Pages 1 through 2 redacted for the following reasons:
- -
Not Responsive

van den Broek, Jude HLTH:EX

From: Elaine Baxter [ebaxter@clpnbc.org]
Sent: Wednesday, October 5, 2011 3:09 PM
To: mwaldie@clpnbc.org
Cc: McLachlan, Debbie HLTH:EX; Stewart, Sharon A HLTH:EX
Subject: CLPNBC Update to Chief Nursing Officers
Attachments: Update CNOs - Practice FINAL Oct.05.11.doc

Megan – please forward this to the CNO group on my behalf.

Hello CNO group – attached is an update that was shared recently with our Board and I have updated with more recent information about Education and Immunization.

Regards,
Elaine

Elaine Baxter
Director, Practice & Policy, CLPNBC
Office: 1-778-373-3112
Toll free: 1-877-373-2201 (BC only)

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College of Licensed Practical Nurses of BC

Update to Chief Nursing Officers
Department of Practice

Date: October 5, 2011
Prepared by: E. Baxter (Director, Practice & Policy)

The Department of Practice update is divided into five sections:

1. Practice Support
2. Education (and the new Provincial PN Curriculum)
3. Immunization
4. Regulations & Restricted Activities Project
5. Quality Assurance

1.0 Practice Support

In June, Bev Kordi joined the College in the Nursing Practice Advisor (NPA) "in-office" role. In collaboration with Janice Harvey (Nursing Practice Consultant), Bev responds to inquiries from registrants, and is beginning to take on other projects related to the Quality Assurance (QA) work of the department.

There are two new regional NPAs in the department, bringing the total to four. Further expansion is being considered for early 2012.

- Northern Health Authority – Tammi Guimond (new) started on August 22/11.
- Vancouver Island Health Authority – Shelley Trimblett has returned to work in the regional role as of August 29/11.
- Interior Health Authority – Denice Evanishin (east/south/Kootenays) and Tracy Patenaude (west/north/Okanagan). Both Tracy and Denice are working with individual projects in addition to responding to registrant inquiries. The NPA tour (previously call "road trip") to a variety of sites in the Interior Health Authority (Kootenay region) in May was very well received, and another was recently completed in the western region. The goal of the tours is to establish further contacts in the area and to orient the other NPAs to the activities surrounding planning a tour. Denice also attended two skills fairs (Salmon Arm and Williams Lake); CLPNBC board member, Muriel Overton, joined her at the Williams Lake event.

2.0 Education (and the new Provincial PN Curriculum)

The Ministry of Advanced Education assigned responsibility and funding for the development of a new Practical Nurse Provincial Curriculum to the BC Academic Health Council (BCAHC) in January 2011. Under the stewardship of the BCAHC, the Project Steering Committee was charged with oversight of the curriculum development process and approval of the new curriculum. The Practical Nurse Education Project Steering Committee formally approved the new Generic Practical Nursing (PN) Curriculum in B.C. in July 2011.

The CLPNBC Board of Directors has passed a resolution that, as of January 1, 2012, the new Provincial Practical Nurse Curriculum (July 2011) will be the only curriculum recognized for Practical Nurse education in B.C. Accordingly, pursuant to the authority conferred on the CLPNBC—under the *Health Professions Act*, RSBC 1996, c.183, s. 19, and the College Bylaws—to recognize PN programs, the CLPNBC will only grant program recognition to those educational institutions that adhere to the Provincial PN Curriculum. *Note: The moratorium on recognition of any new educational programs (private and public) based on the OLD curriculum for practical nurses (pursuant to Schedule B of the CLPNBC Bylaws) will continue.*

The College is beginning the process of formal recognition of educational programs (private and public) based on the **new** Generic PN Curriculum (Provincial Practical Nurse Curriculum - July 2011).

Recognition of programs must be completed by June 30, 2012, after which time educational programs running under the **old** curriculum will cease to be recognized and program graduates will be ineligible to obtain licensure with the CLPNBC.

Information is being posted to the website and sent regularly to the PN program leaders and Clinical Education Leaders in the Health Authorities. The Standards of Education Committee has been involved in the plans for curriculum changes, and will be reviewing the draft framework for the PN Education Program Recognition (PNEPR) process within the next month.

3.0 Immunization

Current statistics for the program are:

720 – Total registration since Nov.30.10
181 – Completed Online Course & Skills Competency Workshop (Certificate Received)
51 -- Passed Online Course – still required to complete Skills Competency Workshop
424 – Withdrawn, Un-enrolled or Removed

Of the 424 that were either un-enrolled, removed or withdrew, 87 had already passed the Online Course but did not take the Skills Competency Workshop. Of those 87, 56 were over 6 months since passing online course and 18 indicated that it was just too expensive. Other reasons from that group of 87 include: pregnancy, now working out of province, decided not to take workshop, taking the RN program, and a few other reasons.

An evaluation of the Immunization Competency Workshop has been completed and has been discussed with the British Columbia Centre for Disease Control (BCCDC) and the Ministry of Health (MOH). It has been decided that a program more specific to LPNs be developed, and we are now working with the person who developed the existing BCCDC Online immunization course to revise the content. As well, we are considering other options for re-certification of LPNs who have been actively immunizing over the past three years. We will provide more information about these initiatives as soon as it is available.

4.0 Regulations & Restricted Activities Project

The College is waiting for the "posting" of the revised regulation by the Ministry of Health before formal consultations with key groups of registrants, employers, unions, and other regulatory organizations can begin. We continue to with staff at the MOH and keep them updated on additional findings as we work through this exciting project.

5.0 Quality Assurance

The Quality Assurance Committee (QAC) has met twice over the summer and is overseeing two projects to gain more information about particular groups of registrants:

- Unemployed & underemployed LPNs,
- Self-employed LPNs

The Continuing Competence project is ongoing. In addition, the staff is preparing a briefing note about the potential of implementing "required hours of practice".

Finally, in 2012 the QAC will oversee the three-year review/revision of the CLPNBC document entitled "Baseline Competencies for Licensed Practical Nurses' Professional Practice (2009)". The QAC will also oversee the next document revisions due in 2013 which are the "Standards of Practice (2010)" and the "Practice Guidelines (2010)".

van den Broek, Jude HLTH:EX

From: Stewart, Sharon A HLTH:EX
Sent: Wednesday, August 17, 2011 11:09 AM
To: 'Elaine Baxter'
Cc: 'Pamela Gole'; Beckett, Daryl K HLTH:EX
Subject: RE: Information for CLPNBC Website
Attachments: Paragraph for website PG.D3.Aug.16.11 EBrevPGrev.docx

Hi Elaine – I've looked at this and then forwarded to Daryl for review/comment. See attached for revisions

Thanks!

Sharon

Sharon Stewart
Executive Director, Health Human Resources Planning
Ministry of Health
Phone: (250)952-3656 Fax (250)952-2125
Cell: (250)216-9748
email: Sharon.Stewart@gov.bc.ca

From: Elaine Baxter [mailto:ebaxter@clpnbc.org]
Sent: Wednesday, August 17, 2011 8:58 AM
To: Stewart, Sharon A HLTH:EX
Cc: Pamela Gole
Subject: Information for CLPNBC Website

Hello Sharon – I am attaching the information we are planning to post on our website and send to all registrants later this week. Pam Gole (our communications consultant) has worked with me on this.

If you have a chance today, would you please review this and let me know if you have any through or revisions.

Regards,
Elaine

Elaine Baxter
Director, Practice & Policy, CLPNBC
Office: 1-778-373-3112
Toll free: 1-877-373-2201 (BC only)

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Upcoming Changes to LPN Practice in B.C.
CLPNBC Update - August 19, 2011

Many of you have heard that the face of healthcare for LPNs in BC is changing. The vital role that an LPN plays on a patient's health management team will become clearer and stronger when, as anticipated, the Ministry of Health releases proposed amendments to the ~~new~~ Nurses (Licensed Practical) Regulation under the *Health Professions Act.*

The CLPNBC is concerned in that information about these changes has been published recently by other organizations, which is incorrect and misleading to LPNs. As the sole LPN regulatory body in British Columbia, the CLPNBC's mandate is protection of the public. We do this by ensuring that our 11,000 registrants have accurate and timely information about their roles and responsibilities in order to ensure safe, competent and ethical nursing practice for the public.

The CLPNBC has been in preliminary discussions with the Ministry of Health regarding possible changes to the regulations and standards ~~for~~ governing LPNs practice. It is the role of the ~~Ministry of Health~~ Minister to ~~write~~ make the regulations which describe the LPN scope of practice, and the role of the CLPNBC to develop the practice standards, limits and conditions that flow from the regulations and the new shared scope of practice/restricted activity model.

We are hopeful that the Ministry of Health will post ~~a revised~~ proposed amendments to the regulations ~~by~~ for public comment during the Fall of 2011. The CLPNBC will be holding extensive consultation with LPNs and key stakeholders to work through this process effectively. It would be premature to speculate about the specifics of the final version of the regulations. We want LPNs to have the right information, and in a timely manner.

Also anticipated in the Fall 2011 is the revised Practical Nurse Curriculum. The Ministry of Advanced Education and the Ministry of Health have not yet signed off on the new Practical Nursing education program curriculum guide, so right now schools aren't able to provide prospective students with information about the new program, how they will deliver it, the exact differences between the current and future program, etc.

(Potential) students should stay in touch with their school to learn more about the new PN program as information becomes available.

Once information has been provided to CLPNBC by the government on both the ~~new~~ proposed changes to the regulations and the revised PN Curriculum, we will also post it on our website, in the College Connection newsletter and via a bulletin to registrants and stakeholders, but not until that information is made publicly available.

In the meantime, please contact Janice Harvey, Nurse Practice Adviser in the CLPNBC Practice Department at jharvey@clpnbc.org with any questions about these upcoming changes.

van den Broek, Jude HLTH:EX

From: Elaine Baxter [ebaxter@clpnbc.org]
Sent: Wednesday, August 24, 2011 1:11 PM
To: Stewart, Sharon A HLTH:EX
Subject: FW: CLPNBC - E-Mail Blast Friday, August 19

FYI

Elaine Baxter
Director, Practice & Policy, CLPNBC
Office: 1-778-373-3112

From: Executive Director
Sent: Friday, August 19, 2011 5:41 PM
To: Julie Nielsen
Subject: Upcoming Changes to LPN Regulation & PN Curriculum - Important Information from your Regulatory Authority

Important Information from the CLPNBC - Please Read
(do not 'unsubscribe' to this important message)

College of Licensed Practical Nurses of BC

Upcoming Changes to LPN Regulation & PN Curriculum

Many of you have heard that the face of healthcare for LPNs in B.C. is changing. The vital role that an LPN plays on a patient's health-management team will become clearer and stronger when, as anticipated, the Ministry of Health (MOH) releases proposed amendments to the Nurses (Licensed Practical) Regulation under the *Health Professions Act.*

The CLPNBC is concerned that incorrect information about these changes, which is misleading to LPNs, has been published recently by other organizations. As the sole LPN regulatory body in British Columbia, the CLPNBC's mandate is protection of the public. We achieve this by ensuring that our 11,000 registrants have accurate and timely information about their roles and responsibilities in order to ensure safe, competent, and ethical nursing practice for the public.

The CLPNBC has been in preliminary discussions with the MOH regarding possible changes to the regulations and standards governing LPN practice. It is the role of the Minister to make the regulations, which describe the LPN scope of practice, and the role of the CLPNBC to develop the practice standards, limits, and conditions that flow from the regulations and the new shared scope of practice/restricted activity model.

We are hopeful that the MOH will post proposed amendments to the regulations for public comment during the Fall of 2011. The CLPNBC will be holding extensive consultation with LPNs and key stakeholders to work through this process effectively. It would be premature to speculate about the specifics of the final version of the regulations. We want LPNs to have the right information, and in a timely manner.

We also anticipate delivery of the revised Practical Nurse Curriculum in the Fall of 2011. The Ministry of Advanced Education and the Ministry of Health have not yet signed off on the new Practical Nursing education program curriculum guide. So, right now, schools aren't able to provide prospective students with information about the new program, how they will deliver it, and

the exact differences between the current and future program, etc.

Prospective students should stay in touch with their schools to learn more about the new PN program as information becomes available.

Once information has been provided to the CLPNBC by the government on both the proposed changes to the regulations and the revised PN Curriculum, we will also post it on our website, in the *College Connection* newsletter, and via a bulletin to registrants and stakeholders. However, this will not happen until that information is made publicly available.

In the meantime, please contact Janice Harvey, Nursing Consultant – Practice and Quality Assurance in the CLPNBC Practice Department, at jharvey@clpnbc.org, with any questions about these upcoming changes.

Patricia McDonald
Executive Director/Registrar
College of LPNs of BC

This message was sent to jnielsen@clpnbc.org from:

clpnbc | 260-3480 Gilmore Way | Burnaby, BC V5G 4Y1, Canada

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van den Broek, Jude HLTH:EX

From: Stewart, Sharon A HLTH:EX
Sent: Tuesday, August 30, 2011 6:21 PM
To: McLachlan, Debbie HLTH:EX
Subject: RE: rough draft for email response to S. 22

Hi – have made some suggestions. We should also give Elaine the chance to take a quick look at the final version before sending this out

From: McLachlan, Debbie HLTH:EX
Sent: Tuesday, August 30, 2011 3:46 PM
To: Stewart, Sharon A HLTH:EX
Subject: rough draft for email response to S. 22

Thoughts?

Hello S. 22

Thank you for email. I have beer S22 so just getting around to responding to folks.

As you reference in your email, there is a lot of activity in the system that can create some confusion - including discussions happening around the development of the new practical nurse curriculum and the pending amendments to the Nurses (Licensed Practical) Regulation. Let me assure you, however, that it is CLPNBC's responsibility to ensure that its registrants receive correct information regarding LPN practice, or activities that may impact practice, including clarifying information that could be construed as incorrect or misleading. This responsibility includes providing timely, accurate messaging regarding impending changes to their registrants' practice and ability for new graduates to register (which includes changes to entry to practice education, regulatory changes and process for practical nursing education program recognition). I think it is fair to say that we all share CLPNBC's concern that LPNs receive correct information regarding changes that impact LPN practice. To maintain consistency, CLPNBC provides this information to interested organizations when they inquire.

Also, I want to assure you that the College has a solid working relationship with Government. Before the dissemination of messaging (whether it is regarding the PN curriculum and pending regulatory amendments, or advising of changes to standards, limits and conditions) to their registrants, CLPNBC consults with the Ministry of Health (and Advanced Education, when applicable), as they did prior to their recent August 18th communication.

In regards to concerns you have raised regarding the College's relationship with the BCNU, these should be raised directly with the colleges. As a regulatory body, the college has an accountability to address stakeholder questions or concerns – whether the stake holder is a union, another college or professional body, or one of their members.

Debbie McLachlan RN, BSN, MN
Director
Health Human Resource Planning
BC Ministry of Health
2-1 1515 Blanshard Street
Victoria BC V8W 3C8

Tel: (250) 952-2803
Debbie.McLachlan@gov.bc.ca

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PROVINCE OF BRITISH COLUMBIA

REGULATION OF THE MINISTER OF HEALTH

Health Professions Act

Ministerial Order No. M 024

I, Michael de Jong, Minister of Health, order that, effective March 1, 2012, the Nurses (Licensed Practical) Regulation, B.C. Reg. 283/2008, is amended

(a) in section 1 by adding the following definition:

"nurse practitioner" means a person who is authorized under the bylaws of the College of Registered Nurses of British Columbia to practise nursing as a nurse practitioner; *, and*

(b) in section 5 by adding "or nurse practitioner" *after* "medical practitioner" *wherever it appears.*

DEPOSITED

February 13, 2012

B.C. REG. 20/2012

Feb. 8, 2012
Date

Minister of Health

(This part is for administrative purposes only and is not part of the Order.)

Authority under which Order is made:

Act and section: *Health Professions Act*, R.S.B.C. 1996, c. 183, s. 12

Other: MO 243/2008

December 16, 2011

R/743/2011/48

Not Responsive

From: McLachlan, Debbie HLTH:EX
Sent: Friday, October 21, 2011 12:26 PM
To: 'Elaine Baxter'
Cc: Stewart, Sharon A HLTH:EX
Subject: RE: proposed amendment to the LPN Regulation re: accepting orders from nurse practitioners

Hi Elaine,

I understand your concerns related to this amendment. It was anticipated that there would be some apprehension raised regarding the amendment versus posting new regulations. The Ministry is still committed to updating the LPN regulations, but this is a minor amendment that will ensure that LPNs can work effectively with NPs until the new regulations can be drafted and posted. As you are well aware, given the degree of consultation that will be required for the LPN revision, the amendment provides a timely alternative to addressing a practice barrier, allowing LPNS and NPs to work together to meet patient needs. As I mentioned previously, this is aligned with work within the ministry related to NP practice that only allowed a small window of opportunity from a timing perspective.

In the future I will, however, when given approval internally, ensure that the college's practice department is made aware of any impending notice.

Regards,

D

Debbie McLachlan RN, BSN, MN
Director
Health Human Resource Planning

BC Ministry of Health
2-1 1515 Blanshard Street
Victoria BC V8W 3C8
Tel: (250) 952-2803
Debbie.McLachlan@gov.bc.ca

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From: Elaine Baxter [mailto:ebaxter@clpnbc.org]
Sent: Friday, October 21, 2011 7:29 AM
To: McLachlan, Debbie HLTH:EX
Cc: Patricia.McDonald@mail10c0.megamailservers.com
Subject: FW: proposed amendment to the LPN Regulation re: accepting orders from nurse practitioners

Debbie – I have clarified with Pat that you & Sharon mentioned the change to her on Friday, Oct 14. Unfortunately, she only made minor mention of it to me with no e-mail or timing notes, and is was just lost in the rest of the conversation. That is definitely an internal "dropping of the ball". So the Practice Dept was unaware of the impending notice.

However, I am sending you this e-mail to let you know the preparation that should have been done if we had known the amendment was even being discussed ...preferably a few weeks ago:

- Meeting with CRNBC to develop a draft SLC that would provide guidance to LPNs and NPs
- Planning for communication to registrants and key stakeholders as to the change and subsequent document(s) for further direction.
- Update on the website to explain (if we could) why the amendment occurred but the revised regulation is still pending.

Although the change is welcomed and was requested in our Phase 1 Report, I don't understand how it came out ahead of the major revision. After meeting with CRNBC yesterday, we have identified a specific issue with the wording and will have a letter to you formally early next week.

Regards,
Elaine

Elaine Baxter
Director, Practice & Policy, CLPNBC
Office: 1-778-373-3112

From: Elaine Baxter
Sent: October-21-11 7:18 AM
To: 'Thorsteinsson, Pamela'; 'Carina Herman'
Cc: Patricia McDonald; Janice Harvey (jharvey@clpnbc.org); Jo Wearing
Subject: RE: proposed amendment to the LPN Regulation re: accepting orders from nurse practitioners

s. 22

Pamela – thanks for your feedback on the meeting ...it was a good discussion.

As you know we had been talking regularly with the Ministry of Health about revising the *Nurse (Licensed Practical) Regulation* and were not aware that this amendment was underway until just a few days before it was posted. Therefore, there had been no discussion with CRNBC about the impact.

We have now met with the appropriate people and will advise you of the next steps as soon as we have worked out the process.

Regards,

van den Broek, Jude HLTH:EX

From: McLachlan, Debbie HLTH:EX
Sent: Wednesday, March 28, 2012 1:34 PM
To: van den Broek, Jude HLTH:EX
Cc: Bracewell, Barb HLTH:EX
Subject: FW: Regulation - ? Teleconference

0058

Debbie McLachlan RN, BSN, MN
Director
Health Human Resource Planning
BC Ministry of Health
2-1 1515 Blanshard Street
Victoria BC V8W 3C8
Tel: (250) 952-2803
Debbie.McLachlan@gov.bc.ca

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From: McLachlan, Debbie HLTH:EX
Sent: Wednesday, June 15, 2011 4:09 PM
To: 'Elaine Baxter'; Stewart, Sharon A HLTH:EX
Cc: 'mwaldie@clpnbc.org'; Ranger, Katelyn HLTH:EX
Subject: RE: Regulation - ? Teleconference

Hi Elaine:

It was a great conference and everyone was thoroughly enjoying themselves. I met some very passionate LPNs and educators.

As for a meeting, yes...in fact Sharon and I met with Daryl Beckett yesterday to discuss next steps - roles and responsibilities with the process and initial dialogue around the CNO feedback on the assumptions. Sharon and I discussed setting up a telephone chat with you folks next week, so your suggestion is timely.

If Megan could connect with Katelyn to arrange a 1 hour telephone meeting that would be great.

Talk to you soon.

D

Debbie McLachlan RN, BSN, MN
Director
Health Human Resource Planning
BC Ministry of Health
2-1 1515 Blanshard Street
Victoria BC V8W 3C8
Tel: (250) 952-2803
Debbie.McLachlan@gov.bc.ca

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From: Elaine Baxter [mailto:ebaxter@clpnbc.org]
Sent: Wednesday, June 15, 2011 3:52 PM
To: McLachlan, Debbie HLTH:EX; Stewart, Sharon A HLTH:EX
Cc: mwaldie@clpnbc.org
Subject: Regulation - ? Teleconference

Debbie and Sharon – I am wondering if we need to arrange a call to discuss next steps. Sorry I did not get a chance to talk with you at the Conference last Friday Debbie, it was a little busy for me at the front. Janice told me that she spoke to you.

If you would like Megan to coordinate a time, just let her know and she will collect Janice, Jo, Pat and me.

Regards,
Elaine

Elaine Baxter
Director, Practice & Policy, CLPNBC
Office: 1-778-373-3112
Toll free: 1-877-373-2201 (BC only)

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Elaine

Elaine Baxter
Director, Practice & Policy, CLPNBC)
Office: 1-778-373-3112

From: Thorsteinsson, Pamela [mailto:Pamela.Thorsteinsson@fraserhealth.ca]
Sent: October-20-11 9:56 AM
To: Elaine Baxter; 'Carina Herman'
Cc: Dickson, Anita; Samra, Maneet; Peck, Sue
Subject: proposed amendment to the LPN Regulation re: accepting orders from nurse practitioners

Hi Elaine and Carina,

I see that the proposed amendment to the LPN Regulation allowing LPNs to accept orders from NPs has now been posted (http://www.health.gov.bc.ca/professional-regulation/pdfs/proposed-amendment-lpn-reg-oct-18-2011.pdf) with feedback timeline shortened to Nov 1st. This is great news and will certainly enhance timely access to care for our patients.

Would you be able to advise re: your respective anticipated "next steps" to support and inform your registrants (e.g. will there be CRNBC and CLPNBC practice standards established), and related prospective timelines so we can sequence our dominos re: employer policy and communications accordingly?

Thanks again for the excellent updates and discussion at our joint-nursing regulatory college meeting on Tuesday.

Kind regards,

Pamela

Pamela Thorsteinsson, RN, BSN, MHS
Director, Professional Practice - Nursing

Professional Practice & Integration
FRASER HEALTH
Ph: 604.953.5112, Loc 769594
BB: 604.897.5307
Fax: 604.953.5137

Not Responsive

From: McLachlan, Debbie HLTH:EX
Sent: Tuesday, May 31, 2011 3:46 PM
To: 'Elaine Baxter'
Subject: RE: Assumption document

Great, thanks

Debbie McLachlan RN, BSN, MN
Director
Health Human Resource Planning
BC Ministry of Health
2-1 1515 Blanshard Street
Victoria BC V8W 3C8
Tel: (250) 952-2803
Debbie.McLachlan@gov.bc.ca

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From: Elaine Baxter [mailto:ebaxter@clpnbc.org]
Sent: Tuesday, May 31, 2011 3:41 PM
To: McLachlan, Debbie HLTH:EX
Subject: RE: Assumption document

Hi Debbie – nothing yet. I will be sending them an update this week on a variety of items (as I do with the Board) ...so I will thank them for the discussion and request comments when able.
Elaine

Elaine Baxter
Director, Practice & Policy, CLPNBC
Office: 1-778-373-3112

From: McLachlan, Debbie HLTH:EX [mailto:Debbie.McLachlan@gov.bc.ca]
Sent: May-31-11 12:09 PM
To: Elaine Baxter
Subject: Assumption document

Hi Elaine:

Have you received feedback from the CNOs around the assumption document?

D

Debbie McLachlan RN, BSN, MN
Director
Health Human Resource Planning
BC Ministry of Health
2-1 1515 Blanshard Street
Victoria BC V8W 3C8
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Not Responsive

From: McLachlan, Debbie HLTH:EX
Sent: Thursday, January 27, 2011 4:11 PM
To: 'Elaine Baxter'
Subject: RE: Teleconference Friday, January 28, 2011 @ 1100 hours

Thanks Elaine:

I will definitely be calling in...not sure about Sharon.

Debbie McLachlan RN, BSN, MN
Director
Health Human Resource Planning
BC Ministry of Health Services
2-1 1515 Blanshard Street
Victoria BC V8W 3C8
Tel: (250) 952-2803
Debbie.McLachlan@gov.bc.ca

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From: Elaine Baxter [mailto:ebaxter@clpnbc.org]
Sent: Thursday, January 27, 2011 4:07 PM
To: Elaine Baxter; McLachlan, Debbie HLTH:EX; Stewart, Sharon A HLTH:EX
Cc: Patricia McDonald; XT:HLTH Harvey, Janice;
Subject: RE: Teleconference Friday, January 28, 2011 @ 1100 hours
Importance: High

S. 22

Hi all – just rechecked the time with Janice and it is 1000 hour (10:00 AM) BC time....it was showing S. 22 on my calendar ....sorry. We will call the teleconference line at 1000.
Elaine

From: Elaine Baxter
Sent: January-27-11 11:49 AM
To: Debbie.McLachlan@gov.bc.ca; Sharon Stewart (Sharon.Stewart@gov.bc.ca)
Cc: Patricia McDonald; Janice Harvey
Subject: Teleconference Friday, January 28, 2011 @ 1100 hours
Importance: High

Hi Debbie and Sharon – I am not sure who is on the call from your end but Pat is calling in from outside the office so I will suggest that we use our teleconference line
Elaine

Date: Friday, January 28, 2011
Time: 1000 hours *Correction*

Teleconference line: S15, S17
Pass code
Moderator (EB)

Here was the preliminary "agenda" that I sent with a few updates.....we can add to it as needed.

Immunization – SLC beyond the current one. I would like to update you on where we are at with this project
- Number of LPNs registered and completed the online course

Education – we just sent out the moratorium info
- I am wondering where the process is at for the new provincial curriculum ...have not heard anything lately. Of particular interest is when/how the Blueprint 2012-16 will be incorporated.

Regulations and Restricted Activities
- Janice and Jo met with the CNOs on January 21 to brief them on the project – they expressed concern re: lack of HHR plan and also about the overall regulatory framework. (we will provide more info by phone.
- Letter from CRNBC and BCNU (attached for your info)

Outstanding question....how can we handle the SLC and other work if the RNs cannot "direct" or "give orders" to the LPNs....this is an issue for the Health Authorities and we should definitely discuss this.

Elaine Baxter
Senior Practice Consultant, CLPNBC
Office: 1-778-373-3112
Toll free: 1-877-373-2201 (BC only)

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Not Responsive

From: McLachlan, Debbie HLTH:EX
Sent: Tuesday, November 23, 2010 12:19 PM
To: 'Elaine Baxter'
Cc: 'Jo Wearing'; XT:HLTH Harvey, Janice; 'Patricia McDonald'; Beckett, Daryl K HLTH:EX
Subject: RE: Draft Assumptions re: Regulations for LPNs

Hi:

Lori and I will call you on Thursday at 9am regarding the education recognition process issue. As for the draft assumptions around regulations...will have to arrange another call/dependent on Daryl's availability

S 15 , S 17

Is it ok for Thursday's call to use Teleconference line: S 15, S 17
Pass code
as planned for last week?

D

Debbie McLachlan RN, BSN, MN
Director
Health Human Resource Planning
BC Ministry of Health Services
2-1 1515 Blanshard Street
Victoria BC V8W 3C8
Tel: (250) 952-2803
Debbie.McLachlan@gov.bc.ca

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From: Elaine Baxter [mailto:ebaxter@clpnbc.org]
Sent: Tuesday, November 23, 2010 12:08 PM
To: McLachlan, Debbie HLTH:EX; Beckett, Daryl K HLTH:EX
Cc: Jo Wearing; XT:HLTH Harvey, Janice; Patricia McDonald
Subject: Draft Assumptions re: Regulations for LPNs

Debbie and Daryl – these are the draft assumptions that Janice and Jo have drafted for use as we work through the process. We would like to talk with you about these before we proceed through the consultations ....so if the Wednesday or Thursday times work for you this week, perhaps we can include this topic as well as the education recognition process

Regards,
Elaine

Elaine Baxter
Senior Practice Consultant, CLPNBC
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From: Elaine Baxter [mailto:ebaxter@clpnbc.org]
Sent: Thursday, October 27, 2011 3:48 PM
To: McLachlan, Debbie HLTH:EX
Subject: FW: Proposed Amendment to Nurses (Licensed Practical) Regulation

Debbie – I know you received this from Pat ....I wanted to provide a little more information related to the process of informing our registrants when the time is clear.

Because we are anticipating a revised Regulation soon and will be doing extensive consultations & education with LPNs on the new regulatory system, we will not be developing an educational initiative solely to this proposed change. If the proposed regulatory change is passed by government, CLPNBC will duly notify registrants that LPNs can now take orders from both exam-qualified nurse practitioners and medical practitioners. This will be done via website notice, e-mail, and newsletter

I would like to schedule a call with you next week to update on the PNEPR ....what does Wednesday look like for you?
Elaine

Elaine Baxter
Director, Practice & Policy, CLPNBC
Office: 1-778-373-3112

From: Megan Waldie
Sent: October-26-11 4:07 PM
To: Professional Regulation Matters (PROREGADMIN@gov.bc.ca)
Cc: Sharon Stewart (Sharon.Stewart@gov.bc.ca); Debbie.McLachlan@gov.bc.ca; hlow@fasken.com; blizzard@crnbc.ca; shaw@crnbc.ca; brunke@crnbc.ca
Subject: Proposed Amendment to Nurses (Licensed Practical) Regulation

Please find attached letter on behalf of Pat McDonald

Regards,
Megan Waldie

College of Licensed Practical Nurses of B.C.
260-3480 Gilmore Way
Burnaby BC, V5G 4Y1
Tel: 778-373-3101 Ext. 4141
Email: mwaldie@clpnbc.org

SAVE A TREE; ONLINE RENEWAL FOR 2012 IS OPEN AND AVAILABLE AT http://www.clpnbc.org/index.php?dbg=36

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ensuring safe, competent and ethical nursing practice

October 25, 2011

Daryl K. Beckett, J.D.
Director, Professional Regulation
Legislation and Professional Regulation
Ministry of Health

EMAIL: PROREGAMIN@gov.bc.ca

Dear Mr. Daryl Beckett:

Re: Proposed Amendment to *Nurses (Licensed Practical) Regulation*

I am writing to provide comment from the College of Licensed Practical Nurses of British Columbia (CLPNBC) on the proposed amendment to the *Nurses (Licensed Practical) Regulation* posted on the government website on October 18, 2011. CLPNBC was advised of this amendment on October 14, 2011 but prior to that, there had been no discussion between the government, CLPNBC, and the College of Registered Nurses of British Columbia (CRNBC) regarding the implications of this proposed amendment.

Since the posting, CLPNBC staff has met with CRNBC staff to discuss the implications of this proposed amendment. The CLPNBC is concerned that the draft amendment does not distinguish the different authorities for nurse practitioners set by the CRNBC through standards, limits and conditions. Our understanding of the other nursing bodies rules is that only the "examination qualified" nurse practitioner is permitted to independently assume the authorities set out in Section 9 of the *Nurses (Registered) and Nurse Practitioner Regulation*, BC Reg. 284/2008.

Licensed Practical Nurses (LPNs) are not yet familiar with the restricted activities system and the concept of orders as defined under the *Nurses (Registered) and Nurse Practitioner Regulation.* As well, it is complex and confusing to explain the differences between the exam-qualified nurse practitioner, the nurse practitioner who practices under supervision of a physician or an exam-qualified nurse practitioner, and the existing regulation for LPNs to practice under the supervision of a registered nurse who is providing services to the patient.

CLPNBC believes that on a proper reading of the CRNBC's RN Regulations and its standards, limits and conditions, only examination-qualified nurse practitioners should be authorized to give orders to LPNs at this time and have discussed this with our CRNBC colleagues and they agree. If the government has concerns with this approach, we would be pleased to discuss this issue further with CRNBC and government. If not, the CLPNBC would request an amendment to the proposed LPN Regulation in order to clarify the Regulation and to restrict the nurse practitioner from whom a LPN may take an order to the "examination qualified nurse practitioner".

If the proposed regulatory change is passed by government, with or without an amendment to the currently posted language, CLPNBC will duly notify registrants that LPNs can now take orders from both exam- qualified nurse practitioners and medical practitioners.

Regards,

Pat McDonald
Executive Director

cc. S. Stewart, Ministry of Health
D. McLachlan, Ministry of Health
H. Low, Fasken Martineau DuMoulin LLP
K. Blizzard, College of Registered Nurses of BC
M. Shaw, College of Registered Nurses of BC
L. Brunke, College of Registered Nurses of BC

PM:mw

Not Responsive

From: Elaine Baxter [mailto:ebaxter@clpnbc.org]
Sent: Tuesday, August 16, 2011 2:16 PM
To: Stewart, Sharon A HLTH:EX; McLachlan, Debbie HLTH:EX; Beckett, Daryl K HLTH:EX
Cc: Patricia.McDonald@spruce.itsd.gov.bc.ca; mwaldie@clpnbc.org; s. 22 XT:HLTH Harvey, Janice
Subject: CLPNBC follow-up re: Regulation/Restricted Activities Project

Hi all – further to our discussions in May & June, we have met with CPSBC regarding some specific restricted activities. Also, we have considered health professionals who may, in future, be considered as able to give direction to LPNs.

Attached is a letter which summarizes our findings.

We would be pleased to talk with you further on these topics at your convenience.

Regards,
Elaine

Elaine Baxter
Director, Practice & Policy, CLPNBC
Office: 1-778-373-3112
Toll free: 1-877-373-2201 (BC only)

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ensuring safe, competent and ethical nursing practice

Ministry of Health Services
2 – 1 1515 Blanshard Street
Victoria, BC V8W 3C8

August 16, 2011

Dear: Debbie McLachlan, Sharon Stewart, and Daryl Beckett

I am writing to provide updated information on the College of Licensed Practical Nurses of British Columbia (CLPNBC) perspective on revisions to the "Nurses (Licensed Practical) Regulation."[1]

In the recent CLPNBC report *Consultation on the Scope of Practice of Licensed Practical Nurses FINAL REPORT Phase 1 (2011)*, CLPNBC identified a number of less common areas of LPN practice that we wanted to discuss with the College of Physicians and Surgeons of BC (CPSBC). We met with CPSBC on July 18, 2011 and as a result have additional recommendations regarding restricted activities.

As well, we have considered the issue of health professionals giving orders to Licensed Practical Nurses (LPNs) and have two recommendations for your consideration.

Restricted activities

There were four activities which required further discussion with the CPSBC – casting, ear syringing, and application of lasers and allergy challenge testing & desensitization treatments. The following summarizes the discussion and recommendations for each of these restricted activities.

Casting

This restricted activity is commonly carried out by both LPNs and unregulated care providers, who are generally known as "ortho-techs." In our meeting with the CPSBC, we explored the possibility of physicians delegating this activity to LPNs. CPSBC does not support physician delegation for either LPNs or the unregulated ortho-techs employed by the Health Authorities (HAs). These individuals are too numerous within HAs to allow physicians to carry out safe and appropriate delegation. CPSBC indicated that if LPNs are going to carry out this activity it should be within the scope of practice of LPNs and require a patient specific physician's order.

CLPNBC recommends that government consider adding "cast a fracture of a bone" to the list of assigned restricted activities "with an order" when posting the revised "Nurses (Licensed Practical) Regulation" for consultation.

CPSBC advised that LPNs should only cast when the fracture does not require "reduction" to ensure accurate bone alignment. Because this activity will require a physician order, we would work with CPSBC to develop the appropriate Standard, Limit & Conditions (SLCs) for LPNs. In addition, we would communicate with the HAs to ensure that CLPNBC's SLC related to required educational preparation for LPNs reflects both the needs of the patients and the current roles of LPNs in the HAs.

[1] *Nurses (Licensed Practical) Regulation*, BC Reg 283/2008.

Ear Syringing

CPSBC advised that, particularly in geriatric populations, there are patients with chronic ear wax build-up that requires regular ear syringing to maintain their hearing. The CPSBC suggested that this activity could be safely carried out by LPNs with the required educational preparation.

CLPNBC recommends that government consider adding "put into the external ear canal up to the ear drum, a substance that is under pressure" to the list of restricted activities "with an order" when posting the revised "Nurses (Licensed Practical) Regulation" for consultation.

CLPNBC would work with CPSBC and other stakeholders to determine the appropriate SLCs for LPNs carrying out ear syringing for the purpose of managing ear wax build-up.

Application of Lasers and Allergy Challenge Testing & Desensitization Treatments

CLPNBC is aware of a limited number of LPNs who are carrying out these restricted activities. However, because these activities appear to occur only in physicians' offices, we have requested that CPSBC consider the use of delegation for LPNs employed in physicians' offices at least on a transitional basis. This will allow CLPNBC more time to understand both the role of the LPNs involved in performing these restricted activities and the availability of required educational preparation.

Health Professionals with Authority to Give Orders to LPNs

In determining the list of health professionals who would be authorized to give orders to LPNs, CLPNBC is assuming that government will likely begin with the list of health professionals authorized to give orders to Registered Nurses (RNs). Pursuant to the "Nurses (Registered) and Nurse Practitioners Regulation,"[2] this list includes those defined within the Regulation as authorized "under an enactment to practice dentistry, medicine, midwifery, naturopathic medicine or podiatry in British Columbia, or a nurse practitioner."

In the Phase 1 Report, CLPNBC recommended that RNs and Nurse Practitioners be included in the list of those authorized to give orders to LPNs. This may already be occurring in some setting within the HAs.

As for including naturopathic physicians in the list of those authorized to give orders to LPNs, CLPNBC cannot identify a setting in which this currently occurs. CLPNBC expects LPNs to have an understanding of the basis of the therapies they carry out and be able to raise any concerns they may have with an order given to them by another practitioner. Because LPNs are not educated in the approaches used by naturopathic physicians to treat their patients, LPNs may be unable to meet the CLPNBC professional Standards of Practice in accepting and acting on such orders.

CLPNBC recommends that naturopathic physicians not be added to the list of health professionals authorized to give orders to LPNs in the upcoming posting.

The posting period will provide the opportunity to determine if there is evidence that naturopathic physicians should be included on the list of those authorized to give orders to LPNs in the final revised "Nurses (Licensed Practical) Regulation."

[2] *Nurses (Registered) and Nurse Practitioners Regulation*, BC Reg 284/2008.

There has been some discussion that Registered Psychiatric Nurses (RPNs) should be included in the group of health professionals who can provide orders to LPNs. This creates concern for the CLPNBC – we did not address the issue of orders from RPNs to LPNs in the Phase 1 Consultation because the "Nurses (Registered Psychiatric) Regulation"3 is also due to be revised. Also, we noted that a recent comparison in Alberta of entry-level RNs, LPNs and RPNs determined that RPNs are distinguished from the other two nursing providers by their depth of knowledge in mental health care.4 CLPNBC does not believe that the autonomous functions currently authorized to RNs are used in mental health settings. As well, we question that RPNs have the equivalent entry-level competencies in the medical, surgical, and geriatric setting where RNs are authorized for some forms of autonomous practice.

CLPNBC recommends that RPNs not be added to the list of health professionals authorized to give orders to LPNs in the upcoming posting.

The appropriateness of their inclusion can be determined when government finalizes the scope of practice of RPNs.

Given the additional information provided in this letter, the CLPNBC would be pleased to have further discussion with you regarding the regulation/restricted activity model prior to posting the revised "Nurses (Licensed Practical) Regulation."

Yours truly,

Elaine Baxter
Director, Practice & Policy (CLPNBC)

cc CPSBC

[3] *Nurses (Registered Psychiatric) Regulation*, BC Reg 285/2008.
[4] *Knowledge and Education at Entry to Practice in Alberta (2009).*

Not Responsive

From: Jo Wearing S. 22
Sent: Thursday, May 19, 2011 4:35 PM
To: McLachlan, Debbie HLTH:EX; Beckett, Daryl K HLTH:EX
Cc: Stewart, Sharon A HLTH:EX; 'Patricia McDonald'; XT:HLTH Harvey, Janice; S22
Subject: RE: Revised Draft LPN Scope

Debbie and Daryl,

I just S22 and reviewed Daryl's notes. I have clarified some overlap that was created as Elaine and Daryl were working from different versions. I think this version has incorporated all Daryl's suggestions. Elaine asked me to send this version on you for review.

We will have copies of both versions and a copy that can be e-mailed to the CNO who will be off site. We can decide tomorrow if you are comfortable with this version.

Jo Wearing
Policy Consultant
604-805-7144
jowearing@shaw.ca

From: Elaine Baxter [mailto:ebaxter@clpnbc.org]
Sent: May-19-11 2:02 PM
To: McLachlan, Debbie HLTH:EX; Beckett, Daryl K HLTH:EX
Cc: Stewart, Sharon A HLTH:EX; Jo Wearing; Patricia McDonald; Janice Harvey; s. 22
Subject: Revised Draft LPN Scope

Debbie and Daryl – I think we captured all of your notes – but because we had incorporated Debbie's before we received Daryl's, we left 5, 6 and 7 as Jo had changed earlier today ..we will leave for further discussion if Daryl's comments are not addressed.

We have hard copies for all of the CNOs and you at tomorrow's meeting. Pat has copies for Jo and Kathy at the air terminal in AM.

Regards,
Elaine

Elaine Baxter
Director, Practice & Policy, CLPNBC
Office: 1-778-373-3112
Toll free: 1-877-373-2201 (BC only)

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College of Licensed Practical Nurses of BC

SCOPE OF PRACTICE for Licensed Practical Nurses

Key issues for Discussion

May 19, 2011

NR

PROPOSED ASSUMPTIONS

This proposed set of assumptions is intended to guide consultation on the scope of practice for Licensed Practical Nurses (LPNs). Agreement among stakeholders on the proposed assumptions is the first step in moving toward a revised Regulation for LPNs. Following discussion with the Ministry of Health, these draft assumptions have been revised from those contained in the consultation document entitled "*CLPNBC Project on Restricted Activities for LPNs"* that was circulated to the Professional Practice Offices (PPOs), Chief Nursing Officers (CNOs), and the MOHS on December 23, 2010.

Each assumption is presented below with further discussion in *italics*.

1. The scope of practice for LPNs will be based on the *Baseline Competencies for Licensed Practical Nurses Professional Practice (February 2009).*

   Agreement has been reached on the 2009 baseline competencies for LPNs and those competencies will be reflected in a revised Nurses (Licensed Practical) Regulation. The new provincial curriculum based on the 2009 competencies will also assist in determining the baseline preparation of LPNs for specific restricted activities. LPNs may move beyond entry level practice through post basic educational preparation. These post basic areas of practice and the required competencies will be determined through an additional consultation process.

2. The requirement for either direction by a medical practitioner who is attending the patient or supervision by an RN who is providing services to the patient will be removed from the revised regulation for LPNs.

   The CLPNBC assumes the requirement for supervision will be removed in the revised regulation for LPNs. The HPC did not recommend a requirement for supervision in its report to the government (Health Professions Council, 2001a, Tab 7A, p. 20). The CLPNBC does not believe that supervision is appropriate for a self-regulated profession working within its legislated scope of practice. The removal of the requirement for supervision from the revised Nurses (Licensed Practical) Regulation does not refer to employment supervision which will continue to be the employer's responsibility to determine.

3. The scope of practice for LPNs will be articulated with restricted activities, both with and without an order. "Order" will be defined as it is in the *Nurses (Registered) and Nurse Practitioners Regulation*. This approach also means LPNs will not require an order to provide services that do not include the performance of any restricted activities.

   The same basic structure used in the Nurses (Registered) and Nurse Practitioner Regulation will be used in drafting the revised Nurses (Licensed Practical) Regulation.

Generally restricted activities that are performed with an order are stated less specifically in the Regulation. This approach reflects the additional control over practice when another provider is required to determine the appropriate intervention by assessing the client and issuing an order to provide a service that includes a restricted activity.

In the new Regulatory Framework the government develops a scope of practice statement and, as/when appropriate to the profession, assigns restricted activities in a Regulation for each profession. The scope of practice statement describes in general terms what a profession does and how it does it. Restricted activities are higher risk clinical activities that must not be performed by any person in the course of providing health care services, except members of a regulated profession that has been granted legislative authority to do so based on their education and competencies. Under the new regulatory system, LPNs will be recognized as having autonomous practice (i.e., ability to act without an order or supervision) for nursing services that do not include restricted activities.

4. LPNs will be authorized to carry out orders given by RNs (and other specified health-care providers such as MDs, nurse practitioners and dentists) to provide a service that includes a restricted activity if:
    - the other providers have the authority to perform that restricted activity without an order, and
    - LPNs may only perform that restricted activity with such an order.

    RNs currently provide clinical direction to LPNs related to nursing care in the form of care plans and verbal instruction in many practice settings, such as direction for wound care. It is likely that RNs will have some areas of autonomous practice (authority to carry out restricted activities without an order) not shared by LPNs. If this occurs, and unless the LPN is able to follow the order of a collaborating RN, the LPN will need to seek an order from an MD or an NP.

    *Under the new regulatory framework, the government has authorized some practitioners to give orders to others. For example, MDs and nurse practitioners can give orders to RNs. Regulatory supervision requires the supervising professional to assess and monitor the competence of the individual they are supervising. However, under an order, the ordering practitioner is responsible only for the **quality** of the order they provide. They are not expected to ensure the **competence** of the practitioner who is carrying out their order.*

    The CLPNBC believes that an order from an RN for services that include specific restricted activities is more appropriate than the current requirement for regulatory supervision of LPNs. The CLPNBC noted that Ontario permits RNs to give orders to LPNs. Some employers may be concerned about the possibility of more friction and hierarchical issues among the nursing groups if RNs give orders to LPNs. In addition LPNs may be assigned primary nurse responsibility for a client rather than sharing a patient assignment with an RN. In that case the RN may be asked to take over care beyond the scope of practice of an LPN or the LPN may obtain an order from an MD or NP.

5. The CLPNBC will focus its standards, limits, and conditions (SLCs) work on the practice of LPNs that is beyond the 2009 baseline competencies.

The Ministry of Health sets the framework for the scope of practice of professionals through the general scope of practice statement and the assignment of restricted activities that may be performed while providing services that fall within the scope of practice statement. The College sets standards, limits and conditions that provide additional clarity regarding the scope of practice of health professionals. The baseline competencies of LPNs are clarified in the 2009 competencies document and the Practical Nursing Education curriculum (currently under development). Therefore, the College has identified as a priority the need to focus on standards, limits and conditions for services that are within scope but beyond baseline practice.

Standards, limits, and conditions developed in consultation with stakeholders, including professions with the authority to order the restricted activity provide additional specificity related to appropriate post-basic activities. This will support more provincial consistency in the post-basic educational preparation and practice of LPNs.

PROPOSED SCOPE OF PRACTICE STATEMENT

The HPC recommended the following scope of practice statement for LPNs:

> The practice of nursing by licensed practical nurses is the provision of health care for the promotion, maintenance and restoration of health; and the prevention, treatment and palliation of illness and injury, including assessment of health status and implementation of interventions (Health Professions Council, 2001b, p. 2).

The HPC indicated that they have set out distinctions between RNs and LPNs in the scope of practice statement and in the Council's recommendations on reserved acts (Health Professions Council, 2001a, p. 20-21). The CLPNBC does not think omission of the word ***planning*** from the scope of practice statement for LPNs is the best way to create a distinction between the two regulated nursing groups.

CLPNBC believes that the word planning should be added to the scope of practice statement to make clear that LPNs are both educated and expected to carry out the nursing process. Additional distinctions in the scope of practice of the two groups would be better addressed through assigned restricted activities.

PROPOSED RESTRICTED ACTIVITIES FOR LPNs

Based on the consultation carried out by CLPNBC a list of restricted activities was developed that the CLPNBC believes could be part of a posted draft regulation. During the posting period the CLPNBC will develop standards, limits, and conditions, where appropriate, in consultation with stakeholders.

Restricted **A**ctivities ***Without*** an **O**rder

For purposes of assessment, put an instrument, or a device, hand, or finger into the external ear canal, and beyond the anal verge.

For purposes of assessment, put into the external ear canal up to the eardrum, air that is under pressure equal to, or less than, the pressure created by the use of an otoscope.

Apply ultrasound for purposes of assessment of bladder volume and blood-flow monitoring.

Compound, dispense, or administer a Schedule 2 drug for the purpose of preventing disease using immunoprophylactic agents

Diagnose anaphylaxis and administer a Schedule 1 or 2 drug to treat anaphylaxis.

Apply electricity using a stand-alone automatic external defibrillator (AED).

Put an instrument, or device, hand, or finger beyond the labia majora (to the urethral and vaginal orifice), for purposes of performing hygiene measures and washing beyond the labia majora (considered a restricted activity by the HPC).

Restricted **A**ctivities ***With*** an **O**rder

Perform a procedure on tissue below the dermis or below the surface of a mucous membrane.

Administer a substance (not a drug):
- by injection,
- by inhalation,
- by mechanical ventilation,
- by irrigation,
- by enteral instillation or parenteral instillation.

Put an instrument or a device, hand, or finger:
- into the external ear canal,
- beyond the point in the nasal passages where they normally narrow,
- beyond the pharynx,
- beyond the opening of the urethra,
- beyond the labia majora,
- beyond the anal verge,
- into an artificial opening in the body.

Apply ultrasound for diagnostic or imaging purposes, including any application of ultrasound to a fetus.

Compound a drug.

Administer a drug by any method.

If nutrition is administered by enteral instillation, compound a therapeutic diet and dispense a therapeutic diet.

RESTRICTED ACTIVITIES REQUIRING ADDITIONAL CONSULTATION

Some additional activities were identified during the consultation period that are being carried out by LPNs or were suggested as appropriate activities for LPNs. These activities are beyond the 2009 baseline competencies. Many of these activities fall under the proposed restricted activities requiring an order (see the above section) and these issues will be clarified during the consultation on limits and conditions for post-basic activities.

The remaining issues (listed below) would require a change in the proposed restricted activities listed in the section above - Proposed Restricted Activities for LPNs. During the posting period additional information can be obtained regarding the best approach to these restricted activities- both with and without an order. Also additional restricted activities may be identified during the consultation period that can be considered for inclusion in the final revised Regulation for LPNs.

Without **an Order**

The following restricted activities carried out by LPNs were identified in the consultation as ones that may be appropriate for independent practice (without an order). However, all restricted activities listed below require additional consultation before the CLPNBC will have the information necessary to recommend to the government that these activities be authorized to LPNs, without an order.

- Wound care.
- TB skin testing.
- Administration of oxygen (other than through the emergency exemption).
- Insertion of a urinary catheter.
- Bowel routines involving suppositories and enemas.

With **an Order**

The following restricted activities are being carried out by LPNs but the CLPNBC believes additional consultation is needed before a determination can be made regarding the appropriateness of inclusion in the scope of practice for LPNs.

- Cast a fracture of a bone.
- Put into the external ear canal, up to the eardrum, a substance that is under pressure.
- Dispense a drug.
- Conduct allergy challenge testing or desensitizing treatments
- Application of laser for the purpose of destroying tissue.

Not Responsive

From: Elaine Baxter [mailto:ebaxter@clpnbc.org]
Sent: Sunday, April 24, 2011 12:17 PM
To: McLachlan, Debbie HLTH:EX; Stewart, Sharon A HLTH:EX; Beckett, Daryl K HLTH:EX
Cc: Patricia McDonald; XT:HLTH Harvey, Janice; S. 22 Megan Waldie
Subject: CLPNBC Consultation Report - Regulation/Restricted Activities

Hello all – attached is the report we have prepared from the preliminary consultation. We look forward to hearing from you within the next 2-3 weeks if possible.

Please let me know if I can provide additional information ...otherwise, I will try to arrange a teleconference the week before we meet with the CNOs (May 20) so we can decide if we should share this early report with them for information.

Regards,
Elaine

Elaine Baxter
Director, Practice & Policy, CLPNBC
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College of Licensed Practical Nurses of BC

Consultation on the Scope of Practice of Licensed Practical Nurses

April 21, 2011

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EXECUTIVE SUMMARY

The current *Nurses (Licensed Practical) Regulation* urgently requires revision because it does not reflect the new regulatory framework in place for other regulated health professions in British Columbia. In particular, Licensed Practical Nurses (LPNs) work closely with other health-care providers such as Registered Nurses (RNs), Nurse Practitioners (NPs), and physicians who have regulations that reflect the new regulatory framework. In the fall of 2010, staff from the Ministry of Health Services (MOHS) began discussions with the College of Licensed Practical Nurses of British Columbia (CLPNBC) regarding a new initiative to begin work on the revision to the current *Nurses (Licensed Practical) Regulation*. After discussion with Ministry staff, it was agreed that the CLPNBC would carry out a focused consultation to provide preliminary feedback to the government. It was understood that continued consultation with LPNs and other stakeholders would likely be required following this initial consultation process. The purpose of this report is to:

- Present the results of the CLPNBC's initial consultation process.
- Provide the CLPNBC's recommendations on the scope of practice for LPNs in B.C. to the government.

Nine focus groups and two meetings with key stakeholders were held between December 2010 and February 2011. LPNs, Health Authority (HA) staff, and educators from entry-level Practical Nurse (PN) programs were included in the consultation. The CLPNBC prepared a consultation document that was circulated on December 23rd to the Professional Practice Offices (PPOs), Chief Nursing Officers (CNOs), and the MOHS. Participants in the focus groups provided input based on the consultation document prepared by the CLPNBC. In addition, regulations were reviewed related to the scope of practice of LPNs in Ontario and Alberta.

The CLPNBC is aware of the limitations inherent in this focused 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. The CLPNBC believes that all common LPN activities are included in the summary of restricted activities identified in this report. In order to guide the significant new employer initiatives that introduce LPNs in new practice areas, or to increase their role in current practice areas, the CLPNBC believes it is critical to implement a revised regulation by the fall of 2011. Because the current regulation describes the LPN scope of practice as "such nursing services related to the care of patients as are consistent with his or her training and abilities," it permits considerable variation in the activities of LPNs in B.C. The CLPNBC is concerned that differences are beginning to appear across the province as employers (even within the same HA) make different decisions regarding appropriate roles and functions of LPNs.

As a result of the consultation process, the CLPNBC makes the following recommendations:

1. Complete a revised regulation for LPNs by fall 2011 so that clarity on restricted activities—with standards, limits, and conditions—will be in place to guide the significant expansion in the utilization of LPNs.
2. Halt expansion of the independent functions of LPNs (beyond the proposed restricted activities summary) until there is time for the CLPNBC—in consultation with stakeholders—to investigate the development/revision of decision-support tools that clarify the LPN role; and to ensure appropriate educational opportunities are available for LPNs taking on additional independent decision-making for restricted activities.
3. Include content in the new provincial PN curriculum related to the new independent role of the LPN in planning nursing care for patients, including the many aspects of nursing care that are not restricted activities.
4. Include RNs and NPs in the list of practitioners able to give orders to LPNs.
5. Clarify that the new provincial curriculum will reflect the Canadian Practical Nurse Registration Examination (CPNRE) Blueprint 2012-2016 document.
6. Develop appropriate post-basic education to prepare LPNs for roles and functions that are beyond entry-level educational preparation.

INTRODUCTION

The current *Nurses (Licensed Practical) Regulation* requires revision urgently because it does not reflect the new regulatory framework in place for other regulated health professions in British Columbia. In particular, LPNs work closely with other health-care providers such as RNs, NPs, and physicians who have regulations that reflect the new regulatory framework. Both the B.C. government and the CLPNBC have done some preliminary work. However, this work has not yet resulted in a comprehensive revision to the regulation for LPNs.

In the fall of 2010, staff from the Ministry of Health Services (MOHS) began discussions with the CLPNBC regarding a new initiative to begin work on the revision to the current *Nurses (Licensed Practical) Regulation*. In November 2010, the CLPNBC sent a set of assumptions to the government for confirmation (See: Appendix 1—"CLPNBC Regulations & Restricted Activities Project (*DRAFT 23Nov10):* Assumptions for confirmation with Government"). The assumptions were intended to facilitate reaching agreement between CLPNBC and the government that would underpin the consultation process. During a teleconference meeting on December 7, 2010, MOHS staff informed the CLPNBC that they were not able to provide feedback on the draft assumptions document until the government began work on a revised *Nurses (Licensed Practical) Regulation*. At this meeting, it was agreed that the CLPNBC would continue with a focused consultation to provide preliminary feedback to the government. It was understood that continued consultation with LPNs and other stakeholders would likely be required following this initial consultation process.

Participants in the consultation process were informed by the CLPNBC that:

> The CLPNBC will be preparing a preliminary report for the government based on this initial phase of consultation. We have informed the government that this preliminary report from the CLPNBC will not be exhaustive of all LPN activities because the timeframe for this phase of the project does not allow for extensive consultation. A subsequent round of consultations will occur once government posts the revised regulation for LPNs. But, depending on the results of this preliminary consultation, the government and/or the CLPNBC may have to follow-up with stakeholders for more information before the posting of a draft regulation for LPNs can occur. Once the CLPNBC has more clarity on the activities that LPNs carry out beyond the 2009 entry-level competencies, we will begin a new consultation process on possible standards, limits, and conditions (CLPNBC Consultation Document: *CLPNBC Project on Restricted Activities for LPNs.* p.1*)*.

The purpose of this report is to:

- Present the results of the CLPNBC's initial consultation process; and
- Provide the CLPNBC's recommendations to the government on the scope of practice for LPNs in B.C.

CONSULTATION PROCESS

Preparing for the Focus Groups

The competencies and roles of LPNs have shifted significantly since the 2000 *Safe Choices* report by the Health Professions Council (HPC). Some information on restricted activities carried out by LPNs can be obtained through a review of the *Baseline Competencies for Licensed Practical Nurses Professional Practice (February 2009)*. However, in a number of areas, the competencies are written too broadly to lead to an understanding of entry-level LPN educational preparation for specific restricted activities. In addition, some activities are carried out by LPNs only after additional post-basic educational preparation, following initial registration as an LPN.

The CLPNBC began the consultation process by reviewing the master list of restricted activities in the Regulation posted by the government - *Health Professions General Regulation: Restricted Activities* (consultation draft, March 19, 2010). In October 2010, the CLPNBC met with a group of educators from PN entry-level programs to request information on the entry-level educational preparation of LPNs related to the performance of specific restricted activities. Following that meeting, and based on the CLPNBC staff's knowledge of common LPN activities following post-basic preparation, a draft list of restricted activities was developed that was intended to reflect common LPN activities.

The CLPNBC also reviewed the regulations for LPNs in both Ontario and Alberta as both provinces have implemented a regulatory framework similar to that of B.C.'s. However, there is difficulty in direct comparison because each of the regulatory frameworks has some significant differences. For example, Alberta does not include the concept of orders in its regulatory framework. In addition, both Alberta and Ontario have completed work to increase entry-level LPN competencies, and the length of PN entry-level educational programs. The preparation of LPNs in those provinces more closely reflects the competencies in the Canadian Practical Nurse Registration Examination (CPNRE) Blueprint 2012-2016 document. A new CLPNBC baseline competencies document that reflects the 2012-2016 CPNRE competencies has been developed but is not yet in use in B.C.

Focus Groups and Key Stakeholder Meetings

Nine focus groups and two meetings with key stakeholders were held between December 2010 and February 2011. The first focus group was held in December and gave the CLPNBC the opportunity to refine the consultation process for the remaining focus groups held in 2011. In December, a teleconference was held with the *Health Professions Act* (HPA) leaders for the HAs to discuss the proposed consultation process. Following that meeting, the CLPNBC prepared a consultation document entitled "*CLPNBC Project on Restricted Activities for LPNs*" that was circulated to the Professional Practice Offices (PPOs), Chief Nursing Officers (CNOs), and the MOHS on December 23, 2010. The assumptions sent to the MOHS were revised and included as part of the consultation document.

Focus groups were held with the PPO in each Health Authority (HA) to collect information on common LPN activities occurring. Six HAs and Providence Health Care provided information to the CLPNBC through six focus groups held by teleconference or in person, and one via email response. Thirty individuals participated in the six focus groups arranged with the PPOs. PPO staff collected data from managers and/or program leads, and in some cases, included these individuals in the focus group for that HA. Some PPOs have existing committees that involve

LPNs, or LPNs work in the PPO office, or in managerial/consultant positions. These LPNs participated in some focus groups. Information was collected by the PPOs from a variety of practice settings, including: urban and rural hospitals; community (public health, home care, and primary care clinics); and residential care.

Two "in-person" focus groups were held with LPNs: one focus group was assembled by the CLPNBC, and one focus group was held with LPNs in a specialized area of practice. A total of 18 LPNs participated in the two focus groups. The focus group assembled by the CLPNBC included LPNs from all the geographical areas represented by the HAs and from acute care, residential care, and home and community-care settings. This focus group included a two-hour introduction and discussion of the new regulatory framework, followed by input on common LPN activities from the LPN focus group participants. At the CLPNBC's request, an employer organized the focus group from a specialized area of practice. The available time permitted only a brief overview of the new regulatory framework for LPN participants.

As described earlier in the document, the CLPNBC held a meeting in October with PN educators to obtain information about entry-level PN educational preparation. One focus group was held with educators from three separate entry-level PN programs located in different areas in B.C. Its purpose was to affirm the information about entry-level PN educational preparation that was gathered in October 2010, and to gain additional insight from PN educators.

Participants in the focus groups provided input and feedback on draft "restricted activities for LPNs" set out in the consultation document entitled "C*LPNBC Project on Restricted Activities for LPNs".* The CLPNBC requested that the consultation document have limited circulation because the timelines for the revised LPN regulation had not been set, and the assumptions underpinning the consultation had not been confirmed by the MOHS staff.

LPNs and employers have been advised previously by the government that the LPN regulation would soon be revised, and then other priorities have delayed the process. The CLPNBC believes that a clear timeline is needed from the government before the CLPNBC engages in extensive consultation with LPNs. LPNs must understand the new regulatory framework to give accurate information as to what restricted activities they are carrying out, and with what degree of independence.

The consultation did not directly include employers from contracted residential care, home support, or First Nations communities. The results from this consultation are preliminary in nature, until a more extensive and comprehensive consultation is conducted with a wider variety of employers and more LPNs.

ASSUMPTIONS UNDERLYING THE CONSULTATION

The CLPNBC developed a revised set of assumptions to guide consultation on the scope of practice for LPNs, based in part on the assumptions circulated earlier to the government (see Appendix 1, CLPNBC Regulations & Restricted Activities Project (*DRAFT 23Nov10): Assumptions for confirmation with Government*).

Each assumption is presented below with further discussion in *italics*.

1. The LPN scope of practice will be articulated with restricted activities, both with and without an order. Order will be defined as it is in the *Nurses (Registered) and Nurse Practitioner Regulation.*

   The CLPNBC assumes that the government would use the same basic structure used in the Nurses (Registered) and Nurse Practitioner Regulation when drafting the revised Nurses (Licensed Practical) Regulation.

2. The requirement for supervision by RNs who are providing services to the patient will be removed from the revised regulation for LPNs.

   The CLPNBC assumes this requirement will be removed in the revised regulation for LPNs. The HPC did not recommend a requirement for supervision in its report to the government (Health Professions Council, 2001a, Tab 7A, p. 20). The CLPNBC does not believe that regulatory supervision is appropriate for a self-regulated profession working within its legislated scope of practice.

3. RNs (and other health-care providers) will be authorized to give an order to LPNs to carry out a restricted activity, **if** they have the authority to carry out that restricted activity without an order, and LPNs do not have that authority.

   RNs currently provide clinical direction to LPNs related to nursing care in the form of care plans and verbal instruction in many practice settings, such as direction for wound care. It is likely that RNs will have some areas of independent practice (authority to carry out restricted activities without an order) not shared by LPNs. If this occurs, and unless the LPN is able to follow the order of a collaborating RN, the LPN will have to seek an order from an MD or an NP.

   Under the new regulatory framework, the government has authorized some practitioners to give orders to others. For example, MDs and NPs can give orders to RNs. Regulatory supervision requires the supervising professional to assess and monitor the competence of the individual they are supervising. However, under an order, the ordering practitioner is responsible only for the ***quality*** *of the order they provide. They are not expected to ensure the* ***competence*** *of the practitioner who is carrying out their order.*

   The CLPNBC believes that an order from an RN for specific restricted activities is more appropriate than the current requirement for supervision of LPNs. Under the new regulatory system, LPNs will be gaining independence for many nursing activities that are not restricted activities. The CLPNBC noted that Ontario permits RNs to give orders to LPNs (College of Nurses of Ontario, 2009, p.13).

4. The CLPNBC will establish standards, limits, and conditions (SLC) for the practice of LPNs.

   This assumption is based on the regulatory framework in place in British Columbia and is consistent with section 5 (1) (1.1) of the Nurses (Licensed Practical) Regulation.

5. The CLPNBC will focus limits and conditions on activities that are beyond the 2009 entry-level competencies.

   The CLPNBC has noted that, particularly in the last few years, LPNs are moving into many new practice areas. Increasingly, this is leading to a situation that is similar to the one the Health Professions Council pointed out in its review of registered nursing.

   > The Council does not doubt that RNs with specialty training do perform the services proposed by the BCNU/RNABC submission, but we were not presented with detailed information about the programs in place to allow for advanced training and education of such practitioners. Moreover the information received at the hearing confirmed that there is no universally accepted certification system in place and a wide variety of training and educational programs, which vary among institutions, are used to establish advanced practice capabilities. Such diverse arrangements are not in the public interest, and universal certification programs, regulated through the College, ought to be established for specialty and advanced practice (Health Professions Council, 2001c, p. 18).

   It is the College's understanding that standards, limits, and conditions and certified practice were introduced by the government in part to address this concern and to support more provincial consistency in the post-basic educational preparation and practice of health professionals.

6. Generally, restricted activities that are carried out with an order can be stated less specifically in the Regulation.

   This assumption was included in the assumptions document sent to staff of the MOHS. Although it was not included in the consultation document circulated during the consultation process, this assumption guided the consultation process. This is the model in the Nurses (Registered) and Nurse Practitioner Regulation, and reflects the additional control over practice when another provider must issue an order.

   For restricted activities with an order, the CLPNBC is providing examples, not an exhaustive list of activities carried out by LPNs. The CLPNBC recommends the use of standards, limits, and conditions developed in consultation with stakeholders, including professions with the authority to order the restricted activity. This approach is more flexible and responsive to changes in practice, rather than attempting to define specific limitations in the Regulation itself.

SCOPE OF PRACTICE STATEMENT

The HPC recommended the following scope of practice statement for LPNs:

> The practice of nursing by licensed practical nurses is the provision of health care for the promotion, maintenance and restoration of health; and the prevention, treatment and palliation of illness and injury, including assessment of health status and implementation of interventions (Health Professions Council, 2001b, p. 2).

Concerns were expressed to the HPC regarding the omission of the words *planning* and *evaluation* in the scope statement for LPNs. The Council responded to these concerns in this manner:

> However the Council's task is not to describe the nursing process but to describe, generally, the scope of practice of the profession. In any event, planning and evaluation are undoubtedly integral to and implicit in the practice of all professions (Health Professions Council, 2001b, p. 2).

However, the CLPNBC notes that the term *planning* is included in the scope of practice statement of RNs. A discussion of the recommended scope of practice statement was included in the focus group with LPNs, which included a detailed overview of the new regulatory framework. There was considerable concern from LPNs about the omission of planning from the LPN scope of practice statement. While the LPNs in the focus group understood that the HPC stated in their report that this does not prevent the LPN from carrying out the nursing process, LPNs are very concerned (based on past experiences) that they will be told that omission of planning in the scope of practice statement prevents them from carrying out planning—an integral part of the nursing process and the CLPNBC's expectations of them.

The HPC indicated that they have set out distinctions between RNs and LPNs in the scope of practice statement and in the Council's recommendations on reserved acts (Health Professions Council, 2001a, p. 20-21). The CLPNBC does not think omission of the word *planning* from the scope of practice statement for LPNs is the best way to create a distinction between the two regulated nursing groups.

The CLPNBC would like to discuss the scope of practice statement for LPNs with the government.

RESERVED TITLES

The Health Professions Council recommended the following reserved titles for Licensed Practical Nurses (Health Professions Council, 2001b, p. 7).

- Licensed Practical Nurse
- Practical Nurse
- Nurse, and
- Any abbreviation of those titles

The CLPNBC agrees with this recommendation.

RESTRICTED ACTIVITIES CARRIED OUT BY LPNs

The CLPNBC developed a consultation document that divided restricted activities into two sections

- without an order; and
- with an order.

Consistent with the assumptions outlined above, the restricted activities to be carried out **without** an order are described in a more specific manner than those carried out **with** an order.

Emergency Exemption

Participants identified some emergency situations—such as administration of oxygen, and diagnosis and treatment of anaphylaxis—in which they thought that LPNs should have the authority to act without an order. Participants were reminded that an emergency exemption does exist under the *Health Professions Act* (*HPA*), and in the current *Nurses (Licensed Practical) Regulation*. An example from the RN regulation was used for discussion purposes. At times, RNs do deliver babies but it is not included in the RN scope of practice because it is not a **common or expected** part of their practice. If RNs are required to deliver a baby, they do so under the emergency exemption.

Participants were asked to consider whether LPNs would commonly be in the situation identified and expected to act independently. If so, the activity should be included in the scope of practice for LPNs so that the CLPNBC can develop standards, limits, and conditions to ensure that LPNs have the educational preparation required.

Restricted activities: without an order (1 through 7)

1. **For purposes of assessment, put an instrument, or a device, hand, or finger into the external ear canal and beyond the anal verge.**

   Participant Responses: There was general agreement that LPNs commonly carry out this restricted activity without an order. Activities identified included rectal checks; rectal swabs as part of infectious control screening; and rectal temperatures—although the performance of this activity on children likely requires an order. LPNs also use tympanic thermometers and otoscopes.

   Summary
   This restricted activity, without an order, was supported in the consultation.

2. **For purposes of assessment, put into the external ear canal, up to the eardrum, air that is under pressure equal to, or less than, the pressure created by the use of an otoscope.**

   Participant Responses: Most participants said that LPNs did not use otoscopes for assessment purposes. Some LPNs described assessing for inflammation, wax, and foreign objects with an otoscope. Currently, B.C. PN entry-level programs cover only theory related to the use of an otoscope.

Summary
LPNs using otoscopes must have this restricted activity contained in the revised LPN Regulation in order to adequately assess the eardrum. The CLPNBC will consult further to determine if a specific limit or condition is needed for LPNs using an otoscope for assessment purposes.

3. **Apply ultrasound for purposes of assessment of bladder volume and blood-flow monitoring.**

Participant Responses:
Participants agreed that this restricted activity for assessment purposes represented common LPN practice. They noted that some practice areas do not have access to this technology, but the activity is included in PN entry-level educational programs.

Some participants supported LPNs using the Doppler to take pulses (pedal pulses) but not to assess the ankle-brachial index (ABI). The ABI is used to assess lower extremity arterial perfusion. The test is critical in determining whether a pressure dressing can be used to treat a venous leg ulcer.

Summary
This restricted activity, without an order, was supported in the consultation. A specific limit related to measuring the ABI can be developed by the CLPNBC.

4. **Compound, dispense, and/or administer a Schedule 2 drug for the purpose of preventing disease, using immunoprophylactic agents.**

Participant Responses:
A separate consultation was occurring related to this restricted activity recently included in the LPN regulation by the government. Currently, LPNs are carrying out flu and pneumococcal immunizations without an order, with an RN on-site. Some participants asked why immunizations given with an order require the same educational preparation as immunizations given without an order (current CLPNBC standards, limits, and conditions). Educators noted that very limited information on immunizations is covered in current PN entry-level programs. Further, they are not sure whether enough information will be added in the new provincial curriculum to prepare entry-level LPNs to give immunizations, even with an order. Only two HAs had current plans to expand independent LPN practice beyond flu and pneumococcal immunizations in Public Health settings.

Summary
The work to develop standards, limits, and conditions for LPNs to carry out independent immunization beyond flu and pneumococcal immunizations is currently on hold. It will be included in the overall project related to the revision of the scope of practice of LPNs.

5. **Diagnose and treat anaphylaxis (epi-Schedule 1 drug as well as pre-filled syringes) or administer a Schedule 1 or 2 drug to treat anaphylaxis.**

Participant Responses:
Some discussion has occurred about removing the requirement for an on-site RN for immunizations. Because of the risk of anaphylaxis, in immunization practice clients are held for at least 15 minutes after the immunization has been administered. Therefore, if

LPNs are going to provide immunizations without an on-site RN, it will be an expected part of practice that they are able to diagnose and treat anaphylaxis.

Some participants thought this restricted activity should be included in the LPN scope of practice without an order because it is an emergency. However, they did not identify situations (other than immunizations) in which diagnosing and treating anaphylaxis would be a common or expected part of LPN practice (e.g. administering new IV medication).

Some participants in the focus groups did not support LPNs administering immunizations without an on-site RN. They thought the RN should be available on-site to provide consultation and to deal with emergencies such as anaphylaxis. Some participants pointed out that the educational preparation of LPNs does not provide them with the background for emergency decision-making. The participants who were involved in the introduction of the "Decision Support Tool for RNs" pointed out that additional education was needed related to this independent activity for RNs, including: quickly determining dosages for different age groups in an emergency situation, and making a diagnosis that is not straightforward. The correct diagnosis is particularly important in the case of some clients, such as the elderly.

Summary
If LPNs are going to immunize without an RN on-site they will require the educational preparation to be able to respond effectively to this emergency. Other practice areas will have to determine whether this is a common and expected area of practice for LPNs, and if so, provide the required educational preparation. This activity is not an entry-level competency for LPNs. Therefore, a condition will be required calling for additional educational preparation for LPNs.

6. **Apply electricity using an automatic external defibrillator (AED).**

Participant Responses:
There was general agreement from participants that this restricted activity should be included in the scope of practice of LPNs. They pointed out that AEDs are increasingly common in public places, and wondered whether AEDs would continue to be considered a restricted activity. Participants are aware of residential care facilities that are installing AEDs and the LPN may be the only regulated health professional on-site. Other participants pointed out that LPNs might not be expected to use an AED. AEDs are being installed in primary-care practice settings but the LPN would not be expected to take the lead in such an emergency. Others said that many residents of residential care facilities have levels of care in place that would preclude use of an AED. Others from acute-care settings indicated that their organizations were considering introducing policies that would involve calling the hospital "code team" instead of using an AED.

In using an AED, there is no requirement for the LPN to diagnose the cardiac rhythm. The AED only issues a shock when the rhythm is appropriate for this intervention. Participants wanted it to be clear that this restricted activity referred only to stand-alone AEDs because the use of the AED function in defibrillators is more complex. A CPR course is available for health professionals, which includes use of an AED. The current entry-level competencies for LPNs do not include use of AEDs.

Summary
Participants generally support including the use of stand-alone AEDs by LPNs if this activity continues to be a restricted activity. If this is an expectation of practice for LPNs in some workplaces they can be prepared through the use of existing educational programs in CPR that include use of an AED.

7. **Put an instrument, or device, hand, or finger beyond the labia majora—excluding the insertion of intrauterine devices—for purposes of performing hygiene measures and washing beyond the labia majora to the urethral and vaginal orifices.**

Summary
This restricted activity was recommended for LPNs by the HPC for purposes of assessment, or assisting with activities of daily living (Health Professions Council, 2001b, p. 4). The CLPNBC is not clear that the government intended to make this basic hygiene measure a restricted activity. However, if the government does see this activity as a restricted activity, then LPNs must have the authority to perform this activity without an order.

Restricted activities: with an order (8 through 28)

This section describes activities carried out by LPNs with an order. As noted in the assumptions for the consultation, the CLPNBC did not attempt to create an exhaustive list of all the activities in each restricted activity. If the government leaves the restricted activity broadly worded, the CLPNBC will work with stakeholders to determine which activities beyond entry-level practice require standards, limits, and conditions. The CLPNBC asked participants in the focus groups to identify activities in the section of the CLPNBC consultation document "with an order" that were being carried out by LPNs "without an order" or as part of a care plan.

8. **Perform a procedure on tissue below the dermis, or below the surface of a mucous membrane.**

Participant Responses:
Wound care
Some participants report that LPNs only carry out wound care that reflects entry-level practice (cleansing, irrigating, and packing and dressing wounds when the wound bed can be visualized). Other participants report that LPNs carry out wound care activities beyond entry-level. Some participants said it would be helpful to have limits and conditions for activities beyond entry-level. Currently, LPNs are caring for more complex wounds and performing wound-care activities that are beyond entry-level practice. This is with post-basic educational preparation using a variety of methods, from formal courses to bedside teaching with no theoretical component.

Most participants reported that LPNs follow an order from an MD or a wound-care plan developed by an RN. Increasingly, a specialist wound-care RN develops the care plans for more complex wounds. Some participants thought that LPNs should have the authority to manage "simple" wounds without an order. However, they were not clear what would constitute this type of wound, or whether these wounds would be below the dermis.

Starting IVs

Participants report that some LPNs were carrying out this activity but HA policy now precludes this. Some participants described plans to have LPNs begin performing this activity. Some LPNs in the focus groups thought LPNs should have the authority to start IVs with an order. This activity is not included in the approved CLPNBC 2009 entry-level competencies. However, initiation, assessment, monitoring, management, and documentation of peripheral infusion therapy are included in the CPNRE Blueprint 2012-2016.

Summary
Wound care performed by LPNs with an order is very common. More consultation is needed to determine whether LPNs care for wounds below the dermis without an order or direction. LPNs practising without an order would need the ability to diagnose the cause of the wound, as well as to treat the wound. Decision-support tools and appropriate education would have to be in place to support this independent activity.

If the government keeps this restricted activity broadly worded and requiring an order, the CLPNBC can work with stakeholders to determine standards, limits, and conditions that would apply to LPNs starting IVs with an order. LPNs taking blood samples could continue this activity with an order, perhaps with standards, limits, and conditions.

9. Cast a fracture of a bone.

Participant Responses:
Casting is being done by LPNs in some HAs, while others use only orthopedic technicians (orthotechs). Some LPNs work as orthotechs. It is not clear how the role of the orthopedic LPN differs from the unregulated orthotech. The post-basic educational preparation of LPNs working in these roles varies significantly. Some B.C. LPNs have graduated from an intensive Alberta program *(Advanced Orthopedics for LPNs* offered through Norquest College) that is designed exclusively for LPNs. It includes a 300-hour MD-supervised preceptorship. Other LPNs have taken employer-based education that may be the same as that of the orthotechs. In B.C., some LPNs have elected to take a formal education program that trains orthotechs. However, it does not prepare them to the same level of the Norquest College program in Alberta.

The amount of physician involvement in applying the cast (some MDs apply the first few layers of casting material before giving an order to the LPN to complete the cast), as well as the amount of supervision of the application of the cast (some MDs check the cast before the client can leave the cast clinic or the ER), is not clear. If LPNs and orthotechs are both in the same workplace, MDs will have to determine whether the provider they are working with is an LPN working within the LPN scope of practice, or an unregulated cast technician requiring regulatory supervision from the MD.

Summary
This restricted activity is not included in the scope of practice of RNs in B.C., or in the scope of practice of Registered Practical Nurses Ontario. Setting or resetting a fracture is included in the scope of practice of LPNs in Alberta (casting is not identified as a restricted activity in Alberta). The Regulation in Alberta requires the LPN to be on the Specialized Practice Register. They must complete an educational program that is approved by the College of Licensed Practical Nurses of Alberta (CLPNA). This is the

same educational program taken independently by some LPNs in B.C. Also, some B.C. HAs have sponsored groups of LPNs to take the program.

The CLPNBC must carry out further consultation with the College of Physicians and Surgeons of BC (CPSBC), as well as with LPNs and managers about this LPN activity. More information is needed to determine whether casting should be performed through delegation/authorization under supervision (as with orthotechs), or be included in the scope of practice of LPNs—likely through some form of certified practice. That is, approval of the required educational program and a specialized register, as occurs in Alberta.

10. Administer a substance (not a drug) by injection.

Participant Responses: LPNs do carry out this restricted activity including administering fluids by subcutaneous injection. Participants noted that a few LPNs are providing TB skin tests with an order, and either reading the test, or having the test read by another practitioner. Some participants suggest that LPNs should be authorized to carry out this activity without an order. Others cautioned that the activity must be performed frequently to maintain expertise in reading the test and in explaining the meaning of the test result, particularly with a positive result. In addition, TB testing in a public-health setting leads to contact follow-up, which these participants are not convinced is an LPN role.

As far as the CLPNBC is aware, the BC Centre for Disease Control (BCCDC)—TB control—does not have a decision-support tool or an educational course to support LPNs to carry out this activity independently. The old paper-based CLPNBC immunization course (no longer available) included a TB testing learning module. LPNs were also required to have their supervisor sign them off on a TB testing skills checklist. A copy was sent to the CLPNBC as a record of their competence, related to the skill of administering the TB test. They were not assessed on their ability to read the test result.

Summary
The CLPNBC recommends that this restricted activity remain under an order until provincial discussions to determine the role of the LPN acting without an order in TB testing, as well as the required post-basic educational preparation, can occur.

11. Administer a substance (not a drug) by inhalation.

Participant Responses:
Participants report that LPNs do administer oxygen with an order—an entry-level competency. There is no consensus on LPNs providing oxygen without an order. Some describe LPNs starting low-volume oxygen and immediately getting help—calling an ambulance or contacting an on-site collaborating RN. A few LPNs reported starting oxygen at rates of up to 6 -10 litres, without an order. Others reported they would not go over 5 litres without an order. They also reported that there were no polices in place within the workplace.

During the consultation, the CLPNBC was unable to establish when the diagnosis of the condition and the treatment of a client presenting with a new symptom of low oxygen saturation would be a common or expected part of the role of an LPN. Clients assigned to LPNs are those whose health outcomes can reasonably be expected to follow an

anticipated path. A client presenting with new, undiagnosed, untreated low oxygen saturation would not meet the health-status criteria for appropriate assignment to the LPN.

Participants involved in the development of the Decision Support Tools for RNs pointed out that the decision-making required related to diagnosing the cause of low oxygen saturation and determining the appropriate treatment (even for the time period until the MD can assume the care) is not straightforward.

Administration of nitrous oxide is not part of entry-level PN preparation but participants note that this is done by LPNs with an order, for example, in emergency rooms. It is not clear where LPNs receive the additional education needed for this activity. Some participants noted that LPNs would not administer nitrous oxide in the maternity setting as the health status of the labouring woman is considered complex and therefore, inappropriate for assignment to an LPN.

Summary
More consultation is needed to determine whether there are situations in which managing a client with an unexpected drop in oxygen saturation would be a common and/or expected part of the LPN role. Otherwise, the emergency exemption—with policies dictating the maximum flow rate—might be the more appropriate approach. The need for standards, limits, and conditions for LPNs carrying out the administration of nitrous oxide with an order can be addressed in the upcoming CLPNBC consultation regarding standards, limits, and conditions.

12. Administer a substance (not a drug) by mechanical ventilation.

Participant Responses:
There was consensus from participants that this restricted activity is performed by LPNs with an order. LPNs care for people on long-term ventilation whose health outcomes can reasonably be expected to follow an anticipated path. Participants agree that this activity is not entry-level and would require additional education. Participants described courses from Pearson, Queen Alexandra, and Aberdeen Hospitals that prepare LPNs for this activity; one participant referred to teaching LPNs in hospital-based education. A few also described client-specific teaching of LPNs.

Summary
The CLPNBC recommends that this activity be included in the scope of practice of LPNs, with an order, and will work with stakeholders to develop standards, limits, and conditions.

13. Administer a substance (not a drug) by irrigation.

Participant Responses:
Participants agreed that LPNs carry out irrigations as identified in the consultation document (enemas, irrigation of bladder following a TUPR, and irrigation of ostomies). Some indicated that LPNs only care for clients with well-established ostomies. One participant reported that LPNs irrigate catheters without an order, while others said this activity is no longer best practice. Educators report that irrigation of ostomies is covered in theory only. Therefore, standards, limits, and conditions might be required for this activity.

Summary
The CLPNBC recommends that this activity be included in the scope of practice of LPNs, with an order.

14. Administer a substance (not a drug) by enteral instillation or parenteral instillation.

Participant Responses:

Enteral Instillation
Participants agreed that LPNs carry out tube feedings both via an N/G tube and peg tubes. They also flush feeding tubes. One participant noted that flushing to keep the feeding tube clear following the administration of a tube feeding or medication is different than unblocking a feeding tube, and does not think LPNs are prepared for the latter activity.

Parenteral Instillation
Participants agreed that LPNs monitor IV infusions and change IV bags for un-medicated IV solutions. LPNs also flush saline locks and add heparin to heparin locks for the purpose of maintaining patency. Participants wondered if that use of heparin would be considered giving an IV medication. They reported that LPNs did not start blood or parenteral nutrition, although they do monitor these infusions.

Initiation, assessment, monitoring, management, and documentation of blood and blood-products are included in the CPNRE Blueprint 2012-2016. Some participants expressed caution regarding adding the initiation of blood to the LPN scope of practice because of: the complexity of most clients needing this therapy; and the level of expectations set out in the Canadian Blood Standards related to the administration of blood.

Summary
If the government includes this broad restricted activity in the scope of practice of LPNs; standards, limits, and conditions can be developed in consultation with stakeholders to limit initiation of blood and blood-products, and total parenteral nutrition. Limits and conditions can be changed, if necessary, once a decision is made regarding the inclusion of the competencies reflected in the CPNRE Blueprint 2012-2016 document.

15. Put an instrument or a device, hand, or finger into the external ear canal.

Participant Responses:

Participants generally agreed that an order would be required for any purpose related to treatment. LPNs administer eardrops to soften earwax. Other activities within this restricted activity were not identified in the consultation.

Summary
The CLPNBC recommends that this activity be included in the scope of practice of LPNs, with an order.

16. To put and instrument or a device, hand, or finger beyond the point in the nasal passages where they normally narrow.

Participant Responses:
Most LPNs and PPOs report that LPNs do not carry out this activity, either to suction or to insert NG tubes. One PPO reported that LPNs were performing deep-suctioning through the nares with clients who had been assessed by the RN as having a less complex health status. Insertion of NG tubes is included in entry-level preparation in other provinces, and LPNs in focus groups were aware of LPNs who did this in B.C.

Summary
The CLPNBC recommends that this activity be included in the scope of practice of LPNs, with an order. Since this is not an entry-level activity; standards, limits, and conditions are likely required and will be developed in consultation with stakeholders.

17. Put an instrument or a device, hand, or finger beyond the pharynx.

Participant Responses:
Participants did not identify activities carried out by LPNs related to this restricted activity.

Summary
This restricted activity is included in the scope of practice of LPNs in Ontario and Alberta, so the government may decide to include this activity in the revised regulation for LPNs. The CLPNBC can establish a limit prohibiting the restricted activity until appropriate LPN activities and educational preparation are identified.

18. Put an instrument or a device, hand, or finger beyond the opening of the urethra.

Participant Responses:
LPNs commonly insert catheters with an order—an entry-level competency. Some LPNs noted that their workplaces are introducing nurse-initiated catheterizations. They thought that LPNs should be able to catheterize following assessment of their client, particularly as they are assigned primary-care responsibility for post-surgical clients, and therefore, the RN does not necessarily know the client. Other LPNs noted they would rather receive an order from a collaborating RN than to call the MD, particularly after hours.

Summary
The CLPNBC recommends that this activity be included in the scope of practice of LPNs, with an order. More consultation is needed to determine whether LPNs should be authorized to carry out urinary catheterization without an order.

19. Put an instrument or a device, hand, or finger beyond the labia majora.

Participant Responses:
Most participants did not identify activities other than those related to giving medications—a separate restricted activity. Some LPNs do take vaginal swabs with an order. A few LPNs report insertion of pessaries and vaginal packing with an order. This is not currently identified as an entry-level competency and is not common.

Summary
The CLPNBC recommends that this activity be included in the scope of practice of LPNs, with an order. It will work in consultation with stakeholders to develop standards, limits, and conditions.

20. Put an instrument or a device, hand, or finger beyond the anal verge.

Participant Responses:
Participants identified activities such as digital stimulation, insertion of over-the-counter suppositories, rectal tubes, and enemas. A few LPNs reported carrying out disimpactions and reducing a rectal prolapse without an order. Most participants reported that LPNs carried out this restricted activity with an order from a physician (often in the form of a pre-printed order), or a care plan developed by the RN. Some LPNs working in residential-care settings described independently customizing the bowel protocol for an individual client, while working in the role of Team Leader.

Other participants cautioned that protocols are sometimes applied without decision-support tools to support best practice. Concerns were expressed about management of constipation through interventions set out in a protocol rather than determining the cause of the symptom and introducing measures to prevent it. A provincial decision-support tool was not developed for use by RNs—even for adult clients—because of the number of factors to consider in determining the correct care, based on the client's disease and health status.

Summary
More consultation is needed to determine whether LPNs should be authorized to carry out this restricted activity, without an order. If decision-support tools and additional education were available, LPNs could independently mange the care of clients receiving over-the-counter oral medications (not a restricted activity), and obtain an order to carry out the restricted activity beyond the anal verge.

21. Put an instrument or a device, hand, or finger into an artificial opening into the body.

Participant Responses:
LPNs care for well-established ostomies, including putting a finger or tube for an irrigation into the ostomy. A few participants expressed concern about LPNs inserting a finger into an ostomy, or irrigating an ostomy because of the additional risk beyond administration of enemas. Participants noted that LPNs do not change gastrostomy tubes. With additional education, LPNs care for clients who have tracheostomies, and suction and change the inner cannula for clients with well-established tracheostomies whose health outcomes can reasonably be expected to follow an anticipated path.

Summary
The CLPNBC recommends that this activity be included in the scope of practice of LPNs, with an order, and will work with stakeholders to develop standards, limits, and conditions.

22. Put into the external ear canal, up to the eardrum, a substance that is under pressure.

Participant Responses:
PPOs reported that they did not have information stating that syringing ears was carried out by LPNs, and is seldom done by RNs either. Some participants noted that there is no decision-support tool to support this activity; that best practice indicates the pressure per square inch (PSI) should be measured during syringing; and that this equipment is seldom available. A few LPNs were aware of other LPNs who syringed ears in residential-care settings, but always with an order to do so.

Summary
It is not clear that LPNs should have the authority to syringe ears, even with an order. More consultation is needed to determine whether LPNs should be authorized to carry out this activity, and if so; what standards, limits, and conditions would apply? The CLPNBC recommends that this restricted activity not be included in the scope of practice of LPNs until a decision-support tool and appropriate education for LPNs are available.

23. Apply ultrasound for diagnostic or imaging purposes, including any application of ultrasound to a fetus.

Participant Responses:
PPOs and most LPNs report that LPNs are not carrying out fetal monitoring. Some participants in PPO focus groups noted that once the decision to apply constant monitoring is made, the woman is high-risk and should be cared for by an RN. Others suggested that LPNs could apply the monitor, with an order, but they should not have the responsibility to interpret the results. At one PPO focus group it was suggested that LPNs could use hand-held Dopplers to take an intermittent fetal heart rate. This would always be done with an order because another practitioner must determine the client's complexity and care needs to decide whether continuous monitoring is necessary. Very little education for obstetrical care is included in current PN entry-level programs. However, LPNs in focus groups noted that LPNs are being hired into labour and delivery areas now, so perhaps with additional education, they could take responsibility for continuous monitoring.

Summary
LPNs are applying continuous monitoring, with an order, although they do not interpret the results. In addition, some participants in the consultation supported using a hand-held Doppler to take intermittent fetal heart rates. Maternity-related competencies are identified in the CPNRE Blueprint 2112-2016. The CLPNBC recommends that this activity be included in the scope of practice of LPNs, with an order. It will work in consultation with stakeholders to develop standards, limits, and conditions.

24. Compound a drug.

Participant Responses:
There was general agreement that LPNs carry out compounding—mixing one or more ingredients—one of which is a drug. They mix insulin and reconstitute medications as part of entry-level LPN practice. Participants note that more of the compounding is being done in pharmacies to reduce errors, but it still occurs and is done by LPNs.

Summary
The CLPNBC recommends that this activity be included in the scope of practice of LPNs, with an order.

25. Dispense a drug.

Participant Responses:
The majority of PPO focus groups reported that LPNs were not dispensing drugs. However, some PPOs and some LPNs report that LPNs are dispensing. They noted that, in the past, both LPNs and RNs were carrying out this role but it was not seen as dispensing. Now, they are re-examining the role. In one PPO focus group, it was noted that LPNs met the standard set out in the CRNBC's Practice Standard for RNs. However, they question whether the CRNBC Standard fits the definition of dispensing (ensure the pharmaceutical and therapeutic suitability of a drug). This PPO group wonders whether only certified-practice RNs meet the definition for dispensing.

Some participants thought repackaging of drugs previously dispensed by a pharmacist was considered to be dispensing. When it was explained that this was not considered dispensing, they indicated that LPNs do not dispense. However, in some focus groups, LPNs described dispensing in an ER with an order (sometimes a verbal order as the MD decided on the medication needed based on the LPNs' assessment of the client, and then ordered the LPN to dispense medication). It is not clear that entry-level educational preparation prepares LPNs to "ensure the pharmaceutical and therapeutic suitability of a drug."

Summary
The *Nurses (Licensed Practical) Regulation*, amended in November 2010, included dispensing of immunological agents. Since the LPN only administers these agents, dispensing is not currently part of the role. LPNs are not on the list of practitioners who will be given access to Pharmanet, and this will be an important safety feature for any dispensing practitioner.

The CLPNBC will consult with the College of Pharmacists on the issue of LPN dispensing. The CLPNBC believes that more clarity—with regard to the responsibilities of practitioners who are dispensing—is required before a decision can be made about including this restricted activity in the LPN scope of practice.

26. Administer a drug by any method.

Participant Responses:
The most common response from participants in both LPN and PPO focus groups was that LPNs do not administer IV medications. There were questions about LPNs putting in heparin as part of IV heparin-lock procedure. Participants asked whether this was IV administration of a drug. Others noted that LPNs generally do not change IV bags that contain medication, but some do change bags with solutions that contain KCL. Also, some specialized practice areas have started to educate LPNs to administer IV medications.

Summary
LPN IV administration of medications is rare, but it is occurring. Administration of IV mediations (except by IV push) is included in the CPNRE Blueprint 2012-2016. If the

government includes administration of medications, by any means, in the scope of practice of LPNs; standards, limits, and conditions can be developed to allow this activity in limited ways until the decision is made regarding the inclusion of new competencies from the CPNRE Blueprint 2012-2016.

27. If nutrition is administered by enteral instillation: compound a therapeutic diet and dispense a therapeutic diet.

    Participant Responses:
    Some participants questioned why dispensing enteral instillations was a restricted activity, since the kitchen aides get the tube-feeding from the storage cupboard and give it to the nurse. Furthermore, people buy these feedings in supermarkets and off-the-shelf in pharmacies. However if it is a restricted activity, it is common practice for LPNs.

    LPNs also compound (mix two kinds of tube-feeding solutions) because the kitchen staff does not always do this.

    Summary
    The CLPNBC recommends that this activity be included in the scope of practice of LPNs. Another practitioner always designs the diet. LPNs follow an "order" (the design of the diet) in compounding the diet, but do not have a specific order to dispense an enteral diet.

28. Conduct allergy challenge testing or desensitizing treatments.

    Participant Responses:
    Participants in PPO focus groups were not aware that this activity was performed by LPNs in HAs. A few LPNs and other participants were aware of LPNs who carried out this activity in physicians' offices. However, they are not clear as to exactly what the LPN does and with what degree of supervision.

    Summary
    The CLPNBC will meet with the CPSBC to discuss whether this restricted activity should be carried out through delegation/authorize under supervision, or with an order.

MEETINGS WITH KEY STAKEHOLDERS

Chief Nursing Officers (CNOs)

The CLPNBC met with the CNOs in late January 2011 to provide an update on the consultation process. However, due to time limitations, a full update was not possible. The CNOs raised a number of concerns regarding:

- The lack of a health human-resources plan for the educational preparation and roles of LPNs in B.C.
- The existing regulatory framework and the need for review before it is applied to LPNs and RPNs.
- Having RNs with the authority to give orders to LPNs may lead to more friction and hierarchical issues among the nursing groups.

There was no time to explore the issues raised by the CNOs. The CLPNBC has recommended to staff of the MOHS that a meeting with the CNOs, the CLPNBC, and the Ministry occur by early April.

The College of Registered Nurses of British Columbia (CRNBC

The CLPNBC met with the CRNBC to discuss proposed standards, limits, and conditions for immunizations. The possibility of RNs giving orders to LPNs for more complex immunizations was discussed. It was agreed at the meeting that if RNs were to give orders to LPNs, the CRNBC would have to create a standard for NPs and RNs giving orders to LPNs. That standard (and joint education and/or communication from the CLPNBC and the CRNBC) may provide an opportunity to set out expectations. In turn, this will help to avoid some of the troublesome aspects that RNs and LPNs sometimes face in getting orders from other practitioners, such as physicians (physician hostility when RNs/LPNs question the MD's order).

Summary
The CLPNBC believes that a meeting between the MOHS, the CNOs, and the CLPNBC is urgently needed to discuss the concerns of the CNOs. If the government decides to authorize NPs and/or RNs to give orders to LPNs, creation of a standard for giving orders and ongoing collaborative work between the CLPNBC and the CRNBC may help to alleviate the concerns raised by the CNOs.

OTHER ISSUES RAISED IN THE CONSULTATION

Independent Practice

Some participants in the focus groups expressed concern about removing the requirement for supervision and allowing more independent practice for LPNs. They are particularly concerned about restricted activities, until the PN entry-level curriculum is expanded to include more critical thinking and clinical judgment, as well as more depth of knowledge in areas such as pathophysiology and pharmacology. They wondered how collaborative practice would be maintained. With such a short educational program, PN Educators do not think that it is reasonable to teach LPNs how to carry out a broad review of all factors involved, which is necessary for independent decision-making. The whole B.C. PN curriculum is based on collaborative practice and they expect that the new curriculum will be the same.

However, LPNs noted that since they were being assigned as the only nurse for clients, they were, therefore, the most appropriate practitioner to plan the care provided to these clients. At times, that might include independence for restricted activities. Other LPNs described shared client assignments with RNs, and the current arrangement of seeking clinical guidance and/or clinical direction from the RN who shares the client assignment with them.

The CLPNBC discussed with participants that under the new regulatory framework, LPNs would have independence in planning much of the care of their clients (all the nursing activities that are not restricted activities). However, the CLPNBC may determine that some of these nursing activities require standards, limits, and conditions.

Direction from RNs

Most participants described LPNs working under some form of clinical direction from RNs. This is consistent with the current regulatory requirement for working under the supervision of an RN who is providing services to patients. Some PPOs described looking at the concept of orders from RNs to LPNs, particularly when introducing nurse-initiated practice. However, no conclusions were reached.

Types of Clients

Some participants discussed the difficulties with the restricted activities system. They believe it is important to retain clarity regarding the types of clients that the LPN cares for, because the key issue is not the task that is performed, but the level of complexity and decision-making involved, based on the client's care needs. They note that clients in all practice areas, including residential care, are becoming increasingly complex.

Lack of Clarity and Consistency in What LPNs Can Do

LPNs reported frustration with the variations in the LPN role—from employer to employer—and what LPNs were permitted to do. They thought that more provincial consistency through standards, limits, and conditions set by the CLPNBC would be helpful, while recognizing that employers may further limit what LPNs can do in a particular workplace. LPNs thought it would be helpful if the CLPNBC provided information to employers and RNs on entry-level competencies, and which activities require additional education. LPNs describe not being able to practise to entry-level, and also being expected to practise beyond entry-level without adequate education or support.

Preparation for Practice Beyond the Entry-to-Practice Level

LPNs reported concerns about the lack of education available in B.C. for LPNs moving into new areas of practice (emergency, obstetrics, operating room, dialysis, mental health). Programs to prepare RNs for specialized practice have been in place for many years. This is not the case for LPNs in B.C. LPNs seeking additional education must often attend programs or courses designed for RNs, which are based on the entry-level competencies of RNs. Educators in these programs may not be familiar with the entry-level competencies of LPNs. Some courses, such as wound care, may be customized by providing different assignments for LPNs and RNs. However, upon graduation, limits on practice are not clear.

Toward the end of the consultation process, the CLPNBC began to discuss a potential model to guide the discussion that is needed to address this issue (Appendix 2). If the Ministry plans to continue to encourage the introduction of LPNs into numerous new practice areas, decisions are needed with regard to appropriate roles for LPNs, as well as the required educational preparation, and the resources to support this education.

Decision-Support Tools (DSTs) for Independent Practice

Some participants thought that DSTs to assist in decision-making for independent practice would be helpful if LPNs were increasingly working without direction/care plans/orders from other practitioners. However, those involved in developing DSTs for RNs pointed out:

- No provincial organization has taken responsibility for maintaining DSTs. It is an HA/employer-specific decision as to whether they want to implement them.
- Updating will be done by each organization, so provincial consistency is not possible.
- The DSTs were developed based on RN entry-level competencies and would have to be reviewed and perhaps customized for LPNs—who would do this and then maintain the LPN-relevant version?
- Significant education was required to prepare RNs for best practice as independent decision-makers.

Other Issues Identified

- The cost for HAs of upgrading large numbers of LPNs if the competencies in the CPNRE Blueprint 2012-2016 are introduced.
- Keep the focus on what LPNs are actually doing.
- Helpful to have some provincial consistency in activities with, and without, an order.
- A multi-stakeholder group is the best way to develop the appropriate scope of practice for LPNs.

SUMMARY AND RECOMMENDATIONS

The CLPNBC is aware of the limitations inherent in this focused consultation process. Unless a widespread consultation occurs, all restricted activities carried out by LPNs in B.C., and clarity as to the degree of independence is not possible. However, the CLPNBC believes that all common LPN activities are included in the summary of restricted activities in Appendix 3.

The CLPNBC believes it is urgent to implement a revised *Nurses (Licensed Practical) Regulation* by the fall of 2011 to guide the significant new employer initiatives to introduce LPNs in new practice areas, or to increase their role in current practice areas. The current *Nurses (Licensed Practical) Regulation* permits considerable variation in the activities of LPNs in B.C. It describes the LPN scope of practice as "such nursing services related to the care of clients as are consistent with his or her training and abilities." The CLPNBC is concerned that inconsistencies are beginning to appear across the province as employers (even within the same HA) make different decisions as to the appropriate roles and functions of LPNs.

The CLPNBC believes that the scope of practice for LPNs should be based on common activities occurring now. If the draft "revised regulation for LPNs" could be posted in the late spring of 2011, the 3-month consultation period would uncover any significant omissions from the list of restricted activities proposed by the CLPNBC in Appendix 3. Some of these less common activities may be appropriate to include in the scope of practice of LPNs with standards, limits, and conditions; while others may require delegation or authorization under supervision. Some current LPN activities may have to be stopped.

> **Recommendation #1:** Complete a revised regulation for LPNs by fall 2011 so that clarity on restricted activities with standards, limits, and conditions will be in place to guide the significant expansion in the utilization of LPNs.

All LPN practice (except certain immunizations) is currently under the direction of a medical practitioner attending the patient or the supervision of a registered nurse who is providing services to the patient. Under the new regulatory framework (assuming the government removes the requirement for supervision), LPNs will gain significant new independence in their practice. Many activities such as counselling, teaching, and administering over-the-counter medications are not restricted activities, but can do harm to clients.

The CLPNBC is not convinced that the factors are in place to safely move to introduce additional independent scope of practice for restricted activities (beyond activities listed in Appendix 3) at this time. Decision-support tools are not maintained on a provincial basis. Those that exist are based on the entry-level competencies of RNs. In addition, few provincially consistent post-basic education programs/courses designed to consider the different entry-level competencies of LPNs and RNs are in place in B.C. The CLPNBC is planning to develop standards for acting without an order, and educational programs that will prepare LPNs in practice to understand the differences between acting without an order, and with an order. Entry-level PN programs must incorporate education about both independent and collaborative practice so that new LPNs are familiar with the responsibilities of acting without an order.

Recommendation #2: Halt expansion of the independent functions of LPNs (beyond the proposed restricted activities summary) until there is time for the CLPNBC—in consultation with stakeholders—to investigate the development/revision of decision-support tools that clarify the LPN role; and to ensure appropriate educational opportunities are available for LPNs taking on additional independent decision-making for restricted activities.

Recommendation #3: Include content in the new provincial PN curriculum related to the new independent role of the LPN in planning nursing care for patients, including the many aspects of nursing care that are not restricted activities.

If the government decides not to assign the same scope of independent practice for restricted activities to LPNs and RNs, then options include:

- The RN takes over the care of the client when the client's care requires an activity that is out of the scope of practice of the LPN.
- The RN has the authority to give an order to the LPN.
- The LPN calls the MD/NP for an order.
- Some other mechanism not currently in the regulatory system is used to describe this relationship of clinical direction to LPNs.

Placing RNs and NPs on the list of practitioners with the authority to give orders to LPNs does not require employers to implement this practice if they have concerns about its impact on relationships between nurses. The LPN could refer the client to the RN for care, or the LPN could call the MD/NP directly for an order. However, if the authority for RNs to give orders to LPNs is not included in the revised Regulation, the current well-established practice of RNs giving clinical direction to LPNs will no longer be possible when a restricted activity is involved (wound care, bowel protocols).

The CLPNBC has not addressed the issue of orders from RPNs to LPNs since the scope of practice of RPNs has not yet been determined, and additional consultation will be required.

Recommendation #4: Include RNs and NPs in the list of practitioners able to give an order to LPNs.

It is important to clarify the planned roles and functions of LPNs through a provincial Health Human Resources plan. Other provinces have expanded the entry-level competencies of LPNs and it is not clear that the new B.C. provincial curriculum will reflect the 2012-2016 CPNRE competencies. Once decisions are made regarding the future entry-level educational preparation of LPNs in B.C., as well as appropriate practice settings for LPNs and practice models within those settings (shared client assignments or independent primary nurse), it will be possible to revise the regulation, if necessary, to reflect this approach.

As noted in this report, concerns exist about the lack of education available in B.C. for LPNs moving into new areas of practice, such as: emergency, obstetrics, operating room, dialysis, and mental health. Few post-basic programs exist that are designed to prepare LPNs to work in these new practice areas. Clarity is needed regarding plans for post-basic specialization for LPNs.

Recommendation #5: Clarify that the new provincial PN curriculum will reflect the CPNRE Blueprint 2012-2016 document.

Recommendation #6: Develop appropriate post-basic education to prepare LPNs for roles and functions that are beyond entry-level educational preparation.

REFERENCES

College of Nurses of Ontario. (2009). *Practice Guideline: Authorizing Mechanisms*. Toronto, ON: Author.

Health Professions Council. (2001a). *Safe Choices: A New Model for Regulating Health Professions in British Columbia* Part 1, Volume 2, Book 1, Tab 7A Licensed Practical Nurses Scope of Practice (Preliminary Report).

Health Professions Council. (2001b). *Safe Choices: A New Model for Regulating Health Professions in British Columbia* Part 1, Volume 2, Book 1, Tab 7B (Post-Hearing Update of Preliminary report: Licensed Practical Nurses).

Health Professions Council. (2001c). *Safe Choices: A New Model for Regulating Health Professions in British Columbia* Part 1, Volume 2, Book 2, Tab 8B (Post-Hearing Update of Preliminary Report: Registered Nurses).

APPENDICES

APPENDIX 1 - CLPNBC Regulations Restricted Activities Project (DRAFT23Nov10):

Assumptions for Confirmation with Government

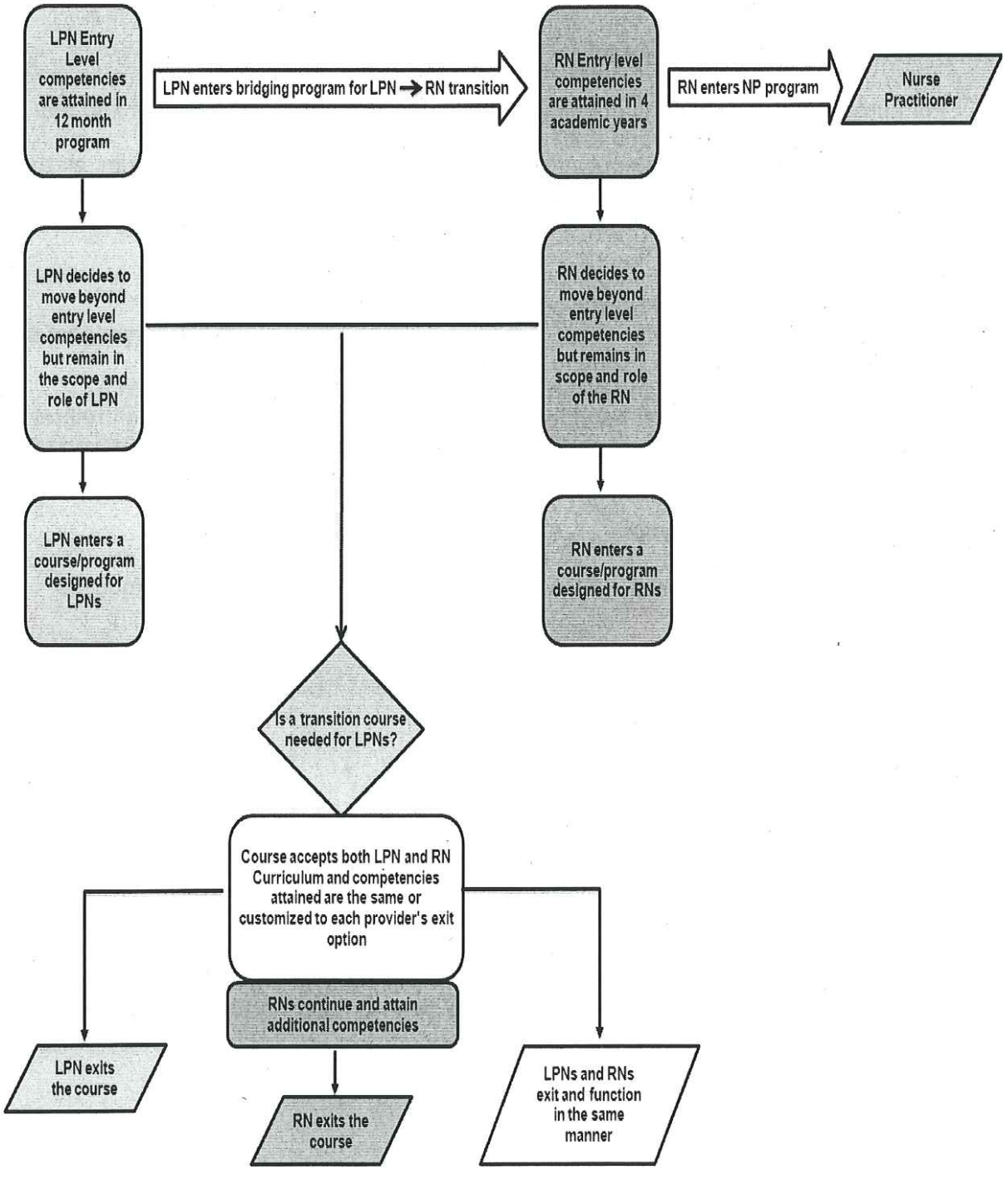
The CLPNBC will soon be launching a focused consultation process to clarify restricted activities carried out by LPNs. The competencies and roles of LPNs have shifted significantly since the 2000 *Safe Choices* report by the Health Professions Council. Some of the information on restricted activities can be obtained through a review of the *Baseline Competencies for Licensed Practical Nurses Professional Practice (February 2009),* which were "blessed" by the Ministry of Health in September 2010. However, in a number of areas, the competencies are written at too broad a level to lead to an understanding of LPN preparation for specific restricted activities. In addition, some activities are carried out by LPNs only after specialized education, following initial registration.

We anticipate that a consultation process carried out by the CLPNBC—which involves key stakeholders—prior to posting by the MOHS of a revised LPN Regulation, will result in fewer concerns and misunderstanding. The CLPNBC will submit a report to government outlining the results of the consultation.

We would like to clarify with government a few assumptions we have before we start the consultation. Our assumptions for the consultation process include:

1. The scope of practice Regulation related to restricted activities will be based primarily on the 2009 Competencies document, not the 2000 *Safe Choices* report of the Health Professions Council.
2. The requirement for supervision by RNs will be removed from the new regulation.
3. The LPN scope will be articulated with restricted activities both with, and without, an order. "Order" will be defined as it is in the RN regulation.
4. Generally, restricted activities that are to be carried out with an order do not have to be stated as specifically in the Regulation. Any restricted activities that will be carried out without an order will be stated in a more specific manner in the revised LPN Regulation.
5. The MOHs is working toward a timeframe of posting the new LPN Regulation in January/ February 2011, and of having the Regulation passed by June 2011.

APPENDIX 2 - Educational Preparation for Practice beyond Entry-Level Competencies



APPENDIX 3 - Summary of Restricted Activities

The following is a summary of proposed restricted activities for Licensed Practical Nurses that the CLPNBC believes could be part of a draft regulation posted by late spring 2011. During the posting period the CLPNBC will develop standards, limits, and conditions, where appropriate, in consultation with stakeholders.

Restricted Activities *Without* an Order

1. For purposes of assessment, put an instrument, or a device, hand, or finger into the external ear canal, and beyond the anal verge.
2. For purposes of assessment, put into the external ear canal up to the eardrum, air that is under pressure equal to, or less than, the pressure created by the use of an otoscope.
3. Apply ultrasound for purposes of assessment of bladder volume and blood-flow monitoring.
4. Compound, dispense, and/or administer a Schedule 2 drug for the purpose of preventing disease using immunoprophylactic agents.
5. Diagnose and treat anaphylaxis (epi-Schedule 1 drug as well as pre-filled syringes) or administer a Schedule 1 or 2 drug to treat anaphylaxis.
6. Apply electricity using (a stand-alone) an automatic external defibrillator (AED).
7. Put an instrument, or device, hand, or finger beyond the labia majora (to the urethral and vaginal orifice), for purposes of performing hygiene measures and washing beyond the labia majora.

Restricted Activities *With* an Order

8. Perform a procedure on tissue below the dermis or below the surface of a mucous membrane.
9. Cast a fracture of a bone.

Administer a substance (not a drug):

10. by injection,
11. by inhalation,
12. by mechanical ventilation,
13. by irrigation,
14. by enteral instillation or parenteral instillation,

Put an instrument or a device, hand, or finger:

15. into the external ear canal,
16. beyond the point in the nasal passages where they normally narrow,
17. beyond the pharynx,
18. beyond the opening of the urethra,
19. beyond the labia majora,
20. beyond the anal verge,
21. into an artificial opening in the body

22. Put into the external ear canal, up to the eardrum, a substance that is under pressure.
23. Apply ultrasound for diagnostic or imaging purposes, including any application of ultrasound to a fetus.

24. Compound a drug.
25. Dispense a drug.
26. Administer a drug by any method.
27. If nutrition is administered by enteral instillation, compound a therapeutic diet and dispense a therapeutic diet.
28. Conduct allergy challenge testing or desensitizing treatments

Restricted Activities Requiring Additional Consultation

***Without* an Order**

The following restricted activities carried out by LPNs were identified in the consultation as ones that may be appropriate for independent practice (without an order). However, all restricted activities listed below require additional consultation before the CLPNBC will have the information necessary to recommend to the government that these activities be authorized to LPNs, without an order.

- Wound care.
- TB skin testing.
- Administration of oxygen.
- Insertion of a urinary catheter.
- Bowel routines involving suppositories and enemas.

***With* an Order**

These activities are being carried out by LPNs but the CLPNBC believes additional consultation is needed before a determination can be made regarding the appropriateness of inclusion in the scope of practice of LPNs.

- Cast a fracture of a bone.
- Put into the external ear canal, up to the eardrum, a substance that is under pressure.
- Dispense a drug.
- Conduct allergy challenge testing or desensitizing treatments.

van den Broek, Jude HLTH:EX

Not Responsive

From: Megan Waldie [mailto:mwaldie@clpnbc.org]
Sent: Friday, April 8, 2011 11:42 AM
To: XT:HLTH Williams, Barbara; adela.krupich@interiorhealth.ca; XT:HLTH Bain, Kim; XT:HLTH Waldner, Liz; XT:HLTH Neill, Debbie; XT:HLTH deLemos, Edna; XT:HLTH Geddes, Susan; karen.nash@viha.ca; Stewart, Sharon A HLTH:EX; McLachlan, Debbie HLTH:EX
Subject: Joint Meeting with CLPNBC, MOHS and CNOs

Hello all – I am now back in the office regularly - sorry that I have not been as available over the past few months (for example not joining you when Janice and Jo Wearing met with you in January about the CLPNBC project for regulation/restricted activities).

I understand that the CNO group expressed some concerns about the regulatory/restricted activity framework. As you know, this framework is set by the Ministry of Health Services. We have been in discussion with Sharon Stewart and Debbie McLachlan a number of times and agree that it would be useful to meet jointly with the CNO group for a more thorough conversation. It would likely be helpful to include discussion about blueprint(s), competency document(s), PN education, etc at that time as well.

In a teleconference on April 7, related to recent regulatory questions, Sharon asked me to coordinate an "in-person" meeting in early May so we can have 2-4 hours of discussion on a variety of topics. Below I have suggested some dates/times that are available...perhaps your group could let us know what works. We would be pleased to hold the meeting at CLPNBC or to sponsor it wherever is most convenient for all.

Week of May 9 – all days are available – suggest 1000-1400
Week of May 16 – only Monday (May 16) or Tuesday (May 17) available

Megan Waldie (Administrative Assistant, Practice) will be coordinating details so I will ask her to forward this to your assistants as well.

Regards,
Elaine

Elaine Baxter
Director, Practice & Policy CLPNBC
Office: 1-778-373-3112
Toll free: 1-877-373-2201 (BC only)

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van den Broek, Jude HLTH:EX

From: McLachlan, Debbie HLTH:EX
Sent: Wednesday, March 28, 2012 1:15 PM
To: van den Broek, Jude HLTH:EX
Cc: Bracewell, Barb HLTH:EX
Subject: FW: CLPNBC Restricted Activities project update
Attachments: CLPNBC restricted activities document for circulation to HPA Leads Dec 23.10.pdf

Importance: High

0058

Debbie McLachlan RN, BSN, MN
Director
Health Human Resource Planning
BC Ministry of Health
2-1 1515 Blanshard Street
Victoria BC V8W 3C8
Tel: (250) 952-2803
Debbie.McLachlan@gov.bc.ca

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From: Janice Harvey [mailto:jharvey@clpnbc.org]
Sent: Thursday, December 23, 2010 1:05 PM
To: McLachlan, Debbie HLTH:EX
Cc: Elaine Baxter; Jo Wearing; XT:HLTH Harvey, Janice
Subject: CLPNBC Restricted Activities project update
Importance: High

Good morning Debbie:

At Elaine Baxter's request, I am sending you a document that we have developed and are sending to the CNO group, prior to a meeting with them in January, as well as to the HPA Leads in each of the health authorities to facilitate discussions with their professional practice office colleagues about the "common activities" that LPNs in each of the health authorities may carry out as part of their roles.

As you may also be aware, CLPNBC is currently carrying out a separate consultation project on standards, limits and conditions for LPNs administering immunizations beyond influenza and pneumococcal. CLPNBC staff working on that project continue to liaise with the BCISC LPN working group, and will be contacting public health people in each of the health authorities regarding that initiative as well.

If you have any questions about the content of the document or either of the CLPNBC projects I have mentioned, or would like to schedule a teleconference with us early in the New Year, please don't hesitate to contact Elaine or me directly and we would be happy to arrange. We also look forward to rescheduling our face to face meeting with you.

Regards and best wishes for a happy holiday,

Janice

Janice Harvey

Nursing Consultant- Practice and Quality Assurance
CLPNBC

#260- 3480 Gilmore Way
Burnaby, BC
V5G 4Y1

Office: 778-373-3101 L4501
Toll free in BC: 1-877-373-2201
Fax: 778-373-3102

*** Online Renewal for 2011 is now OPEN ****

To go directly to the "Renew online" page on the website, paste the following address to your browser's search field:
http://www.clpnbc.org/index.php?dbq=36

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Document to HPA Leads in Health Authorities

CLPNBC Project on Restricted Activities for LPNs

Thank you for agreeing to provide CLPNBC with information on the "common activities" of LPNs working in your health authority. We are gathering information on specific restricted activities that LPNs may carry out in their roles and are beyond the 2009 entry level competencies. This document was prepared to assist you in understanding the information we are seeking. It is not intended to be circulated beyond your Professional Practice Office. However, CLPNBC understands you may need to seek input from others to answer the questions.

College staff will follow up with you to discuss your input sometime in January. We will be preparing a preliminary report for government based on this initial phase of consultation. The government has been informed that this preliminary report from CLPNBC will not be exhaustive of all LPN activities because the short timeframe for this phase of the project does not allow for extensive consultation. A subsequent round of consultations will occur once government posts the revised regulation for LPNs, but depending on the results of our preliminary consultations, government and/or CLPNBC may need to follow up with stakeholders for more information before a posting of a draft regulation for LPNs can occur. Once CLPNBC has more clarity on the activities LPNs carry out beyond the 2009 entry level, we will begin a new consultation process on possible standards, limits and conditions for LPN practice.

Assumptions

CLPNBC has developed a draft set of assumptions to guide this consultation on restricted activities and the scope of practice of LPNs.

1) The LPN scope of practice will be articulated with restricted activities both with and without an order. Order will be defined as it is in the RN regulation.
2) The requirement for "supervision by a registered nurse who is providing services to the patient" will be removed from the revised regulation for LPNs.
3) RNs (and other providers) would be authorized to give an order to LPNs to carry out a restricted activity if they have the authority to carry out that restricted activity without an order, and LPNs do not have that authority.
4) CLPNBC will establish standards, limits and conditions (SLC) for the practice of LPNs.
5) CLPNBC will focus limits and conditions on any activities that are beyond the 2009 entry level competencies.

Restricted activities

CLPNBC has reviewed the master list of restricted activities contained in the *Consultation Draft- Health Professions General Regulation- Restricted Activities* (posted by government March 19, 2010) and developed a list of potential restricted activities for LPNs (both with and without an order) for the purposes of consultation with stakeholders. While we have tried to be inclusive in this list in order to ensure a comprehensive understanding of the common activities of LPNs, some of the restricted activities listed below may not be appropriate to include in the scope of practice of LPNs.

Proposed Restricted Activities WITHOUT an Order

Restricted Activities (without an order)	Entry level (2009) preparation	Comment/ Question
For purposes of assessment put an instrument, hand or finger into the external ear canal and beyond the anal verge	Tympanic thermometer, digital rectal check	
To apply ultrasound for purposes of assessment of bladder volume and blood flow monitoring	Bladder scans, Dopplers for assessment purposes	
Compound, dispense or administer a Schedule II drug for the purpose of preventing disease using immunoprophylactic agents	Not entry level. Included in the revised LPN regulation (2010)	SLCs are in place- currently LPNs limited to influenza and pneumococcal immunizations.
Diagnose and treat anaphylaxis (epi- Schedule I drug/ not pre-filled syringes)	Anaphylaxis is taught in the basic PN program as a concept and part of pharmacology and medication administration	If LPNs work in future without an onsite RN for immunizations (currently on site RN is required) they will require this restricted activity.
Apply electricity using an automatic external defibrillator (AED)	Use in schools/ out in the community- on airplanes, etc	It is unclear if this activity will remain a restricted activity.

Restricted activities with an order

The following activities are identified Canadian Practical Nurse Registration Examination Blueprint 2012- 2016. They include:

- Initiate, assess, monitor and manage infusion of blood and blood products
- Initiate, assess, monitor and manage peripheral infusion therapy (IV)
- Prepare and administer enteral, percutaneous and parenteral (subcutaneous, intramuscular, intradermal and intravenous) medications (excluding IV push)

In the table below we ask if any of these activities are currently being done by LPNs in your Health Authority.

As you review the proposed restricted activities (with an order) in the following section, please identify if LPNs are carrying out any of these restricted activities independently, in other words not guided by an order or care plan developed by another provider.

Proposed Restricted Activities WITH an Order

Restricted Activities (with an order)	Entry- Level (EL) Preparation 2009	Comment/ Question
b) to perform a procedure on tissue		
i) below the dermis	Wound care including cleansing, irrigating, packing and dressing.	Probing, debriding and care of tunnelled wounds NOT entry- level. Do LPNs carry out these activities?
ii) below the surface of a mucous membrane	Same as below the dermis	
c) to cast a fracture of a bone	Not entry- level	Is this activity done by LPNs?

Restricted Activities (with an order)	Entry- Level (EL) Preparation 2009	Comment/ Question
f) to administer a substance **(air, water, not a drug)**		
i) by injection	Fluids, subcutaneous HDC	TB skin testing not entry- level. Do LPNs carry out TB skin testing/ reading results?
ii) by inhalation	Oxygen	Do LPNs administer nitrous oxide?
iii) mechanical ventilation	Care of patient on a respirator. Not entry- level.	With additional education, LPNs are caring for people on long term ventilation whose health outcomes can reasonably be expected to follow an anticipated path.
iv) by irrigation	Saline & water (enema, bladder, ostomies).	Do LPNs carry out any additional activities?
v) by enteral instillation or parenteral instillation	Enteral- saline flushing per NG/PEG tube; tube feedings.	Are LPNs starting IVs or administering blood or TPN?
	Parenteral- monitoring IV infusions (changing IV bags, flushing saline locks).	
g) to put an instrument or a device, hand or finger		
i) into the external ear canal	Tympanic thermometer only theory of otoscope taught	
ii) beyond the point in the nasal passages where they normally narrow	Suctioning nares but not beyond the point in the nasal passages where they narrow.	1) Do LPNs carry out suctioning beyond the nares? 2) Inserting NG tubes is not entry level. Is this done by LPNs?

Restricted Activities (with an order)	Entry- Level (EL) Preparation 2009	Comment/ Question
g) to put an instrument or a device, hand or finger		
iii) beyond the pharynx	not entry level; taught oral only	Do LPNs carry out this restricted activity?
iv) beyond the opening of the urethra	catheterization- is entry- level	
v) beyond the labia majora	insert pessary, vaginal packing	Do LPNs carry out any additional activities?
vi) beyond the anal verge	Digital stimulation and enemas. Rectal tubes.	Do LPNs carry out any additional activities?
vii) into artificial opening in the body	Ostomies; LPNs are taught basic care but not suctioning- basic care of the stoma and tie changes.	Do LPNs carry out any additional activities such as suctioning established trachs?

Restricted Activities (with an order)	Entry- Level (EL) Preparation 2009	Comment/ Question
h) to put into the external ear canal, up to the eardrum, a substance that		
i) is under pressure	Ear syringing- not entry- level.	Do LPNs syringe ears?
j) to apply		
i) ultrasound for		
A) diagnostic or imaging purposes, including any application of ultrasound to a foetus,	Foetal monitoring is not entry level although some of the basic theory is covered.	Are LPNs carrying out foetal monitoring?
m) to compound a drug **(mix one or more ingredients)**	Insulin & reconstituting.	
n) to dispense a drug		Do LPNs dispense?
o) to administer a drug by any method	Entry- level is all routes except IV, intrathecal, epidural and perineural spaces.	Do LPNs administer IV medications?
p) if nutrition is administered by enteral instillation		
ii) to compound a therapeutic diet	Tube feeding is entry level.	
iii) to dispense a therapeutic diet	Tube feeding is entry level.	

Restricted Activities (with an order)	Entry- Level (EL) Preparation 2009	Comment/ Question
u) to conduct challenge testing for allergies		Are LPNs involved in allergy challenge testing?
i) that involves injection, scratch tests or inhalation, if the individual being tested **has not had a previous anaphylactic reaction**		
ii) by any method, if the individual being tested **has had a previous anaphylactic reaction**		
v) to conduct desensitizing treatment for allergies		Are LPNs involved in desensitization treatments?
i) that involves injection, scratch test or inhalation, if the individual being tested **has not had a previous anaphylactic reaction**		
ii) by any method, if the individual being tested **has had a previous anaphylactic reaction**		

Additional Comments:

van den Broek, Jude HLTH:EX

Not Responsive

From: Elaine Baxter [mailto:ebaxter@clpnbc.org]
Sent: Tuesday, November 23, 2010 12:08 PM
To: McLachlan, Debbie HLTH:EX; Beckett, Daryl K HLTH:EX
Cc: Jo Wearing; XT:HLTH Harvey, Janice; Patricia McDonald
Subject: Draft Assumptions re: Regulations for LPNs

Debbie and Daryl – these are the draft assumptions that Janice and Jo have drafted for use as we work through the process. We would like to talk with you about these before we proceed through the consultations ....so if the Wednesday or Thursday times work for you this week, perhaps we can include this topic as well as the education recognition process

Regards,
Elaine

Elaine Baxter
Senior Practice Consultant, CLPNBC
Office: 1-778-373-3112
Toll free: 1-877-373-2201 (BC only)

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CLPNBC Regulations & Restricted Activities Project

DRAFT 23Nov10

Assumptions for confirmation with government

CLPNBC will soon be launching a focused consultation process to clarify restricted activities carried out by LPNs. The competencies and roles of LPNs have shifted significantly since the 2000 *Safe Choices* report by the Health Professions Council. Some of the information on restricted activities can be obtained through a review of the Baseline Competencies for Licensed Practical Nurses Professional Practice (February 2009) which were "blessed" by the Ministry of Health in September 2010. However, in a number of areas, the competencies are written at too broad a level to lead to an understanding of LPN preparation for specific restricted activities. In addition, some activities are carried out by LPNs only after specialized education following initial registration.

We anticipate that a consultation process by CLPNBC which involves key stakeholders prior to posting by MOHS of a revised LPN Regulation will result in fewer concerns and misunderstanding. CLPNBC will submit a report to government outlining the results of the consultation.

We want to clarify a few assumptions we have with government before we start the consultation.

Our assumptions for the consultation process include:

1) The scope of practice Regulation related to restricted activities will be based primarily on the 2009 Competencies document not the 2000 *Safe Choices* report of the Health Professions Council.
2) The requirement for supervision by RNs will be removed from the new regulation.
3) The LPN scope will be articulated with restricted activities both with and without an order. Order will be defined as it is in the RN regulation.
4) Restricted activities that are to be carried out with an order generally do not need to be stated as specifically in the Regulation. Any restricted activities that will be carried out without an order will be stated in a more specific manner in the revised LPN Regulation.
5) MOHs is working toward a timeframe of posting the new LPN Regulation in January/ February 2011 and having the Regulation passed by June 2011.

van den Broek, Jude HLTH:EX

Not Responsive

From: Elaine Baxter [mailto:ebaxter@clpnbc.org]
Sent: Tuesday, August 3, 2010 1:45 PM
To: Beckett, Daryl K HLTH:EX
Cc: Canitz, Brenda HLTH:EX; McLachlan, Debbie HLTH:EX; Patricia McDonald
Subject: CLPNBC letter re: July 22, 2010.

Daryl – thanks for talking with Pat and me on July 22, 2010...it was an informative discussion.

We have summarized our understanding of the conversation in the attached letter.

Not Responsive

NR

Elaine Baxter
Senior Practice Consultant, CLPNBC
Office: 1-778-373-3112
Toll free: 1-877-373-2201 (BC only)

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ensuring safe, competent and ethical nursing practice

July 22, 2010

Mr. Daryl Beckett
Director, Professional Regulation
Ministry of Health Services

Dear Daryl;

Thank you and Brenda Canitz for taking the time to teleconference with the College on July 22, 2010.

We originally contacted you to discuss the progress on the LPN regulation and the restricted activity model. This letter highlights our understanding of some key points from our discussion and our understanding of the actions we agreed upon.

I confirm that you advised that at this time there was no legislative change to the LPN regulation,

I confirm that we advised that significant changes are still required to the regulation and the restricted activity model. You advised that the regulation and restricted activity model were not currently an active file with you.

As well, I confirm that we discussed the Baseline Competencies with Restricted Activities that the College submitted in February 2009 and resubmitted in June 2010. Brenda Canitz expressed some concern that the Entry Level Competencies we re-submitted in June 2010 were different from the February 2009 document of the same name and that the June 2010 Entry Level competencies submitted caused "concern" from unnamed "others".

The only "concern" for the College came from Hospital Employees Union. They wrote to the College expressing concerns about the Practice Guidelines and the Entry Level Competencies. On July 6, 2010 we met with five HEU staff members to clarify misinformation and to provide more details about the development and use of recently revised documents. Enclosed is a copy of our letter to HEU confirming the discussions at that meeting. If you, or Brenda Canitz have received written concerns from anyone, please provide the College with copies of those concerns so that we can address them.

It was the understanding of the College that you seemed to think that the February 2009 Baseline Competencies had been approved, however, Brenda Canitz intervened at this point to say that there may be some questions regarding the February 2009 document. We confirm that you asked the College to provide you with the "red line" version of the Baseline Competencies we submitted in June 2010 for comparison with the February 2009 document. In the interest of making sure we all have the same documents in hand for your review, Pat McDonald asked you to fax, pdf, or send to the College the February 2009 Competencies that you had in your possession. I confirm that you agreed to do that.

For your information, the following is the College understanding of the history of the Baseline Competencies sent to the Ministry. In February **2009,** we sent the document "Baseline Competencies for Licensed Practical Nurses Professional Practice" to the Ministry of Health Services for review and approval. Brenda Canitz convened a group of stakeholders to review this document in April **2010**. The former executive director of the College, John Mayr, was the only

College staff to attend the April 2010 meeting. The revisions suggested by the stakeholders at that meeting were incorporated into the June 2010 document.

Any changes to the February 2009 document we returned to the Ministry of Health in June 2010 was based on a decision by the stakeholders present at the meeting to incorporate the most current national testing service document, the ASI Blueprint 2012. The idea of the stakeholders present at the meeting was that by incorporating the ASI Blueprint 2012, the Competency document became relevant to current practice. The changes did not seem to be major. They related mainly to skills for which practical nurse education already provides the theoretical foundation.

If the revisions incorporated into the June 2010 document are "incorrect" or "unacceptable" to you, the College is seeking approval of the February 2009 document. In the alternative, if the changes to the June 2010 document are "insignificant", then approval of that document is acceptable.

We confirm that we asked a few questions regarding drafting Bylaws for the College, incorporating changes to the Health Professions Act and relevant case law under the Health Professions Review Board. We asked about using the CRNBC bylaws as a model. I confirm your suggestion that the "Chiropractors" bylaws are a good sample to follow for "standardizing" the bylaws of various Colleges. As well, you advised that you are reviewing the bylaws from eight other Colleges and that our bylaws, once they are submitted, will be in the lineup You said you expected to be busy reviewing bylaws until the end of October.

Accordingly, I confirm the follow-up actions that were agreed:

- You will be sending the College a copy of the Baseline Competencies (February 2009) that you currently have. We want to be sure we are working from the same document.
- The College will forward to you, the "redline" Baseline Competency (February 2009) to the Entry Level Competency document (June 2010). Once we have your copy of the February 2009 document, we anticipate completing this process by August 31, 2010.
- Brenda Canitz will confirm a meeting date with stakeholders to complete their review of the Baseline Competencies (February 2009). While difficult to pin down an exact date, group is likely to be able to convene by late September 2010.
- The College will provide you with another copy of the Comparison Restricted Activities & Competencies based upon the Feb 2009 Competency document

Again, thank you for your time, The College will contact you towards the end of August to confirm receipt of your copy of the February 2009 document. As well, we will contact you when we are ready to send you the "red line" version for comparison. Please advise the College of any anticipated changes or delay in the timelines mentioned above. We look forward to continued discussions with you in order to move the CLPNBC forward.

Sincerely,

P. A. McDonald
Acting Executive Director

Elaine Baxter
Senior Practice Consultant, CLPNBC

cc. B. Canitz
cc. Debbie McLachlan

College of Licensed Practical Nurses of BC

Consultation on the Scope of Practice of Licensed Practical Nurses FINAL REPORT Phase 1

NR

June 7, 2011

Table of Contents

EXECUTIVE SUMMARY

The current *Nurses (Licensed Practical) Regulation* urgently requires revision because it does not reflect the new regulatory framework in place for other regulated health professions in British Columbia. In particular, Licensed Practical Nurses (LPNs) work closely with other health-care providers such as Registered Nurses (RNs), Nurse Practitioners (NPs), and physicians who have regulations that reflect the new regulatory framework. In the fall of 2010, staff from the Ministry of Health Services (MOHS) began discussions with the College of Licensed Practical Nurses of British Columbia (CLPNBC) regarding a new initiative to begin work on the revision to the current *Nurses (Licensed Practical) Regulation*. After discussion with Ministry staff, it was agreed that the CLPNBC would carry out a focused consultation to provide preliminary feedback to the government. It was understood that continued consultation with LPNs and other stakeholders would likely be required following this initial consultation process. The purpose of this report is to:

- Present the results of the CLPNBC's initial consultation process.
- Provide the CLPNBC's recommendations on the scope of practice for LPNs in B.C. to the government.

Nine focus groups and two meetings with key stakeholders were held between December 2010 and February 2011. LPNs, Health Authority (HA) staff, and educators from entry-level Practical Nurse (PN) programs were included in the consultation. The CLPNBC prepared a consultation document that was circulated on December 23rd to the Professional Practice Offices (PPOs), Chief Nursing Officers (CNOs), and the MOHS. Participants in the focus groups provided input based on the consultation document prepared by the CLPNBC. In addition, regulations were reviewed related to the scope of practice of LPNs in Ontario and Alberta.

The CLPNBC is aware of the limitations inherent in this focused 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. The CLPNBC believes that all common LPN activities are included in the summary of restricted activities identified in this report. In order to guide the significant new employer initiatives that introduce LPNs in new practice areas, or to increase their role in current practice areas, the CLPNBC believes it is critical to implement a revised regulation by the fall of 2011. Because the current regulation describes the LPN scope of practice as "such nursing services related to the care of patients as are consistent with his or her training and abilities," it permits considerable variation in the activities of LPNs in B.C. The CLPNBC is concerned that differences are beginning to appear across the province as employers (even within the same HA) make different decisions regarding appropriate roles and functions of LPNs.

As a result of the consultation process, the CLPNBC makes the following recommendations:

1. Complete a revised regulation for LPNs by fall 2011 so that clarity on restricted activities—with standards, limits, and conditions—will be in place to guide the significant expansion in the utilization of LPNs.
2. Halt expansion of the autonomous functions of LPNs (beyond the proposed restricted activities summary) until there is time for the CLPNBC—in consultation with stakeholders—to investigate the development/revision of decision-support tools that clarify the LPN role; and to ensure appropriate educational opportunities are available for LPNs taking on additional autonomous decision-making for restricted activities.
3. Include content in the new provincial PN curriculum related to the new autonomous role of the LPN in planning nursing care for patients, including the many aspects of nursing care that are not restricted activities.
4. Include RNs and NPs in the list of practitioners able to give orders to LPNs.
5. Clarify that the new provincial curriculum will reflect the Canadian Practical Nurse Registration Examination (CPNRE) Blueprint 2012-2016 document.
6. Develop appropriate post-basic education to prepare LPNs for roles and functions that are beyond entry-level educational preparation.

INTRODUCTION

The current *Nurses (Licensed Practical) Regulation* requires revision urgently because it does not reflect the new regulatory framework in place for other regulated health professions in British Columbia. In particular, LPNs work closely with other health-care providers such as RNs, NPs, and physicians who have regulations that reflect the new regulatory framework. Both the B.C. government and the CLPNBC have done some preliminary work. However, this work has not yet resulted in a comprehensive revision to the regulation for LPNs.

In the fall of 2010, staff from the Ministry of Health Services (MOHS) began discussions with the CLPNBC regarding a new initiative to begin work on the revision to the current *Nurses (Licensed Practical) Regulation*. In November 2010, the CLPNBC sent a set of assumptions to the government for confirmation. The assumptions were intended to facilitate reaching agreement between CLPNBC and the government that would underpin the consultation process. During a teleconference meeting on December 7, 2010, MOHS staff informed the CLPNBC that they were not able to provide feedback on the draft assumptions document until the government began work on a revised *Nurses (Licensed Practical) Regulation*. At this meeting, it was agreed that the CLPNBC would continue with a focused consultation to provide preliminary feedback to the government. It was understood that continued consultation with LPNs and other stakeholders would likely be required following this initial consultation process.

Participants in the consultation process were informed by the CLPNBC that:

> The CLPNBC will be preparing a preliminary report for the government based on this initial phase of consultation. We have informed the government that this preliminary report from the CLPNBC will not be exhaustive of all LPN activities because the timeframe for this phase of the project does not allow for extensive consultation. A subsequent round of consultations will occur once government posts the revised regulation for LPNs. But, depending on the results of this preliminary consultation, the government and/or the CLPNBC may have to follow-up with stakeholders for more information before the posting of a draft regulation for LPNs can occur. Once the CLPNBC has more clarity on the activities that LPNs carry out beyond the 2009 entry-level competencies, we will begin a new consultation process on possible standards, limits, and conditions (CLPNBC Consultation Document: *CLPNBC Project on Restricted Activities for LPNs.* p.1*)*.

The purpose of this report is to:

- Present the results of the CLPNBC's initial consultation process; and
- Provide the CLPNBC's recommendations to the government on the scope of practice for LPNs in B.C.

CONSULTATION PROCESS

Preparing for the Focus Groups

The competencies and roles of LPNs have shifted significantly since the 2000 *Safe Choices* report by the Health Professions Council (HPC). Some information on restricted activities carried out by LPNs can be obtained through a review of the *Baseline Competencies for Licensed Practical Nurses Professional Practice (February 2009)*. However, in a number of areas, the competencies are written too broadly to lead to an understanding of entry-level LPN educational preparation for specific restricted activities. In addition, some activities are carried out by LPNs only after additional post-basic educational preparation, following initial registration as an LPN.

The CLPNBC began the consultation process by reviewing the master list of restricted activities in the Regulation posted by the government - *Health Professions General Regulation: Restricted Activities* (consultation draft, March 19, 2010). In October 2010, the CLPNBC met with a group of educators from PN entry-level programs to request information on the entry-level educational preparation of LPNs related to the performance of specific restricted activities. Following that meeting, and based on the CLPNBC staff's knowledge of common LPN activities following post-basic preparation, a draft list of restricted activities was developed that was intended to reflect common LPN activities.

The CLPNBC also reviewed the regulations for LPNs in both Ontario and Alberta as both provinces have implemented a regulatory framework similar to that of B.C.'s. However, there is difficulty in direct comparison because each of the regulatory frameworks has some significant differences. For example, Alberta does not include the concept of orders in its regulatory framework. In addition, both Alberta and Ontario have completed work to increase entry-level LPN competencies, and the length of PN entry-level educational programs. The preparation of LPNs in those provinces more closely reflects the competencies in the Canadian Practical Nurse Registration Examination (CPNRE) Blueprint 2012-2016 document. A new CLPNBC baseline competencies document that reflects the 2012-2016 CPNRE competencies has been developed but is not yet in use in B.C.

Focus Groups and Key Stakeholder Meetings

Nine focus groups and two meetings with key stakeholders were held between December 2010 and February 2011. The first focus group was held in December and gave the CLPNBC the opportunity to refine the consultation process for the remaining focus groups held in 2011. In December, a teleconference was held with the *Health Professions Act* (HPA) leaders for the HAs to discuss the proposed consultation process. Following that meeting, the CLPNBC prepared a consultation document entitled "*CLPNBC Project on Restricted Activities for LPNs*" that was circulated to the Professional Practice Offices (PPOs), Chief Nursing Officers (CNOs), and the MOHS on December 23, 2010. The assumptions sent to the MOHS were revised and included as part of the consultation document.

Focus groups were held with the PPO in each Health Authority (HA) to collect information on common LPN activities occurring. Six HAs and Providence Health Care provided information to the CLPNBC through six focus groups held by teleconference or in person, and one via email response. Thirty individuals participated in the six focus groups arranged with the PPOs. PPO staff collected data from managers and/or program leads, and in some cases, included these individuals in the focus group for that HA. Some PPOs have existing committees that involve

LPNs, or LPNs work in the PPO office, or in managerial/consultant positions. These LPNs participated in some focus groups. Information was collected by the PPOs from a variety of practice settings, including: urban and rural hospitals; community (public health, home care, and primary care clinics); and residential care.

Two "in-person" focus groups were held with LPNs: one focus group was assembled by the CLPNBC, and one focus group was held with LPNs in a specialized area of practice. A total of 18 LPNs participated in the two focus groups. The focus group assembled by the CLPNBC included LPNs from all the geographical areas represented by the HAs and from acute care, residential care, and home and community-care settings. This focus group included a two-hour introduction and discussion of the new regulatory framework, followed by input on common LPN activities from the LPN focus group participants. At the CLPNBC's request, an employer organized the focus group from a specialized area of practice. The available time permitted only a brief overview of the new regulatory framework for LPN participants.

As described earlier in the document, the CLPNBC held a meeting in October with PN educators to obtain information about entry-level PN educational preparation. One focus group was held with educators from three separate entry-level PN programs located in different areas in B.C. Its purpose was to affirm the information about entry-level PN educational preparation that was gathered in October 2010, and to gain additional insight from PN educators.

Participants in the focus groups provided input and feedback on draft "restricted activities for LPNs" set out in the consultation document entitled "C*LPNBC Project on Restricted Activities for LPNs".* The CLPNBC requested that the consultation document have limited circulation because the timelines for the revised LPN regulation had not been set, and the assumptions underpinning the consultation had not been confirmed by the MOHS staff.

LPNs and employers have been advised previously by the government that the LPN regulation would soon be revised, and then other priorities have delayed the process. The CLPNBC believes that a clear timeline is needed from the government before the CLPNBC engages in extensive consultation with LPNs. LPNs must understand the new regulatory framework to give accurate information as to what restricted activities they are carrying out, and with what degree of independence.

The consultation did not directly include employers from contracted residential care, home support, or First Nations communities. The results from this consultation are preliminary in nature, until a more extensive and comprehensive consultation is conducted with a wider variety of employers and more LPNs.

ASSUMPTIONS UNDERLYING THE CONSULTATION

The CLPNBC developed a revised set of assumptions to guide consultation on the scope of practice for LPNs, based in part on assumptions circulated to the government in November 2010. At that time MOHS staff informed CLPNBC that they were unable to provide feedbacl on the draft assumptions but agreed that CLPNBC would carry on with the preliminary consultation.

Following the completion of the preliminary consultation described in this document, MOHS staff and CLPNBC met and a revised set of assumptions was developed (see Appendix 1 Assumptions to Guide Consultation on the Scope of Practice for LPNs). These revised assumptions in Appendix 1 will guide the next phase of the consultation.

Each assumption is presented below with further discussion in *italics*.

1. The LPN scope of practice will be articulated with restricted activities, both with and without an order. Order will be defined as it is in the *Nurses (Registered) and Nurse Practitioner Regulation*.

   The CLPNBC assumes that the government would use the same basic structure used in the Nurses (Registered) and Nurse Practitioner Regulation when drafting the revised Nurses (Licensed Practical) Regulation.

2. The requirement for supervision by RNs who are providing services to the patient will be removed from the revised regulation for LPNs.

   The CLPNBC assumes this requirement will be removed in the revised regulation for LPNs. The HPC did not recommend a requirement for supervision in its report to the government (Health Professions Council, 2001a, Tab 7A, p. 20). The CLPNBC does not believe that regulatory supervision is appropriate for a self-regulated profession working within its legislated scope of practice.

3. RNs (and other health-care providers) will be authorized to give an order to LPNs to carry out a restricted activity, **if** they have the authority to carry out that restricted activity without an order, and LPNs do not have that authority.

   RNs currently provide clinical direction to LPNs related to nursing care in the form of care plans and verbal instruction in many practice settings, such as direction for wound care. It is likely that RNs will have some areas of autonomous practice (authority to carry out restricted activities without an order) not shared by LPNs. If this occurs, and unless the LPN is able to follow the order of a collaborating RN, the LPN will have to seek an order from an MD or an NP.

   *Under the new regulatory framework, the government has authorized some practitioners to give orders to others. For example, MDs and NPs can give orders to RNs. Regulatory supervision requires the supervising professional to assess and monitor the competence of the individual they are supervising. However, under an order, the ordering practitioner is responsible only for the **quality** of the order they provide. They are not expected to ensure the **competence** of the practitioner who is carrying out their order.*

The CLPNBC believes that an order from an RN for specific restricted activities is more appropriate than the current requirement for supervision of LPNs. Under the new regulatory system, LPNs will be gaining independence for many nursing activities that are not restricted activities. The CLPNBC noted that Ontario permits RNs to give orders to LPNs (College of Nurses of Ontario, 2009, p.13).

4. The CLPNBC will establish standards, limits, and conditions (SLC) for the practice of LPNs.

   This assumption is based on the regulatory framework in place in British Columbia and is consistent with section 5 (1) (1.1) of the Nurses (Licensed Practical) Regulation.

5. The CLPNBC will focus limits and conditions on activities that are beyond the 2009 entry-level competencies.

   The CLPNBC has noted that, particularly in the last few years, LPNs are moving into many new practice areas. Increasingly, this is leading to a situation that is similar to the one the Health Professions Council pointed out in its review of registered nursing.

   > The Council does not doubt that RNs with specialty training do perform the services proposed by the BCNU/RNABC submission, but we were not presented with detailed information about the programs in place to allow for advanced training and education of such practitioners. Moreover the information received at the hearing confirmed that there is no universally accepted certification system in place and a wide variety of training and educational programs, which vary among institutions, are used to establish advanced practice capabilities. Such diverse arrangements are not in the public interest, and universal certification programs, regulated through the College, ought to be established for specialty and advanced practice (Health Professions Council, 2001c, p. 18).

   It is the College's understanding that standards, limits, and conditions and certified practice were introduced by the government in part to address this concern and to support more provincial consistency in the post-basic educational preparation and practice of health professionals.

6. Generally, restricted activities that are carried out with an order can be stated less specifically in the Regulation.

   This assumption was included in the assumptions document sent to staff of the MOHS. Although it was not included in the consultation document circulated during the consultation process, this assumption guided the consultation process. This is the model in the Nurses (Registered) and Nurse Practitioner Regulation, and reflects the additional control over practice when another provider must issue an order.

   For restricted activities with an order, the CLPNBC is providing examples, not an exhaustive list of activities carried out by LPNs. The CLPNBC recommends the use of standards, limits, and conditions developed in consultation with stakeholders, including professions with the authority to order the restricted activity. This approach is more flexible and responsive to changes in practice, rather than attempting to define specific limitations in the Regulation itself.

SCOPE OF PRACTICE STATEMENT

The HPC recommended the following scope of practice statement for LPNs:

> The practice of nursing by licensed practical nurses is the provision of health care for the promotion, maintenance and restoration of health; and the prevention, treatment and palliation of illness and injury, including assessment of health status and implementation of interventions (Health Professions Council, 2001b, p. 2).

Concerns were expressed to the HPC regarding the omission of the words *planning* and *evaluation* in the scope statement for LPNs. The Council responded to these concerns in this manner:

> However the Council's task is not to describe the nursing process but to describe, generally, the scope of practice of the profession. In any event, planning and evaluation are undoubtedly integral to and implicit in the practice of all professions (Health Professions Council, 2001b, p. 2).

However, the CLPNBC notes that the term *planning* is included in the scope of practice statement of RNs. A discussion of the recommended scope of practice statement was included in the focus group with LPNs, which included a detailed overview of the new regulatory framework. There was considerable concern from LPNs about the omission of planning from the LPN scope of practice statement. While the LPNs in the focus group understood that the HPC stated in their report that this does not prevent the LPN from carrying out the nursing process, LPNs are very concerned (based on past experiences) that they will be told that omission of planning in the scope of practice statement prevents them from carrying out planning—an integral part of the nursing process and the CLPNBC's expectations of them.

The HPC indicated that they have set out distinctions between RNs and LPNs in the scope of practice statement and in the Council's recommendations on reserved acts (Health Professions Council, 2001a, p. 20-21). The CLPNBC does not think omission of the word *planning* from the scope of practice statement for LPNs is the best way to create a distinction between the two regulated nursing groups.

The CLPNBC would like to discuss the scope of practice statement for LPNs with the government.

RESERVED TITLES

The Health Professions Council recommended the following reserved titles for Licensed Practical Nurses (Health Professions Council, 2001b, p. 7).

- Licensed Practical Nurse
- Practical Nurse
- Nurse, and
- Any abbreviation of those titles

The CLPNBC agrees with this recommendation.

RESTRICTED ACTIVITIES CARRIED OUT BY LPNs

The CLPNBC developed a consultation document that divided restricted activities into two sections

- without an order; and
- with an order.

Consistent with the assumptions outlined above, the restricted activities to be carried out **without** an order are described in a more specific manner than those carried out **with** an order.

Emergency Exemption

Participants identified some emergency situations—such as administration of oxygen, and diagnosis and treatment of anaphylaxis—in which they thought that LPNs should have the authority to act without an order. Participants were reminded that an emergency exemption does exist under the *Health Professions Act* (*HPA*), and in the current *Nurses (Licensed Practical) Regulation*. An example from the RN regulation was used for discussion purposes. At times, RNs do deliver babies but it is not included in the RN scope of practice because it is not a **common or expected** part of their practice. If RNs are required to deliver a baby, they do so under the emergency exemption.

Participants were asked to consider whether LPNs would commonly be in the situation identified and expected to act autonomously. If so, the activity should be included in the scope of practice for LPNs so that the CLPNBC can develop standards, limits, and conditions to ensure that LPNs have the practice supports and educational preparation required.

Restricted activities: without an order (1 through 7)

1. **For purposes of assessment, put an instrument, or a device, hand, or finger into the external ear canal and beyond the anal verge.**

   Participant Responses: There was general agreement that LPNs commonly carry out this restricted activity without an order. Activities identified included rectal checks; rectal swabs as part of infectious control screening; and rectal temperatures—although the performance of this activity on children likely requires an order. LPNs also use tympanic thermometers and otoscopes.

   Summary
   This restricted activity, without an order, was supported in the consultation.

2. **For purposes of assessment, put into the external ear canal, up to the eardrum, air that is under pressure equal to, or less than, the pressure created by the use of an otoscope.**

   Participant Responses: Most participants said that LPNs did not use otoscopes for assessment purposes. Some LPNs described assessing for inflammation, wax, and foreign objects with an otoscope. Currently, B.C. PN entry-level programs cover only theory related to the use of an otoscope.

Summary
LPNs using otoscopes must have this restricted activity contained in the revised LPN Regulation in order to adequately assess the eardrum. The CLPNBC will consult further to determine if a specific limit or condition is needed for LPNs using an otoscope for assessment purposes.

3. **Apply ultrasound for purposes of assessment of bladder volume and blood-flow monitoring.**

Participant Responses:
Participants agreed that this restricted activity for assessment purposes represented common LPN practice. They noted that some practice areas do not have access to this technology, but the activity is included in PN entry-level educational programs.

Some participants supported LPNs using the Doppler to take pulses (pedal pulses) but not to assess the ankle-brachial index (ABI). The ABI is used to assess lower extremity arterial perfusion. The test is critical in determining whether a pressure dressing can be used to treat a venous leg ulcer.

Summary
This restricted activity, without an order, was supported in the consultation. A specific limit related to measuring the ABI can be developed by the CLPNBC.

4. **Compound, dispense, and/or administer a Schedule 2 drug for the purpose of preventing disease, using immunoprophylactic agents.**

Participant Responses:
A separate consultation was occurring related to this restricted activity recently included in the LPN regulation by the government. Currently, LPNs are carrying out flu and pneumococcal immunizations without an order, with an RN on-site. Some participants asked why immunizations given with an order require the same educational preparation as immunizations given without an order (current CLPNBC standards, limits, and conditions). Educators noted that very limited information on immunizations is covered in current PN entry-level programs. Further, they are not sure whether enough information will be added in the new provincial curriculum to prepare entry-level LPNs to give immunizations, even with an order. Only two HAs had current plans to expand autonomous LPN practice beyond flu and pneumococcal immunizations in Public Health settings.

Summary
The work to develop standards, limits, and conditions for LPNs to carry out autonomous immunization beyond flu and pneumococcal immunizations is currently on hold. It will be included in the overall project related to the revision of the scope of practice of LPNs.

5. **Diagnose and treat anaphylaxis (epi-Schedule 1 drug as well as pre-filled syringes)**

Participant Responses:
Some discussion has occurred about removing the requirement for an on-site RN for immunizations. Because of the risk of anaphylaxis, in immunization practice clients are held for at least 15 minutes after the immunization has been administered. Therefore, if

LPNs are going to provide immunizations without an on-site RN, it will be an expected part of practice that they are able to diagnose and treat anaphylaxis.

Some participants thought this restricted activity should be included in the LPN scope of practice without an order because it is an emergency. However, they did not identify situations (other than immunizations) in which diagnosing and treating anaphylaxis would be a common or expected part of LPN practice (e.g. administering new IV medication).

Some participants in the focus groups did not support LPNs administering immunizations without an on-site RN. They thought the RN should be available on-site to provide consultation and to deal with emergencies such as anaphylaxis. Some participants pointed out that the educational preparation of LPNs does not provide them with the background for emergency decision-making. The participants who were involved in the introduction of the "Decision Support Tool for RNs" pointed out that additional education was needed related to this autonomous activity for RNs, including: quickly determining dosages for different age groups in an emergency situation, and making a diagnosis that is not straightforward. The correct diagnosis is particularly important in the case of some clients, such as the elderly.

Summary
If LPNs are going to immunize without an RN on-site they will require the educational preparation to be able to respond effectively to this emergency. Other practice areas will have to determine whether this is a common and expected area of practice for LPNs, and if so, provide the required educational preparation. This activity is not an entry-level competency for LPNs. Therefore, a condition will be required calling for additional educational preparation for LPNs.

6. **Apply electricity using an automatic external defibrillator (AED).**

Participant Responses:
There was general agreement from participants that this restricted activity should be included in the scope of practice of LPNs. They pointed out that AEDs are increasingly common in public places, and wondered whether AEDs would continue to be considered a restricted activity. Participants are aware of residential care facilities that are installing AEDs and the LPN may be the only regulated health professional on-site. Other participants pointed out that LPNs might not be expected to use an AED. AEDs are being installed in primary-care practice settings but the LPN would not be expected to take the lead in such an emergency. Others said that many residents of residential care facilities have levels of care in place that would preclude use of an AED. Others from acute-care settings indicated that their organizations were considering introducing policies that would involve calling the hospital "code team" instead of using an AED.

In using an AED, there is no requirement for the LPN to diagnose the cardiac rhythm. The AED only issues a shock when the rhythm is appropriate for this intervention. Participants wanted it to be clear that this restricted activity referred only to stand-alone AEDs because the use of the AED function in defibrillators is more complex. A CPR course is available for health professionals, which includes use of an AED. The current entry-level competencies for LPNs do not include use of AEDs.

Summary
Participants generally support including the use of stand-alone AEDs by LPNs if this activity continues to be a restricted activity. If this is an expectation of practice for LPNs in some workplaces they can be prepared through the use of existing educational programs in CPR that include use of an AED.

7. **Put an instrument, or device, hand, or finger beyond the labia majora—excluding the insertion of intrauterine devices—for purposes of performing hygiene measures and washing beyond the labia majora to the urethral and vaginal orifices.**

Summary
This restricted activity was recommended for LPNs by the HPC for purposes of assessment, or assisting with activities of daily living (Health Professions Council, 2001b, p. 4). The CLPNBC is not clear that the government intended to make this basic hygiene measure a restricted activity. However, if the government does see this activity as a restricted activity, then LPNs must have the authority to perform this activity without an order.

Restricted activities: with an order (8 through 28)

This section describes activities carried out by LPNs with an order. As noted in the assumptions for the consultation, the CLPNBC did not attempt to create an exhaustive list of all the activities in each restricted activity. If the government leaves the restricted activity broadly worded, the CLPNBC will work with stakeholders to determine which activities beyond entry-level practice require standards, limits, and conditions. The CLPNBC asked participants in the focus groups to identify activities in the section of the CLPNBC consultation document "with an order" that were being carried out by LPNs "without an order" or as part of a care plan.

8. **Perform a procedure on tissue below the dermis, or below the surface of a mucous membrane.**

Participant Responses:
Wound care
Some participants report that LPNs only carry out wound care that reflects entry-level practice (cleansing, irrigating, and packing and dressing wounds when the wound bed can be visualized). Other participants report that LPNs carry out wound care activities beyond entry-level. Some participants said it would be helpful to have limits and conditions for activities beyond entry-level. Currently, LPNs are caring for more complex wounds and performing wound-care activities that are beyond entry-level practice. This is with post-basic educational preparation using a variety of methods, from formal courses to bedside teaching with no theoretical component.

Most participants reported that LPNs follow an order from an MD or a wound-care plan developed by an RN. Increasingly, a specialist wound-care RN develops the care plans for more complex wounds. Some participants thought that LPNs should have the authority to manage "simple" wounds without an order. However, they were not clear what would constitute this type of wound, or whether these wounds would be below the dermis.

Starting IVs

Participants report that some LPNs were carrying out this activity but HA policy now precludes this. Some participants described plans to have LPNs begin performing this activity. Some LPNs in the focus groups thought LPNs should have the authority to start IVs with an order. This activity is not included in the approved CLPNBC 2009 entry-level competencies. However, initiation, assessment, monitoring, management, and documentation of peripheral infusion therapy are included in the CPNRE Blueprint 2012-2016.

Summary
Wound care performed by LPNs with an order is very common. More consultation is needed to determine whether LPNs care for wounds below the dermis without an order or direction. LPNs practising without an order would need the ability to **diagnose** the cause of the wound, as well as to treat the wound. Decision-support tools and appropriate education would have to be in place to support this autonomous activity.

If the government keeps this restricted activity broadly worded and requiring an order, the CLPNBC can work with stakeholders to determine standards, limits, and conditions that would apply to LPNs starting IVs with an order. LPNs taking blood samples could continue this activity with an order, perhaps with standards, limits, and conditions.

9. Cast a fracture of a bone.

Participant Responses:
Casting is being done by LPNs in some HAs, while others use only orthopedic technicians (orthotechs). Some LPNs work as orthotechs. It is not clear how the role of the orthopedic LPN differs from the unregulated orthotech. The post-basic educational preparation of LPNs working in these roles varies significantly. Some B.C. LPNs have graduated from an intensive Alberta program *(Advanced Orthopedics for LPNs* offered through Norquest College) that is designed exclusively for LPNs. It includes a 300-hour MD-supervised preceptorship. Other LPNs have taken employer-based education that may be the same as that of the orthotechs. In B.C., some LPNs have elected to take a formal education program that trains orthotechs. However, it does not prepare them to the same level of the Norquest College program in Alberta.

The amount of physician involvement in applying the cast (some MDs apply the first few layers of casting material before giving an order to the LPN to complete the cast), as well as the amount of supervision of the application of the cast (some MDs check the cast before the client can leave the cast clinic or the ER), is not clear. If LPNs and orthotechs are both in the same workplace, MDs will have to determine whether the provider they are working with is an LPN working within the LPN scope of practice, or an unregulated cast technician requiring regulatory supervision from the MD.

Summary
This restricted activity is not included in the scope of practice of RNs in B.C., or in the scope of practice of Registered Practical Nurses Ontario. Setting or resetting a fracture is included in the scope of practice of LPNs in Alberta (casting is not identified as a restricted activity in Alberta). The Regulation in Alberta requires the LPN to be on the Specialized Practice Register. They must complete an educational program that is approved by the College of Licensed Practical Nurses of Alberta (CLPNA). This is the

same educational program taken independently by some LPNs in B.C. Also, some B.C. HAs have sponsored groups of LPNs to take the program.

The CLPNBC must carry out further consultation with the College of Physicians and Surgeons of BC (CPSBC), as well as with LPNs and managers about this LPN activity. More information is needed to determine whether casting should be performed through delegation/authorization under supervision (as with orthotechs), or be included in the scope of practice of LPNs—likely through some form of certified practice. That is, approval of the required educational program and a specialized register, as occurs in Alberta.

10. Administer a substance (not a drug) by injection.

Participant Responses: LPNs do carry out this restricted activity including administering fluids by subcutaneous injection. Participants noted that a few LPNs are providing TB skin tests with an order, and either reading the test, or having the test read by another practitioner. Some participants suggest that LPNs should be authorized to carry out this activity without an order. Others cautioned that the activity must be performed frequently to maintain expertise in reading the test and in explaining the meaning of the test result, particularly with a positive result. In addition, TB testing in a public-health setting leads to contact follow-up, which these participants are not convinced is an LPN role.

As far as the CLPNBC is aware, the BC Centre for Disease Control (BCCDC)—TB control—does not have a decision-support tool or an educational course to support LPNs to carry out this activity autonomously. The old paper-based CLPNBC immunization course (no longer available) included a TB testing learning module. LPNs were also required to have their supervisor sign them off on a TB testing skills checklist. A copy was sent to the CLPNBC as a record of their competence, related to the skill of administering the TB test. They were not assessed on their ability to read the test result.

Summary
The CLPNBC recommends that this restricted activity remain under an order until provincial discussions to determine the role of the LPN acting without an order in TB testing, as well as the required post-basic educational preparation, can occur.

11. Administer a substance (not a drug) by inhalation.

Participant Responses:
Participants report that LPNs do administer oxygen with an order—an entry-level competency. There is no consensus on LPNs providing oxygen without an order. Some describe LPNs starting low-volume oxygen and immediately getting help—calling an ambulance or contacting an on-site collaborating RN. A few LPNs reported starting oxygen at rates of up to 6 -10 litres, without an order. Others reported they would not go over 5 litres without an order. They also reported that there were no polices in place within the workplace.

During the consultation, the CLPNBC was unable to establish when the diagnosis of the condition and the treatment of a client presenting with a **new** symptom of low oxygen saturation would be a common or expected part of the role of an LPN. Clients assigned to LPNs are those whose health outcomes can reasonably be expected to follow an

anticipated path. A client presenting with new, undiagnosed, untreated low oxygen saturation would not meet the health-status criteria for appropriate assignment to the LPN.

Participants involved in the development of the Decision Support Tools for RNs pointed out that the decision-making required related to diagnosing the cause of low oxygen saturation and determining the appropriate treatment (even for the time period until the MD can assume the care) is not straightforward.

Administration of nitrous oxide is not part of entry-level PN preparation but participants note that this is done by LPNs with an order, for example, in emergency rooms. It is not clear where LPNs receive the additional education needed for this activity. Some participants noted that LPNs would not administer nitrous oxide in the maternity setting as the health status of the labouring woman is considered complex and therefore, inappropriate for assignment to an LPN.

Summary
More consultation is needed to determine whether there are situations in which managing a client with an unexpected drop in oxygen saturation would be a common and/or expected part of the LPN role. Otherwise, the emergency exemption—with policies dictating the maximum flow rate—might be the more appropriate approach. The need for standards, limits, and conditions for LPNs carrying out the administration of nitrous oxide with an order can be addressed in the upcoming CLPNBC consultation regarding standards, limits, and conditions.

12. Administer a substance (not a drug) by mechanical ventilation.

Participant Responses:
There was consensus from participants that this restricted activity is performed by LPNs with an order. LPNs care for people on long-term ventilation whose health outcomes can reasonably be expected to follow an anticipated path. Participants agree that this activity is not entry-level and would require additional education. Participants described courses from Pearson, Queen Alexandra, and Aberdeen Hospitals that prepare LPNs for this activity; one participant referred to teaching LPNs in hospital-based education. A few also described client-specific teaching of LPNs.

Summary
The CLPNBC recommends that this activity be included in the scope of practice of LPNs, with an order, and will work with stakeholders to develop standards, limits, and conditions.

13. Administer a substance (not a drug) by irrigation.

Participant Responses:
Participants agreed that LPNs carry out irrigations as identified in the consultation document (enemas, irrigation of bladder following a TUPR, and irrigation of ostomies). Some indicated that LPNs only care for clients with well-established ostomies. One participant reported that LPNs irrigate catheters without an order, while others said this activity is no longer best practice. Educators report that irrigation of ostomies is covered in theory only. Therefore, standards, limits, and conditions might be required for this activity.

Summary
The CLPNBC recommends that this activity be included in the scope of practice of LPNs, with an order.

14. Administer a substance (not a drug) by enteral instillation or parenteral instillation.

Participant Responses:

Enteral Instillation
Participants agreed that LPNs carry out tube feedings both via an N/G tube and peg tubes. They also flush feeding tubes. One participant noted that flushing to keep the feeding tube clear following the administration of a tube feeding or medication is different than unblocking a feeding tube, and does not think LPNs are prepared for the latter activity.

Parenteral Instillation
Participants agreed that LPNs monitor IV infusions and change IV bags for un-medicated IV solutions. LPNs also flush saline locks and add heparin to heparin locks for the purpose of maintaining patency. Participants wondered if that use of heparin would be considered giving an IV medication. They reported that LPNs did not start blood or parenteral nutrition, although they do monitor these infusions.

Initiation, assessment, monitoring, management, and documentation of blood and blood-products are included in the CPNRE Blueprint 2012-2016. Some participants expressed caution regarding adding the initiation of blood to the LPN scope of practice because of: the complexity of most clients needing this therapy; and the level of expectations set out in the Canadian Blood Standards related to the administration of blood.

Summary
If the government includes this broad restricted activity in the scope of practice of LPNs; standards, limits, and conditions can be developed in consultation with stakeholders to limit initiation of blood and blood-products, and total parenteral nutrition. Limits and conditions can be changed, if necessary, once a decision is made regarding the inclusion of the competencies reflected in the CPNRE Blueprint 2012-2016 document.

15. Put an instrument or a device, hand, or finger into the external ear canal.

Participant Responses:

Participants generally agreed that an order would be required for any purpose related to treatment. LPNs administer eardrops to soften earwax. Other activities within this restricted activity were not identified in the consultation.

Summary
The CLPNBC recommends that this activity be included in the scope of practice of LPNs, with an order.

16. To put and instrument or a device, hand, or finger beyond the point in the nasal passages where they normally narrow.

Participant Responses:
Most LPNs and PPOs report that LPNs do not carry out this activity, either to suction or to insert NG tubes. One PPO reported that LPNs were performing deep-suctioning through the nares with clients who had been assessed by the RN as having a less complex health status. Insertion of NG tubes is included in entry-level preparation in other provinces, and LPNs in focus groups were aware of LPNs who did this in B.C.

Summary
The CLPNBC recommends that this activity be included in the scope of practice of LPNs, with an order. Since this is not an entry-level activity; standards, limits, and conditions are likely required and will be developed in consultation with stakeholders.

17. Put an instrument or a device, hand, or finger beyond the pharynx.

Participant Responses:
Participants did not identify activities carried out by LPNs related to this restricted activity.

Summary
This restricted activity is included in the scope of practice of LPNs in Ontario and Alberta, so the government may decide to include this activity in the revised regulation for LPNs. The CLPNBC can establish a limit prohibiting the restricted activity until appropriate LPN activities and educational preparation are identified.

18. Put an instrument or a device, hand, or finger beyond the opening of the urethra.

Participant Responses:
LPNs commonly insert catheters with an order—an entry-level competency. Some LPNs noted that their workplaces are introducing nurse-initiated catheterizations. They thought that LPNs should be able to catheterize following assessment of their client, particularly as they are assigned primary-care responsibility for post-surgical clients, and therefore, the RN does not necessarily know the client. Other LPNs noted they would rather receive an order from a collaborating RN than to call the MD, particularly after hours.

Summary
The CLPNBC recommends that this activity be included in the scope of practice of LPNs, with an order. More consultation is needed to determine whether LPNs should be authorized to carry out urinary catheterization without an order.

19. Put an instrument or a device, hand, or finger beyond the labia majora.

Participant Responses:
Most participants did not identify activities other than those related to giving medications—a separate restricted activity. Some LPNs do take vaginal swabs with an order. A few LPNs report insertion of pessaries and vaginal packing with an order. This is not currently identified as an entry-level competency and is not common.

Summary
The CLPNBC recommends that this activity be included in the scope of practice of LPNs, with an order. It will work in consultation with stakeholders to develop standards, limits, and conditions.

20. Put an instrument or a device, hand, or finger beyond the anal verge.

Participant Responses:
Participants identified activities such as digital stimulation, insertion of over-the-counter suppositories, rectal tubes, and enemas. A few LPNs reported carrying out disimpactions and reducing a rectal prolapse without an order. Most participants reported that LPNs carried out this restricted activity with an order from a physician (often in the form of a pre-printed order), or a care plan developed by the RN. Some LPNs working in residential-care settings described autonomously customizing the bowel protocol for an individual client, while working in the role of Team Leader.

Other participants cautioned that protocols are sometimes applied without decision-support tools to support best practice. Concerns were expressed about management of constipation through interventions set out in a protocol rather than determining the cause of the symptom and introducing measures to prevent it. A provincial decision-support tool was not developed for use by RNs—even for adult clients—because of the number of factors to consider in determining the correct care, based on the client's disease and health status.

Summary
More consultation is needed to determine whether LPNs should be authorized to carry out this restricted activity, without an order. If decision-support tools and additional education were available, LPNs could autonomously mange the care of clients receiving over-the-counter oral medications (not a restricted activity), and obtain an order to carry out the restricted activity beyond the anal verge.

21. Put an instrument or a device, hand, or finger into an artificial opening into the body.

Participant Responses:
LPNs care for well-established ostomies, including putting a finger or tube for an irrigation into the ostomy. A few participants expressed concern about LPNs inserting a finger into an ostomy, or irrigating an ostomy because of the additional risk beyond administration of enemas. Participants noted that LPNs do not change gastrostomy tubes. With additional education, LPNs care for clients who have tracheostomies, and suction and change the inner cannula for clients with well-established tracheostomies whose health outcomes can reasonably be expected to follow an anticipated path.

Summary
The CLPNBC recommends that this activity be included in the scope of practice of LPNs, with an order, and will work with stakeholders to develop standards, limits, and conditions.

22. Put into the external ear canal, up to the eardrum, a substance that is under pressure.

Participant Responses:
PPOs reported that they did not have information stating that syringing ears was carried out by LPNs, and is seldom done by RNs either. Some participants noted that there is no decision-support tool to support this activity; that best practice indicates the pressure per square inch (PSI) should be measured during syringing; and that this equipment is seldom available. A few LPNs were aware of other LPNs who syringed ears in residential-care settings, but always with an order to do so.

Summary
It is not clear that LPNs should have the authority to syringe ears, even with an order. More consultation is needed to determine whether LPNs should be authorized to carry out this activity, and if so; what standards, limits, and conditions would apply? The CLPNBC recommends that this restricted activity not be included in the scope of practice of LPNs until a decision-support tool and appropriate education for LPNs are available.

23. Apply ultrasound for diagnostic or imaging purposes, including any application of ultrasound to a fetus.

Participant Responses:
PPOs and most LPNs report that LPNs are not carrying out fetal monitoring. Some participants in PPO focus groups noted that once the decision to apply constant monitoring is made, the woman is high-risk and should be cared for by an RN. Others suggested that LPNs could apply the monitor, with an order, but they should not have the responsibility to interpret the results. At one PPO focus group it was suggested that LPNs could use hand-held Dopplers to take an intermittent fetal heart rate. This would always be done with an order because another practitioner must determine the client's complexity and care needs to decide whether continuous monitoring is necessary. Very little education for obstetrical care is included in current PN entry-level programs. However, LPNs in focus groups noted that LPNs are being hired into labour and delivery areas now, so perhaps with additional education, they could take responsibility for continuous monitoring.

Summary
LPNs are applying continuous monitoring, with an order, although they do not interpret the results. In addition, some participants in the consultation supported using a hand-held Doppler to take intermittent fetal heart rates. Maternity-related competencies are identified in the CPNRE Blueprint 2112-2016. The CLPNBC recommends that this activity be included in the scope of practice of LPNs, with an order. It will work in consultation with stakeholders to develop standards, limits, and conditions.

24. Compound a drug.

Participant Responses:
There was general agreement that LPNs carry out compounding—mixing one or more ingredients—one of which is a drug. They mix insulin and reconstitute medications as part of entry-level LPN practice. Participants note that more of the compounding is being done in pharmacies to reduce errors, but it still occurs and is done by LPNs.

Summary
The CLPNBC recommends that this activity be included in the scope of practice of LPNs, with an order.

25. Dispense a drug.

Participant Responses:
The majority of PPO focus groups reported that LPNs were not dispensing drugs. However, some PPOs and some LPNs report that LPNs **are** dispensing. They noted that, in the past, both LPNs and RNs were carrying out this role but it was not seen as dispensing. Now, they are re-examining the role. In one PPO focus group, it was noted that LPNs met the standard set out in the CRNBC's Practice Standard for RNs. However, they question whether the CRNBC Standard fits the definition of dispensing (ensure the pharmaceutical and therapeutic suitability of a drug). This PPO group wonders whether only certified-practice RNs meet the definition for dispensing.

Some participants thought repackaging of drugs previously dispensed by a pharmacist was considered to be dispensing. When it was explained that this was not considered dispensing, they indicated that LPNs do not dispense. However, in some focus groups, LPNs described dispensing in an ER with an order (sometimes a verbal order as the MD decided on the medication needed based on the LPNs' assessment of the client, and then ordered the LPN to dispense medication). It is not clear that entry-level educational preparation prepares LPNs to "ensure the pharmaceutical and therapeutic suitability of a drug."

Summary
The *Nurses (Licensed Practical) Regulation*, amended in November 2010, included dispensing of immunological agents. Since the LPN only administers these agents, dispensing is not currently part of the role. LPNs are not on the list of practitioners who will be given access to Pharmanet, and this will be an important safety feature for any dispensing practitioner.

The CLPNBC will consult with the College of Pharmacists on the issue of LPN dispensing. The CLPNBC believes that more clarity—with regard to the responsibilities of practitioners who are dispensing—is required before a decision can be made about including this restricted activity in the LPN scope of practice.

26. Administer a drug by any method.

Participant Responses:
The most common response from participants in both LPN and PPO focus groups was that LPNs do not administer IV medications. There were questions about LPNs putting in heparin as part of IV heparin-lock procedure. Participants asked whether this was IV administration of a drug. Others noted that LPNs generally do not change IV bags that contain medication, but some do change bags with solutions that contain KCL. Also, some specialized practice areas have started to educate LPNs to administer IV medications.

Summary
LPN IV administration of medications is rare, but it is occurring. Administration of IV mediations (except by IV push) is included in the CPNRE Blueprint 2012-2016. If the

government includes administration of medications, by any means, in the scope of practice of LPNs; standards, limits, and conditions can be developed to allow this activity in limited ways until the decision is made regarding the inclusion of new competencies from the CPNRE Blueprint 2012-2016.

27. If nutrition is administered by enteral instillation: compound a therapeutic diet and dispense a therapeutic diet.

Participant Responses:
Some participants questioned why dispensing enteral instillations was a restricted activity, since the kitchen aides get the tube-feeding from the storage cupboard and give it to the nurse. Furthermore, people buy these feedings in supermarkets and off-the-shelf in pharmacies. However if it is a restricted activity, it is common practice for LPNs.

LPNs also compound (mix two kinds of tube-feeding solutions) because the kitchen staff does not always do this.

Summary
The CLPNBC recommends that this activity be included in the scope of practice of LPNs. Another practitioner always designs the diet. LPNs follow an "order" (the design of the diet) in compounding the diet, but do not have a specific order to dispense an enteral diet.

28. Conduct allergy challenge testing or desensitizing treatments.

Participant Responses:
Participants in PPO focus groups were not aware that this activity was performed by LPNs in HAs. A few LPNs and other participants were aware of LPNs who carried out this activity in physicians' offices. However, they are not clear as to exactly what the LPN does and with what degree of supervision.

Summary
The CLPNBC will meet with the CPSBC to discuss whether this restricted activity should be carried out through delegation/authorize under supervision, or with an order.

MEETINGS WITH KEY STAKEHOLDERS

Chief Nursing Officers (CNOs)

The CLPNBC met with the CNOs in late January 2011 to provide an update on the consultation process. However, due to time limitations, a full update was not possible. The CNOs raised a number of concerns regarding:

- The lack of a health human-resources plan for the educational preparation and roles of LPNs in B.C.
- The existing regulatory framework and the need for review before it is applied to LPNs and RPNs.
- Having RNs with the authority to give orders to LPNs may lead to more friction and hierarchical issues among the nursing groups.

There was no time to explore the issues raised by the CNOs. The CLPNBC has recommended to staff of the MOHS that a meeting with the CNOs, the CLPNBC, and the Ministry occur by early April.

The College of Registered Nurses of British Columbia (CRNBC

The CLPNBC met with the CRNBC to discuss proposed standards, limits, and conditions for immunizations. The possibility of RNs giving orders to LPNs for more complex immunizations was discussed. It was agreed at the meeting that if RNs were to give orders to LPNs, the CRNBC would have to create a standard for NPs and RNs giving orders to LPNs. That standard (and joint education and/or communication from the CLPNBC and the CRNBC) may provide an opportunity to set out expectations. In turn, this will help to avoid some of the troublesome aspects that RNs and LPNs sometimes face in getting orders from other practitioners, such as physicians (physician hostility when RNs/LPNs question the MD's order).

Summary
The CLPNBC believes that a meeting between the MOHS, the CNOs, and the CLPNBC is urgently needed to discuss the concerns of the CNOs. If the government decides to authorize NPs and/or RNs to give orders to LPNs, creation of a standard for giving orders and ongoing collaborative work between the CLPNBC and the CRNBC may help to alleviate the concerns raised by the CNOs.

OTHER ISSUES RAISED IN THE CONSULTATION

Autonomous Practice

Some participants in the focus groups expressed concern about removing the requirement for supervision and allowing more autonomous practice for LPNs. They are particularly concerned about restricted activities, until the PN entry-level curriculum is expanded to include more critical thinking and clinical judgment, as well as more depth of knowledge in areas such as pathophysiology and pharmacology. They wondered how collaborative practice would be maintained. With such a short educational program, PN Educators do not think that it is reasonable to teach LPNs how to carry out a broad review of all factors involved, which is necessary for autonomous decision-making. The whole B.C. PN curriculum is based on collaborative practice and they expect that the new curriculum will be the same.

However, LPNs noted that since they were being assigned as the only nurse for clients, they were, therefore, the most appropriate practitioner to plan the care provided to these clients. At times, that might include independence for restricted activities. Other LPNs described shared client assignments with RNs, and the current arrangement of seeking clinical guidance and/or clinical direction from the RN who shares the client assignment with them.

The CLPNBC discussed with participants that under the new regulatory framework, LPNs would have independence in planning much of the care of their clients (all the nursing activities that are not restricted activities). However, the CLPNBC may determine that some of these nursing activities require standards, limits, and conditions.

Direction from RNs

Most participants described LPNs working under some form of clinical direction from RNs. This is consistent with the current regulatory requirement for working under the supervision of an RN who is providing services to patients. Some PPOs described looking at the concept of orders from RNs to LPNs, particularly when introducing nurse-initiated practice. However, no conclusions were reached.

Types of Clients

Some participants discussed the difficulties with the restricted activities system. They believe it is important to retain clarity regarding the types of clients that the LPN cares for, because the key issue is not the task that is performed, but the level of complexity and decision-making involved, based on the client's care needs. They note that clients in all practice areas, including residential care, are becoming increasingly complex.

Lack of Clarity and Consistency in What LPNs Can Do

LPNs reported frustration with the variations in the LPN role—from employer to employer—and what LPNs were permitted to do. They thought that more provincial consistency through standards, limits, and conditions set by the CLPNBC would be helpful, while recognizing that employers may further limit what LPNs can do in a particular workplace. LPNs thought it would be helpful if the CLPNBC provided information to employers and RNs on entry-level competencies, and which activities require additional education. LPNs describe not being able to practise to entry-level, and also being expected to practise beyond entry-level without adequate education or support.

Preparation for Practice Beyond the Entry-to-Practice Level

LPNs reported concerns about the lack of education available in B.C. for LPNs moving into new areas of practice (emergency, obstetrics, operating room, dialysis, mental health). Programs to prepare RNs for specialized practice have been in place for many years. This is not the case for LPNs in B.C. LPNs seeking additional education must often attend programs or courses designed for RNs, which are based on the entry-level competencies of RNs. Educators in these programs may not be familiar with the entry-level competencies of LPNs. Some courses, such as wound care, may be customized by providing different assignments for LPNs and RNs. However, upon graduation, limits on practice are not clear.

Toward the end of the consultation process, the CLPNBC began to discuss a potential model to guide the discussion that is needed to address this issue (Appendix 2). If the Ministry plans to continue to encourage the introduction of LPNs into numerous new practice areas, decisions are needed with regard to appropriate roles for LPNs, as well as the required educational preparation, and the resources to support this education.

Decision-Support Tools (DSTs) for Autonomous Practice

Some participants thought that DSTs to assist in decision-making for autonomous practice would be helpful if LPNs were increasingly working without direction/care plans/orders from other practitioners. However, those involved in developing DSTs for RNs pointed out:

- No provincial organization has taken responsibility for maintaining DSTs. It is an HA/employer-specific decision as to whether they want to implement them.
- Updating will be done by each organization, so provincial consistency is not possible.
- The DSTs were developed based on RN entry-level competencies and would have to be reviewed and perhaps customized for LPNs—who would do this and then maintain the LPN-relevant version?
- Significant education was required to prepare RNs for best practice as autonomous decision-makers.

Other Issues Identified

- The cost for HAs of upgrading large numbers of LPNs if the competencies in the CPNRE Blueprint 2012-2016 are introduced.
- Keep the focus on what LPNs are actually doing.
- Helpful to have some provincial consistency in activities with, and without, an order.
- A multi-stakeholder group is the best way to develop the appropriate scope of practice for LPNs.

SUMMARY AND RECOMMENDATIONS

The CLPNBC is aware of the limitations inherent in this focused consultation process. Unless a widespread consultation occurs, all restricted activities carried out by LPNs in B.C., and clarity as to the degree of independence is not possible. However, the CLPNBC believes that all common LPN activities are included in the summary of restricted activities in Appendix 3.

The CLPNBC believes it is urgent to implement a revised *Nurses (Licensed Practical) Regulation* by the fall of 2011 to guide the significant new employer initiatives to introduce LPNs in new practice areas, or to increase their role in current practice areas. The current *Nurses (Licensed Practical) Regulation* permits considerable variation in the activities of LPNs in B.C. It describes the LPN scope of practice as "such nursing services related to the care of clients as are consistent with his or her training and abilities." The CLPNBC is concerned that inconsistencies are beginning to appear across the province as employers (even within the same HA) make different decisions as to the appropriate roles and functions of LPNs.

The CLPNBC believes that the scope of practice for LPNs should be based on common activities occurring now. If the draft "revised regulation for LPNs" could be posted in the late spring of 2011, the 3-month consultation period would uncover any significant omissions from the list of restricted activities proposed by the CLPNBC in Appendix 3. Some of these less common activities may be appropriate to include in the scope of practice of LPNs with standards, limits, and conditions; while others may require delegation or authorization under supervision. Some current LPN activities may have to be stopped.

> **Recommendation #1:** Complete a revised regulation for LPNs by fall 2011 so that clarity on restricted activities with standards, limits, and conditions will be in place to guide the significant expansion in the utilization of LPNs.

All LPN practice (except certain immunizations) is currently under the direction of a medical practitioner attending the patient or the supervision of a registered nurse who is providing services to the patient. Under the new regulatory framework (assuming the government removes the requirement for supervision), LPNs will gain significant new independence in their practice. Many activities such as counselling, teaching, and administering over-the-counter medications are not restricted activities, but can do harm to clients.

The CLPNBC is not convinced that the factors are in place to safely move to introduce additional autonomous scope of practice for restricted activities (beyond activities listed in Appendix 3) at this time. Decision-support tools are not maintained on a provincial basis. Those that exist are based on the entry-level competencies of RNs. In addition, few provincially consistent post-basic education programs/courses designed to consider the different entry-level competencies of LPNs and RNs are in place in B.C. The CLPNBC is planning to develop standards for acting without an order, and educational programs that will prepare LPNs in practice to understand the differences between acting without an order, and with an order. Entry-level PN programs must incorporate education about both autonomous and collaborative practice so that new LPNs are familiar with the responsibilities of acting without an order.

Recommendation #2: Halt expansion of the autonomous functions of LPNs (beyond the proposed restricted activities summary) until there is time for the CLPNBC—in consultation with stakeholders—to investigate the development/revision of decision-support tools that clarify the LPN role; and to ensure appropriate educational opportunities are available for LPNs taking on additional autonomous decision-making for restricted activities.

Recommendation #3: Include content in the new provincial PN curriculum related to the new autonomous role of the LPN in planning nursing care for patients, including the many aspects of nursing care that are not restricted activities.

If the government decides not to assign the same scope of autonomous practice for restricted activities to LPNs and RNs, then options include:

- The RN takes over the care of the client when the client's care requires an activity that is out of the scope of practice of the LPN.
- The RN has the authority to give an order to the LPN.
- The LPN calls the MD/NP for an order.
- Some other mechanism not currently in the regulatory system is used to describe this relationship of clinical direction to LPNs.

Placing RNs and NPs on the list of practitioners with the authority to give orders to LPNs does not require employers to implement this practice if they have concerns about its impact on relationships between nurses. The LPN could refer the client to the RN for care, or the LPN could call the MD/NP directly for an order. However, if the authority for RNs to give orders to LPNs is not included in the revised Regulation, the current well-established practice of RNs giving clinical direction to LPNs will no longer be possible when a restricted activity is involved (wound care, bowel protocols).

The CLPNBC has not addressed the issue of orders from RPNs to LPNs since the scope of practice of RPNs has not yet been determined, and additional consultation will be required.

Recommendation #4: Include RNs and NPs in the list of practitioners able to give an order to LPNs.

It is important to clarify the planned roles and functions of LPNs through a provincial Health Human Resources plan. Other provinces have expanded the entry-level competencies of LPNs and it is not clear that the new B.C. provincial curriculum will reflect the 2012-2016 CPNRE competencies. Once decisions are made regarding the future entry-level educational preparation of LPNs in B.C., as well as appropriate practice settings for LPNs and practice models within those settings (shared client assignments or primary nurse), it will be possible to revise the regulation, if necessary, to reflect this approach.

As noted in this report, concerns exist about the lack of education available in B.C. for LPNs moving into new areas of practice, such as: emergency, obstetrics, operating room, dialysis, and mental health. Few post-basic programs exist that are designed to prepare LPNs to work in these new practice areas. Clarity is needed regarding plans for post-basic specialization for LPNs.

Recommendation #5: Clarify that the new provincial PN curriculum will reflect the CPNRE Blueprint 2012-2016 document.

Recommendation #6: Develop appropriate post-basic education to prepare LPNs for roles and functions that are beyond entry-level educational preparation.

REFERENCES

College of Nurses of Ontario. (2009). *Practice Guideline: Authorizing Mechanisms*. Toronto, ON: Author.

Health Professions Council. (2001a). *Safe Choices: A New Model for Regulating Health Professions in British Columbia* Part 1, Volume 2, Book 1, Tab 7A Licensed Practical Nurses Scope of Practice (Preliminary Report).

Health Professions Council. (2001b). *Safe Choices: A New Model for Regulating Health Professions in British Columbia* Part 1, Volume 2, Book 1, Tab 7B (Post-Hearing Update of Preliminary report: Licensed Practical Nurses).

Health Professions Council. (2001c). *Safe Choices: A New Model for Regulating Health Professions in British Columbia* Part 1, Volume 2, Book 2, Tab 8B (Post-Hearing Update of Preliminary Report: Registered Nurses).

APPENDICES

APPENDIX 1 – Assumptions to Guide Consultation on the Scope of Practice for LPNs (June 7, 2011):

PROPOSED ASSUMPTIONS

This proposed set of assumptions is intended to guide the next phase of consultation on the scope of practice for Licensed Practical Nurses (LPNs). Following discussion with the Ministry of Health, these draft assumptions have been revised from those contained in the consultation document entitled "*CLPNBC Project on Restricted Activities for LPNs"* that was circulated to the Professional Practice Offices (PPOs), Chief Nursing Officers (CNOs), and the MOHS on December 23, 2010.

Each assumption is presented below with further discussion in *italics*.

1. The scope of practice for LPNs will be based on the *Baseline Competencies for Licensed Practical Nurses Professional Practice (February 2009).*

   Agreement has been reached on the 2009 entry–level competencies for LPNs and those competencies will be reflected in a revised Nurses (Licensed Practical) Regulation. The new provincial curriculum based on the 2009 competencies will also assist in determining the entry-level preparation of LPNs for specific restricted activities. LPNs may move beyond entry- level practice through post basic educational preparation. These post basic areas of practice and the required competencies will be determined through an additional consultation process.

2. The requirement for either direction by a medical practitioner who is attending the patient or supervision by an RN who is providing services to the patient will be removed from the revised regulation for LPNs.

   The CLPNBC assumes the requirement for supervision will be removed in the revised regulation for LPNs. The HPC did not recommend a requirement for supervision in its report to the government (Health Professions Council, 2001a, Tab 7A, p. 20). The CLPNBC does not believe that supervision is appropriate for a self-regulated profession working within its legislated scope of practice. The removal of the requirement for supervision from the revised Nurses (Licensed Practical) Regulation does not refer to employment supervision which will continue to be the employer's responsibility to determine.

3. The scope of practice for LPNs will be articulated with restricted activities, both with and without an order. "Order" will be defined as it is in the *Nurses (Registered) and Nurse Practitioners Regulation*. This approach also means LPNs will not require an

order to provide services that do not include the performance of any restricted activities.

The same basic structure used in the Nurses (Registered) and Nurse Practitioner Regulation will be used in drafting the revised Nurses (Licensed Practical) Regulation. Generally restricted activities that are performed with an order are stated less specifically in the Regulation. This approach reflects the additional control over practice when another provider is required to determine the appropriate intervention by assessing the client and issuing an order to provide a service that includes a restricted activity.

In the new Regulatory Framework the government develops a scope of practice statement and, when appropriate to the profession, assigns restricted activities in a Regulation for each profession. The scope of practice statement describes in general terms what a profession does and how it does it. Restricted activities are higher risk clinical activities that must not be performed by any person in the course of providing health care services, except members of a regulated profession that has been granted legislative authority to do so based on their education and competencies. Under the new regulatory system, LPNs will be recognized as having autonomous practice (i.e., ability to act without an order or supervision) for nursing services that do not include restricted activities.

4. LPNs will be authorized to carry out orders given by RNs (and other specified health-care providers such as MDs, nurse practitioners and dentists) to provide a service that includes a restricted activity if:
    - the other providers have the authority to perform that restricted activity without an order, and
    - LPNs may only perform that restricted activity with such an order.

    RNs currently provide clinical direction to LPNs related to nursing care in the form of care plans and verbal instruction in many practice settings, such as direction for wound care. It is likely that RNs will have some areas of autonomous practice (authority to carry out restricted activities without an order) not shared by LPNs. If this occurs, and unless the LPN is able to follow the order of a collaborating RN, the LPN will need to seek an order from an MD or an NP.

    *Under the new regulatory framework, the government has authorized some practitioners to give orders to others. For example, MDs and nurse practitioners can give orders to RNs. Regulatory supervision requires the supervising professional to assess and monitor the competence of the individual they are supervising. However, under an order, the ordering practitioner is responsible only for the **quality** of the order they provide. They are not expected to ensure the **competence** of the practitioner who is carrying out their order.*

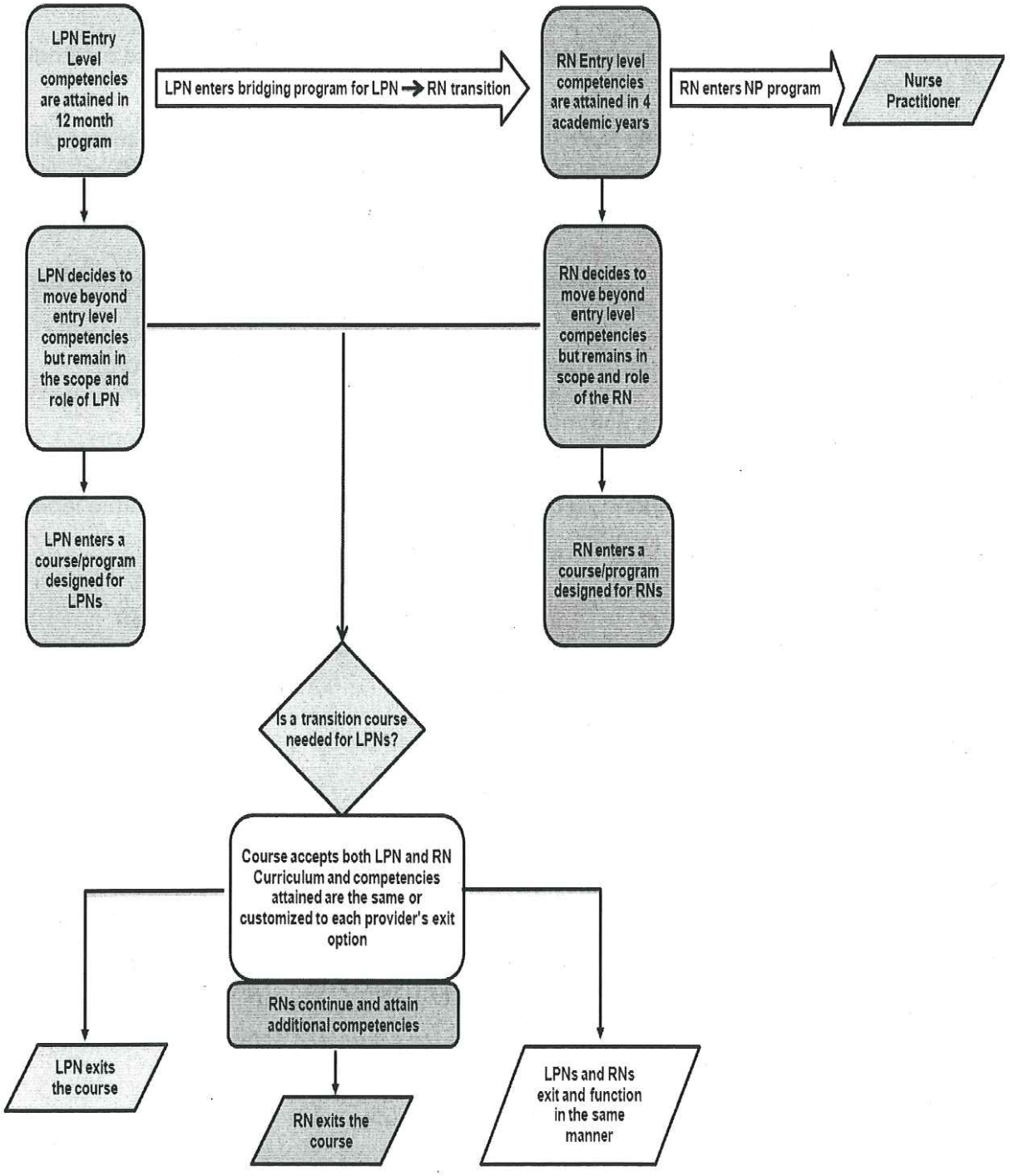
The CLPNBC believes that an order from an RN for services that include specific restricted activities is more appropriate than the current requirement for regulatory supervision of LPNs. The CLPNBC noted that Ontario permits RNs to give orders to LPNs. Some employers may be concerned about the possibility of more friction and hierarchical issues among the nursing groups if RNs give orders to LPNs. In addition LPNs may be assigned primary nurse responsibility for a client rather than sharing a patient assignment with an RN. In that case the RN may be asked to take over care beyond the scope of practice of an LPN or the LPN may obtain an order from an MD or NP.

5. The CLPNBC will focus its standards, limits, and conditions (SLCs) work on the practice of LPNs that is beyond the 2009 entry-level competencies.

The Ministry of Health sets the framework for the scope of practice of professionals through the general scope of practice statement and the assignment of restricted activities that may be performed while providing services that fall within the scope of practice statement. The College sets standards, limits and conditions that provide additional clarity regarding the scope of practice of health professionals. The entry-level competencies of LPNs are clarified in the 2009 competencies document and the Practical Nursing Education curriculum (currently under development). Therefore, the College has identified as a priority the need to focus on standards, limits and conditions for services that are within scope but beyond entry-level practice.

Standards, limits, and conditions developed in consultation with stakeholders, including professions with the authority to order the restricted activity provide additional specificity related to appropriate post-basic activities. This will support more provincial consistency in the post-basic educational preparation and practice of LPNs.

APPENDIX 2 - Educational Preparation for Practice beyond Entry-Level Competencies



APPENDIX 3 - Summary of Restricted Activities

The following is a summary of proposed restricted activities for Licensed Practical Nurses that the CLPNBC believes could be part of a draft regulation posted by late spring 2011. During the posting period the CLPNBC will develop standards, limits, and conditions, where appropriate, in consultation with stakeholders.

Restricted Activities *Without* an Order

For purposes of assessment, put an instrument, or a device, hand, or finger into the external ear canal, and beyond the anal verge (#1).

For purposes of assessment, put into the external ear canal up to the eardrum, air that is under pressure equal to, or less than, the pressure created by the use of an otoscope (#2).

Apply ultrasound for purposes of assessment of bladder volume and blood-flow monitoring (#3).

Compound, dispense, or administer a Schedule 2 drug for the purpose of preventing disease using immunoprophylactic agents (#4).

Diagnose anaphylaxis and administer a Schedule 1 or 2 drug to treat anaphylaxis (#5).

Apply electricity using a stand-alone automatic external defibrillator (AED) (#6).

Put an instrument, or device, hand, or finger beyond the labia majora (to the urethral and vaginal orifice), for purposes of performing hygiene measures and washing beyond the labia majora (#7).

Restricted Activities *With* an Order

Perform a procedure on tissue below the dermis or below the surface of a mucous membrane (# 8).

Administer a substance (not a drug):

by injection (#10),
by inhalation (#11),
by mechanical ventilation (#12),
by irrigation (#13),
by enteral instillation or parenteral instillation (#14).

Put an instrument or a device, hand, or finger:

into the external ear canal (#15),
beyond the point in the nasal passages where they normally narrow (#16),
beyond the pharynx (#17),
beyond the opening of the urethra (#18),
beyond the labia majora (#19),
beyond the anal verge (#20),
into an artificial opening in the body (#21)

Apply ultrasound for diagnostic or imaging purposes, including any application of ultrasound to a fetus (#23).

Compound a drug (#24).

Administer a drug by any method (#26).

If nutrition is administered by enteral instillation, compound a therapeutic diet and dispense a therapeutic diet (#27).

Restricted Activities Requiring Additional Consultation

***Without* an Order**

The following restricted activities carried out by LPNs were identified in the consultation as ones that may be appropriate for autonomous practice (without an order). However, all restricted activities listed below require additional consultation before the CLPNBC will have the information necessary to recommend to the government that these activities be authorized to LPNs, without an order.

- Wound care.
- TB skin testing.
- Administration of oxygen.
- Insertion of a urinary catheter.
- Bowel routines involving suppositories and enemas.

***With* an Order**

These activities are being carried out by LPNs but the CLPNBC believes additional consultation is needed before a determination can be made regarding the appropriateness of inclusion in the scope of practice of LPNs.

- Cast a fracture of a bone (#9).
- Put into the external ear canal, up to the eardrum, a substance that is under pressure (#22).
- Dispense a drug (#25).
- Conduct allergy challenge testing or desensitizing treatments (#28).

Apply ultrasound for diagnostic or imaging purposes, including any application of ultrasound to a fetus (#23).

Compound a drug (#24).

Administer a drug by any method (#26).

If nutrition is administered by enteral instillation, compound a therapeutic diet and dispense a therapeutic diet (#27).

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