



# Nurse Practitioners Moving to the Forefront

## Nurse Practitioners Moving to the Forefront to Improve Access to Care

The work of Nurse Practitioners (NP) is coming more into focus as government and health system stakeholders seek ways to improve access to health care and to reduce waiting times in a variety of settings, including primary care, acute care and emergency services.

Over the last few years, there have been a string of Ontario government initiatives and consultations to see where NPs can be more productively utilized. These initiatives and consultations include expanding the scope of practice for NPs under Bill 179, the *Regulated Health Professions Statute Law Amendment Act, 2009*, which amends the *Regulated Health Professions Act, 1991*, and the development of regulations.

This new legislation expands the scope of practice for some health care providers, including NPs, and helps increase access to care for Ontarians in a number of ways. You can read more about this in a story called "*Nurse Practitioners – Expanded Powers Means Better Access*" found on page 3 of this special pull-out feature section.

ONA has long recognized and supported NPs in their role within the health care system, and has lobbied for the expansion of their scope to ensure they are fully utilized, reflecting their range of skills, ability and education.

More and more NPs are joining ONA Bargaining Units or have become members through arbitration and other legislative means. In view of that, for the first time in our Union's history, ONA gathered together a group of NPs for a focus group to talk about what they see are key issues affecting their practice and their role within the health care system. The focus group was held on September



29, 2010 at ONA's office in Toronto. To prepare for the focus group, an on-line survey was posted on our website at [www.ona.org](http://www.ona.org), in which our NP members were invited to identify key issues and what they see as bargaining priorities for their group.

In this feature section, find out more about this vital component of our union membership and understand our NPs' role as key members of the multi-disciplinary health care provider team, working in tandem with our Registered Nurses, Registered Practical Nurses and other Allied Health members.

You can also read about the history of the development of the NP role in Canada, featuring important milestones, interesting nursing statistics from the College of Nurses of Ontario (CNO) related to NPs, a snapshot of the CNO Standards of Practice for NPs, and interviews with ONA NPs, who talk about the key issues impacting on their practice and what this means for Ontarians.

Enjoy this feature section!

# Who are Nurse Practitioners?

Source: Health Professions Regulatory Advisory Council (HPRAC)

*“A Report to the Minister of Health and Long-Term Care on the Review and Scope of Practice for Registered Nurses in the Extended Class (Nurse Practitioners)” – March 2008*

In Ontario, Registered Nurses (RNs) in the Extended Class (RN-EC) under Ontario's *Nursing Act, 1991*, are Nurse Practitioners (NPs).

NPs have additional knowledge and skills that build on the broad health science education of RNs in the general class. Their training equips them to independently perform some of the diagnostic and treatment functions that lie within the purview of physicians.

Education programs in the 1970s prepared RNs for “extended” responsibilities, and since that time, NPs have worked in Ontario in a variety of settings. In the early years, the role was not widely implemented due to the absence of legislative recognition and government funding.

In 1998, Ontario became the first prov-

ince in Canada to enshrine the NP role in legislation. NPs were authorized to perform a series of controlled acts beyond those done by RNs in the general class, such as prescribing specific medications, ordering certain x-rays and diagnostic tests, and suturing wounds. (Controlled acts are health care activities that carry a substantial risk of harm if performed by unqualified personnel.)

Over the last decade, the Ontario government has invested in education and provided funding to implement the NP role, and further legislative and regulatory changes have been made to support its evolution. For example, amendments to the *Public Hospitals Act, 1990*, and long-term care legislation have enhanced the NP role in hospital outpatient and emergency de-

partments and in long-term care homes.

NPs today work mainly in primary care settings, such as community clinics, family health teams, long-term care homes and physician offices. Many practice in remote communities with limited access to health care services. Ontario currently has about 800 primary care NPs, and about 400 nurses with NP training also work in acute care, mainly in hospitals in highly specialized areas such as cardiac, neonatal care and emergency.

A large body of research confirms the role played by NPs in a range of care settings and across the care continuum.

NPs provide one answer to meeting current and future needs regarding health human resources and skill shortages.

Both in Canada and other countries, the NP role has been introduced to complement and improve access to health services, not simply as a replacement or substitute for physicians or other providers.

## ONA Participates in Ontario NP Consultation

ONA has participated in a number of Ministry of Health and Long-Term Care (MOHLTC) consultations regarding the role of Nurse Practitioners (NPs).

In September 2009, ONA provided comments to the Standing Committee on Social Policy on Bill 179, the *Regulated Health Professions Statute Law Amendments Act, 2009*, with respect to expansion of the Registered Nurse (RN) and NP scope of practice.

Among ONA recommendations for NPs was authorizing their open prescribing of pharmaceuticals. For a full account of what the final legislation includes, see story “*Nurse Practitioners – Expanded Powers Means Better Access*” on page 3.

Most recently, in September 2010, ONA provided feedback on the HealthForceOntario consultation document on hospital

in-patient admit/discharge by NPs.

ONA indicated the process currently in place does not follow best practice for continuity of care. Currently, NPs provide primary care in outpatient family practice settings utilizing their full scope of practice, as well as additional scope with medical directives. With the collaboration and consultation of specialists as required, NPs provide primary care as well as complex chronic disease management.

However, when a client requires admission to hospital with current restrictions on NP practice, he or she must be assessed by the emergency physician. After admission, he or she is then cared for in hospital by the Hospitalist (a physician who provides care to clients who do not have a family [general] practitioner with privileges to practice in hospital).

A University of British Columbia (UBC) Health Services and Policy study described the importance of primary care, with particular emphasis on continuity of care – the continuous relationship, sustained over time, between patients and their care providers.

Since NPs provide primary care to their clients, ONA believes it is essential they follow their clients through the spectrum of a hospital admission.

NPs have the potential to contribute significantly to the improvement of health care delivery in Canada. Failure to extend NPs the authority to admit, treat, transfer and discharge to inpatient settings restricts the efficient and effective practice of NPs, contributes to increased wait times and higher costs, and represents an un-

# Nurse Practitioners – Expanded Powers Means Better Access

In December 2009, the Ontario government passed into law Bill 179, *the Regulated Health Professions Statute Law Amendment Act, 2009*, providing Nurse Practitioners (NPs) and other health professionals license to provide a wider range of health care services.

Although sections of the law still require proclamation because they require regulations to existing legislation, such as the *Nursing Act, 1991*, and the *Regulated Health Professions Act, 1991*, Bill 179 expands the scopes of practice for some health care providers and increases access to care for Ontarians by:

- Allowing NPs, pharmacists, physiotherapists, dietitians, midwives and medical radiation technologists to deliver more services than they now provide.
- Changing the rules for administering, prescribing, dispensing, selling and using drugs in practice for chiropractors

and podiatrists, dental hygienists, dentists, midwives, NPs, pharmacists, physiotherapists and respiratory therapists.

- Removing restrictions on x-rays that can be ordered by NPs and enabling physiotherapists to order x-rays for specific purposes.
- Removing restrictions on the drugs NPs may prescribe, dispense, compound and sell.

“This is a good step forward to address issues of access to care and wait lists by expanding the scope of practice of our NP members, enabling them to fully utilize their skills, competencies and education, and granting patients more choice,” said ONA President Linda Haslam-Stroud, RN. “This initiative provides our NP members opportunities to maximize their contribution to the delivery of accessible, high quality public health care services in Ontario.”

Previously, the acts of prescribing and

dispensing drugs have, with few exceptions, been reserved for physicians and pharmacists. However, the new legislation allows numerous non-physician health care professionals such as NPs to perform these “controlled acts” as part of their professional practice. So while the spectrum of drugs is still limited by the regulations versus an open right to prescribe, NPs can now prescribe, dispense, compound or sell those drugs designated in the regulations.

The Ontario government is now in the public consultation phase for expanding the NP role further by developing regulations to allow NPs to admit, discharge and transfer hospital in-patients.

ONA has submitted a response to the government’s call for consultation on this issue. (See story “*ONA Participates in Ontario NP Consultation Process*” on page 2.)

Other provincial government initiatives for NPs include the development of NP-led clinics in Ontario. (See Story “*Innovative NP-led Clinics Boost Access to Primary Care*” on page 7.)

## Process

fortunate step backwards in terms of promoting client safety and access to health services.

MOHLTC has indicated it will meet with groups such as ONA and individuals to further explore key issues related to NPs admitting, discharging and transferring hospital in-patients.

### References

<http://www.npao.org/Uploads/Mythbusters%20CHSRF%20NPs.pdf>

<http://www.chspr.ubc.ca/research/patterns/continuity>

<http://www.npao.org/specialty.aspx>

[http://www.rnao.org/Storage/67/6119\\_Bill\\_179\\_Consultation\\_Document\\_Questionnaire\\_-\\_RNAO\\_response\\_final.pdf](http://www.rnao.org/Storage/67/6119_Bill_179_Consultation_Document_Questionnaire_-_RNAO_response_final.pdf)

## Regulations Would Expand NP Scope of Practice

Subject to regulations and amendments to other pieces of legislation, Bill 179 will further allow NPs to perform diagnostic functions such as ultrasounds, set or cast a fracture or dislocation of a joint and order an x-ray or a CT scan.

Other acts NPs would be granted authorization to perform with regulatory changes include:

### Under the *Regulated Health Professions Act, 1991*

- Order the application of sound waves for diagnostic ultrasound without restrictions.
- Apply certain forms of energy.
- Order the application of electromagnetism for magnetic resonance imaging.

In addition to Bill 179, the College of Nurses of Ontario (CNO) has requested changes to a number of regulations that would allow NPs to:

- Order treatment and diagnostics for in-patients in hospitals.
- Remove restrictions on lab tests and ultra sound.
- Allow NPs to perform point-of-care lab tests.
- Apply specified forms of energy (e.g. defibrillation).
- Order MRIs, among other forms of energy.

# Did You Know?

**Source: HealthForceOntario.ca**

As of August 2007, the title Nurse Practitioner (NP) became a protected title in Ontario. Only nurses in the Extended Class can use this title.

There are four NP specialty certificates in the Extended Class: NP-Primary Health Care, NP-Pediatrics, NP-Adult and NP-Anesthesia.

## Primary Health Care NPs

- Generally work in community settings and provide standard primary health care services to people of all ages.
- For many people, primary health care NPs are their first and most frequent point of contact with the health care system.
- Examples of the types of health care services provided by primary health care NPs include:
  - Annual physicals.
  - Patient counseling (e.g. mental health, family planning, medication compliance).
  - Health promotion (e.g. smoking cessation).
  - Immunization against diseases, screening for diseases.
  - Treatment for short-term acute illnesses (e.g. infections, minor injuries).
  - Monitor patients with stable chronic illness (e.g. diabetes).
  - Referrals to other health care services (e.g. home care services).
  - Referrals to social services (e.g. housing supports).

## Adult and Pediatric NPs

- Tend to work in hospital settings and provide specialized health services to people with specific health conditions (e.g. neonatal care, cardiovascular disease, diabetes, cancer).
- Although many of these NPs provide health services to patients hospitalized with acute and/or critical illness, they also monitor and treat patients who are ambulatory and living with chronic illness.

- Examples of the types of health care services provided by adult and pediatric NPs include:
  - Patient counseling (e.g. understanding illness progression, treatments).
  - Health promotion (e.g. infection control).
  - Treatment for acute/chronic/urgent illness.
  - Procedures (e.g. defibrillation).
  - Monitor patients with chronic conditions (e.g. diabetes).
  - Referrals to other health and social services (e.g. social work, dietitians, pharmacists).

## Anesthesia NPs

**Source: College of Nurses of Ontario**

- Will help alleviate surgical wait times and improve access to patient care.
- Will facilitate access to surgery, particularly in remote and northern communities.
- The NP anesthesia role is broader than surgical and includes palliative care and pain management.

## What NPs mean for the people of Ontario

A 2003 Ontario study showed that 87 per cent of patients surveyed were very satisfied with the care or advice they received from NPs.

Studies also show that patient outcomes are either the same or improved when NPs participate in patient care.

Some examples of the positive effect associated with NP involvement include: shorter length of hospital stay; improved compliance with clinical practice guidelines; better coordination of patient care; lower rates of clinical complications; lower mortality rates; and improved interprofessional team collaboration.

Because of their positive contributions and the ability of NPs to improve access to health services, Ontario is increasing the supply of NPs so that more people can benefit from their services.

## More NPs in Ontario Than Ever!

Since 2007, Ontario has seen a rapid rise in the number of Registered Nurses in the Extended Class (RN-EC), or Nurse Practitioners (NPs), employed in nursing.

According to College of Nurses of Ontario (CNO) statistics, there were a total of 729 NPs working in Ontario in 2007 (575 full-time, 132 part-time and 22 casual). The following year, 2008, that increased to 868 (701 full-time, 151 part-time and 16 casual) in 2008.

By 2010, there were a total of 1,486 NPs working in Ontario (1,231 full-time, 210 part-time and 45 casual). That's a 49 per cent increase in the number of NPs working in Ontario since 2007!

# Challenges on the Front Lines

**ONA Nurse Practitioner (NP) members are pleased to see the initiatives being taken to expand their scope of practice and to maximize their skills and education. There are some challenges on the front lines however. Here's what they have to say:**



**Lisa Ladouceur, Primary Health Care NP**  
Georgian Bay General Hospital, Local 92

My clients are rostered to me and not to a physician, which gives me a lot more autonomy to manage their care than NPs who work within community health care or family health teams. It is extremely rewarding. Government regulations will give NPs the ability to practice to their full capability, beyond medical directives, once restrictions on our scope of practice are dissolved under Bill 179 in such areas as prescription orders and the admission, transfer and discharge of our clients in hospital. We still continue to deal with interdisciplinary conflict regarding role definitions and duplication of what other providers deem to be their scope. For example, physicians can be territorial and sometimes unwilling to practice, collaborate or consult with NPs because they feel it is a duplication of service. However, I believe the NP role is one of health promotion, disease prevention, and the management of chronic disease, while the physician's focus is on complex medical conditions. I think this difficulty in understanding our role difference is why community health centres and NP-led clinics struggle to find collaborative physicians. But when NPs and interdisciplinary

professionals work together collaboratively, it means the best care for the patient. I'm privileged in that I work with a collaborative physician that not only works with me for the benefit of my patients when needed, but who uses my expertise in nursing and medicine for the benefit of his patients. It's drawing from a different perspective than his, which lends to a more holistic approach in patient care.

**Gloria Nacinovic, Community NP**  
Thunder Bay District Health Unit, Local 14

There have been many challenges and barriers in being an NP. Change has been very slow. There was a significant amount of work done by a dedicated group of community-based NPs to get legislation passed. In the mid-1990s, NPs compromised in order to see legislation passed,

which proved to be barriers to practice. Although there has been some progress in rectifying these barriers, it has been slow to come to fruition. Our counterparts in other provinces have learned from Ontario's experience and seem to have moved forward more rapidly in terms of scope of practice and legislative support for the role. It is good to see some expansion in our scope of practice, and good to see NPs working in a variety of sectors such as hospitals, family health teams and community-based agencies like CCACs, CHCs and public health units. As an NP working in public health, my biggest barrier to practice is the issue regarding referrals to specialists. I also would like to see NPs being able to admit, transfer and discharge hospital patients, which I understand is being addressed through legislation. In addition, I believe harmonization of salaries is important to NPs. The relationship we are able to form with our patients and public support and recognition of our role has been rewarding. To see a steady increase in the number of NPs in the province is exciting. As I said, we aren't there yet, but we are making progress.

## ONA NPs Have Their Say!

More and more NPs are joining ONA Bargaining Units or have become members through arbitration and other legislative means.

In view of that, on September 29, 2010, ONA gathered together a group of 11 NPs for a focus group to talk about what they see are the key issues affecting their practice and role within the health care system.

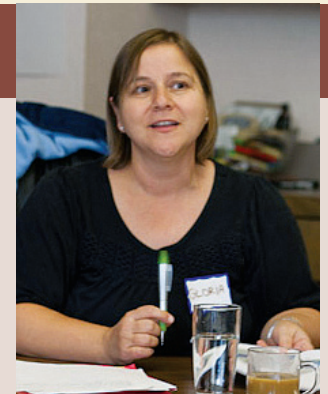
The focus group had three objectives:

- Identify NP issues around workload, salaries and unionization.
- Give ONA guidance on issues of importance to NPs to pursue in bargaining.
- Gain a better understanding of the NP's role and employer expectations.

To prepare for the focus group, ONA developed a short on-line survey for our member NPs accessed through our website at [www.ona.org](http://www.ona.org). We received a very high response rate.

The information garnered from the survey helped form the discussion topics for the focus group.

A report and photos from the focus group will be included in the next edition of *Front Lines*.



# The Road to Respect and Recognition

Nurse Practitioners (NPs) were introduced more than 40 years ago in Canada to help improve access to health care services. In the late 1980s, education was developed for NP roles in primary health care, and in the specialized hospital-based care of neonatal, pediatrics and adult.

Federal legislation was passed in 1998 to expand the scope of practice for NPs, and currently 12 of 13 provinces and territories have enacted legislation to support NPs.

Since the 1980s, even before legislation, regulations and financial support for NPs were put in place, Ontario experienced a gradual increase in NPs employed in hospitals. Now, according to the Nurse Practitioners' Association of Ontario (NPAO), approximately 60 per cent of all Canadian NPs work in Ontario, with more than 400 working in hospitals.

As Ontario and other provinces strive to improve human resource planning and utilization, more and more resources are being put into NP programs as a solution to problems of accessibility and staffing.

In Ontario, a number of initiatives have been put forward by the Ministry of Health and Long-Term Care (MOHLTC) to support the increasingly significant role of the NP. The following highlights the critical path taken towards more respect and recognition for Ontario's NPs:

**FEBRUARY 1998** – The *Expanded Nursing Services for Patients Act* amends the *Regulated Health Professions Act* and *Nursing Act* (as well as other legislation) to provide NPs in the province of Ontario with an expanded scope of practice. With these amendments, NPs registered in the College of Nurses of Ontario (CNO) Extended Class are given the authority to communicate a diagnosis, order specified tests, such as diagnostic ultrasound or x-rays, order electrocardiograms

in non-acute circumstances, prescribe and administer specified drugs and order specified laboratory tests. Pursuant to the *Expanded Nursing Services for Patients Act*, CNO regulates the NP scope of practice.

**APRIL 2002** – Ontario announces a comprehensive Advanced Practice Nursing Strategy, which included policy, regulatory and legislative changes that will enable all nurses to take on greater responsibility for patient care within their scope of practice.

**JUNE 2002** – MOHLTC initiates the NP Integration Study, which is designed to:

- Identify the factors that help and hinder the integration of Primary Health Care NPs (PHCNPs) in practice teams, care settings and the health care system.
- Describe the impact PHCNPs have had on access, quality, outcome, innovation and satisfaction.
- Make recommendations about the data required to continue to evaluate PHCNP practice.

**MARCH 2003** – MOHLTC completes Phase 1 of a policy, regulatory and legislative review to identify and eliminate barriers that prevent primary health care NPs from practicing at their full scope. Amendments are made to remove barriers to the Registered Nurse - Extended Class (RN-EC) scope of practice in hospitals (*Public Hospitals Act* – Regulation 965) and to recognize their role in providing care in long-term care facilities.

**JANUARY 2004** – A study is completed further evaluating the barriers that impact on the integration of NPs into different practice settings and models across the continuum. The study includes 29 recommendations to remove further barriers, including economic, scope of practice, education and human resources.

**JANUARY 2005** – MOHLTC commits to creating an additional 348 NP positions over the following three years. In addition, the Ontario government invests \$1.7-million annually for NP education programs.

**FEBRUARY 2006** – MOHLTC unveils its "Grow Your Own NP" program as part of its commitment to provide more families with access to primary health care, and to support the recruitment and retention of nurses. The program, intended to fill vacancies among government-funded NP positions, provides funding currently allocated to an NP position to sponsor a local RN to obtain her/his NP education. The funding covers salary while the RN is in school, and reimburses education-related expenses. In exchange, NPs must agree to a return-of-service commitment.

**FEBRUARY 2007** – MOHLTC announces funding of \$13.7-million to alleviate pressures in hospitals by building capacity of community-based health care providers under the Geriatric Emergency Management (GEM) program. GEM is intended to divert the elderly away from hospitals by bringing geriatric NPs into emergency rooms to help elderly patients sort out practical issues to get them home more quickly. The funding will: increase home care and community support services; increase CCAC staff in hospitals to allow faster access to community services for hospital patients; and implement geriatric emergency management programs in specific hospitals to increase emergency department nursing services for seniors with complex functional and/or psychological challenges.

**MARCH 2007** – The NP Integration Task Team submits its report to MOHLTC on the Integration of Primary Health Care NPs in Ontario. The Task Team provided 31 recommendations to support further integration of NPs into Ontario's health system.

**AUGUST 2007** – CNO notifies its members that legislation has passed protecting the

# Innovative NP-led Clinics Boost Access to Primary Care

title of “Nurse Practitioner.” As such, only RNs in CNO’s Extended Class have the authority to use the NP title. While the NP-Primary role has been regulated since 1988, CNO now has the authority to regulate three new NP specialties in the Extended Class: NP Pediatrics, NP-Adult and NP-Anesthesia.

**AUGUST 2007** – The Ontario government announces it is investing \$24.5-million to create 80 additional training spots to increase NPs and midwives.

**MARCH 2008** – Ontario announces funding of \$38 million over three years to create a target of 25 NP-led clinics to be implemented by 2012. Three of the clinics are established in 2008. Plans for the clinics were actually unveiled earlier in 2007, as part of the Family Health Care for All strategy.

**FEBRUARY 2009** – MOHLTC selects three sites for new NP-led clinics, Sault Ste. Marie, Belle River Township of Lakeshore and Thunder Bay, from the “Wave 1” call for applications.

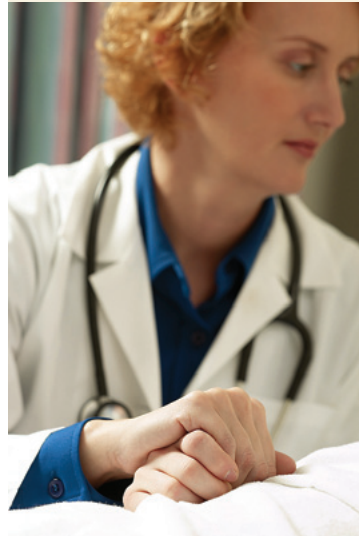
**JUNE 2009** – In the “Wave 2” call for applications, eight NP-led clinics are awarded: Essex County, Canadian Mental Health Association, Belleville, Glengarry, Huronia, Georgian (Barrie), French River and Anishnawbe Mushkiki (Thunder Bay). A “Wave 3” call for applications is planned for 2010.

**DECEMBER 2009** – Bill 179, the *Health Professions Statute Law Amendment Act*, expands the scope of practice for NPs.

**JANUARY 2010** – Ontario’s “Grow Your Own NP” program is extended.

**JANUARY 2010** – The Erie St. Clair LHIN hires eight positions related to geriatrics and palliative care, including NPs, RNs and Advanced Practice Nurses (APNs). In hospitals, NPs liaise with long-term care facilities. In public health and nursing homes, they are usually one position.

**SEPTEMBER 2010** – Forty-four participants have successfully completed the Ontario “Grow Your Own NP” program and are now working in 38 provincial health care organizations.



In August 2010, the Ontario government announced 14 new Nurse Practitioner (NP)-led clinics would be created across the province. A total of 25 NP-led clinics will be established and fully operational in Ontario in 2012.

Ontario’s first NP-led clinic opened in Sudbury in 2007 and provides primary health care to about 3,000 patients. The Belleville clinic, which opened this past August, serves 3,200 patients.

NP-led clinics are intended to improve access to primary care for more than 40,000 Ontario residents.

Funded by the Ontario Ministry of Health and Long-Term Care (MOHLTC), NP-led clinics are an innovative model for delivery of comprehensive primary health care, in which NPs are the lead providers of primary health care. One of the unique features of the NP-led clinic model is its incorporation of nursing leadership.

With the authority to treat common illnesses and injuries, order lab tests, x-rays and other diagnostic tests, NPs work with other health care providers to provide optimum care.

Through a collaborative practice approach that includes Registered Nurses, Registered Practical Nurses, family physicians and other health care professionals, NPs provide comprehensive, accessible and coordinated family health care services to populations that don’t have access to a primary care provider.

NP-led clinics improve the quality of care provided to communities, working with public health units and public health nurses to provide enhanced health promotion, disease prevention and chronic disease management, as well as improved care coordination and navigation of the health care system at the local level.

NP-led clinics also work with other community-based care providers and provide the same comprehensive family health care services as other family practice models, with the key difference being that NPs lead at all levels of the organization, i.e. governance, clinical practice and day-to-day operations.

NP-led clinics differ from walk-in physician clinics in that they provide comprehensive health care over the lifetime of patients.



# Nurse Practitioners Moving to the Forefront

## Unregulated Physician Assistants a Cause for Concern

On May 3, 2006, the Ontario government announced a new classification of health care provider, the Physician Assistant (PA), which assists supervising physicians to deliver medical services within patient care teams in various settings.

Under the direction of the supervising physician, these services may include conducting patient interviews, histories, physical exams, performing selected diagnostic and therapeutic interventions, ordering and interpreting patient laboratory and radiological results and counseling patients on preventive health care.

In April 2009 and September 2009 respectively, the Ministry of Health and Long-Term Care (MOHLTC) announced funding for 20 PAs to work in emergency departments and 15-20 PAs to work within Family Health Teams (FHTs).

ONA has grave concerns about this alarming trend towards using PAs, an unregulated health care provider that is not subject to consistent standards of practice and supervision as determined by a regulatory body such as the College of Nurses of Ontario (CNO), which regulates Registered Nurses (RNs), Registered Practical Nurses and Nurse Practitioners (NPs).

In contrast to NPs, PAs do not work autonomously as independent practitioners, and as such do not bring greater efficiency to the health care system. All their work must be supervised by a physician, who is legally responsible for all the PA's client care, although there is no legal requirement for a physician to be physically present and is only required to be accessible for verbal consultation at all times.

NPs, on the other hand, treat patients independently and bring a nursing perspective with a strong emphasis on health promotion and disease prevention, in addition to the restorative and curative components of care.



NPs also have a much stronger education background, requiring four years of BScN education and a minimum two years of clinical practice prior to entering an NP program. Contrast that to the limited pre-requisite education for application to an Ontario PA program.

Also of concern is the significant cost to the health care system of a PA, with earnings comparable or higher to a more educated and experienced RN at the top rate of pay.

ONA Local and Bargaining Unit leaders have been alerted to watch for violations of the collective agreement as it relates to assigning duties and responsibilities in accordance with the *Regulated Health Professions Act*, and the impact on quality care.

In addition, ONA is going to be monitoring these positions to see if they encroach on the job description, profile or duties of the NP, RN or other ONA classifications.



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