- New nursing graduates eligible for the Nursing Graduate Guarantee initiative an asset. Visit www.hfojobs.ca for current eligibility requirements.
- Variety of clinical experiences preferred.
- Experience working autonomously within an interprofessional team.
- Knowledge of the community.

Language Requirements:

- Based on the community and population being served. An ability to speak multiple languages is an asset.

Computer Requirements:

- Basic computer skills required.
- Experience with electronic medical records is an asset.
- Willingness to use technology and maintain knowledge required.

Requirements

Educational Requirements:

- Completion of a recognized RN education program - Baccalaureate degree in nursing from a recognized university preferred.
- Focused primary care/family practice nursing education an asset.

Registration Requirements:

- Registration, in good standing, with the College of Nurses of Ontario.

Certification Requirements:

- First Aid/CPR training.

Registered Practical Nurse

Role Description:

The primary care RPN practises primarily in the community setting, often in clinics and primary care organizations to provide a range of patient-centred health-care services to individuals, families and communities at all life stages. The primary care RPN is an important member of the interprofessional care team and practises nursing autonomously to their full scope of practice in stable circumstances where there is predictability in the patient's care requirements and health outcomes, and when there is also a limited risk for negative outcomes associated with the nursing care provided. The role of the primary care RPN may include: health promotion, chronic disease management, disease prevention, education, counseling, treatment and supporting care within the RPN scope of practice. The primary care RPN aligns her/his practice with evidence-based strategies that maintain the highest level of continuity for the patient.

Domains of Practice

Assessment:

- Provides a comprehensive physical and psychosocial assessment of patients where care needs are less complex and outcomes are predictable. This assessment includes: collecting health history, identifying presenting concerns, maintaining medication profile, complete physical evaluation, conducting a complete mental health assessment, reviewing social factors and conducting a risk analysis.
- Identifies assessment findings through pattern recognition and co-ordinates further action through a known range of options such as implementing nursing interventions, or referral to another health-care professional within the team.
- Leads health screening services, including: assessing vital signs, monitoring height and weight, assessing vision, performing

electrocardiograms, collecting specimens, administering and interpreting tuberculosis skin testing, and conducting point-of-care testing (i.e. urine dips) using the appropriate authorization mechanisms.

Documentation:

- Maintains thorough and comprehensive documentation in alignment with the *Documentation Practice Standard* from the College of Nurses of Ontario.
- Embraces e-Health and electronic documentation as a method to integrate care delivery.

Quality Improvement:

- Acts as an evidence-based champion, using evidence-based knowledge and best practices to guide practice.
- Contributes to an evidence-based culture within her/his organization.
- Participates in quality improvement initiatives by collecting and reporting health data when required to support continuous quality improvement.

Treatment:

- Remains accessible via telephone and in-person to provide health counseling and to arrange appropriate patient follow-up.
- Supports the delivery of primary care programs including the immunization program, which involves: assessing records, identifying outstanding vaccinations required and administering vaccine when appropriate.
- Provides clinical services for stable patients with a low risk of negative outcomes.

Patient Self-Management:

- Supports health promotion activities such as lifestyle counseling and disease prevention.
- Contributes to the development, monitoring and refinement of individualized care plans in collaboration with the interprofessional team.
- Involves the patient at the forefront of all care decisions.
- Assists patients to interpret less complex health-care findings when stable outcomes are anticipated.
- Ensures appropriate referrals and connections are made.
- Assists in the co-ordination of services and care as much as possible to promote continuity and follow-up.

Management/Administration:

- Participates in the effective day-to-day operation of the organization.
- Supports and maintains the goals and objectives of the team.
- Provides cold-chain management and oversees vaccine supply.
- Contributes to the review, implementation and planning of projects that support effective patient care.
- Contributes to the development of policies/procedures and medical directives.
- Supervises volunteers and staff as necessary.

Planning:

- Provides a nursing perspective to planning activities within the organization.
- Conducts patient needs assessments.

Education:

- Engages in one-on-one patient education, within the RPN role, regarding disease prevention and management.
- Prepares patient education materials in partnership with the RN.
- Supports staff education.

Advocacy:

- Advocates for the patient.
- Advocates for healthy communities.
- Advocates for an environment that facilitates the patient's learning and maximizes their participation and control in meeting their health goals.

Collaboration:

- Collaborates, as an active member of the interprofessional team, with a number of health professionals to support quality patient care.
- Supports an environment that embraces communication and consultation.
- Provides assistance to colleagues when required.

- Consults with a more experienced RPN, RN, NP, physician, or other member of the interprofessional team if an issue arises outside of her/his practice scope, or if unclear.

Knowledge:

Holds expert knowledge and proficiency within the RPN role regarding:

- Current evidence-based practices, leveraging best practice guidelines.
- The effective delivery of primary health care and primary care nursing.
- The social determinants of health.
- Cultural competence.
- Assessment, treatment, health promotion, chronic disease management, disease screening and quality improvement.
- Relevant legislation, regulations and practice standards.

Professional Commitment:

- Maintains membership and involvement in the Registered Practical Nurses' Association of Ontario (RPNAO) and affiliated Interest Groups.
- Exercises evidence-based clinical judgment.
- Practises within defined scope of practice in accordance to her/his knowledge, skill and judgment.

- Maintains a commitment to life-long learning, self reflection and professional development.
- Assists in the orientation of new staff.
- Mentors students from a number of disciplines and professions.
- Maintains the highest level of patient confidentiality.
- Practises in accordance to organizational policy, best practices, legislation, regulation and practice standards.
- Disseminates knowledge to peers and community through publications and presentations.
- Advances primary care through advocacy and scholarly work.

Requirements

Educational Requirements:

- Practical Nursing Diploma from a recognized community college or equivalent.

Registration Requirements:

- Registration, in good standing, with the College of Nurses of Ontario.

Certification Requirements:

- First Aid/CPR training
- Specialty certification encouraged. Examples include:
Diabetes educator;
Venipuncture course;
Asthma Educator; and
Foot Care Certificate.
- Primary Care/Family Practice Nurse focused education an asset.
- Valid Drivers' License and access to reliable transportation (as appropriate).
- Complete WHIMIS training.

Language Requirements:

- Based on the community and population being served. An ability to speak multiple languages is an asset.

Computer Requirements:

- Basic computer skills required.
- Experience with Electronic Medical Records is an asset.
- Willingness to use technology and maintain knowledge required.

Experiential Requirements:

- Three to five years of previous clinical experience an asset.
- New nursing graduate eligibility for the Nursing Graduate Guarantee initiative an asset. Visit www.hfojobs.ca for current eligibility requirements.
- Variety of clinical experiences preferred.
- Experience working autonomously within an interprofessional team.
- Knowledge of the community.

Appendix C:

Phase Two Role Descriptions

Registered Nurse

Role Description:

The primary care RN practises primarily in the community setting, often in clinics and primary care organizations to provide a range of patient-centred health-care services to individuals, families and communities at all life stages. The primary care RN practises autonomously to their full scope of practice and is an important member of the interprofessional care team. Frequently, the primary care RN is a patient's first point of contact with the health system and provides a broad spectrum of health promotion, disease prevention, chronic disease management, education, counseling, treatment and supportive care. The primary care RN maintains competencies based on in-depth knowledge and skills in clinical practice, and holds the expertise required to conduct comprehensive health assessments, including the ability to order and interpret diagnostic testing. Based on assessment findings, the primary care RN is able to use evidence-based knowledge to communicate a diagnosis and implement the appropriate nursing interventions to prevent or treat health conditions, chronic disease and episodic illness within the RN's level of competencies, knowledge, and skills. The primary care RN is active within the community, assessing health needs and advocating for positive change. The primary care RN aligns her/his practice with evidence-based strategies that maintain the highest level of quality and continuity for the patient.

Domains of Practice

Assessment:

- Provides a comprehensive physical and psychosocial patient assessment at regular intervals and when required. This assessment includes: collecting health history, identifying presenting concerns, maintaining medication profile, complete physical evaluation, conducting

a complete mental health assessment, reviewing social factors and conducting a risk analysis.

- Interprets assessment findings and co-ordinates further action such as implementing nursing interventions or referral to a physician or other health professional within the team.
- Provides health screening services, when required, including: assessing vital signs, monitoring height and weight, assessing vision, obtaining pap smears, performing electrocardiograms, collecting specimens, administering and interpreting tuberculosis skin testing and conducting point-of-care testing (i.e. urine dips).
- Orders and interprets diagnostic tests as part of a comprehensive health assessment.
- Identifies and communicates a diagnosis to initiate prompt treatment for health conditions such as chronic diseases and episodic illness within the RN's competencies, knowledge, and skills.

Program Management:

- Identifies, plans, executes and evaluates clinical and education programs to advance health promotion and disease prevention within primary care.

Care Co-ordination:

- Leads long-term, broad and complex care co-ordination from 'womb to tomb.'
- Provides primary care patients with a seamless experience through the health system through timely access and working closely with all health professionals.

- Assists patients with navigating the health system and accessing the right care, at the right time, by the right health professional.
 - Interprets assessment findings and evidence to develop a comprehensive care plan, in collaboration with an interprofessional team that co-ordinates the seamless delivery of care across the lifespan, with a focus on preventing unnecessary hospitalization.
 - Tailors patient care plans and care strategies according to the social determinants of health.
 - Supports the co-ordination of home and community based care programs.
 - Serves as the linkage between long-term care placement co-ordinators and the patient.
 - Identifies risks to achieving optimal patient outcomes and implement strategies accordingly.
- Documentation:**
- Maintains thorough and comprehensive documentation in alignment with the *Documentation Practice Standard* from the College of Nurses of Ontario, and the needs of the interprofessional team.
 - Embraces e-Health and electronic documentation as a method to integrate care delivery.
- Quality Improvement:**
- Acts as an evidence-based champion, using evidence-based knowledge and best practices to guide clinical and work environment practices.
 - Supports development of an evidence-based culture within her/his organization.
 - Participates and leads quality improvement initiatives by collecting, interpreting and reporting health data when required to support continuous quality improvement.
- Treatment:**
- Remains accessible via telephone and in person to provide: triage services, health counseling and to arrange appropriate patient follow-up.
 - Manages immunization programs as required, including: assessing records, identifying outstanding vaccinations required and administering vaccine when appropriate.
 - Provides medication management expertise, including the initiation and renewal of prescribed medication to prevent or treat health conditions, chronic disease and episodic illness within the RN's level of competencies, knowledge and skills.
 - Dispenses and sells medication as appropriate.
 - Provides clinical services with a higher degree of complexity.
- Patient Self-Management:**
- Leads upstream health promotion activities, rooted in the social determinants of health, that also emphasize accessibility, early detection/intervention, lifestyle counseling and disease prevention.

- Leads chronic disease management in collaboration with a nurse practitioner or physician, and other health professionals.
 - Develops, monitors and refines individualized care plans in collaboration with the interprofessional team.
 - Supports patients at identifying and utilizing community resources.
 - Involves the patient in the forefront of all care decisions.
 - Works as a system navigator to ensure appropriate referrals and connections are made.
 - Co-ordinates services and care to promote continuity and follow-up.
 - Assists patients to interpret health-care findings.
- Management/Administration:
- Participates in the effective day-to-day operation of the organization.
 - Supports and maintains the goals and objectives of the team.
 - Acts as a resource to the clinical practice team by providing knowledge and expertise within the RN role.
 - Supports staff development.
 - Leads the review, implementation and planning of projects that support effective patient care.
 - Contributes to the development of policies/procedures and medical directives.
 - Supervises volunteers and staff as necessary.
- Planning:
- Provides a nursing perspective on planning activities within organization.
 - Conducts patient and community needs assessments.
 - Assesses strengths and opportunities within the community.
 - Evaluates programs and practices, and revises as necessary.
- Education:
- Assesses education needs amongst patients and within the community.
 - Identifies readiness for education and acts accordingly.
 - Leads health education programs and strategies, using a variety of innovative and accessible approaches.
 - Engages in one-on-one patient education regarding: health promotion, disease management, disease prevention, mental health, lifestyle, medication management, community supports and social considerations.
 - Prepares patient education materials.
 - Supports staff education.
- Advocacy:
- Advocates for the patient as a care co-ordinator.
 - Advances the principles of primary health care within communities.
 - Advocates for healthy communities through social justice and equality.

- Advocates for an environment that supports the patient's learning and maximizes their participation and control in meeting their health goals.
- Participates in community groups to address identified needs.

Collaboration:

- Collaborates, as an active member of the interprofessional team, with a number of health professionals to support quality patient care.
- Supports an environment that embraces communication and consultation.
- Liaises with community resources and community groups.
- Provides assistance to colleagues when required.
- Consults with a more experienced RN, NP, physician, or other member of the interprofessional team if an issue arises outside of her/his scope or if unclear.
- Fosters strong linkages with public health, academic, long-term care, home health and community care organizations.

Knowledge:

Holds expert knowledge and proficiency within the RN role regarding:

- Current evidence-based practices, leveraging best practice guidelines.
- The effective delivery of primary health care and primary care nursing.
- The social determinants of health.
- Cultural competence.

- Assessment, treatment, health promotion, chronic disease management, disease screening, population health concepts, community development and quality improvement.
- Relevant legislation, regulations and practice standards.

Professional Commitment:

- Maintains membership and involvement in the Registered Nurses' Association of Ontario and affiliated Interest Groups (Family Practice Nurses Interest Group).
- Exercises expert evidence-based clinical judgment.
- Practises within defined scope of practice in accordance to her/his competencies, knowledge, and skills.
- Maintains a commitment to life-long learning, self reflection and professional development.
- Assists in the orientation of new staff.
- Mentors students from a number of disciplines and professions.
- Maintains the highest level of patient confidentiality.
- Practises in accordance with organization policy, best practices, legislation, regulation and practice standards.
- Disseminates knowledge to peers and community through publications and presentations.
- Advances primary care through advocacy and scholarly work.

Requirements:

Educational Requirements:

- Completion of a recognized RN education program - Baccalaureate Degree in Nursing from a recognized university preferred.
- Focused primary care/family practice nursing education an asset.

Registration Requirements:

- Registration, in good standing, with the College of Nurses of Ontario.

Certification Requirements:

- First Aid/CPR training.
- Enhanced assessment education to support the ability to order diagnostic testing and communicating a diagnosis.
- Enhanced pharmacology education to support prescriber role.
- Specialty certification encouraged. Examples include:
CNA Certification;
Diabetes Educator;
Venipuncture course;
Asthma Educator; and
Foot Care Certificate.

- Primary Care/Family Practice Nurse focused education an asset.
- Valid Driver's License and access to reliable transportation (as appropriate).
- Complete WHIMIS training.

Experiential Requirements:

- Three to five years of previous clinical experience an asset.
- New nursing graduate eligibility for the Nursing Graduate Guarantee an asset. Visit www.hfojobs.ca for current eligibility requirements.
- Variety of clinical experiences preferred.
- Experience working autonomously within an interprofessional team.
- Knowledge of the community.

Language Requirements:

- Based on the community and population being served. An ability to speak multiple languages is an asset.

Computer Requirements:

- Basic computer skills required.
- Experience with Electronic Medical Records is an asset.
- Willingness to use technology and maintain knowledge required.

Registered Practical Nurse

Role Description:

The primary care registered practical nurse (RPN) practises primarily in the community setting, often in clinics and primary care organizations to provide a range of patient-centred health-care services to individuals, families and communities at all life stages. The primary care RPN is an important member of the interprofessional care team and practises nursing autonomously to their full scope of practice in stable circumstances where there is predictability in the patient's care requirements and health outcomes and when there is also limited risk for negative outcomes associated with the nursing care provided. The role of the primary care RPN may include: health promotion, chronic disease management, disease prevention, education, counseling, treatment and supporting care within the RPN scope of practice. The primary care RPN aligns her/his practice with evidence-based strategies that maintain the highest level of continuity for the patient.

- Leads health screening services, including: assessing vital signs, monitoring height and weight, assessing vision, performing electrocardiograms, collecting specimens, administering and interpreting tuberculosis skin testing, and conducting point-of-care testing (i.e. urine dips) using the appropriate authorization mechanisms.

Program Management:

- Executes evidence-based primary care programming (i.e. foot care initiatives) based on area of clinical expertise.
- Identifies, plans and evaluates clinical and education programs, in collaboration with the RN to advance health promotion and disease prevention within primary care.

Domains of Practice

Assessment:

- Provides a comprehensive physical and psychosocial assessment of patients where care needs are less complex and outcomes are predictable. This assessment includes: collecting health history, identifying presenting concerns, maintaining medication profile, complete physical evaluation, conducting a complete mental health assessment, reviewing social factors and conducting a risk analysis.
- Identifies assessment findings through pattern recognition and co-ordinates further action through a known range of options such as implementing nursing interventions, or referral to another health professional within the team.

Care Co-ordination:

- Provides support to the care co-ordination process through collaboration with the RN care co-ordinator.

Documentation:

- Maintains thorough and comprehensive documentation in alignment with the *Documentation Practice Standard* from the College of Nurses of Ontario.
- Embraces e-Health and electronic documentation as a method to integrate care delivery.

Quality Improvement:

- Acts as an evidence-based champion, using evidence-based knowledge and best practices to guide practice.
- Contributes to an evidence-based culture within her/his organization.

- Participates in quality improvement initiatives by collecting and reporting health data when required to support continuous quality improvement.

Treatment:

- Remains accessible via telephone and in-person to provide health counseling and to arrange appropriate patient follow-up.
- Manages immunization program, including: assessing records, identifying outstanding vaccinations required and administering vaccine when appropriate.
- Leads wound care programs to promote healing and reduce infection risk.
- Provides clinical services with a low risk of negative outcomes.

Patient Self-Management:

- Supports health promotion activities such as lifestyle counseling and disease prevention.
- Contributes to the development, monitoring and refinement of individualized care plans in collaboration with the Primary Care Registered Nurse Co-ordinator and interprofessional team.
- Involves the patient at the forefront of all care decisions.
- Assists patient to interpret less complex health-care findings when stable outcomes are anticipated.
- Ensures appropriate referrals and connections are made.
- Assists in the co-ordination of services and care as much as possible to promote continuity and follow-up.

Management/Administration:

- Participates in the effective day-to-day operation of the clinic.
- Supports and maintains the goals and objectives of the team.
- Provides cold-chain management and oversee vaccine supply.
- Acts as a resource to the clinical practice team by providing knowledge and expertise within the RPN role.
- Contributes to the review, implementation and planning of projects that support effective patient care.
- Contributes to the development of policies/procedures and medical directives.
- Supervises volunteers and staff as necessary.

Planning:

- Provides a nursing perspective to planning activities within the organization.
- Conducts patient need assessments.

Education:

- Engages in one-on-one patient education, within the RPN role, regarding disease prevention and management.
- Prepares patient education to support stable patients.
- Engages in one-to-one patient education regarding: health promotion, disease management, disease prevention, mental health, lifestyle, medication management, community supports and social considerations.
- Supports staff education.

Advocacy:

- Advocates for the patient.
- Advocates for healthy communities through social justice and equality.
- Advocates for an environment that facilitates the patient's learning and maximizes their participation and control in meeting their health goals.

Collaboration:

- Collaborates, as an active member of the interprofessional team, with a number of health professionals to support quality patient care.
- Supports an environment that embraces communication and consultation.
- Provides assistance to colleagues when required.
- Consults with a more experienced RPN, RN, NP, physician or other member of the interprofessional team if an issue arises outside of her/his scope or if unclear.

Knowledge:

- Holds expert knowledge and proficiency within the RPN role regarding:
- Current evidence-based practices, leveraging best practice guidelines.
 - The effective delivery of primary health care and primary care nursing.
 - The social determinants of health.
 - Cultural competence.
 - Assessment, treatment and disease screening.
 - Relevant legislation, regulations and practice standards.

Professional Commitment:

- Maintains membership and involvement in the Registered Practical Nurses' Association of Ontario (RPNAO) and affiliated Interest Groups.
- Exercises evidence-based clinical judgment.
- Practises within defined scope of practice in accordance to her/his knowledge, skill and judgment.
- Maintains a commitment to lifelong learning, self-reflection and professional development.
- Assists in the orientation of new staff.
- Mentors students from a number of disciplines and professions.
- Maintains the highest level of patient confidentiality.

- Practises in accordance to organization policy, best practices, legislation, regulation and practice standards.
- Disseminates knowledge to peers and community through publications and presentations.
- Advances primary care through advocacy and scholarly work.

Requirements:

Educational Requirements:

- Practical Nursing Diploma from a recognized community college or equivalent.

Registration Requirements:

- Registration, in good standing, with the College of Nurses of Ontario.

Certification Requirements:

- First Aid/CPR training.
- Specialty certification encouraged. Examples include:
Diabetes educator;
Venipuncture course;
Asthma Educator;
Foot Care Certificate.
- Primary Care/Family Practice Nurse focused education an asset.
- Valid Driver's License and access to reliable transportation (as appropriate).
- Complete WHIMIS training.

Experiential Requirements:

- Three to five years of previous clinical experience an asset.
- New nursing graduate eligibility for the Nursing Graduate Guarantee initiative an asset. Visit www.hfajobs.ca for current eligibility requirements.
- Variety of clinical experiences preferred.
- Experience working autonomously within an interprofessional team.
- Knowledge of the community.

Language Requirements:

- Based on the community and population being served. An ability to speak multiple languages is an asset.

Computer Requirements:

- Basic computer skills required.
- Experience with Electronic Medical Records is an asset.
- Willingness to use technology and maintain knowledge required.

Appendix D:

Primary Care Nurse Task Force Literature Synthesis Descriptions

The Registered Nurses' Association of Ontario (RNAO) is leading a ground-breaking Task Force that brings together key stakeholders to review the role of primary care nurses (registered nurses and registered practical nurses) in the delivery of quality and accessible primary care in Ontario. Recommendations aim to optimize the utilization of the 2,873 RNs and 1,412 RPNs currently working in primary care in the province by maximizing their scope of practice.

The need exists to ensure that recommendations provided are in alignment with the best available evidence. Therefore, a decision was made to conduct a scan of the literature. The purpose of this literature synthesis is to identify relevant reports, research articles and toolkits focusing on:

- the role of the primary care nurse;
- expanding nurses' scope of practice; and
- registered nurse prescribing.

CINAHL, MEDLINE and Google Scholar databases were utilized to access information. Members of the Task Force were also solicited to share relevant documents. Each document was assessed to determine relevance in supporting the mandate of the Task Force and the three areas identified above. Acceptable documents were then consolidated into summaries that are captured below.

RESEARCH HIGHLIGHTS

- Primary care nurses report performing non-nursing duties that could be performed by support staff such as preparing rooms, booking appointments and stocking supplies (Allard et al., 2009).
- Only 61 per cent of primary care nurses in one study identified themselves as practising to full scope, while a strong majority (88 per cent) have reported a desire to advance their knowledge through education (Allard et al., 2009).

-
- A Cochrane review suggests that appropriately educated nurses can produce as high quality care as primary care physicians and achieve as good health outcomes for patients (Laurant et al. 2009).
 - Individual studies and reviews of the literature have identified nurse prescribing as being well-received and beneficial to patients. Research has also indicated nurse prescribing as being beneficial to the profession through increased job satisfaction.
 - The Commission on the Reform of Ontario's Public Services (2012) called on government to fully utilize the knowledge and skill of nurses to support sustainability of the health-care system.

BACKGROUND SUMMARIES

Authors	Year	Publication	Study or Report Name	Main Findings
ROLE OF PRIMARY CARE NURSES				
Allard, A., Frego, A., Katz, A., & Halas, G.	2010	Canadian Nurse, 106(3), 20-24.	Exploring the Role of RNs in Family Practice Residency Training Programs	<p>This study used a survey to explore the role of nurses employed in Canadian family practice residency training programs. A total of 127 nurses from 41 program sites completed the survey and findings include:</p> <ul style="list-style-type: none"> • RN respondents reported carrying out clinic activities that could be done by support staff, such as booking appointments (65 per cent), preparing clinic rooms (55 per cent) and restocking supplies (42 per cent). • RN respondents reported carrying out nursing activities such as: providing injections (94 per cent), telephone triage (85 per cent), adult immunization (85 per cent), child immunization (74 per cent), glucose testing (65 per cent), well child assessments (61 per cent), wound care (63 per cent), suture/staple removal (59 per cent), medication review (56 per cent) and ear syringing (56 per cent). • Only seven per cent reported performing breast examinations and eight per cent reported performing pap tests/pelvic exams. • Under two-thirds of RN respondents indicated they had a written job description. • Only 61 per cent of RN respondents felt they were working to full scope of practice. • A strong majority (88 per cent) indicated a desire to participate in programs or courses to further develop clinical nursing skills. • Comprehensive patient care was reported as the primary contributing factor to job satisfaction. • RN respondents who indicated working to full scope of practice had a statistically significant higher level of job satisfaction.

Appendix D: Primary Care Nurse Task Force Literature Synthesis

Authors	Year	Publication	Study or Report Name	Main Findings
Oandasan, I.F., Hammond, M., Gotlib Conn, L., Callahan, S., Gallinaro, A., & Moaveni, A.	2010	Canadian Family Physician, 56(10), 375-382.	Family practice registered nurses – The time has come	<p>A case study approach using purposive sampling was used to provide a picture of the unique role and competencies of family practice RNs. Four main themes emerged:</p> <ul style="list-style-type: none"> • The first theme related to the relationship-centered approach to care delivered by family practice RNs, founded upon trust. • The second theme highlights the family practice RN's unique ability to balance the priorities of patients, colleagues and the clinic as a whole. • The third theme capitalizes on the nurses' commitment to advancing their learning to enhance their abilities. • The fourth theme illuminates the perspectives shared by family practice RNs that family practice is uniquely different from acute care in the manner in which care is delivered.
Akeroyd, J., Oandasan, I., Alsaffar, A., Whitehead, C., & Lingard, L.	2009	Nursing Leadership, 22(2), 73-84.	Perceptions of the Role of the Registered Nurse in an Urban Interprofessional Academic Family Practice Setting	<p>This study used a descriptive qualitative approach to identify perceptions of the role of the RN in an urban academic family practice setting as it relates to interprofessional collaboration. Findings include:</p> <ul style="list-style-type: none"> • Two main themes emerged: role ambiguity and trustworthiness. • The RN's role in the interprofessional family practice setting is poorly defined, largely defined by tasks and blurred with other professionals' roles. • There was disagreement among participants regarding the RN's actual and potential scope of practice. Some participants felt the current scope was too narrow and others felt it was too broad. • The RN's level of trustworthiness, as perceived by family physicians is a critical factor in the level of

Appendix D: Primary Care Nurse Task Force Literature Synthesis

Authors	Year	Publication	Study or Report Name	Main Findings
				<p>collaboration between RNs and family physicians.</p> <ul style="list-style-type: none"> Both RN and family physician participants described RNs' competence as providing good judgment in decision-making and thoroughness in patient care. Family physicians' perceptions of RNs' trustworthiness is also based on the RN's sense of shared responsibility in patient care.
Canadian Nurses Association	2009	Online Resource: http://www.cna-aiic.ca/en/professional-development/nurseone-knowledge-resources/cnas-primary-care-toolkit/	CNA's Primary Care Toolkit	<p>The Canadian Nurses Association (CNA) developed a Primary Care Toolkit as a resource to support RNs and NPs who are building collaborative teams in primary care settings. Highlights of the toolkit include:</p> <ul style="list-style-type: none"> Profiling the benefits of primary care nurses for patients, nurses, physicians and the health care system. These benefits include: increasing access, cost effectiveness, improved patient outcomes and collaboration. Role description of the primary care RN, including other human resource supports such as a sample recruitment plan and interview questions. A business case that solidifies the importance of the RN in primary care. Other resources to support evidence-based practice and building collaborative teams.
Health Council of Canada	2009	Online Resource: http://www.bcpsqc.ca/new/documents/Health%20Council%20f%20Canada%20-%20April%202009.pdf	Teams in Action: Primary Health Care Teams for Canadians	<p>In 2004, governments committed to increasing the use of primary health-care teams in Canada, with a goal of 50 per cent of Canadians having access to these teams by 2011. This report, prepared by the Health Council of Canada, examines primary care teams across the country and derives what they mean to patients and taxpayers. Key findings include:</p>

Appendix D: Primary Care Nurse Task Force Literature Synthesis

Authors	Year	Publication	Study or Report Name	Main Findings
				<ul style="list-style-type: none"> • One third of family doctors reported that they had a formal arrangement to collaborate with a nurse. • 16 per cent of Canadian adults reported having access to a nurse working with a doctor. • Canadians who had additional access to a nurse and/or other health-care professionals were: more than 2.5 times likely to report their health-care provider provided a range of services that met most of their needs; 42 per cent more likely to rate the quality of the health care they received as good, very good or excellent compared to those with access to one provider; 46 per cent more likely to report that they had more knowledge about their conditions; and 67 per cent more likely to report they know how to prevent future problems. • Nearly 70 per cent of Canadians strongly support the idea of team-based care including nurses. • 54 per cent of Canadians indicated that in 2002, they would be satisfied seeing a nurse rather than a doctor for routine health-care services such as ear infections or immunizations, to manage diabetes, to monitor high blood pressure, or to check progress on a surgical wound.
Wong, S.T., Watson, D.E., Mooney, D. & Young, E.	2009	Healthcare Policy, 5(sp), 91-104.	Supply and Distribution of Primary Healthcare Registered Nurses in British Columbia	<p>Given the increasing use of multi-disciplinary teams in the delivery of primary care, the authors conducted a primary care nursing human resource analysis by reviewing registration data in British Columbia. Findings included:</p> <ul style="list-style-type: none"> • 1,277 people per primary care RN ratio; • 990 people per primary care physician ratio;

Appendix D: Primary Care Nurse Task Force Literature Synthesis

Authors	Year	Publication	Study or Report Name	Main Findings
				<ul style="list-style-type: none"> Population health status was not found to be related to supply of primary care RNs. In other words, areas with a lower population health status did not have a greater supply of primary care RNs.
The College of Family Physicians of Canada	2007	Online Resource: http://toolkit.cfp.ca/en/	Primary Care Toolkit for Family Physicians – Appendix 2: The Role of Nurses in Family Practice/Primary Care	<p>This toolkit identifies the important role that nurses play in primary care and how traditionally nurses have not exercised their full potential because the system has not supported their role in primary care. This toolkit references a vision statement released by the College of Family Physicians of Canada in support of every Canadian having access to a family physician and a registered nurse and/or nurse practitioner in primary care.</p>
Price, K.	2007	Contemporary Nurse, 26(1), 7-14.	Nurses in general practice settings: Roles and responsibilities	<p>The author of this paper explored the Nursing In General Practice Initiative (NIGPI) that was implemented by the Australian government in 2001 to increase the number of nurses working in general practice settings. The objectives of this initiative were to improve access and affordability of primary care for rural and remote Australians; improve quality, evidence-based practice and learning systems for primary care; contribute to the prevention and better management of chronic disease; and relieve workforce pressures in general practice. Findings from this paper include:</p> <ul style="list-style-type: none"> An evaluation of the initiative found that all five objectives were met. Between 2003 and 2005 there was a 23 per cent increase in practice nurses, which can be attributed to the NIGPI.

Appendix D: Primary Care Nurse Task Force Literature Synthesis

Authors	Year	Publication	Study or Report Name	Main Findings
				<ul style="list-style-type: none"> The way the NIGPI has emerged has resulted in the scope of practice of nurses being delimited to specific and pre-determined primary care services as paid employees, rather than autonomous professionals. The author references the established role of NPs in Canada and calls for similar work in establishing the role in Australia as a logical next step.
EXPANDING SCOPE OF PRACTICE				
Commission on the Future of Health Care in Canada	2002	Online Resource: http://publications.gc.ca/collections/Collection/CP32-77-2002E.pdf	Report on Citizens' Dialogue on the Future of Health Care in Canada	<p>This Commission wanted to learn the perspective of Canadians on how to sustain the health system in the 21st century. Key findings include:</p> <ul style="list-style-type: none"> Citizens are concerned about the loss of public health nurses in schools. Citizens are comfortable with nurses or NPs assessing needs (triage) and they are also ready to rely on nurses to provide routine care, such as immunizations, and checking progress on a surgical wound or an infection.

Appendix D: Primary Care Nurse Task Force Literature Synthesis

Authors	Year	Publication	Study or Report Name	Main Findings
College of Registered Nurses of British Columbia	2011	Online Resource: https://www.crnbc.ca/Standards/Lists/StandardResources//433ScopeforRegisteredNurses.pdf	Scope of Practice for Registered Nurses	<p>Recently, CRNBC implemented regulations expanding the scope of practice of RNs. A summary of these enhancements includes:</p> <ul style="list-style-type: none"> • Wound care (cleansing, irrigating, probing, debriding, packing, dressing and suturing uncomplicated skin lacerations) without an order. • Managing labour in an institutional setting if the primary maternal care provider is absent. • Ordering ultrasounds and x-rays (except CAT scans) for diagnostic or imaging purposes. • Compound, dispense and administer, without an order, Schedule II medications to treat a condition following an assessment and nursing diagnosis. • Compound, dispense and administer Schedule I medications, without an order, in certain emergencies. <p>Additional education may be required to perform the procedures listed above. RNs must practise within the limits and conditions identified by CRNBC.</p>
Fairman, J.A., Rowe, J.W., Hassmiller, S., & Shalala, D.E.	2011	New England Journal of Medicine, 364(3), 193-196.	Broadening the Scope of Nursing Practice	This commentary identifies that in order to support health-care reform in the United States, and in order to bridge the gap in primary care, all health-care providers (including nurses) must be permitted to practise to the fullest extent of their knowledge and competence.
Gilbert, J.E., Green, E., Lankshear, S., Hughes, E., Burkoski, V., & Sawka, C.	2011	European Journal of Cancer Care	Nurses as patient navigators in cancer diagnosis: review, consultation and model design	<p>This review used both the literature and the perspective of nurses currently in navigator roles to explore patient navigation and its role within the diagnostic phase of cancer care. Key findings include:</p> <ul style="list-style-type: none"> • A number of definitions exist within the literature to describe patient navigation.

Appendix D: Primary Care Nurse Task Force Literature Synthesis

Authors	Year	Publication	Study or Report Name	Main Findings
				<ul style="list-style-type: none"> Navigation can occur through a number of means including self-navigation and navigation with the support of a professional or trained layperson. Limited literature exists that addresses the effectiveness of patient navigation. The literature that does exist suggests positive outcomes within the context of cancer care. RNs possess the knowledge, skill and judgment to provide comprehensive patient navigation. Nurses' understanding of the clinical aspects of care and health-care goals improve their ability to integrate within the interprofessional team. Nurses may be placed within a navigator role without a full understanding of this role. Consultations with the field identified the potential of system navigators to co-ordinate care and improve patient outcomes. There is also the potential for system improvements.
Improving Access in Primary Care Working Group	2011	Hard Copy Report	Strengthening Primary Care Access – Report of the Working Group to the Primary Healthcare Planning Group	<p>The Primary Healthcare Planning Group was established in the Fall of 2010 to build consensus on a strategy for strengthening primary care in Ontario. Five working groups were implemented, including a group focusing on strengthening primary care access. Selected recommendations from this working group include:</p> <ul style="list-style-type: none"> All interprofessional teams are fully functional, with the appropriate mix of professionals working to full scope of practice. All aspects of primary care access must be guided by sound research and evidence, where available.

Authors	Year	Publication	Study or Report Name	Main Findings
Institute of Medicine of the National Academies	2011	Online Resource http://www.iom.edu/Nursing-Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx	The Future of Nursing – Leading Change, Advancing Health	<p>The Institute of Medicine released a comprehensive report on the roles nurses can assume to address the increasing demand for safe, high-quality, and effective health-care services. Highlighted conclusions of the report include:</p> <ul style="list-style-type: none"> • The nursing profession has the potential to effect wide-reaching changes in the health-care system. • Nurses are poised to help bridge the gap between coverage and access, to co-ordinate increasingly complex care for a wide range of patients, to fulfill their potential as primary care providers to the full extent of their education and training, and to enable the full economic value of their contributions across practice settings. <p>Four main messages structure the discussion and recommendations presented in this report:</p> <ul style="list-style-type: none"> • Nurses should practise to the full extent of their education and training. • Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression. • Nurses should be full partners, with physicians and other health professionals, in redesigning health care in the U.S. • Effective workforce planning and policy making require better data collection and improved information infrastructure. <p>The report includes a number of recommendations:</p> <ul style="list-style-type: none"> • Remove scope of practice barriers. • Expand opportunities for nurses to lead and diffuse collaborative improvement efforts. • Implement nurse residency programs.

Appendix D: Primary Care Nurse Task Force Literature Synthesis

Authors	Year	Publication	Study or Report Name	Main Findings
				<ul style="list-style-type: none"> • Increase the proportion of nurses with a baccalaureate degree to 80 per cent by 2020. • Double the number of nurses with a doctorate by 2020. • Ensure nurses engage in life-long learning. • Prepare and enable nurses to lead change to advance health. • Build infrastructure for the collection and analysis of interprofessional health-care workforce data.
Rashid, C.	2010	Journal of Advanced Nursing, 66(8), 1658-70.	Benefits and limitations of nurses taking on aspects of the clinical role of doctors in primary care: integrative literature review	<p>This paper presents an integrative literature review of studies exploring the benefits and limitations of the recent expansion of the clinical role of nurses working in general practice in the United Kingdom. Findings include:</p> <ul style="list-style-type: none"> • Practice nurses felt pressure to perform routine tasks and experienced limited job satisfaction as their scope of practice was restricted. Nurses felt the focus was on meeting targets, rather than patient priorities. • Patients tend to like consultations with NPs because they are unhurried. • Seeing a nurse for 'same day' consultations can leave patients with a perception that things may get missed or that their problem has not been taken seriously. This may be related to the value patients place on time spent with a doctor. • The literature suggests that patients need to be provided with information on nurses' roles and competencies to enable them to make informed choices about which professional they consult. • There is no evidence in the literature to support the assumption that it is more cost-effective for nurses to take on elements of the GP clinical role.

Appendix D: Primary Care Nurse Task Force Literature Synthesis

Authors	Year	Publication	Study or Report Name	Main Findings
				<ul style="list-style-type: none"> Continued support within the workplace is vital if nurses are to develop job satisfaction through undertaking new roles.
Boyd, C.M., Reider, L., Frey, K., Scharfstein, D., Leff, B., Wolff, J., Groves, C., Karm, L., Wegener, S., Marsteller, J., & Boult, C.	2009	Journal of General Internal Medicine, 25(3), 1192-5.	The effects of guided care on the perceived quality of health care for multi-morbid older persons: 18-month outcomes from a cluster-randomized controlled trial.	<p>The authors of this paper describe a cluster-randomized controlled trial of nurse-led guided care in primary care. Guided care in this study involved using an evidence-based multi-faceted approach that included co-ordination of care, supporting access to resources and facilitating a smooth transition between care settings. The patients involved in the study were co-morbid older adults who were followed 18 months after baseline. A control group was also used. Key findings include:</p> <ul style="list-style-type: none"> Participants in the intervention group receiving guided care were twice as likely to highly rate the quality of their chronic care. Health-care processes were improved significantly around goal setting, co-ordination of care, problem solving and patient activation within the intervention group.
Laurant, M., Reeves, D., Hermens, R., Braspenning, J. Grol, R., & Sibbald, B.	2009	Cochrane Library	Substitution of doctors by nurses in primary care (Cochrane Review)	<p>The aim of this Cochrane Review was to evaluate the impact of doctor-nurse substitution in primary care on patient outcomes, process of care, and resource utilization, including cost. Findings include:</p> <ul style="list-style-type: none"> In seven studies where the nurse assumed responsibility for first contact and ongoing care for all presenting patients, no appreciable differences were found between doctors and nurses regarding health outcomes, process of care, resource utilization or cost.

Appendix D: Primary Care Nurse Task Force Literature Synthesis

Authors	Year	Publication	Study or Report Name	Main Findings
				<ul style="list-style-type: none"> • In five studies where the nurse assumed responsibility for first contact care for patients wanting urgent consultations during office hours or off-hours, patient outcomes were similar for nurses and doctors, but patient satisfaction was higher with nurse-led care. The impact on physician workload and direct cost of care was variable. • In four studies where the nurse took responsibility for the ongoing management of patients with particular chronic conditions, there were no appreciable differences found between doctors and nurses for patients, process of care, resource utilization or cost. • The authors conclude that appropriately educated nurses can produce as high quality care as primary care doctors and achieve as good health outcomes for patients. However, this conclusion must be viewed with caution given the methodological limitations of many of the studies. • The authors also conclude doctor-nurse substitution has the potential to reduce doctors' workload and health-care costs, however, such a reduction depends on the context of care.

Authors	Year	Publication	Study or Report Name	Main Findings
Pringle, D.	2009	Nursing Leadership, 22(2), 1-4.	From the Editor-in-Chief – Expanding Nurses' Scope of Practice	The Editor-in-Chief of <i>Nursing Leadership</i> provided commentary on expansions to the scope of practice of RNs in British Columbia. Some nurses have identified that they do not support these changes because they are already fully engaged in their current responsibilities; the shortage of nurses and increased complexity of patients are stretching nursing human resources already. However, the Editor identified a constant shift in the responsibilities of health providers over time and would rather see nurses' scope of practice expand than have responsibilities expand under the mandate of standing physicians' orders. The Editor indicates that expanding scope of practice makes no sense for any health discipline unless some elements of their responsibilities are added to the scope of other disciplines. Nurses have already acquired the competence in many areas to perform expanded responsibilities through experience and mentoring from physicians and nurse colleagues. The Editor calls for additional research to understand how nurses make clinical decisions.
Elwyn, G., Williams, M., Roberts, C., Newcombe, R.G., & Vincent, J.	2008	Quality Primary Care, 16(2), 75-82.	Case management by nurses in primary care: analysis of 73 'success stories'	This qualitative study analyzed case reports in a service innovation evaluation study focusing on nurse-led case management in primary care. Participants were asked to identify 'success stories' that were then consolidated into four themes: <ul style="list-style-type: none"> • Assessment and co-ordination of care - The majority of accounts were descriptions of cases where the nurses had reviewed patients' needs, particularly around the use of medication, and assessed their needs for support from the local

Appendix D: Primary Care Nurse Task Force Literature Synthesis

Authors	Year	Publication	Study or Report Name	Main Findings
				<p>pharmacy or social services.</p> <ul style="list-style-type: none"> • Diagnosis and co-ordination of care – There were 29 accounts recorded where diagnoses were described and where additional care services were arranged or co-ordinated. The majority of these cases were related to cardiovascular or respiratory system problems. • Admission to non-acute bed: Six accounts described admissions to non-acute beds. • Terminal care facilitated – Three cases are described where the case manager facilitated terminal care at home. • The authors conclude that case management by nurses based in primary care provides a type of care that is not currently available to frail elderly patients. The role enables time to be spent assessing the complex needs of patients who live at the margins of independent living.
Oelke, N.D., White, D., Besner, J., Doran, D., McGillis Hall, L., & Giovannetti, P.	2008	Nursing Leadership, 21(1), 58-71.	Nursing Workforce Utilization: An Examination of Facilitators and Barriers on Scope of Practice	<p>The authors of this mixed-method study sought to understand the perceptions of acute care nurses (RNs, LPNs and Licensed Practical Nurses) as to the extent in which they practise to full scope and identify barriers and facilitators in optimizing their roles. Findings include:</p> <ul style="list-style-type: none"> • Nurses in all three occupational groups had difficulty describing their scope of practice. • Approximately 48 per cent of all nurses interviewed felt they were working to full scope, at least some of the time. • Workload, high patient acuity and lack of time were commonly identified as barriers on scope of

Authors	Year	Publication	Study or Report Name	Main Findings
				<p>practice.</p> <ul style="list-style-type: none"> • Ineffective communication among nurses, between managers and staff and with physicians and other health care providers were identified as concerns. • Teamwork and collaborative practice were identified as an enabler to support working to full scope. • RN and LPNs commented on the importance of management and leadership support to facilitate working to full scope. • RNs identified support for and access to educational activities as an essential component of practicing to full scope. • The role of the nurse educator was seen as a factor in facilitating RN's ability to work to full scope, serving as an excellent resource to fill gaps in knowledge and skill.
Redsell, S.A., & Cheater, F.M.	2008	Quality Primary Care, 16(2), 69-71.	Nurses' roles in primary care: developments and future prospects	<p>In this guest editorial the authors review the role of nurses in primary care in the United Kingdom (UK). Comments include:</p> <ul style="list-style-type: none"> • The scope of nurses' role in primary care has been expanded considerably in the past decade and is likely to continue to do so in the medium and longer term. • The role of the nurse has shifted from delegated, task-oriented activities towards seeing patients at the first point of contact and working in partnership with patients.
Courtenay, M. & Carey, N.	2006	Journal of Clinical Nursing, 16(1), 122-128.	A review of the impact and effectiveness of nurse-led care in dermatology	<p>This study aimed to systematically summarize and critically appraise current evidence regarding the impact and effectiveness of nurse-led care in dermatology. Findings include:</p> <ul style="list-style-type: none"> • There is evidence to suggest that nurses are involved in the treatment and management of a

Authors	Year	Publication	Study or Report Name	Main Findings
				<p>broad range of skin conditions.</p> <ul style="list-style-type: none"> • Studies suggest over half of primary care nurses see between 1-5 dermatological patients a week. Eczema is one of the conditions most commonly treated, along with minor burns, warts and verrucae. • One study identified emollients, antibacterials, corticosteroids, keratolytics and tar-based products as the most common treatments supplied, administered or prescribed by nurses under treatment protocols. • Cyrotherapy was the main surgical treatment performed by nurses in a study that indicated there was strong medical support for this activity. • Nurses have identified the need for education and nearly a quarter of nurses in one study claimed to have received no such support. Scalp scaling, infected eczema, pruritis, skin cancer, impetigo, acne and urticaris are areas of concern identified in the literature. • Minor burns, bites, stings, dressings, allergies, warts and verrucas were areas in which nurses responded as having the greatest confidence in handling. • Research suggests that nurse-led interventions supported a reduction in the severity of eczema and use of topically applied hydrocortisone and emollients. • Conflicting research exists as to whether nurse-led interventions improve quality of life for patients

Appendix D: Primary Care Nurse Task Force Literature Synthesis

Authors	Year	Publication	Study or Report Name	Main Findings
				<ul style="list-style-type: none"> suffering from eczema. Some research exists to suggest that patients are happy with nurse-led dermatology services. One study found that nurse-led care enabled patients to receive immediate treatment from an expert as opposed to having to make separate appointments. A quarter of patients seen by the nurse deferred an appointment with a GP.
Lewis, R.	2001	Online Resource: http://careprovider.co.uk/prison/Nurse-Led_Primary_Care.pdf	Nurse-led Primary Care – Learning from PMS pilots	<p>The author of this report evaluated the development of Personal Medical Services (PMS) pilots in primary care which provided opportunities for nurses to work in new ways. These pilots were designed to maximize the use of nursing skill and allow nurses to exercise leadership within the primary health care team. Findings include:</p> <ul style="list-style-type: none"> Nurse-led care is not simply a description of the role of nurses but describes a culture of professional equality and patient-focused services. The new model of care created some local controversy, especially amongst physicians. The nurse-led pilots tended to serve vulnerable populations that are often poorly served by general practice. A new infrastructure is required to support new nursing roles.

REGISTERED NURSE PRESCRIBING

Bhanbhro, S., Drennan, V.M., Grant, R., & Harris, R.	2011	BMC Health Services Research, 11(330) 1-10.	Assessing the contribution of prescribing in primary care by nurses and professionals allied to medicine: a systematic review of literature	The authors of this integrated literature review examined non-medical prescribing in primary care guided by the dimension of quality, effectiveness, acceptability, efficiency
---------------------------------------------------------------	------	------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Appendix D: Primary Care Nurse Task Force Literature Synthesis

Authors	Year	Publication	Study or Report Name	Main Findings
				<p>and access. Findings include:</p> <ul style="list-style-type: none"> Limited evidence was found in relation to indicators of effectiveness (whether the treatment selected was the best available in the technical sense) of non-medical prescribing in primary care. The overall number of research-based studies to evaluate the impact and outcome of non-medical prescribing in primary care were low. In relation to efficiency, the review suggests that patients received services that were timely, seamless and high quality from nurse prescribers. More research is needed on cost-effectiveness. All the studies investigating acceptability of non-medical prescribing indicate that it was well accepted and favoured by patients, nurses, pharmacists and other health-care providers. Findings suggest that acceptability is based not just on immediate levels of satisfaction with the clinical encounter, but perceived value to the health-care system as a whole. The review findings reported that patients considered it was easier, quicker and convenient to get an appointment with a non-medical prescriber and that their access to medicine and health-care professionals improved.
Canadian Nurses Association (CNA)	2010	Hard Copy Report	Registered Nurse (RN) Prescribing – Preliminary Report	<p>CNA has compiled a report to analyze RN prescribing in Canada by reviewing regulations, positions to date, international advances and national status. A summary of findings include:</p> <ul style="list-style-type: none"> Prescribing authority in Canada for RNs is minimal. Trends vary across jurisdictions from RNs having limited authority, to RNs have no

Authors	Year	Publication	Study or Report Name	Main Findings
				<p>authority.</p> <ul style="list-style-type: none"> • A survey of CNA jurisdictions and groups indicated that RN prescribing would have positive outcomes for Canadians including increased access to health care, decreased wait times and improved continuity of care. • The key solutions include: having clear standards and identified competencies; accrediting education necessary to acquire recognized competencies; having credible methods to assess competence; clearly defining the role of the RN in prescribing and involving physicians and pharmacists to address impact on roles in collaboration and increase buy-in. • RN prescribing is occurring in the following countries: Australia, Brazil, Ireland, Jamaica, New Zealand, South Africa, Spain, Sweden and the United Kingdom. • CNA conducted a study tour in the United Kingdom (where nurses can prescribe) and identified three categories of non-medical prescribers: Extended Prescribers (qualified Nurse Independent Prescribers with access to the full British Formulary); District Nurses/ Health Visitors (prescribe through a restricted formulary with a limited range of medicines, dressings, appliances) and Supplementary Prescribing Nurses (nurses that prescribe within an established framework agreed to with a physician). Outcomes have been predominately positive including an evaluation commissioned by the University of Southampton which demonstrated reductions in patient return visits, patients adhering to treatment programs, improved uptake of medication

Appendix D: Primary Care Nurse Task Force Literature Synthesis

Authors	Year	Publication	Study or Report Name	Main Findings
				<p>and better patient outcomes.</p> <ul style="list-style-type: none"> • CNA also visited Ireland where a similar program exists to allow over 100 nurse prescribers to prescribe controlled drugs independently, subject to conditions for certain drugs such as narcotics. • In both England and Ireland, nurse prescribers must receive additional education before being granted the ability.
Jones, K., Edwards, M., & While, A.	2010	Journal of Advanced Nursing, 67(1), 117-126.		<p>This paper reports on a mixed methods single-case study evaluation of the implementation of nurse prescribing in an acute care hospital in England. Findings include:</p> <ul style="list-style-type: none"> • Nurse prescribing was found to benefit patients through service delivery improvement and using staff skills differently. • Nurse prescribers and their colleagues were positive about their role, service changes and their impact on patient care. • No differences were identified between the ways in which nurses and doctors performed prescribing roles, but there was a statistically significant difference between the medication-related information satisfaction ratings of patients who had seen a nurse prescriber, compared to those seen by a doctor.
Stenner, K., & Courtenay, M.	2008	Nurse prescribing roles in acute care: an evaluative case study		<p>This qualitative study interviewed 26 nurses, qualified to prescribe medications for patients with acute and chronic pain, regarding their role. Findings include:</p> <ul style="list-style-type: none"> • Improved speed and convenience for patients. • Improved safety as the person assessing the patient was actually prescribing, thus minimizing risk

Appendix D: Primary Care Nurse Task Force Literature Synthesis

Authors	Year	Publication	Study or Report Name	Main Findings
				<p>for communication error.</p> <ul style="list-style-type: none"> • Nurses reported that combining specialist skills, experience and knowledge of pain medication, together with a comprehensive patient assessment, enabled them to make more clinically appropriate prescribing decisions. • Continuity of care and improved partnerships with patients. • Enhanced efficiency and cost effectiveness. Some of the nurses believed they prevented hospitalization and speeded recovery at home by providing access to medications. • Increased job satisfaction amongst nurses and acquisition of new knowledge. • Increased nurse credibility.
Strickland-Hodge, B.	2008	Quality Primary Care, 16(2), 103-107.	Nurse prescribing: In this discussion paper, the author the elephant in the tries to dispel some of the expressed beliefs about the pharmacological knowledge of nurses in prescribing practice. Discussion points include:	<p>Nurse prescribing: In this discussion paper, the author the elephant in the tries to dispel some of the expressed beliefs about the pharmacological knowledge of nurses in prescribing practice. Discussion points include:</p> <ul style="list-style-type: none"> • In 2006, 0.8 per cent of total prescriptions in the UK were written by a nurse or other non-medical prescriber in primary care. • The curriculum used to train nurse prescribers covers seven main areas: 1) Consultation, decision making, assessment and review; 2) Influences on and psychology of prescribing; 3) Prescribing in a team context; 4) Applied therapeutics; 5) Evidence-based practice and clinical governance; 6) Legal, policy, professional and ethical aspects; and 7) Prescribing in the public health context. • Nurse prescribers are expected to know their limitations and know

Authors	Year	Publication	Study or Report Name	Main Findings
				<p>when and where to refer.</p> <ul style="list-style-type: none"> • Creating more independent prescribers should not encourage isolation but allow decisions to be made simply and efficiently for patient benefit within the prescriber's sphere of competence. It is this aim and not the enhancement of one profession or the role erosion of another that is at the heart of the change. • The author concludes nurse prescribing is a natural extension of the work of many nurses in the primary care, community and hospital settings.
Bradley, E., & Nolan, P.	2007	Journal of Advanced Nursing, 59(2), 120-128.	Impact of nurse prescribing: a qualitative study	<p>This qualitative study used interviews to investigate the impact of prescribing on a group of 45 recently qualified nurse prescribes in the United Kingdom. Findings include:</p> <ul style="list-style-type: none"> • Participants felt that becoming a prescriber has enhanced their self-esteem, job satisfaction, autonomy and nursing practice. • Participants felt more confident in their medication knowledge and ability to collaborate. • Participants felt more encouraged to pay attention to medication, read more information about it and place more emphasis on the impact it has on their patients. • Some nurses were concerned that their practice shifted more towards the medical model. • Participants felt they were more respected within the health-care team and felt that they took pressure off physicians. • Colleagues within the team sought advice from nurse

Authors	Year	Publication	Study or Report Name	Main Findings
				<p>prescribers about medication.</p> <ul style="list-style-type: none"> • Many physicians and other team members seemed to misunderstand the role, feeling that nurse prescribers would now become responsible for repeat prescribing. • Participants felt their new role enabled them to involve patients more fully in their prescribing decisions, as well as providing them with more education about their medication. • One of the main benefits of prescribing was nurses' ability to provide patients with a complete, streamlined package of care.
Courtenay, M., & Carey, N.	2007	Journal of Advanced Nursing, 61(3), 291-299.	Nurse independent prescribing and nurse supplementary prescribing practice: national survey.	<p>This study involved a random sample of 1,377 nurse independent and nurse supplementary prescribers responding to a postal questionnaire in 2006 regarding their prescribing practices. Findings include:</p> <ul style="list-style-type: none"> • 75 per cent of the sample had more than five years of experience in the area of practice where they prescribed prior to undertaking the prescribing program. • The greatest problems encountered in independent prescribing involved restrictions caused by local arrangements (i.e. waiting for prescription pads, budgets and inability to generate prescriptions on the computer). • Approximately 15 per cent reported problems with lack of clinical expertise, lack of peer support, and objections from medical staff and pharmacists. • The greatest problems encountered in supplemental prescribing were related to implementing the Clinical Management Plan (CMP). The main reasons for this difficulty were related to hospital policy, time to set up the CMP and difficulties

Authors	Year	Publication	Study or Report Name	Main Findings
	2005	Journal of Clinical Nursing, 15(1), 22-28.	Attitudes towards, and information needs in relation to, supplementary nurse prescribing in the UK: an empirical study	<p>with access to records.</p> <ul style="list-style-type: none"> The mean number of items prescribed by nurse independent prescribers and nurse supplemental prescribers in a typical week was 17.5 and 6.0, respectively. 53 per cent of nurse supplemental prescribers indicated they were confident to adopt the role of independent prescriber. <p>*A nurse supplemental prescriber enters into a relationship with an independent prescriber (physician or dentist) to implement an agreed, patient-specific clinical management plan with the patient's agreement. Nurse independent prescribers function independently.</p>
Latter, S., & Courtenay, M.	2004	Journal of Clinical Nursing, 13(1), 26-32.		This study reviewed the literature on the first phase of nurse prescribing (1993-2002) in the United Kingdom. Eighteen research-based publications were included in the review. Findings

Appendix D: Primary Care Nurse Task Force Literature Synthesis

Authors	Year	Publication	Study or Report Name	Main Findings
				<p>include:</p> <ul style="list-style-type: none"> • Patients are satisfied with nurse prescribing in a number of areas. In one study, patients identified the nurses as being in a better position to prescribe items from the Nurse Prescribers' Formulary than GPs. • In the same study, no patients identified being opposed to nurse prescribing, however, some patients identified disadvantages related to methods of obtaining a prescription. • A two-year study that focused on an in-depth examination of nurses' broader role in medication management across a range of settings identified that while most patients were generally satisfied with medication interactions with nurses, they also had limited expectations, and some patients had unmet information needs about medications. • Nurse prescribers have identified a number of positive elements to their role across studies, including increased efficiency and heightened job satisfaction. Some nurses identified initial anxiety about writing prescriptions and assuming responsibility previously taken by the GP. However, the authors reported that this anxiety subsided as nurses became more familiar with prescribing. • The adequacy of nurses' knowledge base in pharmacology and the need for further training has been identified as a concern in the literature. One study found that nurse prescribers' actual medication-related knowledge, relative to their high levels of confidence, was not confirmed with performance on case scenarios in two primary care

Authors	Year	Publication	Study or Report Name	Main Findings
				<p>organizations.</p> <ul style="list-style-type: none"> • Prescribing patterns amongst nurses were found to be influenced by the size and makeup of the population(s) being served. A lack of confidence was also cited by relatively inexperienced prescribers. • A consistent finding related to the first phase of independent nurse prescribing was concern over the limits of the original formulary. • In a demonstration site evaluation, nurses considered their prescribing to be more cost-effective than GPs in some areas. Being made aware of the relative price of products led some nurses to prescribe less expensive products that did not compromise care quality. • Peer support through teamwork was found to be a major source of support for nurse prescribers. Working in isolation was found to have a negative influence on prescribing. • Studies have identified a lack of mentorship and clinical supervision amongst many nurse prescribers when they initially begin to prescribe.
While, A.E. & Biggs, K.S.M.	2003	Journal of Advanced Nursing, 45(6), 559-567.	Benefits and challenges of Nurse prescribing	<p>Since 1999, all health visitors and district nurses in the United Kingdom have received additional education to prescribe listed medical products. This study used a survey to review the prescribing practices of these nurses. Findings include:</p> <ul style="list-style-type: none"> • 80.7 per cent of respondents were prescribing less than three times a week. • Respondents were positive about the training program they received. • 68.5 per cent of respondents reported nurse prescribing was at least moderately helpful in their

Appendix D: Primary Care Nurse Task Force Literature Synthesis

Authors	Year	Publication	Study or Report Name	Main Findings
				<p>practice.</p> <ul style="list-style-type: none"> • 96.5 per cent of respondents indicated nurse prescribing provided quicker treatment for patients. • 80 per cent of respondents indicated nurse prescribing enabled job satisfaction. • 85.4 per cent of respondents reported being at least moderately confident in prescribing. Confidence was strongly associated with prescribing frequency. • 67.1 per cent of respondents felt the current prescribing formulary did not meet their prescribing needs. • 95.2 per cent of respondents viewed training and education on assessing and diagnosing conditions as helpful to support their prescribing. • 56.3 per cent of respondents identified at least moderate support from their GP or primary care team for their prescribing role. • The most frequent source of reference identified for prescribing problems were colleagues.
Horton, R.	2002	The Lancet, 359(9321), 1875-1876.	Nurse prescribing in the UK: right but also wrong	In this commentary, the author identifies concern over the expedient expansion of nurse prescribing in the UK. The author identifies the value of nurses and nurse prescribing, however, is concerned that nurses may not be adequately prepared to provide this service to patients without more comprehensive education in pharmacology. The author concludes by stating that nurse prescribing has too much to offer the care of patients to let it flounder through hasty and politically-expedient implementation.

References

- ¹ Commission on the Reform of Ontario's Public Services (2012). Public Services for Ontarians: A Path to Sustainability and Excellence. Retrieved April 16, 2012 from: <http://www.fin.gov.on.ca/en/reformcommission/chapters/report.pdf>
- ² College of Nurses of Ontario (2012). Self-Reported Membership Data (2010).
- ³ Starfield, B. (1998) *Primary Care: balancing health needs, services and technology*. 2nd ed. New York: Oxford University Press, pp 8-9.
- ⁴ Allard, A., Frego, A., Katz, A., & Halas, G. (2010). Exploring the role of RNs in family practice residency training programs. *Canadian Nurse*, 106(3), 20-24.
- ⁵ HealthForceOntario (2007). Interprofessional Care: A Blueprint for Action in Ontario. Retrieved June 6, 2012 from: <http://www.healthforceontario.ca/upload/en/whatishfo/ipc%20blueprint%20final.pdf>
- ⁶ Government of Ontario (1991). Regulated Health Professions Act S.O 1991, Chapter 18. Retrieved April 14, 2012 from http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91r18_e.htm
- ⁷ Ibid
- ⁸ Ibid
- ⁹ Stanford University Evidence-Based Practice Centre (2007). Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Retrieved April 17, 2012 from <http://www.ncbi.nlm.nih.gov/books/NBK44015/pdf/TOC.pdf>
- ¹⁰ Stanford University Evidence-Based Practice Centre (2007). Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Retrieved April 17, 2012 from <http://www.ncbi.nlm.nih.gov/books/NBK44015/pdf/TOC.pdf>
- ¹¹ Ministry of Health and Long-Term Care (2012). Ontario's Action Plan for Health Care. Retrieved April 17, 2012 from http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_healthychange.pdf
- ¹² Green, L.A., Fryer, G.E., Yawn, B.P., Lanier, D., & Dovey, S.M. (2001). The ecology of medical care revisited. *New England Journal of Medicine*, 344(26), 2021-2025.
- ¹³ Institute for Clinical Evaluative Sciences (2006). Primary care in Ontario. Retrieved April 16, 2012 from: http://www.ices.on.ca/file/PC_atlas_chapter1.pdf
- ¹⁴ College of Nurses of Ontario (2012). Self-Reported Membership Data (2010).
- ¹⁵ Allard, A., Frego, A., Katz, A., & Halas, G. (2010). Exploring the role of RNs in family practice residency training programs. *Canadian Nurse*, 106(3), 20-24.
- ¹⁶ Commission on the Reform of Ontario's Public Services (2012). Public Services for Ontarians: A Path to Sustainability and Excellence. Retrieved April 16, 2012 from: <http://www.fin.gov.on.ca/en/reformcommission/chapters/report.pdf>
- ¹⁷ Health Canada (2006). About Primary Health Care. Retrieved June 5, 2012 from: <http://www.hc-sc.gc.ca/hcs-sss/prim/about-apropos-eng.php>
- ¹⁸ Starfield, B. (1998) *Primary Care: balancing health needs, services and technology*. 2nd ed. New York: Oxford University Press, pp 8-9.
- ¹⁹ Health Council of Canada (2009). Teams in Action: Primary Care Teams for Canadians. Retrieved April 16, 2012 from <http://www.bcpsqc.ca/new/documents/Health%20Council%20of%20Canada%20-%20April%202009.pdf>

²⁰ The College of Family Physicians of Canada and The Canadian Nurses' Association (2007). CFPC-CNA Vision Statement on Inter-Professional Care. Retrieved April 16, 2012 from: http://www2.cna-aiic.ca/CNA/documents/pdf/publications/CFPC_CNA_Inter_Professional_e.pdf

²¹ World Health Organization (2008). Word Health Report 2008. Primary Health Care – Now More Than Ever. Retrieved May 24, 2012 from: http://www.who.int/whr/2008/whr08_en.pdf

²² Primary Healthcare Planning Group (2011). Strategic Directions for Strengthening Primary Care in Ontario – Overview of Process and Recommendations of the Primary Healthcare Planning Group. Retrieved May 7, 2012 from: http://trilliumresearchday.com/documents/PHPG_Overview%20of%20Process%20and%20Recommendations_Final.pdf

²³ College of Nurses of Ontario (2012). Self-Reported Membership Data (2010).

²⁴ HealthForceOntario (2007). Interprofessional Care: A Blueprint for Action in Ontario. Retrieved June 6, 2012 from: <http://www.healthforceontario.ca/upload/en/whatishfo/ipc%20blueprint%20final.pdf>

²⁵ Association of Ontario Health Centres (n.d.) Association of Ontario Health Centres. Retrieved April 21, 2012 from <http://www.aohc.org>

²⁶ HealthForceOntario Marketing and Recruitment Agency (2007). Primary Health Care. Retrieved April 16, 2012 from: <http://www.healthforceontario.ca/HealthcareInOntario/PrimaryCare.aspx>

²⁷ Association of Ontario Health Centres (n.d.) Association of Ontario Health Centres. Retrieved April 21, 2012 from <http://www.aohc.org>

²⁸ HealthForceOntario Marketing and Recruitment Agency (2007). Primary Health Care. Retrieved April 16, 2012 from: <http://www.healthforceontario.ca/HealthcareInOntario/PrimaryCare.aspx>

²⁹ Ministry of Health and Long-Term Care (2011). Family health teams. Retrieved June 17, 2012 from: http://www.health.gov.on.ca/transformation/fht/fht_mn.html

³⁰ HealthForceOntario Marketing and Recruitment Agency (2007). Primary Health Care. Retrieved April 16, 2012 from: <http://www.healthforceontario.ca/HealthcareInOntario/PrimaryCare.aspx>

³¹ Ibid

³² Ibid

³³ Ibid

³⁴ Ministry of Health and Long-Term Care (2010). Nurse Practitioner-Led Clinics. Retrieved June 17, 2012 from: http://www.health.gov.on.ca/transformation/np_clinics/np_mn.html

³⁵ HealthForceOntario Marketing and Recruitment Agency (2007). Primary Health Care. Retrieved April 16, 2012 from: <http://www.healthforceontario.ca/HealthcareInOntario/PrimaryCare.aspx>

³⁶ Ontario Family Practice Nurses (2005). The Importance of the Registered Nurse in Family Practice in a Transformed Health Care System in Ontario. Retrieved April 18, 2012 from http://www.rnao.org/Storage/15/919_OFPN_Paper.pdf

³⁷ Ministry of Health and Long-Term Care (2010). Nurse Practitioner-Led Clinics. Retrieved April 16, 2012 from: http://www.health.gov.on.ca/transformation/np_clinics/np_mn.html

³⁸ College of Nurses of Ontario (2012). Registered Nurses In the Extended Class Employed In Nursing In Ontario – Working Status (2003-2010). Retrieved April 16, 2012 from: https://remote.cnomail.org/approot/cno/data_query_tool.htm

³⁹ College of Nurses of Ontario (2011). RN and RPN Practice: The Client, the Nurse and the Environment. Retrieved April 16, 2012 from <http://www.cno.org/Global/docs/prac/41062.pdf>

⁴⁰ Ibid

⁴¹ College of Nurses of Ontario (2011). Nurse Practitioner Practice Standard. Retrieved April 16, 2012 from http://www.cno.org/Global/docs/prac/41038_StrdRnec.pdf

⁴² The Council of the Federation (2012). Premiers Announce Health Care Innovation Working Group. Retrieved April 16, 2012 from: http://www.councilofthefederation.ca/pdfs/Communiqué_Task%20Force_Jan_17.pdf

⁴³ Commission on the Reform of Ontario's Public Services (2012). Public Services for Ontarians: A Path to Sustainability and Excellence. Retrieved April 16, 2012 from: <http://www.fin.gov.on.ca/en/reformcommission/chapters/report.pdf>

⁴⁴ Improving Access in Primary Care Working Group (2011). Strengthening Primary Care Access – Report of the Working Group to the Primary Healthcare Planning Group

⁴⁵ Institute of Medicine of the National Academies (2011). The Future of Nursing – Leading Change, Advancing Health. Retrieved April 16, 2012 from: <http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx>

⁴⁶ Ontario Family Practice Nurses (n.d.) Ontario Family Practice Nurses (OFPN). Retrieved April 16, 2012 from <http://www.rnao.org/Page.asp?PageID=924&ContentID=659>

⁴⁷ Primary Care Nurse Task Force (2012). Terms of Reference. Retrieved April 16, 2012 from http://www.rnao.org/Storage/89/8328_Primary_Care_Nurse_Task_Force_Terms_of_Reference_April_3.pdf

⁴⁸ Allard, A., Frego, A., Katz, A., & Halas, G. (2010). Exploring the role of RNs in family practice residency training programs. *Canadian Nurse*, 106(3), 20-24.

⁴⁹ Akeroyd, J., Oandasan, I., Alsaffar, A., Whitehead, C., & Lingard, L. (2009). Perceptions of the role of the registered nurse in an urban interprofessional academic family practice setting. *Nursing Leadership*, 22(2), 73-84.

⁵⁰ Allard, A., Frego, A., Katz, A., & Halas, G. (2010). Exploring the role of RNs in family practice residency training programs. *Canadian Nurse*, 106(3), 20-24.

⁵¹ Ibid

⁵² Ibid

⁵³ Canadian Nurses Association (2009). CNA's Primary Care Toolkit. Retrieved April 17, 2012 from <http://www.cna-aiic.ca/en/professional-development/nurseone-knowledge-resources/cnas-primary-care-toolkit/>

⁵⁴ University Health Network (2009). Optimizing the Role of the Family Practice Registered Nurse. Retrieved April 18, 2012 from http://www.uhn.ca/About_UHN/programs/MCC/Family_Community/FamilyPractice-RN/roles_competencies/role_1.asp

⁵⁵ University Health Network (2009). Optimizing the Role of the Family Practice Registered Nurse. Retrieved April 18, 2012 from http://www.uhn.ca/About_UHN/programs/MCC/Family_Community/FamilyPractice-RN/roles_competencies/role_1.asp

⁵⁶ Rashid, C. (2010). Benefits and limitations of nurses taking on aspects of the clinical role of doctors in primary care: integrative literature review. *Journal of Advanced Nursing*, 66(8), 1658-1670.

⁵⁷ Oelke, N.D., White, D., Besner, J., Doran, D., McGillis Hall, L., & Giovannetti, P. (2008). Nursing workforce utilization: an examination of facilitators and barriers on scope of practice. *Nursing Leadership*, 21(1), 58-71.

⁵⁸ Commission on the Reform of Ontario's Public Services (2012). Public Services for Ontarians: A Path to Sustainability and Excellence. Retrieved April 16, 2012 from: <http://www.fin.gov.on.ca/en/reformcommission/chapters/report.pdf>

⁵⁹ Fairman, J.A., Rowe, J.W., Hassmiller, S., & Shalala, D.E. (2011). Broadening the scope of nursing practice. *New England Journal of Medicine*, 364(3), 193-196.

⁶⁰ Improving Access in Primary Care Working Group (2011). Strengthening Primary Care Access – Report of the Working Group to the Primary Healthcare Planning Group

⁶¹ Institute of Medicine of the National Academies (2011). The Future of Nursing – Leading Change, Advancing Health. Retrieved April 16, 2012 from: <http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx>

⁶² Commission on the Reform of Ontario's Public Services (2012). Public Services for Ontarians: A Path to Sustainability and Excellence. Retrieved April 16, 2012 from: <http://www.fin.gov.on.ca/en/reformcommission/chapters/report.pdf>

⁶³ Pringle, D. (2009). From the editor-in-chief – expanding nurses' scope of practice. *Nursing Leadership*, 22(2), 1-4.

⁶⁴ Commission on the Future of Health Care in Canada (2002). Report on Citizen's Dialogue on the Future of Health Care in Canada. Retrieved April 16, 2012 from: <http://publications.gc.ca/collections/Collection/CP32-77-2002E.pdf>

⁶⁵ Gallup Economy (2010). Nurses Top Honesty and Ethics List for 11th Year. Retrieved April 17, 2012 from: <http://www.gallup.com/poll/145043/nurses-top-honesty-ethics-list-11-year.aspx>

⁶⁶ Laurant, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R., & Sibbald, B. (2009). Substitution of doctors by nurses in primary care (Cochrane Review). *Cochrane Database of Systematic Reviews*.

⁶⁷ Oelke, N.D., White, D., Besner, J., Doran, D., McGillis Hall, L., & Giovannetti, P. (2008). Nursing workforce utilization: an examination of facilitators and barriers on scope of practice. *Nursing Leadership*, 21(1), 58-71.

⁶⁸ College of Nurses of British Columbia (2011). Scope of practice for Registered Nurses. Retrieved April 17, 2012 from: <https://www.crnbc.ca/Standards/Lists/StandardResources//433ScopeforRegisteredNurses.pdf>

⁶⁹ Institute for Clinical Evaluation Sciences (2012). Payments to Ontario Physicians from Ministry of Health and Long-Term Care Sources 1992/93 to 2009/10. Retrieved April 17, 2012 from http://www.ices.on.ca/file/ICES_PhysiciansReport_2012.pdf

⁷⁰ Ibid

⁷¹ Ontario Nurses' Association (n.d.) Unions and the Ontario Nurses Association. Retrieved April 17, 2012 from <http://www.ona.org/faqs.html#f15>

⁷² Association Of Family Health Teams of Ontario, Association of Ontario Health Centres & Nurse Practitioners' Association of Ontario (2012). Toward a Primary Care Recruitment and Retention Strategy For Ontario.

⁷³ Courtenay, M., & Carey, N. (2006). A review of the impact and effectiveness of nurse-led care in dermatology. *Journal of Clinical Nursing*, 16 (1), 122-128.

⁷⁴ Harlow, E.D., & Burton, J.L. (1996). What do general practitioners want from a dermatology department. *British Journal of Dermatology*, 134(2), 313-318.

⁷⁵ Institute for Clinical Evaluation Sciences (2012). Payments to Ontario Physicians from Ministry of Health and Long-Term Care Sources 1992/93 to 2009/10. Retrieved April 17, 2012 from http://www.ices.on.ca/file/ICES_PhysiciansReport_2012.pdf

⁷⁶ Canadian Nurses Association (2010). Registered Nurse (RN) Prescribing – Preliminary Report.

⁷⁷ Ibid

⁷⁸ Bhanbhro, S., Drennan, V.M., Grant, R., & Harris, R. (2011). Assessing the contribution of prescribing in primary care by nurses and professionals allied to medicine: a systematic review of literature. *BMC Health Services Research*, 11(330), 1-10.

⁷⁹ Jones, K., Edwards, M., & While, A. (2010). Nurse prescribing roles in acute care: an evaluative case study. *Journal of Advanced Nursing*, 67(1), 117-126.

⁸⁰ Stenner, K., & Courtenay, M. (2008). Benefits of nurse prescribing for clients in pain: nurses' view. *Journal of Advanced Nursing*, 63(1), 27-35.

⁸¹ Latter, S., & Courtenay, M. (2004). Effectiveness of nurse prescribing: a review of the literature. *Journal of Clinical Nursing*, 13(1), 26-32.

⁸² Berry, D., Courtenay, M., & Bersellini, E. (2005). Attitudes towards, and information needs in relation to, supplementary nurse prescribing in the UK: an empirical study. *Journal of Clinical Nursing*, 15(1), 22-28.

⁸³ Bradley, E., & Nolan, P. (2007). Impact of nurse prescribing: a qualitative study. *Journal of Advanced Nursing*, 29(2), 120-128.

⁸⁴ Jones, K., Edwards, M., & While, A. (2010). Nurse prescribing roles in acute care: an evaluative case study. *Journal of Advanced Nursing*, 67(1), 117-126.

⁸⁵ Latter, S., & Courtenay, M. (2004). Effectiveness of nurse prescribing: a review of the literature. *Journal of Clinical Nursing*, 13(1), 26-32.

⁸⁶ Strickland-Hodge, B. (2008). Nurse prescribing: the elephant in the room? *Quality Primary Care*, 16(2), 103-107.

⁸⁷ While, A.E., & Biggs, K.S.M. (2003). Benefits and challenges of nurse prescribing. *Journal of Advanced Nursing*, 45(6), 559-567.

⁸⁸ Latter, S., & Courtenay, M. (2004). Effectiveness of nurse prescribing: a review of the literature. *Journal of Clinical Nursing*, 13(1), 26-32.

⁸⁹ While, A.E., & Biggs, K.S.M. (2003). Benefits and challenges of nurse prescribing. *Journal of Advanced Nursing*, 45(6), 559-567.

⁹⁰ Strickland-Hodge, B. (2008). Nurse prescribing: the elephant in the room? *Quality Primary Care*, 16(2), 103-107.

⁹¹ Ministry of Health and Long-Term Care (2012). Ontario's Action Plan for Health Care. Retrieved April 17, 2012 from http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_healthychange.pdf

⁹² Stanford University Evidence-Based Practice Centre (2007). Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Retrieved April 17, 2012 from <http://www.ncbi.nlm.nih.gov/books/NBK44015/pdf/TOC.pdf>

⁹³ Gilbert, J.E., Green, E., Lankshear, S., Hughes, E., Burkoski, V., & Sawka, C. (2011). Nurses as client navigators in cancer diagnosis: review, consultation and model design. *European Journal of Cancer Care*, 20(2), 228-236.

⁹⁴ Stanford University Evidence-Based Practice Centre (2007). Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Retrieved April 17, 2012 from <http://www.ncbi.nlm.nih.gov/books/NBK44015/pdf/TOC.pdf>

⁹⁵ Ministry of Health and Long-Term Care (2012). Ontario's Action Plan for Health Care. Retrieved April 17, 2012 from http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_healthychange.pdf

⁹⁶ Health Council of Canada (2012). Seniors in need; caregivers in distress: What are the home care priorities for seniors in Canada? Retrieved April 16, 2012 from: http://www.healthcouncilcanada.ca/rpt_det_gen.php?id=348

⁹⁷ Boyd, C.M., Reider, L., Frey, K., Scharfstein, D., Leff, B., Wolff, J., Groves, C., Karm, L., Wegener, S., Marsteller, J., & Boult, C. (2009). The effects of guided care on the perceived quality of health care for multi-morbid older persons: 18 month outcomes from a cluster-randomized control trial. *Journal of General Internal Medicine*, 25(3), 235-242.

⁹⁸ Elwyn, G., Williams, M., Roberts, C., Newcombe, R.G., & Vincent, J. (2008). Case management by nurses in primary care: analysis of 73 'success stories'. *Quality Primary Care*, 16(2), 75-82.

⁹⁹ McPherson, K. (2003). Beside Matters: The Transformation of Canadian Nursing, 1900-1990. Toronto: University of Toronto Press.

¹⁰⁰ Ibid

¹⁰¹ Ibid

¹⁰² Ministry of Health and Long-Term Care (2010). Embracing our past, strengthening our future. Nursing Secretariat 10th Anniversary Commemorative Journal. Retrieved April 30, 2012 from <http://www.ontla.on.ca/library/repository/mon/24005/301486.pdf>

¹⁰³ Government of Ontario (2011). Expanding the Role of Nurse Practitioners in Hospitals. Retrieved April 30, 2012 from <http://www.premier.gov.on.ca/news/event.php?ItemID=17522&Lang=EN>

¹⁰⁴ College of Nurses of Ontario (2012). Self-reported membership data. Retrieved by request from the College of Nurses of Ontario.

¹⁰⁵ Ibid

¹⁰⁶ Ibid

¹⁰⁷ Ministry of Health and Long-Term Care (2012). Inter-Professional Share Care – 500 Nurses Initiative. Retrieved April 21, 2012 from: <http://www.health.gov.on.ca/english/providers/physiciansa/500nurses.html>

¹⁰⁸ College of Nurses of Ontario (2012). Self-reported membership data. Retrieved by request from the College of Nurses of Ontario.

¹⁰⁹ Ibid

¹¹⁰ Ibid

¹¹¹ Ibid

¹¹² Registered Nurses' Association of Ontario (2010). Position Statement – Strengthening Client Centered Care in Hospitals. Retrieved April 21, 2012 from http://www.rnao.org/Storage/66/6055_RNAO_Client_Centred_Care_Position_in_Hospitals_FINAL_Feb_18_2010.pdf

¹¹³ Ibid

¹¹⁴ College of Nurses of Ontario (2012). Self-reported membership data. Retrieved by request from the College of Nurses of Ontario.

¹¹⁵ Registered Nurses' Association of Ontario (2010). Position Statement – Strengthening Client Centered Care in Hospitals. Retrieved April 21, 2012 from http://www.rnao.org/Storage/66/6055_RNAO_Client_Centred_Care_Position_in_Hospitals_FINAL_Feb_18_2010.pdf

¹¹⁶ Registered Nurses' Association of Ontario (RNAO). Survey of Casual and Part-Time Registered Nurses in Ontario. Retrieved April 21, 2012 from http://www.rnao.org/Storage/12/713_RNAO_part_time_casual_report.pdf

¹¹⁷ College of Nurses of Ontario (2012). Self-reported membership data. Retrieved by request from the College of Nurses of Ontario.

¹¹⁸ Statistics Canada (2011). Population by year, by province and territory. Retrieved April 21, 2012 from: <http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo02a-eng.htm>

¹¹⁹ Ministry of Finance (2010). Ontario Population Projections Update, 2010-2036. Retrieved April 21, 2012 from: <http://www.fin.gov.on.ca/en/economy/demographics/projections/>

¹²⁰ Statistics Canada (2011). Population by year, by province and territory. Retrieved April 21, 2012 from: <http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo02a-eng.htm>

¹²¹ Ministry of Finance (2011). Ontario Population Projections Update, 2010-2036. Retrieved April 21, 2012 from: <http://www.fin.gov.on.ca/en/economy/demographics/projections/>

¹²² College of Nurses of British Columbia (2011). Scope of practice for Registered Nurses. Retrieved April 17, 2012 from: <https://www.crnbc.ca/Standards/Lists/StandardResources//433ScopeforRegisteredNurses.pdf>

¹²³ Wong, S.T., Watson, D.E., Mooney, D., & Young, E. (2009). Supply and distribution of primary healthcare registered nurses in British Columbia. *Healthcare Policy*, 5(sp), 91-104.

¹²⁴ Ontario Physician Human Resources Data Centre (2011). 2010 Active Physicians in Ontario by Specialty and LHIN. Retrieved April 21, 2012 from: <https://www.ophrdc.org/public/download.aspx?fileType=pdf&fileName=2010%20Active%20Physicians%20by%20Specialty%20of%20Practice%20and%20LHIN.pdf>

¹²⁵ Ministry of Finance (2011). Ontario Population Projections Update, 2010-2036. Retrieved April 21, 2012 from: <http://www.fin.gov.on.ca/en/economy/demographics/projections/>

¹²⁶ College of Nurses of Ontario (2012). Self-reported membership data. Retrieved by request from the College of Nurses of Ontario.

¹²⁷ Ibid

¹²⁸ Ministry of Finance (2011). Ontario Population Projections Update, 2010-2036. Retrieved April 21, 2012 from: <http://www.fin.gov.on.ca/en/economy/demographics/projections/>

¹²⁹ Ministry of Health and Long-Term Care (2012). Ontario's Action Plan for Health Care. Retrieved April 17, 2012 from http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_healthychange.pdf

¹³⁰ Commission on the Reform of Ontario's Public Services (2012). Public Services for Ontarians: A Path to Sustainability and Excellence. Retrieved April 16, 2012 from: <http://www.fin.gov.on.ca/en/reformcommission/chapters/report.pdf>

¹³¹ College of Nurses of Ontario (2012). College of Nurses of Ontario Membership Statistics Report 2011. Retrieved April 21, 2012 from: http://www.cno.org/Global/docs/general/43069_stats/43069_MembershipStatistics2011.pdf

¹³² Association of Family Health Teams of Ontario, Association of Ontario Health Centres & Nurse Practitioners' Association of Ontario (2012). Toward a Primary Care Recruitment and Retention Strategy For Ontario.

¹³³ Ibid

¹³⁴ Ibid

¹³⁵ Ibid

¹³⁶ Ibid

¹³⁷ Canadian Family Practice Nurses Association (n.d.). Sample Role Description for Registered Nurse in Family Practice. Retrieved April 23, 2012 from http://www2.cna-aiic.ca/CNA/documents/pdf/toolkit/Sample_Role_Description_e.pdf

¹³⁸ Government of Ontario (1991). Regulated Health Professions Act S.O 1991, Chapter 18. Retrieved April 14, 2012 from http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91r18_e.htm

¹³⁹ Ibid

¹⁴⁰ Ibid

¹⁴¹ University of Surrey (2010). Nurse Independent/Supplementary Prescribing. Retrieved May 30, 2012 from: <http://www2.surrey.ac.uk/healthandsocialcare/study/CPD/msc/Microsoft%20Word%20-%20V300.pdf>

¹⁴² Pringle, D. (2009). From the editor-in-chief – expanding nurses' scope of practice. *Nursing Leadership*, 22(2), 1-4.

¹⁴³ Way, D., Jones, L., & Busing, N. (2000). Implementation Strategies: "Collaboration in Primary Care – Family Doctors & Nurse Practitioner Delivering Shared Care": Discussion Paper Written for the Ontario College of Family Physicians. Retrieved June 6 from: <http://www.eicp.ca/en/toolkit/hhr/ocfp-paper-handout.pdf>

¹⁴⁴ Registered Nurses' Association of Ontario (2010). RNAO Summer Institutes: The Must-Attend Professional Development Events of the Summer! Retrieved June 11, 2012 from: <http://centrepointrnao.ca/article/3/27>

¹⁴⁵ George Brown College (n.d.) Registered Nurse – Family Practice Nursing (Postgraduate) Program (S415). Retrieved May 30, 2012 from: <http://www.georgebrown.ca/S415-2012-2013/>

¹⁴⁶ Canadian Nurses Association (2011). Clinical Nurse Specialists. Retrieved May 2, 2012 from: <http://www.cna-aiic.ca/en/professional-development/nurse-practitioner-and-clinical-specialists/clinical-nurse-specialists/>

¹⁴⁷ Registered Nurses' Association of Ontario (2012). Nursing Best Practice Guidelines. Retrieved May 2, 2012 from <http://rnao.ca/bpg>

¹⁴⁸ Registered Nurses' Association of Ontario (2012). Clinical Practice Guidelines Program. Retrieved June 15, 2012 from: <http://rnao.ca/bpg/guidelines/clinical>

¹⁴⁹ Registered Nurses' Association of Ontario (2012). RNAO Annual General Meeting Media Release. Retrieved May 2, 2012 from: <http://rnao.ca/news/media-releases/2012/04/25/rnao-annual-general-meeting-agm>

¹⁵⁰ College of Nurses of Ontario (2010) Membership Statistics

¹⁵¹ Canadian Nurses Association (2011). Specialty certification. Retrieved May 16, 2012 from: <http://www.cna-aiic.ca/en/professional-development/specialty-certification/>

RNAO is the professional association representing registered nurses (RNs) working in all roles and sectors in Ontario. RNAO's mission is to foster knowledge-based nursing practice, promote quality work environments, deliver excellence in professional development and advance healthy public policy to improve health. RNAO promotes the full participation of present and future RNs in improving health, and shaping and delivering health-care services. RNAO believes health is a resource for everyday living and health care a universal human right. As a member-driven organization, RNAO is a forceful advocate on social and political issues related to nursing, health and health care. RNAO also leads the internationally acclaimed Best Practice Guideline Program to develop, disseminate, and support implementation and evaluation of evidence-based clinical and healthy work environment guidelines.

J **2** 0 **1** **2**
J U N E

Registered Nurses' Association of Ontario

158 Pearl Street, Toronto, Ontario M5H 1L3

Tel: (416) 599-1925 / 1-800-268-7199

Fax: (416) 599-1926 Email: info@rnao.ca

www.RNAO.ca