

CLINICAL PRACTICE

Self-regulation of the nursing profession: Focus on four Canadian provinces

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Abstract

The regulation of the nursing profession in Canada is achieved through provincial self-regulatory mechanisms, thereby trusting the profession itself to register, license, monitor, and discipline its members for the protection of the general public. It is incumbent upon every registered nurse to learn and understand the self-regulatory framework of the jurisdiction in which they practice. If a nurse moves his/her practice from one province to another, differences in the regulatory framework between jurisdictions can cause confusion. Unfortunately, information on regulatory differences is not always readily available or easily accessible. This article will compare and contrast the self-regulatory framework for RNs in the context of four Canadian provinces: British Columbia, Alberta, Saskatchewan and Ontario. The impact of similarities and differences across these jurisdictions on practicing registered nurses will be highlighted.

Key Words: Nursing, Self-regulation, Canada, Law, College

1 Introduction

The regulation of the nursing profession in Canada is achieved through provincial self-regulatory mechanisms, thereby trusting the profession itself to register, license, monitor, and discipline its own members appropriately for the benefit and protection of the general public. However, the legislation enacting such self-regulatory processes is not identical between provinces/territories and therefore the requirements for Registered Nurses (RNs) differ depending on geographical location. Although it is critical for every nurse to understand the regulatory framework in the jurisdiction in which they practice, differences across the country can cause confusion for nurses who move to a different province to practice and there is little current literature on inter-jurisdictional mobility to assist either the migrating nurses or to help guide policy planners more generally.^[1,2]

Although 88% of RNs in 2011 who had graduated from a Canadian RN program either did not move after graduation, or eventually returned to their original jurisdiction to practice,^[3] mutual recognition agreements (MRAs) that exist between provinces are intended to facilitate easier movement of nurses between many Canadian jurisdictions.^[2] In fact, many nurses enter the profession with the perception that nursing is a mobile career, with employment options existing both inside and outside Canada.^[4] However, the relative ease of transition associated with MRAs may wrongly lead a nurse to believe that no differences in professional practice exist. It is certainly incumbent on nurses to learn and understand the boundaries of their professional role in their jurisdiction but such information is not always readily available/apparent or easily accessible. This article will compare and contrast the self-regulatory framework for RNs in the context of four Canadian provinces: British Columbia (BC),

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Alberta, Saskatchewan and Ontario; within Canada, the top three destinations for nursing graduates who moved after graduation has typically been British Columbia, Alberta and Ontario.^[3]

2 What is self-regulation?

Self-regulation is the ability of a profession to predominantly control its own admission standards and requirements as well as the norms for its practice. In determining who should make decisions about, and thereby regulate, a particular profession, the authority-granting body must consider who holds special expertise and knowledge within and about the profession.^[5] Being granted self-regulatory status is a recognition that a profession itself is best qualified and situated to define the practice and boundaries of its own profession^[6] through identifying, implementing, monitoring and addressing deviation from its own standards of education, its practices and its own articulated professional ethics framework.^[7] In other words, a self-regulating profession becomes accountable for the competence and the conduct of its members, and the reputation of that profession in the eyes of the general public will largely depend on how effectively the professional body exercises its powers of admission and removal from its membership ranks.^[8] In all Canadian provinces and territories, nurses have been granted the ability by their respective governments to regulate their own profession.

3 Regulation of RNs in a Canadian context

3.1 What is “Nursing”?

With few exceptions, such as in Alberta, the definition of “nursing”, “Registered Nurse” and/or “nursing practice” in Canada is provided within provincial enabling legislation.

Although each province and territory in Canada defines these terms slightly differently, all of these definitions serve the same purpose: to describe the scope and nature of professional nursing practice within that province or territory by identifying those acts and procedures that constitute such practice.^[9] Despite some regional differences in definition, it is accurate to state that, across the country, RNs are self-regulated health care professionals who work in both an autonomous capacity as well as in collaborative relationships with other health professionals for the benefit of their patients.^[10]

3.2 Relevant legislation

In Canada, responsibility for the legislation that enables the self-regulation framework of the nursing profession has been granted to the provincial/territorial governments.^[11] Each province and territory has elected to create their particular enabling legislation in different ways; some have created one law that is solely nursing-specific to regulate the profession (e.g. Saskatchewan’s *The Registered Nurses Act, 1988*^[12]) while others have created ‘umbrella’ health profession legislation with a schedule that then pertains specifically to nursing, such as BC (the *Health Professions Act*^[13] and its associated *Nurses (Registered) and Nurse Practitioners Regulation*^[14]). Still other provinces and territories utilize a combination of both methods (e.g. Ontario’s use of the *Nursing Act, 1991*^[15] and the *Regulated Health Professions Act, 1991*^[16]).

The phrases “enabling legislation” and “bylaws” will be used throughout this article. Depending upon the context and specific references, the phrase “enabling legislation” refers to the Acts/Regulations listed in Table 1 for each respective province, while the phrase “bylaws” refers to the remaining documents identified in this same Table for each respective province.

Table 1: Province-Specific Enabling Legislation and Bylaws

Province	Enabling Legislation	Bylaws
BC	<ul style="list-style-type: none"> • <i>Health Professions Act (HPA-BC)</i> ^[13] and associated regulations 	<ul style="list-style-type: none"> • <i>Bylaws of the College of Registered Nurses of British Columbia</i> ^[19]
Ontario	<ul style="list-style-type: none"> • <i>Regulated Health Professions Act, 1991 (RHPA)</i> ^[16], including <i>Health Professions Procedural Code (Schedule 2 of RHPA) (HPPC)</i> ^[17] and associated regulations • <i>Nursing Act, 1991 (Nursing Act)</i> ^[15] and associated regulations 	<ul style="list-style-type: none"> • <i>College of Nurses of Ontario By-laws</i> ^[20]
Alberta	<ul style="list-style-type: none"> • <i>Health Professions Act (HPA-A)</i> ^[18] and associated regulations 	<ul style="list-style-type: none"> • <i>Bylaws Pursuant to the Health Professions Act</i> ^[21]
Saskatchewan	<ul style="list-style-type: none"> • <i>The Registered Nurses Act, 1988 (TRNA)</i> ^[12] 	<ul style="list-style-type: none"> • <i>Saskatchewan Registered Nurses' Association Bylaws 2013</i> ^[22]

3.3 Provincial regulatory bodies for the nursing profession

The terminology for the regulatory body itself that is created through legislation is also different between provinces; in some provinces, such as BC and Ontario, the regulatory body for nurses is legally entitled a “College” while the legislatures of other provinces, such as Saskatchewan, have chosen instead to entitle their regulatory body as an “Association”. Still others, such as Alberta, use both terms in their name such that their regulatory body for nurses is known as the “College & Association of Registered Nurses of Alberta”. Although these differences in nomenclature can be confusing (to those both inside and outside the profession), it is important to understand that all of these bodies hold regulatory power of and over RNs in their respective provinces. Generally speaking, the difference in the scope of purpose and function of each such body lies largely in whether or not enabling legislation combines (1) the self-regulatory arm of nursing (i.e. regulating nursing roles, education, entry-to-practice requirements, licensing, continuing competence of members, and complaints/discipline), which would reflect a “College” function; and (2) the professional arm of nursing (i.e. advocacy for members of the profession), which would be an “Association”, or if these functions are maintained separately.^[9] This general distinction noted in literature does not however, hold true in Saskatchewan since their regulatory body is functionally both a College and an Association and yet is labelled as solely an Association. For the purposes of this article, the word “College” shall be used to represent both the Colleges and Associations of interest.

3.4 Key elements of the Canadian regulatory framework for RNs

According to the Canadian Nurses Association (CNA),^[7] there are eight elements of the Canadian regulatory framework for RNs: legislative mandate; title protection; scope of practice; requirements for initial licensure/registration; standards for nursing practice and ethics; continuing competence; professional conduct reviews; and evaluation of the effectiveness of College regulatory approaches. Given the relative paucity of publicly-available information regarding College evaluation mechanisms, and the larger implications for RN practice that are inherent in elements of the framework other than legislative mandate and evaluation, neither the mandate nor evaluation components will be considered further in this article. Each of the remaining six components will be examined for the provinces of BC, Saskatchewan, Alberta and Ontario.

3.4.1 Title protection

To ensure public safety, it is important that certain titles be protected for use only by authorized individuals or groups. “Protected titles help the public more easily identify qualified practitioners and . . . access their regulatory Colleges” (p.

13)^[23] and more easily distinguish between regulated and unregulated health care professionals.^[7] Certain protected titles, such as “registered”, will apply to more than one profession for those provinces having umbrella legislation (i.e. BC, Alberta and Ontario).

All four provinces explicitly protect the title of “nurse” and “registered nurse” in their enabling legislation for use only by registrants of the nursing College or Association in that province. Only certain provinces explicitly identify certain abbreviations of these titles through this protection process while other provinces simply indicate more generally that abbreviations of protected titles are not permitted for use by anyone except College registrants. For example, Saskatchewan explicitly protects the abbreviations “Reg. N.” and “R.N.” while Alberta and Ontario protect the abbreviation “RN”. While BC does not explicitly protect any particular title abbreviations by explicit name in its enabling legislation, the enabling legislation in all four provinces do note more generally that abbreviations of any protected titles are likewise protected.

3.4.2 Scope of practice

The overall breadth (or “scope”) of registered nursing practice in all four of the subject provinces is, unsurprisingly, relatively similar considering that all of the subject provinces have signed MRAs to facilitate easier movement of nurses between these various jurisdictions.^[2] The definition of “scope of practice” is most clearly articulated by the Saskatchewan Registered Nurses Association (SRNA) in a definition that is very applicable to the scope of practice present in all of the four provinces:

[a] legally defined scope of practice promotes safe, ethical, quality care that responds to the needs of the public. Scope of practice is the range of roles, functions, responsibilities and activities RNs are educated and authorized to perform [and] communicates the competencies and professional accountability of RNs, individually and collectively”. (p. 2)^[24]

Of the four provinces, only Alberta draws an explicit distinction in its documentation between the “overall” scope of practice of the registered nursing profession and the “actual” scope of practice of individual RNs. In this context, the College & Association of Registered Nurses of Alberta (CARNA) delineates the overall scope of practice in its enabling legislation and in various CARNA standards, guidelines and position statements.^[25] The actual scope of practice of individual RNs then requires nurses to practice within that overall scope of practice but with specific actions determined by the needs and health goals of clients and limited by individual nurse competencies and employer policies.

Controlled/restricted acts model

Three of the four provinces, BC, Ontario and Alberta, use a controlled (or “restricted”) acts model as the basis for their scope of practice and thereby identify certain acts as being either beyond or within the scope of RN practice in their province. A controlled/restricted acts model of health care

professions delineates that certain “restricted activities” (or “controlled acts”, as they are known in Ontario) present a significant risk of harm to those members of the public upon whom such activities are practiced; specific competencies and skills are viewed as necessary to carry these skills out safely and therefore each such activity is reserved for performance by certain health care professions only.^[25-27] Some provinces, such as BC and Alberta, specifically articulate in their enabling legislation those restricted activities that are within the scope of practice of nursing. However, Ontario has elected to highlight such activities in a different format; the RHPA^[16] identifies all of the controlled acts that are limited to practice by certain health professions in the province (not only those that are applicable to nursing). The Nursing Act^[15] then lists those controlled acts that are considered to be “authorized acts” for RNs in Ontario. A nurse moving to practice in Ontario must therefore be careful not to simply review the list of “controlled acts” in the RHPA^[16] and make the mistaken assumption that the full list is applicable to RNs. One might initially suspect that the list

of protected acts for nursing would be virtually identical across the provinces, even if the specific language associated with the acts are not. For example, some restricted or controlled acts that appear in the enabling legislation of all three provinces are: performing a prescribed procedure below the dermis or mucous membrane and placing an instrument, hand or finger beyond the external ear canal, beyond a certain point in the nasal passages, beyond the pharynx (or larynx, in the case of Ontario), beyond the labia majora, beyond the opening of the urethra, beyond the anal verge, and into an artificial opening of the body. While some differences in allowable RN practice across the provinces are worth noting, only a limited number of these differences are likely to be applicable to a significant number of practicing nurses. For example, only BC’s enabling legislation explicitly identifies the following as being restricted acts within a nursing scope of practice: making a nursing diagnosis to identify a condition as being the cause of signs and/or symptoms in a person; administering a solution by irrigation or enteral instillation for the purpose of assessing, ameliorating or resolving a condition that has been identified through a nursing diagnosis; fetal heart monitoring; and applying electricity for the purpose of defibrillation in the context of emergency cardiac care. Further, only BC and Alberta articulate the management of labour as a restricted act permitted for RNs although BC places the qualifier on such activity as

only being permitted if the primary maternal care provider is absent. While it may appear at first glance as if a detailed list

of differences between the three subject provinces could, in some practice settings and circumstances, result in different nursing practices, the reality is that nursing practice is quite similar in these jurisdictions. In fact, there are several reasons why a given activity listed as restricted in one province may not appear in the restricted list of another province but nurses in the latter province may still be able to engage in it:

- (1) The activity may not be considered of sufficient risk to public safety as to warrant it being designated as a restricted activity in a particular province. For example, the scope of practice of RNs in BC is subdivided into those activities that are not restricted (and therefore are not listed as restricted acts in enabling legislation) and those that are. If a particular activity was considered by BC authorities to be of fairly minimal risk, it would not be identified as a restricted act in that province but still could be considered sufficiently risky in another province to be designated as such.
- (2) A particular activity may be included as a restricted act in one province but simply not be permitted in another province as part of a RN’s scope of practice.
- (3) What is listed as a restricted or controlled activity in one province for RNs may not appear in a similar list for another province, even though it is still an activity that can be delegated to RNs. “Delegation is a formal process in which a regulated health professional... authorized and competent to perform a procedure under one of the controlled acts, delegates... that procedure to someone, regulated or unregulated, who is not authorized by legislation to perform it” (p. 6).^[26] Therefore, a particular activity identified in the list of restricted activities for BC may not similarly appear in the restricted list for Ontario but Ontario RNs may still be able to perform the activity when cloaked in the protection of an appropriate delegation process.
- (4) Enabling legislation may set out specific exceptions to its list of restricted activities. For example, the list of restricted activities for BC RNs includes performing venipuncture for the purpose of collecting a blood sample. While this activity is not listed as a controlled act for Ontario RNs, regulations under the RHPA^[16] contains certain exceptions to allow persons who are not authorized as members of a particular regulated profession to perform controlled acts. One such exception is that a person who takes a blood sample from a vein is legally undertaking this act, even if he/she is not a member of a profession explicitly authorized to do so by way of the controlled acts authorizations, if employed by a licensed laboratory (s. 11).^[28]

Saskatchewan model

Of the four provinces of interest, only Saskatchewan has elected not to use a “restricted” or “controlled” acts model to identify scope of practice boundaries for its RNs. Instead, the SRNA contends that the TRNA^[12] “clearly defines the scope of registered nursing practice [and each] and every RN is accountable to practice within this definition” (p. 1).^[24] Section 2(k) defines the practice of registered nursing as “the performance or co-ordination of health care services. . . for the purpose of promoting, maintaining or restoring health, preventing illness and alleviating suffering where the performance or co-ordination of those services requires: (iii) the knowledge, skill or judgment of a person who qualifies for [nursing] registration; (iv) specialized knowledge of nursing theory. . . ; (v) skill or judgment acquired through nursing practice. . . ; or (vi) other knowledge of biological, physical, behavioural, psychological and sociological sciences that is relevant to the knowledge, skill or judgment [earlier] described. . . ”.^[12]

Interestingly, a similar (if abbreviated in some provinces, such as Ontario) definition of the RN scope of practice also exists in the enabling legislation of the other three subject provinces. However, those other provinces have still elected to add explicit identification of restricted or controlled acts to supplement and clarify permissible scope of practice within the more general legislated definition of nursing. In Saskatchewan, rather than using a restricted acts template, the SRNA provides policies, standards, competencies, codes and guidelines (similar to what exists in the other three provinces as well) to supplement the central legislated definition. It would be interesting to explore the thought process of Saskatchewan nursing policy leaders in depth regarding specific restricted activities identified in the enabling legislation of the other provinces in order to better understand the steps that they undertake to determine whether a particular act is or is not within a Saskatchewan RN’s scope of practice, given the more generalized direction offered in this regard by their lawmakers and regulatory body.

3.4.3 Requirements for initial licensure/registration

Various criteria for initial licensure/registration for nurses in Canada are set to ensure that all RNs entering the profession have “the necessary knowledge, judgment, attributes and skills to provide safe, competent and ethical care” (p. 2).^[7] In all four of the subject provinces, enabling legislation grants the ability to establish those particular conditions and qualifications that must be met in order for an application to obtain registration as a member of that College. However, only two of the four subject provinces, BC and Ontario, utilize their bylaws for the purpose of identifying specific entry requirements for the profession; the remaining two provinces instead rely almost exclusively on legislative provisions to specify entry to membership require-

ments. Only the initial requirements for licensure and registration as a RN will be considered here, as opposed to graduate nurse or any other category of nursing registration.

The following are some of the common characteristics of the admission requirements to the nursing profession in the four subject provinces.

- (1) All four subject provinces require potential nursing membership candidates to have successfully completed a recognized basic nursing education program, that being a baccalaureate degree in nursing.^[29]
- (2) All four subject provinces require new candidates for RN membership to have successfully completed at least one professional examination, that being the Canadian Registered Nurses Examination (CRNE). However, as of 2015, the common professional entry examination will be the National Council Licensure Examination for Registered Nurses (NCLEX-RN).^[30] The only province in Canada that currently has an examination requirement in addition to the common professional entry examination is Ontario. Candidates who wish to register in the RN General Class category in Ontario must also successfully pass the Registered Nurse/Registered Practical Nurse Jurisprudence Examination, an online test which assesses a candidate’s knowledge of nursing regulation, scope of practice, professional responsibility and accountability, ethical practice and nurse-client relationships.^[31] The other subject provinces have not, to date, followed suit in this regard although this position may be in the process of being re-considered by at least some nursing regulatory bodies.^[32]
- (3) Three of the four subject provinces explicitly require candidates to demonstrate that they are of “good character” but the manner in which such good character must be demonstrated differs. In BC, applicants are required to complete a Statutory Declaration in which the applicant declares him or herself to be of good character and declares any past criminal convictions^[33] while, in Alberta, applicants must provide written references from an employer or educational facility about the applicant’s practice and/or provide a statement about any past criminal convictions or professional conduct investigations/disciplinary matters, and/or “any other evidence as required” (s. 11).^[34] In Saskatchewan, the SRNA requires applicants to answer “good character questions” (para. 38)^[35] in an online application and the SRNA may request references as well. Only Ontario does not explicitly use the phrase “good character” when describing its College membership requirements. However, Ontario enabling legislation does identify other requirements that point to good character as an overarching theme. The applicant’s past and present conduct must show reasonable grounds for the College of Nurses of On-

tario (CNO) to believe that the applicant will practice nursing in a legal manner, with decency, honesty and integrity, and will display an appropriately professional attitude. The CNO also requires applicants to declare any past criminal or professional misconduct/incompetence convictions, involvement in current professional proceedings or investigations, and any refusals by any regulatory body to allow the applicant to practice a profession.^[36] In addition to the requirement of applicant good character, three of the four provinces also require that the applicant demonstrate evidence of fitness to practice. Only Saskatchewan does not state such a requirement in either its enabling legislation or its bylaws, although it is possible that the SRNA is adequately capturing this admittedly elusive concept through questions it asks of applicants in its online application form and other requirements such as references.

- (4) Two of the four subject provinces (BC and Alberta) require that applicants have demonstrated English language proficiency. The enabling legislation in Ontario requires that an applicant have demonstrated proficiency in either English or French while Saskatchewan only requires demonstration of adequate proficiency in the English language if the applicant graduated from a jurisdiction other than Saskatchewan.^[35]
- (5) All four of the provinces identify entry-level practice (ETP) competencies that an applicant is expected to meet. These ETP competencies are considered to be foundational for nursing practice and are required as basic building blocks for nursing practice, irrespective of the eventual practice area selected for employment.^[37] Three of the provinces have virtually identical ETP competency categories, consisting of the following required nursing skills and abilities: cognitive, behavioural, communication, interpersonal, physical (or psycho-motor in Ontario), sensory perceptual, and environmental. Only the College of Registered Nurses of British Columbia (CRNBC) has elected to use its own Professional Standards as the conceptual framework through which to organize its ETP competencies and highlight their regulatory purpose. The ETP competencies framework articulated by the CRNBC yields the following four overarching categories of requisite nursing skills and abilities: (1) professional accountability and responsibility and regulation; (2) knowledge-based practice; (3) client-focused provision of service; and (4) ethical practice.

The following represent some of the admission requirements to the nursing profession in the four subject provinces that are more variable.

- (1) With respect to past offences, only BC specifically

notes in its enabling legislation that the College may refuse to grant membership to an applicant on the basis of past criminal convictions, a cancellation of the entitlement to practice a health profession in any jurisdiction, or the voluntary relinquishment of an entitlement to practice a health profession in any jurisdiction in order to prevent the commencement or completion of an investigation/review that had the potential to remove the applicant's entitlement to practice their health profession. Ontario's enabling legislation expresses similar concerns and requires an applicant to disclose details of such matters to the College but does not explicitly indicate that such disclosures could lead to a refusal of membership (although, of course, that is a logical conclusion to such a requirement). It is possible that Ontario legislators infer from other requirements previously discussed (e.g. that an applicant must practice with decency, honesty, integrity, professionalism and in conformance with the laws) that there may be circumstances disclosed to the College about past history that could effectively prevent the applicant from being able to reassuringly commit to those requirements, thus necessitating a refusal of membership. Neither Alberta nor Saskatchewan mandate disclosure of past criminal or professional conduct history through either their enabling legislation or bylaws. However, one could make the argument that such a line of questioning of an applicant would be inherent in the good character and fitness to practice aspects of their initial membership requirements.

- (2) Only BC specifically mandates a criminal record check as part of its initial membership requirements.

A recent study that considered challenges to cross-Canada nurse mobility found that, by far, the greatest challenges to migration between provinces relate to licensing requirements and the licensing process. Participants considered this process to be both "lengthy and inconsistent... and [it] represent[ed] the key factor impeding their interest in moving across Canada to work" (p. 38).^[38]

3.4.4 Standards for nursing practice and ethics

Establishing (and enforcing) appropriate standards of practice for a health care profession is an essential component of self-regulation as they are foundational in ensuring that members of the regulated profession understand what the profession, employers and the public expects of its RNs.^[7] The enabling legislation in all four subject provinces contains a reference to the role of the College with respect to the standards of practice for members, including a specific reference to the role of a College in establishing and maintaining/monitoring a specific standard related to ethics and ethical practice. Although only three of the four provinces explicitly identify enforcement of such an ethical practice

standard or code as being a role of the College, the remaining province of Ontario has (reasonably) interpreted the wording of their enabling legislation as giving them the authority to take on this function.

Three of the four subject provinces have specifically adopted the CNA Code of Ethics^[39] document as part of the ethical practice aspect of their regulatory framework. The Colleges in BC, Alberta and Saskatchewan have entrenched the adoption of that document in their standards of practice, thereby serving explicit notice to members that they are expected to abide by the contents and direction of that document. In contrast, the CNO has elected to use its own Ethics Practice Standard as a stand-alone document; at the end of that document, the Code of Ethics^[39] is listed as an additional resource for members but the expectations and content of that Code are not specifically entrenched into the Practice Standard in the same manner as in other provinces. The Code of Ethics^[39] is also not identified specifically in the “Ethical Practice” ETP Competency^[40] nor is it raised in the “Ethics” standard listed in the CNO’s Professional Standards.^[41]

All four of the Colleges regard violations of standards of practice to be a disciplinary matter in the form of professional misconduct or unprofessional conduct. In Ontario and Alberta, this is set out explicitly in their enabling legislation while BC and Saskatchewan have, quite reasonably, interpreted their legislated definitions of professional misconduct as including such behaviours and actions.

With respect to the organization of their standards of practice, each of the four provinces has elected to pursue this responsibility slightly differently. The Standards of Practice of the CRNBC are comprised of: (1) four Professional Standards that provide an overall framework for nursing practice within this province; (2) nineteen Practice Standards which set out the requirements for nurses to achieve with respect to specific topics such as consent and dispensing medications; and (3) various Scope of Practice Standards which identify standards, limits and conditions on the RN scope of practice in the province.^[42] In contrast to BC, CARNA has developed five Practice Standards on the same issues as the Professional Standards in BC; the SRNA has labelled its “standards of practice” as its “Standards and Foundation Competencies” and these are the same five standards as are listed in BC’s Professional Standards.^[43]

The CNO has subdivided its standards into three categories: Professional Standards, Practice Standards and Practice Guidelines. There are currently seven Professional Standards, some of which (such as Accountability, Continuing Competence, Ethics, Knowledge, Knowledge Application, Leadership and Relationships (therapeutic and professional))^[41] are very similar to those in the other three provinces. Similar in intention to BC’s Practice Standards, the CNO’s Practice Standards are provided to members as

guidance in more specific subject areas that are very targeted toward public protection, such as documentation, ethics, and restraints.^[44] Finally, the CNO has developed 17 Practice Guidelines to supplement its various standards and to provide additional direction on expectations pertaining to more specific practice areas/responsibilities; in this regard, Ontario’s Practice Guidelines (on issues such as consent, influenza vaccinations, and telepractice) are quite similar in intent to BC’s Practice Standards.

3.4.5 Continuing competence

Another integral component of the nursing regulatory framework is the establishment of a continuing competence program that allows nurses to demonstrate the ways in which they have maintained their professional competence and enhanced their practice.^[7] The Colleges in all four subject provinces are required by their enabling legislation to establish such a continuing competence program. This same type of program is labeled ‘quality assurance’ in both BC and Ontario and as ‘competence assurance’ in Saskatchewan but, for the purposes of this article, the word “Program” will be used to refer to the applicable program in each of the provinces.

The basic requirements of the Program in each of the subject provinces certainly appear to be reaching for the same goal but each takes a slightly different path.

- (1) Only BC and Alberta mandate a particular number of practice hours that RNs must complete within a certain time frame in order to renew their active practice membership in the following year.
- (2) All four of the subject provinces specify that a member must undertake a self-assessment to allow them to evaluate their practice with reference to their province’s standards of practice.
- (3) Three of the four subject provinces require that a member must obtain feedback in some form. Some provinces, such as BC, require that this practice feedback be from a “peer” (although this term is not defined by any of these provinces) while others, such as Alberta, do not mandate that peer feedback in particular is required.
- (4) All four of the subject provinces require that their members develop and implement a formal learning plan as part of their Program.
- (5) In BC, Alberta and Saskatchewan, there is an explicit requirement for the RN to evaluate the effect of the previous year’s professional development on their practice. However, the wording of this requirement is slightly different between these provinces. In Alberta and Saskatchewan, the RN is required to evaluate in writing the learning that they acquired through the implementation of their previous year’s learning plan. In BC, the RN is required to submit a written declaration that he/she has evaluated the effect of past learning

on his/her practice but the wording of the BC requirement does not actually require the member to evaluate the learning that has actually been achieved through their previous learning plan. Instead, the member could evaluate their general learning and professional development over the past year but is not required to actually assess the benefit of the learning plan that they had previously created (and presumably implemented). The true benefit to the RN and to the College (and, through the College to the general public) of a RN generating a learning plan is therefore unclear since the RN never needs to actually declare if they met the goals that had been set out in that plan.

Three of the four provinces allow in their enabling legislation for a targeted or random detailed practice assessment of some kind (known as an “audit” in all subject provinces except Ontario, which refers to this process as a “practice assessment”) to be conducted on a sample group of registrants each year. While neither the enabling legislation in Saskatchewan nor the SRNA bylaws mention that audits are to be conducted on College members, it is clear in SRNA’s own documentation that an annual member audit process is considered a key component of the SRNA Program.^[45] Perhaps unsurprisingly, the requirements of the audit process differ by province as well. In BC, the audit consists of five specific questions asked of both targeted and randomly selected RNs at the time they complete their online registration renewal, such as “how did you maintain a record of your self-assessment in [specify year]?”^[46] In contrast, CARNA members who are randomly selected to participate in the audit process do not answer specific BC-type questions but instead must complete their usual Program requirements and report activities and plans to CARNA through its online submission system. CARNA members then complete an online practice reflection for the coming practice year, submit their membership renewal application and pay their annual membership fee.^[47] The SRNA takes a different approach to the previously-discussed two provinces, requiring that members who are randomly selected for an audit must submit a continuing competence audit survey form “and/or” the member’s previous Program documentation. Once the requisite documentation is submitted, the criteria upon which the content of those documents are reviewed and evaluated by the SRNA include evidence of participation in the Program for each practice year and evidence of completion of learning activities and evaluation of the impact of learning on nursing practice.^[45] Auditors provide written feedback to the member regarding whether they have met those criteria. It is interesting to note that the SRNA documents do not explicitly state that auditors have the authority to issue follow-up learning or performance activities to the member in the event that the member does not meet the evaluation criteria, nor do the documents state that the auditors are required (or even permitted) to share their written feedback and con-

clusions with SRNA itself to allow SRNA to identify which members have or have not successfully completed this aspect of their Program requirements. Therefore, the true extent of the impact of the audit process, and the feedback that is generated through that process, remains unclear from a member and public protection perspective.

Ontario’s practice assessment forms the basis of its audit process for RNs. If a RN is randomly selected to engage in the practice assessment step, a CNO Peer Assessor reviews the member’s submitted learning plan, the member writes objective multiple-choice tests based upon selected practice documents, and then the Peer Assessor submits a report to the CNO Quality Assurance Committee based upon the learning plan and test results. The Committee then decides if the member has successfully completed their Practice Assessment component of the audit process (in which case the member exits the process) or if the member must complete various follow-up activities.^[48] This is quite similar to the purpose for which CARNA engages in an audit process and the manner in which its audit results are used. These purposes and usages of audit-generated information are very different from the stated purpose of the BC audit process, which is not directly aimed at the practice of individual RNs. Instead, the CRNBC states that its purpose in instituting an audit process is “. . . to collect more detailed information about nurses’ participation in the. . . Program. CRNBC uses the information from the audit to improve the. . . Program and to identify ways to better support nurses to meet the Standards of Practice” (para. 3).^[46] This statement reflects a more general purpose that appears to be aimed at supporting the betterment of nursing practice in the province rather than the individual lens used for this process in other provinces.

In all of the provinces, it is made clear that member participation in, and cooperation with the Program process is a mandatory requirement of continued membership in the College. With the exception of Saskatchewan, the provinces’ enabling legislation and/or relevant Bylaw sections require members to engage fully in the audit component of the Program process. Instead, the SRNA indicates that “members [selected for an audit] are advised by mail *and requested* to forward information which will include a continuing competence audit survey form and/or the Program documents [emphasis added]” (p. 10).^[45] Further, a lack of compliance with the Program in Alberta and Ontario is considered to be unprofessional conduct in Alberta and professional misconduct in Ontario, both of which are disciplinary offences. Both BC and Saskatchewan note that participation in the Program is required for renewal or reinstatement of registration, and the SRNA does state in its bylaws that its registrar may suspend a RN’s license to practice if required components of the annual reflective practice review are not completed; however, neither province explicitly identifies a lack of participation in the Program as being a disciplinary offence.

3.4.6 Professional conduct review

Another component of the regulatory framework for nurses in Canada is the existence of a professional conduct review program empowered to investigate and act upon a complaint pertaining to the practice of a member RN.^[7] Such complaints can arise from any member of the public, other health care professionals, an employer, or any other individual/body who interacts with a particular RN, or it can even be the result of a self-report generated by a RN. Once it has been established through the relevant investigatory mechanism that the practice of a RN has fallen below the requisite standard, a College is obligated to take the appropriate action against that RN for the purpose of protecting the public.

All four of the subject provinces have established the framework of a complaints, investigation and discipline process for their respective Colleges. The following are examples of key ways in which the frameworks in the four subject provinces are similar:

- (1) Three of the provinces mandate that any formal complaints about the practice of a RN must be submitted in writing to the College. Only Ontario has made allowance for the submission of complaints in forms other than writing (such as audio or video recordings), likely for the purpose of ensuring that those with physical disabilities are not precluded from submitting complaints about RN care providers to their regulatory body.
- (2) Once an investigation into a RN's practice has been completed, the investigation arm of the College (or the disciplinary arm, which is a separate entity in some provinces such as Ontario) in any of the four provinces has a number of options available to it, ranging from taking no further action if the allegations are deemed unsubstantiated, to issuing a reprimand or caution to the investigated member, requiring the investigated member to pay a fine or to undertake additional education in the subject area of concern, suspending the investigated member or cancelling their registration altogether. The College may also impose a combination of such consequences on the member, if deemed appropriate.
- (3) Three of the four subject provinces (BC, Alberta and Ontario) have each instituted some form of alternative dispute resolution process to which complaints may be referred. For example, the CRNBC created the Consensual Complaint Resolution (CCR) process as one option to fulfill the requirement for a resolution process noted in its enabling legislation and By-laws. This process is viewed as collaborative in nature rather than punitive and is the manner by which the majority of the formal complaints made to the CRNBC are resolved.^[49] A written "consent agreement" is negotiated between the member and the CRNBC; this agreement contains a description of the

nurse's background, education and experience, the nature of the complaint, a summary of the negotiations that were conducted, identification of those who will be notified about the agreement, any undertakings to which the nurse agrees to resolve the practice concerns, and a description of how and when those undertakings will be considered complete. In contrast to the other three provinces, the SRNA has not instituted a formal alternative dispute resolution process, nor is one required or contemplated by its enabling legislation and/or bylaws in the manner of the other subject provinces.

- (4) With respect to publication of investigation and discipline decisions, the CRNBC does publish complaint outcomes on its website or, occasionally, in local newspapers, if a member's registration has been restricted, suspended or terminated but the details of the complaint and/or any negotiation process are not similarly published.^[49] The nurse's name must be kept private in certain circumstances, such as if the member has a health issue, such as an addiction, that has been either admitted by the member him/herself or has been proven to the Discipline Committee as preventing the member from practicing safely. In Alberta, CARNA^[50] indicates on its website that its Hearing Tribunal is given authority under its enabling legislation to make a publication order and can publish both identifying information and settlement details to the extent permitted by the ratification agreement that has been reached by the parties.^[51] The written decisions of the SRNA Discipline Committee, including its reasons for the decision it has rendered, is made publicly available, although witness and client names are removed from the public document, and such decisions are also published in the official publication of the SRNA, known as the News-bulletin. In Ontario, the decision issued by a discipline panel, including its reasons for the decision it has rendered or a summary of those reasons, are made publicly available through the College's annual report and in any other publication of the College that the College chooses to utilize for this purpose. The name of the subject member RN must also be published with the decision.
- (5) With respect to appeals and reviews, all four provinces have mechanisms by which the disciplinary decision (or an inquiry decision) may be appealed and/or reviewed. Depending upon the province, and the party who is requesting the appeal or review, the appeal or review may be decided either by another committee within the regulatory body (e.g. in Alberta, an appeal of a decision of the Hearing Tribunal is made to the CARNA Council) or to the external court system (e.g. a subject member of CARNA may appeal the decision of CARNA Council to the Alberta

Court of Appeal).

There are also a number of key differences between the Colleges in the four subject provinces with respect to their professional conduct review programs.

- (1) Each of the four provinces defines professional misconduct of members slightly differently. In Alberta, “unprofessional conduct” is defined in its enabling legislation and a very lengthy list of potential behaviours all fall into this category of undesirable conduct with the potential for resulting discipline by the College, including the display of lack of knowledge, skill or judgment in practice, contravention of the standards of practice or code of ethics, failing or refusal to comply with an investigation process, and conduct that harms the integrity of the nursing profession. A different framework exists in Saskatchewan, where reports which allege improper practice by RNs can do so on two potential grounds: professional incompetence and/or professional misconduct, both of which are defined in the enabling legislation. Professional misconduct is defined very broadly in the TRNA^[12] as being “any matter, conduct or thing, whether or not disgraceful or dishonourable, that is contrary to the best interests of the public or nurses, or tends to harm the standing of the profession of nursing” (s. 26(1)). While this same legislation defines professional incompetence broadly as well, it also provides numerous specific examples of the types of behaviours and practices that would qualify under this heading. For example, if a RN abuses a client physically or verbally, falsifies treatment records, inappropriately discloses confidential information belonging to a client, fails to comply with the profession’s code of ethics, or contravenes the enabling legislation or the SRNA bylaws, then the RN could be considered as having committed professional incompetence. In Ontario, formal complaint allegations may be related to any of professional misconduct, incompetence or incapacitation of a member. Professional misconduct is defined within the enabling legislation and includes such activities as contravening or failing to meet a standard of practice of the profession, inappropriately delegating a controlled act, abusing a client verbally, physically or emotionally, falsifying a record, contravening a provision of the enabling legislation and failing to cooperate with a College investigation. Allegations of incompetence are based on concerns that the client care provided by the RN demonstrate such significant and repetitive deficiencies in knowledge, skill and/or judgment (rather than a single breach of the practice standards of the CNO) that restrictions on the RN’s practice are viewed as necessary to ensure the safety of current and future clients.^[52] With respect to allegations of incapacity, there is a legal

meaning to this word that is used in the context of self-regulating professions and it means that the RN is alleged to have a physical or mental health condition that impairs his/her ability to provide care to the extent that the member requires restrictions on practice or cannot be allowed to practice at all.^[52]

- (2) There are a number of situations in each province in which there is a duty to report to the College, the receipt of which must be treated as a formal written complaint. The only mandatory reporting situation identified in Alberta’s enabling legislation involves an employer reporting to CARNA if it has terminated the employment of a member for reasons of conduct that is, in the view of the employer, unprofessional conduct, or if the member has resigned because of such conduct. However, BC and Ontario both explicitly identify a number of other circumstances in which a mandatory report is required, such as a member becoming aware that another registrant may have committed sexual misconduct against a client.

4 Conclusion

This article has considered the nursing regulatory frameworks that are in place in four Canadian provinces: BC, Ontario, Alberta and Saskatchewan. There were certainly many fundamental similarities between the frameworks in these four provinces that make MRAs, aimed at increasing workplace mobility and easing such transitions, possible. However, there were also a number of key differences explored. Such differences could undoubtedly make professional practice more challenging for nurses who either do not fully understand the regulatory framework of their particular practice jurisdiction or who do not appreciate that the presence of a MRA does not necessarily mean that parameters and expectations of nursing practice are identical across those provinces. Given some of the unexpected differences between provinces, it would be ideal for all provincial Colleges to join forces to create a publicly-available, comprehensive resource that would highlight key differences between the regulatory framework that has developed in each province; this could only assist new, established and transferring nurses to better protect both their licence and their patients, although it is recognized that such a resource would require periodic updating and therefore could be costly to maintain. Increased research on inter-jurisdictional differences, and the impact of regulatory differences on nursing practice, is necessary to provide guidance to those nurses considering migration as well as policy planners who need to focus on making such transitions as seamless as possible. There can also be no question however, that the responsibility of ensuring that a particular RN has developed a solid understanding of the regulatory framework of the jurisdiction in which he/she intends to practice will always, in the end, fall upon that individual RN.

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