Authorized Prescriber
transition project

Authorized Prescriber Employer Toolkit

a collaboration of:

College of Registered Nurses of Manitoba

THE COLLEGE OF REGISTERED PSYCHIATRIC NURSES of MANITOBA

Shared health Soins communs Manitoba

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Intro and background

The purpose of this toolkit is to provide an introduction of the Nurse Authorized Prescriber (AP) role in Manitoba. A significant public need has been identified for the AP role for Registered Nurses (RNs) and Registered Psychiatric Nurses (RPNs). 3 central practice areas have been identified as areas of focus for the AP role:

- Sexual and reproductive health
- Diabetes management
- Travel health

This role permits RNs and RPNs, who complete a specialized education program, to prescribe medications for specific client populations. This differs from the current approach whereas RNs and RPNs administer medications with a prescriber's order. Under the current Regulated Health Professions Act, the Authorized Prescriber Role has been added for RNs, and will be added under General Regulation for RPNs.

The goal of the AP role is to:

- Target gaps in access and care for structurally disadvantaged populations and persons living with chronic illness
- Decrease health care costs through nurse-driven primary, secondary, and tertiary approaches to care
- Promote timely treatment for Manitobans in the areas of sexual and reproductive health, diabetes management, and travel health
- Expand the RN and RPN scope of practice to better meet the health needs of Manitobans

A nurse in the AP role engages in critical inquiry to determine holistic plans of care. Following thorough assessment, diagnostic reasoning and planning occurs; engaging the client and their supports as appropriate. Care involves ordering specific diagnostic tests and prescribing drugs and vaccines relevant to the AP's areas of practice. APs maintain the responsibility of interpreting and managing the client's test results, evaluating treatment, and working collaboratively with other health care providers to ensure the overall health needs of the client are met.

Why does this matter for clients, communities and populations?

Community members, including underserved and stigmatized populations, will benefit from increased access to timely comprehensive care for unmet health needs, close to home. The AP role has the potential to reduce the number of visits or provider contacts required to obtain a diagnosis, health education, and treatment for common conditions. AP care focuses on health promotion and illness prevention, using harm reduction principles. Clients can benefit from receiving prescriptions for vaccines and contraception in addition to treatment for infections and chronic conditions. Health education and referral to other care providers or community supports contributes to holistic care.

There are several populations identified to benefit from the AP role. These include but are not limited to:

- Residents living in northern, rural or remote areas
- Inmates in a correctional facility
- Individuals living with diabetes
- Survivors of sexualized violence
- Those seeking sexual and reproductive health services
- Clients in need of travel health services
- Street involved populations
- Gender minorities
- Persons living with chronic disease
- Adolescents/Youth

Potential areas of practice for APs

There may be opportunity to implement the AP role in the following practice areas:

- Community clinics (including STI, teen clinics, community health)
- Northern and remote nursing stations/clinics
- Transgender Health Clinic
- Sexual Assault Nurse Examiner Program
- Rural health clinics
- Correctional facilities
- Access Centres
- Chronic Disease Management
- Urgent Care and Emergency Departments
- Outpatient areas (ie: Mental Health, HIV Clinic)
- Public Health
- Home Care
- Cervical Screening Programs
- Long Term Care

Benefits to employer

In addition to providing benefits to targeted populations and the community as a whole, the AP role provides several benefits to the employer. Some of these benefits include:

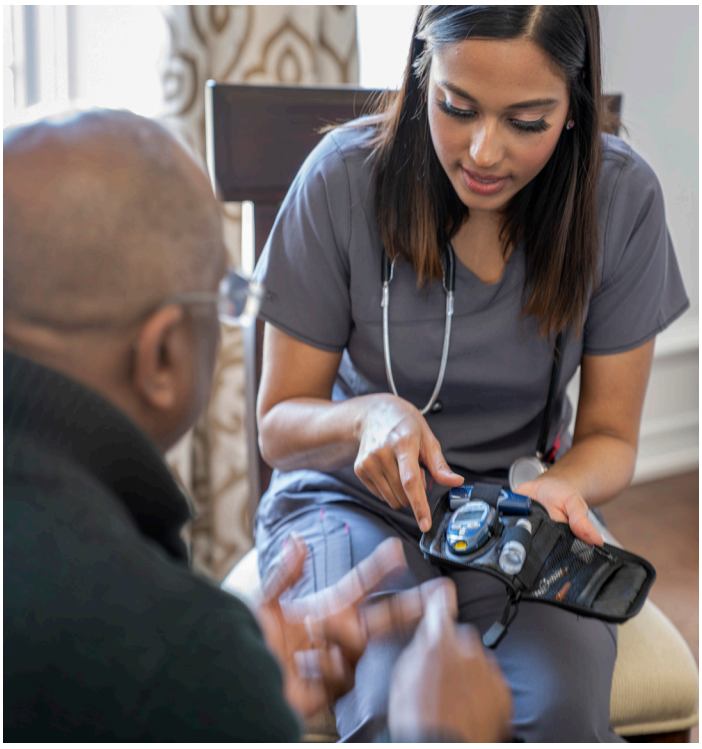
- Increased job satisfaction for nurses which strongly correlates with nurse retention
- Improved team functioning, workplace satisfaction and productivity due to freeing up time for additional care provision by other health care providers
- Improved client outcomes due to cost efficient and safe comprehensive care

See Appendix B

Care delivery model

A nurse AP role works well within an interprofessional collaborative care model. Key considerations for the type of care delivery model selected for a particular setting include the complexity, predictability, and risk of negative outcomes associated with the care being delivered, as well as the needs of the population.

Environmental factors such as overall staff mix, proportion of novice and expert nurses, and available resources, should also be considered in determining the best care delivery model for a particular setting. Care delivery models incorporating the AP role should consider the needs of the client population being served when developing postings to consider if they require an RN (AP), RPN (AP) or if the position can be posted as either RN/RPN (AP).



Site/Program/Service readiness

Early engagement of the interprofessional care team on the unit/program/service is strongly encouraged and is imperative to success. Discussions should not only include members on the interprofessional team but those who may be outside the organization as well. Increased awareness of the role can facilitate uptake and immediate results, potentially reducing wait times and helping to balance workloads.

Examples of stakeholders to engage with include, but are not limited to:

- Senior management
- Nursing leadership
- Medical leadership
- Clients
- Allied health leadership
- Unit/Program/Service leadership
- Formal and informal clinical leaders
- Members of the pharmacy team
- Diagnostic/laboratory services teams

Questions to consider when assessing site readiness include:

- Are there client needs that would be better met with the introduction of the AP role?
- To what extent is the introduction of the AP role consistent with the values, attitudes, beliefs and goals of the practice environment?
- To what extent are staff motivated to welcome the AP?
- Is there resistance to the introduction of the AP?
- Is the staffing complement on the unit/program/service stable or changing?
- Are there other priorities within the setting that will compete with the initiative?
- What experiences have the members of the healthcare team had working with an AP?
- How will clients best benefit from the role of the AP?
- Will collaboration with other prescribers be accessible to the AP?

To prepare for the AP role, the workplace will want to identify stakeholders and consider:

- Populations served
- Staffing
- Setting
- Health outcomes
- Administrative aspects
- Team integration
- Role evaluation
- Sustainability

Refer to the following document to guide this process: Exploring the Implementation of the RN(AP) Role

Team collaboration

Once the decision to introduce the RN/RPN AP role has been confirmed, the healthcare team will need dedicated time to refine, clarify, and reorganize team roles, responsibilities, and expectations.

Refer to the Practice Document: Interprofessional Collaborative Care for more information on collaboration with team members:

Interprofessional Collaborative Care

During the process of implementing the role, opportunity should be made available for all team members to openly voice concerns and issues that may arise. Management and team leaders should ensure that all questions receive timely responses.

Human resource/labour relation issues

There will be human resource and labour relation considerations related to the introduction of the AP role, which are undetermined at this time. It may be helpful to consider if the AP role can be integrated into an existing role, or whether a new role will need to be created.

Employers also need to consider the cost benefit analysis of introducing a new role, and the potential cost and savings to the system (see Appendix B for more information).

Further considerations include:

- Should the role be trialed as a pilot prior to implementing on a permanent basis?
- Do job descriptions need to be updated or revised?
- Do the qualification requirements support recruitment internally and/or externally?

The employer and AP may consider consulting the Canadian Nurses Protective Society for more information on insurance and liability.

Communication plan

Communication may need to target:

- Staff on the unit/program/ service where the AP is being introduced (priority focus for communication)
- Other staff in the organization
- Members of the interprofessional team
- Unions
- Nursing Practice Councils
- Clients and families
- General Public

Key messages to be considered include:

- Rationale for introducing the AP role into this particular setting
- Potential contributions of the AP to the team and care on the unit/program/ service
- Impact of AP introduction on the roles of other members of the team
- Plans for the AP to be introduced to additional units/ programs/services
- Benefits of the AP role to the client and community
- The responsibilities of the AP, including scope of practice

Possible communication mechanisms:

- Leadership meetings
- Staff meetings
- Huddles at shift change
- Staff email system
- Newsletter
- Existing committee structures
- Regional Health Authority websites and communication
- Communication with interprofessional collaborations and other health professionals

Evaluation

The introduction of the AP to a new practice setting should be evaluated relative to the impact on client care outcomes, team functioning, and client/family/staff satisfaction.

Potential research questions should target the impact of the introduction of the AP on such indicators as:

- Client outcomes
- Client satisfaction with care delivery
- Team/staff satisfaction with the addition of the AP role
- AP competency
- Benefits to employer

Client outcomes may include:

- Perception of being well cared for
- Client engagement with care plan
- Perception of the AP's knowledge of clients, families and populations
- Trust and confidence in the care provider
- Collaboration amongst care providers
- Decreased hospital admissions related to the area of practice
- Increased access to contraception, contributing to decreased unplanned pregnancies and therapeutic abortions
- Reduced visits to emergency departments for unintended consequences (ie: complications related to diabetes, sexually transmitted infections, and travel related illnesses)
- Symptom resolution or reduction
- Reduction in travel related illnesses
- Quality of life

Quality of care

The role of the AP has the opportunity to bring to the setting distinct impact on quality of care.

The AP strives to deliver quality care through the following:

- Individualized one-on-one time, enhancing or supporting client-centered care
- Delivering preventative health care with a focus on health promotion
- Increasing access to targeted medications and vaccines with reduced barriers
- Streamlining access to care using a health equity approach
- Practicing with harm reduction principles
- Connecting clients to community resources and assisting with system navigation
- Using critical inquiry and synthesizing specific knowledge, skill, and judgement to independently apply diagnostic reasoning and decision-making
- Independently prescribe drug treatment, and monitor and evaluate treatment response, contributing to continuity of care
- Collaborating with other care providers to ensure the overall needs of the client are met

Resources

College of Licensed Practical Nurses of Manitoba, College of Registered Nurses of Manitoba, & College of Registered Psychiatric Nurses of Manitoba. (2020). *Nursing in a Team Environment.* Retrieved from https://crpnm.mb.ca/about-rpns/scope-of-practice/publications/

College of Registered Nurses of Manitoba (2019). *Scope of Practice for RNs.* Retrieved from https://www.crnm.mb.ca/uploads/document/document_file_254.pdf

College of Registered Nurses of Manitoba (2018). *Scope of Practice for RN(AP)s.* Retrieved from https://www.crnm.mb.ca/uploads/document/document_file_238.pdf

Additional resource documents are available upon request by contacting the College of Registered Nurses of Manitoba and the College of Registered Psychiatric Nurses of Manitoba.

Survey Regarding the RN & RPN Authorized Prescriber (AP) Role

As we move closer to the May 31 2022 date when the AP notation transition period ends, we are hoping to ensure all employers and registrants have a greater understanding of this notation, its scope of practice and benefits to the public.

We invite you to complete a short survey on the AP role and provide feedback on this publication. Information from this survey will be utilized for developing future resources

Take the Survey

Appendices

Appendix A

Comparison of Practice Roles: Authorized Prescriber (AP) and Nurse Practitioner (NP)

Category for Comparison	RN(AP) or RPN(AP)	RN(NP) RN(Nurse Practitioner)
Title and membership class	• RN(AP) or RPN(AP) title • RN membership class • (AP) notation	• RN(NP) title & membership class
Role (employer determined)	• RN(AP) or RPN(AP) (unless employer determines other role)	• Nurse Practitioner (unless employer determines other role)
Competencies	• RN or RPN entry level competencies • RN(AP) or RPN(AP) competencies • As developed via Nurse Prescriber advanced certificate & professional development	• RN entry level competencies • RN(NP) entry level competencies • As developed via Master's level education & professional development
Scope of Practice	• RN or RPN scope of practice plus • RN(AP) or RPN(AP) scope of practice o Prescribe from a schedule o Order/receive diagnostics from a schedule	• RN(NP) scope of practice including o Prescribe Schedule 1 drugs and vaccines o Order/receive diagnostics (no schedule) o Setting a fracture/dislocation
Classification per Collective Agreement		Nurse Practitioner

Appendix B

Cost/Benefit Analysis Literature Review (Rapid Review)

When examining the cost/benefit of Authorized Prescribing by RNs or RPNs, the peer-reviewed research literature considers the following facets in comparison to usual available care (physicians):

- **Safety:** Nurse Prescribing is as safe or safer than prescribing by physicians (Drennan et al 2009; Gielan et al 2014; Latter et al 2010; Weeks et al 2017).
- **Effectiveness:** Nurse Prescribing is as effective or more effective for patient outcomes (such as glycated hemoglobin, systolic blood pressure or any other patient outcomes measured in the research) (Gielan et al 2014; Weeks et al 2017).
- **Client satisfaction:** Clients are as satisfied or more satisfied with prescribing by nurses compared to physicians (Drennan et al 2009; Gielan et al 2014; Latter et al 2010; Weeks et al 2017). Additional time available to clients by nurses may be one of the significant contributing factors.
- **Acceptance by other care providers:** Other health care providers (physicians as well as other team members) generally accepting of nurse prescribers (Gielan et al 2014; Latter et al 2010; Weeks et al 2017). A variety of drivers may contribute to acceptance by other health care providers such as improved work-life balance, trust of the work by nurse prescribers however a deeper examination of these driving factors would be required to fully understand these findings.
- **Client access to care:** This outcome was not measured in the literature found as it was assumed there would be an increase in client access.
- **Cost (financial) and/or savings:** The literature noted the gap in research for financial costs related outcomes. (Weeks et al 2017). However, one study by i5 H data for the National Health Service (2015) demonstrated that an economic evaluation of nurse prescribing is possible and did show a cost savings for the health care system.

Limitations

All articles included in this review referred to prescribing however, some focused on non-medical prescribing and not only nurse prescribing (i.e. by nurses or pharmacists). The two systemic reviews found a risk of positive bias toward nurse prescribing compared to usual care, however, Weeks et al (2017) states there is still an overwhelming evidence in favour of nurse prescribing.

References

Drennan J, Naughton C, Allen, D, Hyde A, Felle P, O'Boyle K, Treacy, P. (2009) *National independent evaluation of the nurse and midwife prescribing initiative.* University College Dublin, Dublin.

Gielen, S., Dekker, J., Francke, A., Mistiaen, P., Kroezen, M. (2014). *The effects of nurse prescribing: a systematic review.* International Journal of Nursing Studies: 2014, 51(7), 1048- 1061.

Latter, S et al (2010). *Evaluation of nurse and pharmacist independent prescribing.* University of Southampton Keele University.

NHS Health Education North West (2015) i5 Health. *Non-Medical Prescribing (NMP): An Economic Evaluation*

Weeks G, George J, Maclure K, Stewart D. (2017). *Non-medical prescribing versus medical prescribing for acute and chronic disease management in primary and secondary care (Review)*. Cochrane Database of Systematic Reviews 2016, 11. Art. No.: CD011227.

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