HPRAC

HEALTH PROFESSIONS REGULATORY ADVISORY COUNCIL

ADVICE TO THE MINISTER OF HEALTH

SEPARATE COLLEGE FOR REGISTERED PRACTICAL NURSES

June 1996

ADVICE TO THE MINISTER OF HEALTH

SEPARATE COLLEGE FOR REGISTERED PRACTICAL NURSES

TABLE OF CONTENTS

SUMMARY

THE REFERRAL

On June 22, 1994 the Minister of Health asked the Health Professions Regulatory Advisory Council (HPRAC) to provide advice on the issue of whether a separate College for Registered Practical Nurses would be in the public interest. The Minister indicated that it might be of benefit for HPRAC to examine a distinct scope of practice for practical nursing, and issues relating to labour relations, effectiveness, cost effectiveness and human resource planning

HPRAC conducted a public review that involved fourteen participants. Each of these groups submitted at least one written position paper on the issues related to the referral.

CONCLUSIONS AND RECOMMENDATIONS

HPRAC's conclusions and recommendations are summarized in Section 3.6 on page 49, and in Section 4.7 on page 67.

1. INTRODUCTION

1.1 THE ROLE OF HPRAC

In interpreting its role and responsibilities, the Health Professions Regulatory Advisory Council (HPRAC) understands that its duties as outlined in Section 11 of the *Regulated Health Professions Act, 1991* (*RHPA*), are carried out in order to assist the Minister of Health in ensuring regulation and coordination of the health professions in the public interest (*RHPA,* Section 3). HPRAC further believes that the public interest is promoted by adherence to the principles which underlie the *RHPA*, specifically:

- protection of the public from harm (minimizing the risk of harm)
- quality of care (as related to professional standards of practice)
- accountability (through effective structures and mechanisms)
- accessibility (in each of its forms: geographic, linguistic, barrier-free, etc.)
- equity (in the availability of opportunities for choice of health care providers)
- equality (among health professions)

The advice which follows is based upon these principles and upon HPRAC's responsibility to promote the public interest.

1.2 THE REFERRAL

During the public consultations prior to the passage of the *RHPA, 1991* and the *Nursing Act, 1991*, the government made a public commitment to refer the request for a separate College for Registered Practical Nurses (RPNs) to HPRAC. Consequently, on June 22, 1994 the Minister wrote to HPRAC requesting the Council[1] to consider the fundamental question of:

> *"whether a separate College for RPNs would be in the public interest. That is, how would a separate College better protect the public from harm?"*

The Minister requested that HPRAC consider five sources of information in responding to the fundamental question, including:

1) *Records of debate (if any) on the issue during the Health Professions Legislation Review (HPLR) and relevant submissions made to the Standing Committee on Social Development in 1991 prior to the passage of the RHPA.*
2) *Consumer needs.*
3) *The views of other regulated or unregulated health professions.*
4) *The experience of other Canadian provinces (and elsewhere if relevant) with respect to this issue.*
5) *Any other directly relevant research/opinions available to the Council.*

[1] The Minister's letter is included as Appendix A.

The Minister's letter provided a summary of additional background information about the Referral. In this material, the Minister suggested that it may be of benefit to HPRAC to examine at least two sets of issues:

> *"Should the Advisory Council recommend a separate College for RPNs, it is likely that there would need to be a distinct scope of practice defined for RPNs (versus that of Registered Nurses)."*
>
> *"Adding complexity to the issue is the growth of "health care aides" who may also request regulation under RHPA in the future. There are additional concerns about their overlap with RPNs, labour relations issues, cost-effectiveness issues, and human resource planning issues. It is unlikely that a review of what is "in the public interest" would be complete without addressing these related matters."*

1.3 THE REFERRAL PROCESS

On receipt of the Minister's letter, HPRAC developed a set of questions which were designed to provide the basis for a substantive proposal from the Registered Practical Nurses Association of Ontario (RPNAO) When the RPNAO submitted their first proposal in February of 1995, HPRAC then opened the process to a written public consultation on that proposal.

After a review of the public submissions, HPRAC decided that a public meeting was not likely to elicit additional relevant information. HPRAC had questions about the RPNAO's first submission however, and requested that the RPNAO respond to them. The RPNAO responded in December 1995 with their second submission. The proposals included in this second submission were sufficiently different from the RPNAO's first proposal that HPRAC decided another round of public consultation needed to be held. This second round was completed in March 1996.

The following "Calendar" provides more specific dates for key events in the Referral. The correspondence referred to in the "Calendar", and a list of the 14 organizations and individuals that participated is included in Appendix B.

1.3.1 RPN Referral Calendar

DATES	REFERRAL EVENTS
June 22, 1994	Minister's Letter to HPRAC.
October 28, 1994	HPRAC's letter to RPNAO requesting a response to HPRAC's questions.
February, 1995	RPNAO first submission to HPRAC, in response to October 28, 1994 letter.
December 9, 1994 - July 24, 1995	Public consultation (first round) based on RPNAO's proposal. 18 organizations and individuals participated.

DATES	REFERRAL EVENTS
September 22, 1995	HPRAC's letter to RPNAO stating that a public hearing will not be necessary, but requesting further discussion of (a) proposed scope of practice, (b) proposed self-initiation of authorized acts, (c) delegation, assigning and initiating, and (d) support for self-governance.
December 18, 1995	RPNAO's second submission to HPRAC, in response to the September 22, 1995 letter.
January – March 23, 1996	Public consultation (second round), based on RPNAO's second submission, and responses to other participants in first round.

1.4 BACKGROUND TO THE REFERRAL

1.4.1 A Short History of Practical Nursing[2]

The profession of nursing is rooted in practical nursing. The occupation of "domestic nursing", or "private duty nursing" was prevalent in homes that could afford such care in Europe and North America prior to World War I[3]. Until that time most people in North America were cared for in their own households, generally by early practical nurses who had some experience with caring for the sick in their own families or through employment, and whose responsibilities were largely those extra domestic tasks related to caring for someone who is ill. Hospitals existed primarily for the poor, and recruited former patients and untrained attendants to work on the wards.

A component of the history of nursing is the increased use of certification and registration in the competition for existing jobs. In Canada this history is similar to that in other countries. The first Ontario "Nightingale" training school for nurses was established in St. Catharines in 1874[4]. Graduates of this new kind of training worked as private duty nurses and as visiting nurses with the Victorian Order of Nurses. There was considerable effort made to establish "trained" nursing as a profession for middle class women, and to differentiate trained nurses from untrained practical nurses, thus assisting trained nurses in competing with practical nurses for the higher paid, more skilled jobs. It was not until the burgeoning of hospitals at the turn of the century, however, that the training of nurses began to take place in large numbers.

The growth of hospitals and hospital-based nursing training in Ontario paralleled that of the U.S. Only 430 hospitals which trained nurses existed in

[2] For consistency we have used the contemporary title "practical nursing" to refer to the occupation throughout the report.

[3] Judi Coburn, *"I See and I am Silent: A Short History of Nursing in Ontario"*, in Women at Work in Ontario, 1850-1930, Janice Acton, Penny Goldsmith and Bonnie Shepard, eds. Canadian Women's Educational Press, Toronto, 1974, pp.127-164.

[4] Judi Coburn, above, p.135.

the U.S. in 1900, but by 1920 there were 1,800[5]. During this period most hospitals were primarily staffed by nurse trainees, who provided the hospitals with inexpensive, apprenticeship labour. The formal training was minimal: 160 hours over a two year apprenticeship. Nurses would graduate from this training to look for work in the private duty or community nursing labour market, using their certificate to assist them in competing with untrained practical nurses.

From the late 1800s there was a tension in the private duty nursing labour market between graduate nurses who used their qualifications to compete for higher paying jobs, and practical nurses whose advantage continued to be their lower wages. Private duty nursing required individual, direct relationships with patients and complete responsibility for nursing care, which became more complex as nursing became a recognized and more complex profession. In 1916 the Ontario Commission on Unemployment found that certification did not guarantee full employment: graduate nurses could only find an average of 8 months work per year in the private duty market[6]. The private duty employment of both graduate and practical nurses began to decline during the depression of the 1920s and 1930s. Towards the end of the 1930s there was some growth in the employment of both classes of nurses in hospitals. The Wier Survey in 1929 found that physicians used practical nurses in 62% of the cases of average acuteness, indicating a similar division of labour between practical nurses and graduate nurses as exists today[7]. By 1930 the proportion of Canadian graduate nurses to practical nurses in hospitals and private duty employment was 3:1, the same proportion as in the present labour market[8].

During the decline in employment during the 1930s the competition between the two groups increased, and practical nurses began to feel the need for their own 'certification' to strengthen the capacity to compete with graduate nurses in the declining private market and the potentially new hospital labour market. Private institutions, sometimes providing courses by correspondence, were the first to offer this kind of certification. The employment of trained and untrained practical nurses in hospitals increased through the Second World War, in part because of the displacement of graduate nurses into the war effort, and in part because of the elimination of the practice of staffing hospitals with nurse apprentices.

Nurses began calling for legislative recognition of the profession in 1912. It was not until after the 1929 Weir Survey of Nursing Education found that the apprenticeship hospital training was exploiting nursing trainees that Canadian provincial governments developed registration procedures and began to set standards for nursing training and practice. In 1946 the Ontario Minister of

[5] Robert Brannon, Intensifying Care, Baywood Publishing, Amityville, New York, 1994.

[6] The Report of the Commission on Unemployment in Ontario, Government of Ontario, 1916. p.185-186.

[7] R.M.Weir, Survey of Nursing Education in Canada, University of Toronto Press, Toronto, 1932.

[8] Judi Coburn, above. Table B. p.163.

Health conducted an inquiry into the use of practical nurses (nursing assistants) in Ontario Hospitals, which resulted in their inclusion in the 1947 Nursing Act. The history of the regulation of RPNs in Ontario is marked by the following pieces of legislation:

REGULATION OF PRACTICAL NURSING IN ONTARIO

1947 →	The *Nursing Act, 1947* for the first time provided for the title "Certified Nursing Assistants". The Department of Health was responsible for regulation of nursing assistants.
1951 →	The *Nurses' Registration Act, 1951* established that the Registered Nurses Association of Ontario (RNAO) was responsible for the registration of, and establishing standards for RNs. The Department of Health continued to be responsible for regulation of nursing assistants.
1963 →	The *Nurses Act, 1963* established the College of Nurses (CNO) to regulate the profession of nursing with regard to the protection of the public. Both RNs, and the re-named "Registered Nursing Assistants" were regulated by the College. The *Act* required that the representative of Nursing Assistants on the Council was to be an RN.
1973 →	The *Health Disciplines Act, 1973* changed the composition of the CNO Council to 17 RNs, 8 RNAs, and 8 public members.
1993 →	The *Regulated Health Professions Act* changed the title of "Registered Nursing Assistant" to "Registered Practical Nurse".

Official and professional recognition of the role of practical nurses has evolved since the professional group was first regulated. The College of Nurse's *1976 Standards of Nursing Practice for Registered Nurses and Registered Nursing Assistants* was the first statement detailing the role within nursing for nursing assistants. It specified that nursing assistants were the assistants of RNs, that is they were directly supervised and directed by RNs in all health care settings. This formally changed in 1991. The *CNO's Standards of Practice for Registered Nurses and Registered Nursing Assistants, 1991* eliminated the requirement that practical nurses be directly supervised by RNs, but restricted the independent practice of practical nurses by i) requiring adherence to pre-set care plans and ii) type of patient.

1.4.2 History of the Referral

The RPNAO has made a number of submissions to the government in the past ten years requesting separate regulation of registered practical nurses. These submissions have been commented on by other regulatory bodies, health professional associations and unions as well as by government bodies, creating an on-going debate that at times has been heated and contentious.

The RPNAO's first requested self-regulation during the Health Professions Legislative Review (HPLR) In 1987 the HPLR re-affirmed the combined regulation of RPNs and RPNs, based on the observations that:

RPNs are full members of the College,

- RPNs on the College Council have full voting status,
- RPNs were divided on the separate College issue,
- RNs and RPNs do not have an employer-employee relationship which might cause regulatory disagreement.

The RPNAO was dissatisfied with this conclusion and made a further presentation on August 27, 1991 to the Standing Committee on Social Development during hearings on the *RHPA.* It was during these hearings that the government made a public commitment to refer the request for a separate RPN College to HPRAC.

1.5 OUTLINE OF HPRAC'S REPORT TO THE MINISTER

The report that follows is intended to provide the Minister with a review of the submissions made during this Referral, an understanding of HPRAC's analysis of the issues raised by the Referral, and a discussion of the range of options that might address the public interest issues that are at the core of the Referral. Section 2 is a summary of submissions; Section 3 outlines our analysis, and Section 4 discusses options and outlines HPRAC's recommendations.

2. SUMMARY OF PARTICIPANTS' SUBMISSIONS [9]

In this section the positions of participants are summarized with respect to their consideration of (i) the protection of the public interest, (ii) the distinctiveness of RPNs as a profession, (iii) appropriate structures of governance and (iv) support for a separate college. This categorization of the issues has developed from a thorough review of the submissions made to HPRAC, and of the central questions raised by the referral.

The Minister's letter of June 22, 1994 requested HPRAC to consider information from different sources of information, including:

i) Records of debate (if any) on the issue during the HPLR and relevant submissions made to the Standing Committee on Social Development in 1991 prior to the passage of the RHPA.

ii) Consumer needs.

iii) The views of other regulated or unregulated professions.

iv) The experience of other Canadian provinces (and elsewhere if relevant) with respect to this issue.[10]

v) An other directly relevant research/opinions available to the Council.

The key participants in the Health Professions Legislative Review (HPLR) hearings that related to practical nursing and those who made submissions to the Standing Committee are the same as those who have made submissions to HPRAC. The general positions taken by participants in this referral do not significantly differ from those presented to earlier hearings. The submissions we have received, however, are more comprehensive, including far more developed proposals. Consequently in this section we will primarily refer to the submissions made to HPRAC.

The summary does not review each submission, although it does capture significant disagreements between participants concerning statements made in other participant's briefs. It is intended to provide an overview of the arguments in support of and opposing the creation of a separate RPN College.

2.1 PROTECTION OF THE PUBLIC INTEREST

2.1.1 Public Interest Arguments Supporting a Separate RPN College

i) Public Choice of Health Care Professional

The public interest would be better met by a clear distinction between RNs and RPNs that enable the public, health professionals and employers to choose the appropriately trained, cost effective professional for each care situation. RPNs

[9] Please refer to Appendix B for a list of those organizations and groups that participated in the referral. This list provides an index for the acronyms used in this section.

[10] The regulation of practical nursing in other provinces is discussed in Section 3.2.4.

have been and continue to be underutilized in the health care system[11], in large part because they are constrained through the structures of the CNO in using their professional training to its full capacity. (RPNAO, a Collective of RPNs[12], OMA, CMAAC, ODHA, OCHU)

ii) Public Choice of a More Adaptable Professional

A smaller College would enable RPNs to become a more adaptable profession, capable of responding more quickly to new health care emphases on health promotion, affordable long term care, community care and improved coordination of rehabilitation services. (RPNAO, OMA, OCHU)

The aging population of the province is making different demands on the health care system, requiring more non-acute day-to-day home care or community based care. Separate regulation will enable RPNs to play a major role in this development. (RPNAO, ODHA)

iii) Public Protection From Harm

The existing structure does not allow the development of timely, or clearly defined scope and standards of practice for RPNs. The current CNO structures take too long to develop standards of practice and to handle complaints. Public interests would be better protected by a separate college which could communicate directly to the public, develop separate and more comprehensive standards of practice, and its own review and disciplinary procedures. (RPNAO, OMA, OAMRT)

iv) Public Protection From Harm Through Greater Inter-professional Collaboration

Independent colleges will foster, as they have in other provinces, more cohesive, collaborative and cooperative efforts between RPNs and other colleges and health care professionals. A separate college would develop a scope of practice and standards of practice that would be clearer to other health care professions. (RPNAO, Collective of RPNs, OMA, CMAAC, OCHU)

v) Professional Self Determination And Equality Between Professions

> *"[A] profession which wishes to be separately regulated, and which has already met the tests for regulation under the RHPA should be entitled to such separate regulation." (OMA I, p.3)*

[11] The RPNAO conducted a study in 1991 on the utilization of the skills of RPNs in hospitals, homes for the aged, nursing homes and the VON. The survey found wide variations in RPN practice and consistent under-utilization of RPNs particularly in hospital settings.

[12] This Collective made their first submission to HPRAC as RPN members of the CNO Council. Six of the seven elected RPN representatives on the Council signed the submission. Subsequently they withdrew their original paper, and re-submitted a revised version to HPRAC as "A Collective of RPNs". It is HPRAC's understanding that they did this at the request of the CNO. (RPNAO letter, October 12, 1995)

The public interest is better served by professionals who are in charge of their own agenda. The professional interests of registered nurses unduly dominate the existing regulatory structure. The structure does not create adequate opportunities for the development of RPNs, either in the regulatory processes of the College or as a professional group. Consequently members of the professional group are under-valued, and under-utilized, meaning that the health care system itself is not using its human resources efficiently. (RPNAO, OMA, CMAAC, OCHU) *"I see a similarity in the lives of older women and RPNs in as much as women of my generation were often not people in their own right but had their lives controlled by fathers, then husbands"*. (Older Women's Network)

vi) Better Educated Professionals Protect the Public From Harm

A separate college dedicated to RPNs would develop basic and continuing education programs more suited to the professional needs of RPNs. (RPNAO, OMA)

2.1.2 Public Interest Arguments Opposing a Separate RPN College

i) Public Protection from Harm

The overlap in the scope of practice between RPNs and RNs is too great to be effectively regulated by two colleges. It would necessarily create public and professional confusion and will not enhance the protection of the public from harm. (SEIU, CNO, RNAO)

The RPNAO's statement that complaints and disciplinary hearings take too long, and consequently that the CNO does not adequately protect the public from harm, is based on information that is out of date. A marked improvement has taken place in the proportion of cases that are reviewed within four months since 1992-93. In 1994 only 23% of complaints were not processed within four months, and only 15% of all investigations were not processed within that time period. (CNO)

ii) Public Choice of Health Care Professional

RPNs are underutilized in the workplace, but this is not a problem of the regulatory body or the existing standards of practice. It is a problem related to human resource management decisions made in health care settings which do not allow RPNs to practice to the full extent of the existing scope of practice. (SEIU Local 204)

The public must be able to differentiate between different categories of nurses, but this would not necessarily be better achieved by separate colleges. *"This is an issue of particular importance in our day when RNs and RPNs are being laid off in large numbers and replaced by unregulated, far less educated workers. It is only fair to consumers that they be given clear information regarding the training and education of the person providing their care."* (ONA, p.2)

iii) Public Access to Regulatory Bodies

Informed public or consumer choice is more likely to be achieved if there is one college for nursing. The potential for public confusion, along with confusion among other health care providers, is a unique concern in the case of RNs and RPNs because both share the title of "nurse". Separate regulation would create an unnecessary barrier to the public's ability to access regulatory bodies. (CNO, CMLTO, RNAO, ONA)

The distinctions between "nurses" (RPNs, RNs and NPs) are not publicly understood, and they are not as great as distinctions between professions regulated by the OMA, for instance. "*Since there is concern in the RHPA that the public cannot understand the title 'doctor' as used by non-physicians (clinical chemists, microbiologists, geneticists, etc.), we have some concerns whether the public could easily understand major differences in 'nurses'*". (OSCC)

iv) Effective and Timely Standards of Practice and Public Confidence in Standard Setting

The standards of practice for RPNs and RNs are clear. What is not consistent is how these standards are translated in practice settings. The existence of two regulatory bodies could actually aggravate this issue. (RNAO)

A single regulatory structure is the best context for RNs and RPNs to work together to develop standards which benefit the public and are, at the same time, mutually beneficial. Further, "*a stable organization, with proven mechanisms for consultation and information exchange is required to respond to and to implement rapid change in the public interest.*" (CNO I, p.9) Public confidence in the establishment of standards could be jeopardized if there is inconsistency between standards and practices of two such closely intertwined disciplines. Disputes between separate regulatory bodies would require increased reliance on third parties (the government) to resolve differences, with consequent time consuming delays in regulatory activities. (CNO, SEIU Local 204, ONA, RNAO)

v) Ability of Nursing to Participate in Checks and Balances Within the Larger Health Care System

A single college with the combined resources and a larger membership is a more effective advocate for changes that promote higher quality nursing care, and for influencing broader health care directions and strategies. (CNO)

vi) Better Educated Professionals Protect the Public From Harm

Even though standards of practice set the direction for education, coordinating career progression between programs is very difficult. It will be even more difficult if education programs must respond to two regulatory sets of standards. (CNO, ONA)

2.2 DISTINCTIVENESS OF PRACTICAL NURSING AS A PROFESSION

2.2.1 Support for Recognition of Practical Nursing as a Profession

i) RPNs Are Hands-on Care Providers

Registered practical nurses are a separate profession from registered nurses. They are the appropriate care professionals for practical "hands on", or "bedside care" in acute care and long term care facilities, and can, with extra training, be the appropriate professional in community care. The RPNAO predicts that increasingly RPNs will fill most bedside care roles, while RNs will increasingly focus on more complex care, more complex assessments and on planning, administration, teaching and research. (RPNAO, CMAAC, OAMRT, ODHA, OCHU)

ii) RPNs Should Be Fully Recognized As Independent Practitioners

The role of the RPN has evolved *"from that of an overall institutional assistant through to a specific nursing assistant role and eventually to an independent practitioner in a collaborative nursing and health care environment"*. (Collective of RPNs p.7, and RPNAO)

The HPLR recommendation to grant dental hygienists a separate college included the rationale that it was a conflict of interest for dentists to both regulate and employ dental hygienists. The situation is parallel for RPNs: *"the roles of some RNs dictate that they have considerable influence over the employment of RPNs"*. (ODHA p. 2, and RPNAO)

iii) Scope And Authorized Acts

HPRAC Comments: In order to be recognized as a profession, practical nursing requires a scope of practice statement which assists the public and other practitioners in understanding what the profession does, the methods it uses, and the purposes for which it uses these practices. The RPNAO made two proposals during the course of the referral. For ease of reference, *Figure 1* provides the reader with a comparison between scope of practice statements that currently govern RPNs and those proposed in the RPNAO's first and second submissions. *Figure 2* provides a similar comparison between current and proposed authorized acts, again, as presented to HPRAC by the RPNAO.

RPNAO Submission I proposed a scope of practice statement that was very similar to that of Nursing, and that RPNs would be responsible for:

a) a greater range of procedures within the controlled acts assigned in the current Nursing Act.

b) self initiation of several procedures within these controlled acts.

RPNAO Submission II proposed a new scope of practice statement, and withdrew the proposal that RPNs be able to self-initiate controlled acts. This scope of practice statement slightly modifies the current Nursing scope statement, but adds specific limitations to RPN practice related to the condition of the patient. It provides a basis for a greater independence and assessment

role for RPNs. In particular, any reference to RPNs working within the context of a care plan, even with stable patients, has been removed. (RPNAO's second scope statement was explicitly supported by OMA.)

SCOPE OF PRACTICE STATEMENTS		
CURRENT STATUS ***1991 Nursing Act*** **General Statement: RNs and RPNs**	**RPNAO SUBMISSION** **General Statement**	**RPNAO SUBMISSION II** **General Statement**
"The practice of nursing is the promotion of health and the assessment of the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function."	"The practice of practical nursing is the provision of practical care to prevent illness, to promote, maintain and restore health and social well-being, to assess, provide care for and treat health conditions by supportive, preventive, therapeutic and rehabilitative means and to care for they dying by palliative means."	"The practice of practical nursing is the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, rehabilitative and palliative means: i) when there is a normally expected outcome, and ii) when the outcome is or becomes unpredictable, provided the practical nurse is acting under the direction of or in collaboration with a member of another health profession"
1990 CNO Standards of Practice "RNA's (RPNs) are able to practice independently when the client's condition is common enough that the outcome is predictable, allowing the RNA to implement pre-set care plans that include a limited range of interventions. RNAs seek the collaboration of RNs in client situations that are beyond this scope."		

Figure 1

iv) Recognition of Practical Nursing in Other Jurisdictions

The RPNAO requested the protection of the title "licensed practical nurse", rather than "registered practical nurse", in order to establish common recognition of the profession across the country. (RPNAO)

All other Canadian provinces have separate regulation for RNs and RPNs. Support for professional and regulatory recognition was expressed by professional associations in Manitoba, Saskatchewan, New Brunswick, and Quebec as well as from the Canadian Association of Practical Nurses and Nursing Assistants. (RPNAO, Collective of RPNs, OCHU)

v) Distinctiveness of Practical Nursing Training

RPNs are a distinct profession because their educational requirements are different from that of other classes of nurses. *"[B]oth RNs and RPNs can achieve high levels of expertise in their respective fields, but an RPN will not become an RN merely because she has reached a high level of expertise."* (OMA I, p.1)

RPN education has a separate focus from the training received by RNs. It focuses more than RN training on health challenges such as stress, anxiety, crisis, pain, inflammation and neoplasia, health problems with regulatory mechanisms and common health problems encountered across a client's lifespan. They also receive a higher ratio of clinical practice courses than RN students. (RPNAO, OCHU)

The existence of high school RPN diplomas should not disqualify the occupation from recognition as a profession under the RHPA. In 1994 11% of the CNO's successful RPN registrants were graduates of high school programs. Courses in both institutions are designed to prepare graduates to pass the same country-wide Canadian Nurses Association Test for practical nurses and that all applicants must pass this test in order to register with the CNO. (RPNAO)

2.2.2 Opposition to Recognition of Practical Nursing as a Profession

i) Nursing is One Discipline

"Nursing is one discipline with two categories of practitioners: registered nurses and registered nursing assistants [RPNs]. RNs and RPNs study the same body of knowledge, but RNs study it in greater depth and breadth." (CNO I, and CNO 1990 Standards of Practice. Also SEIU Local 204, CMLTO, RNAO, ONA)

ii) Scope of Practice and Authorized Acts - Response to RPNAO's Proposals

There is a great deal of overlap in the scope of practice of RNs and RPNs. (CNO, SEIU Local 204, ONA, RNAO) The only substantial difference between the RPNAO's first proposed scope of practice statement and the current Nursing Scope of Practice is the reference to "practical nursing". This is not a sufficient distinction. (CNO, RNAO, ONA)

In the RPNAO's second scope of practice statement, the parameters of "normally expected" and "unpredictable" patient outcomes are overly simplistic. The distinction between patients whose condition is stable and those whose condition is unpredictable is not always clear in practice. Current economic and social changes mean that the conditions of patients both in acute care settings and in long term, home and community settings are more complex. The statement proposes that at the moment at which an RPN needs to begin to work under the supervision of another health care practitioner, the RPN must be able to i) recognize the change in the patient's condition and ii) another health care practitioner must be available. Both of these assumptions are problematic in practice. (RNAO)

The phrase in the RPNAO's second statement that reads *"under the direction of or in collaboration with another health care professional"* needs clarification. In situations where RPNs are working outside of their scope of competence to

AUTHORIZED ACTS

1991 NURSING ACT	RPNAO SUBMISSION I		RPNAO SUBMISSION II
RPN and RPN Authorized Acts 1. Performing a prescribed procedure below the dermis or a mucous membrane.	Current RPN Practice: No self-initiation by RPNs but practice of three Acts 1. Performing a prescribed procedure below the dermis or a mucous membrane, specifically: a) All RPNs can perform: cleansing, soaking, probing, debriding, packing, dressing and treating open areas of the skin; b) RPNs with extra training can perform: irrigating; c) RPNs can be delegated to perform: suturing of subcutaneous tissue and closing skin.*	Proposal I: RPN Self-Initiated Acts and Procedures 1. Performing a prescribed procedure below the dermis or a mucous membrane, specifically: cleansing, soaking, probing, debriding, packing, dressing and irrigating.	Proposal II: No Self-Initiation by RPNs, But Practice of 3 Acts 1. Performing a prescribed procedure below the dermis or a mucous membrane
2. Administering a substance by injection or inhalation.	2. Administering a substance by injection or inhalation, specifically: a) All RPNs can perform: inhalation therapy (oxygen, ventolin, atrovent, becolvent); intracutaneous injections (TB & allergy injections); subcutaneous injections (insulin); insertion of cannula attached to IV line, connection and monitoring IV line; peritoneal dialysis, in community care settings. b) RPNs with extra training can perform: i) intramuscular injections (iron injections for post partum or elderly patients, and tetanus for young patients)	2. Administering a substance by injection or inhalation.	2. Administering a substance by injection or inhalation.
3. Putting an instrument, hand or finger i) beyond the point in the nasal passages where they normally narrow	3. Putting an instrument, hand or finger i) beyond the point in the nasal passages where they normally narrow, specifically: a) All RPNs can perform: removing packing from nasal passages; inserting catheters to suction newborns and persons with chronic respiratory ailments	3. Putting an instrument, hand or finger i) beyond the point in the nasal passages where they normally narrow	3. Putting an instrument, hand or finger i) beyond the point in the nasal passages where they normally narrow

1991 NURSING ACT	RPNAO SUBMISSION I		RPNAO SUBMISSION II
ii) beyond the larynx	ii) beyond the larynx, specifically: a) All RPNs can perform: care for permanent tracheostomy with a healed stoma; suctioning up to and including the trachea	ii) beyond the larynx	ii) beyond the larynx
iii) beyond the opening of the urethra	iii) beyond the opening of the urethra specifically: RPNs with extra training can perform: bladder catheterization	iii) beyond the opening of the urethra, specifically: bladder catheterization	iii) beyond the opening of the urethra
iv) beyond the labia majora	iv) beyond the labia majora, specifically: a) All RPNs can perform: repositioning vaginal prolapse; performing douches, placing tampons, suppositories & creams, removal of foreign objects	iv) beyond the labia majora, specifically: repositioning vaginal prolapse; performing douches, placing tampons, suppositories & creams, removal of foreign objects	iv) beyond the labia majora
v) beyond the anal verge	v) beyond the anal verge, specifically: a) All RPNs can perform: taking rectal temperatures, treatment of hemorrhoids, administering enemas and suppositories, disimpacting and removing foreign objects	v) beyond the anal verge, specifically: examination to assess the need for disimpaction, treating hemorrhoids, administering enemas and suppositories, reposition a prolapse, and removing foreign objects	v) beyond the anal verge
vi) into an artificial opening into the body	vi) into an artificial opening into the body, specifically: a) All RPNs can perform: care and suctioning of permanent tracheostomy with a healed stoma; suprapubic catheters; administering medications into bowel colostomy	vi) into an artificial opening into the body, specifically: reinserting a tracheostomy tube	vi) into an artificial opening into the body
vii) beyond the external ear canal	vii) beyond the external ear canal, specifically: a) All RPNs can perform: ear syringing, examination with an otoscope, instilling ear drops		vii) beyond the external ear canal

Figure 2

operate independently, they should work "under the direction of" another health care professional. (ONA)

The controlled act of putting an instrument, hand or finger beyond the external ear canal, or beyond the orifice of the external ear canal into the middle ear space is done by only a relatively small number of physicians. It appears that RPNs do not actually practice this controlled act. (OMA)

iii) Both RNs and RPNs are Hands-on Practitioners

The CNO and ONA took exception to the position that RPNs are the providers of hands on care at the bedside and RNs are being directed away from that aspect of nursing and towards planning, administrative, teaching and research functions. *"[H]ands-on and client care and contact continues to be a primary focus of the majority of both RNs and RPNs".* (CNO II, p.2) They report that there has been no change in the proportion of RNs working in direct care in the last five years, while in the same period there has been a small decrease in the proportion of RPNs working in direct care. In 1994 81% of RNs and 87% of RPNs worked in direct care. (CNO) *"The notion that **planning** and **administering** care can exist in isolation of what is actually happening at "the bedside" is a model of care that is not in the public interest".* (RNAO I)

iv) Autonomy of RPNs is not Sufficient Grounds for Separate Profession

The 1990 Standards of Practice recognize that RPNs are professionals who are autonomous from RNs. That is, they are not required to work under the direct supervision of an RN, and are expected to work as an autonomous member of a health care team. This is a recognition of increased responsibility and scope of competence, not a recognition of RPNs as a separate profession. (CNO)

v) Criteria of Separate Body of Knowledge is Not Met

RPNs do not draw on separate and distinctive body of knowledge from that of "nursing". The core curricula in programs for RNs and RPNs are identical for the first one or two semesters. (RNAO) While it is not possible to identify two separate and distinctive bodies of knowledge, this should not be the key determinant for combined/separate regulation. (CNO)

vi) Criteria of Educational Requirements for Entry to Practice is Not Met

High school programs are the point of entry to the profession for a small number of RPNs. This does not meet the criterion for regulation under the RHPA that requires that practitioners have completed a post-secondary program. (CNO)

vii) Effective Regulation Already Exists

RPNs have been regulated effectively within the CNO for over 30 years. RPNs have experienced significant development over these 30 years. The 1990 Standards of Practice acknowledge for the first time that RPNs, performing within the parameters of these standards, are autonomous professionals rather than "assistants" to RNs. The effectiveness of these changes should be assessed before any further separation of the profession occurs. (CNO, RNAO,CMLTO)

Because RPNs are already regulated, the CNO takes the position that *"the only standard against which to measure arguments for professional regulation is whether separate regulation better serves the public interest"*. (CNO II, p.1, our emphasis)

The RPNAO submissions raise a question of the ability of the profession to self-regulate in the public interest: *"the RPNAO appears to focus more on recognition for the RPN than on the public interest"*. (CMLTO)

viii) Nursing is in a State of Considerable Change.

The relationship between RNs and RPNs as different 'classes' of Nurses has been to some extent addressed in the 1990 Standards, but relationships between RNs, RPNs and unregulated health support workers, and the potential greater use of Nurse Practitioners are all still unclear. *"In Council's view the establishment of a two college model before there is a clear vision of the future of nursing could constrain subsequent reforms"*. (CNO I p.9) The creation of a separate RPN college could badly fracture nursing at this point in its evolution. (CNO, RNAO, ONA)

ix) Recognition of the Same Title as Other Jurisdictions

The RPNAO's request to protect the name "licensed practical nurse" reflects a misunderstanding of the difference between the registration model of regulation under the RHPA, and licensing models of registration in other jurisdictions. (CNO)

2.3 ISSUES WITH CURRENT GOVERNING STRUCTURES AND STANDARDS OF PRACTICE

2.3.1 Support for Changing Current Governing Structures

i) CNO Structures Contribute to Disputes Between RPNs and RNs.

The history of disputes between RPNs and RNs over the kinds of tasks and responsibilities that can be safely handled by RPNs is a history of injustices which "*only help to reinforce the need for two separate Colleges, where the RPN will be encouraged and permitted to grow and develop to their full potential in the nursing profession*". (RPNAO I, p.45) The structures of the CNO allow concerns and issues related to registered nurses to dominate. This, combined with the difference in workplace status of RPNs and RNs, has "*provided continued opportunities for RNs to protect their competitive interests*". (RPNAO, I, p.36) In particular:

- it took 9 years to develop the 1990 standards of practice. (Collective of RPNs)
- CNO did not conduct public education about the name change from "Registered Nursing Assistant" to "Registered Practical Nurse".
- CNO has developed Guidelines for RNs working in special practice situations, (e.g. birthing centres) but has not developed similar guidelines for RPNs.

- CNO did not allow the RPN members of the Council to make a 'minority' report, as Council members, to HPRAC on the question of a separate College for RPNs.
- Between 1991 and 1993 the CNO conducted consultations concerning the initiation of controlled acts by both RNs and RPNs. Five drafts of the report were widely circulated, and had the broad support of both RNs and RPNs. The fifth draft included an acknowledgement of a broader range of responsibilities for RPNs and their ability to self-initiate procedures within three controlled acts. The "fifth draft" that had broad approval included the following:

> *"The greater depth & breadth of knowledge of RNs provides a foundation to make the appropriate decision to perform and to manage the outcomes of procedures with both predictable and less predictable outcomes, whereas the depth and breadth of knowledge of RPNs provides the foundation to make the appropriate decision to perform and to manage the outcomes of procedures with predictable outcomes." (RPNAO I, p.43)*

and, self initiation by RPNs of the following procedures:

> *i) in the dermis or a procedure related to the care of wounds below the dermis or mucous membrane, in particular cleansing, soaking and dressing.*
>
> *ii) that require putting an instrument or finger(s), a) beyond the anal verge or b) into a well-established artificial opening into the body to assess or assist an individual with health management activities. (RPNAO I, p.43)*

In 1993 the final draft was not widely circulated in advance of a Council meeting (CNO states that it was circulated to Council in advance) This draft withdrew the self initiation by RPNs. It was not supported by the RPNs on Council and was passed because of the RN majority.

ii) 1990 CNO Standards of Practice Restrict the Full Use of RPNs Professional Training

Because the distinctions between RNs and RPNs are detailed primarily in standards of practice, the standards provide a focus for disagreements. Particularly the *1990 Standards of Practice:*

- restrict RPNs to the use of *pre-set procedures*, and *to selecting priorities within an existing care plan*. This is a basic disagreement with the broad limitations on RPN practice in the *Standards*. RPNs are trained to assess and develop care plans. (RPNAO, Collective of RPNs)
- imply that *RPNs don't delegate or assign tasks* to other RPNs or other health care workers. Some RPNs, however, are supervisors of RNs, RPNs and unregulated health care workers. (RPNAO)
- allow RPNs with post-basic training to administer intramuscular injections (such as iron and tetanus) only to healthy school children. The CNO's *Guidelines for Decisionmaking* state that administering intramuscular injections to elderly clients involves a higher risk than with children. RPNs disagree with this interpretation, and argue that the limitation positions RNs in an advantageous position, to be the best choice of practitioner in

situations where hospital management is replacing "primary nursing" with "team nursing" (RPNAO and OCHU)

- restrict *bladder catheterization* by RPNs (in CNO's *Guidelines for Decision Making,* not the *Standards*) to those RPNs who have additional training. RPNs argue that they are taught this procedure in their basic training. (RPNAO)
- exclude the current practice in some health care institutions where RPNs conduct *venipuncture* and *start intravenous lines without medications*.
- limit *where RPNs are able to practice independently by the condition of the patient*. While this was a complaint in the RPNAO's first submission, the second submission adopts this as the preferred way to distinguish the practice of RPNs from RNs.

2.3.2 Opposition To Changing The Current Governing Structure

i) The CNO's Priorities Are Relevant to Both RNs and RPNs

With the exception of the government's nurse practitioner initiative, the CNO's priorities have been equally relevant to the two groups, including responding to the proclamation of the RHPA, the program for abuse prevention, development of consent to treatment procedures, development of the quality assurance program, etc. The work that has been done on development of standards for nursing administrators, educators and researchers was intended to provide direction for both RNs and RPNs. (CNO, RNAO) The perception that the guidelines for nurses in independent birthing centres was for RNs only derives from a typing error in one strategic plan. (CNO)

ii) The 1990 Standards Were Developed and Adopted by Both RNs and RPNs

The *1990 Standards of Practice*, which recognize RPNs as autonomous professionals, were developed by all classes of nurses, and did not come about purely as a result of RPN pressure (as RPNAO claims). The standards are in a constant process of development, and become formalized only after consultations with RNs and RPNs across the province. From the Council's perspective, the *1990 Standards* represent a significant recognition and promotion of a new independent and expanded role of RPNs. (CNO)

iii) Standards of Practice Disputes

There is consistent confusion in the RPNAO submission between the responsibilities that can be taken by RPNs with basic training, and those that can be taken by those who have additional training. The frequent inconsistencies in the RPNAO's descriptions of the relationships between RPNs to other health practitioners reflects an apparent unfamiliarity of the RPNAO with the language of the RHPA. (CNO) "*It is important that we not confuse necessary change and progression with the lack of consistent standards. These are not the same thing.*" (RNAO)

2.4 PROPOSALS FOR A NEW GOVERNING STRUCTURE

2.4.1 A Separate RPN College

i) Proposed RPN Council

8 elected members and 6 public members who would sit for 3 year terms. (RPNAO)

ii) Proposed College Staff

1 Registrar, 4 Directors, and 20 professional and support staff. (RPNAO)

iii) Budget

The proposed annual budget is $2,245,000, which is based on no increase in the current $70 fee RPNs pay to the CNO. The submission assumes a division of the current assets of the CNO. (RPNAO)

iv) No Significant Increase In Public Costs

The RPNAO proposes that the CNO retain 14 elected members and 12 public members, and that consequently the separation would not involve significant increase in public funding for public members.

v) Increase in Public Costs Other Than Those of A College

RPNAO claims that public costs would not increase, but a separate College would necessitate an increase in costs related to possible duplication of effort and resources to clearly identify differences between RNs and RPNs, duplication of services to regulate nursing practice, and the effort and resources required to achieve consensus between two separate bodies. (CNO, SEIU Local 204, RNAO, ONA)

2.4.2 Changes within the CNO

i) Accommodation of Perceptions of Unfairness

The CNO acknowledged that *"there are elements in CNO's structures and processes which have at times contributed to perceptions that RPNs are not treated fairly within a combined regulatory structure"*. (CNO I, p.2) It also recognizes that these perceptions are fed by the historic work relationship between the "supervisory" role of the RN and the "assistant" role of the RPN. The Council does not see restructuring as necessary, but is prepared to ensure that:

- all members have the necessary knowledge and skills to participate effectively in Council decision making
- the College will take a greater role in ensuring that employers are aware of the breadth and scope of practice permitted to RPNs
- a working group will make recommendations on whether an 'extended class' of RPNs should be able to initiate controlled acts (established June 1995) (CNO)

ii) Better Representation of RPNs and RNs in CNO Structures

An equal number of RNs and RPNs on the Council of the CNO would address the concerns raised by the RPNAO. (SEIU Local 204)

A different balance between RNs and RPNs on Council, in committees and on staff could have avoided the current situation. (OAMRT)

iii) Revision of the Nursing Act

In October 1995 ONA proposed to the Minister that the *Nursing Act* should be revised to include three scope of practice statements, one each for RPNs, RNs and NPs. (ONA)

iv) Shift in Regulatory Focus

RPNs are experiencing some difficulties that all CNO members face. "*The regulatory process, in general, needs to become less punitive and more educative, and that the responsibility for providing appropriate care must be assumed by more than the individual practitioner.*" (RNAO I)

v) Effective Use of the Quality Assurance Program

The inconsistency in the use of RPNs and their underutilization should be addressed by the Workplace Assessment component of the CNO's Quality Assurance Program. This could "*ensure that agencies do their part in utilizing the appropriate professional to provide the right care in the right place in a timely manner.*" (RNAO II, p.2)

2.5 SUPPORT FOR A SEPARATE COLLEGE

2.5.1 Among RPNs

The RPNAO represents 5,500 RPNs. That is 15.9% of 34,569 RPNs registered with the CNO, and 20.9% of the 26,252 RPNs who were employed in the province in 1994. According to a 1992 survey of 21,920 RPNs, 1,012 (or 4.6% of those surveyed) supported the creation of a separate College, and 50 (.2% of those surveyed) registered their opposition.

Six of the seven RPN members of the CNO Council support a separate college, as does the Ontario Council of Hospital Unions/CUPE which represents approximately 5,000 RPNs.[13]

2.5.2 Other Organizations

Chinese Medicine and Acupuncture Association of Canada supports the formation of a separate RPN College, as does the Older Women's Network,

[13] OCHU was the only participant in the referral that took a different position in this referral than during the 1987 HPLR. They state that in 1987 "*OCHU held the position that the very serious problems at the CNO could possibly be addressed through changes within the existing College structure. But we were wrong.*"

Ontario Association of Medical Radiation Technologists, Ontario Dental Hygienists' Association and the Ontario Medical Association.

2.6 OPPOSITION TO A SEPARATE COLLEGE

2.6.1 Among RPNs

The CNO represents approximately 34,500 RPNs. In February 1994 the CNO Council passed the motion that *"The College of Nurses support one college for RNs and RPNs"*. However, the decision was not unanimous: the motion was supported by 22 members, opposed by 10 while 2 abstained. (CNO) As we have noted above, at least six of the seven elected RPN Council members opposed this decision.

The RPN Committee of Service Employees International Union Local 204 which represents approximately 3,000 RPNs, opposes a separate RPN College.

2.6.2 Other Organizations

The College of Medical Laboratory Technologists of Ontario opposes a separate RPN college, as do the Registered Nurses Association of Ontario and the Ontario Nurses' Association.

2.7 FROM SUMMARY TO ANALYSIS

In HPRAC's view both those groups who support a separate College and those who do not have presented strong arguments about the appropriate protection of the public interest, the distinctiveness of RPNs as a separate profession, and appropriate structures of governance. The strength, and at times the passion of these opposite arguments is an indication of the seriousness of the tensions that are at the centre of this referral.

In Section 3 HPRAC analyses the material summarized above. We begin with a summary of questions that arise from the public interest arguments made by the participants. The section includes discussions of whether practical nursing can be considered a separate profession, and of the effectiveness of the current system of combined regulation

3. ANALYSIS

3.1 INTRODUCTION – A SEPARATE COLLEGE AND THE PUBLIC INTEREST

HPRAC was requested by the Minister to address the question of "*whether a separate college for Registered Practical Nurses would be in the public interest. That is, how would a separate college better protect the public from harm*."

The Minister suggested that it was unlikely that a review of what is in the public interest in this referral would be incomplete without an examination of the issues related to the overlap between RPNs and unregulated health care aides, labour relations, cost-effectiveness and human resource planning. HPRAC has taken this advice into account, and particularly addresses questions related to health care aides later in this section.

HPRAC has arrived at its advice by beginning with two inter-related questions which directly follow from the Minister's question:

1) What is required by the *RHPA* to establish a separate college? That is, is a separate college for RPNs a feasible proposal?

2) What does a review of the public interest issues raised by the participants indicate about the underlying problems with the current situation, and consequently the conditions under which a different regulatory structure might be both feasible and in the public interest?

3.1.1 Overview of Public Interest Issues

A review of the public interest principles that HPRAC has developed on the basis of the *RHPA* has provided the first step in our analysis. These principles include: the protection of the public from harm, ensuring the quality of care, accountability of the profession, accessibility of the profession, equity among individuals related to health care and equality among professions. Not all of the principles necessarily apply in all situations. The principles which specifically apply in this referral are those related to protection from harm, quality of care, accountability, accessibility, and equality.

In HPRAC's view, both those groups supporting a separate RPN college and those who are opposed have presented strong, plausible arguments that the public interest will be protected by their proposals. What emerges from the following introductory overview is a significant set of questions about the conditions under which a separate college would be in the public interest, and whether the public interest is being adequately protected in the current situation. The reader will note that the principles are inter-related, and the issues raised in the referral can be related to more than one principle.

PUBLIC INTEREST PRINCIPLES	HPRAC's ASSESSMENT OF PUBLIC INTEREST ISSUES IN THIS REFERRAL
PROTECTION FROM HARM The *RHPA* mechanisms enable a College to hold its members accountable, provide them with safe practice guidance, and provide the public with assurance that they are protected from harm. These mechanisms include the harm clause, scope of practice statements, those controlled acts authorized to a profession, title protection, standards of practice, and regulations made under the *RHPA* and profession specific Acts.	• Would the proposed RPN scope of practice statement adequately assist the public and practitioners in understanding the distinction between what practical nurses and nurses do, or the methods they use, or the purpose for which they do it? • If practical nursing is not a separate profession, is there a greater risk of harm to the public if there are two regulatory structures? • Do existing CNO *Standards of Practice* provide its members with safe practice guidance?
QUALITY OF CARE Quality of care means the appropriate care to achieve a positive outcome. This balance is affected by informed consumer choice, professional standards of practice and public concerns about safe, affordable care.	• Do current tensions in the relationships between RNs and RPNs in the College and in health care workplaces jeopardize the quality of care in any setting? • Could disputes relating to standards of practice between two closely related, but separately regulated professions create undue public cost, and inconsistent quality of care? • Are the CNO's 1990 Standards of Practice sufficiently clear to enable consumers, employers or other health professionals to choose practitioners on an informed basis? • Have the CNO's structures and Standards created any blocks to RPNs practicing to the full extent of their professional competence, and consequently, has public choice been unduly limited?
ACCOUNTABILITY The accountability principle means that self-governing Colleges have a primary duty to serve and protect the public interest by regulating the relationship: i) between the health care provider and the patient/client, ii) between the practitioner and their College, and iii) between the College and the public.	• Has the relationship between nursing professionals and their College been dominated by the professional interests of RNs, and damaged RPNs capacity to practice to the full extent of their professional competence? • Is the relation between professionals and the public jeopardized by the size of a combined structure and its capacity to respond to the volume of complaints? • Does combined regulation of two groups in one college best protect the public by making it easier to locate a practitioner in the case of a complaint?

PUBLIC INTEREST PRINCIPLES	HPRAC's ASSESSMENT OF PUBLIC INTEREST ISSUES IN THIS REFERRAL
ACCESSIBILITY Considerations such as financial means, geography, language,. physical barriers, etc. should not preclude access to safe, affordable health care services. The public interest is best protected by the promotion of safe, affordable health care.	• Are there undue restrictions on the practice of RPNs which reduce the range of choice of practitioner, and consequently limit the public's choice of care giver? • Are current limitations on RPN practice necessary to the safety of the public?
EQUALITY All regulated professions are regulated under one comprehensive Health Professions Procedural Code, and are subject to the same rules regardless of size, scope of practice or membership composition. The public interest is protected and promoted by the equal treatment of professions. Legitimate differentiations between professions are found in each profession's scope of practice, their authorized acts, and the unique education and training requirements that establish qualifications for entry to practice. The *RHPA* recognizes that there is some overlap in the scope of practice of several professions.	• Does the existing regulatory structure create a situation of unfairness for RPNs? Are there structural opportunities for the dominance of the professional interests of RNs? • As above, does the proposed scope of practice statement adequately assist the public and practitioners in understanding what practical nurses do, the methods they use, and the purpose for which they do it?

This review of the substantive public interest issues raised in this referral has contributed to the shape of the analysis that follows. First, it has clarified and emphasized the importance of a set of questions which follow from the second of the Minister's questions: "*How would a separate college better protect the public from harm?*" In Section 3.3 we discuss in some detail the following public interest issues that have been raised about the combined regulation of RNs and RPNs:

i) Do the current tensions between the two professional groups, and the current standards of practice jeopardize the quality of care and principles of equality?

ii) Does the current regulatory body unduly limit the ability of practical nurses to practice to the full extent of their professional competence, and consequently are quality of care and public accessibility jeopardized?

iii) Does the size and composition of the current regulatory body jeopardize or ensure public accountability?

Secondly, the review of public interest issues raised by participants has raised two questions which are central to our discussion of possible governing structures. They are discussed in detail in Section 4:

i) If practical nurses are not a separate profession from other classes of nurses, would a greater risk of public harm be created by two separate colleges?

ii) If practical nurses can be considered separate from other classes of nurses and is separately regulated, how can the public be protected from inconsistent standards?

Conclusion

The public interest issues raised in this referral provide a strong set of criteria for assessing the existing situation, and have helped shape our discussion of options. However, our review of public interest issues has not provided an adequate framework for the assessment of the feasibility of a separate college, or the conditions under which a separate college for RPNs would be in the public interest. HPRAC has found further guidance with these questions from the HPRAC Criteria for Regulation.

3.1.2 HPRAC Criteria for Regulation

Currently under the *RHPA* there is one model for the relationship between a recognized health profession and the establishment of a regulatory structure. This is where a recognized profession is legislated under a separate act, is described by a distinct scope of practice statement and is regulated by one college. The exception is the College of Speech Pathology and Audiology where two professions are legislated under one act, and regulated by one college.

The lack of precedent for other regulatory models has not limited HPRAC's examination of the possible resolutions to this referral. We have, however, needed to establish whether the first two components of the usual structure, i.e. recognition of practical nurses as a separate profession and the development of a separate scope of practice statement, can be achieved. HPRAC has further considered whether these two components are necessary for the creation of a separate college, and if they can not be achieved by practical nursing, on what basis a new model might be created.

The Minister of Health has recognized practical nurses/nursing assistants as members of a health profession needing regulation since 1947 when they were regulated under the Nursing Act. Furthermore, having included RPNs under the 1991 Nursing Act, the Minister already recognizes that RPNs meet the HPLR criteria for regulation. The following summary of the current status of RPNs in relation to the criteria HPRAC has drawn from the HPLR suggests that when the question is shifted from whether this group is *eligible for regulation* to whether this group is *eligible for their own independent regulation*, several criteria (5 and 8) reveal issues that are helpful in further exploring the question.

HPRAC CRITERIA FOR REGULATION	RPN STATUS
1. The profession's members are engaged in activities that are relevant to the Minister of Health.	RPNs are health care professionals
2. Risk of harm arises in the practice of the profession.	RPNs carry out procedures within the scope of nursing when it is reasonable to expect that serious physical harm may result from the treatment, advice or from their omission.
3. Sufficient numbers of the profession's members are not monitored by other professionals or supervisors	RPNs have been able to practice independently of the supervision of another health professional, in situations where the patients condition is predictable, since the CNO 1990 *Standards of Practice*. That is, they are no longer "assistants".
4. The profession is not already regulated effectively under another regulatory mechanism.	Criterion doesn't apply to professions already regulated under the *RHPA.*
5. The profession calls upon a distinctive body of knowledge.	RPNs draw on a distinct body of knowledge. *However the issue remains whether it is a sufficiently distinct body of knowledge from that of nursing.*
6. Educational requirements for entry to practice the profession must be completion of a post secondary program.	RPNs do not all graduate from a post secondary program, but high school and college program graduates must pass the same qualifying test for registration.
7. The profession's leadership has shown the ability to favour the public interest.	RPN elected representatives have been members of the CNO Council since 1973. They have experience as members of a body whose responsibility is to regulate in the public interest.
8. The profession's membership is likely to comply with self regulation.	RPNs have complied with CNO regulation since 1963. *However, it is not clear whether the majority of RPNs want a separate college or to continue joint regulation with RNs.*
9. The size of the profession is sufficient to support a College.	An RPN college of 35,000 would be among the largest regulatory bodies under the *RHPA*.

Conclusion

The combined review of public interest principles raised by this referral and HPRAC's criteria for regulation has provided a framework for the remainder of this analysis, and for the options explored in Section 4. The following issues require discussion in some depth in this section:

i) The feasibility of a separate college. A key question in addressing this issue is whether practical nursing is a separate profession.

ii) The effectiveness of combined regulation. Are quality of care and accountability maximized in the present governing structure?

iii) Do RPNs want a separate college?

3.2 IS PRACTICAL NURSING A SEPARATE PROFESSION?

Practical nursing is already recognized as a professional group requiring regulation under the *RHPA*. That is, its members are already recognized as health professionals. The question raised by this referral is whether practical nursing should be recognized as a health profession that is separate from nursing.

The *RHPA* provides little guidance on the question of whether, when, or how a professional group which has developed as a class within a larger, regulated professional group might become formally recognized as a separate profession and eligible for its own regulation. In the absence of such guidance, participants in this referral have constructed two strongly held sets of beliefs about whether practical nursing is a separate profession from other classes of nursing. They can be summarized as follows:

- *RPNs are a separate profession:* RPNs have a professional association; are separately regulated in other jurisdictions; are commonly and practically recognized as being different than RNs in health care settings; have a different scope of competence[14] than RNs; have different training programs than RNs; and practice independently from RNs.
- *RPNs are a professional class within the profession of nursing:* RPNs indeed have all of the above distinctive characteristics, but the body of knowledge that they refer to is common to both RNs and RPNs since a large segment of RPN training is identical to RN introductory level training; and within the range of overlapping scopes of competence RPN practice is virtually identical to that of RNs. The RPNAO argues that RN and RPN practice with stable patients should be identical, and indicates that the aspiration of many RPNs is to be recognized as a "nurse" with stable patients. As one RPN envisions it, a separate college would be "*where the RPN will be*

[14] The term "scope of competence" is used here to indicate the combination of the scope of practice of a professional group, standards of practice, and individual experience and training. It is a term that is used by the CNO to capture the combination of the general competence of a professional group and that of a specific individual. It is not intended to convey a legal requirement.

encouraged and permitted to grow and develop to their full potential in the nursing profession." (RPNAO I, p. 45) The CNO states that RPNs have, and should continue to have less decision making scope than RNs, even with stable patients. Other professional classes of nurses could include nurse practitioners (proposed in Ontario), and psychiatric nurses (separately regulated in some other jurisdictions).

In order to assess whether practical nursing is a separate profession, HPRAC has examined the RPNAO's proposed scope of practice statement, the body of knowledge that they draw on, the degree of professional separation in other jurisdictions and their relation to the *RHPA*, and parallels with other health care professions. None of these indicators stand alone as criteria for recognition of a profession, but must be examined in relation to one another.

The discussion in this section focuses only on whether practical nursing can be considered a separate profession from other classes of nursing. A discussion of whether the distinctions made are adequate or necessary for the creation of a separate regulatory structure is taken up in Section 4.

3.2.1 Proposed Scope of Practice Statement

A regulated profession's scope of practice statement must adequately assist the public and practitioners in understanding what the profession does, the methods it uses, and the purposes for which it uses these practices. The statement is to contain "*a general statement describing, but not licensing, the profession's scope of practice*". (HPLR Report, p.3)

The RPNAO proposed Scope of Practice Statement is as follows:

> *The practice of practical nursing is the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, rehabilitative and palliative means:*
> ***i) when there is a normally expected outcome,***
> *ii)* ***when the outcome is or becomes unpredictable, provided the practical nurse is acting under the direction of or in collaboration with a member of another health profession.*** *(RPNAO II. Emphasis on those phrases that do not appear in the Nursing Act)*

For ease of comparison, the Scope of Practice Statement in the 1991 Nursing Act is as follows:

> *The practice of nursing is* ***the promotion of health and*** *the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means* ***in order to attain or maintain optimal function.*** *(Emphasis on those phrases that do not appear in the RPNAO proposal)*

In this second submission the RPNAO acknowledged that is it a challenge "to capture, in very general language, distinctions which are more apparent at the level of detail contained in standards of practice rather than in a scope of practice statement". (RPNAO II, p. 2)

The introductory part of the RPNAO's proposed statement differs from the existing nursing scope of practice statement with respect to three phrases. It

substitutes "practical nursing" for "nursing", and drops two phrases which RPNAO appears to have judged more likely to describe RNs: "*the promotion of health*", and "*in order to attain or maintain optimal function*". It seems to HPRAC that these are integral functions of RPNs current practice, and are desirable goals for the care of all patients, including those whose condition is relatively stable. Consequently, HPRAC believes that the statement provides no basis for distinguishing the philosophy of RPNs from RNs.

The statement, in effect, distinguishes the professional group exclusively by the condition of patients, rather than by description of the profession. This proposal would provide the public with a clear description of when they could expect to be treated by a practical nurse, but not how the kind of care they should expect from a practical nurse might differ from the care provided by a registered nurse. The creation of this kind of confusion is not in the public interest.

The RPNAO argues that RPNs are the providers of practical, bedside care, and that RNs are more removed from direct patient care, or only provide more complex care and administrative support. HPRAC does not accept this view. Figures provided by the CNO indicate that in 1994 81% of RNs and 87% of RPNs worked in direct care.

It is HPRAC's opinion that RPNAO's statement does not sufficiently distinguish or describe the profession or its philosophy. The statement provides a good description of practical nursing, but it does not sufficiently distinguish it from other classes of nursing.

HPRAC does recognize that the proposal represents a formulation of the potential and desire for increased decision making responsibility for RPNs and creates the possibility of removing certain current restrictions on RPN practice. In particular, by making no reference to RPNs working within standard care plans it creates the possibility for RPNs to make decisions related to standard care plans for patients in stable conditions, rather than implementing decisions already made by other health care professionals. HPRAC has accepted the position put forward by the RPNAO, and that is accepted by ONA and the OMA, that RPNs have some training in the assessment of patient conditions, knowledge of standard care plans, and can make a limited range of decisions relating to the care of stable patients.

Any regulatory body that considers adopting this definition of the RPN scope of practice (whether it is a separate or combined regulatory body) must resolve one issue related to the wording of the proposal. The relation of RPNs to other professions needs to be more clearly worked out in situations where the outcome of a patient's condition is or becomes unpredictable. The RPNAO acknowledges that in these situations "*there is a need for a level of knowledge which is beyond the knowledge and theory base of the RPN*". (RPNAO II, p.6) If RPNs are working beyond their scope of knowledge, they should be working "under the direction of", not "in collaboration with" a member of another profession. The RPNAO proposes both. In HPRAC's view, this is not acceptable.

i) Controlled Acts

The RPNAO has requested the same controlled acts as are currently authorized to nursing. They propose that RPNs not self-initiate any procedures related to these controlled acts. At this time the controlled acts authorized to nursing, and consequently to RPNs, are:

1. Performing a prescribed procedure below the dermis or a mucus membrane
2. Administering a substance by injection of inhalation
3. Putting an instrument, hand or finger
    i) beyond the external ear canal
    ii) beyond the point in the nasal passages where they normally narrow
    iii) beyond the larynx
    iv) beyond the opening of the urethra
    v) beyond the labia majora
    vi) beyond the anal verge
    vii) into an artificial opening into the body

The proposal requests the status quo. The RPNAO is not proposing that RPNs self-initiate any controlled acts at this point, although their most severe complaints about the restrictions on their practice have arisen around whether they can initiate a limited number of controlled acts.

Conclusion

It is HPRAC's opinion that RPNAO's proposed scope of practice statement does not sufficiently distinguish the profession or its philosophy. It does, however, capture the current aspirations of the professional group, and does describe what they do.

Self-initiation of controlled acts by RPNs is clearly still contentious, and will very likely be raised with the Minister in the near future. A more detailed discussion of this possibility is included in Section 4.4

3.2.2 Distinct Body of Knowledge

Among the ways that a profession can be recognized as a separate profession for the purposes of the RHPA is the distinctiveness of the body of knowledge that the profession draws on. HPRAC has examined the body of knowledge that practical nurses draw on in order to satisfy ourselves as to whether, regardless of the sufficiency of the proposed scope statement, RPNs might be considered as a separate profession because the body of knowledge that they draw on is distinct.

In Ontario Registered Practical Nurses receive their training in 34 community college programs and 7 high school programs for mature students. In 1994 11% (or 178) of the successful RPN registrants with the CNO were high school graduates; 89% (or 1,465) were college graduates. The high school adult education programs are two years long. The college programs are 3 semesters long. Graduates from both programs must pass the same Canadian Nurses

Association Testing Service (CNATS) exam for practical nurses in order to be registered with the CNO.

The college programs offer the clearest opportunity to compare the bodies of knowledge studied by RPNs and RNs. Most community colleges have faculties or departments of Nursing in which there are two programs: diploma nursing and practical nursing. Practical nursing programs are 3 semesters long, while diploma nursing programs are 6 semesters. Practical nursing programs have been lengthened by one semester as a direct consequence of the change in level of RPNs' responsibility outlined in the CNO's 1990 Standards of Practice. The provincial education standards for the proportion of clinical hours in both programs are similar: 64% of practical nursing students' hours are practical learning experiences: 63% of nursing diploma students' hours are practical learning experiences.

The Ministry of Education's 1991 Recommended Provincial Standards for both RN and RPN courses are a response to the CNO's 1990 Standards of Practice. They state:

> *"The distinguishing factors between the learning outcomes of the nursing program and the nursing assistant program are the depth of understanding, and the types of situations in which the graduate will be expected to function." (p.3).*

Provincial Program Standards – Nursing Assistant Programs state:

> *"Situations in which the nursing assistant graduate will be expected to function tend to be straightforward with a limited number of variables, the outcome is predictable, and even though the practitioner is expected to function independently, guidance is available." (p.3).*

The Provincial Program Standards Nursing Programs state:

> *"Situations in which the nursing graduates will be expected to function tend to be complex with a number of variables, the predictability of the outcome may be uncertain and the individual is expected to function with a high degree of independence." (p.3).*

Further, the Ministry recommends that both programs need to address the common elements of the standards of practice for the two categories of practitioners "*so that interested individuals will be assured reasonable access to the higher level program with appropriate recognition for skills and abilities already developed either through formal or informal education and experience.*" (p.1). This suggests that many of the skills developed by practical nurses, both in college programs and at work are applicable to all classes of nurses.

The first semester and a half of the Practical Nursing programs HPRAC reviewed were identical to the Nursing Diploma courses. In a review of five Metro Toronto college programs, we found that the courses that are designed specifically for practical nurses (*Nursing Theory II, Nursing Practice II, Pathology & Therapeutics*, etc.) have identical names as the Nursing Diploma courses, but have a slightly different course content. We did find a course named *Practical Nursing Theory* at Centennial College, although its description is similar to the Nursing Theory II courses at other colleges.

The focus of the second and third semester clinical experience in practical nursing programs is to consolidate introductory nursing theory in a variety of settings including acute care, long-term care, psychiatric care and obstetrics. The RPNAO suggests that nursing diploma students miss this training, and focus on more complex care in specialty areas of medical-surgical nursing, community nursing, rehabilitation nursing, psychiatric nursing and maternal/child nursing. However, both diploma nursing and practical nursing students start their clinical experience in the first semester, and it is not likely that diploma nursing students are doing significantly more complex practicum work than practical nursing students in their early semesters. They are likely to learn similar skills to RPNs at this point in their training, although not in the same depth.

The RPNAO states that CNATS sets practical nurses registration exams on:

- principles and concepts from "the body of nursing knowledge": growth and development; anatomy and physiology, pathophysiology, nutrition, psychology and microbiology.
- "nursing measures" and underlying rationale: comfort and hygiene measures, safe and effective use of technologies, creation of a therapeutic environment, protection from risk and injury, health instruction, diagnostic and therapeutic measures. (RPNAO I p.78)

Continuing education courses are available to RPNs (i.e. program graduates who have successfully passed the CNATS) in medications, community nursing, occupational health, foot care, psychiatric nursing, asepsis, operating room procedures, physical assessment, pain assessment and management, palliative care, gerontology, IV therapy, ECG reading, and therapeutic touch.

A small number of RNs apply to become registered as RPNs. In order to be eligible for dual registration with the CNO, the applicant must take a one semester "RPN socialization" course at a college and then pass the RPN registration test. HPRAC understands these college courses to be RPN 'refresher' courses offered by continuing education departments, and that they include reviews of the scope of RPN practice and professional relations.

Conclusion

To the best of HPRAC's understanding, there does not appear to be a body of knowledge that RPNs draw from that is separate from that of nursing. Nor have the referral's participants demonstrated that a distinct body of knowledge of practical nursing is developing. The distinctions that emerge from this review are those related to a specialization in the introductory level of the nursing body of knowledge, and certain restrictions on the practice of practical nurses related to the limitations of that professional group's education.

3.2.3 Distinct Standards of Practice

The CNO *1990 Standards of Practice* are the most precise formalization of the practice of both RNs and RPNs, providing a point by point comparison of the basic practice requirements of each group. HPRAC has particularly examined those standards which are common for both groups. We believe that, regardless of sufficiency of the proposed scope statement and distinction of the body of

knowledge as it is currently taught, RPNs might be considered a separate profession if their practice was sufficiently different from other classes of nurses.

The differences between the two groups are generally described through a) additions of more complex procedures, assessment, and planning to the RN list, and/or b) limitation of certain decision making responsibilities for RPNs. The Standards rarely describe differences in the responsibilities or practices that RNs and RPNs hold in common. The descriptions of RN and RPN practice in three areas that are commonly understood as bed-side care illustrate this point:

SELECTED COMPARISON OF RPN AND RN STANDARDS OF PRACTICE[15]			
RPNS		**RNS**	
STANDARD 5: IMPLEMENTING		**STANDARD 5: IMPLEMENTING**	
7.	Promotes comfort and hygiene by:	7.	Promotes comfort and hygiene by:
7.1	bathing client or assisting client with bathing	7.1	bathing client or assisting client with bathing
7.2	assisting client with hygiene	7.2	assisting client with hygiene
7.3	using touch, massage, and stress reduction techniques	7.3	using touch, massage, and stress reduction techniques
7.4	applying heat and cold	7.4	applying heat and cold
8.	Promotes elimination by:	8.	Promotes elimination by:
8.1	using and teaching routines and dietary control	8.1	using and teaching routines and dietary control
8.2	caring for drainage tubes and collection devices	8.2	caring for drainage tubes and collection devices
8.3	providing ostomy care	8.3	providing ostomy care
8.4	administering enemas and suppositories	8.4	administering enemas and suppositories
8.5	disimpacting	8.5	disimpacting
8.6	irrigating bladder	8.6	irrigating bladder
		8.7	performing bladder catheterization
9.	Promotes balance between rest/ sleep and activity by:	9.	Promotes balance between rest/ sleep and activity by:
9.1	using and teaching routines and pacing of activities	9.1	using and teaching routines and pacing of activities

[15] CNO 1990 Standards of Practice p.34–37. These examples have been selected to illustrate the similarities in practice between RPNs and RNs in areas of common or overlapping practice, particularly in bed side care. The RPNAO has provided us with no information that counters this formal description, or which suggests that RPNs carry out these bed side procedures any differently than RNs. The differences between the two standards are highlighted by the use of italics in this text.

SELECTED COMPARISON OF RPN AND RN STANDARDS OF PRACTICE[15]			
RPNS		RNS	
STANDARD 5: IMPLEMENTING		STANDARD 5: IMPLEMENTING	
9.2	facilitating diversional activity	9.2	facilitating diversional activity
9.3	encouraging exercise and ambulation	9.3	encouraging exercise and ambulation
		9.4	*using and teaching relaxation techniques.*

The disputes related to the Standards of Practice are summarized in Section 2 and Section 3.3.2. They have focused mostly on whether RPNs should be able to carry out particular procedures such as bladder catherization or intramuscular injections. They are not related to whether RPNs can or do conduct their practice in a different manner than RNs, but about how much of the nursing scope can be practiced by an RPN.

Conclusion

The Standards of Practice, and even the disputes around the Standards of Practice provide no suggestion that the practice of RPNs is different than that of RNs when they are working in situations where the patient's condition is stable, and where the tasks required do not exceed the educational training for practical nurses.

3.2.4 Distinctions Between RHPA and Regulation of RPNs in Other Jurisdictions.

Participants' submissions have argued that practical nursing can be considered a separate profession because practical nurses are separately regulated in other jurisdictions.

Practical nurses are regulated health professionals in all Canadian provinces and territories. In all provinces except Ontario, a separate practical nursing or nursing assistant act has established the practical nursing professional organization as the regulatory body. The Yukon is an exception, where the Ministry of Health registers and regulates nursing assistants. Ontario is the only province that has created regulatory Colleges which are separate from professional associations. In this province, professional associations have been charged with representing the interests of a profession, while Colleges have been charged with representing the interests of the public. Consequently the process of recognition of practical nurses as professionals has been different in Ontario: neither the RNAO or the RPNAO are the regulatory body. The College of Nurses was established in 1963 to regulate both RNs and RPNs. There is no parallel to this situation in other Canadian jurisdictions.

In no province other than Ontario are practical nurses regulated by a structure that has similar public representation to the *RHPA*'s college structure. The Councils of the other provincial practical nursing professional associations are described in legislation, and tend to include representatives from nursing and doctors' associations, the Ministry of Education and employers' associations. Other provincial governments appoint a small number of public members to these Councils. Those provinces that have responded to our request for information have indicated the following:

PUBLIC MEMBERS REPRESENTED ON PRACTICAL NURSING COUNCILS IN OTHER JURISDICTIONS

PROVINCE	PUBLIC MEMBERS
B.C.	2
Alberta	an unspecified number
Saskatchewan	2
Manitoba	12% of the council
Nova Scotia	1
New Brunswick	0
Newfoundland	1

Several provinces are in the process of creating legislation which will bring all health care professions under the same legislative umbrella, but will allow for separate acts or regulations for each health care profession. In Alberta and British Columbia at least, Licensed Practical Nurses will continue to have a separate act or regulation, but the existing regulatory bodies will not change. The draft legislation relating to practical nurses that we have seen from both Alberta and British Columbia does not indicate that the intention is to introduce a system which is organized around a separation of professional and public interests.

Further comparisons include:

i) No other provincial legislation includes a general statement distinguishing practical nursing from any other profession.

ii) All provincial legislation defines LPNs/RNAs according to delegation or supervision, and includes paragraphs that limit services which can be delegated to those which are "consistent with LPNs/RNAs training and ability". (British Columbia, Alberta, Saskatchewan, Manitoba, New Brunswick, Newfoundland)

- The most recent legislative change is removing reference to RNs as being the only health professionals who can delegate to practical nurses in some provinces. It is of interest to note that Ontario RPNs have achieved earlier, and possibly greater autonomy from RNs under

the Ontario joint regulatory structure than practical nurses in other provinces.

- Newfoundland and New Brunswick make a distinction in the kinds of services that can be delegated to LPNs by the *condition of the patient*. In Newfoundland LPNs can only "assist" with acutely ill patients, while they can "undertake or assist" in the care of other patients.
- British Columbia modifies delegation according to *location of patient* (in a health care institution or in the patient's home).

iii) Only the proposed Alberta legislation would define LPNs according to the "health services" that they provide (this provides some parallel with the *RHPA*'s authorized acts, although the systems are sufficiently different to make direct comparison difficult).

iv) In British Columbia and Manitoba there are three regulated nursing professional groups: registered nurses, practical nurses and psychiatric nurses.

Conclusion

This review of regulation in other jurisdictions is of limited assistance with the discussion of whether practical nursing is a separate profession for the purposes of the *RHPA.* Most legislative systems in other Canadian jurisdictions continue to be licensing systems. The *RHPA* has moved away from licensing monopolies for each health care profession to a system which recognizes overlapping scopes of practice of distinct health care professions.

Legislation in other Canadian jurisdictions has recognized that practical nurses should be regulated health professionals, and governments have made decisions about the appropriate regulatory body based on the practice of enabling existing professional associations to handle the regulation of their members. However, neither the profession nor legislators in other provinces have needed to define whether practical nursing is a profession that is distinct from nursing, or whether a nursing 'college' that is already removed from the professional associations is the appropriate regulatory body.

3.2.5 Parallels or Precedents in Other Health Professions

There are a number of situations in Ontario where different regulated health professionals draw on similar bodies of knowledge to treat patients with similar conditions. Stated in the language of the *RHPA*, this means that different professions have overlapping scopes of practice.

Several participants have argued that there is a parallel between the situation of RPNs and RNs, and that of dental hygienists and dentists, and that this creates a precedent for the recognition of RPNs as a separate profession. The parallel is that the scope of practice of dental hygienists is completely encompassed within the scope of practice of dentistry. Dental hygienists were recognized as a profession which should be separately regulated by the HPLR prior to the introduction of the *RHPA*.

There are, however, several differences between the situation of dental hygienists and RPNs which are significant in HPRAC's view. The first is that dental hygienists can distinguish their profession from dentists by their activity, and their scope of practice is a very specific portion of the scope of dentistry. The RPNAO has not been able to distinguish practical nursing by activity, precisely because there is a large and indistinct overlap with the activities of other nurses. The second difference is that the public has a clear understanding of the difference between dental hygienists and dentists. The precision of the profession's title assists with public recognition because it reflects what the profession does: which could be characterized as their being 'hygienists of the teeth'. The public understanding of the difference between practical nursing and other classes of nursing can not help but reflect the difficulties that members of the profession have in making the distinction between the two groups. The third difference is that the education program for dental hygienists is completely separate from the education program of dentists. The training for the two professions is offered in separate educational institutions and training for dental hygienists is not recognized as providing any accreditation towards dentistry. This is not true of the training for practical nursing: practical nursing and nursing programs are offered within the Nursing Departments of Community Colleges, at least 50% of practical nurses training is identical to that of other classes of nurses, and practical nursing courses can be accredited to a certificate in nursing.

Conclusion

The situation of dental hygienists has some significant parallels with the situation of RPNs, but it also has significant differences. The differences, particularly that dental hygienists have been able to establish a distinguishable scope that is publicly understood, and that they have distinct education programs mean that they are not a precedent for a separate RPN College.

3.2.6 Conclusion: Is Practical Nursing a Separate Profession?

While the *RHPA* enables different professions to overlap their practices, HPRAC interprets the intention of the Act as enabling professionals with significantly different practices which draw on different bodies of knowledge to practice within the range of the same controlled acts. In this referral, two groups of professionals are proposing to regulate a set of practices that are difficult to distinguish even at the level of standards of practice with the same group of the public, i.e. stable patients. With a second group of the public, i.e. patients whose condition is unstable, some differences between the two groups are more obvious, but there is still substantial overlap between the two professional groups and a lack of clarity about the reporting relationship between the two groups.

In the course of this analysis HPRAC has developed a set of indicators which have assisted in assessing whether practical nursing is a separate profession with significantly different practices from other classes of nursing. HPRAC believes that no one of these indicators alone establishes or disqualifies a professional group as a separate profession. Each professional group must be assessed separately, and all relevant factors must be considered both separately and as a whole.

INDICATORS OF A SEPARATE PROFESSION	HPRAC'S ASSESSMENT OF PRACTICAL NURSING
Does the professional group have a scope of practice that is distinguishable from other health professions?	The RPNAO's proposed scope of practice statement does not sufficiently distinguish practical nursing from other classes of nursing.
Does the professional group have an approach to its practice, or philosophy that is distinguishable from other health professions?	Neither the practice, philosophy nor approach of practical nursing have been demonstrated as different than that of other classes of nurses. The distinctions that have been demonstrated in the referral relate to a specialization in the introductory level of the nursing body of knowledge, and certain restrictions on the practice of practical nurses related to the limitations of that group's education.
Does the professional group have separate and distinct training?	RPNs receive identical theoretical training to RNs for the first half of their education, and then receive another 1.5 semesters of training that is related to a specialization in the introductory level of the nursing body of knowledge.
Does the professional group rely on a body of knowledge that is distinguishable from that of other health professions?	Practical nursing draws on a body of knowledge that all participants and educators involved refer to as "nursing theory and practice". There isn't a separate body of knowledge that could be considered "practical nursing".

As a result of our assessment of the above indicators, HPRAC believes that practical nursing is not a separate profession. At the same time we recognize that public interest considerations other than the ability to establish that practical nursing is a separate profession might warrant the formation of a separate regulatory structure. In the following section we will particularly explore the public interest issues related to the current situation.

3.3 THE EFFECTIVENESS OF COMBINED REGULATION: ARE QUALITY OF CARE AND ACCOUNTABILITY JEOPARDIZED IN THE PRESENT GOVERNING STRUCTURE?

In this next section HPRAC looks at three central issues raised by the referral's participants in order to analyze the effectiveness of the combined regulation of RPNs and RNs. The RPNAO argues that RNs have used their majority on Council to protect their professional advantage by:

i) maintaining restrictions on RPNs' ability to self-initiate certain procedures within the controlled acts authorized to nursing

ii) imposing restrictions on RPN practice which are not warranted by their training

iii) limiting RPNs' participation in self-regulation

In the following discussion we first examine whether the structures of the regulatory body provide undue opportunities for RNs to act more in their professional interest than in the public interest. Second, we examine whether the CNO's Standards of Practice unduly limit the RPNs practice and contribute to the underutilization of RPNs in the workplace. The third discussion is an examination of whether the current Statutory Committees enable RPNs to participate fully in self-regulation.

The public interest is not met by situations where the struggle between two professional groups could affect the quality of care, and where the professional development of one group is restricted by another. In the following discussion and in Section 4 HPRAC considers the question of whether the public interest concerns are serious enough to warrant the dissolution of the current regulatory structure and the creation of two separate colleges, or if there are other options which might address these concerns.

3.3.1 Assessment Of RN And RPN Relations

There are significant pressures on the relationship between RPNs and RNs that are beyond any created by the regulatory body. As long as RPNs are paid less than RNs there is likely to be a consistent pressure from employers to expand their use and the range of procedures which they can safely handle. Lay-offs have exacerbated existing tensions between these two classes of nurses. Similarly, the tensions between regulated nursing professionals and unregulated health care aides are increasing as budget strapped administrations attempt to cut costs by downloading components of nursing to the lower paid unregulated health care workers. No matter what regulatory structure governs RNs and RPNs, these are issues that need to be recognized as separate from, but constantly influencing the relations within a regulatory system.

As our brief history of the development of practical nursing suggests, the relations between nurses and practical nurses have been consistently marked by labour market competition. Since the birth of nursing in the late 1800s, the two groups have struggled to capture larger segments of work in public health institutions and community care nursing. The development of the two professional groups prior to World War II illustrates the growing ability of the more highly trained nurses to control the development of a segmented profession, and to consistently protect their labour market and professional interests through the control of professional title and standards. On the other hand, it also shows us that there have been very few moments in this history where the more highly trained and paid registered nurses have not felt some threat from the interests of home-based and institutional employers in hiring lower paid nursing assistants and aides.

At the same time, it must be emphasized that the history of these relationships is also about the creation of a complex profession, and the lively, growing and continuously negotiated understandings about which professional group

was/is able to carry out what tasks within an expanding, increasingly complex list of procedures.

The question here is whether the structures of the regulatory body contribute to the tensions in the labour market and to the underutilization of RPNs in the workplace. The RPNAO charges that the regulatory structures provide "*RNs with the opportunity to protect their competitive interest vis-a-vis RPNs*" (RPNAO I, p.36) The relevant structures of the CNO include the membership, the Council, the staff and Statutory and By-law Committees. The composition of the CNO's membership has been constant for many years: two thirds are RNs and one third are RPNs. The representative structure of the Council was established in legislation in 1973. Since then, fourteen of the twenty one member seats on the CNO Council have been held by RNs and seven have been held by RPNs. There are currently 18 public Council members. Pursuant to the *Nursing Act, 1991*, one of the two Council Vice Presidents must be a RPN. Three of the 23 staff are RPNs. Most of the Statutory Committees have a representative structure that parallels that of the Council: two thirds RNs, one third RPNs, and just less than 50% public members.

First, it must be recognized that the current structure democratically represents the composition of the membership. Some of the difficulties the CNO has encountered are experienced by many organizations that attempt to recognize and support the rights of a minority group in the context of a representative system that reproduces the majority throughout its decision making structures.

In HPRAC's assessment, two of the instances cited by the RPNAO illustrate the ability of the interests of the larger professional group to over-ride those of the minority in Council, where the decisions made appear to be in the professional interest of RNs rather than the public interest.

The most immediate to this referral is the instance of how the CNO handled the representation of the interests of their RPN members on the question of whether they should be governed by a separate College. The six RPN Council members who opposed the College's position were not able to sway the Council vote (10 opposed the vote and 2 abstained). The CNO has made strong public interest arguments supporting its position. But it has not recognized the split based on professional class in the vote, and has provided no official mechanism for the RPN members to present a 'minority' report to HPRAC representing the views of the 35,000 RPNs who elected them.

The second instance is the CNO's decision making process after a 1993 consultation about the self-initiation of controlled acts. A broad consultation was conducted with RNs and RPNs in the province, who were asked whether RPNs should be able to self-initiate any of the three controlled acts authorized to nursing. The report was drafted six times. The fifth draft proposed limited ability for RPNs to self-initiate certain controlled acts, and was widely circulated. HPRAC assumes that this draft proposed these changes because there was considerable support for them among both classes of nurses.

However, the proposal for RPN self-initiation was removed from the final version and was circulated to board members only. It was passed with 10 of the 39 Council members opposing it. It should be noted that in this instance, the presence of public members on the Council did not prevent this clear split between the two professional classes. The CNO has had several opportunities to respond to the RPNAO's interpretation of these events and to explain to HPRAC the public interest rational for the withdrawal of the self initiation proposal, but has chosen not to.

The scope of competence of practical nursing, and of the profession of nursing as a whole is developed and expanded by sometimes formalized, and sometimes informal processes of creating consensus among a range of health care practitioners, employers and educators. HPRAC recognizes that this is a complex process. However, the CNO's removal of the proposal that RPNs can safely self-initiate certain controlled acts will ensure that it will take considerable effort to place it back on this complex inter-professional agenda.

These instances indicate that the public interest imperative of the *RHPA*, and the large numbers of public members on the Council do not always successfully mediate situations which apparently favour the interests of the larger professional group. The CNO has chosen to consider the accusations of unfairness to be misunderstandings on the part of individual council members of the role of public interest regulation. There may be some truth to this observation, but it does not address the structural problem: when issues split the membership and the Council based on RN and RPN interests, it is possible for the RN majority to simply outnumber the RPN votes or representatives.

In HPRAC's view the structure of the CNO's Council and the composition of its membership have led to practices which in several instances have limited the development of RPNs, and have created a perception of unfairness in the organization's dealings with RPNs. All parties to this referral acknowledge, with varying degrees of emphasis, that relations between RNs and RPNs are very tense, if not actually deteriorating. While it may be that many of the tensions in these relations are rooted in the workplace, the structural difficulties in the regulatory body can not help but negatively affect the day to day work relations between the two groups and the quality of care in acute and long term care facilities.

Conclusion

Any undue limitation of the ability of a professional group to practice to the full extent of their training is not in the public interest. It affects the quality of care that is available to the public by restricting consumer choice of quality care.

Tensions between these two professional groups have been exacerbated by the structures of the regulatory body. It is not in the public interest for this level of antagonism to be a feature of the operating relations of a regulatory body.

The straightforward representation by population structure of the CNO contributes to incidents of, and perceptions of unfairness. It is not in the public interest for RPNs to continue to be regulated by a body with this structure.

3.3.2 CNO 1990 Standards of Practice

In their first submission the RPNAO focused much of their case for separate regulation on complaints related to the CNO's *Standards of Practice, 1990*, arguing that they contributed to the underutilization of RPNs in the workplace. The Association presented in some detail the limitations that the standards place, unduly in their interpretation, on RPNs' responsibilities for assessing and planning, the restricted number of procedures that are delegated by physicians to RPNs, and the limitations on the self-initiation of controlled acts by RPNs. They also took issue with specific interpretations of the predictability of patient outcomes by the CNO and by the administration of various health care facilities.

The RPNAO's complaints tended not to focus on the underutilization of the entry level skills of RPNs in health care settings, but on when and how these skills could be expanded. They generally elaborated a fundamental disagreement with the distinctions between RNs and RPNs made in the *Standards of Practice*, which state that RPNs do not have adequate training to perform specific assessing, planning, implementing, and evaluation procedures, and which limit their independent practice to procedures with patients whose condition is predictable.

The RPNAO's second submission removed the relevance of most of their complaints to the analysis of this referral. In this submission they removed the proposal that RPNs self-initiate procedures within the controlled acts, thus taking off the table one set of complaints related to the standards of practice.[16] Further, the second submission accepts distinctions between RN and RPN practice based on the condition of the patient that are virtually identical to those that appear in the current *Standards*. That is, in their second submission, the RPNAO indicated that they accepted the limitations of RPNs ability to self-initiate controlled acts and distinctions based on the condition of the patient that are outlined in the CNO's *Standards of Practice*.

The history of disputes has, however, enabled HPRAC to make a general observation about a systemic difficulty which, we suggest, has unduly opened up the possibility for past disputes, and if unchanged will create the possibility for more.

Standards of practice elaborate a profession's scope of practice, i.e. they provide more detailed information about the general scope statement and the procedures within the profession's authorized acts that will be practiced by its members. Standards of practice protect the public from harm by further detailing the specific practice of a profession, and the circumstances in which members of this profession may treat or advise a person with respect to their health in circumstances where it is reasonably foreseeable that serious physical harm may result from that treatment or advice.

Standards of practice must be sufficiently clear to give unequivocal guidance to members of the profession of their responsibilities and liabilities. They must be

[16] HPRAC's response to the RPNAO's proposals regarding self initiation is noted in 3.2.1 and 4.6.3.

understandable to members of the public so that they may identify when a health care practitioner has breached the standards. The CNO's standards of practice have two published components: the *1990 Standards of Practice*, *Guidelines for Decisionmaking About Added Nursing Skills and Sanctioned Medical Acts*.

The *Standards* provide a guideline for the basic requirements for safe practice for RNs and RPNs. The CNO emphasizes that these are minimum expectations and that they are not intended to restrict either RNs or RPNs from developing further competence. The standards for basic requirements are clear, and should function as an adequate mechanism for holding RN and RPN members accountable for the basic requirements of their profession.

The *Guidelines* provide examples of, but not definitive lists of situations where RPNs could take on additional responsibilities to those described in the *Standards* as long as they receive additional training. The *Guidelines* list five criteria that provide the limitations on RPN practice: i) the patient's condition is stable and predictable; ii) there is limited risk of harm; iii) RPN basic training and the individual's subsequent experience and training provides a sufficient base for carrying out the task; iv) the agency has sufficient and appropriate resources to teach the skill; and v) staff have the opportunity to maintain competence in a skill.

The *Guidelines* make it obvious that RPNs can practice at different levels in different health care facilities, which means that there is scope for the development of individuals and the professional group as a whole. However, both individuals and the professional group are dependent on the judgement and interpretation of administrators as to whether additional training and responsibility for RPNs is affordable and sustainable. Nowhere is there a straightforward, accessible direction on the upper limits of RPN practice.

The absence of clear "upper" limits negotiated by the professional group within the regulatory body, in a situation where individuals negotiate professional progression and limits with their employers, appears to be the source of unnecessary tension and dispute between RNs and RPNs. These kinds of disputes are about whether the limitations imposed in practice are fair where, for example: a group of RPNs can change dressings when an RN is not on a shift, but are restricted when an RN is on shift; a group of RPNs who felt they were trained for, and had assumed the responsibility for determining the urgency of care in an Emergency Room, but then were restricted from doing so; or some RPNs have been trained to suture superficial lacerations on the skin but have been restricted by the CNO's determination of which class of nurse will perform that delegated act. These examples raise questions about the distinctions that are made in practice, and what kinds of distinctions should be made between RPNs who have considerable workplace training and entry level RNs. HPRAC believes that the source of many disputes will not be resolved unless the upper limits of practice of all nursing classes are more clearly defined.

It should be noted that the CNO is considering the creation of an RPN "extended class". (CNO II) Our understanding is that they propose formal

recognition of RPNs who have additional education and workplace experience through the development of minimum standards for this group. In HPRAC's view, this could go a long way to addressing some of the current disputes, particularly if it were accompanied by career laddering: that is, clear basic and 'upper' limits of practice for each class of nurse, accompanied by a description of how experience, on the job training and formal courses contribute to an individual's ability to apply for registration in another class. This would be consistent with the CNO's claim that RPNs are a class within the profession of nursing, and not a separate profession.

Conclusion

Because the distinctions between RNs and RPNs are formally articulated in the standards of practice, they provide the focus for much of the disagreement between the two groups. HPRAC believes that the formulation of CNO's 1990 *Standards of Practice* does not readily handle the current level of contention, and perhaps contributes to it by failing to provide consistent, clear guidelines that are understandable by members of the profession, employers and the public concerning the distinctions between the practice of RPNs and RNs.

The combination of the *Standards* and the *Guidelines for Decisionmaking* do not provide a clear guide for practitioners to understand precisely what RPNs with different levels of training can not do. The 'upper' limits of RPN practice are uneven across individual practitioners and health care facilities, which is not by itself a harmful situation. The lack of clear limits can create situations in health care facilities and within the Council where they become the focus for regular disputes between RPNs and RNs. This tension is not in the public interest.

3.3.3 Statutory Committees

The RPNAO has raised a set of public interest concerns relating to the complaints and discipline functions of the current governing body. They argue that joint regulation is not effectively accountable to the public because such a structure requires time to define, mediate and discipline two sets of professional standards and interests.

The CNO indicates that "*There are RPN perceptions that RPN issues often get subsumed or lost in more complex RN issues, and there is insufficient RPN participation in the staffing of the College and unequal representation on College statutory and ad hoc committees. Member representation on the Complaints, and Quality Assurance Committees, for example, generally follows the model of member representation on Council which has an RN membership twice that of the RPN membership*." (CNO I, p.8) HPRAC believes that these "RPN perceptions" reflect substantive, structural issues which represent a limitation of the regulatory development of this professional group. Of the 23 professional staff at the CNO, only 3 are RPNs. Proportional representation among the professionals on complaints committees and discipline hearings means that RPNs are not judged by their peers and the public members of the Council.

More specifically, the RPNAO argues that RPN complaints tend to be less complex than RN complaints, and that because RPN discipline hearings do not

take as long that i) RPN complaints suffer in the present regulatory body and ii) a regulatory body dedicated to RPNs would be able to process complaints and discipline within the statutory time limit.[17]

In response, the CNO reports that its record of complaints processed before the statutory 120 day limit has markedly improved, but in 1994 23% of complaints were still not processed within that time frame. (CNO II, p. vi) In HPRAC's view this over-extension of the statutory limit is a problem. At the same time, HPRAC recognizes that this situation is not unique to the CNO and that many Colleges are having difficulties processing complaints within this time frame.

Conclusion

Whatever regulatory body handles RPN complaints and discipline, it must undertake measures to ensure that all complaints are processed within the statutory time lines.

Any limitation on the professional development of a group of practitioners is not in the public interest. Full participation by each professional class, and peer review by members of each class are necessary components of self-regulation.

3.3.4 Conclusion: Are Quality of Care and Accountability Jeopardized in the Present Governing Structure?

HPRAC believes that the public interest is jeopardized by the current level of antagonism between RNs and RPNs. Further, HPRAC believes that a number of these tensions relate to the governing and committee structures of the CNO. The representation by population structure of the CNO contributes to incidents and perceptions of unfairness, and to situations which jeopardize the regulatory body's ability to be accountable to the public, and to maintain and enhance the quality of care. RPNs should not, therefore, continue to be regulated by a body with this structure.

From time to time RPNs have been limited by the structures of the regulatory body in their professional development and their ability to practice to the full extent of their professional training. In particular, the majority on Council has recently blocked the development of multi-professional consensus around the ability of RPNs to initiate certain procedures relating to controlled acts; and, proportional representation on statutory committees limits the capacity of RPNs to participate in self-regulation. The blocks to the professional development of, and to the capacity for peer review by this professional class potentially limit the range of safe, affordable health care available to the public.

HPRAC does not believe that the CNO's standards of practice limit the development of RPNs as a professional group, but has identified the lack of clear definition of 'upper' limits of RPNs professional practice as an unnecessary flash point for disagreement between RNs and RPNs both in health care facilities and within the regulatory body. The lack of clear,

[17] The CNO reports that the average discipline hearing for RPNs took 2.5 days, while hearings for RNs took 4.6 days. CNO communication, April 10, 1996.

accessible 'upper' limits also makes it difficult for members of the public to understand the full range of the professional scope of an RPN. Consequently the governing body's ability to be accountable to the public, and to maintain and enhance the quality of care is jeopardized.

The relations between these two professional groups are increasingly tense. It is not in the public interest for this apparent level of antagonism to be a regular feature of the operating relations of a regulatory body.

3.4 DO RPNS SUPPORT A SEPARATE COLLEGE?

HPRAC does not know what level of support for a separate college exists among the approximately 35,000 RPNs in Ontario.

The only body that represents all RPNs in the province is the CNO, who had 34,569 RPN members in 1994. The Registered Practical Nurses Professional Association of Ontario had a membership of 5,520 in 1994. That is, the RPNAO represents 15.7% of RPNs in the province. The RPNAO claims that over 90% of its members support a separate college. We have no reason to doubt this claim.

Other participants in the referral who represent RPNs and who support the formation of a separate college are unions. Their members may or may not be RPNAO members. They include the Ontario Coalition of Hospital Unions (OCHU) which represents 7,500 members, and the Practical Nurses Federation of Ontario which represents 1,000 RPNs.

One large union local that represents RPNs has written to HPRAC opposing the formation of a separate college. This is the Service Employees International Union (SEIU), Local 204, which reports 5,000 RPN members, that is, just slightly fewer than the RPNAO. We received a letter from an individual member of this Local who is also a member of the "Collective of RPNs" who participated in the referral, who claims that the union did not consult broadly on this position, and that it does not represent the position of all members. Subsequently, SEIU has disputed this claim, stating that the position was developed by the RPN committee of the Local and has been consistently discussed since 1987.

In 1992 the RPNAO conducted a survey of 21,920 RPNs who were actively practicing in the province about their support for a separate college. Of the 1,062 respondents (a 4.8% rate of response), 1,012 or 95% supported a separate college while 50 did not support this development. HPRAC has seen this survey and has substantial concerns about its validity as an objective measurement. The survey question "*Should RNAs have their own separate college?"* is appended to a statement of the six reasons the Association believed that RPNs should have a separate College. A number of these statements were inflammatory and/or speculative, including: "*we need a College that will base decisions in the public interest, not in the interest of protecting RN jobs*"; a separate College will "*improve the basic training program for our profession and encourage continuing education opportunities*"; and "*a separate College would not cost the profession any more in terms of registration fees*".

Consequently, on September 22, 1995 HPRAC asked the RPNAO whether they would be willing, if so requested, to contract an independent organization to conduct a referendum on the question of a separate college for RPNs. The Association responded by indicating that the cost of such a large survey was substantial, but that they would be willing to proceed should all other hurdles to a separate college be cleared. They also suggested that the burden of proof of support or lack of it rested with those RPNs who are opposed to the formation of a college. HPRAC decided not to formally request the survey, because we recognized that even with a clear mandate of support from a majority of RPNs, other issues in the referral constituted significant hurdles to RPNs achieving a separate college.

Conclusion

HPRAC's assessment of the situation is that there is considerable cohesion among RPNs in their desire to improve the position of RPNs. However, we are not certain of the proportion of support for a separate college among RPNs.

3.5 RELATIONS BETWEEN RPNS AND UNREGULATED HEALTH CARE AIDES

The Minister raised the issue of the relation between the regulation of RPNs and the increased use of health care aides in acute and long term care institutions. Health care aides are unregulated "generic" health care workers who have less training than RPNs. There are strong parallels in the labour market competition between RPNs and health care aides, and the tensions between RNs and RPNs.

HPRAC has received no submissions, and very little information about scope of practice of health care aides during this referral. We recognize that a complex set of questions need to be resolved relating to the use of health care aides and their relations not only with RPNs, but with other health professionals and the public. HPRAC recommends that the Minister undertake a separate investigation of the public interest implications of substitution and utilization of health care aides and other generic health care workers in all health care settings.

Such a review should address the public interest issues related to the use of health care aides. Questions which need to be addressed include:

- What tasks can health care aides undertake in the provision of safe affordable care?
- What overlap, if any, is there in the scopes of practice of RPNs, RNs and health care aides?
- What nursing tasks, if any, can be delegated or assigned (by RPNs, RNs, or other health professionals) to aides who have no formal nursing background?
- If health care aides do not undertake any controlled acts, should they be regulated?

- If the occupation is not regulated, and it's members carry out tasks that are regulated "nursing tasks", how is it accountable to i) the public interest or ii) the nursing profession?

Conclusion

HPRAC recommends that there be an investigation of the public interest implications of the utilization of health care aides and other generic workers in all health care settings. This investigation should pay particular attention to the impact of the use of health care aides on the regulation of nursing (RPN and RN scopes of competence).

3.6 CONCLUSIONS AND RESOLUTIONS

A review of the public interest principles raised by this referral and HPRAC's criteria for regulation have led us to approach the question referred by the Minister by examining i) whether practical nursing is a separate health care profession, ii) whether the current combined regulation of RNs and RPNs sufficiently protects the public from harm, and iii) whether there is support for a separate College among RPNs. We also discussed a sub-set of the Minister's question: how the increased use of health care aides might affect the regulation of RPNs and the public interest.

i) Having developed a set of HPLR related indicators to assist in determining whether an already regulated health professional group is a separate profession, and examining the proposal in the light of these indicators, *HPRAC has concluded that practical nursing is not a separate profession from nursing.* This means that the *RHPA* regulatory model of one profession, one scope of practice, one act, and one regulatory body does not readily apply to RPNs.

ii) The review of whether joint regulation acts to sufficiently protect the public interest has raised a number of serious issues. HPRAC has concluded that the public interest is jeopardized by current relations between RNs and RPNs and by some of the structures of the CNO, and that RPNs must not continue to be regulated under such a structure. That is, *the status quo is not an option which is likely to operate in the public interest.*

iii) The review of the information we have received has not provided us with a clear estimate of the proportion of support among RPNs for a separate College.

iv) The information received in this referral about the relation between the use of health care aides and the regulation of practical nursing has not been sufficient to allow HPRAC to comment. HPRAC recommends that the Minister investigate the public interest implications of the utilization of health care aides and other generic workers in all health care settings.

The following section introduces a number of possible responses to this situation. The options that are presented to the Minister are shaped by a discussion of two outstanding concerns that arise from this analysis: the necessity to balance HPRAC's concern about unduly or prematurely fracturing

a profession, with the necessity for ensuring the full development of all professional groups or classes regulated within one College. A central component to any resolution will be the cooperation of both RPNs and RNs. In fact, any resolution that does not require, foster and build cooperation between these two groups will not operate in the public interest.

4. OPTIONS

In this section HPRAC will present the Minister with a discussion of a range of options which might address the problems presented in this referral. The discussion also provides HPRAC's preferred option.

4.1 CONSIDERING THE PUBLIC INTEREST, HOW SHOULD RPN GOVERNANCE BE ORGANIZED?

The following three issues broadly summarize HPRAC's conclusions from our analysis and provide the context for this section's discussion of options for the regulation and governance of RPNs.

i) any resolution of the situation must provide adequate room for development of all professional groups or classes regulated within one College

ii) the regulatory system must have the ability to consistently recognize when a professional group has developed into a distinct profession, or when a professional group is unnecessarily fracturing

iii) any effective governing structure must have the capacity to adequately protect the public from inconsistent standards and undue, dispute related costs to the profession and members of the public

4.1.1 Fracturing of Nursing

In HPRAC's view, the creation of a separate College for any professional group before they are able to demonstrate that they are a distinct health profession would represent the inappropriate fracturing of that profession. As our analysis has indicated, practical nurses have not been able to demonstrate that they are a profession distinct from other classes of nurses.

Further, in the course of this referral both RNs and RPNs have described how the profession of nursing, practical nursing included, is in a considerable state of change and development. As the RPNAO has pointed out, the entry requirements for RNs are being reconsidered, with the possibility of requiring RNs to have a university degree being the most significant possibility. These requirements, however, have not changed yet and are not likely to in the immediate future. RPNs are working through, in practice, their relatively recent independence from RNs, and are in discussions about the creation of an RPN "extended class". The anticipated recognition of nurse practitioners will necessitate a set of adjustments within the profession and the regulatory body which will take some time. Further, the profession is experiencing new pressures created by the re-organization of the health care sector, particularly from downsizing and the increased use of unregulated health care workers to do tasks formally carried out by regulated health professionals. These kinds of changes could be better addressed by a unified profession. Any fracturing at this moment could weaken the capacity of all of the profession's component groups to respond to these changes and pressures, and their ability to maintain a focus on the public interest related to such changes.

The creation of a separate piece of legislation, the formation of a regulatory College and the assumption of all their attendant costs to the members of a profession and the public are not to be undertaken lightly. HPRAC does not believe that internal dissension alone, particularly a certain amount of the somewhat predictable (although not desirable) overflow of professional competition into the regulatory body, is sufficient to establish a separate regulatory mechanism. If dissident professional groups were able to apply to the Minister for a separate college on the basis of evidence of internal professional competition, Colleges could find themselves with more groups prepared to fracture, and the RHPA could find itself with an unanticipated multitude of regulatory bodies. HPRAC believes that only substantial public interest issues should be able to over-ride the requirement that any group aspiring to a separate college must establish that they are a distinct profession.

4.1.2 Scope for Development of a Class of Professionals within a Profession

Having said that the primary criteria for any group aspiring to self-regulate is that they establish that they are a distinct profession, HPRAC recognizes that there must be adequate room for the development of all professional groups or classes regulated within each College and that the regulatory system must have the ability to consistently recognize when a professional group has developed into a distinct profession.[18]

This has led HPRAC to recommend that the RHPA principles which promote the autonomy of all health professions should be operating within Colleges that regulate different classes or groups of professionals as well as between regulated professions. That is, within each College, members of different classes or groups should, as part of individual professional development and the development of their professional group, be as fully involved as possible in the regulatory mechanisms and decision making related to their group. As this referral illustrates, limitations of the practice and regulatory participation of a professional group can contribute to situations that can jeopardize quality of care and accountability mechanisms.

This further suggests that Colleges which regulate more than one professional group will need to develop structures and procedures that attend with considerable sensitivity to the balance between organizational democracy, meeting the needs of the majority of members, and protecting the ability of a minority group to self direct and develop to its full potential within a majority rule structure.

[18] HPRAC recommends that the indicators developed in Section 3.2.6 act as the basis for assessing any future requests relating to whether a professional group is ready to become a separate profession.

4.1.3 Coordination of the Development of Standards for Overlapping Scopes of Practice

In our review of public interest principles in Section 3, we recognized that a significant concern had been raised regarding the capacity to adequately protect the public from inconsistent standards and undue, dispute related costs to the public and members of the profession of any regulating process or structure.

As we have stated, HPRAC believes that where RNs do the same tasks as RPNs, they are done based on the same philosophy and body of knowledge. Consequently any regulatory mechanism, whether it is combined or separate must have the capacity to coordinate the development of standards of practice in a way that meets the aspirations of both professional groups, but does not create public or professional confusion. From our analysis of the material received in the referral, this appears to be precisely the point of communication breakdown and dispute between RPNs and RNs.

In whatever resolution the Minister chooses, special attention must be paid to improving the communications between the two groups. Because of the similarity of the procedures performed, philosophy and knowledge base of the two professional groups, there will be tensions in any process and structure that regulates their practice. While the RPNAO predicts that relations will improve if the two groups do not need to continually negotiate the scope of their competence within the same regulatory body, HPRAC has found little to warrant this perception. The disputes and negotiations between two separate bodies could be equally fractious. This concern indicates that either:

i) the existing regulatory body must be restructured so that joint regulation can effectively facilitate this kind of communication, or

ii) a new form of dispute resolution mechanism must be created that can effectively mediate between two Colleges.

4.2 INTRODUCTION TO DISCUSSION OF OPTIONS

Between the creation of a separate college for RPNs and maintaining combined regulation within the current regulatory body there are a number of other options which do not currently exist, but are not impossible within the RHPA. Most legislation under the *RHPA* provides for the regulation of one profession under its own Act which includes a scope of practice statement describing the profession, and the mandate for one regulatory College.

In order to ensure that all options have been explored in this referral, HPRAC has looked at the following range of options.

SECTION NO.	OPTION DESCRIPTION
4.3	**Combined regulation of RPNs and RNs within an Unrestructured CNO** ✂ This option would be a recognition that RNs and RPNs are a single profession, and that the current regulatory structure is sufficient
4.4	**Combined regulation of RPNs and RNs within an Restructured CNO** ✂ This option would be a recognition that RPNs and RNs are a single profession, but that there are significant difficulties in the current regulatory structure.
4.5	**Separate Colleges for Professional Classes of the Same Profession** ✂ This option would be a recognition that RPNs and RNs are a single profession but stretching the RHPA's practice of regulating a profession with a single Act and single College..
4.6	**A Separate College for the Profession of Practical Nursing** ✂ This option would be a recognition that RPNs and RNs are not a single profession, or recognizing that for other public interest reasons the RHPA should not regulate RPNs and RNs as a single profession.

All options are discussed fully below. There are a number of these options that are not advisable, in HPRAC's view, but two deserve serious consideration. These are a revised CNO structure (4.4.4), and a separate RPN college which recognizes that public interest considerations necessitate the creation of such a body, and that these over-ride the RHPA's model of establishing colleges for separate professions (4.4.6).

HPRAC's discussion of these options indicates the Advisory Council's strong preference for the revised CNO structure. We recognize that this option would require significant compromise on the part of both the central parties to the referral. In HRPAC's view this option acknowledges the serious concerns presented by each party and is, in our opinion, the best way to protect the public interest. Nevertheless, we will discuss a separate RPN College proposal in some detail, despite its inherent difficulties, indicating where there are strengths and where there are issues that would need further development should the Minister choose to follow this route.

4.3 COMBINED REGULATION OF RPNS AND RNS WITHIN AN UNRESTRUCTURED CNO

The logic of this option is that practical nursing is not a separate profession from nursing, and that RPNs are a class of nurse. It would be a statement that the public interest is being adequately protected in the present governing structure.

Legislative Features:
- Existing act and scope of practice statement
- Existing college
- No internal standards development and dispute resolution mechanisms

Please see Section 3.3 for a detailed discussion of the difficulties in the current governing structure. The current governing structure unduly limits the professional practice of RPNs and has contributed to a situation where the relations between RNs and RPNs have deteriorated. The level of antagonism between the two groups jeopardizes the effective operating of the regulatory body and its ability to act in the public interest. RPNs should not continue to be regulated by a body with this structure. HPRAC strongly recommends that this option not be considered.

4.4 COMBINED REGULATION OF RPNS AND RNS WITHIN A RESTRUCTURED CNO

The logic of this proposal is that practical nursing is not a separate profession from nursing, and that RPNs are a class of nurse. It recognizes that the public interest is not being adequately protected in the present governing structure and requires an internal re-structuring of communication and dispute resolution mechanisms related to the common standards of practice.

Legislative Features:
- No legislative change: existing act and scope of practice statement
- New college by-laws which create new internal standards development and dispute resolution mechanisms

HPRAC recommends this as the preferable option. In doing so, HPRAC recognizes that it is recommending a significant intervention in the self-regulation of the profession as it is currently constituted. HPRAC believes, however, that this is a far less intrusive response to significant public interest concerns than other options which involve the dissolution of the current College, the division of assets and the creation of external dispute resolution mechanisms.

4.4.1 HPRAC's Proposed Restructuring

The following proposal for restructuring the CNO is intended to:

i) create adequate room for the development of all professional groups or classes regulated within the college. Simple proportional representation has not made it possible for RPNs to develop to their full potential

ii) recognize the concerns of RPNs by establishing on-going, more formalized, standards development for each professional group, while building in recognition that different classes of nurses have overlapping scopes of competence which may require coordination and dispute resolution

iii) establish a fair disputes resolution mechanism

iv) maintain the current majority representational structure, thus protecting the democratic interests of the RN majority, while ensuring that the decisions that are the most contentious are not left to unmediated majority rule decision making. Simple parity representation between RNs and RPNs would not be fair to the RN majority.

v) create sufficient opportunity for the development of regulatory capability within each professional group by creating consistent opportunities for peer review

vi) not fracture the profession

vii) ensure a fair transition process

In order for this proposal to work, HPRAC recognizes that it must be clear enough so that RPNs and RNs can see how their interests in the regulatory body can be, and are intended to be, adequately addressed. Its success also rests in the willingness of RPNs and RNs to work through a complex restructuring process. The largest risk in the proposal is the potential for mis-communication that may be created by any decision which does not pursue the express goal of the RPNAO (a separate College). Lack of acceptance by RPNs, possibly by RNs and by those who staff the current structure could make such a College ungovernable.

4.4.2 A Fair Transition Process to a Fairer Structure

In order to avoid reproducing the current structural problems in a revised structure, HPRAC first recommends that any direction to restructure be well defined by the Minister. This concern has motivated the extent to which we have detailed the following proposal: the current structure has not adequately addressed the issues raised in our analysis (Section 3), and is not likely to be seen by RPNs to fairly interpret general directives. Second, HPRAC recommends that a carefully constructed Transition Team of people knowledgeable about the current structure be given full authority to work out the details of the Minister's instruction.

This Transition Team should be composed of:

- a Mediator, acceptable to both RNs and RPNs on the CNO Council
- an RPN and an RN from Council
- the senior RN staff
- the senior RPN staff

The Transition Team should be allowed one year to accomplish the necessary changes, including the required By-law changes. This proposal does not require any changes to Regulations: however, the Transition Team or the Minister may recommend further changes which would require regulatory revisions. HPRAC would urge the Minister to expedite the approval of any new Regulations within the one year time period.

4.4.3 Fairer Structures

The structures of the CNO can be revised to create more room for the development of all professional groups or classes regulated within the college,

and to better address the consistent tension around standards of practice. Please see *Figure 3: Proposed CNO Council*, for an organization chart of the following proposals. It is HPRAC's assessment that the following changes require by-law but not legislative revisions and that these can be made by the Council. It should be noted that the structure and mechanisms could be expanded to include similar accommodation of Nurse Practitioners.

Council

- The Council would retain its current representative structure. The required change in the Council procedures would be the introduction of an automatic procedural mechanism which would table any decision proposed by a Practice Committee that was opposed by one professional group, and refer it to the Practice Coordinating Committee for further develop-ment.

Executive Committee

- The Executive Committee would retain its current structure of 1 President, 1 RN VP and 1 RPN VP. The College's By-laws or regulations should be amended so that the position of President is filled by an RN and RPN alternatively, in situations where a public member is not the President.

RPN & RN Practice Committees

- RPN and RN Practice Committees would be created by By-law. There is nothing in the *RHPA* that makes any of the statutory committees responsible for the development of standards of practice, although a number are responsible for enforcing the implementation of the standards.

  The size and composition of the Practice Committees would be determined by the Transition Team, although they should be relatively small, and include a proportional number of public members (proportional to their numbers in Council). The Practice Committees would be responsible for developing recommendations for the standards of practice relevant to each professional group, and would be staffed by someone with the qualifications of that professional group. They would be responsible for being knowledgeable about the concerns of and proposals being made by the Practice Committees of other professional groups. These groups should:

  i) develop HPRAC's recommendations in Section 3.3.2 that clear 'basic' and 'upper' limits of practice for each class of nurse be developed, accompanied by a description of how experience, on the job training and formal courses contribute to an individual's ability to apply for registration in another class.

  ii) continue to work out how to implement the 'extended class' for RPNs.

  iii) revisit the self-initiation regulations that govern RPNs and RNs to determine which practices within the controlled acts can be practiced by each professional group and under what supervisory conditions. This may ultimately lead to changes in the *Nursing Act.* (See Section 4. 6.3)

Practice Coordinating Committee

- The Practice Coordinating Committee would not be a standing committee. It would be constituted when necessary, and would be composed of a chairperson who is a public member of Council who is acceptable to both RNs and RPNs on Council; one RN and one RPN from Council; and one senior RN staff member and one senior RPN staff member. If necessary the committee would have the ability to hire a mediator who is acceptable to both RNs and RPNs on Council. This committee is responsible to the Council for handling referrals about disputes relating to Standards of Practice and further developing proposals that resolve those disputes.

Common Committees

- The remainder of the College's by-law and statutory committees would remain joint committees. The statutory committees, including Registration, Patient Relations, Complaints, Discipline, and Fitness to Practice and Quality Assurance would develop practices which respect the principle of self-regulation for each professional class. Any hearings or investigation panels would be constituted so that RNs are judged only by RNs and public members, and RPNs are judged only by RPNs and public members. Those hearings and investigations relating to RPNs should be staffed by RPNs, and those relating to RNs should be staffed by RNs.

4.4.4 Practice Committees and the CNO's Quality Assurance Program

The CNO may be considering, including the development of standards of practice, as part of its Quality Assurance Program. HPRAC's proposal would lead the College in a different direction. The *RHPA* does not explicitly place the development of standards of practice in any statutory committee. The development of standards is a significantly different operation than those that are required of Quality Assurance Committees in the legislation. In this instance, as we have argued above, it is also a contentious activity which requires careful attention to how it is situated in the decision making structures of the College.

However, should the Minister, or the Transition Team decide that it is essential that the development of standards be the responsibility of the Quality Assurance Committee, then HPRAC strongly recommends that this committee be restructured through changes to the Regulations which constitute its membership. It should take the place of the Practice Committees in the above proposal. In order to avoid reproducing the current problems in the College, a restructured Quality Assurance Committee should:

i) be constituted as a committee that has full parity between RNs and RPNs. This would require adding an additional RPN member of the Council to the committee, through an amendment to the Regulations.

RECOMMENDED RESTRUCTURING OF THE CNO

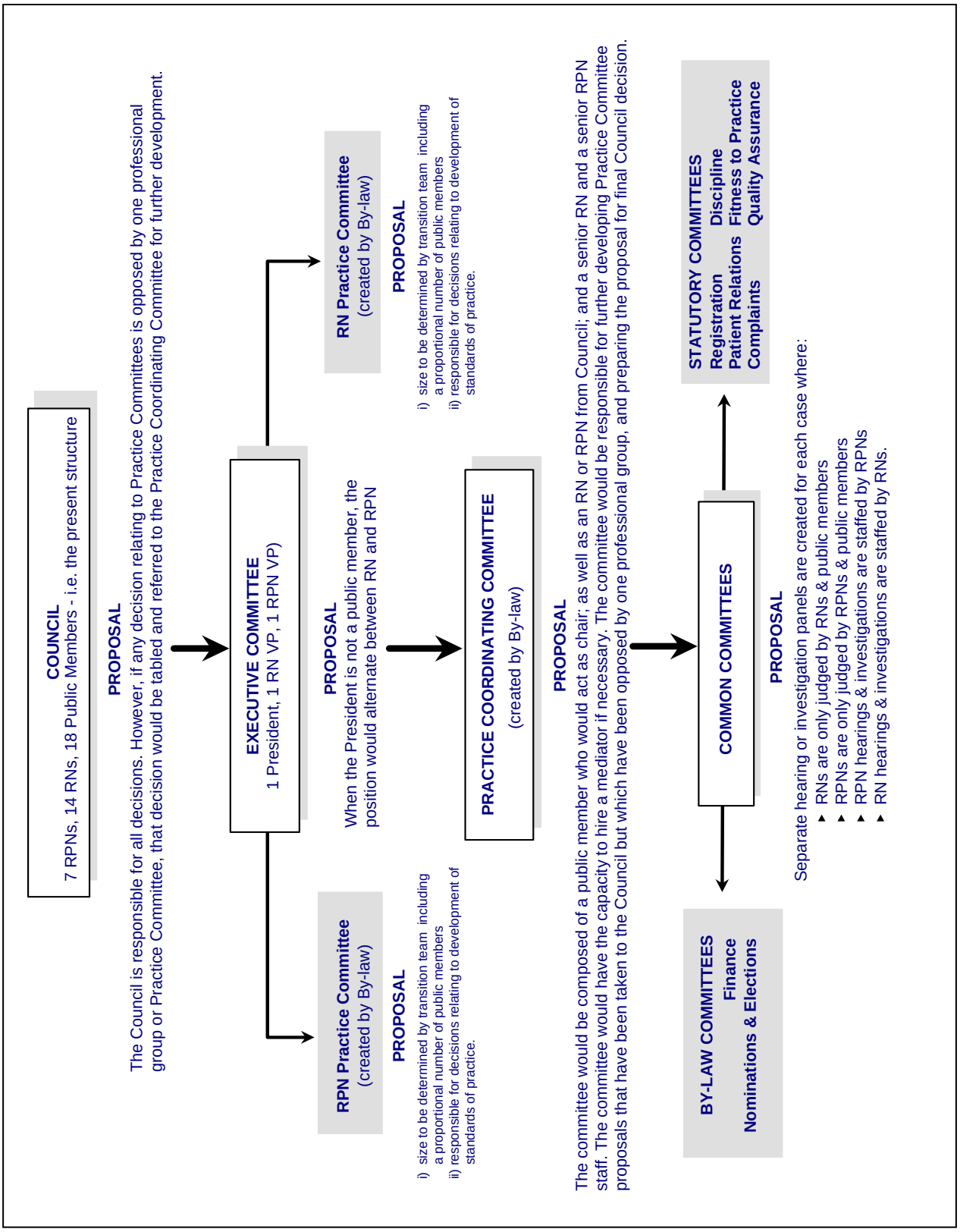

Figure 3

ii) The current Quality Assurance Committee is composed of 2 RN Council members, 1 RPN Council member, 4 public members of the Council, 2 non-Council RNs and 2 non-Council RPNs. A reconstituted Quality Assurance Committee that is responsible for the development of standards could be structured as follows:

RPN QUALITY ASSURANCE COMMITTEE	RN QUALITY ASSURANCE COMMITTEE
2 – RPN Council members 2 – Public Council members 2 – RPNs not from the Council	2 –RN Council members 2 – Public Council members 2 – RNs not from the Council

4.4.5 Time Table for Review

The revised structure should be reviewed regularly by both the CNO and the Minister. Regular review may bring about changes that allows the structure to operate more effectively in the interests of the public. The CNO should minimally review the changes every six months for the first two years and every year thereafter, making changes based either on the consensus of Council, or on the recommendation of a body with the same composition as the Transition Team. The Minister should review the revised structure after three years of operation.

4.4.6 Costs

This proposal would require the CNO to find ways to fund the new internal structure. The budgets for the RN and RPN Practice Committees should be similar, because the tasks are the same for both, and are not affected by the difference in numbers of members. Accordingly the Practice Committees will require similar, not proportional resources. The appointment of a mediator for the Transition Team and a mediator(s) for the Standards Coordinating Team should be paid for by the College.

4.4.7 Other Non-Recommended Possibilities for Restructuring

In the course of developing the above proposal HPRAC considered two other possible ways of achieving the desired changes in the CNO structure. There were significant difficulties with both, as discussed below. HPRAC's opinion is noted here for the information of the Minister, and any other parties who are considering this restructuring option.

i) RPN and RN Parity on the Council

HPRAC considered the proposal made by SEIU that the Council be restructured to include equal numbers of elected RNs and RPNs, along with public members. HPRAC believes that this proposal could create more problems than it would resolve. An immediate, practical concern was that the relations between the two groups are such that a parity structure could create a completely "hung" Council on all governance issues - that is, those issues which are beyond those which appear to be the focus of the tension within the regulatory body could become politicized as well. A broader, structural

concern was that straight parity representation rarely adequately addresses the issues of a minority, and creates a situation where the majority, in this case RNs, are likely to feel unfairly represented. In HPRAC's judgement, more effective solutions are developed by analyzing and problem solving around specific points of conflict, and enabling the parties to self-govern to the fullest extent possible within the Council.

ii) Devolution of Council Decision Making to Committees

HPRAC looked at whether it was possible for the proposed RPN and RN Practice Committees to have full decision making authority for the development of standards of practice and quality assurance. That is, we were attempting to define the limits of the concept of "the fullest possible self government by each group". In practice this proposal would have meant that the Council would devolve its decision making responsibility to RPN and RN Practice Committees to develop and approve standards of practice, so that decisions about these issues would be brought to the Council for information only.

On examination it became clear that devolving this level of decision making would require considerable restructuring of the HPPC as well as the Nursing Act and that it could be problematic to achieve. The existing legislative framework does not allow College Councils to delegate their authority to either statutory committees or to committees created by by-laws. The only body that the Council can delegate decision making powers to is the Executive Committee, and this is the relatively limited ability to make certain decisions between meetings of the Council.

This examination gave rise to the proposal detailed above in this section, which leaves the Council with full decision making authority, but creates two new mechanisms. The first are the Practice Committees, which provide new, profession-specific forums for the development of standards of practice. The second is the dispute resolution process specifically designed for cases where representatives of the two professional groups are split on decisions about standards of practice.

4.5 SEPARATE COLLEGES FOR PROFESSIONAL CLASSES OF THE SAME PROFESSION

There are two legislative routes which could create a separate college for different classes of the same profession. Both would require deviation from the usual interpretation of the RHPA's practice of establishing one regulatory body for one profession. The rationale for making this kind of legislative exception would need to be that the public interest can not be protected by a joint governing structure. In HPRAC's view, neither of these options are advisable, but both are possible.

4.5.1 A Separate RPN College Related to Nursing by a Shared Act and Scope of Practice

The logic of this model is that practical nursing is not a separate profession from nursing, but that RPNs should not remain in the CNO because the public interest can not be protected by a joint governing structure. It would necessitate communication and dispute resolution between the two Colleges around both interpretations of scope of practice and the act. It would require a legislated dispute resolution mechanism for mediating differing or conflicting interpretations.

Legislative Features:

- Revised Nursing Act
- Existing nursing scope of practice statement
- Two colleges
- Legislated dispute resolution mechanism

The strength and weakness of this model is that two Colleges would be interpreting the same Act and scope of practice statement. Its strength is that it reflects the reality of these two professional groups: they are not separate professions and they share the same professional practice with patients whose condition is stable. It creates the possibility of a strong, legislated process which would require coordination of and resolution of disputes over the interpretation of overlapping scopes of practice. Its weakness is that significant disputes are likely, particularly in the area of standards, and could be costly. Its inconsistency with other *RHPA* regulatory processes could be confusing for members of the profession, members of other health professions, and for the public.

HPRAC views this model as a legislated version of the revised CNO proposal detailed in 4.4 above, but recommends that it not be considered because of the increased difficulty it would create in resolving disputes.

4.5.2 A Separate RPN College Related to Nursing by a Shared Scope of Practice

The logic of this model is similar to that of 4.5.1, above: that practical nursing is not a separate profession from nursing, but that RPNs should not remain in the CNO because the public interest can not be protected by a joint governing structure. It would remove the necessity for common interpretation of one Act, however, and require definition of communication and dispute mechanisms related to interpretation of the common scope in each act.

Legislative Features:

- Two Acts: "Nursing" (revised) and "Practical Nursing"
- Existing nursing scope of practice statement
- Two colleges
- Legislated dispute resolution mechanisms in two Acts

This model is closer to the usual interpretation of the RHPA, where a College is created by a separate Act. It maintains the reflection of the reality of these two professional groups: they are not separate professions and they share the same

professional practice with patients whose condition is stable. However, it splits the regulation of the profession of "nursing" more profoundly than the model in 4.5.1, and places any coordination and dispute resolution mechanism in two separate Acts, rather than within one Act.

HPRAC recommends that this option not be considered. While it is closer to the usual interpretation of the RHPA than the model in 4.5.1, it both fractures the profession of nursing more profoundly, and creates a dispute resolution mechanism that is not likely to be as effective as either the restructuring proposed in 4.4., or that of the model in 4.5.1.

4.6 A SEPARATE COLLEGE FOR THE PROFESSION OF PRACTICAL NURSING

This is the proposal made by the RPNAO. The logic of this proposal is either that practical nursing is a separate profession from nursing, or that RPNs should not remain in the CNO because the public interest can not be protected by a joint governing structure. If practical nursing is recognized as a separate profession, the interpretation of scopes of practice for practical nursing and nursing should not require additional dispute resolution to that required by other professions with overlapping scopes of practice.

Legislative Features:

- Two scope of practice statements
- Two Acts: "Nursing" (revised) and "Practical Nursing"
- Two colleges
- Dispute resolution mechanism in existing Ministry and RHPA bodies.

HPRAC recognizes that it is possible that the Minister may decide, for reasons other than that practical nursing is a separate profession, that RPNs should be regulated separately from RNs but that the *RHPA* should not be deviated from to create either of the models described in 4.5.1 or 4.5.2. The creation of a separate Act with a separate scope of practice statement is the most straightforward way to create a separate college. What follows are HPRAC's observations and recommendations on the public interest considerations related to the RPNAO's proposed College.

4.6.1 Title

The RPNAO requested that the title "Licensed Practical Nurse" be protected in any separate legislation. They argued that this is the consistent title used in those jurisdictions that have abandoned the title "nursing assistant". The *RHPA,* however, is not a licensing system and reference to "licence" in the title is inappropriate. HPRAC recommends that the protected title for practical nurses continues to be "Registered Practical Nurse", as in the *Nursing Act 1991.*

4.6.2 Scope of Practice Statement

In order to develop this option, the Minister would need to accept that in this situation the scope of practice statement would not sufficiently distinguish practical nursing as a separate profession, but that it could adequately describe it. The RPNAO's final proposal limits, or defines the practice of RPNs by the condition of the patient and by practice with other health professionals. Limitation of practice by the condition of the patient is unusual among professions regulated under the RHPA, but does not appear to be prohibited by the *RHPA*.

In HPRAC's view, the RPNAO's statement is an accurate description of the practice of the professional group, and would be recognizable to health professionals and the public. But it is also our view that practical nurses do not have a distinct practice or philosophy from other classes of nurses. Therefore HPRAC recommends that the RPNAO should not be requested to make further attempts to create distinctions for the purposes of legislation.[19]

HPRAC recognizes that the RPNAO's statement represents the desire for, and creates the possibility of greater decision making responsibilities for RPNs caring for stable patients by not making reference to standard care plans. The statement also appears to create the possibilities for greater RPN decision making responsibilities in situations where the patient's outcome is unpredictable, proposing that in these situations RPNs work *"under the direction of or in collaboration with a member of another profession"*. As we have noted in Section 3.2.1, the RPNAO acknowledges that in these situations there is a need for knowledge that is beyond that of the RPN. The scope statement should make it clear that when RPNs are working outside of their scope of competence, they should work only *under the direction o*f another health professional.

Any definition of practical nursing based on the RPNAO's proposed statement should be accompanied by entry to practice standards and a clear definition of the top range of the scope of competence of RPNs. (See Section 3. 3.1)

4.6.3 Controlled Acts

The RPNAO has requested the same three controlled acts as are currently authorized to nursing. (See Section 3. 2.1) RPNs currently carry out a limited number of procedures within these authorized acts, under the direction of another health professional. For ease of reference, the proposed authorized acts for RPNs, the RPNAO's withdrawn proposal for self-initiated procedures, and a list of procedures within the authorized acts that RPNs currently carry out under the direction of another health professional are charted as Figure 2.

HPRAC recommends that should a separate scope of practice be developed, the Act should include limits on controlled acts which would include those

[19] See Section 3.2.1 for the discussion of the RPNAO's proposed scope of practice statement.

practices noted in the RPNAO's submission, and listed in the second column of Figure 2. These practices should be further limited by notation about which class, or grade of RPN nurse could practice each procedure, and when these procedures should be ordered by another health professional. For instance, the controlled act of performing a prescribed procedure below the dermis or a mucous membrane might be defined in the legislation as follows:

SAMPLE OF RECOMMENDED DETAIL IN ANY ACT REGULATING RPNS [20]

Performing a prescribed procedure below the dermis or a mucous membrane.

All RPNs can perform:

- cleansing
- soaking
- probing
- debriding
- packing
- dressing
- treating open areas of the skin.

Extended class RPNs (or some other designation of those RPNs that have training beyond the entry to practice requirement) can also perform:

- irrigating

RPNs can be delegated by the appropriate health professional to:

- suture subcutaneous tissue and close skin

It should be noted that there is some contention about whether RPNs should be given the controlled act of "putting an instrument, hand or finger beyond the external ear canal". Although this is one of the acts authorized to nursing, the OMA points out that the controlled act of putting an instrument, hand or finger beyond the external ear canal, i.e. beyond the orifice of the external ear canal into the middle ear space is done only by a small number of physicians. The RPNAO interprets this act as including the procedures of ear syringing, examination with an otoscope and instilling ear drops, which are carried out by RPNs. These are not, in the OMA's interpretation, procedures within a controlled act. The OMA's interpretation raises a question which is outside of the scope of this referral, i.e. whether this is an act that should be authorized to nursing, but highlights a problem with the existing legislation and regulatory situation. This is the kind of situation which would be avoided if both RN and RPN practices within a controlled act were clarified in legislation.

[20] This recommendation is consistent with HPRAC's recommendation to the Minister about the changes needed to the *Nursing Act* in order to effectively regulate Nurse Practitioners.

i) Self Initiation of Controlled Acts

The RPNAO has withdrawn their initial request for the self-initiation of procedures within these authorized acts. Given the lack of clarity regarding the professional group's intentions regarding self-initiation, and the disputes related to the proposal, HPRAC recommends against any self-initiation of controlled acts by RPNs without further review.

However, the strength of feeling about self-initiation on the part of many RPNs makes it almost certain that, on the establishment of a separate College, an RPN Council would pursue the process of defining procedures which could be self-initiated by RPNs. (See Section 3.3.1) HPRAC recommends that any future proposals for self-initiation from a separate RPN College should be defined in legislation.

4.6.4 Dispute Resolution Mechanisms

As HPRAC has noted above, the logic of this option is that practical nursing is a profession like any other regulated by the RHPA. This suggests that the legislation of any special coordination of standards development or dispute resolution mechanisms relating to overlapping scope of practice issues with RNs would not be appropriate. That being said, it is crucial to recognize that in this instance the fact that one scope of practice of one group is fully encompassed in the broader scope of another is not likely to stop being contentious. HPRAC believes that the best way of handling this would be to ensure that those existing RHPA mechanisms which are designated by the Minister as the route for dispute resolution are noted in the legislation or regulations. The only existing mechanisms are HPRAC or the Ministry itself.

4.6.5 Entry To Practice Requirements

In Section 3.3.4 HPRAC observed that a focus of tension between RNs and RPNs is created by the wide range of education, experience and practice among RPNs, combined with an absence of formal upper limits of RPN practice. This observation is equally relevant for a separate college as for a combined college.

HPRAC recommends that a separate RPN college register classes of RPNs and that the entry level requirements for all classes be specified in legislation. The College should develop a career ladder: basic and 'upper' limits of practice for each class of RPN, accompanied by a description of how experience, on the job training and formal courses contribute to an individual's ability to apply for registration as another class of RPN.

4.6.6 Proposed Structure

The RPNAO proposes an RPN College that would have a Council composed of 8 elected members and 6 public members. They would sit for three year terms. They propose a staff of 25, including a Registrar, 4 Directors, and 20 support staff. HPRAC finds no difficulties with this structure.

4.6.7 Costs

i) RPN College

The RPNAO proposes an annual budget of $2,235,000. It's revenue estimates are based on the current CNO fee of $70 for RPNs, plus $100,000 from an unspecified source. The proposal assumes a division of the current assets of the CNO, although does not specify proportions or amounts. The process of the division of assets has not been identified as a problem by the RPNAO, but HPRAC notes that it could be extremely difficult, contentious and costly.

HPRAC's assessment of the proposed budget is that it may be underestimated. The RPNAO estimates are similar to current CNO expenditures on RPN members. It is HPRAC's observation that smaller regulatory bodies incur larger costs per member, and that there is a good possibility that the expenses of both the proposed RPN College and the RN College will increase. Any increase in costs, or loss of revenue would necessitate a fee increase.

ii) Costs to Government

The RPNAO argues that public costs would not increase significantly. They make the assumption that the CNO would also significantly restructure, retaining a Council of 14 RNs and 12 public members. If this is indeed acceptable to the CNO and the Minister, there would be no increase in the number of public members between the two colleges, and no increase in their costs.

Throughout this section HPRAC has observed that the apparatus of a separate piece of legislation has public costs, and that any disputes that are unresolvable within a College, or that are between Colleges also have public costs. HPRAC anticipates that there will be disputes between an RPN College and the CNO because of their overlapping scopes of practice. These disputes could translate into costs in Ministry time, or in HPRAC referrals.

4.7 SUMMARY: OPTIONS

HPRAC has presented the Minister with the range of potential options which we have explored in order to make a strong recommendation about a structural/legislative solution to the situation that has been presented in this referral. We stated at the beginning of the discussion that any course of action would be incomplete if it did not take the following into account:

i) Any regulatory body must provide adequate room for development of all professional groups or classes.

ii) The regulatory system must have the ability to consistently recognize when a professional group has developed into a distinct profession.

- HPRAC recommends that the indicators developed in Section 3.2.6 should act as the basis for assessing any future requests relating to whether a professional group is ready to be come a separate profession.
- These indicators have led us to recommend that practical nursing not be recognized as a distinct profession.

iii) The regulatory system must have the ability to recognize when a professional group is unnecessarily fracturing. In this case, because practical nursing and other classes of nursing are one profession, and because the profession is in considerable change, fracturing the profession by splitting the regulatory structure should only be done for over-riding public interest reasons.

- In HPRAC's assessment, the only legitimate, over-riding public interest rationale for splitting the regulatory structure for nursing would be that any structure that combines RNs and RPNs is ungovernable. HPRAC recognizes that the current structure is not working in the public interest, but is not prepared to state that any combined regulatory structure would not work.

iv) Any effective governing structure must have the capacity to adequately protect the public from inconsistent standards and undue, dispute related costs to the profession and members of the public.

4.7.1 Preferred Option

HPRAC recommends the restructuring of the combined regulatory body specifically so that the current tensions and disputes relating to standards of practice which jeopardize the public interest are addressed. Recommended components include:

i) a transition team

ii) alternating access by RPNs to the position of the president

iii) creation of RPN and RN Practice Committees which would:

- be responsible in turn for new RPN and RN Standards of Practice and Quality Assurance Committees, each of which would be staffed by members of the respective class of nurse
- develop clear basic and upper limits of practice for each class of nurse
- develop and implement the 'extended class' of RPN
- prepare regulatory changes which would define which practices within Controlled Acts can be practiced by each class of nurse, and under what supervisory conditions.

iv) creation of a Standards Coordinating Committee which would provide the disputes resolution mechanism for disagreement about standards of practice on the Council

v) composition of any hearings or investigative panels based on the principle that each class of nurse should be investigated and judged by others within her class, along with public members

vi) a review mechanism which requires internal six month reviews and a review by the Minister after three years

4.7.2 Recommendations on Other Options

i) HPRAC strongly recommends that the combined regulation of RPNs and RNs within the CNO as it is currently structured not be maintained.

ii) **HPRAC does not recommend deviating from the RHPA model to allow one Nursing Act to create two Colleges,** regardless of this option better describing the relation of the two professional groups and the potential strength of a dispute resolution mechanism.

iii) If the Minister's assessment is that the regulatory separation of RPNs and RNs is the best course of action, HPRAC recommends that a Practical Nursing Act establish a separate RPN College, and that the Nursing Act be amended to include reference to a dispute resolution mechanism common to both Acts. Recommended components include:

a) the protected title of "Registered Practical Nurse"

b) the RPNAO's proposed statement as a general scope of practice statement, with the clarification that in situations where the outcome of the patient's condition is unpredictable, that RPNs work "under the direction of" a members of another profession

c) a clear definition of the entry and top range of the scope of practice of more than one class of RPN developed by the new College, and that this be included in legislation

d) the specification in the new Act of those procedures within the three requested controlled acts that can be carried out by RPNs (eventually specified by classes of RPN), and under what supervisory conditions

e) no self-initiation of any controlled acts at this point. If self-initiation of controlled acts is approved in the future, they should be specifically included in the Practical Nursing Act

f) a dispute resolution procedure based on existing RHPA mechanisms, designated in both the Practical Nursing Act and the Nursing Act

g) the RPNAO's proposed Council structure of 8 elected members and 6 public members