

# HOSPITAL EMPLOYEES' UNION

*Submission to the Ministry of Health*

*on the proposed*

## ***Nurses (Licensed Practical) Regulation***

December 21, 2012



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# INTRODUCTION

The Ministry of Health (the “Ministry”) has given notice of the proposed repeal and replacement of the Nurses (Licensed Practical) Regulation (the “Regulation”), to implement the shared scope of practice/restricted activities regulatory model for the Licensed Practical Nurse (LPN) profession. The Hospital Employees’ Union (HEU) represents over 2,000 LPNs in British Columbia, including the vast majority of unionized LPNs employed in long-term care (LTC) facilities across the province.

The LPN workforce in the LTC sector has increased dramatically over the last several years (76 percent between 2006 and 2010, according to CIHI, 2012). As the delivery of health care in BC continues to move closer to home, into smaller and sometimes more remote facilities, and as LPN utilization in these settings expands, it is becoming increasingly critical that LPNs be permitted to work independently and to their full scope of practice.

HEU has represented LPNs for over 60 years, and we have been a leading proponent of their professional autonomy and full and effective utilization. Over the last two years, we have engaged in broad-based consultative processes with our LPN members, drawing on their front-line knowledge and expertise in our analysis of the regulatory framework for the practice of their profession.

We appreciate the opportunity to submit our comments to the Ministry regarding the proposed new Regulation.



# BACKGROUND

Health care policy leaders in BC and elsewhere have long-called for the expansion of LPN practice and utilization (see, e.g., Seaton Commission, 1991; HAHPARRC, 2002).

In its report in 1991, the Royal Commission on Health Care and Costs (the “Commission”) criticized the underutilization of LPNs in BC, and urged the Ministry to require the use of LPNs in various settings “where their employment is consistent with efficiency and quality care” (Seaton Commission, 1991). Mandated, broadly, to examine the effectiveness of all aspects of BC’s health care system, the Commission recommended that all nurses, including LPNs, be deployed “at the highest level possible” given their skills, education and training.

The report of the Commission was the main impetus for the scope of practice and legislative review conducted by the Health Professions Council (the “Council”) between 1992 and 2002. Notwithstanding its key proposal to remove the requirement for direction or supervision over all nursing services provided by LPNs, the Council did not go far enough in terms of its recommendations regarding the types of activities that LPNs can perform independently.

Since the time of the Council’s final report in 2002, there has been a substantial increase in the number of LPNs working in BC. However, while the per capita rate of LPNs has also risen significantly, it remains exceptionally low (the lowest among Canadian provinces in 2010, according to CIHI, 2012).

Similarly, the advancement of LPN education, scope of practice and professional opportunities over the last two decades has been substantial, yet remains unfinished.

Various barriers to optimal LPN utilization and full scope of practice remain. Chief among them, are the current provisions of the Regulation.<sup>1</sup>

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<sup>1</sup> Other barriers affecting the ability of LPNs to work to full scope include heavy workloads and staff shortages (see Oelke, et al., 2008).

# CORE PRINCIPLES

Research, policy and advocacy around the utilization and regulation of LPNs and other health care professionals have stressed the following core principles.

## *1. Safe and Effective Care*

Above all else, decisions around human resource planning and utilization of health care professionals must be geared towards providing safe and effective care. Research suggests that various patient outcomes (including symptom control, length of stay, and patient hygiene and nutrition) may be related to the scopes of practice and staff mix in a facility (see HAHPARRC, 2002).

The potential benefits of deploying LPNs and other health professionals to their full scope of practice include: addressing nursing shortages, increasing employee morale and productivity, improved teamwork, increased emphasis on training and mentorship, and improved quality of care, patient safety and patient outcomes (see HAHPARRC, 2002).

LPNs, themselves, believe that expanding their role and autonomy would benefit patients and residents. Over 80% of HEU LPNs recently surveyed indicated that greater independence would allow them to provide better and more efficient care (HEU, 2012).

## *2. Efficiency and Accessibility*

Government, health authorities and employers recognize that we can provide patients and residents with greater choice and enhanced access to more efficient care by training and authorizing health professionals to provide a wider range of services and expanding their scope of practice (see, e.g., British Columbia, 2010). Legislation that “unduly restricts the scope of practice of skilled personnel may be contrary to the public interest in greater supply and accessibility” of health care services (McLeod, 1974).

The costs of not deploying health professionals effectively may include low productivity, high staff turnover, increased illness and injury rates,

staff shortages, and reliance on overtime (see HAHPARRC, 2002). As the Canadian Nursing Advisory Committee observed in 2002:

Some of the shortages that afflict [health care] workplaces could be eliminated if nurses and other health care practitioners were permitted to work to their full scope of practice. We cannot afford to continue on this path, and we can use our precious resources much more wisely than we do now (CNAC, 2002).

In its final report and recommendations, the committee urged government, regulators and employers to maximize the scope of practice of LPNs and others, and to allow them to function to the maximum of their professional abilities.

### ***3. Moving Forward***

The regulatory regime for LPNs should not only reflect current practice, education and training, but it should also allow for growth and advancement in the profession, as well as ongoing evolution in the health care system. The framework for regulating LPNs “should not entrench a paternalistic function” over their profession “or reserve exclusive areas of practice” for other health professionals for no good reason (HPC, 2000).

Just as the new provincial curriculum was designed to be relevant and dynamic going forward (see BCAHC, 2011), so must be the new rules governing LPN practice. The objectives of safe, effective, efficient and accessible care cannot be achieved within a rigid and static regulatory framework that prevents LPNs from working to full scope and creates barriers to their skill development and utilization.

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Our comments on the proposed new Regulation are rooted in the core principles described above.

## RESERVED TITLES

The Ministry has proposed a new provision setting out titles reserved for exclusive use by members of the LPN profession. We support this proposal.

Specifically, we are pleased that LPNs have finally been granted express statutory authorization to refer to themselves as “nurses.” The HEU has long-asserted that LPNs must be permitted to use the title “nurse,” despite strong opposition from other stakeholders (see, e.g., BCNU, 2000).

The proposed provision on reserved titles is consistent with the findings and recommendations of the Council (HPC, 2000). More importantly, it is an acknowledgement that LPNs have been, and continue to be, an integral part of the nursing profession in British Columbia.

RESERVED TITLES



# SCOPE OF PRACTICE

The Ministry has proposed a new scope of practice statement for LPNs. We support this proposal, in part; however, it is our position that certain revisions are warranted.

## *1. The New Model*

We welcome the Ministry's implementation, through the proposed new Regulation, of the shared scope of practice/restricted activities regulatory model for the LPN profession. Under this model, many services provided by, and restricted activities granted to, one profession may overlap, or be shared, with those of other professions.

This approach is consistent with the enduring trend in health professions regulatory policy "towards reducing exclusivity in order to enhance interdisciplinary practice, improve accessibility to health care services and increase consumer choice, while at the same time maintaining the fundamental objective of protecting the public" (HPC, 2000). It promotes flexibility in the allocation of roles between the various, overlapping health disciplines, as well as efficiency and effectiveness in the utilization of each profession's mix of skills.

## *2. Direction or Supervision*

According to the scope of practice statement in the current Regulation, an LPN may provide nursing services consistent with her training and ability. However, with one, narrow exception (immunization), all nursing services provided by LPNs must be carried out under the direction of the attending medical practitioner (or nurse practitioner) or under the supervision of a registered nurse (RN) who is providing services to the patient or resident.

We have consistently opposed the direction/supervision requirement in the current Regulation, as it prevents LPNs from practicing independently within the range of competencies (i.e. knowledge, skills, clinical judgment, attitude, and abilities) developed through their education, training and experience.

HEU LPNs employed in LTC facilities advise that, currently, RN supervision (in respect of an LPN's activities within her range of competencies) is often an inefficient formality, which does not enhance resident safety or quality of care. Moreover, as the College of Licensed Practical Nurses of British Columbia (the "College") explained well-over a decade ago, the supervision requirement may sometimes result in inappropriate or counterproductive outcomes:

The situation often arises that a Registered Nurse who does not have a particular competency at the practice level, e.g. tracheostomy care, is supervising a Licensed Practical Nurse who not only has the competency for trach care but also has a post-basic specialty program in that area (quoted in HPC, 2000).<sup>2</sup>

Indeed, according to the College, there are LPNs "who have had more experience, who have gained more knowledge and exhibit better judgment than a registered nurse in some aspects of care" (quoted in HPC, 2000).

We are, therefore, pleased that the new regulatory model and proposed scope of practice statement remove the direction/supervision requirement from the Regulation.

### *The new statement*

Under the scope of practice statement in the proposed new Regulation, LPNs may practice "practical nursing," which is defined as follows:

**"practical nursing"** means the health profession in which a person provides the following services:

- (a) health care for the promotion, maintenance and restoration of health;
- (b) prevention, treatment and palliation of illness and injury, by
  - (i) assessing health status, and
  - (ii) planning and implementing interventions.

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<sup>2</sup> Similarly, HEU LPNs advise that, in many LTC facilities, primary responsibility for wound care falls on LPNs, some of whom have completed post-basic education and training in wound care. As a result, at the practice level, it is the LPNs, not the supervising RNs, who are particularly competent with respect to wound care activities.



This new statement represents an important and meaningful change in the regulatory definition of the parameters of the LPN profession. It affirms that LPNs may practice independently in respect of non-restricted activities within their range of competencies. This is a significant step forward, away from outdated and uninformed views of LPN practice. For example, some have previously questioned the basic competencies of LPNs to assess health status and implement interventions (see BCNU, 2000). We commend the Ministry for leaving these inaccurate perceptions behind.

Thus, the proposed new scope of practice statement represents movement in the right direction; however, it does not go far enough.

### ***3. Evaluation and Coordination***

The proposed new scope of practice statement omits the evaluating and coordinating functions performed by many LPNs. As a result, it does not accurately reflect current LPN practice, education and training, and may be a barrier to professional advancement and health system evolution. Accordingly, we recommend that the practical nursing definition be amended to read as follows:

**“practical nursing”** means the health profession in which a person provides the following services:

- (a) health care for the promotion, maintenance and restoration of health;
- (b) prevention, treatment and palliation of illness and injury, **primarily** by
  - (i) assessing health status,
  - (ii) planning, implementing and **evaluating** interventions, and
  - (iii) **coordinating health services.**

#### ***Evaluation***

Monitoring and evaluating the effectiveness of nursing interventions is a baseline competency of LPNs (CLPNBC, 2009). LPNs play an integral role in the evaluation of nursing care (BCAHC, 2011; Assessment Strategies, 2012).

The evaluating function performed by LPNs should be recognized in their scope of practice statement.

### *Coordination*

LPNs employed in LTC facilities are increasingly performing supervisory roles, including coordinating the care services provided by other staff. The coordinating function currently performed by some LPNs should be recognized in their scope of practice statement. The statement should not be a barrier to LPN advancement into leadership roles requiring higher levels of skill and responsibility.

### *“Primarily”*

Finally, to prevent an interpretation of the scope of practice statement that excludes other, secondary aspects of LPN practice, and consistent with the structure of the RN scope of practice statement (see Nurses (Registered) and Nurse Practitioners Regulation, B.C. Reg. 284/2008), the definition of practical nursing should be amended (as indicated above) to include the word “primarily.”



## RESTRICTED ACTIVITIES

The Ministry has proposed two lists of restricted activities that LPNs may perform while providing the services described in their scope of practice statement. We have fundamental concerns regarding this proposal. It is our position that revisions are warranted, following additional consultation and study.

### ***1. Restricted Activities that Do Not Require an Order***

The proposed list of restricted activities that LPNs may perform without an order does not accurately reflect the full scope of current LPN practice, education and training, and may be a barrier to the timely and effective performance of basic care activities undertaken to maintain the comfort and safety of patients and residents.

#### ***Wound care***

For example, the proposed list excludes wound care. Under the new regulation, LPNs would require an order to perform a procedure on tissue below the dermis or below the surface of the mucous membrane. Yet, as the Council heard from the College over a decade ago, “LPNs have had the prerequisite knowledge and skill to perform these procedures since at least 1984 at the entry level” (HPC, 2000). Indeed, the Council was told that “LPNs graduate with the knowledge, skill, ability and judgment to carry out” these and other physically invasive activities.

Wound care is covered in the provincial curriculum (BCAHC, 2011) and is included in the College’s baseline competencies for LPN practice (CLPNBC, 2009). Over half of HEU LPNs recently surveyed indicated that they currently perform wound care independently, without an order (HEU, 2012). HEU LPNs employed in LTC facilities advise that they commonly and independently provide wound and skin management care that would fall within the “procedure below the dermis” restricted activity (requiring an order) under the new Regulation.

Particularly in LTC settings, the need to perform wound care often arises unexpectedly, not having been covered by a pre-printed order. And not all of these situations are necessarily considered “emergencies” within the

meaning of the *Health Professions Act*. As a result, under the proposed new Regulation, an LPN may need to seek an order from another health professional (likely an RN or medical practitioner) before performing necessary wound care activities within her range of competencies. LPNs surveyed indicated that this new requirement will cause delay and could negatively impact the health and safety of residents. They also commented that requiring LPNs to obtain orders from RNs could cause friction between nurses; a concern that appears to be shared by health employers (see CLPNBC, May 2011; see also CLPNBC, April 2011).

Additionally, almost half of HEU LPNs surveyed indicated that requiring LPNs to obtain an order from an RN to perform wound care could create a need for employers to hire more RNs.<sup>3</sup> Moreover, over 50 percent agreed that the additional RNs hired would be employed to perform LPN duties. This would be an inefficient and ineffective step back for both nursing professions, and for the system as a whole.

### *Oxygen*

The above discussion of wound care is offered as a specific example to illustrate our general concerns regarding the proposed lists of restricted activities. A further case in point, among others, is the administration of oxygen.

The administration of oxygen is excluded from the proposed list of restricted activities that LPNs may perform without an order. Under the new Regulation, LPNs would require an order to administer a substance by inhalation. Yet, oxygen administration is covered in the provincial curriculum (BCAHC, 2011) and is included in the College's baseline competencies for LPN practice (CLPNBC, 2009).

Over 60 percent of HEU LPNs recently surveyed indicated that they currently administer oxygen independently, without an order. HEU LPNs employed in LTC facilities advise that they commonly and independently perform activities in relation to oxygen saturation, which would fall within the "administer a substance" restricted activity (requiring an order) under the new Regulation.

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<sup>3</sup> We note that the Ministry has, indeed, recently committed to hiring 2,125 new full-time RNs over the next four years (see British Columbia, 2012).

LPNs surveyed and interviewed commented that, in LTC settings, oxygen is sometimes administered in non-emergency situations. Depending on the facility, this activity may not be covered by a pre-printed order. In these instances, under the proposed new Regulation, an LPN would need to seek an order from another health professional (likely an RN or medical practitioner) before performing necessary oxygen administration activities within her range of competencies. Approximately 70 percent of LPNs surveyed indicated that this new requirement will have a negative impact on their practice. They also commented that the requirement will cause delay, and could negatively impact the care and comfort of residents.<sup>4</sup>

## ***2. Restricted Activities that Require an Order***

Our comments above similarly apply to the proposed list of restricted activities that LPNs may only perform with an order. The list does not accurately reflect the full scope of current LPN practice, education and training, and may be a barrier to the timely and effective performance of basic care activities undertaken to maintain the comfort and safety of patients and residents.

### ***Bowel care***

For example, the proposed list of restricted activities without an order includes putting an instrument, device or finger beyond the anal verge *for the purpose of assessment*, but not for the purposes of ameliorating or resolving a condition identified through the making of a practical nursing diagnosis. Activities beyond the anal verge for these purposes require an order. Yet, measures to maintain regular elimination are covered in the provincial curriculum (BCAHC, 2011) and are included in the College's baseline competencies for LPN practice (CLPNBC, 2009).

Indeed, in its submissions to the Council, CLPNBC argued that LPNs have the knowledge, skill, ability and judgment to carry out activities

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<sup>4</sup>We have heard the suggestion that, in practice under the proposed new Regulation, in the instances described, LPNs could administer oxygen immediately, and then subsequently obtain a covering order. This suggestion, however, raises additional concerns, in relation to the vulnerability of LPNs (professionally, and in their employment) asked to perform restricted activities without proper authorization, in the expectation, but with no assurance, that authority will be granted after the fact in the form of a covering order.

beyond the anal verge independently (HPC, 2000). And CLPNBC continues to take the view that bowel routines involving suppositories and enemas may be appropriate for independent practice (without an order) by LPNs (CLPNBC, April 2011).

HEU LPNs employed in LTC facilities advise that they commonly and independently carry out rectal disimpactions – an activity not covered in their pre-printed orders. Under the proposed new Regulation, however, before carrying out a disimpaction, an LPN would need to take the time to first seek out an order from another health professional (likely an RN or medical practitioner), thus impairing the LPN’s ability to assist and improve the comfort of a constipated resident.

### ***3. Moving Forward***

Not only are the lists of restricted activities in the proposed new Regulation inconsistent with the full scope of current LPN practice and the present range of LPN competencies, but they also reflect a rigid and static regulatory regime, lacking a vision and framework for broader and more effective LPN utilization through specialized education and advanced skill development.

As the Council noted in 2001, a profession’s entry-level program of education and training does not always encompass the full range of services actually provided by many members of the profession. Rather, the ability to perform certain restricted activities may be “developed through post-basic training and education programs” (HPC, 2001).

This approach is reflected in Alberta’s regulatory framework for LPN practice, which provides for three levels of authorization for the performance of restricted activities (see Licensed Practical Nurses Professional Regulation, Alta. Reg. 81/2003):

1. “Basic” restricted activities are covered in Alberta’s entry-level LPN program. All LPNs are authorized to perform these activities.
2. “Additional” restricted activities may be performed by LPNs who have acquired the necessary competencies through work experience, on-the-job education and training, or post-basic education.

3. “Specialized” restricted activities may be performed by LPNs who have acquired the necessary competencies through advanced education recognized by the College of Licensed Practical Nurses of Alberta.<sup>5</sup>

Likewise, Manitoba’s LPN regulation allows for registration as an “advanced” LPN (see Licensed Practical Nurses Regulation, Man. Reg. 27/2002). These are LPNs who have acquired advanced practical nursing knowledge and competency (in satisfaction of criteria established by the College of Licensed Practical Nurses of Manitoba) through an education or training program, and, as a result, are authorized to practice in one or more specialized areas.

We note that, in a similar way, the regulation governing the RN profession in BC provides for “certified practices” that RNs can carry out only after they have completed a certification program approved by the College of Registered Nurses of British Columbia (CRNBC). This allows an individual RN to work to a fuller scope of practice, within the range of competencies developed through her education and training. Notably, certification allows RNs to carry out some restricted activities independently that would otherwise require an order (CRNBC, 2010).

We urge the Ministry to review the regulatory regimes for LPNs in Alberta and Manitoba, as well as its own regime for RNs, and to adopt a similar approach through revisions to the proposed new Regulation. We note that the inclusion in the Regulation of provisions like those in the RN regulation may be particularly important for remote communities and smaller LTC facilities, where there are no resident health professionals authorized to give orders to LPNs, but where these types of health professionals visit the community or facility periodically and are available to consult with the LPNs as needed.

Ultimately, the new Regulation should reflect the “important fact” that “not all members of a profession are necessarily competent to perform all of the [restricted activities] assigned to the profession” (HPC, 2001). Accordingly, we recommend that the Regulation be revised to provide

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<sup>5</sup> Under Alberta’s LPN regulation, these authorizations are subject to the LPN’s individual competence. The regulation also restricts an LPN to performing restricted activities that are appropriate to her area of practice and the specific procedures being performed.

a more flexible, progressive and forward-looking framework for LPN practice. It will then, appropriately, be up to the College, in consultation with LPNs, to define the applicable standards, limits and conditions of practice, including the education, training and competencies required for the performance of each of the restricted activities granted to the profession (see HPC, 2001).

# RESTRICTED ACTIVITIES





## CONCLUSION

With the necessary revisions, we have no doubt that the new Regulation can move the LPN profession in BC forward significantly. But further review and discussion are required. As the College stated in acknowledging the limitations of its recent consultation process, “unless a widespread consultation occurs, all restricted activities carried out by LPNs in B.C. may not be identified, and clarity on the degree of independence is not possible” (CLPNBC, 2011).

The objectives of safe, effective, efficient and accessible care will not be fully realized under the proposed new Regulation, as it is currently drafted. The Regulation does not grant LPNs the level of independence that they have earned, it does not promote the skill development and post-basic education that LPNs seek, and it does not allow for the full and effective utilization of LPNs that our health care system needs. This is not only problematic for LPNs, themselves, but also for health authorities and health employers, who “are actively seeking opportunities to improve the utilization of all health care personnel, including Licensed Practical Nurses” (FBAJPC, 2008). Moreover, the deficiencies in the Regulation, and its apparent inconsistency with other provincial regimes, pose potential interjurisdictional issues, for BC LPNs seeking employment in other provinces, for employers concerned with the interprovincial mobility of their employees, and for regulatory bodies charged with the governance of LPN practice in their respective jurisdictions.

We hope that the Ministry will consider our comments and recommendations. We would welcome the opportunity to work with the Ministry and the College on revisions to the proposed new Regulation.

CONCLUSION



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