House of Commons
Chambre des communes
CANADA

Standing Committee on Health

HESA • NUMBER 021 • 2nd SESSION • 41st PARLIAMENT

EVIDENCE

Tuesday, April 8, 2014

Chair

Mr. Ben Lobb

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● (0845)

[*English*]

The Chair (Mr. Ben Lobb (Huron—Bruce, CPC)): Good morning ladies and gentlemen. We're back again on our study on this nice, rainy morning, but it's better than snow.

Once we're through with our witnesses we have about 10 or 15 minutes set aside at the end of our committee meeting, when we'll go in camera to discuss committee business. We'll ask our guests to leave at that time. We'll probably end about 15 minutes early so that we can have about 10 minutes for committee business.

We have a number of great witnesses today.

We have Judy Morrow from the Canadian Association of Practical Nurse Educators. We also have Debbi Templeton. Share your time as you see fit.

Just so that everybody knows, you have 10 minutes or thereabouts to do your presentation. If you have any questions, ask at any time.

Ms. Judy Morrow (Board Member, Canadian Association of Practical Nurse Educators): Good morning, Mr. Chair and members of the committee.

My name is Judy Morrow. I am the provincial program manager for the practical nursing education program in Nova Scotia. With me is Debbi Templeton, coordinator of health programs, from New Frontiers School Board in Ormstown, Quebec. We are here this morning representing the Canadian Association of Practical Nurse Educators, or CAPNE.

I would like to thank the committee for the opportunity—

Mr. Terence Young (Oakville, CPC): I have a point of order, Mr. Chair.

Excuse me, Ms. Morrow. I beg your pardon.

The Chair: Yes, Mr. Young.

Mr. Terence Young: I'd like to ask for unanimous consent to get the presentations from the witnesses here today. I realize that they're only available in English, and it's nobody's fault, but it would be much easier to get more out of this meeting if we had them.

The Chair: Do we have unanimous consent?

An hon. member: No.

The Chair: Okay.

I'm sorry, Mr. Young.

Carry on, Ms. Morrow.

Ms. Judy Morrow: I'd like to thank the committee for the opportunity to comment and provide input on behalf of the Canadian Association of Practical Nurse Educators this morning.

The Canadian Association of Practical Nurse Educators, or CAPNE, was formed in 2000, with the initial meeting held in Manitoba. At that meeting there were practical nursing educators and licensed practical nursing regulatory bodies from each province and territory, with the exception of Quebec.

CAPNE is the national voice for practical nursing education in Canada, with representation on the board from all provinces and territories. CAPNE's objectives include supporting and enhancing the quality, effectiveness, and consistency of practical nursing education across Canada.

In support of our strategic goals, a national educators conference is organized annually and takes place in a different province each year. These conferences have been very successful, with an average of about 120 participants from across Canada in attendance and much great feedback from attendees. The venue provides the opportunity for practical nursing educators to get together, to collaborate, to share best practice stories, and to gain a clearer understanding of the big picture of practical nursing education across the country, as well as learn and understand more clearly the role of the licensed practical nurse, or registered practical nurse, as it is called in some provinces.

Over the years, some common themes have been identified as issues, or barriers, perhaps, by practical nurse educators across Canada. I will speak to some of those now.

The first is the difficulty in obtaining appropriate clinical education sites in which LPNs, the licensed practical nurses, or RPNs, registered practical nurses, work to full scope of practice, especially in mental health and maternal child nursing areas in some jurisdictions.

Second, with increased competition for clinical sites, simulation has been seen as a way to augment clinical experience, but not everyone has access to good simulation labs or good equipment, because of the cost of set-up and maintenance. Simulation in more remote areas of the country may not be readily available, and this is seen as a barrier in some instances.

The third is difficulty in obtaining clinical instructors. These positions are on a part-time casual basis, and it's difficult to attract qualified nurses for short-term casual work.

Then we raise the issue of the role of clarity. The role of the practical nurse may vary from setting to setting and from province to province in terms of the ability to work to their full scope of practice. Often, fellow health care staff do not fully understand the role of the LPN or RPN, because the role can vary a great deal depending upon the setting in which the individual is working.

In Ontario, for example, the Nursing Act identifies scope of practice for an RN and an RPN in the same statement, noting that nursing is one profession with two categories. From this, some argue, the scope of practice statement for nursing in Ontario is the same, which technically it is. Confusion can arise when "scope of practice" is being defined and used in two different ways. We feel it would be helpful to have more clarity in terminology, and on a national scale.

While role clarity is sometimes fuzzy for the LPN or RPN, there are many provincial differences and there is possibly more confusion in respect to the role of the unregulated health care worker. This can cause much confusion at the national level whenever we talk about the LPN and RPN role in terms of delegation to the unregulated worker.

Some areas identified as important in the future of practical nursing education as we move forward include: first, providing opportunities for inter-collaborative education, for example, forming teams of students from different disciplines to work collaboratively within their respective roles and scopes of practice in a clinical experience so as to bring about positive outcomes in meeting their learning goals; second, exploring the possibility for students and/or faculty to exchange between provinces and other regions of Canada in order to gain a broader national perspective; third, having continuing opportunities for international placements for practical nursing students in order for them to work inter-collaboratively and develop cultural competence and learn first-hand about health care standards, the role of the health care team, and health care issues that affect populations outside of Canada.

● (0850)

Continuing to support the transition of internationally educated nurses into the Canadian nursing system is identified as very important and has been a standing agenda item for our board for some time. This offers many benefits. I believe we all see that the nursing shortage will likely happen. It hasn't to the extent we anticipated some time ago, but it's inevitable that it is about to happen, given the age of the nursing population at this point.

For example, data for Nova Scotia from the Canadian Institute for Health Information's "Regulated Nurses, 2012" report shows a decrease in the overall number of licensed practical nurses of 1.5% from 2011 to 2012, with the average age of the LPN in the province being 45 years. On par with the RN population age, many LPNs can retire in the next few years. In addition to filling the gap in much-needed nursing positions, well-educated and experienced IENs, internationally educated nurses, help make our health care system more culturally diverse. As our population ages, these individuals, IENs in other words, will play an important role in sustaining Canada's health care system.

An issue brought forward in Quebec is that all nurses there who are internationally educated must have English proficiency, of course, as they do in every other province, but they must also have French proficiency. Under current legislation, graduates of nursing programs have to obtain a licence in the province from which they graduated before they can move on to become licensed in another province. Without passing the French exam, they cannot be licensed; therefore, they cannot move on to another province or become licensed in another province. This extra layer can certainly limit the internationally educated nurse's success.

In conclusion, on the topic of internationally educated nurses, I'd like to share with you a best practice story from my province, Nova Scotia. Over the past four years the College of Licensed Practical Nurses of Nova Scotia, CLPNNS, in partnership with the Nova Scotia Community College, NSCC, and with funding from the Nova Scotia Office of Immigration, has developed and implemented a program for internationally educated nurses. This program is called the pathway to success. The program builds on the internationally educated nurse's education and experience, leading to a credential as a licensed practical nurse and employment in Nova Scotia.

Since 2010 CLPNNS has licensed 113 IENs as LPNs in Nova Scotia, and today approximately 90% are currently employed in Nova Scotia. In March the pathway project received the 2014 International Qualifications Network, IQN, innovation award at the awards ceremony held in Ottawa. We currently have funding for this project until the end of June, and we're looking forward to meeting the educational requirements of possibly up to 20 more internationally educated nurses in that timeframe.

Thank you very much for your time this morning.

● (0855)

The Chair: Thank you very much.

Next up, from the Canadian Nurses Association, are Dr. Barbara Mildon and Josette Roussel.

Go ahead, for 10 minutes please.

Dr. Barbara Mildon (President, Canadian Nurses Association): Thank you for inviting the Canadian Nurses Association to be part of today's proceedings.

I am Barb Mildon, president of CNA. I am pleased to be joined by Josette Roussel, who is a senior nurse consultant at CNA. I am a certified community health nurse and have worked in clinical and management positions in both B.C. and Ontario for many decades. My current role is vice-president of professional practice, human resources and research, and chief nurse at the Ontario Shores Centre for Mental Health Sciences in Whitby, Ontario.

CNA is the national professional voice of registered nurses in Canada. We support registered nurses in their practice, and we advocate for healthy public policy and a quality, publicly funded, not-for-profit health care system. A federation of 11 provincial and territorial nursing associations and colleges, CNA represents more than 150,000 registered nurses and nurse practitioners across the country.

Today we will share some information about registered nurses in Canada, provide an overview of the factors affecting nursing scope of practice in Canada, present a best practice example, and three recommendations on ways the federal government can support efforts to optimize the roles of nurses through legislation and as an employer of nurses.

In Canada there are three regulated nursing professions: registered nurses, licensed practical nurses, and registered psychiatric nurses. For registered nurses three national groups actively support the profession: CNA, the Canadian Nurses Association, is the professional voice; the Canadian College of Registered Nurse Regulators is the regulatory or licensing voice; and the Canadian Federation of Nurses Unions advances the socio-economic concerns of nurses in the country.

Registered nurses are the largest regulated health profession in Canada. According to the Canadian Institute for Health Information, there were 356,422 regulated nurses working in Canada in 2012. These break down into 292,883 RNs, 99,935 licensed practical nurses, which my colleagues have already explained are called registered practical nurses in Ontario, and 5,528 registered psychiatric nurses, who exist only in Canada's four western provinces and the Yukon. We have over 4,000 nurse practitioners across the country. Over 60% of registered nurses work in acute care settings, 15% in community health care, and nearly 10% work in long-term care.

CNA defines scope of practice as those activities that registered nurses are educated in and authorized to perform as set out in legislation and complemented by the standards, guidelines, and policy positions of provincial and territorial nursing regulatory bodies.

There are four specific controls on nursing scope of practice. First, legislation by provincial and territorial governments establishes the broad scope of nursing practice. Second, the requirements for education, standards of practice, and continuing competence are established by the nursing regulatory colleges or associations. Third, the individual nurse assesses his or her competence to carry out an activity within his or her scope of practice. Finally, there are the settings in which the nurse practices, including the requirements of the employer, and the needs, which of course are front and centre, of patients and clients.

In Canada the federal, provincial, and territorial governments also have acts and regulations which augment the nursing acts. All of these influence the scope of RN practice. For example, the federal Controlled Drug and Substance Act describes the drugs that RNs and nurse practitioners can administer. There are the jurisdictional acts and regulations related to RNs pronouncing death in long-term care facilities.

For a best-practice example that illustrates scope and limitations we can look to the British Columbia Nurses (Registered) and Nurse Practitioners Regulation, section 6, which states that registered nurses may carry out wound care without an order. I

● (0900)

n B.C., that means a nurse can cleanse, irrigate, probe, debride, pack, and dress wounds. However, many jurisdictions do not allow for this autonomous practice and still require an RN to have a doctor's order to do this activity. Even though B.C. has an expansive and defined regulation for autonomous scope of practice activities, there are employers in B.C. who may not allow RNs to perform this activity, which is another barrier to RNs working to full scope.

CNA believes that safe nursing practice in the interest of the public and optimal deployment and retention of registered nurses are best served when provincial and territorial governments and their nursing regulatory bodies adopt a comprehensive regulatory framework that reflects the reality of RN practice and clear responsibility and accountability mechanisms for scope of practice activities by competent nurses.

My colleague from CCRNR will speak directly about this and the important work under way to update the regulatory framework for nursing and ultimately support the harmonization of regulations across Canada. My colleague from the Canadian Association of Schools of Nursing will provide similar specifics concerning education of RNs.

CNA recommends that this committee recommend to the federal government that they create a federal, provincial, territorial table to support harmonization of variations in scope of practice legislation. At this table the jurisdictional legislators, the RN regulators, educators, and employers could come to consensus on how to adjust legislation, professional regulatory frameworks, and standards of practice so that RNs can carry out consistent and optimal scopes of practice across the country.

In this way RNs working at the top of their scope of practice can be best utilized to promote cost-effectiveness and access to care in all parts of Canada, which would also enhance the mobility of nurses throughout our country and the retention in the workforce.

We see this recommendation as building on past successful collaborations with Health Canada and the federal, provincial, territorial tables, specifically the Canadian Nurse Practitioner Initiative report in 2006 which, among other things, led to the identification of barriers and enabling factors to optimize the role of nurse practitioners across Canada. This initiative articulated legislative and regulatory barriers to full scope of practice for nurse practitioners, including the regulations needed for them to be autonomously able to prescribe controlled drugs and substances.

While the federal government enacted those regulations in 2012, less than half the jurisdictions in Canada have implemented those welcomed changes. Accordingly, we recommend that this committee identify the development of a harmonization strategy as a requirement of any collaborative work that results in expanded scope of practice.

This recommendation is also an opportunity for the federal government to optimize RN scope of practice in its role as the fifth largest employer of registered nurses in Canada. As this committee heard, RNs provide care and program support in Health Canada, Correctional Services, the Canadian Forces, Citizenship and Immigration, Employment and Social Development, and Veterans Affairs.

Harmonized recognition of RN qualifications would enhance the mobility of nurses working for the federal government, making it easier to fill federal vacancies, and would be especially helpful in enhancing emergency preparedness during times of pandemic or other public health crises. The harmonizing work under way by our regulator colleagues stands to be greatly enhanced by the creation of a dedicated federal, provincial, territorial table to support its implementation.

This leads me to CNA's second recommendation for federal government action to optimize scope of practice, namely to address the remaining barriers to implementation of the nurse practitioner role.

First, NPs should be added to the list of professionals exempted from section 14 of the Food and Drugs Act. This would enable them to distribute samples of pharmaceuticals they are already prepared and authorized to prescribe to patients. The exclusion of this authority is a direct example of a scenario where legislation needs to change to keep up with evidence-based changes to scope of practice.

● (0905)

Second, NPs should be recognized as health professionals who are authorized to sign claim forms for federally administered programs, such as the disability tax credit certificate, CPP disability benefits, employment insurance benefits, and benefits under the Public Service Superannuation Act.

Many jurisdictions have passed consequential amendments to provincial acts allowing NPs to assess and sign various forms. We recommend that the federal government review existing policies where physician signatures are required to determine if nurse practitioners have the knowledge and skill to be included as signatories, thereby increasing access for Canadians to timely benefits that affect their health.

To the third component of the committee's study, CNA recommends that the federal government, as an employer, support skills training and continuing education for its nurses. National specialty certification exams are offered by CNA for RNs in 20 areas of nursing practice. This credential demonstrates that an RN is qualified and competent in several elements of specialty nursing practice. Promotion and support of this credential by employers is a way for the federal government to support a best practice in skills training for RNs.

My final comments relate to the role of registered nurses in practice in Canada, which I hope will be helpful in considering interprofessional practice.

There is a universality to nursing, particularly in acute care settings, in that registered nurses are assigned to entire patient populations. While individual patients among such a population may also be assigned to a behavioural specialist or a physiotherapist, etc., to support that patient's recovery, those decisions are made on an individual basis. Nurses are the professionals responsible for providing care from morning to morning. Their involvement in care is a constant. The principles of safe staffing and effective teams demand that each person within a team understand each other's scope and role, and keep the needs of the patient at the very centre of the care.

We appreciate your consideration of these recommendations and look forward to your questions.

Thank you.

The Chair: Thank you very much.

Next up is Dr. Cynthia Baker, from the Canadian Association of Schools of Nursing.

Go ahead, please.

Dr. Cynthia Baker (Executive Director, Canadian Association of Schools of Nursing): Good morning. My name is Cynthia Baker, and I am the executive director of the Canadian Association of Schools of Nursing.

CASN—*ou l'ACESI en français*—is the national voice of nursing education in Canada. On behalf of CASN, I would like to thank the health committee for inviting us here today to speak to this very important and timely study.

[*Translation*]

We are pleased to have the opportunity to present our views on this subject.

[*English*]

First, I will begin with some information about CASN. Second, I would like to take a quick look at my crystal ball and share with you some health care issues we see coming down the road—well, actually we see them just around the corner. We believe they have important implications for scopes of practice, health team collaboration, and nursing education. I will conclude with an area where we see the federal government playing an essential role.

First about CASN, we are a national and bilingual organization of the 91 schools of nursing offering baccalaureate and/or graduate programs of nursing in Canada. Our mandate is to promote high-quality nursing education across the country.

Currently there are a total of 53,184 students in our member schools: 48,962 of them are in baccalaureate programs, 2,776 in master's programs, 999 in nurse practitioner programs, and 447 in doctoral programs for nurses. Nursing faculty currently number 8,192 across the country.

● (0910)

[*Translation*]

I would like to point out that our Quebec members and francophone nursing schools outside Quebec— in New Brunswick, Ontario and Alberta—are very engaged and active.

[*English*]

We also have member schools in rural and remote areas of Canada, for instance, Aurora College in the Northwest Territories and Arctic College in Nunavut. Many schools of nursing have adopted special measures to ensure that aboriginal communities access their programs, and CASN works closely with the Aboriginal Nurses Association of Canada to improve the recruitment and retention of aboriginal nursing students.

What does CASN do? As part of its mandate, CASN is the national accrediting body for baccalaureate nursing education. We have formal memoranda of understanding with a number of regulatory associations linking provincial regulatory approval to pan-Canadian educational standards. Accreditation is important in ensuring pan-Canadian educational standards.

I would like to take this opportunity to add that Canadian nursing education is widely acclaimed internationally. Many actually consider it to be the best in the world. CASN is currently assisting governments in Bangladesh,

[*Translation*]

and also in Haiti,

[*English*]

to strengthen the quality of their respective nursing programs through accreditation and curriculum evaluation.

We develop educational guidelines, frameworks, and resources to promote high-quality nursing education across the country. For example, we have guiding principles and essential components for nurse practitioner programs and guiding principles and essential components for bridging programs for internationally educated nurses.

Other initiatives target areas of health care needing greater curricular emphasis, such as interprofessional collaboration. With help from Health Canada we develop national competencies in teaching and learning resources to build faculty capacity to teach palliative and end-of-life care. Similarly, we have created competencies and teaching toolkits to assist faculty in preparing nursing students to deliver care in technology-enabled environments.

Our methodology ensures that the frameworks are well developed, but I think that more importantly, the pan-Canadian process we use mobilizes the targeted curriculum change by engaging our membership,

[*Translation*]

including our francophone members,

[*English*]

building consensus nationally and producing momentum to shift education for nurses.

As a national organization working in nursing education, we often find this challenging, because education and health are largely provincial and territorial matters. However, time and time again CASN has seen the importance of a national harmonization of nursing education. A nurse may be educated at the University of Alberta but may find employment in northern B.C., rural Saskatchewan, or downtown Toronto. These environments present different nursing demands, but our nursing graduates should be prepared for all of them. CASN sees an important role for the federal government in the scope of practice, skills training, and curriculum development for health care professionals.

As to future trends—my crystal ball—the burden of disease and health care delivery is shifting as the population ages and obesity rates rise. The health care issue facing the largest number of Canadians today, we believe, is how to live with or support someone living with multiple, complex, interacting, and often incapacitating chronic conditions. Cases of dementia are also rising rapidly, and the need for palliative end-of-life care is increasing as a result of the aging of the population. As the very first baby boomers are only 67, we are seeing only the tip of the iceberg. We believe that these issues are likely to grow exponentially in the next three decades.

I know that the health committee studied chronic disease in 2012 and I have read the report with a great deal of interest. There has already been a 100% increase in home care in Canada, but the demand continues to surge. The need for long-term care facilities and hospice care is also likely to grow, even with an increase in home care. While a team of health care professionals needs to be involved, the core services are provided by registered nurses, practical nurses, and personal care workers. CASN also sees a growing role for nurse practitioners in these areas.

There is an urgent need to support community-based long-term management of chronic illness with a much better collaborative system of care in which continuity and coordination are emphasized. There is an associated need to remove scope-of-practice barriers for nurse practitioners, to support registered nurses and practical nurses in working to their full scope of practice, and to align nursing education curricula in support of this.

Notwithstanding a shift to community-based services, I would like to stress that the acute care hospital is likely to continue to be a major employer of nurses. People are hospitalized for trauma and episodic illness, but the majority have chronic conditions requiring surgery or requiring the management of symptoms that have become life-threatening, such as heart attacks.

The complexity of hospital nursing care has increased significantly because patients are much sicker than they used to be, they stay for a much shorter time, and managing the technology and the treatments, which typically falls to the nurses, is far more complex than in the past. Actually, this is true of home-based care as well.

Many well-designed studies have shown irrefutably that the education of nurses is critical to patient safety and patient outcomes. The most recent, published in *The Lancet* in February 2014 was conducted in nine European countries and reported that an increase in the proportion of nurses with bachelor's degrees was associated with a significant decrease in patient deaths, whereas a decrease in the share of nurses with bachelor's degrees was associated with a significant increase in patient deaths. Researchers concluded that reducing the number of appropriately educated registered nurses is often tempting but is not a wise place to cut costs.

To speak to the federal role, the federal government has supported national initiatives to promote change in health professional education in the past, and these are currently improving health care. Interprofessional education promoted by Health Canada is now incorporated in the accreditation standards of eight Canadian health professions, including ours. Palliative and end-of-life care is another good example in which it has been promoted in medicine, in medical education, in nursing education, and in the education of social workers. I think we are seeing the fruits of this.

CASN recommends that the federal government continue to improve health care by supporting national initiatives that will influence health professional education and the preparation of new practitioners. In light of the growing burden of chronic disease in Canada, we believe there is a critical need to develop a national framework to guide the future of nursing education based on an examination of the scopes of practice of nurse practitioners, registered nurses, and practical nurses, as well as intraprofessional and interprofessional collaboration as part of this framework.

● (0915)

Thank you.

The Chair: Moving right along, now we have Paul Fisher, chairperson of the Canadian Council for Practical Nurse Regulators.

Go ahead, sir.

Mr. Paul Fisher (Chairperson, Canadian Council for Practical Nurse Regulators): Good morning.

Mr. Chair and members of the committee, I'm very pleased to have the opportunity to appear before you today as chair of the Canadian Council for Practical Nurse Regulators to provide an overview of the profession of practical nursing from the regulatory lens and respond to your questions pertaining to scope of practice for licensed practical nurses.

I have been a licensed practical nurse for 31 years in the province of Newfoundland and Labrador. My clinical experience has included mental health, medicine, surgery, emergency care, and community discharge planning. For the past 15 years I have been employed as the executive director and registrar of the College of Licensed Practical Nurses of Newfoundland and Labrador.

The Canadian Council for Practical Nurse Regulators is a federation of provincial and territorial members identified in legislation as responsible for the safety of the public through the regulation of licensed practical nurses. The mandate of the Canadian Council for Practical Nurse Regulators is to support the regulation of licensed practical nurses through collaboration, collectively, internally, and externally, with other provincial and territorial regulatory organizations to maintain and enhance professional relationships; to support provincial-territorial organizations with regard to decision-making, resource allocation, management issues, and individual provincial-territorial regulatory laws and resources; additionally, to support processes that allow for accountability and responsibility for decisions and which recognize the individuality of the jurisdiction; and to promote excellence in practical nursing regulation by demonstrating leadership, best practice, innovation, and professional development.

Canadians expect their health care system to provide them with safe care and to support them in becoming as healthy as possible. Meeting this expectation requires that licensed practical nurses be educated and capable of providing safe, competent, and ethical nursing care. Licensed practical nurses must demonstrate the capacity to meet jurisdictional entry-to-practice competencies and be able to practice within the context of relevant legislation and regulations while adhering to professional standards of practice and codes of ethics for the profession. Through legislation, the practical nursing profession is also granted the authority to recognize and set standards of education and standards of practice for the profession, with an obligation to protect and serve the public interest.

The practice of licensed practical nurses spans a continuum from novice to expert and may encompass clinical practice, administration, education, research, consultation, management, regulation, policy, and system development. Through their entry-level education program, licensed practical nurse experience, and continuing education activities, licensed practical nurses gain the theoretical and practical foundation to provide safe, competent, and ethical nursing care. Licensed practical nurses care for people of all ages regardless of gender, ethnicity, or social situation, and in a variety of practice settings, such as hospitals, communities, homes, clinics, schools, and residential facilities. Their practice requires knowledge about health and illness, human biological sciences, the pathophysiology of diseases, health promotion and prevention, teaching and learning, and health care systems.

Licensed practical nurses have a duty to practice safe and appropriate nursing care and to practise collaboratively with other members of the health care team. They practise autonomously within their own level of competence and seek guidance from other health care professionals when aspects of the care required are beyond their individual competence. The psychosocial components of care, including interpersonal, communication and teamwork skills, are fundamental to safe and effective practice.

Licensed practical nurses are required to practise in accordance with the standards of practice for their profession. The standards of practice are authoritative statements that define the legal and professional expectations of licensed practical nursing practice. In conjunction with the Code of Ethics for Licensed Practical Nurses, they describe the elements of quality LPN practice and facilitate mobility through interjurisdictional mutual understanding and agreement on expectations and requirements for their practice.

As members of a self-regulating profession, LPNs are personally responsible for meeting the standards of practice. The legislative responsibility for setting, monitoring, and enforcing the standards of practice lies with the provincial and territorial regulatory authorities.

● (0920)

The policies and practices of employing organizations do not relieve LPNs of accountability to meet these standards of practice. Where the legislation and this standards of practice document conflict, legislation will apply.

Traditionally, nurses have worked together to provide quality care, and have actively sought the responsibility for self-regulation of that care through legislative authority. As mentioned earlier, there are three groups of professional nurses in Canada: licensed practical nurses, or registered practical nurses as they're called in Ontario, registered psychiatric nurses, and registered nurses. They are responsible to their respective professional nursing regulatory bodies.

Scopes of practice continue to evolve over time due to changes in the health care environment and the health care delivery system. It is essential that there be cooperation and collaboration between and among professional nurses, the nursing regulatory bodies, government, employers, and educational institutions in order to provide guidance to nurses and ensure public safety. Regulatory bodies, in collaboration with other members, will advocate for the development of public policy that fosters health promotion and wellness.

According to the Canadian Institute for Health Information, the supply of licensed practical nurses eligible to practise in Canada grew by 23.2% between 2008 and 2012, reaching a total of 99,935. During the same period, the LPN workforce increased by more than 18%, from 74,380 to 88,211. The rate of LPNs per 100,000 population increased from 223 in 2008 to 253 in 2012.

Underutilization of the LPN scope of practice has been a long-standing issue for the profession in Canada. It is imperative that these issues be addressed. I believe the federal, provincial, and territorial governments need to change the way health human resource planning is conceptualized in Canada. It is not acceptable to regulate a profession and then permit others to arbitrarily restrict the practice of that same regulated health professional. Limiting the practice of nursing professionals to roles that are less than those enabled by educational preparation and regulatory authority wastes precious nursing human resources at a time when the health care system can ill afford it.

Ensuring that the right mix of providers is available to meet the needs of Canadians is everybody's business. Federal, provincial, and territorial governments need to ensure that licensed practical nurses are included in local, provincial, and national policy-making decisions and committees that affect nursing practice.

Licensed practical nurses have an important contribution to make in the delivery of appropriate, effective nursing services in Canada. A concerted effort is required on the part of the federal, provincial, and territorial governments to eliminate barriers that limit practical nursing student access to clinical placement practice experience and that prevent LPNs from practising to their full scope of practice within health care settings across Canada.

In closing, like many other health professionals, practical nurse regulators are very committed to having their members provide the right care to the right person by the right caregiver to optimize care and resource utilization while ensuring public safety for the provision of nursing services in Canada.

The Canadian Council for Practical Nurse Regulators is keenly interested in engaging with national and provincial professional authorities and organizations to contribute to the dialogue and to keep abreast of new initiatives that may benefit the Canadian health care system.

Thank you once again for the opportunity to be here with you today.

● (0925)

The Chair: Thank you very much, Mr. Fisher.

Last but certainly not least is Anne Coghlan, from the Canadian Council of Registered Nurse Regulators.

Thank you for joining us this morning via video conference. You have 10 minutes, please.

Ms. Anne Coghlan (President, Canadian Council of Registered Nurse Regulators): Good morning, Mr. Chairman and members of the committee.

I'm pleased to present to you this morning as president of the Canadian Council of Registered Nurse Regulators.

The Canadian Council of Registered Nurse Regulators, or CCRNR, was established in 2011 as a national organization comprising the 12 provincial and territorial regulatory bodies with mandates to regulate the practice of registered nurses and nurse practitioners in Canada.

CCRNR recognizes the regulatory autonomy of its provincial and territorial members, while remaining committed to the benefits of collaborative dialogue and harmonized approaches to regulation for the protection of the public. Our goal is to provide a forum for provincial and territorial regulators to work together to serve and protect the public interest by advancing excellence in nursing regulation.

As a national organization for the exchange of information regarding regulatory trends, best practices, policy, and legislation, CCRNR participates in national and international discussions to represent and promote an understanding of nursing regulation. We are uniquely positioned to provide the regulatory perspective and to support the public protection mandates of provincial regulators in discussions at the federal level.

I would like to briefly address the term “scope of practice”. Scope of practice is given to a profession in provincial and territorial legislation. Members of the profession work within this scope to the extent of their individual knowledge, skill, and ability. Often the scope of practice of one profession overlaps with the scopes of practice of other professions.

Our regulatory processes are designed to ensure members of the profession are competently working within their defined scope. While there are some differences in the scope of practice for registered nurses across provinces and territories, there are also significant similarities. We share a set of national entry-to-practice competencies, which inform nursing curricula, and a common registration exam reflective of the common requirements for safe nursing practice across Canada.

Scopes of practice evolve with changes in the regulatory and health care environment. Discussions around expanding the scope of practice or authority given to a profession should include consideration of the regulatory mechanisms needed to ensure that public protection is maintained. These include educational requirements, standards to support safe practice, and mechanisms to ensure continuing competence of the profession.

It is also critical that scope of practice discussions take place in collaboration with regulators of other members of the health care team. For example, CCRNR has begun discussions with our colleagues at the Federation of Medical Regulatory Authorities of Canada and the National Association of Pharmacy Regulatory Authorities on common regulatory issues.

I'd like to briefly highlight three examples of CCRNR's work to harmonize regulatory frameworks designed to support the protection of the public in Canada.

CCRNR is a key participant in the creation of the National Nursing Assessment Service, together with our colleagues who regulate practical nurses and psychiatric nurses. With funding support from Human Resources and Skills Development Canada, which is now Employment and Social Development Canada, as well as provincial and territorial governments, the National Nursing Assessment Service will support consistency in the initial assessment of internationally educated nurse applicants and support labour mobility.

CCRNR is also working to harmonize expectations for safe practice by nurse practitioners in response to the federal government's introduction of the new classes of practitioners regulations under the Controlled Drugs and Substances Act. For example, CCRNR has identified criteria for educational courses to be offered across the country to ensure that all nurse practitioners have the necessary competencies to support safe prescribing of controlled substances.

● (0930)

With support from Employment and Social Development Canada, CCRNR is about to embark on a national analysis of nurse practitioner practice in Canada. We will examine the similarities and differences that exist in individual provinces and territories, and we'll use this information to develop consistent approaches for regulating nurse practitioners across the country.

From our work on these foundational initiatives, CCRNR has identified additional opportunities to support consistency in the regulation of nursing's scope of practice. We will be exploring the creation of a national framework for nursing regulation, which we hope will lay the groundwork for a national mobility agreement.

In closing, the Canadian Council of Registered Nurse Regulators is committed to working with stakeholders across the health care system to support the delivery of consistent, safe, ethical health care across settings, geography, and roles. As the federal government continues to explore the question of scopes of practice and other issues regarding nursing in Canada, CCRNR looks forward to extending our collaborative efforts and offering the collective regulatory expertise of our members in future discussions.

Thank you for the invitation to speak with you this morning, and I am pleased to respond to any questions you may have.

● (0935)

The Chair: Thank you very much.

We're now on to the question and answer portion of our meeting. I would just ask the members of Parliament, due to the size of our panel today and the fact that we have a guest via video conference, that we do our best to ask specific questions so that we can keep it concise and we have a good flow of questions and answers.

Ms. Davies, you're first. Go ahead, please.

Ms. Libby Davies (Vancouver East, NDP): Thank you to all of our presenters for being here today. Hearing you today I feel as though a light bulb has turned on and we're realizing how complex this question is regarding scope of practice and regulation and all the different players involved. I don't know how you manage to navigate the system. Anyway, it's a very interesting subject.

I have two questions.

First, as I understand it from what you've said today, the scope of practice, which falls under provincial or territorial legislation, can differ from province to province, and even where it does differ, there can be conflicts with another profession in that what is actually regulated you may not actually be able to practise. I think I got that from pretty well all of you.

I wonder how we solve that. Is the ideal situation to basically have one scope of practice that's agreed to for RNs, for nurse practitioners, for LPNs, and for psychiatric nurses apply across the country? I'm not quite clear on that. If your answer is yes, I assume then that the role of the federal government is to help facilitate that. Do you see that as a goal, to try to bring some sort of conformity?

For example, I know that in various trades there is what we call the Red Seal program, through which you can get to a level where you can then operate anywhere across the country. I get the sense that we don't have that in the nursing professions. That's one question that maybe Dr. Mildon and Ms. Coghlan could answer.

Second, I was very interested, Dr. Mildon, in your statistic. I think you said that 60% of nurses are in acute care, 15% are in community care, and 10% are in long-term care. There's the whole question of health human resource planning. I imagine the question of shortages varies from place to place, but I still hear stories from nurses who work at the big hospitals in Vancouver, for example, who say that they're continually on call, and they're practically exhausted from stress and overwork. Even in the larger places, there seem to be shortages, so God knows what it's like in small communities where there aren't any resources at all or there are very few.

There is the question of shortages and how we need to make a shift. There is a growing need, for example, in home care, long-term care, and palliative care, and there is more of a shift into community care, but we don't want to do that at the expense of acute care. In terms of the planning for human health resources, where are we falling behind if we want to make sure that doesn't happen?

I realize that's a very big question, but anything you can do to help us sort out what our role should be from a federal perspective would be very helpful. Could you address both of those questions, and if Ms. Coghlan would also like to answer, that would be helpful.

● (0940)

Dr. Barbara Mildon: Excellent. Thank you very much for the question.

First, in terms of harmonization of scopes of practice across the country, I will give you a very resounding and enthusiastic yes. We totally believe that would be helpful in several ways. I mentioned the concept of mobility across the country. Several of the presentations today have echoed that. A harmonization of scopes of practice would enable nurses to more easily and more portably travel across the country to provide care where they are needed. That may also indirectly address some of the more geographically based shortages. As well, the notion of responding in an emergency situation would be helped by harmonization of scopes of practice.

It would certainly address the confusion that can appear in our health care system around the scope if we could all basically collaborate on understanding a single scope. I believe if we did that as a group of nursing organizations and providers, we could help our employers understand that scope and not be as concerned about imposing further restrictions, given their unique situations. So on your question with regard to harmonization, my answer is yes.

With regard to the HHR issues, there was some wonderful work done under the auspices of the federal government not that many years ago, the Canadian nursing study, the CNAC study, but also the nursing sector study. Basically I think what happens is that the health care system shifts. The needs of our patients, clients, and residents shift, and some of those predictions that we made didn't come true. The shift to care in the community is actually happening, but what has changed is that it's being provided by different groups of providers. In particular, unregulated providers are a key part of care in the community today as we help seniors age in place.

I suggest that HHR planning is still a somewhat moving target. We are understanding it better, I think, as we go forward. As for what to do to improve the shortages, again, it's a complex mix of employer practices as much as regulatory and association-type support.

Ms. Libby Davies: Could I just interrupt you, as the time here is short.

When you say that the shift is taking place into the community but it's a different group of people and it's unregulated, what does that mean? Are you saying there isn't training or that it's just not part of one of the regulatory systems? Should we be concerned about that?

Dr. Barbara Mildon: That's a difficult question to answer. I would invite my colleague, Josette, to respond to that. But from my perspective, it means that the care that's being provided is often support care, supportive care: meal preparation, shopping, laundry, personal care, the care that may not require the direct provision of registered nurse or licensed practical nurse oversight.

Having said that, we know from CIHI, and the statistics are clear, that if we look at home care provided by RNs, in recent years it has deteriorated or decreased considerably as those types of services go forward. But I would not like to leave you with the impression that unregulated providers are not safe. They certainly are in terms of their own scope. Although they are not a regulated profession yet, they may well become in the future.

The Chair: Thank you very much. We're over time.

Mr. Lunney, you have seven minutes, sir.

Mr. James Lunney (Nanaimo—Alberni, CPC): I'd like to thank all of you for your presentations.

It's a bit of a disadvantage to us, when you cover so much technical information with numbers and the number of nurses in every category, not to have your presentations in front of us. That simply has to do with the French translation issue. They needed to be here in time for translation so that we could have them in front of us.

That's more for the committee in terms of giving our presenters time to get their presentations in so that they can be translated.

I want to pick up on the question of nurse practitioners. You've all talked about three different categories of nurses that are recognized, RNs, LPNs, and RPNs, and then registered psychiatric nurses in the west. Now we have nurse practitioners. My question has to do with the education process for nurse practitioners and who they are currently regulated by.

Ms. Coghlan, I know you referred to that. I'd ask you to expand a little bit for us on what currently exists and how nurse practitioners are being educated. Where does that take place? Is it a post-BN program, for example? As well, who are they currently regulated by?

● (0945)

Ms. Anne Coghlan: I'd be happy to assist the committee with that.

Nurse practitioners are registered nurses who have obtained additional education and clinical experience, for the most part at the master's level across Canada, and they are regulated by the regulatory bodies for registered nurses across Canada. In Ontario, the regulatory body regulates registered nurses, registered practical nurses, and nurse practitioners.

Mr. James Lunney: Thanks for that. Again, we're talking about jurisdictional issues there, and which nurses are the right mix for which assignment and so on, and now we have nurse practitioners in there.

Dr. Mildon, you mentioned a federal-provincial-territorial table to try to address this.

Cynthia Baker, I think you were talking about a national framework for education.

Can I ask you both to expand on your vision for what these would look like and what outcomes you would anticipate coming out of these?

Dr. Barbara Mildon: The best example I can give you, as I alluded to in my presentation, is the Controlled Drugs and Substances Act, where we appreciate so much the work of Health Canada in working with nurses at CNA and with others to expand that provision so that nurse practitioners could prescribe narcotics, opioid-based narcotics, and drugs used in mental health, such as benzodiazepines.

However, that work stops short of brokering a collaboration across the country whereby those changes could be more immediately implemented into practice. What is happening as we speak is that approximately half the country has now reached the ability, under provincial or territorial legislation, to enact those provisions. The other half of the country is still working to do that.

So here the federal government did a great job, and we had what we needed, but it's very slow to be taken up. If there were such a table as a federal-provincial-territorial table that looked at harmonizing those at the point of brokering them, we believe there would be more immediate uptake.

Mr. James Lunney: Are you talking, then, about an organization that might exist for a period of months or maybe a year to analyze this and try to sort out all of these things, or are you talking about creating some kind of permanent institution?

Dr. Barbara Mildon: I don't think that it even may need to be an institution. I think it may need to be just another step that's recognized as part of those kinds of processes.

Mr. James Lunney: Thank you.

Ms. Baker, what about your national framework?

Dr. Cynthia Baker: Yes. I think I was influenced to some extent by the work that the physicians have done and are doing on their future of medical education in Canada project, their current work, which I believe they presented last week, in which they're looking at, I think, generalists, specialists, and specialization and linking that to human resources.

I see a real need for this in nursing, given what I've been discussing in terms of chronic illness, acute care, and the three categories of practical nurses, registered nurses, and nurse practitioners, a national look at harmonizing.... The outcome would be a harmonization of the education required to prepare practitioners in the future to meet the needs that we see linked to these changes that are coming down or growing in the next number of years. I don't know whether that is very clear. I'm using something of the processes that we have developed in involving all kinds of stakeholders, employers, regulatory bodies, and educators across the country to build this framework.

Then again, we did this with nurse practitioner education, and I think it has an influence. It has no clout legally, but it has influence nationally.

Would you agree?

● (0950)

Ms. Josette Roussel (Senior Nurse Advisor, Professional Practice, Canadian Nurses Association): Yes.

Dr. Cynthia Baker: In terms of harmonizing the preparation of new nurse practitioners, it's this type of exercise.

Mr. James Lunney: Thank you for that.

In this study, of course, we're looking at how to best optimize health human resources. You have had some experience now, in the last number of years, for many years, obviously, of nurses working in northern remote communities. I'm wondering if you could help the committee understand the challenges nurses face in these settings, where there aren't the same resources that you have in the city. Where you have nurses in remote rural communities, what are the challenges they're facing in that area and what are the opportunities to improve those?

Dr. Barbara Mildon: Thank you for that question.

Ironically, I would suggest that if from a purely scope-of-practice perspective, nurses in remote and rural areas are most likely to be able to work to their full scope because of the shortage of resources. From a scope-of-practice perspective, they have full scope; they are often the only provider in an isolated setting, and they thrive on that kind of practice. It's when we come closer into urban settings that the scope of practice begins to get narrower and narrower.

Again, your focus is scope of practice. I don't think rural remote is an issue that way. I think the issue is why, when that nurse leaves the north setting or the rural remote setting and comes into an urban setting, he or she suddenly experiences these greater constraints. That speaks to the harmonization that my colleagues and I have spoken to this morning.

The Chair: Thank you very much, Mr. Lunney.

For the next round, we'll have Ms. Fry, please.

Hon. Hedy Fry (Vancouver Centre, Lib.): I want to thank all of you for bringing together something that is intriguing me.

I understand the provincial jurisdictions for regulation, etc., and for scope of practice.

As you all know, in the health accord, which is no longer there, there was a piece that talked about an HHR plan, a plan for looking at the whole issue of harmonizing and at scope of practice to ensure that, no matter where you lived in Canada, if you were an RN or a licensed physician or any other health care provider, you would be able to work anywhere in Canada where you were needed. This made a lot of sense because we knew that would happen.

That's not happening. That didn't happen. That was cut off at the knees some time in 2007. So, I think we need to talk about how we get back on track for this, because it's essential. That's my first question.

I also wonder if you can tell me why so many nurses, RNs and LPNs, who are working in the system have only contract work. They cannot get a full contract in which they are working and getting all the necessary benefits, and they keep working on a contract basis, which seems to me to be a ridiculous use of educated people. That's the second question I want to ask.

The third question is about nurse specialists. Given that we're looking at home community care models, how do you see the mix of nurse practitioners, LPNs, RNs, and people working in the acute care system unfolding?

Those are three questions: how the mix, including specialists, is unfolding; how we get into an HHR pan-Canadian strategy now that it's no longer there; and why nurse employment is on a contractual basis only, which I think is a crying shame.

The Chair: Who would you like to direct those questions towards, Ms. Fry?

Hon. Hedy Fry: Barbara can take the first one on the HHR strategy.

Dr. Barbara Mildon: I'm happy to start, and I invite Anne and others to join in. I'll be very quick.

With regard to staff mix, CNA does have an evidence-based staff mix review tool which it has published. I have personally used that in my practice, most recently in the past year when we were looking at our patient population.

I work in a mental health tertiary hospital where our patient criteria or patient characteristics changed, so we applied this evidence-based process to look at whether we had the right staff mix. In one of our units, we found that we had poor nurse satisfaction. The nurses were not satisfied with their roles, because they were doing a fair bit of non-nurse work, work that could be done by others. We had a patient population that had become extraordinarily complex over the years, and that really directed us then to add registered nurses to that mix.

In the same hospital at the same time, we took a second unit, went through the same process, and found that in fact we needed more licensed practical nurses, or RPNs as they are called in Ontario, for the same reasons. There is an imperative today to use the evidence-based tools to look at our staff mix, always with a focus on patient needs. Staff mix, I believe, is a constantly dynamic function.

The HHR strategy pieces basically speak to nurse employment. Nurse employment is a complex combination of several factors. Number one, again, is needs of patients. Do we have a consistent number of patients in a setting? Do we have an ebb and flow of patients coming and going? How many do we need at what point? When we look at health system funding, that's always an issue.

Another factor is nurses' choices themselves. Some nurses do actually choose to be contract or to not take full-time jobs because doing so gives them greater flexibility in planning their lives.

It's a combination of those three complex factors.

I would leave it at that.

● (0955)

Hon. Hedy Fry: Does anyone else want to answer some of that?

Ms. Anne Coghlan: I'd be happy to respond to your first question, Dr. Fry.

In terms of mobility and the ability of nurses to move across the country, I would say we've made great strides in that work. Regulators have been working for many years to harmonize the requirements, and the agreement on internal trade put further mechanisms in place.

There are now mechanisms for nurses who are regulated in one jurisdiction to very quickly become regulated in another jurisdiction. The added piece to that is what I mentioned earlier in terms of the creation of the national nursing assessment service, so that once internationally educated nurses have been registered or regulated in an individual jurisdiction, they then will be recognized for mobility across Canada.

While you may be disappointed with some of the outcomes of the health accord, the work that regulators have been engaged in across Canada has gone a long way to support labour mobility.

Hon. Hedy Fry: I am told by many nurses I meet that choice alone is not their reason for contractual work and that many of them cannot get full-time work. They even work overtime on contract work, but I think that their concern is that they don't get the benefits because they're not full-time permanent workers in the health care system.

Paul is nodding his head. Did you want to say something about that?

Mr. Paul Fisher: Yes, for the practical nursing profession in many provinces, 90% of new graduates are probably only getting casual employment.

We constantly hear from those graduates that significant factors include: one, the health authorities not receiving funding for the number of full-time equivalent positions to allow them to make a position permanent or, say, temporary, for one or two years; and two, the high amount of sick time. If a person is a permanent full-time employee, then that's an added benefit with a cost that the employer has to absorb; whereas for practical nurses, depending on what union they're in, if they work as a casual employee, they might not get those same sick benefits, so it's not as big a financial burden for the employer.

The Chair: The next round is for seven minutes. Ms. Adams.

Ms. Eve Adams (Mississauga—Brampton South, CPC): I'd like to thank all of you for joining us here today, and I'd especially like to reach out and compliment the tens of thousands of nurses you represent. Whether they're nurses who are coming out through VON to tend to elderly parents in our homes, or the wonderful nurses who show nothing but exceptional compassion in a palliative care unit, your members really do make the difference day in and day out for Canadians across the country, so thank you. We very much value the service that is provided by your members.

The challenge that we face is that primarily a scope of practice is something that is set by the different provinces and territories. What we're hoping to do here as a committee is to offer some best practices guidance to the provinces on how we might be able to ameliorate health care through innovation.

For instance, recently, I was fortunate enough to provide a very large amount of money, about $6.5 million, to McMaster University for a collaborative care research project. This project has community volunteers going out into the community, working with individuals who are at risk of developing illness, and so on. The community members then come back in and report to nurses and physicians. This was funded through the Canadian Institutes of Health Research. Through the limited levers available to the federal government, we're trying to provide demonstration opportunities for best practices. We have every confidence that the $6.5 million should come forward and benefit not only the GTA area but also offer some type of guidance across the country.

Are you aware of any other projects like that? Perhaps you could speak to what the best practices might be that you are aware of, where we can go out and leverage the wonderful abilities of our nurses across the country.

● (1000)

Dr. Barbara Mildon: I'm happy to speak to that, and thank you for the funding. I know it will make a difference.

Yes, I think what you're speaking to are innovative HHR practices. You're really at the heart of what needs to evolve as we go forward.

In the case you've described, this is breaking down barriers between sectors, between, for example, a hospital and its walls, the community, which is permeable, and even long-term care settings. We still need to work further on breaking down those barriers.

We are seeing the emergence of some programs, such as those that I'll refer to as family health trusts, where the family health trust is a combination of physicians and other allied health groups, including registered nurses and allied health professionals. They can go out into the community to take care of their rostered patients. This is also a best practice in utilization. It allows registered nurses, for example, to not only get to know the family in the family health trust, because it is essentially an access to care, but it also allows them to go into the homes and meet the needs there.

We can give you more information on those projects, from CNA's perspective, but they are beginning to emerge.

Ms. Eve Adams: The other role that I know you're all experts in and that the federal government holds is obviously to offer nursing services and health care services in remote and northern communities. We do struggle to ensure that we are able to provide as much nursing care as possible. It is difficult to recruit into the north, though. You're quite right that nurses in the north are able to actually practise to their full scope of practice. We're hoping, though, to continue to remove barriers so that we can continue to provide top-notch health care to our northern communities.

Could you perhaps speak to any suggestions you might have, for instance, giving drug samples, or anything else that nurses in northern communities are not able to provide right now, but you think they're fully qualified or ought to be quickly qualified to do?

Dr. Barbara Mildon: Again, I will speak to nurse practitioners in particular, with the recommendations we made to remove some of the restrictions from their signing various federal forms and so forth, and being able to give samples of drugs. That they can prescribe the drug, but they can't actually give a sample of the drug is quite ironic. This would enable them to help patients on the spot. Usually these are drugs such as blood pressure medication to reduce blood pressure that's too high and dangerously high, etc. Removing those barriers would really make a difference.

The other thing, in terms of supports specifically to our nurses who work in the north, is that notion of skills training. Concerning the national type of education programs that are available—of course I need to mention CNA's own various certification programs—we need to ensure that those nurses are confident in their skills and have the resources that they need to call on when they are faced with some of the very complex situations that they cope with.

Those would be my thoughts there.

Ms. Eve Adams: Thank you.

Is there anybody else who wants to comment on what else we ought to be doing to assist nurses in northern communities? I'm simply focusing on that because that actually is a core responsibility for our ministry, the Ministry of Health, and for the federal government.

Dr. Baker.

Dr. Cynthia Baker: I think of support for students in the north in terms of nursing education, because they will stay in their communities, but there are lots of barriers to their success in educational programs. So programs supporting students, not just the recruitment of students in the north into northern programs, but retention of students, programs to support their retention in the program so that they graduate, they graduate well, and they go out to work in their communities, would be, in my mind, an approach to this issue.

● (1005)

Ms. Eve Adams: Thank you.

Mr. Fisher, do you have anything to add to that? I don't mean to put you on the spot.

I have just one final question, then. Is there anything that you would recommend the federal government do in order to clarify scopes of practice?

Ms. Morrow, you're nodding your head.

The Chair: Ms. Morrow, if you could respond as briefly as possible, that would be appreciated. Thank you.

Ms. Judy Morrow: Certainly, no problem.

Along with what has been said here this morning, I believe that we need to identify what scope of practice means, first of all. Maybe we need to go back to the definition of what scope of practice is before we move forward and identify what each different nurse within the nursing family does within that scope of practice. I think we have a bit of groundwork to do first, and then I believe that we need to move forward. What's happening out there, from what I'm seeing, is that there's a scope of employment, and then there's a scope of practice, and the two tend to collide, so we need to go back to the basics.

The Chair: Thank you very much.

Mr. Morin is going to ask questions for five minutes.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): Thank you very much, Mr. Chair.

I will continue with what my colleagues, Ms. Davies and Ms. Adams, were saying about home care.

As experts, you said that the population is aging. Older people in particular want to have more services at home. Dr. Mildon mentioned that pilot projects seemed to have good results. It was said that in order to ensure that there are national standards, a committee could be created and the federal government could take the lead. That could help the provinces meet their own specific needs.

Do all the provinces and territories have this need and do they have the will to move forward in order to improve home care services? My question is for anyone who would like to answer.

My second question is the following.

In concrete terms, what more could we do at the federal level to help the provinces and territories enhance the home care services they provide? In my own riding, public services are unable to meet the need. The number of seniors who are turning to the private sector is increasing because they really want home care.

Can you answer these two questions?

Ms. Josette Roussel: I will answer the question in French and then my colleague will add her comments.

In the work and the research we have done with our colleagues, we have found that people across Canada want to find models or best practices that will lead to positive change without making major investments. These models can be at the team level. We have to examine the needs of different populations.

We can give you a number of examples in our written submission. They are not necessarily models based on specialty nurse practitioners. They may be models where registered nurses and other team members provide community services. As you mentioned, mostly seniors need these services.

In some communities, some nurses do not work to their optimal scope of practice. Our members have told us that their skills are underutilized. Only 40% of nurses' community health skills are utilized. That is what our research has indicated. We are trying to make changes to certain models of practice. That is my answer to your first question.

As for what could help, I believe that there are many examples we could share with the provinces and territories in order to improve home care.

I will let my colleague add her comments on this subject.

● (1010)

[*English*]

Dr. Barbara Mildon: Thank you very much for the question.

I will quickly add in the interest of time that I think you're speaking much to the history of the evolution of home care in Canada, which of course is not covered under the Canada Health Act, so that has always rendered home care very vulnerable to individual interpretation, but also to funding envelopes. I agree with you 100%. We are seeing situations where once the funding envelope is gone for a certain service, people go on a waiting list and they simply don't get the service.

I do know efforts were made in more recent years to come up with a federal agreed-upon basket of home care services across the country. Perhaps we need to revisit those activities. Other than that, again, it is up to the whims, really, of funding in the various jurisdictions.

Mr. Dany Morin: Do I have more time, Mr. Chair?

The Chair: You have 10 seconds, so use it wisely.

Mr. Dany Morin: Or not.

The Chair: Okay. Thanks very much.

Next up, would Mr. Wilks like to go, or Mr. Young?

Mr. David Wilks (Kootenay—Columbia, CPC): Mr. Young.

The Chair: Mr. Young.

Mr. Terence Young: Thank you very much to all of you for being here today.

I was thinking about what Cynthia Baker said about long-term care and the aging population. For 13 years I've been serving on the board of a not-for-profit seniors residence in Toronto. We have three towers and 300 residents. We provide supportive care up to a certain level, but our average age is 89. Really we're almost like a nursing home for ambulatory seniors. In fact we had a birthday party in August for 14 ladies who are all over 100 years old. So it's not just the baby boom; it's the aging population. People are living a lot longer.

I want to relate a personal story, because it's perfectly relevant. My mother, in a not-for-profit seniors residence, last year had a heart attack and went to hospital. When she was ready to come out, she was what they call—you would all know this—a two-person transfer. It took two personal support workers to get her from the bed to a wheelchair and back. They couldn't accommodate her unless she paid for her own nursing care. Now, they haven't built any long-term care beds in Ontario. They say, “No, no, we're providing care in the home.”

They told me that my mother needed 16 hours of care a day. I talked to the CCAC, and they said they'd give her three. I said, “No, you have this wrong; she needs 16.” They said they'd give her three.

I got some advice from different people and I called back and negotiated. It was like a house deal, or a car deal. I said, “Well, if you pay from 8 a.m. until noon, my mother will pay the rest.” The person called me back and said she asked her manager, who said yes to that.

Luckily my mother was able to pay for that until she got into a long-term care facility, but the wave is coming, in Toronto in particular. For seniors who have a house in Toronto, they can afford it. Their houses are worth from $600,000 to $800,000, and over $1 million, so they can afford to pay for their care. It would have been $12,000 a month for my mother, at $25 an hour. But there are many who can't afford it, and no one wants to talk about it. We need to really optimize care for seniors who need different levels of care.

What should nurses be able to do, and then what should personal support workers be able to do in these facilities, in supportive housing and in long-term care facilities? What should doctors be doing? Who should be doing what? This is your chance to get on the record all those things you've been thinking about.

The second part of the question is for Barbara Mildon and then anybody else who wants to comment on it.

Is turf protection a problem in caring for patients, and in particular seniors? If it's a problem, please take this opportunity to identify it.

I'd like to start with Cynthia Baker.

● (1015)

Dr. Cynthia Baker: That's a great question: what should everybody be doing? That's part of my thinking in terms of frameworks. I don't think it's clear at all. I think that's where we need to have a conversation across the country with all kinds of groups, all kinds of stakeholders, defining what the....

I mean, there is legislation about scopes of practice, etc., but all of this is relatively new. I don't think it's clear, and I think we need to work it out. I think that's the first step, in my mind, towards when we get that worked out, then how do we educate and align the education in terms of what everybody should be doing?

I don't know whether my colleagues would agree, but I don't think it's that clear. Things will overlap, but I do think we need to work it out. I think we need to align education, because I think this is really what the health care needs will be in 2020.

Mr. Terence Young: Do you have any ideas on how to start working it out?

Dr. Cynthia Baker: Yes. I would set up a national task force, with stakeholders representing the nurse practitioner education and regulation, registered nurse regulation and education, the Canadian association of schools of...the Canadian Nurses Association, other professions, physicians, other stakeholders in the group—

Mr. Terence Young: So we just lock them in a room and tell them to work it out, or—

Dr. Cynthia Baker: No, I'd set that up and give them a two-year mandate—

Mr. Terence Young: Two years.

Dr. Cynthia Baker: —to conduct focus groups, surveys, and work, with national forums bringing it together and synthesizing this information, developing and coming out with the kinds of clarification....

If I understand correctly, that's what the physicians are currently doing, but they're looking more at generalist versus specialization, this type of thing.

Mr. Terence Young: I'd like to ask Barbara Mildon the same question, please.

Dr. Barbara Mildon: Thank you.

I'll speak first—

The Chair: Ms. Mildon, we're up against the time, so very briefly, please.

Dr. Barbara Mildon: I'll be very brief.

For long-term care settings, nurses should be able to manage care in place. The Ontario government recently announced funding for nurse practitioners in long-term care settings. That means that your mother may not have had to go to the hospital in the first place. She may have been able to be cared for in that setting.

First of all, it's to maximize scope of practice so we can care for in place. Second, with regard to turf, I don't think it's turf; I think it's confusion. I think there is legitimate confusion, particularly in the area of overlap. I will particularly state the RN and LPN roles. The clarification needs to be constant. It needs to be case-based or patient-based.

Those would be my suggestions.

The Chair: Okay. Thanks very much.

We almost could get this meeting done today because everybody who we need to be in the discussion is here today. Maybe we'd better just lock the door.

Next up is Mr. Gravelle.

Go ahead, sir, for five minutes.

Mr. Claude Gravelle (Nickel Belt, NDP): Thank you to the witnesses for being here.

I probably heard every single one of you talk about the scopes of practice.

Is there an inventory of the best scopes of practice in the provinces or in Canada for hospitals? If there is not an inventory of these scopes of practice, what's preventing it from happening? What do we have to do to make this happen?

I'm directing this question to anybody.

Dr. Barbara Mildon: I would invite Anne to speak to this. I'm happy to as well.

Anne, would you like to start?

Ms. Anne Coghlan: Yes. Thank you.

First of all, I believe that the provincial and territorial nurse advisers have recently conducted a project to collect the different scopes of practice that exist in provinces and territories across Canada. That compilation, if you will, has been done.

I think, though, that we need to go back to that term. Scope of practice is a very broad term. I would argue that there are more similarities across Canada than there are differences in the actual articulation of scope of practice. Where there are differences is in the enactment of the scope, that is, what it looks like in terms of individual nursing practice, how employers interpret this scope, and how it's regulated.

In my earlier remarks I commented on the work that we're doing to harmonize the regulation of this scope of practice. I don't think it's so much an issue of looking at the differences in how it's articulated; I think it's more an issue of the enactment of those scopes of practice.

● (1020)

Dr. Barbara Mildon: I believe Paul can also respond from the practical nurse regulator perspective.

Mr. Paul Fisher: Underutilization of practical nurse scope of practice is a key issue in that regard.

I think that when we're looking at how care is delivered, we also need to include members of the general public in regard to the consultation process, which sometimes we fail to do.

Dr. Barbara Mildon: I would add very quickly that, as both my colleagues have alluded to, wouldn't it be wonderful if we had a single definition of scope of practice and standards of practice across the country? I think that's the aim of what we need to do.

Mr. Claude Gravelle: Is it preventing us from having a single definition?

Dr. Barbara Mildon: That's a loaded question.

Mr. Claude Gravelle: It's a loaded panel.

Dr. Barbara Mildon: Again, we need to look at where the jurisdictional authority for health is vested within the jurisdictions. I think that in itself creates the first barrier. But I think the work you're doing as a committee is trying to break down that barrier. I think with your deliberations and your recommendations we're getting closer to that. With the work that my colleagues have spoken to, it's their work to lead harmonization across the country.

Mr. Claude Gravelle: Thank you.

How much more time do I have?

The Chair: You still have a minute and thirty seconds to solve all the problems here.

Mr. Claude Gravelle: I read in a report, I believe it was from Manitoba, that there's this Toyota management system where an employee can stop the production line and fix the problem. In hospitals it means an internal hotline where the first-line employees, nurses, can stop and try to fix a problem. This is being done in New Zealand where there's been a 35% increase in efficiency. In the United States the Virginia Mason Hospital & Medical Center in Seattle started that program in 2002 and it's considered one of the levers.

Is this happening in Canada with nurses? If it's not, why not?

Dr. Barbara Mildon: I'm happy to say that it absolutely is happening in Canada. It has several names. I think you're referring to the lean methodology, which is well known in hospitals and in health care settings.

There's also a program related to that called Releasing Time to Care. We've had wonderful projects taking place across the country. Vancouver Coastal Health Authority is well known and had one in more recent years. The basic premise is twofold: number one, to maximize patient safety, because it is about patient safety; and number two, it's about having time to care, about having the nurses or our colleagues at the bedside or on the home side, wherever they may be, with patients.

This is well known. It is happening. Again, as with most things, you won't find a consistent implementation of it. You'll find pockets of it across the country.

Mr. Claude Gravelle: What's preventing us from being consistent throughout the country?

Dr. Barbara Mildon: I would point quickly to the work of the Council of the Federation and their health innovation working group. This is in fact what they're trying to do: to bring these best practices forward. Most recently, they have adopted a couple of models of best practice related to diabetes foot care, for example, and so forth, so it is happening. It's just not the tidal wave that I think you as a committee are looking for.

● (1025)

The Chair: Thank you very much, Mr. Gravelle.

Mr. Wilks, please, for five minutes.

Mr. David Wilks: Thanks to the witnesses for being here today.

Dr. Mildon, in your presentation you touched on the modification of section 14, I believe it was, of the FDA, the Food and Drugs Act, with regard to the administration of sample drugs by registered nurses and nurse practitioners, I believe. We just went through a study on prescription drug abuse that identified a lot of flaws in the system, shall we say. I want to get your read on that, and probably that of Mr. Fisher as well. With regard to the sample drugs that are handed out by the big pharmacare people, it's normally an aggressive marketing process that they go through. They're providing a new drug into the market on a sample basis, and sometimes, if not all the time, the risks are higher than with the known drugs.

I'm curious to know, from the perspective of the registered nurses and nurse practitioners, if they're given the authority to hand out a sample drug, what information they would provide with regard to that sample drug. If they believe the sample drug is not applicable to that patient, would they refuse to provide it?

Dr. Barbara Mildon: Again, my regulatory colleagues may wish to respond, but very quickly I'll say that this is why we have regulated health professionals. They are under the obligation to practise in a safe, evidence-based way, so I can pretty safely guarantee that no registered nurse would give a patient a sample of a drug that they do not need and for which they've not provided that patient with information about what the drug does, why they need to take it, and how they need to take it.

The drugs that they would give out are drugs that the patient would see.... For example, I'll go back to blood pressure. There's a host of blood pressure medications on the market. All of them have various side effects. Some of them are more effective than others with particular patients. Sometimes you have to try two, three or four blood pressure medications until you get the effect of reducing and controlling that patient's blood pressure. That is why giving out samples is so helpful.

But from a safety perspective, I have no hesitation in saying that you wouldn't find a nurse giving a sample inappropriately.

Mr. David Wilks: Does that also include, from the perspective of the nurses...if there are potential adverse reactions to those drugs, would you let the patient know that as well?

Dr. Barbara Mildon: Most definitely. That is a key part of giving education about drugs and we're mandated to do that.

Mr. David Wilks: Thank you.

Is there anyone else on the panel who would like to speak to that? If not, I'll carry on to my next question. Thank you very much.

I'm going to change my role here. From the perspective of nursing in Corrections Canada, there are challenges between the federal system and the provincial system in that, as you know, those who are in the federal penitentiaries are serving much longer sentences and sometimes—well, all the time—for more serious crimes. Is there a difference or are there challenges in the nursing profession with respect to the federal penitentiary system compared to the provincial jail system? Are there different challenges? Or are there opportunities for which we could equal the scope of practice to allow better movement between those two systems?

I don't know who could answer that. I'm sorry. There are too many knowledgeable people here.

Anne, I saw you put your hand up. Thanks.

Ms. Anne Coghlan: I'm happy to start.

I would say that the standards are the same, and the expectation for nurses, regardless of what setting they're working in, is the same.

I think some of the challenges in the facilities you're talking about relate to a blurring of roles and an understanding within the setting of the role of a nurse as opposed to the role of a correctional officer. There are times when nurses are put in positions where their ability to practise according to the standards of the profession is not well understood and may be compromised because of the way settings are staffed and the policies and requirements in those facilities.

Mr. David Wilks: Dr. Mildon.

● (1030)

Dr. Barbara Mildon: I would agree with my colleague, and I would add that CNA has a specialty group of corrections nurses. We'd be happy to provide further information to follow up on this.

I also want to make the point that we have issues with our corrections facilities with people who need mental health care. Sometimes nurses are grappling with trying to provide the mental health care in those settings when they need different settings.

Mr. David Wilks: Thank you very much.

Thank you, Mr. Chair.

The Chair: Thank you very much.

I'd like to thank all the panellists who took the time this morning to participate.

If any other thoughts came out of the discussion and you didn't have a chance to express in your initial statements, you can send a memo to either the clerk or the analyst to round out what we've discussed today.

Again, thank you. All the members of Parliament here had a chance to ask questions, and we got into a good discussion.

We're going to suspend for a couple of minutes. I'll ask our guests to leave, and then we'll get into our committee business.

[*Proceedings continue in camera*]

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