Soins infirmiers et cardiorespiratoires

FSSS CSN

New conditions for obtaining a permit to practise the nursing profession in Québec

The next generation of nurses

August 2011

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Introduction

At its February 20, 2009 Federal Council, the Fédération de la santé et des services sociaux–CSN shared a first report from an ad hoc committee with its unions. The committee had done a preliminary analysis of the review of conditions for obtaining a permit to practise as a nurse in Québec in response to a propose for a joint consideration of the matter from the Ordre des infirmières et infirmiers du Québec (OIIQ).

That first report outlined the current and future state of the nursing profession, the sustainability of the profession, the promotion of expertise and experience in nurses' work, prospects for meeting the current and future needs for a labour force in the context of labour shortages and the angle from which the Federation should pursue its joint work with the other union organizations concerned and the OIIQ.

In the wake of this first report, the Fédération was mandated to continue the discussions that had been begun with the other union organizations and the OIIQ, taking five aspects into account:

1. Ensuring recognition of the experience and expertise of nurses already working in the system;
2. Ensuring that a nursing labour force is available to work after three years of college studies;
3. Ensuring that transitional measures are put in place to avoid any exclusions;
4. Ensuring that these new provisions do not further aggravate the labour shortage;
5. Ensuring that educational institutions introduce a bridging procedure to allow nurses who don't have recognized experience in the three fields (critical care, primary care in the community and mental health care) to acquire certain knowledge or competencies, for example in critical care.[1]

The Fédération has therefore pursued its work of discussion and reflection. The person responsible for this work, Nadine Lambert, vice-president responsible for nursing and cardio-respiratory care

[1] Ad hoc committee report: *Révision par l'Ordre des infirmières et infirmiers du Québec de l'obtention des permis de pratique infirmière,* presented to the Sectoral Federal Council for the class of nursing and cardio-respiratory care personnel, February 20, 2009, Laval.

personnel, participated in seven meetings, including an inter-provincial discussion with Ontario and New Brunswick.

A second ad hoc committee was set up to continue the thinking and discussions on this, including the new aspects introduced during the last seven meetings on the review of the conditions for obtaining a permit to practise the nursing profession.

The FSSS set up a working group composed of nurses from various kinds of workplaces and different regions of Québec. The nurses in the group had different levels of education – college, university or overseas. The group's mandate was to analyse all the information received, come to grips with the issues for the future of the nursing profession, analyse the positive or negative effects of such a review and, finally, make recommendations.

The ad hoc committee was composed of **Valérie Alain**, nurse technician who pursued studies at the bachelor level, practising since 2000 in sectors of activity like hemodialysis and chronic care at the CSSS d'Arthabaska-Érable, in the Cœur-du-Québec region; **Claudie Figaro**, nurse with a State diploma from France, practising in Québec in the following sectors of activity: emergency care, psychiatry, home care and ambulatory care, at the CSSS des Collines, in the Outaouais; **Claude Vonkerckbuer**: nurse holding a nursing diploma from Belgium and 10 university credits in Québec, practising for 10 years in Québec on the float team of the CSSS de Memphrémagog, in the Estrie; **Wilgod Dagrin**: baccalaureate nurse from the DEC-bacc training program; e began his career at Hôpital du Sacré-Cœur in Montréal and now works at the CSSS de Bordeaux-Cartierville-Saint-Laurent, mainly in CHSLDs as nurse team leader and nurse assistant to the immediate superior; **David Pelosse**: baccalaureate nurse, with CEGEP training in natural sciences and a bachelor of nursing, working in intensive care at Hôpital Sacré-Cœur, in Montréal; **Sylvain Fournier**: nurse with a CEGEP diploma and now doing a bachelor's degree, he works in intensive care at the CHU Sainte-Justine; **Noémie Pilon**: nurse working in mental health at the Pavillon Albert-Prévost, Hôpital Sacré-Cœur, in Montréal; **Samira Harakat**: nurse with a CEGEP diploma, a bachelor of nursing and working on a master's, working in intensive care at the CHU Sainte-Justine; **Claude Bouthillier**, FSSS union staff representative; **Nadine Lambert**, vice-president responsible for nursing and cardio-respiratory

care personnel, with a CEGEP diploma and 15 university credits, has worked in surgery, cardiology, multi-specialities, float team and intensive care at the CHU Sainte-Justine.

This paper presents an analysis of the evolution of the health-care system and the nursing profession and its future, based on observations on current conditions and the challenges and issues facing this profession. It concludes with the committee's recommendations.

Transformation of the health-care system

Aging population, multiple pathologies and chronic illness

In the past 20 years, Québec's health-care system has undergone many changes. There has been a marked aging of the population. Aging and longer life expectancy has brought the emergence of multiple and chronic pathologies in individuals. This new complexity means that their medical needs are greater, which in turn requires more complex and intensive care in the community, institutions, intermediate resources, etc.

According to Statistics Canada, seniors are extensive consumers of health care and services. Its *Canadian Community Health Survey* (CCHS) indicated that in 2003, 88% of Canadians 85 or older consulted a general practitioner, 92% reported having taken at least one medication, 14% were hospitalized and 15% received home care. As well, the study highlighted the fact that one third of hospitalizations for people aged 65 or more, as well as more than half the total length of hospital stays came from this group of people. Other survey data indicated that the rate of hospitalization is three times higher than for people under 65. In other words, this group is hospitalized repeatedly and for longer stays. The data in this study showed that the probability of seniors being hospitalized was closely connected with their chronic health conditions.

The chronic nature of illness and the loss of autonomy that goes along with aging causes seniors to turn to various care services to compensate for their lack of autonomy. If their autonomy and capacity for self-care allow, they use home care to compensate for their inadequate capacity to take care of themselves. Otherwise, they live in CHSLDs, intermediate resources (RIs) and non-institutional resources (RNIs), and many of them wind up in hospital beds or on gurneys in

emergency departments when their health makes it necessary. In short, we see that seniors are present in many sectors of Québec's health-care system.

Scientific and technological progress

Increased scientific knowledge and technological advances have led to the development of diagnostic and therapeutic methods. To illustrate this, think of hemodialysis, hemofiltration, EMCO[2] and the sophisticated devices needed for the work in these sectors. Or take intensive care, which incorporates cardiac monitoring, various invasive diagnostic and therapeutic methods (electrophysiology, hemodynamics, various ventilators, etc.), or home care, with peritoneal dialysis, multiple intravenous therapies through a central line, etc. The growth in the medical world's empirical knowledge has led to tremendous progress in terms of life expectancy. In the 1980s, for example, one of the only treatments available for a patient hospitalized for a heart attack was nitroglycerin or xylocaine, and the mortality risk was high. Today, there is a wide range of antiarrhythmic and anti-ischemic drugs, as well as surgery like angioplasty and coronary bypasses that enable to patients to recover relatively readily from heart attacks. Technological advances increase our patients' life expectancy, but at the same time make it necessary to manage and monitor people suffering from complex diseases and pathologies that used to be the exception in the past.

As well, access to technological progress shortens hospital stays. The shift towards ambulatory care occurred in conjunction with these other changes. In this approach, patients are directly involved in managing their own health and convalescence, and this consequently requires changes in the kinds of services available.

Government policy and orientations in health care

In the mid-1990s, the Ministry of Social Affairs initiated a shift towards ambulatory care – a "de-hospitalization", as it is sometimes called. Not only did the new technologies make it possible to considerably reduce the number and length of hospitalizations, they also shunted the people still

[2] ECMO: Extracorporeal membrane oxygenation.

needing all forms of care – physical health, mental health and social services – towards home care, CLSCs or services closer to their living environments.

This reorganization of health care had a number of repercussions, resulting in various changes in the way care is delivered. Patients were deinstitutionalized, hospital stays got shorter and more care was delivered at home. Various resources like intermediate resources, family-type resources and private residences emerged. Instead of episodes of care being managed solely by the medical team (physician, nurse, pharmacist), they are now handled by a multi-disciplinary team including the patient and family.

Parallel to the increased complexity and intensity of care and the transformation of health-care institutions, nurses are called upon to assess health needs, co-ordinate interventions with professionals and the various other workers in the different institutionalized care environments and in the community. They have to provide better support for people at risk, clinical environments and the community.

Health and social service centres (CSSSs)

In 2003, the Québec government passed an *Act respecting local health and social services network development agencies*, giving agencies the responsibility of establishing a new form of organization of services in each region based on local service networks (RLSs). The creation of 95 local services networks across Québec in June 2004 was aimed at bringing services closer to the population and making them more accessible, better co-ordinated and continuous.

At the heart of each of these local networks is an institution called the health and social service centre (or CSSS, *centre de santé et de services sociaux*). Born out of mergers of local community service centres (CLSCs), residential and long-term care centres (CHSLDs) and in most cases a general or university hospital, the CSSSs are the cornerstone of the local service network, ensuring the accessibility, continuity and quality of services for the population of each local territory.

Within this structure, the CSSS co-ordinates the activities and services offered by the various components of the local service network. By definition, the local network for each CSSSS includes medical clinics, family practice groups, community organizations and other private resources.

CLSC mission

A CLSC provides primary care in prevention, curative care, rehabilitation, reinsertion and palliative care for to the population of a given territory, in people's living environments, schools, at home or inside the CLSC.

With the major shift to ambulatory care in the 1990s, the longer life expectancy of an aging population and technological and medical advances, the care offered by CLSCs changed.

Since the 1990s, the work of CLSC nurses has changed at a dizzying pace. Today, there is systematic monitoring of people with complex chronic diseases (e.g., heart or renal failure, chronic obstructive pulmonary disease), home administration of antibiotics through a central venous line, palliative care involving various treatments that were previously only available in hospitals, etc. As well, they work in collaboration with a variety of other health-care workers, with the nurse providing the common denominator.

All these new needs have led to home care becoming an integral part of care in Québec. Nurses are called upon to care for patients in a holistic way. This kind of care requires heightened autonomy and clinical judgment from nurses.

In performing their duties, nurses must monitor patients from an early stage, screen for complications, adjust medical care in accordance with standing or collective prescriptions and provide support to users and their families through support measures and education. They have to assess the needs of clients who are covered by the program of assessment and orientation in private residences, which doesn't have the same organizational structures as the public health-care system. Consequently, in addition to assessing the care needed by a client, nurses have to ensure that the environment meets the client's needs adequately, and may be faced with training a non-professional working for a private residence, etc. Obviously nurses' level of autonomy has reached a second and third level in their practice, and Bill 90 contributed to this. In performing the duties described above, nurses must have control of their practice and the client's environment. They have to co-ordinate both the care that falls within their field of practice and see to the care delivered by other professionals or non-professionals, like occupational therapists, health and social service

aides (family aides), nursing assistants, etc. To meet the demands of the health-care system, nurses starting out have to acquire much more knowledge and competencies than used to be the case, and college (CEGEP) training no longer suffices entirely to cope with these new realities.

Residential and long-term care centres (CHSLDs)

CHSLDs are another environment in which the practice of nurses has changed, evolving from participation in direct patient care using the acts provided for their field of practice to the co-ordination of health needs and acts reserved for nurses for this clientele, which has undergone substantial changes as well.

To start with, nurses in CHSLDs co-ordinate the care provided by a multi-disciplinary team (nursing assistants, beneficiary attendants, etc.). They co-ordinate care activities in the living environment in collaboration with other professionals, families and outside resources.

CHSLDs today don't have much in common with the CHSLDs of the 1990s. The new clientele requires a much higher level and intensity of care. In CHSLDs, 46% of clients are over 85 years of age. In addition to neurodegenerative diseases, they have physical illnesses. It's a far cry from people with health problems linked solely to aging. Here again, nurses have to take a comprehensive approach to care for these clients.[3]

General, specialized and university hospitals

General, specialized and university hospitals have also been affected by the shifts and changes. Technological and medical advances combined with shortages of physicians and nurses and the changes introduced by Bill 90 have modified care, care levels and work teams.

Once again, the role of nurses has evolved and expanded.

As well, the shortage of nursing staff has made it much more necessary for nurses to be autonomous. Just look at the number of years of experience that nurses on night shifts have. The new generation of nurses often find themselves alone or working with relatively inexperienced

[3] *Un milieu de vie de qualité pour les personnes hébergées en CHSLD*, Ministerial orientations, October 2003, p.8, p.14.

colleagues, caring for patients requiring high levels of care or who are acutely ill, and they co-ordinate care with other professionals like nursing assistants. Furthermore, the shortage of medical resources means that they have to provide care and treatment autonomously, referring to various standing or collective prescriptions.

Furthermore, these young nurses are also working in units with a high intensity of care, like emergency departments, intensive care units, etc., even when they are still candidates for admission to the practice of the nursing profession!

Labour shortages in nursing: where are we at now, and where will we be tomorrow?

Back when the Bouchard government set a zero deficit as its overriding goal in 1996, there were massive numbers of early retirement. About 4,000 experienced nurses left the health-care system. At the same time as they were leaving, quotas limited admissions to training programs in CEGEPs and universities. The result of these changes was a shortage of nurses that has gotten steadily worse over the years.

By the early 2000s, there were labour shortages in a number of sectors, and much worse shortages in some regions. In addition to the early retirements, there were other factors that aggravated the shortages: demographic decline, difficult working conditions, many employment opportunities in other fields and, of course, upcoming wave of baby-boomers leaving for well-deserved retirement. The shortage is forecast to reach a peak in 2013.

In February 2010, there were 14,680 nurses who were 55 or older, and 10,900 between the ages of 50 and 54. This is a far cry from the situation in 1996, when the retirement of 4,000 nurses already had such a major impact on the system. What will happen when these 25,580 nurses leave the health-care system? Quite apart from the absolute number, which we don’t have much control over, there is the whole issue of the expertise that will be lost.
This expertise has been an invaluable resource in the past on which new nurses could rely as they perfected their training and developed their autonomy; but already, newer nurses can no longer count on it.

Number of nurses, by age, working in the public health-care system on February 15, 2010[4]			
Age (58 is the average retirement age in the system)	Number in the health-care system	% of the number of nurses who work in the system	Total number of nurses on the roll of the Order, by age, who are unemployed, working in the public health and social services system or in other fields
54 years old	1,875	86%	2,181
55 years old	1,819	84%	2,166
56 years old	1,501	76%	1,976
57 years old	1,410	75%	1,881
58 years old	1,160	71%	1,634
59 years old	967	65%	1,489
60 years old	700	62%	1,129
61 years old	458	51%	899
62 years old	398	48%	831
63 years old	278	48%	581
64 years old	214	45%	476
65 or older	533	33%	1,618
Total 58 to 65	**4,708**	**54%**	**8,657**
Total	**11,313**	**67%**	**16,861**

[4] OIIQ, nombre d'infirmières de 54 ans ou plus et pourcentage par situation et secteur d'emploi selon l'âge au 15 février 2010, *infostats*, volume 2 no. 3, April 2010, Chart no. 2.

Nurses 55 or older by sector of activity	
Sector of activity	**% of nurses aged 55 or older**
Mental health	23.2%
Geronto-geriatrics	24.5%
Perioperative care	22.1%

In all sectors of activity and nearly all regions of Québec, workloads and the shortage of resources that already exists mean that young nurses have to rely on themselves in many situations. As well, the growing shortages of medical and professional resources aggravate the burden of chronic diseases for society and the health-care system.

Some will say: “It’s simply a matter of providing better supervision in the workplace, or in-service training.” This may, of course, look like a good idea. But is it realistic, at a time when the government is slashing training budgets and some employers no longer consider it necessary to give more than a few days of training to a young nurse starting out in an emergency department?

So far, these approaches have not been adequate or conclusive. In the current context, they are necessary, but much more needs to be done, given that many experienced nurses will be leaving the health-care system in the coming years. In a brief published in July 2005, the Youth Committee of the OIIQ raised two major concerns about the reality of new nurses – the “next generation” joining the labour force. One of these concerns is the transfer of clinical expertise. There are fewer nurses, and there will be even fewer in the future to ensure the transfer of knowledge.

What else can be done? What are the solutions for ensuring the transfer of knowledge necessary for new nurses, with a view to ensuring the safe, high-quality, optimal practice of the profession for the population of Québec in a health-care system undergoing major changes?

The place of nurses and their new role

The adoption of the *Act to amend the Professional Code and other legislative provisions as regards the health sector* (Bill 90) and its implementation over the years has helped clarify and modify the

roles and enhance the activities and fields of practice of the various health professionals, including nurses.

These are the 14 activities reserved to nurses under this Act:

1. assessing the physical and mental condition of a symptomatic person;
2. providing clinical monitoring of the condition of persons whose state of health is problematic, including monitoring and adjusting the therapeutic nursing plan;
3. initiating diagnostic and therapeutic measures, according to a prescription;
4. initiating diagnostic measures for the purposes of a screening operation under the *Public Health Act* (2001, Chapter S-2.2) ;
5. performing invasive examinations and diagnostic tests, according to a prescription;
6. providing and adjusting medical treatment, according to a prescription;
7. determining the treatment plan for wounds and alterations of the skin and teguments and providing the required care and treatment;
8. applying invasive techniques;
9. participating in pregnancy care, deliveries and postpartum care;
10. providing nursing follow-up for persons with complex health problems;
11. administering and adjusting prescribed medications or other prescribed substances;
12. performing vaccinations as part of a vaccination operation under the *Public Health Act*;
13. mixing substances to complete the preparation of a medication, according to a prescription;
14. making decisions as to the use of restraint measures.

And these are the ones stemming from the *Act to amend the Professional Code and other legislative provisions in the field of mental health and human relations* (Bill 21):[5]

1. assessing mental disorders… if the nurse has the university degree and clinical experience in psychiatric nursing care, to be determined under regulations adopted by the OIIQ;
2. deciding on the use of isolation measures;
3. assessing a child not yet admissible to preschool education who shows signs of developmental delay, in order to determine the adjustment and rehabilitation services required.

[5] OIIQ, *Le journal*, November, December 2009, Adoption of Bill 21.

Before Bill 90, the nurse had a role in collecting data to enable the physician to assess a person's state of health, after which she or he contributed to assessing signs and symptoms in the patient's on-going treatment. Since Bill 90, the defining characteristic of the nursing profession is **the role of comprehensive assessment**. According to the OIIQ (2011), "assessing means making a clinical judgment about a person's physical and mental condition and communicating the conclusions. Clinical judgment may lead to carrying out complex interventions or even to initiating diagnostic and therapeutic measures and adjusting medications and other substances in accordance with a prescription."

To illustrate, take the new role of the nurse in the context of heart failure. This pathology often leads to kidney failure, leaving the patient with two serious medical problems. Two distinct concomitant pathologies result in a complex health condition and the additional use of medications with potential interactions. This phenomenon requires that the nurse have a solid knowledge of physiopathology, pharmacology and methods of mitigating the signs and symptoms of the disease and the side-effects of medications.

In this case, the nurse must be able to develop her or his clinical judgment and professional autonomy in order to monitor and follow the patients. The nurse must analyse the data that she or he collects before communicating her conclusions to other professionals. **The nurse now has a role in the decision-making process. Through her or his clinical judgement, the nurse influences the therapeutic plan and other professionals.**

Not to mention the fact that nurses must now have great professional autonomy, i.e., be free to act on a fully informed basis and make independent clinical decisions in the best interests of the user.

Nurses must also have control over their practice. They must constantly update their knowledge and know how to get the conclusive data that enable them to keep their practice contemporary. They must be able to monitor patients with complex pathologies and detect potential complications.

According to the OIIQ's *Perspective infirmière* paper, a nurse's four main roles are: health promotion, the therapeutic process, functional rehabilitation, and the prevention of disease,

accidents, social problems and suicide. This means that nurses must work in advance of and follow up on their patients' health. They play a fundamental role in all spheres of a continuum that begins with health and ends in death. They provide continuity in primary prevention (protection/education/promotion), secondary prevention (screening) and tertiary prevention (diagnosis/treatment).

In addition to their roles under Bill 90 and the functions they perform, nurses must develop skills in communicating with other professionals, providing support for educating clients and their families, demonstrate and develop expertise in various environments and acquire skills in seeking conclusive data.

The place of nurses in patient care is central to the multi-disciplinary team

The role of nurses is pivotal, because they ensure follow-up with patients. They are also the ones who call on other health workers when they judge that a patient requires certain types of care. Nurses are present throughout the care process, from the assessment at the outset and during the episode of care to ensure follow-up.

The shortage of expertise and excessive workloads put nurses just starting out in difficult situations. For example, it is not uncommon to see:

- one nurse with six months' experience and two candidates for admission to the practice of the nursing profession on the night shift in a department;
- one young nurse with 70 patients, 4 nursing assistants and 8 beneficiary attendants in a CHSLD;
- one young nurse who winds up with more patients due to a lack of personnel.

Previously, these situations were the exception. They are now commonplace. New nurses are expected to arrive well-prepared and as functional as if they already had years of experience. It is a situation that puts tremendous pressure on the young nurses just starting in the profession.

They may be discouraged by heavy workloads, dissatisfied with the work, anxious (which can take the form of various physical or psychological symptoms), or even burn out early in their nursing

career. Situations like these that discourage young nurses may even cause them to leave the profession.

Academic nursing education (now and in the past)

In 2001, the DEC-bacc training was introduced in Québec following a program review of nursing education endorsed by the Ministère de l'Éducation du Loisir et du Sport[6] (MELS) with a view to better preparing nurses for the current job market and simultaneously providing a bridge to university education. At the same time, technical training at the college level was reviewed and adjusted. Following this program review, the MELS stipulated that the college (CEGEP) program was initial training and that certain professional activities of nurses, such as critical care, care education, management and research required more advanced clinical knowledge and skills provided by university training.[7] So some training previously given at the college level was shifted to the university level to allow for the development and enrichment of others at the college level – again, due to changes in workplace realities. It should be kept in mind that the responsibility of educational institutions is to train people to meet the demands of the labour market satisfactorily as soon as they graduate. Furthermore, one of the roles of professional orders is to protect the public, which means ensuring that nurses just starting out in the profession are able to meet the health-care demands of the population of Québec.

A table in appendix outlines the division between competencies taught at the college and university levels.[8]

The number of nurse clinicians in Québec is growing year after year, as various studies show. In 2008-2009, 29.7% of nurses practising in Québec had a baccalaureate (bachelor's degree). As well, 34.8% of nurses with a DEC were pursuing university studies.

[6] Orientation relative à la révision des programmes de formation en soins infirmiers présenté par Pauline Marois et Jean Rochon, Québec, March 4, 1998, www.mels.gouv.qc.ca/press/cprsss98 .
[7] Orientation relative à la révision des programmes de formation en soins infirmiers présenté par Pauline Marois et Jean Rochon, Québec, March 4, 1998, www.mels.gouv.qc.ca/press/cprsss98 .
[8] Rapport du comité des spécialistes soumis au comité directeur sur la formation infirmière intégrée, December 2000, ministère de l'Éducation du Sport et des Loisirs. P. 20, 21, 22, 23, 24, 25.

In 2001, a bridging process towards university studies was created in Québec. The DEC-bacc is a mutual agreement between CEGEPs and universities to ensure the continuity of college education. The effect of this "bridge" was to encourage students to continue their studies and make it easier to earn a university degree. There are a number of reasons for nurses to continue university studies:

- increasing their knowledge;
- being up-to-date in their training;
- expanding their field of practice;
- gaining access to more positions;
- enhancing their clinical judgment;
- increasing their professional autonomy;
- enhancing their leadership on the inter-disciplinary team.

According to data from the OIIQ document entitled *Évolution de l'effectif infirmier au Québec* (Trends in nursing personnel in Québec), the proportion of nurses holding a baccalaureate (bachelor of nursing degree) (excluding those who have completed graduate studies in nursing) has increased by about 0.7% a year since 2000-2001.

But various shortcomings have been observed in the new DEC nursing training. According to an October 2009 OIIQ document entitled *La pratique de l'infirmière en santé mentale* (Nursing in mental health), fewer hours are being devoted to psychiatry. In 2000-2009, training in mental health was a matter of local initiative. The number of hours spent in internships varies from one kind of institution to another, ranging form 0 to 144 hours. What should nursing practice be under Bills 90 and 21? How to respond and be able to do an assessment of a person's mental condition or mental disorders with little or no references in the matter?

Initial training must correspond to the reserved activities in the field of mental health and cannot be an exception, because in both routine and specific care, we deal with people who have mental problems and other illnesses.

Section 17 of the Code of Ethics of Nurses stipulates that "*A nurse shall act competently in fulfilling her or his professional duties. To that end, the nurse shall take into consideration the limits of her or*

his knowledge and skills." If due to a lack of knowledge, a nurse cannot do this assessment, another qualified professional will do it. Can we afford to lose this expertise or even risk losing these reserved acts?

In the same vein, critical care and family health have been transferred to the DEC-bacc program of university training. This means that nurses receive very little training in these fields of practice at the college level. Yet the family is an integral part of each patient. Furthermore, it is not necessary to have university training to work in a critical care setting or any other specialty. New nurses arriving in the labour force are much less prepared to deal with the reality of various care settings that are becoming more high-risk given the shortage of experienced nurses, workloads and higher levels of care in all activity centres.

Transmission of knowledge and uneven employer-provided training

In the current context of nursing in Québec, increasingly heavy workloads prevent experienced nurses from passing on their knowledge to new nurses. They lack time to orient new nurses. New nurses must arrived well-prepared to cope with this reality. We therefore have to look at alternatives that can improve the transmission of knowledge and ensure its standardization and sustainability.

According to the OIIQ Youth Committee's 2005 brief, the establishment of health and social services networks has not included much in the way of measures to encourage the transfer of clinical expertise.

The training given by employers varies from one institution to another, ranging from a few days to a few weeks. For example, the CHU Sainte-Justine, which is an ultra-specialized tertiary centre, provides 15 days' of training on surgery-trauma units. The same number of days of training is given at the CSSS d'Arthabaska-et-de-l'Érable, a general and specialized health-care centre. With such wide variations in the amount of orientation time, it is impossible to pass on the same quantity of knowledge. Nurses' training must therefore be standard and complete when they leave the classroom. Candidates for admission to the practice of the nursing profession can't rely on

employer-provided training; they must be autonomous as soon as they enter the labour force. The training given by employers is related to the specific features of a given workplace; institutions can't be expected to give general training in nursing. Labour shortages and financial costs prevent any more training than what is now offered from being given.

The influence of other professionals on our profession

When we compare ourselves with other professionals who have reserved activities, we can see that the majority of them (14 out of 19 professions) must have a university degree.

In their daily practice, nurses collaborate and interact with various professionals. Apart from nursing assistants and respiratory therapists, most of the others – nutritionists, occupational therapists, physicians, pharmacists, physiotherapists, psychologists, social workers, etc. – have university degrees. Nurses find themselves at the intersection of all these professionals, and in the course of their work they are expected to have skills that at least touch on each of the professions with which they work.

When the Office des professions authorizes a person to engage in a reserved or shared activity, it is because that person has proven that she or he has the knowledge and skills acquired during her or his training, not expertise acquired over the years. Furthermore, the Professional Code now allows for adjustments, with activities added by regulation, without it being necessary to revise the Code from A to Z. A good example of this is the regulation giving nursing assistants a new activity: intravenous therapy. We are increasingly confronted with the reality of the growing role and place of professionals other than nurses, justified precisely by their training.

We have to maintain the place nurses have always had and give future nurses the means to keep that place. The sustainability of our profession, its credibility and leadership within the multi-disciplinary team depend on it.

Nurses in Canada

An undergraduate university degree as a prerequisite for practising as a nurse is not a new idea. The document *Le baccalauréat comme exigence d'entrée dans la profession*, by the Canadian Nurses Association (CNA), reports that discussions on university training date back to 1918. In 1982, the CNA took a stand in favour of a bachelor's degree as the minimum training required in Canada. **Québec is the only province in Canada that does not require nurses to have a university degree.**

The OIIQ's 2010 document, *Le baccalauréat comme condition d'obtention du permis d'exercice de la profession d'infirmière,* notes that except for Québec, all Canadian provinces have, as a result of either legislation or the demonstrated need to increase the level of training to better meet the needs of the population, changed the conditions for entering the nursing profession, while of course respecting nurses already working in the health-care system. New Brunswick is the Canadian province where the situation is the most similar to ours.

On February 29, 2001, Nadine Lambert, FSSS vice-president responsible for nursing and cardio-respiratory care personnel, took part in a day of discussions with Ontario and New Brunswick. Representatives of the professional orders and unions in the two provinces were present, along with the president of the CNA. The objective of the day was to understand the path travelled that nurses have travelled, the issues and challenges facing them as well as the solutions that led to the transition from one form of training to another as the entry requirement for the nursing profession.

In New Brunswick, there were two ways to enter the nursing profession before 1998, very similar to our education model: through nursing schools or through university.

The transition from one to the other occurred taking into account the apprehensions and specific characteristics of each (both for nursing schools, which have not disappeared, but have instead become integral parts of the university curriculum, and for nurses who did not have a bachelor's degree), with planning for a transition period to make the process harmonious. For example:

- a grandfather clause for nurses who don't have a bachelor's degree;
- no restrictions on the right to practise for nurses who don't have a bachelor's degree;
- a resolution recognizing the value of expertise.

The change was implemented over a period of seven years. Two years were devoted to consulting all the interested parties, and then five years to the transition.

We took advantage of this meeting to question our colleagues about our own concerns, such as fears about aggravating the labour shortage, discouraging young people from continuing nursing studies, the possibility of lower pass rates, recognition of nurses already working in the system who don't have a bachelor's degree, etc.

They responded that the change had not caused greater labour shortages, reduced enrolment in nursing or resulted in fewer graduates a year, and that nurses' expertise was recognized. They argued the following advantages with employers and the government of New Brunswick:

- standardized training;
- easier multi-disciplinary work;
- safer and better quality of care;
- nurses are better prepared and equipped right from entering the profession to take on the role, duties and responsibilities that await them now and in the future.

Portrait of Canadian provinces

Passage from nurse to bachelor nurse

1998: Prince Edward Island	Process completed
1998: New Brunswick	Process completed
2000: Saskatchewan	Process completed
2005: Ontario	Process completed
2006: British Columbia	Process completed
2011: Manitoba	In transition
2011: Alberta	In transition

Today, 89% of nurses in Canada have a bachelor's degree.

Québec compared with other French-speaking countries

A very recent publication entitled *Analyse et mise en contexte des profils de formation infirmière dans différents pays francophones* prepared by the Université de Montréal for the Secrétariat international des infirmières et infirmiers de l'espace francophone (SIDIIEF) shows that Québec lags significantly behind other countries when it comes to nursing education.

Take France, for example: the "Diplôme d'État d'infirmier' includes 1,395 more hours of training than Québec's CEGEP diploma (DEC). And here, the nursing DEC includes 660 hours of general courses like philosophy, French, etc.

An analysis of the chart *Synthèse de la formation infirmière de base dans différents pays francophones, SIIDIEF 2008, 2011*, shows that in a number of countries, a university degree is the standard entry requirement for the nursing profession. Here are a few examples:[9]

Country	Number of years of school before training	Length of nursing education	Diploma or degree required	Total number of years of studies to qualify for graduate studies
Algeria	12 years	3 years	State graduate nurse (Infirmière diplômée d'État - IDE)	15 years
Lebanon	10-13 years	3 or 4 years	Technical bachelor's (brevet), T.S diploma, licence	16-17 years
Luxemburg	11 years	4 years	Luxemburg diploma of nursing, general care	14 years
France	12 years	3 years	Licence	15 years
French Switzerland	12-13 years	4 years	Bachelor of nursing	15-16 years

Since October 2008, the Québec government has had an agreement with France on the mutual recognition of professional qualifications. The agreement allows for recognition that the training of

[9] *Analyse comparative et mise en contexte des profils de formation infirmière dans différents pays francophones*, Université de Montréal, Faculté des sciences infirmières, Secrétariat national des infirmières et infirmiers de l'espace francophone, bibliothèque et Archives nationales du Québec 2011, p.13, p.16.

various professionals, such as nurses, is adequate for French nurses to work as professionals in Québec, and vice versa.

In the France-Québec agreement, Québec's baccalaureate (bachelor) nurses are recognized and can work as nurses in France, unlike nurses who have a CEGEP diploma (DEC), who don't have access to the profession in France.

This is one example of the kind of limitation with which the next generation of nurses will be increasingly confronted. We don't want to promote the exile of our future nurses – quite the contrary! We have always been proud of being recognized as having training that was equal to and even at times superior to that of others; but this is no longer the case.

Apprehensions about a transition to new criteria for obtaining a permit to practise the nursing profession

A transition to a bachelor's degree as the requirement for practising the profession of nursing will certainly cause some apprehensions, some of which have already been mentioned. It is to be expected that nurses holding a college diploma who are already part of the labour force will fear for their jobs, apprehend having to return to school or being restricted in their reserved activities, etc. In contrast, nurse clinicians could oppose recognition of nurse technicians who don't have a university level of training.

There could be a disenchantment with nursing as a profession, or a shortage of personnel because of fewer graduates for one or two years.

Advantages of a transition to new criteria for obtaining a permit to practise the nursing profession

Notwithstanding the apprehensions described above – faced by the other Canadian provinces too – we can also see a number of advantages flowing from such a transition leading to enhanced knowledge and competencies upon entry into the profession.

↑ satisfaction at work;

↓ burnout;

↓ intention of leaving the profession;

↑ leadership;

↑ professional autonomy;

↑ control over the profession and the environment;

↔ maintenance of activities reserved to nurses;

↑ collaboration with an inter-disciplinary team;

↑ expertise, knowledge and clinical judgment;

↑ new nurses better prepared to meet the needs of the labour market and therefore more pleasure in the work;

↑ increased quality of care provided by new nurses;

↑ enrolment in training program;

- standardized training;
- in the medium run, a single category of nurses entering the profession;
- standardization of inter-provincial recognition and recognition vis-à-vis other French-speaking countries.

Conclusions/Recommendations

In conclusion, Québec's health-care system has undergone many transformation in recent decades. A number of factors influence the current context of care, such as an aging population, technological progress, the shift to ambulatory care and labour shortages. These changes were followed by Bills 90 and 21, which enhanced the duties, activities and responsibilities of health-care professionals. New nurses have to be better trained right from their arrival in the nursing labour force.

Our reading on the role of nurses and training now given in Québec compared with training in other provinces and other countries, we are forced to conclude that the nursing training given at the college level is no longer adequate in the current context, due to significantly fewer hours of training specifically in nursing. A complementary solution, standard at all levels, is necessary to allow future nurses to acquire the knowledge and competencies deemed to be basic, to fulfil the roles and carry out the duties and responsibilities that the Québec health-care system and the health of Québec's population require.

Given the nursing education now available in Québec, we conclude that university training could be a solution, since the missing knowledge is already taught at that level. This training would become the condition for obtaining a permit to practise as a nurse in Québec(i.e., the DEC curriculum in nursing and the two-year baccalaureate (bachelor's) program (DEC-bachelor) or the DEC curriculum, two years in science in science and the bachelor of nursing, without eliminating the possibility of earning a baccalaureate or bachelor's degree through an accumulation of certificates).

We shouldn't lose sight here of the fact that none of this will affect nurses who already work in the health-care system and who have acquired experience on the job that has enabled them to keep pace with technological change and all the other changes in the system, developing the necessary knowledge and skills. Because of the many problems encountered by recently graduated nurses in integrating into the various workplaces, we think that new nurses need to be given more resources. For a number of years now, we have been faced with a lack of vision on the part of those who govern us, and by a lack of understanding, fear or apprehensions on the part of others. We have

been stuck putting out fires that had been allowed to grow into strong blazes. All too often we only see the tree directly in front of us. This time, we are looking at the entire forest and will find a solution before the next generation of nurses flees the profession.

An analysis of the current and future situation as described throughout this document leads us to consider that if the OIIQ decides to pursue the enhancement of academic knowledge as a new condition for obtaining a permit to practise the nursing profession in Québec, such a process should be considered seriously and be aimed at:

1. **Recognition** of the experience and expertise of nurses now working in the health-care system;
2. Access to positions for nurses with experience and expertise who don't have a baccalaureate (bachelor's degree);
3. Facilitating the updating of the knowledge and competencies of nurses with recognized experience and expertise;
4. Availability of a nursing work force after three years of college (CEGEP) studies;
5. The establishment of transitional measures to avoid any exclusions;
6. Ensuring that these new provisions don't aggravate labour shortages;
7. Colleges and universities co-ordinating the content and training to ensure that it is complementary;
8. College education, either general or technical, remaining a prerequisite for admission to university;
9. Enrolment in the CEGEP nursing program automatically constituting an application for the baccalaureate (bachelor's) program;
10. Measures to facilitate family/work/study balance (part-time bachelor degree studies, leave for studies from institutions).

In short, keep in mind that the nursing profession is a vital and decisive component of the health-care system.

Appendix

Competencies taught at the college and university levels

CHSLD clients			
Types of activity	**Types of care**	**DEC clinical fields and activities**	**University clinical fields and activities**
Clinical activities	Long-term care	Clients requiring care corresponding to physical, intellectual and cognitive deficits	Clients requiring complex care such as psycho-geriatrics, multiple pathologies and complex psycho-social situations
Clinico-adminstrative activities	Development and co-ordination of the care program	Co-ordination of the care team	Development of care programs Co-ordination of the inter-disciplinary team Co-ordination within an integrated network of care and services

Hospitalized clients			
Types of activity	**Types of care**	**DEC clinical fields and activities**	**University fields and activities**
Clinical activities	General care Care in complex situations Critical care	Clients requiring general care in medicine and surgery, phase 1 rehabilitation, perinatal care and psychiatry	Clients requiring phase 2, 3 or 4 rehabilitation Consolidation and development of competencies to intervene in complex care situations Clients requiring care in: psycho-social complexity, critical care (e.g., emergency, recovery room, major burn care, intensive psychiatric care)
Clinico-administrative activities	Follow-up and co-ordination of activities and clients		Care, teaching, systematic monitoring of the client, infection prevention and control, evaluation of the quality of care and the co-ordination of services in the health-care system

Ambulatory clients			
Types of activity	**Types of care**	**DEC clinical fields and activities**	**University fields and activities**
Clinical activities	Ambulatory care in hospitals/rehabilitation centres	Clients requiring care in general medicine or surgery, like day surgery	Clients requiring complex care in medicine and surgery such as clinics for renal or heart failure, diabetes, oncology, etc. Preparatory care for elective surgery Monitoring of clients in mental health
	Ambulatory care in CHSLDs/day and respite centres Ambulatory care in CLSCs	Clients requiring preparatory or post-hospital care	Consolidation and development of competencies for intervening in complex care situations Clientele: child/family/youth, pregnancy care, basic care, post-hospitalization, medicine, surgery, intravenous antibiotics therapy, parenteral hyperalimentation, health advice/infosanté/mental health
	Ambulatory care for groups		Nutrition, group education

Ambulatory clients			
Types of activity	**Types of care**	**DEC clinical fields and activities**	**University clinical fields and activities**
Clinico-administrative activities	Follow-up and co-ordination of care, prevention and promotion program		Development of care and teaching program Systematic monitoring of clientele (AIDS, COPD) Development and implementation of prevention and promotion Co-ordination within the network

Home care clients			
Types of activity	**Types of care**	**DEC clinical fields and activities**	**University clinical fields and activities**
Clinical activities	Care for people with a temporary loss of autonomy		Clients requiring general and specialized care at home: post-natal follow-up, post-hospitalization, chronic diseases, terminal phase and support for natural caregivers
Clinico-administrative activities			Training and supervision of personnel providing assistance Planning and co-ordination of support/assistance care Co-ordination within an integrated network of care and services

Clients in community settings			
Types of activities	**Types of care**	**DEC clinical fields and activities**	**University clinical fields and activities**
Clinical activities	Care in schools		Care, screening, teaching, health education
	Care in the workplace		Care, screening, teaching, health education
	Care in prisons		Care, screening, teaching, health education
Clinico-administrative activities	Monitoring of the care, prevention and promotion program		Development and implementation of the care, prevention and health promotion program Evaluation of the quality of care

Definitions

In this paper, unless the context indicates otherwise, the following (mostly French) acronyms mean:

Bacc: Baccalaureate, or bachelor's degree

CEPI: Candidate for admission to the practice of the nursing profession

CHSGS: general and specialized hospital

CHSLD: Residential and long-term care centre

CHU: University hospital

CLSC: Local community service centre

CNA: Canadian Nurses Association

COPD: Chronic Obstructive Pulmonary Disease

CSSS: health and social services centre

DEC: College studies diploma (CEGEP diploma)

ECMO: Extracorporeal membrane oxygenation

GMF: Family practice group

MELS: Ministère de l'Éducation du Loisir et du Sport

OIIQ: Ordre des infirmiers et infirmières du Québec

PTI: Therapeutic nursing plan

RI: Intermediate resource

RLS: Local services network

RNI: Non-institutional resource

SIDIIEF: Secrétariat international des infirmières et infirmiers de l'espace francophone (International secretariat of nurses in French-speaking areas)

SS: Systematic monitoring

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