RNs and RPNs – Room for Both, So What's the Issue?

Employer actions in recent years have clearly threatened the job security of ONA's RN members, and/or interfered with their ability to meet their professional obligations.

In a time of fiscal restraint, one way employers have chosen to cut costs – aside from downsizing the nursing workforce and reducing nursing care hours – has been to transfer work from higher-paid RNs to lower-paid classifications like RPNs or unregulated care providers (UCPs).

Protecting our members' jobs and their professional status is of paramount concern for ONA. This feature section looks at the current trend towards replacing RNs with RPNs, which in many workplaces is creating an inappropriate skill mix that ultimately threatens the quality of patient care.

We also look at labour relations strategies ONA is utilizing to protect our members from job dislocation and downsizing and what you as a front-line ONA member can do to educate and protect yourself in this scenario.

ONA believes there is room for both RNs and RPNs within the health care system. However, we firmly believe that government and employers should stop balancing budgets on the backs of nurses and our patients, residents and clients.

Both RNs & RPNs Have a Role in Health Care

While ONA believes there is room in the health care system for RNs and RPNs, both valued, professional nursing care providers with integral skills and functions, each must practice within their scope of practice and in accordance with their ongoing nursing knowledge and competencies.

Practice differences exist between the RN and RPN in the performance of certain patient care activities. As the regulatory body for both the RN and RPN, the College of Nurses of Ontario (CNO) sets professional standards and practice guidelines that guide all nurses' practice. The appropriate category of nurse to provide care is determined based on characteristics of the patient population and the stability and predictability of the patient care environment. These factors also influence the level of autonomy and the degree of consultation necessary to ensure safe quality patient care.

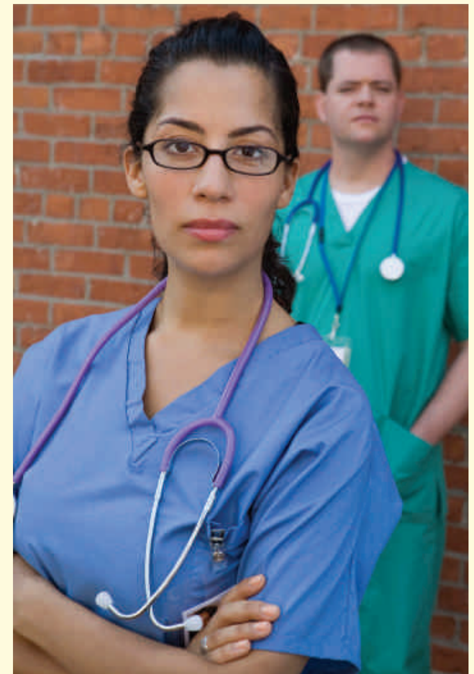
The main difference between the RN and RPN is the foundational knowledge based on their nursing education and the entry to practice requirements. Their roles are further influenced by ongoing education, professional development and nursing knowledge.

For RNs, entry to practice now requires a four-year baccalaureate in nursing (BScN or BN). Because RNs have more comprehensive education, they have a more in-depth and broader knowledge base to draw on in areas such as clinical practice, critical thinking and research utilization. They can work in any setting and with any type of patient, and can care for clients with any complexity of needs in unpredictable situations and in any environment, whether in surgical units, long-term care, home care settings, intensive care settings or emergency departments.

RPNs now require a college diploma in practical nursing obtained over two years. Their education is more focused and less in-depth. As such, RPNs are more appropriately utilized for the care of patients with less complex needs and with more stable and predictable conditions.

Skill Mix Key to Quality Patient Care

According to CNO's *Practice Guideline on the Utilization of RNs and RPNs (2009)*, an appropriate skill mix is critically important to provide



quality patient care. Health system decision-makers must consider the appropriate utilization of RNs and RPNs in the practice setting for more efficient and effective patient outcomes.

Competencies and nursing knowledge must be considered when the skill mix is changed, i.e., when reorganization occurs or a reconfiguring of the ratio of RNs to RPNs, such as with a model of care change. As well, there is a growing body of research that demonstrates a strong link between a higher percentage of RNs in the staff mix and nursing-sensitive patient/client outcomes.

While all nurses practice from the same scope of practice, the level of autonomy and amount of consultation required for each category of nurse varies depending on the category of nurse, the complexity of the client and the stability of the environment. However, health-care agencies are interpreting CNO standards and guidelines in the current fiscal climate

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and applying inappropriate skill mixes aimed at bringing down costs. Driven more by cost and budgetary pressures than quality, they are thus decreasing the number of RNs despite a concurrent increase in patient acuity.

The shared legislated scope of practice for RNs and RPNs is also causing confusion for nurses, employers, the public and even nursing organizations related to which category of nurse is prepared to meet the varying needs of patients.

The relationship between RN staffing levels and better patient outcomes has been the focus of many nursing research studies. In studies of medical and surgical patients, it was found that a higher proportion of RN hours in the staff mix resulted in shorter lengths of stay, lower rates of urinary tract infections, lower rates of upper gastrointestinal bleeding and lower rates of pneumonia, shock or cardiac arrest and failure to rescue.

Further, not only does a higher RN ratio reduce the number of negative patient outcomes and increase patient safety, it does so without increasing costs (*Canadian Nurses Association, Research Summaries Regarding Nurse Staffing, January 2005*).

When the patient's acuity, complexity, stability and predictability indicate that a patient requires the care of an RN, ONA believes that an RN should be assigned to provide that care. This ensures the best possible care and positive outcomes of the patient. This is supported by a plethora of research and will provide continuity of care and caregiver. It will also prevent fragmentation of care and the increased potential risk of negative patient outcomes.

Why this is Important

Changes to both RN and RPN nursing programs have led to a blurring of roles for the two categories, creating a need for clarification and a way to clearly delineate the two roles within the health care system.

New practical nurse program standards established by the provincial Ministry of Training, Colleges and Universities in January 2005 comply with CNO's professional standards, practice expectations and entry to practice requirements for Ontario RPNs. However, these changes have put job security and the professional role of RNs at risk, given the difference in compensation levels. With RNs earning higher incomes, employers now have an economic incentive to move work from RNs to RPNs.

However, when RPNs are assigned clients whose acuity and complexity are inappropriate for them, they are at risk of working beyond their scope of practice and compromising their professional standards.

Subsequent actions by the College have also caused further alarm. In 2010, CNO circulated for pre-consultation a draft guideline document: *Working Together: RNs, RPNs and Unregulated Care Providers (UCPs)*. ONA found that the document, which merged three separate guidelines on utilization of RNs, RPNs and UCPs, not only failed to distinguish between RNs and RPNs and to provide clarity around their utilization, it was "vague, confusing and hard to understand."

In September 2010, a letter to CNO President George Fieber and Executive Director/Chief Executive Officer Anne Coghlan, from ONA President Linda Haslam-Stroud, RN, explained why ONA could not support the draft document.

"We do not feel these draft guidelines support patient safety and we are concerned that implementation without significant

What You Can Do

As a front-line RN or RPN, you should identify and articulate the RN skills that are beyond the scope of practice of the RPN, and become familiar with the decision factors in CNO's *Practice Guideline on the Utilization of RNs and RPNs*.

Become familiar with CNO's *Three Factor Framework: The Nurse, The Client and The Environment*. The factors necessary in determining the appropriate category of nurse are based on patient needs and the environment in which the care is being provided. All three factors must be considered and evaluated for relevant importance:

- **The Nurse:** Each category of nurse has a set of specific competencies. Evidence supports that practice differences between RNs and RPNs exist in the areas of knowledge, application of knowledge, leadership and decision-making. Identifying the practice expectations within these areas will impact the decision on the appropriate category of nurse to provide care and influence the degree of collaboration and consultation required.
- **The Patient:** Overall care requirements are influenced by client acuity and the complexity of care needs, the predictability of outcomes of care and the risk of negative outcomes in response to care. The overall care requirements can be placed on a continuum from less complex to highly complex.
- **The Environment:** Includes such aspects as the stability/predictability of the environment, the available practice supports and consultation resources and other environmental factors. All must be part of the evaluation process to support nurses in clinical decision-making. The less stable these factors are, the greater the need for RN staffing.

In addition, employers, non-nurse care teams and patients also need to be aware that technical performance of a patient care intervention by a nurse is always accompanied by a specific level of cognitive ability, such as critical thinking, decision-making and professional judgement.

Cognitive ability is gained through foundational knowledge, ongoing learning and knowledge application. The foundational knowledge of RNs and RPNs differs in the depth and breadth of knowledge, thus the level of autonomous practice is different.

RNs meet the nursing needs of clients regardless of the complexity of their conditions in all practice environments.

RPNs have greater autonomy when caring for clients with less complex conditions but require consultation and collaboration to meet more complex client care needs.

changes will put client safety at risk," said Haslam-Stroud in the letter.

"As you are aware, nursing employers across the province are making decisions to implement skill-mix changes that are being driven by severe budgetary pressures. Our experience has been that these employers are not ensuring that client assignments are being made safely in accordance with the current *Three Factor Framework – The Nurse, The Client, The Environment,* nor are they ensuring both nurse administration/managers and front-line nurses are even knowledgeable regarding how to interpret and implement the Framework."

In closing, Haslam-Stroud wrote, "We represent the majority of front-line RNs in the province and are advocating for a document that provides clarity to RN/RPN utilization and allows our members a practical application to guide decision-making."

Recently in June 2011, a year after the first document was issued, CNO came out with a new draft document now named *"The Three Factor Framework,"* which continues to merge three separate guidelines on utilization of RNs, RPNs and UCPs. This draft document reflects some of ONA's suggested amendments, which came out of our feedback in 2010. However, ONA still has many of the same serious concerns, and provided further feedback to CNO in July 2011.

Specifically, ONA remains concerned that some of the terminology is still unclear or vague and open to misinterpretation, and that the omission of elements from the original practice guideline promotes lack of clarity, confusion and misunderstanding.

"The practice guideline must be comprehensive, clear and easy to interpret, and apply to both administrative and front-line nurses," said Haslam-Stroud.

In 2010, Haslam-Stroud called for a meeting with CNO, the Registered Nurses' Association of Ontario (RNAO) and the Registered Practical Nurses Association of Ontario (RPNAO) to discuss the draft document further, but the CNO has not responded to this request.

Using the PRC Workload Form to Deal with Skill Mix Concerns

- Use the terminology/words found in CNO's *Three Factor Framework,* as well as CNO's practice standards and guidelines, when filling out Professional Responsibility Workload Report Forms (PRWRF). The PRWRF is one of the most important tools ONA has in its arsenal to deal with workload issues impacting on quality patient care.
- Explicitly link the practice concerns related to issues such as the model of care, patient assignment, or category of nurse assigned, etc., to the impact on your ability to deliver safe, proper nursing care.
- Document any nursing intervention or care that is delayed or not done at all, i.e., what is the impact to the patient and what is missed, delayed or not completed. A few examples include delayed or missed medication delivery, missed assessments, or treatments, less than required or expected turning and/or repositioning, etc.
- Document details of the occurrence, working conditions, patient care factors (changes in acuity) and recommendations (i.e., adjust RN staffing).

Using the workload form and the Professional Responsibility Complaint (PRC) process is a highly effective way to address concerns related to skill-mix changes.

When ONA members use the CNO *Three Factor Framework* to document concerns related to appropriate category of care provider and present this information to administrative nurses, they are meeting their professional standards and accountabilities.

Where to Find Help

- Consult with your Bargaining Unit representatives, who may in turn consult with ONA staff, i.e., your Labour Relations Officer (LRO) and/or Professional Practice Specialists.
- Utilize the PR workload report forms in situations where you are not able to meet your standards and practice expectations. These can be obtained from your Bargaining Unit and Local leaders.
- Visit ONA's Professional Practice section on our website for more information and to download a copy of our member guide *Professional Practice Concerns and Professional Responsibility Complaints* at *http://www.ona.org/professional_practice.html.*
- Review the CNO learning modules at *www.cno.org/prac/learn/modules/utilization/index.htm.*
- You can also contact CNO's Practice Support line at 1-800-387-5526 or 416-928-0900 (in Toronto). See the CNO website for more contact information at *www.cno.org.*

Other Resources

- CNO, *2008 Practice Guideline on Utilization of RNs and RPNs* at *www.cno.org.*
- CNO *Standards of Practice* at *www.cno.org.*
- Canadian Nurses Association (CNA) 2003 Position Statement on *Staffing Decisions for the Delivery of Safe Nursing Care* at *http://www.cna-nurses.ca/cna/documents/pdf/publications/PS67_Staffing_Decisions_Delivery_Safe_Nursing_Care_June_2003_e.pdf*
- ONA Hospital Collective Agreement (Central and Local Issues) on ONA's website in the Hospital Sector section.at *www.ona.org*
- CFNU *Enhancement of Patient Safety through formal Nurse-Patient Ratios: A Discussion Paper http://www.nursesunions.ca/report-study/enhancement-patient-safety-through-formal-nurse-patient-ratios-discussion-paper-october*

For ONA Bargaining Unit and Local Leaders

Log onto the Local Executive section at *www.ona.org* for the following manuals:

- *Bargaining Unit and Local Executive Accountabilities with Role Descriptions.*
- *ONA Guide to Job Security and Professionalism.*

An ONA Win! IAC Backs Sault RNs Concerns over Hemo Staff Mix

Documenting Workload Issues Results in Recommendations for Improvements

An Independent Assessment Committee (IAC) made a number of recommendations in April to address staffing and workload concerns raised by RNs who work on a renal hemodialysis unit at Sault Area Hospital (SAH).

Chief among their concerns was that the hospital had replaced RN positions with RPNs, although the patients in the unit suffer from complex conditions with unpredictable outcomes that require the broad scope of practice, skills, competencies and experience of RNs.

As a result of its investigation, the IAC recommended:

- The ratio of RPNs should not increase beyond 10 per cent of the total nursing skill mix as the renal unit patient population is at the very lower limit of being able to support an RN/RPN skill mix.
- The employer should implement a patient assessment tool to clearly identify the patients who can be safely cared for by autonomously practicing RPNs, and develop a policy that identifies the patient conditions/situations where the RN is appropriate to provide safe and effective care.
- RPNs must not be assigned patients that are inappropriate for RPN care, even if this means calling in an additional RN.
- The renal program continues to have a full-time nurse educator position, which the IAC considers pivotal and should be staffed. However the position remains unfilled.

The IAC, a panel of three experts who conducted a hearing into the concerns of the renal RNs in late February, also confirmed the RNs' contention that they have been required to perform more work than is consistent with quality patient care.

"RNs have a professional obligation to provide safe patient care," said ONA President Linda Haslam-Stroud, RN. "We are very pleased the IAC has heard the evidence and acknowledged ONA nurses' concerns – and issued 30 recommendations to improve their ability to provide safe, quality care to hemodialysis patients."

After considering the evidence, the IAC concluded that the professional practice supports and decision-making tools provided by the hospital were insufficient to support the integration of RPNs into the unit. It also identified a lack of nursing management leadership during the planning and implementation of the RN/RPN skill mix, and stated there is no question the RNs' sense of trust and sense of "team" has been damaged and will need to be rebuilt.

"The IAC report found there was no vehicle for nurses to have a voice in terms of operational or clinical decision-making, and we are hoping these recommendations will give them that voice," said Haslam-Stroud. "We look forward to working with the employer to resolve these serious issues so hemodialysis patients can receive the care they so deserve."

Got a Question About RN/RPN Scope Issues? Ask CNO!

Recently, an RN working in an endoscopy recovery area of an Ontario hospital asked the College of Nurses of Ontario (CNO) Practice Liaison Officer about the role of RPNs in caring for/monitoring sedated clients.

The RN's unit had recently changed from an all-RN skill mix, resulting in staffing levels where one RN would be working with two RPNs. An RN would not always be physically present in the department, but would be "nearby for consultation."

The Practice Liaision Officer wrote back the following response: "…We have been very clear over the years that it is outside the scope of an RPN to monitor a sedated patient. Therefore it is inappropriate to have an RPN left alone in your recovery room. In fact, we have said in the past the RPN should not be part of the recovery team given the restrictions around sedation. It is more appropriate for the RPN to care for the client prior to the procedure. I hope this clarifies our stance."

Protecting Our Work and Quality Care

ONA has been tracking the deletion and addition of RN positions across the province for some time. At the June 2011 Provincial Coordinators Meeting (PCM), we reported that a total of 2,513 RN positions had been deleted to date in Ontario.

In fact, although 159 nursing jobs were created, they were offset by the loss of 2,672 positions. Of those, 1,357 were full-time.

"As a union, ONA is a strong advocate for its members, as well as the patients, residents and clients entrusted to their care," said ONA President Linda Haslam-Stroud, RN.

"When our members are losing their jobs, seeing their work improperly transferred or assigned to RPNs or even unregulated care providers, and when their livelihoods and careers are at risk, we look to do everything possible to fight on their behalf. As such, we are employing a number of strategies to deal with job displacements."

Strategies include:

- Grievances.
- *Public Sector Labour Relations Transition Act (PSLRTA)* applications.
- Jurisdictional Dispute (JD) applications.
- Professional responsibility workload complaints.
- Complaints to the College of Nurses of Ontario (CNO).

Regarding JD applications, when RPNs are moved into jobs and areas traditionally performed by RNs, either ONA or the RPNs' union can file a JD seeking a ruling from the Ontario Labour Relations Board (OLRB) on which group of workers, or professionals in this case, have the right to perform the work in question. ONA has filed a number of JDs to date, and continues to do so as the need arises.

While our primary position is that the lost work reverts to RNs, OLRB could impose other alternatives. One of the alternatives is to amend Bargaining Unit scope clauses to include both RNs and RPNs in a single Bargaining Unit. Because of the very clear community of interest between the two groups of professionals, ONA sees this as a viable alternative.

"As we know, health care is evolving and restructuring every year and ONA continues to look proactively at ways to best represent our members and ensure they can provide safe, quality care for their patients, residents and clients," said Haslam-Stroud.

ONA's Bargaining Unit leaders are monitoring for skill mix in recovery teams within your facilities caring for clients recovering from sedation. They are also well prepared on the procedures and processes for dealing with these issues for the protection of ONA members' jobs and quality patient care, so you can raise any questions you have with them.

You can also ask CNO specific questions on RN/RPN scope of practice issues. It is especially important to get any responses in writing. It is also very important to link questions to the specific fact scenario in your workplace, rather than asking generic or broad questions that may produce a generic or broad response.

Send your questions to CNO via e-mail, regular mail or fax. Write to: College of Nurses of Ontario, 101 Davenport Road, Toronto, ON. M5R 3P1. Send by fax to: (416) 928-6507.

To send your questions by e-mail, go to CNO's website at *www.cno.org*. Click on "Contact Us" and "E-mail the College," and then select the link "I am a nurse or applicant" to bring up an on-line form to fill out. Type your question right on the form.

Sample Questions to Ask CNO

1. Can an RPN be assigned to care for patients who are on cardiac monitors in the ER?
2. Can an RPN work independently in outpatient clinics such as pacemaker clinics etc. without an RN present or immediately available?
3. In a busy emergency room in a large city, there is an offload area staffed solely by an RPN. This is a busy area with a high turnover of patients. The initial triage was done by an RN but the reassessment and care of the patients is being done solely by the RPN; there is no RN present in the area – is this appropriate?
4. What should a nurse should do if requested to practice outside her scope of practice, or is directed to do something by someone else who is practicing outside her or his scope of practice?

For additional assistance, contact CNO's Practice Support line at 1-800-387-5526 or 416-928-0900 (in Toronto). See the CNO website for more contact information at *www.cno.org*.

Labour Relations Strategies to Protect Our Work

ONA believes the following principles should apply whenever job security issues arise:

- Maintain seniority rights.
- Adhere to the collective agreement.
- Provide for the right to union representation.
- Protect professional status.
- Adhere to the *Regulated Health Professions Act (RHPA)* and CNO Standards of Practice, and other statutes relevant to staffing levels.

In order to deal with the improper placement of RNs in the workplace, ONA exercises all legal options open to enforce our members' rights, including:

- Grievances alleging: improper layoff; failure to provide proper notice of layoff; failure to provide layoff options; failure to provide severance packages; improper contracting out of work assignments to non-Bargaining Unit staff; inappropriate assignment of duties and responsibilities that are inconsistent with quality patient care.
- Labour-Management Committee (i.e., Hospital-Association Committee) discussions or submissions.
- Professional responsibility complaints.
- Jurisdictional disputes at the Ontario Labour Relations Board (OLRB).
- *Public Sector Labour Relations Transition Act (PSLRTA)* applications.
- CNO complaints, where appropriate.
- Media statements or campaigns.
- Lobbying government officials.

ONA strategies are first and foremost to protect and retain the work of our members.

Bargaining Unit and Local leaders are well prepared on the procedures and processes for dealing with these issues for the protection of ONA members' jobs, for actively seeking to bring new positions into the Bargaining Unit if appropriate and to preserve quality patient care.

They will follow up on any new and expanded nursing roles/classifications for inclusion in the Bargaining Unit. This includes filing grievances and referring them to arbitration if required.

In addition to ONA Bargaining Unit and Local leaders in the hospital sector, ONA provides guidance and tools to leaders in other sectors (i.e., community and long-term care) to assist them on behalf of members in the case of layoffs, contracting out of Bargaining Unit work and assignments and minimum staffing.

Shouldice RNs and RPNs: Making it Work

The RNs and RPNs at Shouldice Hospital, Thornhill, just north of Toronto, are an excellent example of how the two classifications can work together as a team to provide quality care for their patients.

The secret to their success is ensuring that each classification has a voice both in the practice setting and in the union environment.

"My job is to make sure they know that ONA is there for them," says fifth-year Bargaining Unit President Marie-Claire Caron, an Operating Room nurse who represents approximately 67 nurses – virtually half-and-half RNs and RPNs.

"Our executives are a good mix of RNs and RPNs, which means they each have the opportunity to raise issues of importance to their respective classification. I personally set out to make sure we have good representation from both groups. We all work very well together," says Caron, who also serves as Vice-Coordinator for Local 16.

The Bargaining Unit executive consists of seven nurses, including an RPN Unit Rep, an RPN OR Rep, an RPN Grievance Rep and an RPN on the Negotiating Team, along with Caron and one other RN. In fact, an RPN was part of the original Bargaining Unit, first organized 11 years ago.

Caron says professional practice and skill mix aren't an issue at Shouldice because the RNs and RPNs function within clearly defined roles, although both groups would like the opportunity to see their roles expanded.

"On our surgical unit, our RNs and RPNs work well as a team within their defined roles," says Caron. "Quite a few of the RPNs have been working here for around 20 years or more so they have a lot of experience to draw on."

The RNs and RPNs are under one collective agreement at Shouldice, which does not participate in central bargaining. As such, the RN and RPN wage grids are set out separately in the collective agreement and there are differences in some conditions of work for the two classifications, such as vacation periods and different vacation accruel rates, as well as differences in shift and weekend premium pay. The RNs also have 10 steps on the grid (including the 25-year rate), while the RPNs have four steps, capping at three years. The contract expired in March and the group is heading into a new round of negotiations.

"RPNs know they are taking over RN jobs at some facilities because they are paid less, and they respect the concerns of RNs. But they don't want to be viewed as less important or less professional," says Caron.

"They want to feel every bit as well represented as RNs by their union. I tell them ONA works very hard on their behalf to make sure their rights are protected in the workplace. I think they will see this as more and more RPNs become part of the union," says Caron.

Caron understands the concerns of RPNs just about as thoroughly as she understands RNs because she worked as an RPN for 18 years prior to becoming an RN in 1996.

"I know where they are coming from because I've been there. And as an RN, I understand the RNs' issues too. I hope that is reflected in the job I do in representing them," says Caron.

Quality Care a Key Point in Arbitration Decisions

Replacing RNs with RPNs or unregulated care providers is creating challenging labour relations problems, and quality of care concerns in Ontario health care facilities, particularly in hospital and long-term sectors.

Article 10.12 (a) of ONA's Hospital Central Collective Agreement states as follows: "Nurses will be assigned duties and responsibilities in accordance with the *Regulated Health Professions Act* and other applicable statutes and regulations thereto. Hospitals will not assign such duties and responsibilities to employees not covered by this agreement unless those duties and responsibilities are appropriate to the position occupied by the person to whom the duties and responsibilities are being assigned and are consistent with quality patient care."

Under this language, there are two considerations:

1. Is it appropriate to assign RN duties to RPNs?
2. Is it consistent with quality patient care to assign the duties to RPNs?

Article 2.04(b) of the central nursing homes template says: "Reassignment to other employees of work normally performed by members of the Bargaining Unit shall not result in the termination, layoff or reduction in hours of any member of the Bargaining Unit."

One obvious limitation of this provision is that it only applies when at least one of our members is laid off, terminated or has her/his hours reduced. With respect to the scope of the work protected ("work normally performed"), there is a range of jurisprudence, both at ONA and elsewhere, especially on the issue of overlapping job duties.

On the negative side, one arbitrator held that if the work could be performed by RPNs, it did not qualify as work normally performed by RNs *(ONA vs. VON, Lanark Branch [Cantin, September 7, 1992])*. Other arbitrators have used more positive language that protects both the type and volume of work performed *(ONA vs. Little's Nursing Home [Tecumseh] Ltd. [R.J. Roberts, May 10, 1983]; ONA vs. Versa Care Centre [Harris, March 24, 1997];* and *ONA vs. Marshall Gowland Manor [Verity, January 23, 1997])*.

ONA has had a number of successful arbitrations regarding this issue, such as:

ONA vs. The Scarborough Hospital (Keller, November 17, 2005) – Laying off RNs to hire RPNs is not consistent with quality care in the circumstances of the case.

ONA vs. Hastings Centennial Manor (Brent, December 16, 2003) – RN must replace RN, even if this results in premium pay.

ONA vs. City of Kingston (Rideaucrest Home for the Aged) & CUPE (Mikus, August 15, 2000) [Board] – No one outside of the Bargaining Unit shall perform work normally performed by members of the Bargaining Unit.

ONA's Bargaining Unit and Local leaders are well prepared on the procedures and processes for dealing with these issues for the protection of ONA members' jobs and quality patient care.

Nursing by the Numbers

The number of RNs employed in nursing in Ontario increased by 10.56 per cent from 84,944 in 2003 (beginning of first Liberal provincial government term) to 93,916 in 2010, an increase of 8,972 RNs (5,289 more RNs from 2003-2007 and 3,683 more from 2007-2010).

That's according to College of Nurses of Ontario (CNO) 2010 statistics, supported by the Ontario government's Management Information Systems (MIS) payroll data.

For 2010, there was total increase in the number of nurses employed in Ontario, 2,753, breaking down as follows:

- 745 RNs (from 93,171 to 93,916).
- 1,642 RPNs (from 28,800 to 30,442).
- 366 for RN(EC) (from 1,120 to 1,486).

Ontario continues to show a 3:1 ratio of RNs to RPNs, even though employers continue to adopt skill-mix change, especially in the hospital sector. However, RPNs were employed in Ontario at a rate of almost 45 per cent greater than RNs in 2010.

Research Underscores Need for More RNs and Appropriate Skill Mix

There is considerable research showing a strong correlation between higher levels of RN staffing and lower patient morbidity and mortality rates, with better patient outcomes. Further, it emphasizes the importance of appropriate skill mix of RNs and RPNs. The following is from research supporting these views:

- When more RNs are working on a hospital unit and the amount of RN overtime hours are reduced, there are correlated lower readmission rates and visits to the emergency room within the first 30 days after hospital discharge. *(Quality and Cost Analysis of Nurse Staffing, Discharge Preparation and Post Discharge Utilization, Health Services Research, 2011.)*
- The risk of death increased on shifts in which RN hours were eight hours or more below target staffing levels, or where there was a high turnover of patients related to admissions, discharge and transfers. Staffing levels should be adjusted to account for the effect on workload and patient outcomes related to the number of admissions, discharges and transfers. *(Nurse Staffing and Inpatient Hospital Mortality, New England Journal of Medicine, 2011.)*
- A higher percentage of RNs on a shift was significantly associated with fewer falls and medication administration errors. Every shift must be adequately staffed with the right numbers, skill mix and experience level of nursing staff. *(Journal of Nursing Administration, 2011.)*
- Assignment of the most appropriate caregiver is based on the patient's complexity and care needs and the degree to which the patient's outcomes are predictable, with RNs assigned total nursing care for complex and/or unstable patients with unpredictable outcomes and RPNs assigned total nursing care for stable patients with predictable outcomes. *(RNAO Position Statement: Strengthening Client Centred Care in Hospitals, 2010.)*
- An appropriate nursing care delivery model and skill mix is paramount to optimize resident, staff and organizational outcomes. Access to RNs is linked to resident outcomes, such as death rates, hospitalizations, discharges to home, functional outcomes, fewer pressure ulcers, urinary tract infections, urinary catheter and antibiotic use. *(RNAO Position Statement: Strengthening Client Centred Care in Long-Term Care, 2010).*
- A higher proportion of RNs in the skill mix of licensed care providers has been associated with shorter lengths of stays and lower rates of shock and cardiac arrest, urinary tract infections, pneumonia and respiratory failure among medical and surgical patients. *(Canadian Nurses Association Fact Sheet: Value of Registered Nurses, 2009.)*
- The more RNs present during hemodialysis (i.e., a richer RN skill mix), the less likely frequent adverse events will occur. *(Relationships Between RN Staffing, Processes of Nursing Care and Nurse-reported Patient Outcomes in Chronic Hemodialysis Units, Nephrology Nursing Journal, 2008.)*

- Increased RN staffing in acute care hospitals is linked to lower rates of hospital-related mortality and adverse patient events, including failure to rescue. *(The Association of RN Staffing Levels and Patient Outcomes, Medical Care, 2007).*
- A higher proportion of RNs and more RN hours per day are associated with reduced lengths of stay, lower rates of urinary tract infections and upper gastrointestinal bleeding, lower rates of pneumonia, shock or cardiac arrest and failure to rescue. *(Canadian Nurses Association, 2005.)*
- The consequences of uninformed and cost-driven decision-making can be serious: the nursing staff mix itself may create the conditions that could lead to clinical errors and result in adverse outcomes for patients, nurses and organizations. *(Canadian Nurses Association, Nursing Staff Mix, A Key Link to Patient Safety, Nursing Now: Issues and Trends in Canadian Nursing, 2005.)*

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