PANEL REPORT

The Regulated Health Professions Act Consultation

June 15, 2016

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1. Project Background

The *Regulated Health Professions Act* (RHPA) was proclaimed into force on January 1, 2014. The RHPA will replace the individual acts for 22 regulated health professions. Each profession will function under two regulations, these being Practise Regulation and College General Regulation. These regulations set out scope and standards of practice. Within these regulations, each profession must define a set of reserved acts which control activities that could pose a risk to the public. A goal of the RHPA is to facilitate improved access to safe, quality care in a timely manner. The Act also enables health professionals to be provided with the authority to work to their full scope to ensure access to the health care system. The professions, under the Act, will continue to be self-regulating. Sometimes the scopes of the professions may overlap.

The reserved act model has already been implemented in Ontario, British Columbia and Alberta. A reserved act may be performed by more than one profession. The Acts are carried out within a scope of practice framework where practice is not allowed beyond the scope of practice and access and to reinforce patient safety. (There is overlap between professions using terminology of restricted activities or controlled Acts). This model is intended to improve system capacity. The concept behind the RHPA is that regulated health professions must be granted the legislative authority to perform reserved acts in the course of providing health care and they must have the knowledge and skills to perform them.

The *Reserved Acts for Registered Nurses (RARNs)* lists tasks and procedures that registered nurses can perform depending on their knowledge, skill and experience. It also depends on the environment where they serve. (E.g.: In rural and remote communities where there is less easy access to a physician, nurses work at the maximum scope of their practice.) The RHPA will provide accountability, and ensure that an employer provides necessary oversight for these advanced functions. The boundaries of individual nurse scope of practice are determined by the employer.

The College of Registered Nurses of Manitoba (CRNM) has worked with Manitoba Health, Seniors and Active Living (MHSAL), and consulted with stakeholders, including its members, Regional Health Authorities, and other health profession regulators to develop a proposed list of reserved acts to be authorized for the profession under *the RHPA.*

Under the RHPA, reserved acts are not exclusive to any one health profession, and are intended to encourage the practice of inter-professional care. Within the proposed Nursing General Regulation, three groups are identified:

1. Registered Nurse
2. Registered Nurse (Authorized Prescriber)
3. Registered Nurse (Nurse Practitioner)

Understanding of the reserved acts proposed to be granted to registered nurses requires a recognition and awareness of the foundations of registered nursing practice and scope of practice in the context of current educational preparation, level of autonomy and registered nurses practicing to their level of knowledge, skill and judgment. An expanded scope of practice supports the concept of interdisciplinary healthcare system. Reserved acts can be performed by nurses with safety and effectiveness, with the proper accountable safeguards in effect.

MHSAL undertook public consultations on the reserved acts proposed to be authorized for the profession of registered nursing under the RHPA in December 2015. Unfortunately, these public consultations were held close to Christmas, and stakeholders were given 30 days to provide feedback. Many stakeholders felt this was too rushed, and the timing was not ideal. Given the nature of the feedback received by MHSAL in the consultations relating to the proposed reserved acts, it was determined that additional work was required before the regulations are enacted in order to ensure their successful implementation. Based on the feedback, more

specific consultations with key stakeholders were required, in order to develop a full understanding of the effect the changes may have in Manitoba. Any changes to these regulations require approval by Government.

In order to assist MHSAL and CRNM in the review, issues raised through the consultation process and to provide advice that will assist in the finalization of the reserved acts for registered nurses, a Panel of leaders from both the medical and nursing professions was formed. The Panel was created to assist in the review of the issues and to report to the Minister with recommendations.. Dr. Brian Postl, Dean of Max Rady College of Medicine and the Rady Health Sciences at the University of Manitoba and Dr. Beverly O'Connell, Dean of Nursing at the University of Manitoba were appointed as the panel co-chairs. The Panel met with 11 stakeholder groups to discuss issues and concerns raised about the RHPA.

The Panel undertook the following:

1. Prior to meeting with any stakeholders, the Panel met with representatives of the CRNM and MHSAL for a comprehensive briefing on *The Regulated Health Professions Act* and the regulations, including the key features of the reserved acts proposed to be authorized for the profession of registered nursing and the consultations done in developing the regulations. The CRNM also provided to the Panel its comments on the feedback received in the context of the legislation;
2. The Panel reviewed the feedback received and identified issues and concerns requiring further discussion/consultation with key stakeholders;
3. Facilitated 11 stakeholder meetings;
4. Reviewed reserved acts for RNs;
5. Reviewed interjurisdictional comparison of selected Reserved Acts for Registered Nurses; and
6. Provide to the Minister advice and any recommendations that the Panel feels are appropriate to deal with concerns identified in its review of the feedback received during the public consultations.

The following principles guided the work of the Panel:

(i) Public safety in the provision of health care is paramount;

(ii) The public interest is best served when health professions work together collaboratively to maximize the safety, quality and choice of services for the public in any field of health care;

(iii) Reserved acts granted to health professions must reflect a health profession's current practice in the delivery of health care in Manitoba, and recognize modern scopes of practice in terms of benefits to the health care system; improved access and capacity to treat individuals or health populations should be promoted.

(iv) The reserved acts granted to a health profession may overlap with the practice of, or be shared by, another regulated health profession(s) based on the education and competencies of the profession.

The Panel met with the following stakeholders from March to May 2016:

1. College of Registered Nurses of Manitoba (CRNM)
2. Manitoba College of Family Physicians (MCFP)
3. Manitoba Nurses Union (MNU)
4. Association of Registered Nurses of Manitoba (ARNM)
5. College of Physicians and Surgeons of Manitoba (CPSM)
6. Regional Health Authorities, including senior medical and nursing leadership
7. Nurse Practitioner Association of Manitoba (NPAM)
8. Physicians in charge of specialty areas (Travel Health, STD's, Homecare.)
9. Health Canada, First Nations and Inuit Health Branch (FNIHB)
10. Doctors Manitoba
11. Shock Trauma Air Rescue Service (STARS)

(See Appendix A for list of attendees)

Health Professions Advisory Council (HPAC)

The Health Professions Advisory Council (HPAC) was established in 2011. The HPAC provides advice to government on issues around professional regulation and reviews applications from unregulated professions that apply to become regulated under the RHPA. The Council helps maintain consistent regulation for all health professions. The Act precludes any member of a regulated health profession from sitting on the Council.

Upon request from the Minister of Health, the Council provides advice on issues related to the RHPA including:

- which professions may perform certain services or procedures in the course of providing health care that pose a risk of harm to patients or clients if not performed correctly or competently;
- the use of professional or occupational titles and other work-related descriptive terms by members of a regulated health profession or other people;
- entrance-to-practice requirements for health professions including education, training, technical achievement, competencies, credentials and other procedural requirements;
- the continuing competency programs established by colleges;
- health human-resource planning and management; and
- any other matter related to the act.

It is suggested that the membership of the HPAC be expanded, to include individuals who have worked in healthcare. In addition, each time there is an issue with a particular healthcare profession; it would be advisable to have a member from that particular profession provide advice to the council to hear that particular issue. (For example, if the HPAC is hearing a pharmacy related issue, a pharmacy health professional should provide such advice)

2. Key Themes of Issues and Concerns

Background Summary

As part of the implementation process of the RHPA and the Reserved Acts for Registered Nurses (RARNs) the College of Registered Nurses Manitoba (CRNM) was required to consult widely with other health care professions to ensure that all issues and concerns were addressed in the development of the RARNs. The CRNM provided the panel with a list of groups they had consulted and a paper trail of correspondence with the medical profession, in particular, the College of Physicians and Surgeons as the main collaborating group (See Appendix B).

In December 2015, Doctors Manitoba raised a series of concerns of what was being proposed in the Reserved Acts for Registered Nurses and a lack of an adequate communication process about this legislation.

Overview of Issues and Concerns

The major finding from the consultations revealed a number of re occurring themes about the issues and concerns. In general, both the medical and nursing professions were supportive of the RHPA and the need for the Manitoban public to receive quality and safe care. There were differing views presented by the nurse and doctor groups and differing perspectives presented within the medical profession depending on their roles and their understanding of what was being proposed by the RARNs. In addition, there were other process issues that emerged that will need to be addressed to ensure a more collaborative and seamless approach to the implementation of the RHPA by the other twenty one health professional groups. It was very evident that the consultation process required an approach that was accessible by the “rank and file” membership of doctors. The group specific findings will be summarized and presented under the following sections: Responses from 1) the medical profession, 2) the nursing profession, 3) the health authority groups, and 4) process issues.

Medical Profession

In general, the medical professional groups raised a number issues and concerns related to the lack of a broad inter-professional consultation process about the proposed legislation. They felt that the thirty day feedback timeframe was too short and a need for a more robust communication strategy. They also voiced concerns about the ambiguity of the language used in the RARNs, its lack of specificity in identifying the group of nurses associated with the listed scope of practice details and the requisite education and training required with the extended scope of practice. They raised questions about how skill proficiency/competency of the RNs, RN (NPs) RN (AP) will be maintained and audited on an on-going basis to ensure public safety.

Many doctors voiced concerns of what was being proposed in the RARNs. They felt the proposed nursing scope of practice in relation to ordering diagnostic tests, diagnosing and prescribing were beyond the educational preparation of the RN, RN (NP), RN (AP). They commented that what was being proposed for the scope of nursing practice was unrealistic when comparing the length of doctor education to nursing education programs. Doctors repeatedly voiced concerns about the reserved acts providing a pathway for nurses more generally extending their scopes of practice to the detriment of public patient safety. They voiced concerns about nurse malpractice issues that could emerge as a result of this lack of educational preparation and patient adverse events. It was evident from our discussions with these groups that what was being proposed within the RARNs were not fully understood by all and these misunderstandings were causing unnecessary concerns and alarms within the medical profession. For example, what is being proposed is that RNs can diagnose and manage care related to hypoglycemia, urinary retention, constipation, anaphylaxis, some wound care and minor second-degree burns. RNs do not diagnose diseases or disorders (See Appendix C for Reserved Acts Practice Analysis, [2016] for further role clarification). Nurses diagnosing diseases was a major concern voiced by many doctors and this concern maybe addressed with information detailed in Appendix C.

It was evident that some of the medical professionals were unaware of what occurred in current practice settings in specific practice areas (rural and remote health care settings, STD, reproductive health, Travel Health) and the nature of how that practice had been endorsed by the medical profession under the current delegated act.

Another concern voiced by the medical profession was that nurses' extended scope of practice had the potential to creep into medical domain (particularly general primary health care practice) and potentially erode medical primary health care provider's income base. They saw the erosion of their role as medical practitioners as being a negative outcome of the RHPA.

Nursing Profession

The nursing professional groups had less concerns than their medical colleagues. There was not one nursing group that complained about a lack of consultation on the development of the RARNs. In general, they felt that the RARNs adequately represented their scope of practice especially in their specialty roles and within remote and rural practice settings. They endorsed what was covered within the RARNs as they felt it represented what they did in everyday practice in their specialty fields as it identified and acknowledged their broader scope of practice. They repeatedly confirmed that they had assumed these extended role with approval from the health care authority employer and that these practices sometimes occurred as result of a lack of medical practitioners out of hours or/and in their geographical settings. They appreciated the detail in the RARNs that described their role in these circumstances, its transparency in listing the extended practice roles were assuring as it provided them with a general legal safety net. In our meeting with CRNM, it was emphasized that the RARNs had to be read and understood in the context of nurses' professional responsibility and in particular, Standard 11 in the Standards of Practice for Registered Nurses (2013); Item Ten, where nurses are required to acknowledge limitations in knowledge, judgment, and/or skills and function within those limitations and Item Eleven, where nurses are to take personal responsibility for professional conduct and fitness to practice.

The Nurse Practitioner Association of Manitoba (NPAM) supported the CRNM's proposed restricted acts under the RHPA. They felt it was important for appropriate health care system access for patients and the community in this province. They did voice concerns about the proposed blended RN (NP) title as it was difficult to use within the electronic medical records system that only allows for two letters. NPAM strongly preferred maintaining their (NP) acronym which worked as identification in the electronic medical records system and the patients and the community at large understood the type of health care professional they were consulting with.

Health Authorities

The Health Authorities strongly reinforced the context of practice where nurses increased patients' access to care due to a lack of availability of the medical profession. They reinforced that the RARNs need to be broad so they address the contextual conditions in rural and remote settings and in public health care. They felt that what was listed in the RARNs were not revolutionary but depicted what nurses already do in particular settings and with disadvantaged groups out of business hours. They reinforced that much of what is listed well represents current practice and they cautioned restricting nursing scope of practice which potentially could create an environment of uncertainty for what nurses can do and restrict patient access to care in particular settings. Health care employers pointed out that it is important to have legislation that supports current practice. They also pointed out that the RHPA and the reserved acts were actually more conservative and restrictive than current legislation and it provided for greater structure and scrutiny on extended scope of practice educational programs and determining health care professionals' competency on an on-going basis. Similar views were expressed by STARS Senior Administration.

Process issues

There were other issues and concerns raised in the discussions that related to general process issues. An important concern related to how the twenty two professions would continue to communicate as scopes of practice emerged and changed in the future. Importantly, the need for a process to oversee and guide scope of

practice changes for all of the twenty two health care professions. This body could serve to resolve any professional disputes (dispute resolution process).

There was also some concern on identifying the components of the act that could remain outside a legislative process so as to make any professional adjustments to scope of practices issues less encumbered and more nimble.

The inter-professional collaborative language, processes and intent does not seem to be part and parcel of the RHPA and this aspect deserves more attention and needs to be addressed.

3. Response of the Panel

Observations

The RHPA, and the draft proposed regulation in question speak incompletely to the need for collaborative care models between and among professions to be the key feature of engagement. There is considerable evidence that such models improve care, safety, and efficiency. Instead, the act and regulation leave room to interpret the proposal as within professional silos. This will in fact if, implemented in this way, increase risk of patient harm and interprofessional disputes. The Canadian Academy of Health Sciences has recently published a paper on collaborative care models that could and should provide direction in that regard (See appendix D).

The communication processes used in reviewing the proposals was quite complete within nursing. It was adequate with CPSM although some message fragmentation may have occurred with a recent change in leadership while this was in process. The communication was inadequate with Doctors Manitoba and the physician community. Indeed within RHAs, communication did not involve Senior Medical Directors and Vice-Presidents, Medicine.

There is much to be learned from this process as it contributed significantly to the concerns that have been expressed in regard to both content and intent.

The roles defined in reserved acts could be broadly categorized into:

- Areas where there has been significant delegation through use of protocols (travel health, women's health, sexually transmitted diseases, chronic disease management are examples). These have received strong support from physicians involved and have improved access to care for patients with these specific needs.

- Rural, remote, aeromedical transport where these skills are often required to meet specific and acute needs, usually when physicians are unavailable or don't provided that service.
- Nurse practitioners who function independently, sometimes in nurse clinics (Quick Care), and sometimes in collaborative models (Access Centres). These function to improve access, once again often when physician based care is unavailable or unattainable.

These roles are being done now without the same degree of oversight and regulation that would come with the reserved acts.

Nurses will function in reserved act roles with their own liability protection. They will be required to be certified and to maintain competence for each reserved act that is not covered in the entity to practice preparation of a graduate nurse (R.N.). The certification will formally involve educational institutions and may involve physicians' participation in curriculum development and course delivery.

Tests ordered by nurses within reserved acts will be the responsibility of that nurse or delegate (to receive and act upon test results). Moreover in a truly collaborative model, consultations between physicians and nurses will provide support necessary to improve access, care and maintain patient safety. Reviewing similar work in other jurisdiction suggests that the proposed changes are not comparatively aggressive relative to those other jurisdictions.

Within this expanded educational medicine, there may be a requirement for access to patient-based experiences to ensure competence. This may put some additional strain on an already taxed educational environment and will need to be closely monitored. It is noted these efforts closely parallel discussion on competency-based education as an emerging model of training health professionals.

Although all professionals may professionally incorporate under the RHPA, it is important to remember that most nurses function as employees of an RHA or affiliated agency contract (MOU's etc.). As such, the scopes of practice will be set within that employment agreement. It will be essential that regions work collaboratively to ensure consistent application within and between regions. Fragmentation between regions will exacerbate differences in care and increase risk to patient safety.

Within that context, it is important to note that reserved actions apply to nurses with specific competence and serving in a specific role and geographic. Nurses, even if qualified, may not perform reserved acts if they are functioning in a place where these are not necessary. In a hospital setting for example, the physician of record admits and discharges patients and will remain responsible for the care of the patient. Nurses will not be independently ordering tests, medications, or perform other functions if they are not required that that setting. These issues will be closely monitored by CRNM. It is noted that currently 5% of nurses and 20% of nurse practitioners are audited annually. This degree of regulatory oversight will continue.

We have noted the RHPA expands the potential for increased scopes of practice for all professions. The only profession with a now complete scope of practice is the medical profession. Scopes of practice within that profession have a high degree of variability. The act also defines that there will be overlapping scopes of practice. If well used in collaborative models, this will allow improved access to care.

There is concern that some aspects of primary care medical practice may be eroded. This potential does exist. It is a phenomena occurring in health care throughout Canada, Europe, and USA. The true risk of substantial income erosion for medical practitioners in this environment is remote at the present time. There are many needs not adequately met by the health system. These changes should allow physicians to move into gaps that now exist to improve patient care. Ultimately it may require changes to how physicians are remunerated, to allow for these transitions to occur.

There are 20 more professions yet to develop their set of reserved acts. It would be naïve to think this can be accomplished without change, and perhaps significant change. Having said that, there are no mechanisms short of opening a medical act that allows professions to bill the system within a Fee for Service environment that exists for a small number of professions delivering within a defined basket of services.

There are likely to be disputes that arise as these changes are "negotiated" between professions. The key mitigating construct must be the effort to jointly build collaborative care models. When that is insufficient, it is necessary to develop robust dispute resolution processes that ensure we "don't get stuck" in moving forward towards a better health care system that meets the needs of patients and the community.

4. Panel Recommendations

Based on the eleven stakeholders meetings and the documents listed in Appendix E, it is recommended that:

1. The interprofessional consultation and implementation of the profession-specific reserved acts continue to proceed.
2. Some consideration be given to simplifying the language used in the reserved acts so its interpretation is more specific and unambiguous.
3. Collaborative care models and their development must be a key component of any profession developing its regulations and reserved acts.
4. An effective communication strategy be a key element to moving forward. A broad communication plan must be developed for all professions, and its execution closely monitored. The communication should broadly include professions but should also include and engage the public to ensure their understanding of roles, scopes of practice, self-regulation and as we have seen, reserved acts.
5. A robust dispute resolution process must be defined and a "body" assigned to define and implement a process. This could well be the Health Professions Advisory Council or an augmented HPAC as this will require considerable effort. The augmentation could include representation from retired health professionals or advisors to the Committee, and potentially subject matter experts around specific issues being discussed. The same "body" could monitor communication processes, regional collaboration and public awareness.

Appendix A: Attendees at RHPA meetings

Regulated Health Professions Act Consultation

Meeting Attendees

College of Registered Nurses of Manitoba

Manitoba College of Family Physicians

Manitoba Nurses Union

Association of Registered Nurses of Manitoba

College of Physicians and Surgeons of Manitoba

Regional Health Authorities

Nurse Practitioner of Manitoba

Physicians in Charge of Specialty Areas

First Nations and Inuit Health Branch (FNIHB)

Doctors Manitoba

STARS

Appendix B: CRNM consultations with stakeholder groups

Stakeholder Consultation re: Reserved Acts (RHPA)

Provincial Region	Site	Practice Area
CancerCare Manitoba	CancerCare Manitoba	Clinic Staff: Managers, Front Line Staff
		Nursing Department: CNO, Management, Educators, Navigator
		Mb Bone Marrow & Transplant Program
		Haem Lab: Managers, Front line Staff
		Referral Office
		Screening Programs: Directors & Staff
		Pain Clinic: NP
		Chief Nursing Officer
WRHA	Churchill	Clinical Services Manager
	Community Health	Home Care
		Long Term Care
		Travel Health
		Primary Care Nursing Team
		Home Nutrition Program Dietitian
	Concordia Centre	Occupational Health & Safety (Regional)
		Chief Nursing Officer
	Grace General Hospital	Vascular Medicine: Manager
		Medicine: Manager
		Surgery: Manager & Nursing Team, Educators
		Bed Utilization: Manager
		Nursing: Managers & Front Line Staff
		ICU
	Health Sciences Centre	Anaethesia, Manager
		Child Health, Program Director
		Cardiac Sciences Clinical Nurse Specialist
		Women's Health: Program Director, Clinical Nurse Specialist
		Blood Conservation: Manager & Coordinator
		Corporate Office
		Diagnostic Imaging
		Education, Director
		Immunology Clinic
		CHOR: Manager
		Medical Sonography: Director
		Medicine: Manager, Nursing Team, Educator
		MOPG
		Neonatal and Pediatric Transport Staff
		Nuclear Medicine
		Mood Disorder Clinic: Manger
		Obstetrics: Labour & Delivery Manager, Nursing Team
		Oncology
		Pain Clinic
		Parenteral Nutritian Therapy Team
		Pediatric Diagnostic Imaging
		Sexual Assault Nursing Team
		Surgery: Manager, Nursing Team
		Womens' Health Program Director
	Kildonan Medical Centre	Clinical Pharmacists
		Primary Care Nurses
	Misercordia Health Centre	Pain Clinic Staff
		Ophthamology Clinic Staff

	Riverview Health Centre	Continence Clinic Staff
		Long Term Care Ventilation Manager
	St. Boniface General Hospital	Vascular Access Team
		Cardiac Care Clinic Staff
		Cardiac Clinic Continuing Education Staff
		Cardia Clinic - Post Op Discharge Team
	Seven Oaks General Hospital	Medicine Nurse Educator
Interlake Eastern Region	Selkirk Mental Health Centre	Mental Health Nursing Team: Managers
	Beausejour	Public Health: Immunization Program: Manager, Director, Team Leads
	Stonewall	Public Health: Immunization Program: Manager, Director, Team Leads
Northern Region	Flin Flon	Nurse Manager, ER, Med/Peds, Chemo, Dialysis
		Public Health - Chronic Disease, Primary Health
		CRN, Medicine/Pediatrics
	The Pas	Nursing
		Executive Director, Clinical Services
	Thompson	CEO
		Nursing Director
		Executive Director Clinical Services
		Director Primary Care Clinics
		Pharmacist
Prairie Mountain	Snow Lake	Nursing Clinic Staff
	Brandon	Palliative Care and Supportive Care Teams
		Surgery: Surgical Suite Team
		Ambulatory Care
		PE Clinical P.G.
		Dialysis
		GI Clinic Staff
		Home Care
		Executive/Corporate
		Maternal & Child: Managers, CRN, Nursing Staff
		Primary Care Nursing Team (including Management)
	Swan River General	ER
	Dauphin	Public Health
	Ste. Rose du Lac	Public Health
	Dauphin	Regional Acute/PCH
		Medicine
		Surgery
		Immunization & Communicable Diseases Director
	Grandview/Gilbert Plains	Acute Care
	Birtle/Russell	Manager, Acute/PCH
	Erickson	LTC/Transition
Southern Health	Shoal Lake	Educator, ICP, Allied Health
	Portage la Prairie Hospital	Manager, ER/ICU
	Portage la Prairie Hospital	Director of Patient Services
	Portage la Prairie Hospital	Nursing
	St. Pierre Jolys	Nurse Practitioner
	St. Pierre Jolys	Director
	St. Pierre Jolys	Clinical Resource Nurse
	Steinbach	Clinical Services Manager
		Primary Health Care: Regional Manager, Director
		Public Health Director
Diagnostic Services of Manitoba		Chief Medical Officer
Diagnostic Services of Manitoba		Board Member
		Chief Medical Officer
Other	Private Clinic	Plastic Surgery Staff
	Winnipeg Clinic	Nurse
	Klinic	Nursing Team: Manager, Sexual Transmitted Infections Team
	Youville Centre	Nursing Team: Manager
	Manitoba Health	Legislative Unit
	Manitoba Health, Healthy Living & Seniors	Policy Consultants
	Women's Health Clinic	Nursing & Management Staff

International & National Organizations	Practice Area
Saskatchewan Registered Nurses Association	Practice Manager Vascular Access Team
CancerCare Ontario	Nursing Director Psychosocial Oncology Lead
Keewatin Air Ambulance	Flight Nursing Staff
College & Assocation of Registered Nurses of Alberta	Policy & Practice Consultant Team
National Association of Pharmacy Regulatory Authorities	Professional and Regulatory Affairs Team
First Nations Inuit Health Branch (Garden Hill, Lac Brochet, Red Sucker Lake, St. Theresa Point, Oxford House, Winnipeg Offices)	Executive Director, Nursing Station Staff, Practice Consultants, Nurse Educators (Regional), Nursing Team (Community Health), Clinical Placement Coordinators
Health Canada	
Ireland	Executive Team, Care of Older Persons, Nurse Led Minor Injuries Team, Community Mental Health
Capital Health Region (Alberta)	Travel Health Team

Educators

Brandon University
Red River College
University of Manitoba
University de Sainte Boniface

Province of Manitoba Regulatory Bodies

College of Physicians & Surgeons of Manitoba
College of Pharmacists of Manitoba
College of Licensed Practice Nurses of Manitoba
College of Registrered Psychiatric Nurses of Manitoba
College of Occupational Therapists of Manitoba
Manitoba Schizophrenic Society

Reserved Acts Summary:

Scope of practice for the profession of registered nursing

Registered Nurse
Registered Nurse (authorized prescriber)
Registered Nurse (nurse practitioner)

29 February 2016
College of Registered Nurses of Manitoba

Introduction

1. This analysis reflects a provincial view of RN practice. There are approximately 13,500 RNs in the province. RNs graduate from bachelor of nursing programs as generalists and develop specialist knowledge over time. Therefore, the reserved acts require interpretation through the lens of the registered nursing profession and as individuals in practice.
2. Access to care is a safety issue and therefore a regulatory issue when scope of practice is involved. Registered nurses work in collaboration with other regulated and unregulated team members to deliver client-centered health-care services through the broadest scope of practice possible. They are responsible and accountable to their behaviours and actions.
3. These reserved acts are interpreted through a registered nursing lens.

Definitions

a) Additional education means a course, program of study, training or other structured process that meets the approved criteria and whose purpose is to provide a member with the competency to perform a reserved act. A number of reserved acts require additional education before they are performed. This education addresses the needed competencies required to perform more advanced reserved acts.

b) An order means an instruction or authorization for a specific client that is given to a member to perform a reserved act by
(a) a registered nurse (nurse practitioner);
(b) a registered nurse (authorized prescriber);
(c) a physician; or
(d) any other person who engages in health care as a practising member of a health profession regulated under the Act or a profession-specific Act listed in Schedule 2 of the Act; who is legally permitted and competent to give the order.

c) A clinical decision tool is a document whose purpose is to guide, based on evidence, the assessment, diagnosis or treatment of a client-specific problem.

d) An approved practice setting means any of the following:
(a) a hospital designated under *The Health Services Insurance Act*;
(b) a personal care home designated under *The Health Services Insurance Act*;
(c) a hospital or care facility operated by the government, the government of Canada, a municipal government, a regional health authority or an Indian Band;
(d) a setting other than a hospital or health care facility described in clause (c) if the registered nursing care provided at that setting is part of a program operated by the government, the government of Canada or a regional health authority;
(e) a health care facility that is operated by a non-profit corporation and is funded by the government of Manitoba or a regional health authority.

Reserved Act	Practice Analysis and the impact on the public receiving care
RN Reserved Acts	
Reserved Act 1 - Diagnosis A registered nurse may make a diagnosis that is appropriate to the member's practice of registered nursing and communicate it to an individual or his or her personal representative in circumstances in which it is reasonably foreseeable that the individual or representative will rely on the diagnosis to make a decision about the individual's health care	Registered nurses gather the necessary data required to make an informed diagnosis. This includes completion of a client's history, medication history, physical assessment and lab data. A provincial consultation with RNs about ordering lab tests illustrated the extent to which RNs are diagnosing. Across practice settings, they are required to assess the client and make a determination for next steps. The nursing process provides a framework for these next steps. The nursing process includes care planning according to a specific framework that consists of: • assessment of the client and analysis of data • development of a care or treatment plan • interventions which may or may not include reserved acts • evaluation and modification of the care or treatment plan. Examples of diagnoses that RNs make include: • urinary tract infections • anemia • hyperglycemia • hypokalemia • chlamydia • gonorrhea • pregnancy • febrile neutropenia Registered nurses must identify both issues and strengths of the clients they serve. Identifying issues may be in the form of a diagnosis. This is done within their level of competence in order to expedite care. They refer to others' expertise or consult with an appropriate professional when the issue exceeds their knowledge base and scope of practice. As a registered nurse develops additional competencies through education and experience, the diagnoses they independently manage grows such as in the RN(AP) and RN(NP) scopes of practice.
Reserved Act 2 – Ordering and receiving the results of lab tests A registered nurse may order or receive reports of screening or diagnostic tests for the purpose of assessing, diagnosing or resolving a health condition that is appropriate to the RN's practice if the RN practises in an approved practice setting and the registered nurse (a) uses a clinical decision tool* in place at the approved practice setting; or (b) collaborates with (i) a registered nurse (nurse practitioner),	The practice of RNs ordering lab tests or receiving lab test results is not new. This practice has gone on for decades. Under this nursing regulation, RNs will no longer order tests under the name of a colleague but will order lab tests in a manner that accurately reflects their own profession and accountability. A formal provincial consultation was implemented to gather detailed information on what ordering or receiving a lab test looks like in registered nursing practice. Consultations included discussion in-person and by teleconference/Telehealth with: • rural and urban emergency departments • personal care homes • public health settings • primary care clinics • acute care – rural and urban • CancerCare • First Nations and Inuit Health nursing stations and health centres Commonly ordered lab tests include:

Reserved Act	Practice Analysis and the impact on the public receiving care
(ii) a registered nurse (authorized prescriber), (iii) a physician, (iv) a physician assistant, or (v) a clinical assistant who is legally permitted and competent to order or receive those reports. Note: X-rays are commonly ordered as well. Please see reserved act 10 for more information.	• electrolytes • blood glucose • hemoglobin A1C • complete blood count • troponins • urine for culture and sensitivity and urinalysis • quantitative beta human chorionic gonadotropin (hCG) (pregnancy test) RNs competently order lab tests in order to prevent delays to client care. This routine practice occurs in settings that include emergency departments, public health units, personal care homes, intensive care units, remote nursing stations, oncology clinics and primary care. RNs anticipate the needs of their clients based on their scope of practice and the clinical decision tools that are in place. RNs receive lab test results in most practice settings. Labs are triaged and the RN takes action based on the level of urgency. This may include immediate consultation with an MD or NP. Often a non-urgent result is placed on the client's file for review when the MD or NP is available. As registered nurses develop additional competencies, the lab tests that they order, receive, interpret and manage independently increases. This is seen in the RN(AP) and RN(NP) scopes of practice. RNs may order a lab test under a unit or nursing group provider number which is not individualized but reflects the practice setting. RN(AP)s will be assigned a provider number and the tests that are ordered and received will be returned in their name. RN(AP)s already have an assigned provider number and order and received tests under their name
Reserved Act 3 - Performing a procedure on tissue: a) below the dermis b) below the surface of a mucous membrane c) on the surface of the cornea **NOTE:** based on feedback during consultations changes were made to the proposal – i.e., the requirement for an order for arterial puncture and line placement was removed from the provisions.	A registered nurse may perform any procedure on tissue below the dermis. This statement refers to entry-level reserved acts such as wound care, establishing an intravenous line, etc. a) These RN-initiated reserved acts mean that RNs can provide timely care. For example, waiting for an order before establishing an intraosseous line on a client who needs immediate care may result in unintentional harm to the client. Additional education supports the competencies of the nurse to provide safe care. i. Sharp wound debridement e.g. in home care ii. Suturing e.g. FNIH or primary care iii. Intraosseous line placement e.g FNIH or pediatrics settings iv. Umbilical venous and umbilical arterial line insertion e.g. transport nurses v. Arterial puncture and arterial line insertion e.g. transport nurses and acute care in the north vi. Peripherally inserted central catheter insertion e.g. tertiary care and acute care in the north vii. Escharotomy e.g. transport nurses viii. Needle thoracostomy for decompression e.g. transport nurses ix. Cricothyroidotomy e.g. transport nurses b) A registered nurse may perform a procedure below the surface of a mucous membrane. e.g wound care c) A registered nurse may perform a procedure on the surface of the cornea. e.g. fluorescein staining for foreign body removal.

Reserved Act	Practice Analysis and the impact on the public receiving care
Reserved Act 4 - Insert or remove an instrument or device, hand or finger a) into the external ear canal b) beyond the point in the nasal passages where they normally narrow c) beyond the pharynx d) beyond the opening of the urethra e) beyond the labia majora f) beyond the anal verge or g) into an artificial opening in the body.	a) e.g. tympanic thermometer, hearing aid insertion, otoscope b) e.g. nasogastric tube insertion, nasopharyngeal swabs for influenza-like illness c) e.g. orogastric tube insertion c) If a registered nurse has completed additional education, the registered nurse may insert or remove an instrument or a device, hand or finger beyond the pharynx for the purpose of establishing an advanced airway e.g. supraglottic airway (FNIH) or endotracheal intubation (transport settings). d) e.g. urinary catheter insertion e) e.g. pelvic exam, vaginal exam for assessing progression of labour e) If a registered nurse has completed additional education, the registered nurse may insert or remove an instrument or a device, hand or finger beyond the labia majora for the purpose or purposes of intrauterine device insertion, cervical cancer screening or pelvic examination. To meet public need, employers currently provide education to RNs. e) If a registered nurse has completed additional education and there is an order, the registered nurse may insert or remove an instrument or a device, hand or finger beyond the labia majora for the purpose of intrauterine insemination. e.g. in fertility clinics f) e.g. digital rectal exam g) e.g. re-inserting a tracheostomy during care, re-inserting a suprapubic catheter
Reserved Act 5 - Administer a substance a) by injection b) by inhalation c) by mechanical ventilation d) by irrigation e) by enteral instillation e) by parenteral instillation (with an order with the exception of normal saline) f) by transfusion with an order (with an order) g) using a hyperbaric chamber (additional education and an order)	a) e.g. tuberculin testing (a biologic) b) e.g. oxygen c) e.g. oxygen; normal saline for a bronchial wash d) e.g. Kelly irrigation of a bladder e) e.g. Ringer's lactate per IV (needs an order) e) e.g. flushing a feed tube with water f) e.g. blood or blood products g) If a registered nurse has completed additional education and there is an order, the registered nurse may administer a substance by using a hyperbaric chamber. The order and additional education ensure that an RN is working collaboratively with an expert in evidence-informed hyperbaric chamber therapy.

Reserved Act	Practice Analysis and the impact on the public receiving care
Reserved Act 7 - Compounding a drug or vaccine. **Reserved Act 8** - Dispensing or selling a drug or vaccine.	Registered nurses in Manitoba will not be authorized to compound, dispense or sell a drug or vaccine
Reserved Act 9 –If there is an order, a registered nurse may administer a drug by any method (other than by intravitreal injection). If the drug is an over-the-counter drug, the registered nurse may administer it by any method without an order. If a registered nurse has completed additional education and there is an order, the registered nurse may administer a drug by intravitreal injection.	If there is an order, a registered nurse may administer a drug by any method (other than by intravitreal injection). As part of entry-level practice, RNs administer drugs by routes that include oral, nasal, sublingual, intramuscular, subcutaneous, intravenous, transdermal, vaginal, rectal and topical. If the drug is an over-the-counter drug, the registered nurse may administer it by any method without an order in order to prevent delays in care. Over-the-counter drugs are available by self-selection to the public and do not require an order or prescription. RNs who administer drugs that are over-the-counter require the knowledge, skill and judgment to do so. If a registered nurse has completed additional education and there is an order, the registered nurse may administer a drug by intravitreal injection. The ophthalmology staff at Misericordia Health Centre proposed an expansion to the scope of practice of RNs in the clinic with retinal ophthalmologists. The practice team (employer, RNs and an ophthalmologist) described this need for retinal client care due to increased demands in this area. They proposed that experienced ophthalmology RNs with additional competencies are permitted to include this care in their practice in order to reduce wait times.
Reserved Act 9 – A registered nurse may administer a vaccine by any method in accordance with the provincial requirements in any of the following circumstances: (a) the vaccine is included in a publicly-funded provincial immunization program; (b) the vaccine is required as part of a communicable disease response; (c) there is an order for the vaccine to be administered.	RNs working in programs requiring the use of vaccine administration do so with the necessary knowledge, skill and judgment. Many RNs are experts in the area of vaccine knowledge and administration. The need for an "order" to administer a vaccine that is listed as part of a publically funded program is outdated and does not meet the public's need for timely access to care. An order is required for a vaccine that is outside of the publicly funded schedule.
Reserved Act 10: A registered nurse may a) apply ultrasound	A registered nurse may a) apply ultrasound for any of the following: o blood flow imaging (e.g. arterial-brachial indices); o bladder volume measurement (e.g. bladder scanning); o fetal heart monitoring (e.g. pre-natal care); o peripherally inserted central catheter lines insertion (e.g. to assess vessels and structures for insertion of PICCs). a) With additional education and an order, a registered nurse may apply ultrasound for fetal assessment. RNs are involved in ultra-sounding women for fetal assessment in order to assist in supporting the client and her family in the event of a fetal demise and the psychosocial counselling it requires; for genetic abnormalities and organizing appropriate follow-up; and to provide pre-natal

Reserved Act	Practice Analysis and the impact on the public receiving care
	education.
Reserved Act 10 b) apply electricity for: ii) cardiac pacemaker therapy iii) cardioversion (additional education and an order) iv) defibrillation (additional education) v) electrocoagulation (additional education and an order) vi) electroconvulsive shock therapy (additional education and an order) x) transcutaneous cardiac pacing (additional education and an order)	ii) A registered nurse may apply electricity for cardiac pacemaker therapy. e.g. an RN with expertise in cardiac pacemaker therapy determines the program rate and output as well as manages the clinic and consults with physicians as needed. With additional education, a registered nurse may apply electricity for the purpose of: iii) cardioversion e.g. ER and ICU settings; iv) defibrillation e.g. ICU and ER practice settings, Code teams; v) electrocoagulation e.g. wound hemostasis in RN First Assist roles; vi) electroconvulsive shock therapy e.g. RNs participate in the application of ECT as part of an interprofessional team. They prep, monitor and recover the client. They manually secure application of electrodes during delivery of shock; x) transcutaneous cardiac pacing e.g. in ER settings.
Reserved Act 10 d) non-ionizing radiation in the form of a laser (additional education)	d) With additional education, a registered nurse may apply non-ionizing radiation in the form of a laser for the purpose of destroying tissue during a dermatological procedure. e.g. in dermatological care RNs may use laser for skin resurfacing, treating hyperpigmentation and promoting collagen production. Note that this practice is currently being done by unregulated laser technicians. Regulating the use of laser in RN practice promotes safety of the public through Standards of Practice and education.
Reserved Act 10 e) apply x-ray (with additional education and for a specified purpose) e) order x-ray (under the adjacent conditions and for a specified purpose)	e) With additional education, a registered nurse may apply X-rays for diagnostic or imaging purposes at a federal nursing station to the chest or a limb of an individual who is more than 24 months old. Applying X-rays in a federal nursing station is a long standing practice. While it is ideal to have a medical radiation technologist provide this care, an RN with additional education and limitations on practice applies the X-ray for the purposes of facilitating access to a diagnosis. e) A registered nurse may order X-rays for the purpose of diagnosing a health condition or fracture and to confirm line or tube placement that is appropriate to the registered nurse's practice in an approved practice setting and the registered nurse: (a) uses a clinical decision tool in place at the approved practice setting; or (b) collaborates with (i) a registered nurse (nurse practitioner), (ii) a registered nurse (authorized prescriber), (iii) a physician, or (iv) a physician assistant, who is legally permitted and competent to order X-rays.
Reserved Act 11 – In relation to a therapeutic diet that is administered by parenteral instillation, an RN may: a) select ingredients for the diet if the RN has completed additional education and b) administer the diet In relation to a therapeutic diet that	a) selection of ingredients is based on monitoring studies and in collaboration with the RD and MD. Collaboration was a strong theme with this particular reserved act in the area of ingredient selection. b) administering TPN is part of RN practice. b) RNs may mix together two cans of different enteral nutrition. This is how we interpreted “compound”.

Reserved Act	Practice Analysis and the impact on the public receiving care
is administered by enteral instillation an RN may compound or administer the diet.	RNs administer the diet by tube feed.
Reserved Act 13 – A registered nurse may put into the external ear canal, up to the eardrum, water that is under pressure equal to or less than the pressure created by the use of an ear bulb syringe or ear wash system.	e.g. in primary care or personal care homes and according to best practices
Reserved Act 14 –A registered nurse may manage the labour or the delivery of a baby within a facility where labour and delivery services are provided.	Labouring women has been a historical part of RN practice and in collaboration with a primary maternal care provider. Delivery was included in this reserved act as babies will sometimes arrive whether or not their maternal care provider is present!
Reserved Act 20 –A registered nurse may perform a psycho-social intervention with an expectation of modifying a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, the capacity to recognize reality, or the ability to meet the ordinary demands of life if the registered nurse (a) has completed additional education; and (b) performs it in collaboration with a person who engages in health care as a practising member of a health profession regulated by legislation who is legally permitted and competent to perform it.	RNs working in mental health settings practice psycho-social intervention within this reserved act that include: Cognitive behaviour therapy in the area of trauma Some limited group therapy in collaboration with other health providers
Reserved Act 21 – In relation to allergies, a registered nurse may a) perform challenge testing by any method if emergency protocols are in place; or b) perform desensitizing treatment by any method if emergency protocols are in place.	RNs currently work in allergy testing clinics and in collaboration with other care providers.
RN Authorized Prescriber Reserved Acts	
Reserved Act 1 - A registered nurse (authorized prescriber) may make a diagnosis that is appropriate to the member's practice as a registered nurse (authorized prescriber) and communicate it to an individual or his or her personal representative in circumstances in which it is	An RN(AP) may also perform an RN reserved act. RN(AP)s will acquire additional competencies through a course of instruction at Red River College. An RN(AP) provides care within three practice areas: travel health, reproductive health or diabetes health. An RN(AP) will only be able to prescribe certain medications in these areas. It is necessary to note that the RN(AP) role will not replace other health-care providers. The role is a necessary extension of care that is currently provided by

Reserved Act	Practice Analysis and the impact on the public receiving care
reasonably foreseeable that the individual or representative will rely on the diagnosis to make a decision about the individual's health care. **Reserved Act 2** -A registered nurse (authorized prescriber) may order or receive reports of screening or diagnostic tests listed in the Schedule. **Reserved Act 6 -** A registered nurse (authorized prescriber) may prescribe a drug or vaccine listed in the Schedule.	RNs in order to address the needs of a community. The attached schedule outlines the prescriptive and lab test authority of the RN(AP). Note that the schedule has had the following amendments: The scope of practice in travel health is focused on preventive care. Therefore, the schedule for malaria, altitude sickness and traveller's diarrhea requires amendment to say (underlined words indicated an addition): Malaria Chemoprophylaxis Altitude Sickness Prophylaxis Traveller's Diarrhea Prophylaxis Other changes: Glucose -6-Phosphate Dehydrogenase (G6PD) - omitted from schedule as it was felt that this test was better ordered from an acute care centre for better management of results.
RN Nurse Practitioner Reserved Acts **A registered nurse (nurse practitioner) is a registered nurse who has completed advanced education to autonomously provide a broader of health care than a registered nurse. This role emerged in Manitoba in 2005.** **This designation signifies that the RN has completed advanced education (or has demonstrated substantially equivalent education and experience) and has passed an approved exam demonstrating extended practice competencies. Only an RN registered on the extended practice register can use the titles:** • **registered nurse (nurse practitioner) or RN(NP)**	
Reserved Act 1- reserved act 1: A registered nurse (nurse practitioner) may make a diagnosis and communicate it to an individual or his or her personal representative in circumstances in which it is reasonably foreseeable that the individual or representative will rely on the diagnosis to make a decision about the individual's health care.	While there is overlap between scope of practice with an RN and RN(AP), an RN(NP)'s scope of practice is broader reflecting the depth and breadth of their education. An RN(NP) is a registered nurse who has completed advanced education to autonomously provide a broad range of health-care services.
Reserved Act 2 – A registered nurse (nurse practitioner) may order or receive reports of screening or diagnostic tests.	This is current practice. NPs order and receive lab tests autonomously.
Reserved Act 3 - Performing a procedure on tissue: a) below the dermis b) below the surface of a mucous membrane c) on the surface of the cornea	a): e.g. a punch biopsy b): e.g. sutures c): e.g. fluorescein staining for foreign body removal).
Reserved Act 4 – a): A registered nurse (nurse practitioner) may insert or remove an instrument or a device, hand or finger into the external ear canal. b): A registered nurse (nurse	Please see RN Reserved Acts.

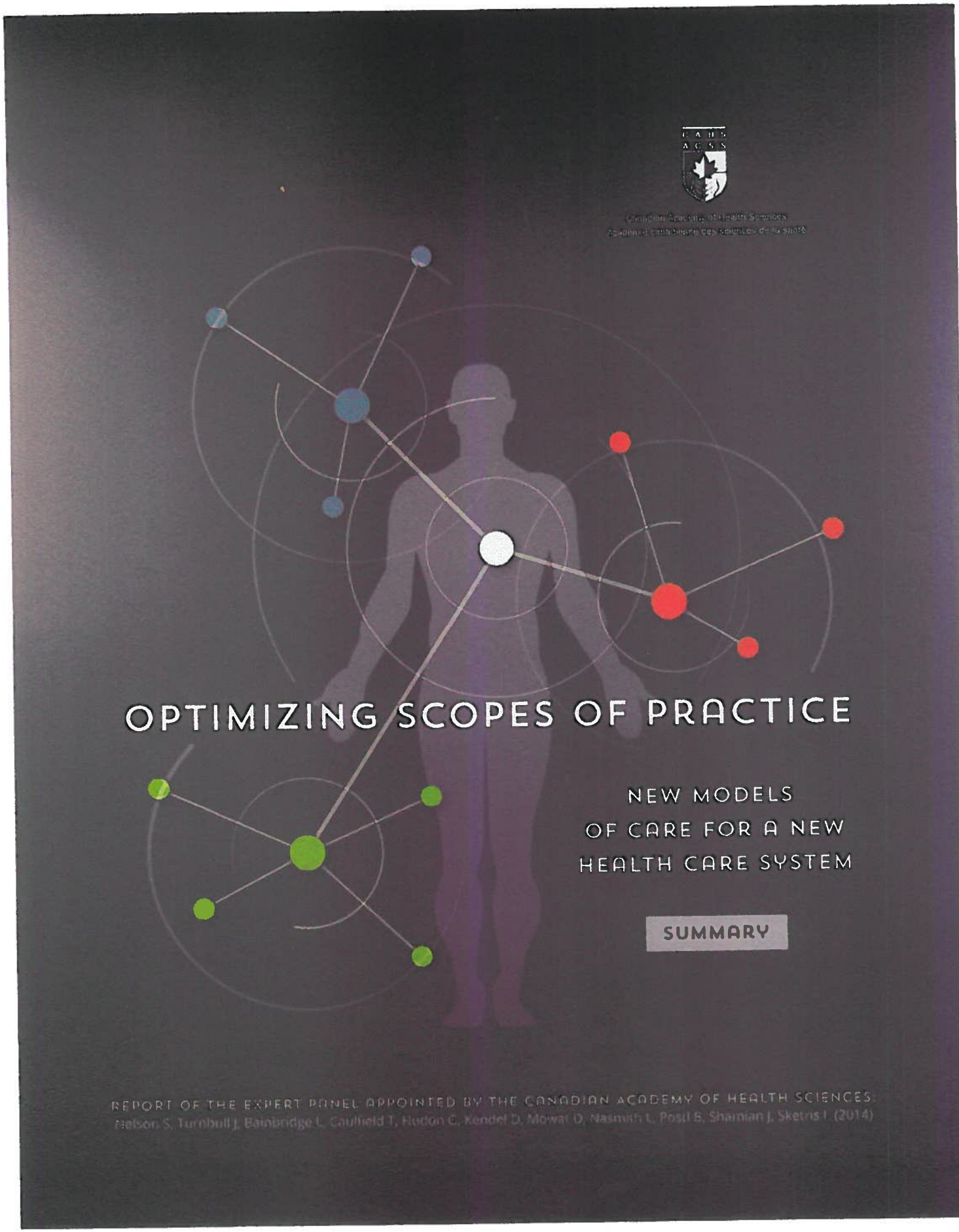
Reserved Act	Practice Analysis and the impact on the public receiving care
practitioner) may insert or remove an instrument or a device, hand or finger beyond the point in the nasal passages where they normally narrow. c): A registered nurse (nurse practitioner) may insert or remove an instrument or a device, hand or finger beyond the pharynx. d): A registered nurse (nurse practitioner) may insert or remove an instrument or a device, hand or finger beyond the opening of the urethra. e): A registered nurse (nurse practitioner) may insert or remove an instrument or a device, hand or finger beyond the labia majora. f): A registered nurse (nurse practitioner) may insert or remove an instrument or a device, hand or finger beyond the anal verge. g): A registered nurse (nurse practitioner) may insert or remove an instrument or a device, hand or finger into an artificial opening in the body.	
Reserved Act 5- a): A registered nurse (nurse practitioner) may administer a substance by injection. b): A registered nurse (nurse practitioner) may administer a substance by inhalation. c): A registered nurse (nurse practitioner) may administer a substance by mechanical ventilation. d): A registered nurse (nurse practitioner) may administer a substance by irrigation. e): A registered nurse (nurse practitioner) may administer a substance by enteral or parenteral instillation. f): A registered nurse (nurse practitioner) may administer a substance by transfusion. g): A registered nurse (nurse practitioner) may administer a substance by using a hyperbaric chamber.	See RN Reserved Acts.
Reserved Act 6- a) A registered nurse (nurse practitioner) may prescribe a drug b) A registered nurse (nurse practitioner) may prescribe a	(a) a drug that is listed in Schedule 1 of the *Manual for Canada's National Drug Scheduling* *System* published by the National Association of Pharmacy Regulatory Authorities, as amended from time to time; (b) a drug other than a drug referred to in clause (a), if the registered nurse (nurse

Reserved Act	Practice Analysis and the impact on the public receiving care
vaccine.	practitioner) is an employee of a regional health authority or health care facility who is permitted to do so by a written policy of the authority or facility; (c) prescribe any non-prescription drug in order to permit the individual to access a drug plan that covers non-prescription drugs. This item is subject to the restrictions set out in the *Controlled Drugs and Substances Act* (Canada) and the regulations under that Act.
Reserved Act 7- Compounding a drug or vaccine **Reserved Act 8-** Dispensing or selling a drug or vaccine	Registered nurse (nurse practitioners) will not be authorized to compound, dispense or sell a drug or vaccine.
Reserved Act 9- A registered nurse (nurse practitioner) may administer a drug or vaccine by any method.	See RN reserved act.
Reserved Act 10- Nurse Practitioner a) apply or order ultrasound	a) If a registered nurse (nurse practitioner) has completed additional education, they may apply ultrasound for diagnostic or imaging purposes. a) A registered nurse (nurse practitioner) may order ultrasound for diagnostic or imaging purposes.
b) apply or order electricity for: ii) cardiac pacemaker therapy iii) cardioversion iv) defibrillation v) electrocoagulation vi) electroconvulsive shock therapy x) transcutaneous cardiac pacing	b) A nurse practitioner may apply or order the application of electricity for ii) cardiac pacemaker therapy (apply or order); iii) cardioversion (apply or order); iv) defibrillation (apply or order); v) electrocoagulation (apply or order); vi) electroconvulsive therapy (apply or order) vii) electromyography (order); ix) nerve conduction studies (order); x) transcutaneous cardiac pacing (apply or order).
c) order the application of magnetic resonance imaging	c) A nurse practitioner may order the application of electromagnetism for magnetic resonance imaging. This is current practice in order to improve public access to care.
d) order or apply non-ionizing radiation in the form of a laser	d) A nurse practitioner may apply non-ionizing radiation in the form of a laser for the purpose of destroying tissue during a dermatological procedure (e.g. skin resurfacing, treating hyperpigmentation, and promoting collagen production). d) A nurse practitioner may order the application of non-ionizing radiation for the purpose of cutting or destroying tissue or medical imagery.
e) apply (under specified conditions) or order x-rays e) order computerized axial tomography	e) With additional education, a nurse practitioner may apply X-rays for diagnostic or imaging purposes at a federal nursing station to the chest or a limb of an individual who is more than 24 months old. e) A nurse practitioner may order the application of X-rays for diagnostic or imaging purposes. e) A nurse practitioner may order ionizing radiation for diagnostic or imaging purposes but only in the form of computerized axial tomography but not positron emission tomography or radiation therapy.

Reserved Act	Practice Analysis and the impact on the public receiving care
Reserved Act 11- In relation to a therapeutic diet that is administered by enteral instillation, a registered nurse (nurse practitioner) may (a) select ingredients for the diet; or (b) compound or administer the diet. In relation to a therapeutic diet that is administered by parenteral instillation, a registered nurse (nurse practitioner) may (a) select ingredients for the diet; or (b) administer the diet.	See RN reserved act. Exception is that an RN(NP) may work with other professionals in selecting ingredients for an enteral diet.
Reserved Act 12- A registered nurse (nurse practitioner) may set or cast a fracture of a bone or a dislocation of a joint.	The restriction of reserved act 12 to NP practice is intended to broaden public access to care.
Reserved Act 13- A registered nurse (nurse practitioner) may put into the external ear canal, up to the eardrum, a substance that is under pressure.	See RN reserved act.
Reserved Act 14- A registered nurse (nurse practitioner) may manage labour or the delivery of a baby within a facility where labour and delivery services are provided.	See RN reserved act.
Reserved Act 20 – A registered nurse (nurse practitioner) may perform a psycho-social intervention with an expectation of modifying a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, the capacity to recognize reality, or the ability to meet the ordinary demands of life if the registered nurse (nurse practitioner) (a) has completed additional education; and (b) performs it in collaboration with a person who engages in health care as a practising member of a health profession regulated under the Act or a profession-specific Act listed in Schedule 2 of the Act and who is legally permitted and competent to perform it.	See RN reserved act.

Reserved Act	Practice Analysis and the impact on the public receiving care
Reserved Act 21- In relation to allergies, a registered nurse (nurse practitioner) may (a) perform challenge testing by any method if emergency protocols are in place; or (b) perform desensitizing treatment by any method if emergency protocols are in place.	See RN reserved act.

Appendix D: Optimizing Scopes of Practice



OPTIMIZING SCOPES OF PRACTICE

NEW MODELS OF CARE FOR A NEW HEALTH CARE SYSTEM

SUMMARY

REPORT OF THE EXPERT PANEL APPOINTED BY THE CANADIAN ACADEMY OF HEALTH SCIENCES:
Nelson S, Turnbull J, Bainbridge L, Caulfield T, Hudon C, Kendel D, Mowat D, Nasmith L, Posti B, Shamian J, Sketris I (2014)

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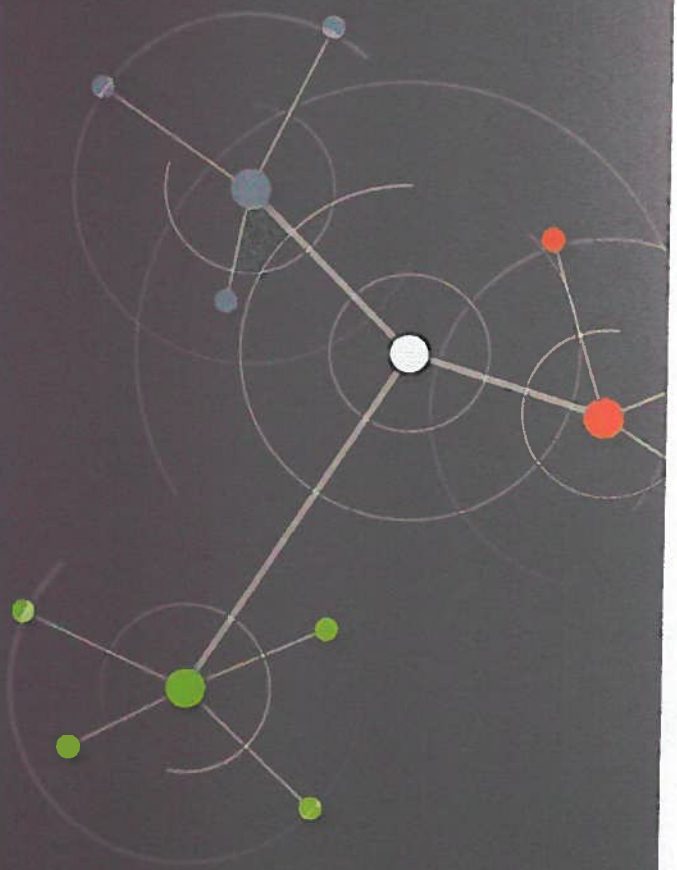


LETTER FROM THE PRESIDENT OF THE CANADIAN ACADEMY OF HEALTH SCIENCES

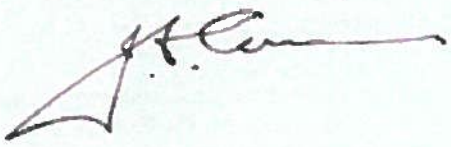
On behalf of the Canadian Academy of Health Sciences (CAHS), I am pleased to present this assessment: **Optimizing Scopes of Practice: New Models of Care for a New Health Care System.** *The assessment had its origins in the CAHS Forum of September 2011, which focused on the future of Canada's health care system. Deliberations after the Forum led to a realization of the importance of scopes of practice to innovation in Canada's health care system.*

I wish to extend the sincere gratitude of the CAHS to the co-chairs, Jeff Turnbull, University of Ottawa, and Sioban Nelson, University of Toronto, and to the distinguished members of the Expert Panel. This publication is the culmination of their 24 months of careful review of the evidence and development of innovative recommendations. I wish also to thank Ivy Bourgeault, University of Ottawa, Scientific Director of the Canadian Health Human Resources Network, for vital contributions to this assessment.

Appreciation is due also to Dale Dauphinee, McGill University, Past-Chair of the CAHS's Standing Committee on Assessments, for the guidance that he and his dedicated committee provided for this assessment from its earliest phases to its successful conclusion. I wish to extend a sincere "thank you" to Carol Herbert, Western University, who provided critical oversight of the process as it neared conclusion. I wish also to acknowledge Tom Marrie, Past President of CAHS, for his leadership in building the early momentum and securing sponsors for this assessment.

Every CAHS assessment requires the financial sponsorship of visionary organizations. This assessment was supported by a large number of organizations, which generously contributed anywhere from $5,000 to $50,000. The CAHS is profoundly grateful to each of these sponsoring organizations. They are acknowledged in the introductory pages of this report.

The leadership of the CAHS brings this assessment to the attention of the Canadian public, confident that it will be of substantial value in national efforts to strengthen and sustain the health care system so highly valued by all Canadians.



John A. Cairns, MD, FRCPC, FCAHS

President (2013–2015),
Canadian Academy of Health Sciences

THE CANADIAN ACADEMY OF HEALTH SCIENCES

The Canadian Academy of Health Sciences (CAHS) provides "scientific advice for a healthy Canada" (Canadian Academy of Health Sciences, 2009, p. 1). It is a non-profit charitable organization, initiated in 2004 to work in partnership with the Royal Society of Canada and the Canadian Academy of Engineering. Collectively these three bodies comprise the founding three-member Council of Canadian Academies. The Canadian Institute of Academic Medicine played a leadership role in developing the Canadian Academy of Health Sciences, ensuring the inclusion of the broad range of other health science disciplines.

The Canadian Academy of Health Sciences is modeled on the Institute of Medicine in the United States and provides timely, informed, and unbiased assessments of urgent issues affecting the health of Canadians. The process of the Canadian Academy of Health Sciences' work is designed to ensure appropriate expertise, integration of the best science, and avoidance of the bias and conflict of interest that frequently confound solutions to difficult problems in the health sector. The Academy's assessments provide an objective weighing of the available scientific evidence at arm's length from political considerations and with a focus on the public interest.

Assessment sponsors have input into framing the study question; however, they cannot influence the outcomes of an assessment or the contents of a report. Each Academy assessment is prepared by an Expert Panel appointed by the Canadian Academy of Health Sciences and undergoes extensive evaluation by external reviewers who remain anonymous to the Panel until the study is released. Final approval for release and publication of an Academy report rests only with the Board of the Canadian Academy of Health Sciences.

The Canadian Academy of Health Sciences is composed of elected Fellows from diverse disciplines both within and external to the health sector. It is both an honorific membership organization and a policy research organization. The Fellows are elected to the Academy by a rigorous peer review process that recognizes demonstrated leadership, creativity, distinctive competencies, and a commitment to advance academic health sciences.

Expert Panel Members

This Expert Panel represents a diverse range of expertise and perspectives, exemplifying the reputation of the Canadian Academy of Health Sciences for objectivity, integrity, and competence:

Sioban Nelson (co-chair), University of Toronto

Jeff Turnbull (co-chair), Ottawa Hospital

Lesley Bainbridge, University of British Columbia

Timothy Caulfield, University of Alberta

Gilles Hudon, former Director of Health Policy and Professional Development, Federation of Medical Specialists of Quebec

Dennis Kendel, former Registrar of the College of Physicians and Surgeons of Saskatchewan

David Mowat, Medical Officer of Health for Peel Region, Ontario

Louise Nasmith, University of British Columbia

Brian Postl, University of Manitoba

Judith Shamian, International Council of Nurses, Ontario

Ingrid Sketris, Dalhousie University

Project Team: Canadian Health Human Resources Network (CHHRN)

Ivy Lynn Bourgeault, Scientific Director of CHHRN, University of Ottawa

Gillian Mulvale, McMaster University

Katelyn Merritt, Project Manager, CHHRN, University of Ottawa

Biographies of the Expert Panel members, Project Team, Legal Consultant and CAHS liaison are in Appendix 4. All members volunteered their time and expertise to address this critical issue and were required to declare in writing any potential conflicts of interest. These are available for review on request.

Legal Consultant

Nola M. Ries, University of Alberta and University of Newcastle (Australia)

Biographies of the Expert Panel members, Project Team, Legal Consultant and CAHS liaison are in Appendix 4. All members volunteered their time and expertise to address this critical issue and were required to declare in writing any potential conflicts of interest. These are available for review on request.

External Reviewers

External reviewers provided candid and constructive comments to assist the Canadian Academy of Health Sciences in ensuring that this report meets its standards for objectivity, evidence, and responsiveness to the study charge. The external reviewers were:

Dr. J. Lloyd Michener, Professor and Chairman, Department of Community and Family Medicine, and Clinical Professor, School of Nursing, Duke University

Dr. Nancy Edwards, Professor, School of Nursing and Institute of Population Health, University of Ottawa, Scientific Director of the Institute of Population and Public Health, CIHR

Dr. Julie Fairman, Nightingale Professor of Nursing and Director of the Barbara Bates Center for the Study of the History of Nursing, School of Nursing, University of Pennsylvania

Dr. Richard Reznick, Dean, Faculty of Health Sciences, Queen's University

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PREFACE: A MESSAGE FROM THE CO-CHAIRS

Over the last decade, it has become increasingly clear that our health care system in Canada is underperforming relative to investment. This has led to widespread calls for change and the recognition that a new health care system must be built upon collaborative care models, where the right professional provides the highest quality of care in the right setting and at the right time based upon the needs of the individual patient. Determining the optimal scopes of practice of these health care providers will be an essential element in leading health care transformation for the future. Unfortunately, the systems in place for determining and regulating scopes of practice have done more to preserve the status quo than promote change. As a result the Canadian Academy of Health Sciences commissioned a report towards the end of 2012 to address the following question: What are the scopes of practice that will be most effective to support innovative models of care for a transformed health care system to serve all Canadians?

We were honoured to be named as co-chairs of a distinguished Expert Panel, which spent the next 18 months addressing this question. We were fortunate to partner with the Canadian Health Human Resources Network (CHHRN) which, through its extensive knowledge base and network, completed an exhaustive scoping review and conducted focused interviews with opinion leaders in the field.

During this process we recognized the importance of non-regulated and informal health providers as well as the need to consider health promotion strategies in any comprehensive plan for health care reform. However, this review focuses primarily upon regulated health professions and their contribution in supporting collaborative models of care and transforming our health care system.

The report calls for a new approach towards determining scopes of practice based upon community need. This approach would empower the collaborative practice team to determine the relative responsibilities of the different practitioners and the team would be held accountable through an accreditation process within a professional regulatory environment.

The report concludes with specific recommendations to those key stakeholders who are required to make this transformation a reality.

As co-chairs, we would like to take this opportunity to thank the members of the Expert Panel for their unlimited energy and expertise. We would also like to highlight the importance of those individuals who gave freely of their time as key informants and reviewers. This report would not have been possible without Ivy Bourgeault and the team at CHHRN, especially the tireless Katelyn Merritt. We thank them for their remarkable efforts. Finally, we would also like to thank the Academy for trusting us with such an important task.

We hope that this report will be the beginning of a process of thoughtful discussion and debate that must at all times put the future of the health care system and the welfare of our patients and communities first and foremost.

Sioban Nelson *Jeff Turnbull*

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EXECUTIVE SUMMARY

Recent shifts in the socio-demographic and epidemiologic profile of Canadians, transformations in technology, and the ongoing concern over the return on investment of health care dollars have led to a wide recognition of the need for health care system transformation. Efforts to both preserve and improve upon the successful elements of the Canadian health care system continue to be insufficient to meet the evolving health care needs of *all* Canadians. The various elements of the current system were largely created to respond to acute, episodic care provided in hospitals and most often by individual physicians. Over the decades, these elements have become enshrined in legislative, regulatory, and financial schemes that challenge adaptation to shifts in population health care needs. Health care organizations and personnel seeking innovative solutions must often work around these barriers in order to optimize resources and improve quality of care. These models typically remain localized and lack the structures or systematic supports that would enable broader scalability. This Assessment directly addresses the optimal scope of practice of health care providers through an examination of these issues and calls for system-wide transformation that builds upon ongoing quality improvement initiatives to better meet patient, community, and population needs.

With health care professionals at the frontline of service delivery, an examination of the utilization of health human resources (HHR) is required. This endeavour includes an investigation of the tasks and responsibilities outlined within each health profession (referred to as *scopes of practice*); the configurations in which health professionals interact (referred to as *models of care*); and the educational, legal, regulatory, and economic contexts in which both scopes of practice and models of care are embedded. In response to the challenge of providing high-quality and accessible care, the scopes of practice of some health care professionals, such as pharmacists and nurse practitioners, have been extended and new professions and roles, such as pharmacy technicians and health navigators, have been developed in several jurisdictions across Canada. In some cases, however, these roles have been introduced without full articulation of how these new roles will be integrated into existing service delivery models or how they will impact the scopes of practice of existing health professions. Beyond extending scopes of practice for some health care professions, optimization of existing scopes of practice must be determined in alignment with the models of care in which they function. The misalignment of Health Human Resources capacities with the need to provide health care services relevant to population demands is a global issue for which we are seeking a Canadian solution.

Objectives and Research Question

The objectives of this Assessment were to conduct a review of the evidence regarding the optimization of health care professional scopes of practice, drawing upon the Canadian Academy of Health Sciences' network of scientists, professional leaders, and health care professionals to provide an expert analysis. Led by an Expert Panel and its two chairs, this Assessment

also represented the first time the Canadian Academy of Health Sciences (CAHS) had partnered with a knowledge exchange network in the relevant field, the Canadian Health Human Resources Network (CHHRN), which took the lead as the Project Team. CHHRN provided not only content expertise but also access to an extensive national and international network of scholars and Health Human Resources innovators. The charge developed by the Academy and assigned to the Expert Panel in partnership with CHHRN was to address the following question:

What are the scopes of practice that will be most effective to support innovative models of care for a transformed health care system to serve all Canadians?

Approach

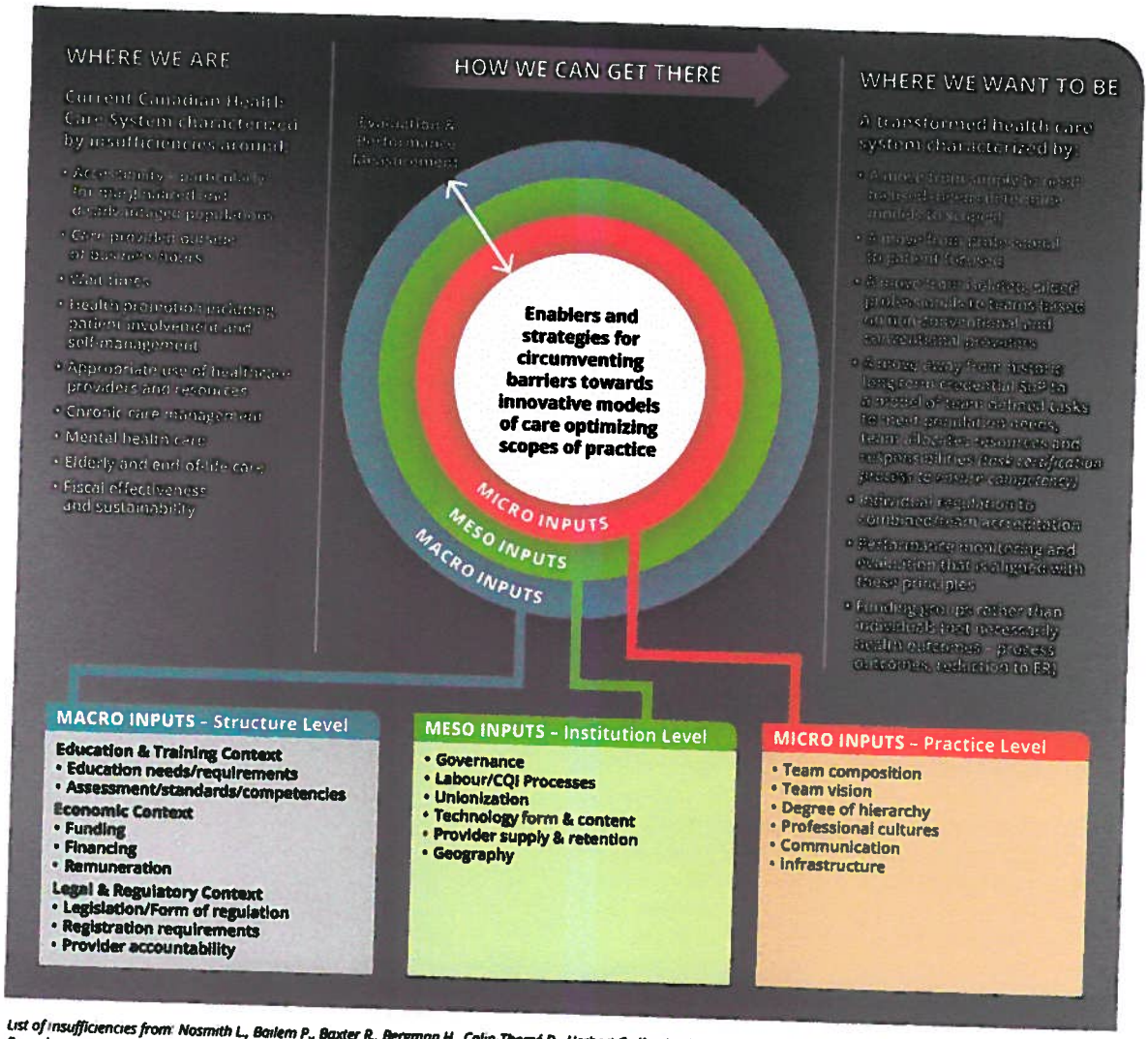
Using the Health Council of Canada's *Triple Aim Plus,* that comprises better health, better care, and better value presented through a health equity lens, the Project Team undertook a systematic process to identify promising approaches related to the optimization of health care professional scopes of practice. There were three elements to the data collection and synthesis: (1) a scoping review to systematically map out the existing literature relevant to scopes of practice from both published and unpublished sources, (2) 50 key informant interviews to augment findings from the literature, and (3) Expert Panel meetings to discuss the state of the evidence and implications for Health Human Resources planning and policy decision making. This report reflects the consensus of the Expert Panel members, which was developed over a series of in-person and teleconference deliberations over an 18-month period.

The conceptual framework, which was developed as part of the Assessment process, guided the data collection and analysis and is shown below. Briefly, it maps out ***where we are***—describing the insufficiencies of the present health care system—and ***where we want to be***—highlighting the Expert Panel's vision statement and target outcome indicators for patients, health care professionals, and the health care system. Depicted in the middle of the framework is a model of ***how we can get there***—focusing on various levels of structural inputs that influence the optimization of health care professional scopes of practice and supportive models of care.

Our explicit focus was to synthesize ways through which the reconfigurations of scopes of practice and models of care, especially in a collaborative care environment, have the potential to initiate transformation of the health care system in order to better meet patient, community, and population needs.

CONCEPTUAL FRAMEWORK:

Scopes of practice that support innovative models of care that better address population health needs and a transformed Health Care System



List of insufficiencies from: Nosmith L., Baslem P., Baxter R., Bergman H., Colin-Thomé D., Herbert C., Keating N., Lessard R., Lyons R., McMurchy D., Ratner P., Rosenbaum P., Tamblyn R., Wagner E., & Zimmerman B. (2010). Transforming care for Canadians with chronic health conditions: Put people first, expect the best, manage for results. Ottawa, ON, Canada: Canadian Academy of Health Sciences.

Findings

Recognizing the variability of both communities and practice circumstances and the need to support models of collaborative care, the Expert Panel felt that a new approach towards determining and assigning scopes of practice was required. This strategy, one that is focused on the patient and is flexible and accountable, would ensure that the right provider gives the best care in the most appropriate location. Critically, the model proposes that the health care team or institution be held accountable for assigning appropriate and optimal scopes of practice within a regulated structure.

The findings from the scoping review and key informant interviews were organized into micro (practice), meso (institution), and macro (structure) levels based on the interventions assessed for quality improvement. In the table below, we depict the fluidity of key barriers that can provide an opportunity to become key enablers for optimizing scopes of practice and supporting innovative models of care through modification or circumvention of structure or function.

Over the course of this Assessment, we identified an emerging consensus that optimizing scopes of practice paired with supporting evolving models of shared care can provide a multidimensional approach to shift the health care system from one that is characteristically siloed to one that is collaborative and patient-focused.

BARRIERS AND ENABLERS: OPTIMAL SCOPES OF PRACTICE WITHIN COLLABORATIVE CARE ARRANGEMENTS AT THE MACRO, MESO, AND MICRO LEVELS

	BARRIERS	ENABLERS
MACRO	***Health care professional accountability/liability concerns***	• ***Educating professionals and courts*** on changes to legislation that recognize the principles of shared care models
	Educational needs/requirements that inhibit professionals working to full or optimal scope	• ***Establishing practicums and residencies*** that foster inter-professional competencies • ***Post-licensure credentialing*** for continued competency development over the course of a career
	Rigid legislation/regulations	• ***Expanding adoption of more flexible legislative frameworks*** that can be interpreted at the local setting
	Payment models that do not support changes in scopes of practice	• ***Alternative funding*** (e.g., bundled or mixed payment schemes) to include all health care professionals and to be aligned with desired outcomes
MESO	***Communication across multiple care settings***	• Implementation and upkeep of ***electronic medical records*** essential for all respective health care professionals (and for patients themselves) to have timely access to the most up-to-date information on treatment and status
	Professional protectionism	• Representation of the interests of professions in the context of collaborative care arrangements and ***inter-professional standards/overlapping scopes of practice***
	Accountability	• Broader application of collaborative performance measures and an overall quality assurance framework through involvement of ***accrediting bodies***
	Availability of evidence	• Systematic monitoring and evaluation (with specific focus on inputs and outputs) to estimate cost incurred for introducing change and the ***long-term return on investments***
MICRO	***Professional hierarchies***	• ***Change management team:*** a designated role for managing changes in scopes of practice and models of care
	Professional cultures (lack of trust and role clarity; job protectionism, turf wars, task escalation)	• ***Continuing professional development*** to cultivate team thinking and develop levels of trust around relative competencies • ***Team vision:*** to reinforce that the ultimate goal is the improved well-being of the patient; who provides the care is secondary to the quality and accessibility of services provided
	Communication among health care professionals	• ***Instilling group mentality:*** internalization of shared responsibility across health care professions • Scheduling of ***regular meetings*** for health care team members to consult on appropriate care strategies and problem-solving strategies; integrating ***information communication technologies*** • ***Co-location*** to have different types of health care professionals and services functioning in a shared space

**The summary box above has been informed by data collected from both the scoping literature review and the key informant interviews. The points presented were selected based on emerging themes and discussions among the Expert Panel members.*

Recommendations

The recommendations provide a blueprint for action that will lead to the creation of more flexible environments to enable the scalability of promising initiatives around optimal scopes of practice and innovative models of care. Beyond the issue of transforming barriers into enablers, our analysis of scopes of practice innovations revealed that a common characteristic of innovation is that it circumvents largely macro-level structural barriers. This finding supported our focus on the broader context of health professional scopes of practice that may be better able to address patient, community, and population health needs. We are calling for the implementation of an integrative structural framework that supports the optimization of health care professional scopes of practice and innovative models of care. At the same time, we recognize the unique skills and abilities specific to different professions as critical to best practice in collaborative care models. Rather than recommending changes to the scopes of practice of individual health care professions, we are proposing an evidence-based approach characterized by three overarching elements:

- The approach is supportive of innovative models of care.
- The approach is flexible in order to respond to the varying needs of patients and communities.
- The approach is accountable to the public and to funders.

This approach recognizes the importance of collaboration among health care professionals as a central feature of the future of the health care delivery system. This level of collaboration requires shared responsibility at the practice and institution levels with accountability for the quality of services provided, based on the needs of the respective communities. Entry-level scopes of practice should arise from pre-licensure professional training and then expanded scopes of practice should arise from supplemental training in special competencies and be formally recognized. We are proposing two levels of accountability that are interrelated and articulated: firstly, a regulatory model that ensures the individual health care professional's competence and secondly, an accountability model embedded within collaborative health care practice through a proposed accreditation structure that ensures all members are working to their optimal scopes of practice in order to better meet patient, community, and population health needs.

To enable this transformation, the recommendations are directed at the multiple constituencies that define, fund, oversee, and regulate scopes of practice. Priority actions are set out under each recommendation.

A. The Federal Government: Provide leadership and support to encourage the expansion of collaborative care models and the evolution of scopes of practice.

Priority Actions

- A1. Convene a national summit of all stakeholders to discuss a coordinated and prioritized plan of action based on the recommendations in this document.
- A2. Develop an infrastructure that provides arm's-length evidence and evaluation of the health workforce with both HHR planning and deployment through optimal scopes of practice as its mandate.
- A3. Earmark research funds to address gaps in the literature, particularly those at the meso and macro levels.
- A4. Develop a national framework for guidelines and quality standards for optimal, expanded, and overlapping scopes of practice.
- A5. Promote best practices and facilitate subsequent scale-up and sustainability of initiatives across the country.
- A6. Support the development and ongoing implementation of umbrella health professional regulatory legislation across provinces and territories.

B. Provincial/Territorial Governments: Take the lead to create systems of funding, financing, and remuneration that enable collaborative models of care that align with patient outcomes.

Priority Actions

- B1. Adopt alternative funding structures to support collaborative practice among professionals within and across settings.
- B2. Initiate a review of professional and union collective agreements to examine their impact on flexibility in health professional scopes of practice.
- B3. Ensure accountability for collaborative, patient-oriented care through accreditation.
- B4. Develop mechanisms that support a move to team- or institution-based liability coverage.
- B5. Support system-wide adoption of information technologies that foster optimal scopes of practice.

C. Regulatory Bodies: Take the lead to align regulations in order to enable respective professionals to better meet population health needs within collaborative care models, particularly in cases of overlapping and expanded scopes of practice.

Priority Actions

- C1. Work collaboratively with professional certification bodies to create national standards and competency frameworks that recognize training and recertification in areas of overlapping and changing scopes of practice.
- C2. Recognize certificates for advanced competencies that enable expanded scopes of practice.

D. Accrediting Bodies, in partnership with Quality Councils wherever possible, take the lead in establishing an accountability model through the accreditation and performance measurement of collaborative care arrangements at the community, primary care, and institution levels.

Priority Actions

- D1. Build on existing standardized performance metrics for collaborative care models.
- D2. Build on existing metrics to inform lifelong learning and collaborative competency development for practitioners at pre- and post licensure.
- D3. Expand accreditation to additional levels of health care service provision to include collaborative care models.

E. Pre-licensure and Continuing Professional Education Providers accelerate the ongoing development of pre- and post-licensure education practices that foster collaborative care and reflect the changing nature of required competencies.

Priority Actions

- E1. Mandate and embed interprofessional, competency-based education across the professions so that interprofessionalism is an essential competency (rather than an additional competency).
- E2. Develop certificates for advanced collaborative practice competencies.
- E3. Develop mechanisms to support widespread engagement in lifelong learning to build and enhance collaborative care competencies.

F. Professional Associations and Unions take the lead in supporting collaborative care practice models as meeting the needs of the individual professions represented and recognizing that this is the context in which most members work or will work.

Priority Action

- F1. Contribute to the establishment of evidence-informed guidelines for collaborative care models in which their members participate.

Although these recommended actions are provided in itemized format, their implementation cannot occur in isolation. There is an interactive and iterative relationship between each recommendation and its development that is based on a common vision of "where we want to be" to be implemented over time.

Conclusion

Increased flexibility around scopes of practice and models of care is required to meet the changing population health needs and the diversity represented in communities across Canada. To determine optimal scopes of practice, clearly defined roles and tasks are best delineated at the local practice level relative to community needs and resources. Enabling greater flexibility requires an approach that takes into consideration changes over the course of a health professional's career, including skills development, certification processes, skills mix, and professional interests. For such changes to be adopted and scaled up over time, there needs to be both a systematic, evidence-based approach to furthering individual- and team-level accountability and a new balance between regulated individual practice and the accreditation of collaborative care arrangements. This is best afforded through the alignment of education, regulation, and funding models to optimize health professional scopes of practice. It is this collaborative practice model that must have the flexibility to best utilize the scopes of practice of team members within an accountable and regulated environment in the context of patient, community, and population health care needs.

In summary, the proposed recommendations provide a blueprint for action to align optimal scopes of practice with innovative models of care through educational, legal, regulatory, economic, and evaluative structures. Consideration and adoption of the recommendations will require time and cooperation from all stakeholders. The ultimate goal is for the transformation of scopes of practice and models of care to enable the future health care system to best meet the needs of Canadians.

Appendix E: List of documents reviewed for Panel Report

i. RHPA

ii. Nursing Regulation Proposal

iii. Inter-jurisdiction Compressor Selected Reserve Acts

iv. Doctors MB Feedback compilation

v. STARS Submission

vi. Literature review re Effectiveness

vii. Nurse Practitioners Patient Care

viii. Teams and Scope of Practice and Effectiveness

ix. Submission of Manitoba Medical Students Association

x. Submission of Professional Association of Residents and Interns Manitoba

xi. Optimizing Scopes of Practice (Report by expert panel of CAHS 2013)

xii. Manitoba Health Overview of RHPA and RN Proposed Reserve Acts

xiii. Submissions made to MB Health

- A Vision for Canada
- Family Practice: The Patient's Medical Home 2016

xiv. Manitoba Health Registered Nurse Prescribing – Cross Jurisdictional Comparisons

xv. Standards of Practice for Registered Nurses

xvi. Standards of Practice for Extend Practice

xvii. Standards of Practice for Registered Nurse Certified Prescribers