CANADIAN NURSES ASSOCIATION

Framework for Registered Nurse Prescribing in Canada

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50 Driveway
Ottawa, ON K2P 1E2

Tel.: 613-237-2133 or 1-800-361-8404
Fax: 613-237-3520
Website: www.cna-aiic.ca

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INTRODUCTION

To better meet population health needs, and improve access to care in the spirit of *the right provider at the right time and right place*, a number of jurisdictions across Canada have implemented or are considering implementing some level of registered nurse (RN) prescribing (see Appendix A). The National Expert Commission report (2012) echoed such a policy direction, calling for an expanded scope of practice for RNs.

While implementing RN prescribing is more difficult by the complexity of Canada's federated governance model, in which provinces and territories are responsible for delivering health care, the process would benefit from having a common framework supported by national, provincial and territorial collaboration. To promote consistency, credibility, mobility and public engagement, it would also be useful to adopt a pan-Canadian approach before the design and regulation of RN prescribing goes much further. In addition, these efforts would benefit by considering Canada's experience with implementing the nurse practitioner (NP) role and the experience of other countries with implementing RN prescribing.

Canadian and global trends, issues and outcomes on nurse prescribing (and non-physician prescribing generally) have been documented by the Canadian Nurses Association (CNA) (2013, 2014a), the International Council of Nurses (Ball, 2009), and by scientists, experts and agencies in countries that have implemented nurse prescribing, including Australia, Canada (Forchuk & Kohr, 2009; Sketris, Ingram, & Lummis, 2007), Hong Kong, Ireland, Jamaica, the Netherlands, New Zealand (Wilkinson, 2011), South Africa, Spain, Sweden, the U.K. and the U.S.

Overall, implementation has led to improvements in care. In Ireland, for example, not only has nurse and midwife prescribing been positively received, it has "improved services to patients and service users through reduced waiting times" while making more effective use of the "skills, knowledge and expertise of nurses" (Adams, Cuddy, Flynn, Lorenz, & MacGabhann, 2010, p. 188). In the U.K., Berry and her team found public attitudes toward RN prescribers to be positive (Berry, Courtenay, & Bersellini, 2006), and a number of additional studies have found that non-medical prescribing was well received by patients, has enhanced access to care and has improved the continuity of care (Bhanbhro, Drennan, Grant, & Harris, 2011; Jones, Edwards, & While, 2011; Stenner & Courtenay, 2008; Latter & Courtenay, 2004).

Published best practices on implementing RN prescribing are few, which most likely reflects its complexity and its relative novelty on a broad scale. However, as countries have moved toward nurse prescribing, various principles, lessons and implementation frameworks have emerged that indicate what issues must be addressed to succeed — for example, in Canada (CNA, 2014a), England (U.K. Department of Health, 2006), Ireland (Ireland Health Service Executive, Office of the Nursing Services Director, 2008) and Spain (Jurado, 2013).

While no national frameworks exist for countries with a federated model like Canada's, some of those published offer direction for actual prescribing activities — both generally (U.K. National

Prescribing Centre, 2012; National Prescribing Service [Australia], 2012) and within specific practice settings such as diabetes care (Stenner, Carey, & Courtenay, 2010; Nursing Council of New Zealand, 2014) — for example, the overarching "common competency" framework in the U.K. (U.K. National Prescribing Centre, 2012). These frameworks will be particularly useful once larger implementation activities (e.g., legislation) are complete.

CNA has undertaken significant activities to support RN prescribing, which include

- a study tour of England and Ireland in 2009;
- a 2010 board motion explore RN prescribing;
- consultations with our nursing specialty groups and jurisdictions, following the National Expert Commission's recommendation to expand the RN scope of practice;
- a national roundtable on RN prescribing in response to the National Expert Commission's action plan; and
- an update on RN prescribing activities to the board in June 2014.

During the June 2014 board dialogue, a motion was approved for CNA to develop an enabling framework and action plan for RN prescribing over a period of three months. In a subsequent meeting, CNA staff and the Canadian Council of Registered Nurse Regulators agreed that a framework which government decision-makers could use whenever a jurisdiction was considering the implementation of RN prescribing would be the most useful. This document, which is the result of the 2014 motion, seeks to provide such a framework for RN prescribing in Canada.

KEY ELEMENTS

Vision and Principles

This vision that guided the framework was to have registered nurses prescribing a limited range of diagnostic tests, medications and treatments across designated settings using clinical decision tools, based on nine principles (See Figure 1) describing the practice of RN prescribing in Canada:

1. Relevant to population health and system needs
2. Safe
3. High quality
4. Universally accessible
5. Transparent
6. Evidence based
7. Collaborative
8. Patient centred
9. Sustainable

Figure 1.
Vision, principles and key elements of a framework to guide RN prescribing in Canada

Vision

Registered nurses prescribing a limited range of diagnostic tests, medications and treatments across designated settings using clinical decision tools.

Guiding principles

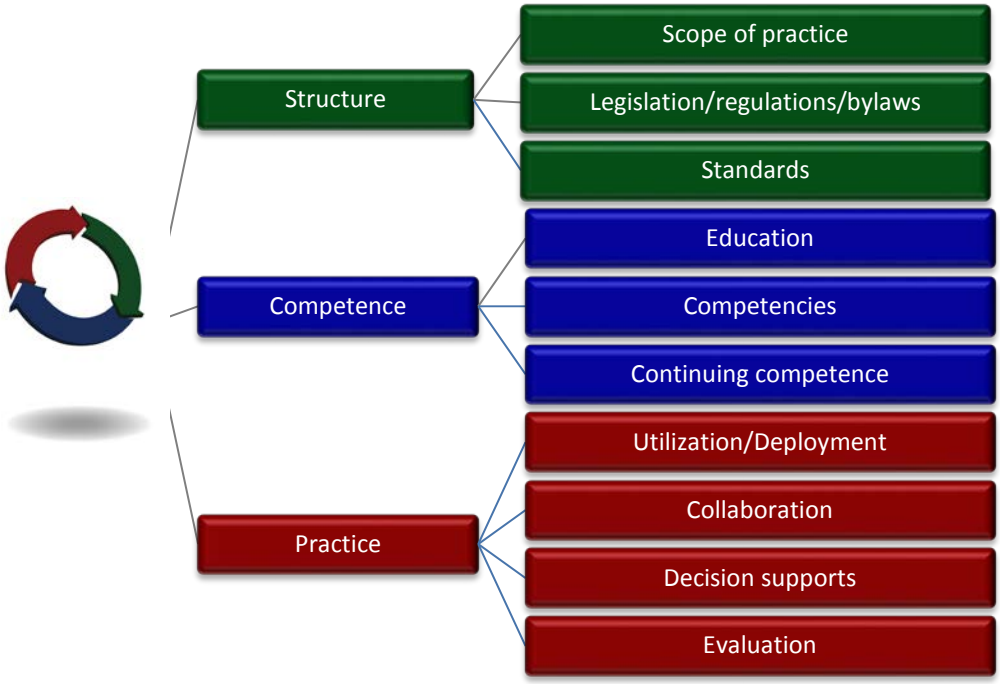
Relevant
Safe
High quality
Universally accessible
Transparent
Evidence based
Collaborative
Patient centred
Sustainable

The three fundamental, interdependent elements grounding the model are:

1. **Structure** — the defining factors for RN prescribing and the legislation, regulations and standards that frame the role and grant prescribing authority to qualifying RNs
2. **Competence** — the knowledge, skills, judgment and attributes an RN requires to practise safely and ethically in a designated role and setting
3. **Practice** — all aspects of RN prescribers' hands-on clinical practice, from activities, practice settings and tools to employment conditions, the management of risks, collaboration with other providers and the evaluation of outcomes, safety and quality.

These key elements are the basis for the 10 strategic areas that should be considered by any jurisdiction wishing to implement RN prescribing (see Figure 2).

Figure 2.
Framework for RN prescribing in Canada



I. Structure

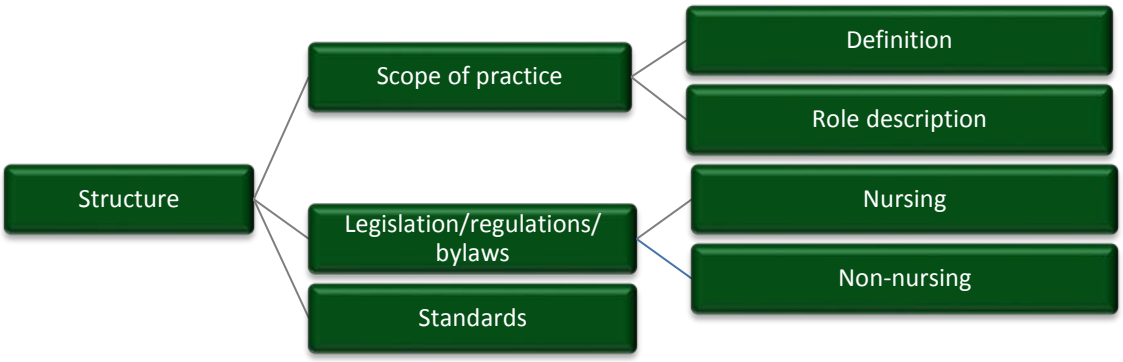
Structure refers to the provisions required to define the RN prescriber role, determine who will qualify to practise, and establish the legislative, regulatory and professional supports to both implement the role and ensure its safety and effectiveness.

Driven by aims to improve care without compromising patient safety, all jurisdictions in Canada with nurse prescribing have developed legal/regulatory frameworks and professional supports (e.g., bylaws and standards) outlining what, how much and to whom RNs can prescribe. In the process of this development, most jurisdictions have identified the need to improve

- access to services;
- the use of practitioner skills and knowledge (i.e., maximize scope of practice);
- team effectiveness;
- health-care cost-effectiveness;
- patient satisfaction; and
- compliance with recommended therapies.

Prescribing is a controlled act. For RNs to have prescribing authority within their individual scope of practice, legislative and regulatory amendments are required across Canada to grant them this power, both in areas that govern the profession directly and in areas such as infection control. Yet, history has taught us the importance of keeping the legal wording that defines RN prescribing broad rather than assuming a stance of control and restriction.[1] RNs are accountable for their practice, and RN prescribing will take place in the context of professional and individual competence (including an RN's knowledge, experience, skills and judgment) and the legislated scope of practice.

Figure 3.
Structural elements of RN prescribing



[1] There is no consensus in the field on the use of the term "prescribing."

I. STRUCTURE

Key element	Recommendation	Evidence or rationale
Scope of practice	**Definition of role and protection of title** Adopt a pan-Canadian definition and title[2] for the RN prescriber in all provinces and territories. • RN prescribers are experienced RNs with baccalaureate or higher education levels,[3] who have achieved the competencies required for RN prescriber registration or licensure in a province or territory. • RN prescribers possess and demonstrate the competencies to use clinical decision tools to: o deliver diagnosis of an identified range of health conditions; o order and interpret a limited range of diagnostic tests; o prescribe and dispense a limited range of pharmaceuticals; and o perform specific procedures within their legislated scope of practice. *[2] There is no consensus in the field on the need for title protection.* *[3] There is no consensus in the field on whether RN prescribing is a post-RN skill or is one that should be basic to all RNs in the future.*	• To be useful in a regulatory or legislative context, the definition of RN prescriber must be clearly and succinctly distinguished from that of an NP. • We know from having multiple categories of regulated nurses in Canada, and from the NP implementation experience of the past decade, that it is confusing to the public and to governments when nursing work is described in various ways, using different titles in different jurisdictions for the same role.
	Protect the "RN prescriber" designation/title in legislation and regulations in all Canadian jurisdictions.[4] *[4] There is no consensus in the field on the need for title protection.*	• Restricting the use of professional titles is the primary way the public can distinguish regulated health-care professionals from unregulated health-care providers and distinguish among regulated health-care professionals. Members of the public have begun to understand the NP title in terms of its role and range of services, and it will be important to differentiate that role from RNs who prescribe and RNs who do not. • Regulated designation/title protection is tied to specific educational and practice qualifications. Although this protection will enhance public safety, RNs who do not have the qualifications to prescribe will be unable to use the RN designation/ title. For those individuals, opportunities to obtain the qualifications will need to be made available.

Key element	Recommendation	Evidence or rationale
	Role description Develop and adopt a pan-Canadian description for the RN prescriber role in all jurisdictions across the country.[5] Functions of the role: • Using an evidence-based, holistic approach that emphasizes health promotion and partnership development, RN prescribers complement rather than replace other health-care providers. • RN prescribers blend their knowledge of nursing theory and practice with their legal authority and clinical decision tools to order and interpret select diagnostic tests; prescribe select pharmaceuticals, medical devices and other therapies; and perform select procedures within their competence and scope of practice. • RN prescribers carry out these actions using clinical decision tools for the purposes of: diagnosing and/or treating acute and chronic disease; promoting, protecting, maintaining, rehabilitating or supporting health; preventing illness or injury; and supporting end-of-life care. • After initial assessment and diagnosis, which may include consultation with an NP or physician, the RN prescriber may prescribe from a limited formulary and order a limited range of diagnostic tests and therapeutic interventions. *[5] There is no consensus in the field as to whether this framework adequately distinguishes an RN prescriber from an NP prescriber.*	• More than 3,600 NPs now practise across all provinces and territories (Canadian Institute for Health Information, 2014). Given the infrastructure of education, regulation and legislation already in place in settings across Canada, *there is no intent or need to duplicate that function*, since this could be confusing to governments, other providers and the public. Avery and James (2007) concluded that, in the U.K., "It is now time to build prescribing into the development of advanced nursing practice" (p. 316). Canada has already legislated the NP role, which authorizes a fully autonomous practice that includes assessment, diagnosis and prescribing from a relatively unrestricted formulary.
Legislation, regulations and bylaws	Enact and implement a broad scope of practice for RN prescribers by the use of enabling legislative and regulatory wording based on common, pan-Canadian core competencies. The specifics on scope of practice are reserved for regulatory body bylaws. Amend existing federal/provincial/ territorial nursing and other non-nursing statutes so that they will enable and be consistent with RN prescriber practice. • Legislation should permit RN prescribing to evolve over time so that changes at the regulatory college level can reflect emerging system and population health needs without	• The RN prescriber scope of practice should be flexible in its recognition of overlapping practice with other providers and in its ability to respond to changing population health and system needs. • Legislation and regulations should be broad enough to avoid amendments each time an aspect of RN prescribing, such as setting or list of conditions, is changed. • Examples of non-nurse legislation include: Federal o Agreement on Internal Trade o Canada Health Act o mutual recognition agreements with other nations

Key element	Recommendation	Evidence or rationale
	requiring subsequent legislative changes.	(e.g., the U.S.), regions (e.g., the E.U.) Provincial/territorial o hospitals acts o laboratory acts o acts governing other health-care professionals (e.g., physicians, NPs, pharmacists)
Standards	Develop and enforce pan-Canadian standards to define parameters and to guide and monitor RN prescriber practice. Practice standards for nurse prescribers are typically defined using all or some of the following domains: • clinical pharmacology • consultation, history-taking, diagnosis, decision-making and therapy • influences on prescribing • prescribing in a team context • evidence-based practice and clinical governance • legal, policy and ethical aspects of prescribing • professional accountability and responsibility • prescribing in the public health context Develop and adopt a standardized, pan-Canadian Prior Learning Assessment and Recognition (PLAR) process and other tools to determine candidate qualifications to enter RN prescriber practice.	• As with other expanded nursing roles, standards of proficiency for nurse prescribing are typically set out by regulatory nursing bodies. In some cases, however, standards and related competencies for independent prescribing (including physician and non-physician prescribers) have been set collaboratively.

II. Competence

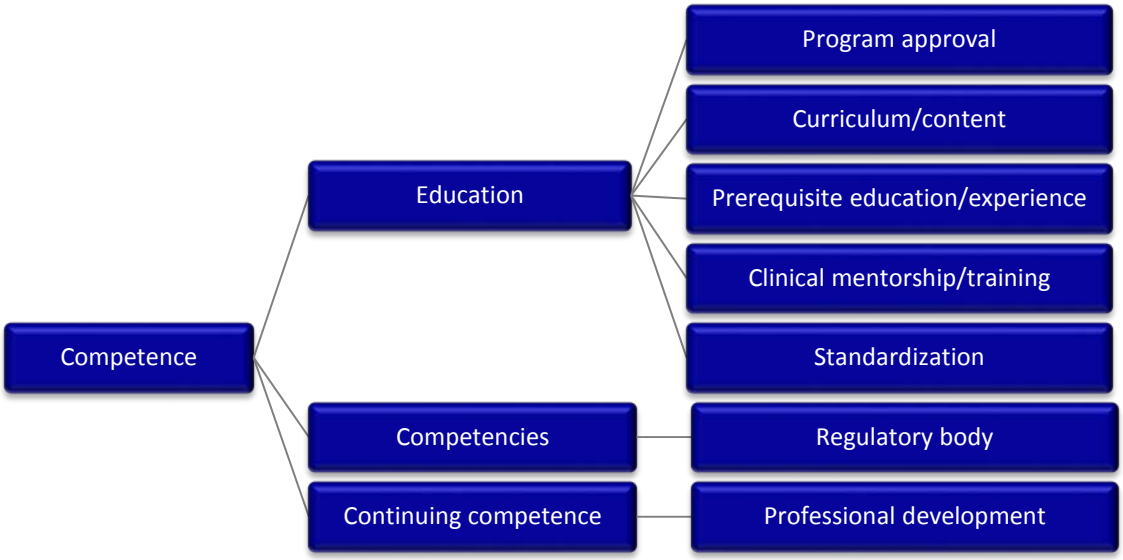
A strong knowledge base is a critical prerequisite for nurse prescribing practices. Consequently, many authors have highlighted the importance of adequate preparation, including advanced education in pharmacology and medication management as well as other key elements of the diagnostic and disease management process (Green, Westwood, Smith, Peniston-Bird, & Holloway, 2009). Research in this area has found that current RN prescriber educational programs prepare nurse prescribers adequately for their roles (Latter, Maben, Myall, Young, & Baileff, 2007; Latter et al., 2011). Some literature also highlights specific nurse prescriber needs, such as robust pharmacology training, support to strengthen novice nurse prescribers' confidence levels and opportunities for continuing professional development (Latter & Courtenay, 2004; Latter, Maben, Myall, & Young, 2007).

Therefore, comprehensive education programs that address nurse prescribers' initial (entry level) and ongoing educational needs will be critical to the success of the RN prescribing role. Some of the key assumptions for RN prescriber post-basic educational programs are that they

- be accessible, flexible and transferable;
- reflect national core competencies;
- be grounded in the nursing profession's values, knowledge, theories and practice;
- be responsive to diverse client needs;
- reflect the principles of adult learning;
- promote critical thinking and diagnostic reasoning; and
- combine elements of theory and practice.

Studies on nurse prescribers have found that patients expect appropriate checks and balances to be in place to monitor performance and professional competence (Hobson, Scott, & Sutton, 2010). Although regulators and organizations set standards and policies regarding the maintenance of continuing competence, for the most part it's the individual practitioners who seek out learning and professional development. For this reason, it is important for programs to consider how they enable or hinder nurses as they pursue educational opportunities.

Figure 4.
Competence elements of RN prescribing



II. COMPETENCE

Key element	Recommendation	Evidence or rationale
Education	Establish and adopt minimum pan-Canadian entry requirements for RN prescribing education. As a minimum, pan-Canadian entry requirements for prescribing education for RNs must include: • a baccalaureate degree in nursing or higher; • three years' (full-time equivalent) relevant clinical experience after initial registration within the previous five years; and • demonstrated critical thinking and risk assessment skills (i.e., the submission of real case studies or essays, if evidence is available to support these).	For stand-alone nurse prescribing courses, specific entry requirements have typically been established. For example, in Ireland and the U.K. (where independent RN prescribing is well developed), RNs must meet the following application criteria: • a minimum of three years' post-registration experience within the previous five years; • specialist skills, qualifications and experience within their specific clinical field (Ireland requires a minimum of one full-time year); • demonstrated support from their current employer (e.g., release time for education and organizational supports for the nurse's clinical placement, including a medical practitioner mentor/collaborator).
	Establish and adopt pan-Canadian requirements and standards for post-basic RN prescribing education programs. Requirements and standards should include: • curricula that consist of: o clinical pharmacology o clinical decision-making and diagnostic skills o consultation management o issues related to treatment adherence o legal and ethical considerations o professional accountability and responsibility o working in interprofessional teams • a minimum number of classroom and clinical practice (internship) hours • faculty/supervisor requirements • a required program length • assessment and evaluation methods and tools • modalities for program delivery	Content for nurse prescribing education programs is fairly similar across countries and typically involves teaching in the areas listed (Stewart, MacLure, & George, 2012). Best Practice • The Irish Nursing Board's Requirements and Standards for Education Programmes for Nurses and Midwives with Prescriptive Authority (2007) further defines learning outcomes and educational content. • Ireland and the U.K. are described as having particularly advanced education programs. Courses are delivered using a blended learning model, in which students participate face-to-face, online and through video-conference. So most programs require that applicants have the necessary technological literacy (Adams et al., 2010). • There is a small body of literature examining different approaches in nurse prescribing education. For example, a recent study of independent nurse prescriber programs in the U.K. found that online learning through virtual patient teaching helped nurses develop skills in history/assessment, decision-making and prescription writing (Hurst & Marks-Maran, 2011).

Key element	Recommendation	Evidence or rationale
	Mandate jurisdictional approval of post-basic RN prescribing education programs by the RN regulatory body based on pan-Canadian requirements and standards.	• As nursing is a self-regulated profession, responsibility for program approval is most appropriately given to the RN regulatory body to ensure consistency and quality of education. Similar approvals exist for RN and NP education programs.
Competencies	Establish and adopt pan-Canadian RN prescribing competencies based on specific domains of competence. Consider the development of a shared competency framework for all professionals engaged in prescribing. • Competencies must rest with the RN prescriber; they must be transferable, and the RN prescribing practice must be portable across employers, i.e., not tied to a specific employer or another health-care professional. • A Canadian shared competency framework could be similar to the one created in the U.K. by the National Prescribing Centre, part of the National Institute for Health and Care Excellence.	• Canada requires national RN prescribing competencies to support mobility and establish role clarity and consistency with the public and other stakeholders. Although many frameworks have been created specifically for the nurse prescriber role, shared competency frameworks for all prescribing health professionals have also been developed (Nuttall, 2007). For example, in the U.K. (U.K. National Prescribing Centre, 2012), nine main competencies guide knowledge and skill requirements for all prescribers: • knowledge • options • shared decision-making • safe • professional • always improving • the health-care system • information • self and others
Continuing competence	Establish pan-Canadian continuing competence requirements. As a starting point, continuing competence requirements should include: • a minimum number of practice hours/days in the additional authorized practice • a minimum number of professional development hours over a specific time period • standardized tools to support evidence of continuing competence (e.g., a letter from the applicant's employer confirming the number of prescribing practice hours) • a self-reflection/reflective practice review	• Evaluations of nurse prescribers show that they see themselves as having increased knowledge but that, in order to consolidate it, they need protected learning time and access to continuing professional development (Nuttall, 2007). In particular, access to continuing professional development activities has been shown to increase confidence levels in nurse prescribers (Courtenay, Carey, & Burke, 2007). Formal support structures, such as regular clinical supervision, are seen as critical to meeting nurses' ongoing learning requirements (Stenner & Courtenay, 2008). As well, given that prescribing trends are always evolving, habitual continuing professional development is highly recommended, particularly in pharmacology and new medicines (Green et al., 2009).

Key element	Recommendation	Evidence or rationale
	Develop and implement an interprofessional continuing professional development (CPD) system for RN prescribers, with additional supports for novice prescribers.	• There is a widely held belief that CPD activities contribute significantly to nurses' ability to improve the quality of health care (Carey & Courtenay, 2010) — although CPD can come in a variety of forms, from informational learning to formal accredited programs and courses. In a recent analysis of U.K.-based, non-physician prescriber CPD needs, participants identified physical and diagnostic skills as a key area for ongoing development (Green et al., 2009). Moreover, pharmacological knowledge continues to be the greatest nurse prescriber need, both for initial preparation and for ongoing professional development (Carey & Courtenay, 2010). As a result, some authors have highlighted the importance of multidisciplinary approaches to CPD — building on and learning from the expertise of senior pharmacists and physician colleagues — for addressing nurse prescribers' learning needs (Jones, 2008). • In the U.K.'s National Health Service, non-physician prescribing leads were used at the organizational level to provide support, coordination, communication and clinical governance for nurse prescribers. A recent study found that using prescriber leads helped establish non-physician prescribing in health-care organizations. • RN prescribers are least confident when they first qualify. Without support at this early stage, they can lose confidence and stop using their prescribing skills. Support for newly qualified prescribers is therefore vital (M. Courtenay, personal communication, February 4, 2014).

III. Practice

The third pillar of the framework considers the practice of RN prescribers, including

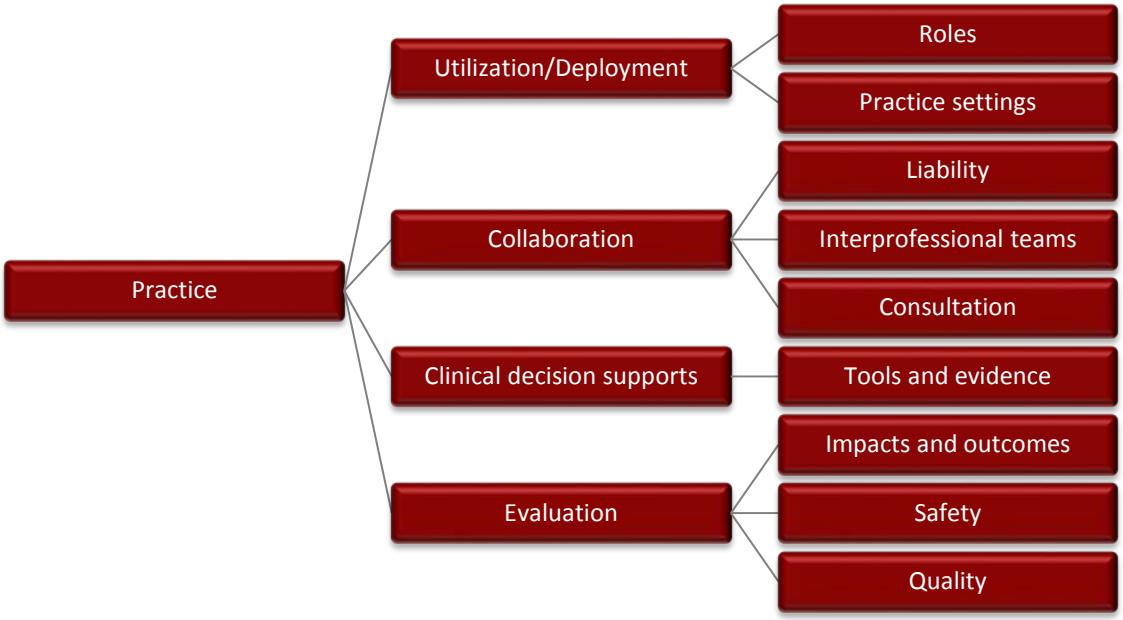
- their specific activities and practice settings;
- employment conditions;
- risk management;
- collaboration with other providers;
- tools required to do the job; and
- the evaluation of practice outcomes, safety and quality.

A key area in implementing RN prescribing practice involves the perceptions, reactions and support of other health-team members. Some studies have identified positive interprofessional outcomes from new prescribing models. Yet, many studies and reports have highlighted tensions in the effort to advance nurse prescribing. For example, studies in mental health settings have identified concerns about role conflict between nurses and psychiatrists (Jones, 2008; Rana, Bradley, & Nolan, 2009). Other authors have found that, while physicians might agree in principle to the RN prescribing role, disagreement remains on how this role should be implemented. Many studies have also found that physicians (both as individual practitioners and as medical associations/bodies) have concerns about patient safety in relation to nurse prescribing roles (Jones, Edwards, & While, 2011).

The introduction of RN prescribing roles in Canada has also received some resistance. In many Canadian jurisdictions, advocacy work on RN prescribing has felt pushback, particularly from the medical profession. For example, the Ordre des infirmières et infirmiers du Québec's recent efforts to advocate for independent nurse prescribing received substantial opposition from physician groups (Daoust-Boisvert, 2013). Similarly, Canadian Medical Association representatives described efforts to enhance the role of pharmacists in diagnosing and prescribing as a potential threat to patient safety (Weeks, 2008).

In terms of interprofessional relations, we have yet to see enough research to monitor the impact of Canadian RN prescribing roles. More information is needed to understand how enhancing the RN scope of practice with nurse prescribing influences RN relationships with other nursing and health-care colleagues. This is particularly important given that many nurse prescriber roles currently use a collaborative prescribing approach (whereby RNs work closely with other prescribers, such as NPs and physicians).

Figure 5.
Practice elements of RN prescribing



III. PRACTICE

Key element	Recommendation	Evidence or rationale
Utilization	Roles Adopt a pan-Canadian approach to the prescribing role and function of RN prescribers. RN prescribers in Canada have a baccalaureate degree or higher education level, along with additional education and experience. They possess and demonstrate the competencies for using clinical decision tools to: • deliver a diagnosis of an identified range of health conditions; • order and interpret a limited range of diagnostic tests; • prescribe and dispense a limited range of pharmaceuticals; and • perform specific procedures within their legislated scope of practice.	• Many deficiencies in Canada's health-care system stand in the way of equitable access to primary care (e.g., the lack of a primary care provider, long wait times, lack of convenience, increasing costs). There is an increasing acceptance by various stakeholders of RNs' value for improving access, patient experience and quality-of-care outcomes. RNs enjoy high levels of public trust and confidence (Weeks, 2008). There is growing evidence that patients are happy with the advice, information and practice of RN prescribers (M. Courtenay, personal communication, Jan 28, 2014) as well as compelling evidence for the effectiveness of RN prescribing (Courtenay, personal communication, January 28, 2014; Fittock, 2010; Watterson, Turner, Coull, & Murray, 2009). • RNs overwhelmingly agree that o they are not working to their full scope of practice (Courtenay, Carey, & Stenner, 2011). o they want to make use of their knowledge and skills, and they want to provide patient-centred care in a seamless delivery model (Canadian Nurses Protective Society [CNPS], 2006). • Research indicates that nurses whose scope of practice includes prescribing: o are satisfied with their practice o have enhanced self-esteem, job satisfaction and autonomy compared with other RNs who don't prescribe o have increased confidence of their knowledge of medications and their ability to collaborate o pay more attention to medication and read information more carefully o put more emphasis on the impact medication has on their patients o feel they are more respected and that prescribing alleviates pressure on physicians o feel more involved with patients o have the ability to tell patients more about their treatments and treatment plans o feel they can provide patients with a complete, streamlined package of care (Canadian Medical Protective Society & CNPS, 2013). • Several Canadian jurisdictions have already moved

Key element	Recommendation	Evidence or rationale
		forward with RN prescribing and are currently at different stages of establishing RN prescribing in their jurisdictions (see Appendix A). Pan-Canadian efforts would help to achieve early harmonization and consistency in standards, competencies and research.
Deployment	Practice settings RN prescribers should initially be deployed across a wide range of community health settings.[6] As a minimum, community health settings should include: • community health centres • primary care teams/clinics • home care • immunization clinics • mobile vans of all types • NP-led clinics • public health departments and programs • schools • quick-care clinics/walk-in clinics • remote health centres and nursing stations • sexual health clinics • street nursing programs Once established in these community-based settings, RN prescribing could be extended to other areas based on population health and system needs over time. Develop and disseminate common tools to assist employers and teams in successfully integrating RN prescribing within existing service delivery models. Tools and resources to support RN prescribing may include: • guides for managers to implement RN prescribing • RN prescriber job descriptions • organizational policies and procedures to support RN prescribing To participate in RN prescribing, each practice setting must meet established conditions and criteria related to structural support and safety.	• Millions of Canadians do not have regular access to a primary care provider and, among those who do, many complain they must wait too long to see their provider. • Lengthy wait times are a symptom of a health-care system whose priorities are in need of rebalancing (CNA, 2011). • Most people in emergency departments do not have emergency (or even truly urgent) health issues and could be safely registered, diagnosed, treated and discharged (or sent on to other providers) by RNs in the community. • There is evidence and "exciting examples [that] well-educated, trained and experienced nurses, practising to their full scope of practice, are essential for the transformation of care for Canadians" (National Expert Commission, 2012, p. 37). When the talents and competencies of nurses working in clinical settings are put to full and efficient use, outcomes for clients, nurses and organizations are maximized and health-care system effectiveness is strengthened. • Service organizations have to think about how they will employ RN prescribing, and how it will both fit into existing service delivery models and affect the need for capacity building. Practice settings need assistance to think through logistics such as hours of coverage and how to handle issues like absences of RN prescribers (M. Courtenay, personal communication, February 4, 2014). • Although practice- and organization- related conditions are important aspects of nurse prescribing, there is very little evidence regarding these domains. It is clear, however, that the successful integration of RN prescribers relies heavily on strong regulatory and educational structures and on a well-developed clinical infrastructure. For example, RN prescribing in Ireland and the U.K. highlight the need for a number of organization-based supports, including o organizational policies regarding RN prescribing; o risk-management systems;

Key element	Recommendation	Evidence or rationale
	Settings that are implementing RN prescribing must have: • organizational policies in place for RN prescribing • an ability to demonstrate that the organization can safely manage and ensure quality prescribing practices • risk management systems and processes for reporting adverse events incidents, near misses and medication errors • access to a drugs and therapeutics committee • mechanisms to audit the introduction of RN prescribing practices • a plan for developing the capacity of RN prescribing and support for new prescribers [6] *There is no consensus in the field on whether RN prescribers should initially be deployed across a wide range of community health settings.*	o a drugs and therapeutics committee; o prescribing site coordinators; o mentors for prescribers' clinical teaching; and o ongoing support for continuing education (Watterson, Turner, Coull, & Murray, 2009). • To advance practice-based efforts, some jurisdictions have developed resources to enable the integration of nurse prescriber roles. For example, in the U.K., the National Prescribing Centre has developed a guide for managers who are looking to implement nurse prescribing (Fittock, 2010). Such resources are crucial, given that managers and administrators must think about how nurse prescribers will fit into existing service delivery models to ensure successful integration and use of this role (M. Courtenay, personal communication, January 28, 2014). As well, the authors highlight a number of areas that could further improve this role, such as clearer roles and responsibilities, strategic support and the provision of protected time (Courtenay, Carey, & Stenner, 2011)
Collaboration	Liability All members of a health-care team, and the health institution that employs or has them under contract, should have adequate professional liability insurance or protection responsive to the types of liability that may be incurred (direct and vicarious) (Canadian Nurses Protective Society [CNPS], 2006; Canadian Medical Protective Association & CNPS, 2013; CNPS, personal communication, August 8, 2014). Before the working relationship begins, an initial consideration of the RN prescriber role and scope of practice should prompt a discussion about the scope of employment or contract for services the health institution has with the RN prescriber. There should also be written confirmation about the source and amount of legal defence funding for professional liability claims involving the RN prescriber (CNPS, personal communication, August 8, 2014).	• Each health-care professional is accountable for his or her professional practice. Most Canadian nurses are employees, and a court may order that the employer pay damages on their behalf (according to the legal doctrine of vicarious liability). Therefore, the introduction of the RN prescriber role should prompt a re-evaluation by all parties about the extent of their liability protection to ensure it addresses the increased scope of practice and attendant risks (CNPS, personal communication, August 8, 2014). • Professional liability insurance or protection is available to Canadian nurses in a variety of ways: o by membership with a provincial or territorial nursing organization that is a member of the Canadian Nurses Protective Society o as a benefit of registering with their nursing licensing body o through their employer's insurance coverage o through professional liability insurance individual nurses purchase from an insurance company (CNPS, personal communication, August 8, 2014)

Key element	Recommendation	Evidence or rationale
	Interprofessional teams To participate in RN prescribing, each practice setting must meet established conditions and criteria related to interprofessional team knowledge, practice and relationships. Develop and implement an interprofessional mentoring and CPD system for RN prescribers. Interprofessional team conditions must include: • identification in the practice setting of a named physician and/or an NP who has agreed to help develop the RN prescribing arrangements; and • a multi-professional education strategy, including ongoing communication to team members about RN prescribing, the RN prescriber scope of practice, the referral process, and outcomes measurement **Consultation** All sites participating in RN prescribing must demonstrate evidence of reliable access to an effective consultation process with physicians, NPs, pharmacists, other RNs and/or other health-care professionals appropriate to the practice setting.	• The cooperation and support of health-care professionals is crucial to the success of nurse prescribing (Bradley & Nolan, 2007). • Physician mentorship and teaching has been identified as an essential part of nurse prescriber education in many countries (Bradley & Nolan, 2007). Collaboration with physicians and other health-care providers also serves a number of other functions, including the support and continuous learning to further develop nurses' confidence and skills in prescribing (Stenner, Carey, & Courtenay, 2009). • The U.K. prescribing program requires physicians to mentor student prescribers and to work with them for 12 days in practice. Afterwards the physicians must sign off on their students' competence. Through this program doctors understand nurse prescribing and are reassured. As a result, they are not a barrier to the role (M. Courtenay, personal communication, February 4, 2014). • Therefore, engaging physicians early on and identifying and addressing the enablers and barriers in collaborative practice are crucial when considering the RN prescribing role.
Clinical decision supports	Create a roster of evidence-informed, pan-Canadian, clinical decision tools that is developed and approved by physicians, NPs, RN prescribers, pharmacists and other health-care professionals. All settings employing RN prescribers must use the clinical decision tools appropriate to the local setting and practice context.	Clinical decision tools to assist in assessment, diagnostics and treatments that include prescribed pharmaceuticals must be provided for each health issue across the range of RN prescribers' diagnostic practice. These tools are the established method to guide RN prescribing for a select range of conditions in some Canadian jurisdictions.
Evaluation	**Impacts and outcomes** Establish and/or modify provincial/ territorial and pan-Canadian electronic data systems to capture discrete, valid and reliable data on RN prescribers; for example, workforce data (including a minimum data set), prescribing patterns, costs and other defined outcomes and measures. Put structures in place within practice settings to monitor, audit and evaluate RN prescribing.	The measurement of outcomes is critical to continuous quality improvement and practice evaluation.

Key element	Recommendation	Evidence or rationale
	Safety and quality Develop and implement a minimum data set for indicators of RN prescriber practice patterns (including details of the number and type of prescriptions written), adverse events and related outcomes. Regulatory bodies must establish, monitor and maintain quality assurance and continuing competence standards and requirements. All employment settings must put structures in place to participate in RN prescribing data collection systems.	Canadian RNs are accountable for the quality and safety of the care they deliver (CNA, 2007; 2014b).

CONCLUSION

The preceding framework is organized around three the key elements of structure, competence and practice as well as 10 related strategic areas. According to the results of our literature review and examination of best practices in other jurisdictions, action is required in the following 30 areas to successfully implement RN prescribing in Canada.

STRUCTURE

Scope of practice

1. Adopt a pan-Canadian definition and title for the RN prescriber in all provinces and territories.
2. Protect the “RN prescriber” designation/title in legislation and regulations in all Canadian jurisdictions.
3. Develop and adopt a pan-Canadian description for the RN prescriber role in all jurisdictions across the country.

Legislation, regulations and bylaws

4. Enact and implement a broad scope of practice for RN prescribers by the use of enabling legislative and regulatory wording based on common, pan-Canadian core competencies. The specifics on scope of practice are reserved for regulatory body bylaws.
5. Amend existing federal/provincial/territorial nursing and other non-nursing statutes so that they will enable and be consistent with RN prescriber practice.

Standards

6. Develop and enforce pan-Canadian standards to define parameters and to guide and monitor RN prescriber practice.
7. Develop and adopt a standardized, pan-Canadian Prior Learning Assessment and Recognition (PLAR) process and other tools to determine candidate qualifications to enter RN prescriber practice.

COMPETENCE

Education

8. Establish and adopt minimum pan-Canadian entry requirements for RN prescribing education.
9. Establish and adopt pan-Canadian requirements and standards for post-basic RN prescribing education programs.
10. Mandate jurisdictional approval of post-basic RN prescribing education programs by the RN regulatory body based on pan-Canadian requirements and standards.

Competencies

11. Establish and adopt pan-Canadian RN prescribing competencies based on specific domains of competence.
12. Consider the development of a shared competency framework for all professionals engaged in prescribing.

Continuing competence

13. Establish pan-Canadian continuing competence requirements.
14. Develop and implement an interprofessional continuing professional development (CPD) system for RN prescribers, with additional supports for novice prescribers.

PRACTICE

Utilization/Deployment

15. Adopt a pan-Canadian approach to the prescribing role and function of RN prescribers.
16. RN prescribers should initially be deployed across a wide range of community health settings.
17. Develop and disseminate common tools to assist employers and teams in successfully integrating RN prescribing within existing service delivery models.
18. To participate in RN prescribing, each practice setting must meet established conditions and criteria related to structural support and safety.

Collaboration

19. All members of a health-care team, and the health institution that employs or has RN prescribers under contract, should have adequate professional liability insurance or protection responsive to the types of liability that may be incurred (direct and vicarious).
20. Before the working relationship begins, an initial consideration of the RN prescriber role and scope of practice should prompt a discussion about the scope of employment or contract for services the health institution has with the RN prescriber. There should also be written confirmation about the source and amount of legal defence funding for professional liability claims involving the RN prescriber.
21. To participate in RN prescribing, each practice setting must meet established conditions and criteria related to interprofessional team knowledge, practice and relationships.
22. Develop and implement an interprofessional mentoring and CPD system for RN prescribers.
23. All sites participating in RN prescribing must demonstrate evidence of reliable access to an effective consultation process with physicians, NPs, pharmacists, and/or other health-care professionals appropriate to the practice setting.

Clinical decision tools

24. Create a roster of evidence-informed, pan-Canadian, clinical decision tools that is developed and approved by physicians, NPs, RN prescribers, pharmacists and other health-care professionals.
25. All settings employing RN prescribers must use the clinical decision tools appropriate to the local setting and practice context.

Evaluation

26. Establish and/or modify provincial/territorial and pan-Canadian electronic data systems to capture discrete, valid and reliable data on RN prescribers; for example, workforce data including workforce data (including a minimum data set), prescribing patterns, costs and other defined outcomes and measures.
27. Put structures in place within practice settings to monitor, audit and evaluate RN prescribing.
28. Develop and implement a minimum data set for indicators of RN prescriber practice patterns (including details of the number and type of prescriptions written), adverse events and related outcomes.
29. Regulatory bodies must establish, monitor and maintain quality assurance and continuing competence standards and requirements.
30. All employment settings must put structures in place to participate in RN prescribing data collection systems.

APPENDIX A

RN prescribing in Canada: Current activities and status by jurisdiction

Jurisdiction	Current Activities and Status
Alberta	• The College and Association of Registered Nurses of Alberta is developing and finalizing standards for RN prescribing. RNs will be able to prescribe in specific settings for particular patient populations/needs.
British Columbia	• The College of Registered Nurses of British Columbia is leading the use of certified practice: RNs in certified practice have the authority to independently administer and dispense certain drugs that normally require a prescription or an order. Certified practice categories include contraceptive management, sexually transmitted infections, remote practice and RN First Call (rural practice).
Manitoba	• The College of Registered Nurses of Manitoba is developing a RN prescribing role (currently referred to as "RN authorized prescriber") that will be linked to specific practice settings and specialties (e.g., primary care, public health, reproductive health).
New Brunswick	• RN prescribing not in place.
Newfoundland and Labrador	• RNs working in specific areas of the province may (under authorization through their employer) provide patients with selected medications in specific situations.
Nova Scotia	• RN prescribing not in place.
Northwest Territories	• RN prescribing not in place.
Nunavut	• RN prescribing not in place.
Ontario	• RN prescribing not currently in place.
Prince Edward Island	• RN prescribing not in place.
Quebec	• The Ordre des infirmières et infirmiers du Québec is in the process of implementing RN prescribing for specific situations and patient needs.
Saskatchewan	• The Saskatchewan Registered Nurses' Association is in the midst of implementing "additional authorized practice." This is somewhat similar to the certified practice approach in British Columbia.
Yukon	• RN prescribing not in place.

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