Interpreting and Modifying the Scope of Practice of the Registered Nurse
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Executive Summary

The College of Registered Nurses of Nova Scotia (CRNNS) is receiving many requests from registered nurses, employers and other health profession regulators seeking assistance in determining whether registered nurses can perform particular tasks/interventions/functions not previously considered to be within the role of the registered nurse. The purpose of this paper is to inform CRNNS of the existing options that nursing and other regulators in North America use to determine what activities/tasks/interventions can fall within individual scope of practice of the registered nurse and to assist in determining CRNNS’ role and a regulatory framework for interpreting or modifying the registered nurse scope of practice.

There were two elements to the collection of data for this policy paper. First, a review of the literature relevant to scope of practice for registered nurses was conducted for the last 10 years from published sources including a review of all scope of practice documents published by all Canadian RN regulators and numerous international nursing regulators in the US, Australia, and New Zealand. A number of principles related to scope of practice were developed based on the review of the literature. Second, structured one hour telephone interviews were conducted with a representative from each of the Canadian RN regulatory bodies (with the exception of Quebec). In addition, interviews were conducted with representatives from the Nursing and Midwifery Council of Australia; Nursing Council of New Zealand and the Nursing and Midwifery Council of the UK. Interviews were also conducted with a representative from the National Council of State Boards of Nursing (NCSBN) in the US which is a national organization representing the collective voice of nursing regulation in the US. A representative from the American Nurses Association was also interviewed to get the perspective of a professional association in relation to scope of practice.

Decision making frameworks and regulatory guidance on how to manage additions to the RN scope of practice as well as safe systems for delegation and supervision are key tools for managing changing scopes of practice (Department of Health, Ireland, 2011). Many regulators in Canada and internationally are now adapting more permissive approaches to defining scopes of practice and transferring greater accountability for making scope of practice decisions to the individual practitioner and employer. A number of regulators have developed decision making frameworks to assist registered nurses and employers make informed decisions about making additions to the RN scope of practice based on an interpretation of the scope. However, it is important to remember that any decision making frameworks need to consider any prohibitions existing in legislation. Two decision making frameworks have been developed for this paper to address the:

1. Addition of new roles, functions and accountabilities based on an interpretation of scope of practice

2. Addition of new roles, functions and accountabilities requiring a modification to the scope of practice for registered nurses

For additions of a new role, function or accountabilities to the RN scope of practice through an interpretation of the scope of practice, the policy recommendation is for CRNNS to introduce a decision making framework to assist RNs and employers make informed and appropriate decisions. The decision making framework provides a moderate degree of regulatory oversight in that written and clear guidelines are provided to employers and RNs. The RN and employer are required to use CRNNS’ decision making framework to decide the appropriateness of a new addition to the individual scope of practice of an RN. The decision making framework developed for this policy paper gives considerable accountability to the RN and the employer but answers to the decision points that may initiate College involvement and oversight. The greater the risk to client safety, the more regulatory oversight is required. The RN and employer may also consult with CRNNS at any point in the process. Decision points have also been developed for CRNNS to assist in their decision making if consulted.

There are two policy options to allow registered nurses to incorporate new roles, functions and accountabilities that are not within the scope of RN practice. To incorporate new roles, functions and accountabilities that are
not within the scope of RN practice and where the new addition is restricted by a statute regulating the practice of another health profession, CRNNS may seek a modification to the scope of practice of the profession via legislative changes to the RN Act and Regulations. Modification requires regulatory oversight by CRNNS and consultation with all the other stakeholders via the mechanism established by the Nova Scotia Regulated Health Professions Network. It also must be recognized that changes to legislation can be a lengthy and labor intensive process. However, with a modification of the scope of practice for the RN, as with a new interpretation to scope of RN practice, the new role/function becomes a permanent part of the RNs scope of practice. A decision making framework with decision points has been developed to assist registered nurses and employers prepare for initial discussions with CRNNS when seeking a major change or addition to the RN scope of practice. Decision points have also been developed for CRNNS to assist in their decision making.

The second policy option relates to delegation, specifically for the RN acting in the delegatee role. CRNNS can continue to allow the RN to accept delegated functions with written guidelines provided by CRNNS while allowing for the additional option to establish inter-professional ad hoc working groups when necessary to review requests for additions to RN scope. This may be an interim step as there are fewer and fewer delegated functions necessary as more and more roles/functions have been added to the scope of RN practice. Several of the interviewed regulators believe that delegation may be more limited in the future as all health professions are encouraged to be working at optimal scope of practice and governments are supportive of all health professions working to “full” scope. CRNNS has traditionally allowed the RN to accept delegations from other health professionals, most notably physicians; however, recently there has been a query as to whether the current RN Act (2006) prohibits an RN from accepting a delegation. Delegation is a viable option to allow an RN to add a new activity or competency to their individual scope of practice if there is support in the regulatory body’s legislation and/or policy documents and no prohibition in the legislation of another health professional group. If the current RN Act can be interpreted to allow for the RN accepting a delegation and/or the necessary changes can be made to the health profession regulations, the RN acting in a delegatee role could continue. With delegation, the new activity does not become part of the scope of practice of the individual RN but remains a delegated function.

Introduction

The scope of practice of a regulated health profession is defined in their practice legislation (RN Act, 2006, Medical Act, 2011). Scope of practice forms the foundation on which competencies and practice standards are developed, informs curriculum content, assists with staffing decisions and health care workforce planning. Generally, the scope of practice defined in legislation is broad enough to allow for some flexibility in interpreting the scope of practice of a profession to allow for changes in practice, evolving trends and new models of care. Major modifications in practice require changes in the legislation, consultation with the members of the profession, government, the public, employers and other health professionals. On occasion, proposed modifications in scopes of practice have created tensions with other professions as it has been perceived that the proposed changes are encroaching into their scope or area of practice (NCSBN, 2009). However, it is now accepted that no one health profession has a completely unique scope of practice and that many professions share competencies. One task or activity does not define a profession; rather, it is the entire scope of competencies that make a profession unique. With increasing patient acuity, increasingly complex care, the advent of new technologies, and a health system expectation that all health care professionals work to their optimal scope of practice, discussions around interpreting and/or modifying the RN scope of practice are timely.

CRNNS is receiving many requests from registered nurses, employers and other health profession regulators seeking assistance in determining whether registered nurses can perform particular tasks/interventions/functions not previously considered to be within the role of the registered nurse. These decisions are at times challenging because often these tasks/interventions/functions are beyond entry-level practice and are not in taught basic nursing education program but could be considered to be within the scope of practice of nursing.
There is currently a need for CRNNS to clarify its regulatory role in relation to individual scope of practice and to determine a regulatory framework for analysis and decision making around how changes are made to the interpretation and/or modification of the legislated scope of practice of RNs, including making decisions about individual RN scope of practice to facilitate timely, accessible client care. The Nova Scotia Regulated Health Professions Network Statute (2012) provides for a mechanism to enable a process for interpreting or modifying the scope of practice for the professions in the best interest of the public. The Nova Scotia Regulated Health Professions Network comprised of 21 regulated health professions is an excellent vehicle for sharing information and making policy recommendations related to interpretation and modification of health profession scopes of practice. The decision making framework prepared by CRNNS may be useful the network as it works with its members to address health system needs with regard to health professions scope of practice.

For many years, CRNNS has used the processes of delegated function to address changing needs of the health care and address client care needs. This process has evolved over time with CRNNS and the College of Physicians and Surgeons of Nova Scotia playing less of a role in determining these functions and the District Health authorities taking on more of role related to changing roles. CRNNS is now questioning whether or not the delegated function process is still viable or if there is another process that would take us into the future. This is an even more timely issue as changes to the Medical Act allows for the Board of the College of Physicians and Surgeons to make policy with regards to decisions around delegation.

**Purpose**

The purpose of this paper is to inform CRNNS of the existing options that nursing and other regulators in North America use to determine what activities/tasks/interventions can fall within the scope of practice of the registered nurse, assist in determining CRNNS’ role and develop a regulatory framework for interpreting or modifying the registered nurse scope of practice. This includes an assessment of whether there is a need for the framework to include competency development beyond the Entry-Level competencies to address what employers are calling “Advanced Nursing Skills”.

It is not intended to be an academic paper but rather a document which will provide direction in assisting the registered nurse, the regulator and the employer in making decisions to allow registered nurses to practice to their optimal scope of practice and to add to the legislated scope of practice for the profession.

**Definitions**

**Scope of practice of the profession**: in Nova Scotia, means the roles, functions and accountabilities which registered nurses are educated and authorized to perform. (RN Act, 2006.) The overall scope of practice for the profession sets the outer limits on nursing practice.

**Individual scope of practice**: in Nova Scotia, means the roles, functions and accountabilities that an individual is educated and authorized to perform (RN Act, 2006). The scope of practice of an individual may be narrower than the scope of practice of the profession. However, while the scope of an individual registered nurse may be narrower than that of the profession, an individual may have more specialized and in-depth knowledge and competence in one area of practice.

**Interpretation of scope of practice**: An addition or incorporation of new role, function or accountability to the scope of practice of a profession that is within the current legislated authority for the profession. An interpretation of scope of practice can be considered an interpretation when the role, function or accountabilities have not traditionally been within the practice of nursing but are consistent with the definition of the practice of nursing in the enabling legislation. In addition, there cannot be any restriction present in a statute regulating the practice of another health profession or alternatively the function may be within the public...
domain. Functions that are in the public domain can be incorporated into the scope of practice of any regulated health professionals. An interpretation to scope of practice may be applied across the profession or be used to make a decision around scope of practice for an individual.

**Modification of scope of practice**: major proposed change in competencies or profession’s scope of practice requiring actual changes in the current legislation or initiating a modification of scope of practice through the process outlined in the Nova Scotia Regulated Health Profession Network Act (2012). A modification to the scope of practice may be required when 1) the role, function or accountability is not currently within the scope of practice of nursing 2) the new addition is restricted by a statute regulating the practice of another health profession. A modification also might be required when the role, function or accountability may be considered within the scope of practice of nursing but the risk is significant enough to consider a legislative change to the scope of practice for the profession. Example: Registered Nurse taking on broad prescriptive authority or conducting minor surgery, administering general anesthesia.

**Optimal scope of practice**: means that individual registered nurses are performing at the highest level of their competencies (knowledge, skills and judgment) and, thereby, making their greatest contribution to client outcomes. (CRNNS Ends document, 2011).

**Full scope of practice**: means that registered nurses are fully utilizing their role, responsibilities and competencies for which they have been educated and are authorized to perform. (CRNNS Discussion paper Scope of Practice, 2009).

**Expanded scope of practice**: There are varied terms for expanded scope in the literature. A common definition is that it refers to a situation where a nurse with demonstrated nursing expertise assumes responsibility for a health care activity which is currently outside of their scope of practice, both the profession and individual scope of practice. (BC Government, 2009). However, regulatory authority mechanism needs to exists to permit an expansion to the scope of practice such as certified acts.

**Advanced Nursing Practice**: an umbrella term used to describe an advanced level of nursing practice requiring graduate level education that maximizes the use of in-depth nursing knowledge and skills to meet client needs. (MacDonald et al, CNA, 2005) An essential component of advanced nursing practice is the capacity to expand the boundaries of nursing practice and to effect system changes in health care. (CRNNS, 2014)

**Principles related to Scope of Practice**

1. Protection of the public is the priority in scope of practice decisions.
2. Primary reason for any proposed change in scope of practice of a profession is to meet client health needs and enhance client care outcomes.
3. Health professions are continuously evolving to meet population health needs.
4. No health profession today has a completely unique scope of practice, so overlapping scopes of practice and competencies are inevitable.
5. Scope of practice of a profession needs to be flexible enough to respond to health care needs.
6. Regulators, employers, educators, and government must be responsive to changes to support evolving scopes of practice.
7. Registered nurses are accountable for making professional judgments about when an activity is beyond their competence or scope of practice.
8. Nursing practice is complex and cannot be reduced to a list of tasks or activities.

9. There are many factors that influence individual scope of practice including provider education, experience, employer policy, patient population, context of practice, risk management framework and organizational culture.

10. Decisions related to interpretation and modification of scope of practice must be made in a collaborative context with regulators, educators, employers, the public and other stakeholders.

11. Health profession regulators cannot control every aspect of the practice of the profession; rather provide direction through the development of standards, guidelines and policy documents.

Methodology

There were two elements to the collection of data for this policy paper. First, a review of the literature relevant to scope of practice for registered nurses was conducted for the last 10 years from published sources using Pub Med and CINAHL. Google Chrome was used to expand the search into grey and other published literature. In addition, all documents related to scopes of practice published by all Canadian RN regulators and numerous international nursing regulators in the US, Australia, and New Zealand were reviewed. Second, structured one hour telephone interviews (see Appendix A for interview guide) were conducted with a representative from each of the Canadian RN regulatory bodies (with the exception of Quebec) which included the Association of Registered Nurses of Newfoundland and Labrador (ARNNL); Association of Registered Nurses of Prince Edward Island (ARNPEI); New Brunswick Nurses Association (NANB); College of Nurses of Ontario (CNO); Saskatchewan Registered Nurses Association (SRNA); College of Registered Nurses of Manitoba (CRNM); College and Association of Registered Nurses of Alberta (CARNNA); College of Registered Nurses of British Columbia (CRNBC); Yukon Registered Nurses Association (YRNA); and the Registered Nurses Association of Northwest Territories and Nunavut (RNANT/NU). In addition, interviews were conducted with representatives from the Nursing and Midwifery Council of Australia; Nursing Council of New Zealand and the Nursing and Midwifery Council of the UK. Interviews were also conducted with a representative from the National Council of State Boards of Nursing (NCSBN) in the US which is a national organization representing the collective voice of nursing regulation in the US. A representative from the American Nurses Association was also interviewed to get the perspective of a professional association in relation to scope of practice. (See Appendix B for a full list of those interviewed).

Literature Review

Scopes of practice for health professionals are defined in the legislated definition of the practice for that profession and in the case of nursing, complemented by standards, policies and competencies defined by the regulator. Three Canadian provinces currently have health professions umbrella legislation specifically British Columbia, Ontario and Alberta. CRNM is anticipating umbrella health profession legislation in 2015 so many of their current processes will change. Both Australia and New Zealand have umbrella health professions legislation. The umbrella legislation broadly defines scope of practice for all their regulated health professions with a more specific definition for a particular profession enshrined in the associated regulations. Most nursing authors and regulators define scope of practice as roles, functions and activities registered nurses are educated and authorized to perform. Recently, several regulators have added competent to this definition (CARNNA, 2011). Although CRNNS is the only regulator in Canada who specifically defines the scopes of practice for the profession and for the individual in their legislation (Registered Nurses Act, 2006), a number of the other regulators contacted make a similar distinction in their policy documents.

There is relatively little research on scope of practice as a general concept with the majority of the research descriptive in nature and focused on advanced practice and nurse practitioners in various clinical settings (White
et al, 2008). There is a variety of terminology used to describe scope of practice and conflicting definitions for the same terms. Generally, it is agreed that full scope of practice means that registered nurses are fully utilizing the competencies (knowledge, skills and judgment) for which they have been educated and are authorized to perform. In other words, full scope is defined by the boundaries of practice for the profession. Although there has been a great deal of discussion in the literature about assisting registered nurses to practice to “full” scope, others note that no registered nurse can ever practice to “full” scope as they are constrained by their education, experience, patient population, clinical setting and the nature of their job description. So perhaps full scope should mean working to full competencies within a particular setting and patient population, e.g., critical care. Recently, there has been increasing discussion that optimal scope may be a more accurate term which is defined by the CRNNS as individual registered nurses performing at the highest level of their competencies (knowledge, skills and judgment) and, thereby, making their greatest contribution to client outcomes.

The health care system has been undergoing significant changes in the last 10-15 years. Changes include new ways to provide patient care, greater primary care and more care in the community (IOM, 2010). Nurses are well positioned to meet changing health care needs by virtue of their education, experience, broad scope of practice and their adaptive capacity (ibid, 2010). The constraints of outdated policies, regulations, and cultural barriers including those related to scopes of practice will have to be lifted for both advanced practice nurses and general registered nurses to allow for necessary improvements to the health care system (IOM, 2010).

Concurrently, regulation of health care professionals has also been changing in recent years. Self regulation is being displaced, restructured and more tightly supervised as regulator rules are consolidated, transferred to new institutions and subjected to new layers of regulatory oversight (Lahey, 2011). Right touch regulation refers to the minimal regulatory force required to achieve the desired outcomes (Council of Health Care Regulatory Excellence, 2010). When regulation is appropriate, it should be simple and to the degree required to achieve the best result.

Optimizing the registered nurse contribution to health is not solely related to the incorporation of a particular skill or activity but to the complex interplay of professional attributes, experience, learning, scientific knowledge and critical thinking (Nursing and Midwifery Office, Queensland, 2005). In recent years, the scopes of practice of some health professionals such as nurse practitioners have been extended and new professions and roles such as pharmacy technicians have been developed in some Canadian jurisdictions (Optimizing Scopes of Practice, 2014). Optimizing scopes must be determined in alignment with the models of care in which they function (ibid, 2014).

The literature also indicates that many registered nurses in Canada believe their knowledge and competencies are not being fully utilized (White et al, 2008). There is work at the national level to address legislation and regulation in relation to scope of practice and maximizing the potential of the RN role. CNA supports diagnosis and prescribing activity for registered nurses in Canada by 2020. (CNA, National Nursing Action Plan, 2012).

Defining regulatory approaches to scope of practice is critical in a time of changing health needs, health care delivery, workforce shortages, overlaps in scopes of practice among health professionals and new technologies (JHpiego, 2009). Practitioners are being educated to meet an increasingly high set of standards, yet remain underutilized in their day-to-day practice. Re-defining and expanding health professionals’ scopes of practice will allow them to provide a level of care more reflective of their qualifications, while increasing the efficiency and accessibility of health care (Summary of Input on the Conversation on Health, BC Government, 2007).

In some jurisdictions, the scope of practice for a profession is defined quite narrowly, which although it provides greater clarity, it leaves few opportunities for the practice to evolve and respond to health care priorities (JHpiego, 2009). In the jurisdictions surveyed in this paper, the legislation defines the practice of nursing quite broadly allowing for room for interpretation and additions to the scope of practice of the registered nurse. Scopes of practice should be sufficiently broad and flexible to permit freedom for innovation, growth and change (ICN 2009). The determinants of nursing practice which enable changes to scopes of practice include
legislated authority, regulatory standards, evidence informed practice, individual registered nurse competencies and the organizational/employer policies and support for practice (Nursing and Midwifery Board of Australia, 2010). Influences for change to nursing practice may arise from technological advances, work practice changes, emergence of new health care roles, changes in other health professions, resource changes including changes in the numbers of available health professionals (ibid, 2010). As Pringle states (2009), the best reason for adding additional responsibilities to the registered nurse scope of practice is that patients will have better care if one provider can manage a full range of activities and reduce wait times. The practice of nursing is a dynamic profession which evolves continually in response to scientific and technical advancements in the health field, increases in nursing education and training, and in response to patient health care needs. Periodic review of scopes of practice is therefore essential to ensure consistency with current health needs and to support improved health outcomes. Health care professions need to remain flexible regarding scope of practice issues and, at the same time, make careful, informed decisions regarding changes to the scope of practice.

The National Council of State Boards (NCSBN) in 2009 collaborated with a consortium of six health professional regulators to produce a guide for assessing scope of practice proposals. The guide identified criteria for assessing the need to make modifications to the broad scope of practice of a profession. Thus, it provides some objective measures to use in evaluating the need for changes to practice legislation and assists both regulators and legislators. If a profession can provide supporting evidence in these areas, the proposed changes in scope of practice should be adopted. The paper identifies four foundational areas for consideration:

1. Established history of the practice scope within the profession. Has the profession evolved towards adding the new skill or competency and how does it enhance current expertise?

2. Education and training. Does current entry level education prepare graduates to perform the skill, and if not, how will competence be assessed on the new skills? Are their standards and criteria established for necessary education programs and how will this be evaluated?

3. Evidence. Is there evidence that the new skill or competency will be beneficial for the public and enhance access to quality health care?

4. Regulatory environment. Is the regulatory organization prepared to manage the modification to scope of practice and the regulatory issues associated with the modification such as defining standards, assessment tools, education programs, complaints etc?

The NCSBN document states that it is critical to review scope of practice issues broadly to allow for innovation and to facilitate all health professionals in providing services to the full extent of their knowledge, education, experience and skills. This work is consistent with a 2005 document published by the Federation of State Medical Boards in the US. The Federation has developed a list of relevant questions and actions to assist in the objective review of the existing scope of practice of a profession and an assessment of the implications of any scope of practice changes.

Registered nurses graduate with defined entry level or foundational competencies to perform complex cognitive functions and highly technical skills (SRNA, June, 2014). The rapidly evolving nature of nursing practice may require competencies that are not currently taught in undergraduate nursing education programs but are still assessed to be within the current legislated scope of practice of the registered nurse. It may also require competencies that are not considered to be within the current scope of practice of the profession and require a separate process, such as a delegated function. Historically, tasks added to the registered nurse scope of practice that were not taught in nursing education programs as entry level competencies but were considered to be part of nursing practice were often performed as advanced nursing skills requiring a certification process, for example, the introduction of intravenous medications by RNs in the 1970s. Over time, many of these advanced skills became part of the scope of RN practice and were incorporated into undergraduate nursing education. Due
to these rapid changes, it is no longer feasible or appropriate for a regulatory body or employer to maintain an up-to-date “task list” for a nurse’s scope of practice. It is also not realistic for regulators to respond individually to the extensive volume of practice questions whether a specific task or procedure is permitted under the registered nurses scope of practice although they need to be available for consultation.

Recently, there have been calls for changes in nursing education programs as there appears to be some disconnect between the skills of newly graduated nurses and employer requirements. This is happening nationally and internationally. Currently, there is a Committee called the Registered Nurse Education Review Committee in Nova Scotia which is implementing a comprehensive review of nursing education programs to determine what changes are required to improve the quality, sustainability and accountability of nursing education in Nova Scotia (Nursing Education Review Steering Committee, March 21, 2014).

Many regulators in Canada and internationally are now adapting more permissive approaches to defining scopes of practice and transferring greater accountability for making scope of practice decisions to the individual practitioner and employer. A number of regulators have developed decision making frameworks to assist registered nurses and employers make informed decisions about what activities can be added to the RN scope of practice (CRNM, 2013; Nursing Council of New Zealand, 2011) In addition, several Canadian regulators have developed initiatives to allow registered nurses to add new competencies that have not been considered to be part of the RN scope of practice (NANB, 2013; ARNNL, 2006)

These new regulatory approaches are consistent with recommendations from the recent Expert Panel Summary Report on Optimizing Scope of Practice (2014). The summary report proposes a new model in relation to scope of practice, one in which the health care team or institution be held accountable for assessing appropriate and optimal scopes of practice within a regulated structure. Rather than recommending changes to the scopes of practice of individual health care professions, the Expert Panel is proposing an evidence based approach with three overarching elements which include support for innovative models of care; flexibility to respond to patient and community needs and accountability to the public and funders. The summary report identifies a number of recommendations aimed at creating more flexible environments to support the optimization of health care professional’s scopes of practice and innovative models of care. There are a number of recommendations from the Expert Panel for the federal government, jurisdictional regulators, accrediting bodies, pre-licensure and continuing education providers and professional associations and unions. The recommendation for regulatory bodies is for them to take the lead to align regulations in order to enable respective professionals to better meet population health needs within collaborative care models, particularly in cases of overlapping and expanded scopes of practice. There are two priority actions under this recommendation: 1) work collaboratively with professional certification bodies to create national standards and competency frameworks that recognize training and recertification in areas of overlapping and changing scopes of practice 2) recognize certificates for advanced competencies that enable expanded scopes of practice.

**Summary of Interview Results**

**Scope of Practice**

**Policy Documents, Legislation**

Of the ten Canadian and three international nursing regulators interviewed (NCSBN and ANA interview results will be reported separately), nine (69%) have a written policy statement on scope of practice. The majority of those with policy documents find it both necessary and useful. All but two of the interviewed regulators reported that there was a great deal of interest from registered nurses, employers, government and other stakeholders in adding activities or tasks to the RN scope of practice. Several regulators commented that governments are very interested in having all health professionals work to their “full scope” of practice.
Respondents reported that scope of practice for the profession was defined in their definition of the practice of nursing in their practice legislation. None (other than CRNNS) had specific definitions for individual scope of practice or the profession scope of practice in their practice legislation, but almost half made that distinction in their policy documents (ARNNL, 2006; Nursing and Midwifery Council of Australia, 2010), however two respondents with umbrella legislation reported that as a regulator, they only deal with issues related to the scope of practice of the profession. Interestingly, the UK Nursing and Midwifery Council do not have the RN scope of practice or the practice of nursing defined in either their legislation or in any policy documents although they do for midwifery. The definition of an RN is “anyone who is on the Register”. The UK NMC are currently consulting with ICN and are considering adding the ICN definition of nursing practice to their documents. However, in a recent survey of their members, almost 25% rejected the ICN definition of nursing as it was too clinically focused and did not reflect non clinical practice.

**Legislative Barriers and Enablers**

In relation to enablers and barriers in their practice legislation specific to scope of practice, almost all regulators noted that the major enabler was that the definition of the practice of nursing in their legislation was sufficiently broad to facilitate additions to the registered nurse scope of practice. However, two jurisdictions with umbrella legislation noted that profession specific provisions can be a barrier to change or require a lengthy process to effect change. One regulator noted that most scope of practice definitions speak to “hands on” nursing practice and can be problematic for questions related to non clinical nursing. Another barrier that was identified was the existence of other legislation that may inhibit nursing taking on new activities. Otherwise, few barriers were reported. The UK Nursing and Midwifery Council stated that their legislation, the Nursing and Midwifery Order gave them the power and authority to set all standards, a major enabler.

**Regulatory Mechanisms, Decision Making Tools and Criteria**

The answers to regulatory mechanisms, decision making tools and criteria (questions five to eight) were very similar so are combined here for ease of understanding and interpretation. When asked what regulatory and decision making tools and/or criteria were used to assist in making interpretations to the individual or profession scopes of practice, all regulators reported they used their respective practice legislation, standards of nursing practice, competencies, scope of practice documents and on occasion, CNPS or legal counsel. Many regulators stated that they used the expertise of their practice consultants (often augmented by policy) to respond to questions regarding individual scope of practice. However, it is not realistic for regulators to respond to numerous such queries and as one regulator stated, “It is not the role of a regulator to tell registered nurses what is and is not in their own scope of practice.” A number of regulators have developed different mechanisms to assist registered nurses and employers make informed decisions about what activities can be added to the RN scope of practice that are specific to and dependent on the respective practice legislation. (CRNM, 2013; Nursing Council of New Zealand, 2010).

The College of Nurses of Ontario (CNO) which is under a controlled acts model of umbrella legislation has an authorizing mechanism document (CNO, 2014) to give RNs the authority to implement treatment plans and protocols. The authorizing mechanisms could be an order, initiation, directive or delegation- which one is appropriate depends on the RN category, role and practice setting. With initiation, registered nurses who meet certain conditions have the authority to initiate specific controlled acts without an order or directive using a clearly defined process and conditions. The actual opportunity, however, to initiated controlled acts may be constrained by other legislation or by employer policy, for example, RNs cannot initiate hospital treatments in Ontario such as admission and discharge as they do not have authority in the legislation. The CNO decision tree for initiation of authorized practices includes competence of registered nurse; client factors such as presence of nurse- patient relationship; assessment of client; risks/benefits; predictable outcomes and any other relevant situational factors; environmental supports; documentation requirements and accountability.
CRNBC, also under a Health Professions Act, uses a restricted activities model. Their scope of practice document (CRNBC, 2014) states that RNs only provide care within their defined scope of practice with two exceptions, life threatening emergencies and where a formal delegation process is in place. However, CRNBC has the authority to decide which activities are within the scope of practice of the profession within the defined scope of practice statement in their Regulations. There are three kinds of nursing practice; general, certified and nurse practitioner. General practice includes both restricted and non-restricted activities that could be implemented with or without an order. Certified practice requires RNs to be certified through an educational program approved by CRNBC in four categories; contraceptive management, STI, remote nursing practice and RN First Call. CRNBC also has limits and conditions which are developed as necessary and approved by their Board. Limits define what RNs are not permitted to do and conditions describe under what circumstances RNs can carry out an activity. The criteria for establishing limits and conditions for an activity include 1) provincial need 2) significant risk 3) not recognized as “nursing practice” and this needs to be communicated 4) RNs and stakeholders believe limits and conditions are necessary. It is also noted that these CRNBC limits and conditions may not be necessary when the BC government has finalized the master list of restricted activities. Interestingly, CRNBC has a scope of practice “inquiry form” which is used to collect information from registrants to help CRNBC make informed decisions about a request for a role or activity to be considered part of registered nurse practice.

Alberta also has umbrella health legislation using a restricted activities model. Restricted activities for registered nurses are described in the Regulations for nursing under the HPA. If CARNA wishes to add a new competency to the RN scope of practice, they must work with government, employers and other stakeholders to get the change in their regulations, for example, they are currently negotiating adding limited RN prescribing to the Regulations. The CARNA informant noted it is a time consuming and onerous process requiring significant consultation with government and other health professions under HPA.

In summary, for these three Canadian regulators under the umbrella health professions model, it is apparent that their defined processes for interpretation and modification to the RN scope of practice are somewhat complex and also are very specific to their practice legislation.

Other regulators operating under a single nursing practice act have developed decision trees or decision making frameworks as analytical tools to assist nurses, employers and other stakeholders in determining whether or not an activity or action is within the scope of practice of a registered nurse. The Registered Nurses Association of Newfoundland and Labrador (ARNNL) previously approved all scope of practice changes which were extensive, time consuming and often needed the approval of other disciplines and resulted in a list of approved skills. ARNNL (2006) has developed a decision making process whereby decision making for specialty and shared competencies moves to the individual registered nurse and employer who want to incorporate a new competency into nursing practice. Specialty competencies refer to new or emergent interventions requiring skills beyond entry level but still within the scope of nursing practice. The concepts may have been introduced in undergraduate education programs but additional education is required before these specialty competencies can be implemented by the registered nurse. Shared competencies refer to competencies that are within the scope of practice of more than one health professional e.g., medication administration. In order for ARNNL to support RNs performing either specialty or shared practices, scope of practice principles must be met. The principles are 1) adherence to legislation and regulatory standards 2) identified client need 3) research and evidence based 4) involves collaboration of all stakeholders 5) supported by necessary education and authorized by agency / employer 6) regular evaluation. For registered nurses not employed by a health authority with the necessary supporting structure, the RN must contact ARNNL for guidance.

The ARNNL actual process for decision making has two parts, assessment and implementation. Under assessment are the requirements for the employer to have a process reflecting the ARNNL principles; assessment of benefits and risks to clients; assessment of the research, client needs and predictability of outcomes; and adequate supports. Implementation includes written employer policy; education process to
insure RN competency and appropriate agency support. The maintenance of competency is the responsibility of the individual registered nurse.

The Nurses Association of New Brunswick (NANB) has developed a collaborative decision making process for registered nurses and employers to use when evaluating requests to introduce a new post entry-level procedure (PELP) into RN practice. PELPs (NANB, 2013) are nursing procedures that are not part of basic nursing education, are not currently part of work expectations for an RN and are being introduced into nursing practice in specific patient settings. PELP replaces old terminology such as advanced nursing skills, specialized skills and delegated medical functions. However, PELPS are different than delegation—once acquired and maintained; PELPS become part of the permanent scope of practice of the individual registered nurse.

PELPs also have a defined process with specific requirements similar to the ARNNL. It includes the following:

» Is the PELP reasonable, appropriate and evidence based?
» Has there been an assessment of risks and benefits?
» Does the RN have the required competencies—initial and maintenance?
» Is there clinical support required to manage possible complications?
» What is the frequency of the interventions?
» Is there written employer policy?
» Is there an education program, including policy for continuing competency?
» Does the organization have a quality practice environment?

The Saskatchewan Registered Nurses Association (SRNA) has also developed new initiatives to optimize the scope of practice of an RN and enhance client care. These are specialty practices and additional authorized practices. Specialty practices (SRNA, 2014) are beyond the entry level competencies acquired in undergraduate education but are still within the scope of general RN practice. These specialty practices are applicable in numerous clinical settings and require either a Procedure or an RN clinical protocol. The education for specialty practices is employer approved. SRNA requires an assessment to be done to determine if it is appropriate to introduce a specialty practice. The assessment includes:

» Is it within RN scope?
» Evidence based?
» Client benefit/value?
» Assessment of risks and benefits?
» Frequency to maintain competences?
» Appropriate resources (personnel, equipment etc)?
» What is required for initial competencies development and to maintain competence?
» Can the RN manage the potential outcomes?

Under implementation, employers must have the appropriate policies and procedures; education and other resources; regular performance reviews and maintenance of the appropriate records and documentation.
Additional authorized practices (SRNA, 2014) are specific for primary health care in northern settings. The RN with additional authorized practices can independently diagnose, prescribe and treat limited common medical disorders guided by clinical decision making tools e.g., cystitis. The education for this must be SRNA approved and this designation is on the Register with special designation.

The College of Registered Nurses of Manitoba (CRNM) in a document entitled “Determining the Scope of Practice of an Individual Registered Nurses (2013) defines decision making criteria for analysis and possible extension of the RN scope of practice. The criteria are: 1) public need 2) stakeholder agreement 3) practice setting support 4) adequate liability protection 5) within legislated scope of practice of individual RN 6) new service meets RN Act provisions for included services. (Note that there are new Regulations in development to allow RNs who meet requirements in the Regulations to order and receive diagnostic and screening tests; prescribe medications designated in the Regulations and perform minor surgical procedures) 7) RN has the required competencies or can acquire them 8) competence can be maintained and 9) periodic evaluation.

The RNANT/NU has two decision making models for scope of practice decisions (2010). One is oriented for registered nurses in deciding if a particular activity is within their scope of practice. The second model is for transferred health functions to assist RNs, employers, Boards and other stakeholders make informed decisions regarding scope of RN practice. The framework is very similar to those described previously by the other regulators but will be included here.

Factors for the RN decision making framework are:

» Is the RN competent?

» Is the added function consistent with the RNANT/NU Standards of Nursing Practice?

» Does the RN have the knowledge, experience and resources?

» Are there written employer policies?

» Is it a basic nursing function?

» Is the RN currently certified by the employer to perform the function?

If the additional function is not a nursing function, then it may be a transferred health function and the decision making model is:

» Would clients benefit from an RN performing this function?

» Can the RN manage any potential complications?

» Is it consistent with RN Standards of Nursing Practice?

» Is there a written agreement between nursing and the transferring health professional?

» Are there the necessary resources to develop, implement and maintain a certification program for the transferred function?

Two of the three international regulators surveyed have also developed decision making frameworks for nursing and midwifery practice. The Nursing and Midwifery Board of Australia has developed a national framework for the development of decision making tools for nursing and midwifery practice (2010) which consists of two parts; a set of principles and then a template for decision making tools. Interestingly, the guiding principles were developed within the context of national workforce strategies promoting diversity, flexibility and responsiveness. The regulatory representative stated that their Board is required to balance workforce flexibility with the
requirement for public protection. The decision making tools assist in making decisions about both the individual scope of practice of the RN as well as the scope of practice for the profession. The framework “assists RNs when determining and assessing their own practice and assists employers and others in making decisions about interpreting and changing practice.” The framework includes criteria for assessing activities deemed to be within the RN scope of practice and also with activities not within the RN scope of practice.

The decision making framework for activities within the RN scope of practice include a comprehensive client assessment; a consideration of the organization’s quality and risk management framework and their staffing and resource capacity (if the organizational capacity insufficient, consider consultation or client referral) and the appropriateness of the RN to perform the function considering the client health status, need for specific nursing knowledge, consistency with legislation and organizational policy; the model of care requires an RN and is there appropriate education and supervision for the RN. The other model for those activities not within the RN scope of practice includes an assessment of whether the RN can integrate the activity into practice and whether the employer will initiate and support the change. If yes, the following areas are required:

» Can the activity be legally performed by a registered nurse?
» Do the professional standards support the activity?
» Is a risk assessment needed?
» Is there a consultation plan with all relevant stakeholders?
» Is there employer support and written policies?
» Does the RN have the education, authority, experience, capacity, competence and confidence to perform?

The Nursing Council of New Zealand has developed a Guideline to assist registered nurses and employers to understand the RN scope of practice and to help them make decisions about expanding the scope of practice of RNs in different and evolving health care contexts. The Council (2010) defines expanded practice as occurring when an RN with demonstrated nursing expertise assumes responsibility for a health care activity which is currently outside of their current scope of practice. Expanded practice may include areas of practice that have not previously been in nursing or have been the authority of other health professionals. There is a formal pathway to role expansion that entails further education and credentialing but they clearly differentiate it from the role of the nurse practitioner.

The decision making process for expanding the scope of RN practice requires collaboration between the RN and employer and includes the following questions:

» Will it improve client health outcomes?
» Is it appropriate for RN to do?
» Is the new activity supported by legislation and practice standards?
» Has a risk assessment been completed by the RN?
» Are organizational policies and procedures in place to support the activity?
» Will the organizational culture and interdisciplinary team accept the change?
» What is the education and practice requirement?
» Has the process been established to assess competencies and for ongoing education to maintain competencies?
» Does the RN understand and accept the accountability?

» Is there ongoing monitoring and evaluation of the expanded activity?

The Council has also identified the responsibilities for employers:

» Appropriate policies and procedures to support the expanded practice

» Appropriate skill mix of staff

» Clear role descriptions for RNs in expanded practice with policies, quality and risk management support

» Employer must assess the RN to determine if competent to do expanded role and document that assessment

» Processes must be in place to monitor the outcomes of expanded practice and report on the outcomes.

The UK Nursing and Midwifery Council as previously stated do not have a written definition of the practice of nursing or scope of practice in legislation or in their standards documents. The interviewee stated “individual RN scope of practice is determined where they are working.” However, one of their major reference documents is the Standards for Pre-registration Nursing Education which defines what nursing students must demonstrate to be fit for practice at the point of registration with the NMC. They contain the requirements and guidance that all Approved Education Institutions (AEIs) and their partners within the UK must adhere to in the development and delivery of education programs. The regulators use this document extensively in making decisions regarding RN scope of practice. However, as noted, significant authority is given to the individual practitioner, employer and/or the health care operator to make decisions regarding additions to the RN scope of practice.

In summary, five of the 10 surveyed Canadian regulators have a decision making framework or model to assist RNs and employers who are considering adding tasks or functions to the RN scope of practice. All of the frameworks are very similar in terms of identification of the responsibilities of the RN and employer. Decision making frameworks and regulatory guidance on how to manage additions to the RN scope of practice as well as safe systems for delegation and supervision are key tools for managing changing scopes of practice (Department of Health, Ireland, 2011). Scope of practice changes require individual practitioners and employers to develop robust systems to support competence assurance and safe clinical performance (Ibid, 2011). The decision making framework used by the Nursing Council of New Zealand seems to be the broadest and most comprehensive framework from all surveyed. In addition to the standard questions posed by the majority of the regulators with frameworks, New Zealand added some significant and important questions to their framework for both the RN and the employer. Generally, the majority of the interviewed regulators stated that a regulator needs to provide guidance to enable employers and individual registered nurses to make changes and to ensure that the registered nurses have the required competences. According to the regulators surveyed, although the regulator needs to be available for consultation if required, there is no additional regulatory oversight provided or required beyond the identified frameworks.

Initial and Continuing Competency

When the regulators were asked what regulatory mechanisms they used to ensure initial and continuing competence when tasks or activities are added to the RN scope of practice, the majority of respondents reported they have no regulatory oversight mechanisms, the individual registered nurse and employer have the major responsibility. The regulatory requirements are identified in their decision making frameworks and/or policy documents and that is all that is required. A number of respondents did note they have a Continuing Competence Program (CCP) with an audit mechanism which provides some degree of regulatory oversight. CARNA is currently developing a process for ensuring initial and continuing competency for major new additions
to RN scope, for example, they are currently negotiating with government and other stakeholders to change the Regulations to allow for limited RN prescribing. CNO also noted that with any new major addition such as NPs prescribing controlled drugs, they would oversee the education to ensure it is appropriate. The UK NMC uses the previously mentioned Standards for Pre-registration Nursing Education (2010) to provide guidance on initial competency.

Not Within Scope of Practice

When the regulators were asked how they decide if an activity or task is not in the scope of practice of a registered nurse, there were a variety of answers. The main factors were consistency with the practice legislation and undergraduate nursing education as well as best practice/research and the guidance provided in their policy documents and decision making frameworks. One regulator with umbrella legislation noted that it has to be allowed in their regulations- if not; it has to be a delegation and stated “It is not the regulators job to advocate for the expansion of nursing practice.”

Advantages, Disadvantages and Risks

When asked what they viewed as the advantages, disadvantages and risks associated with adding to the RN scope of practice, again the regulators had very similar answers. In terms of advantages, the main responses were: meeting public and community needs and access to timely care; recognizing nursing’ ability to respond to community needs, advancing the profession of nursing and assisting with shared understanding of the RN role.

The major disadvantages were that it can create too much work and overload for both the RN and employer; process can be onerous and time consuming especially if the legislation has to be changed and lastly, the question was asked whether we are diluting the essence of nursing practice by adding non nursing tasks to the scope of practice.

Risks identified were that any addition has to be competency based to prevent risks to patient safety; adequate education to attain and maintain needed competencies and there is always the potential for abuse or being done for the wrong reasons.

Scope of Practice Terminology

In relation to the question regarding the use of the terms entry level skills, advanced nursing skills, full scope, advanced scope, expanded scope, optimal scope, certified acts, and restricted acts, there was some commonalities in their responses. All regulators have eliminated the old “list “of basic nursing skills although as one regulator stated, “it is always a challenge to describe scope of practice when there is no list of what RNs can and cannot do”. All refer to student expectations on graduation as entry level competencies or entry to practice competencies. The majority also do not use the term advanced nursing skills. This has been replaced with specialty nursing practice (ARNNL; SRNA); post entry-level procedures (NANB); expanded scope (Nursing Council of New Zealand) and expanded scope for certified practice (CRNBC). RNANT/NU does use the term advanced special nursing functions.

The majority of the regulators were not aware if the practice setting (employer) differentiated entry-level competencies from “advanced nursing skills.” However, CNO did state that employers to some extent do differentiate between different levels of nurses, e.g., RNs and CNSs. CNO has a document on supporting learners- not just new graduates- but for any RN who is changing practice settings with different competencies required. None of the regulators provided any additional guidance to the employer around determining what skills requires additional knowledge and supervision other than what is included in their various documents and guidelines.
ARNNL, like all regulators has eliminated a list of advanced nursing skills or procedures. ARNNL communicates the entry level competencies for new graduates to graduates, employers and other stakeholders. ARNNL recognizes that there will be tasks/skills that are within the RN scope of practice that may not be covered in undergraduate education or, more likely, although covered, the graduate is not proficient in implementing the skills/competencies upon graduation. Further learning is necessary and must be obtained through additional education or practice before implementation. The employer is expected to fill the gap and provide the education, policy and practice support with little regulatory oversight by ARNNL.

As previously identified, NANB differentiates entry level competencies from post entry-level procedures which are defined as those nursing procedures that are not part of undergraduate nursing education, are not currently part of RN work expectations and are being introduced into nursing practice, in specific practice settings. The new terminology (Examining Requests for Post Entry-Level Procedures, 2013) replaces old terms such as advanced nursing tasks, specialized skills, added competencies etc that were often used in the workplace. There is little regulatory oversight beyond the guidance provided in the NANB document.

As previously discussed, SRNA has developed additional authorized practices, specialty practices and delegation to support evolving practice and public needs and has developed documents defining the necessary Standards.

RNANT/NU uses Advanced Special Nursing Functions which refer to those competencies over and above those taught in undergraduate nursing education but are still within the RN scope of practice. These are employer driven and additional education is required. The regulator has little oversight but their scope of practice document provides some decision making guidance for the employer in relation to making decisions about adding to the registered nurse scope of practice.

Eight of the 13 interviewed regulators report that they do, on occasion, use the term full scope of practice, however, none had written definitions. Two regulators stated that there is no such thing as full scope as no one RN can ever work to full scope due to constraints from education, practice setting, environment etc. The term advanced scope is reserved for advanced practice nurses. Eight regulators reported using the term expanded scope but with the exception of New Zealand, reserved it for advanced practice roles (SRNA), certified practice (CRNBC) or RNs working in northern nursing stations. Only three regulators reported using the term optimal scope but none had a definition for it despite the fact one had it in their Board’s strategic directions. Certified Acts was used only by CRNBC and reserved acts were used by CARNA and CRNBC and these were legislation based.

The UK Nursing and Midwifery Council representative stated that they do use the term entry level requirements but none of the other terms such as full scope, optimal scope, expanded scope etc. However, he stated that the UK RN Program is a three year long degree program requiring over 4,000 hours, over half of which are clinical practice hours (2,300). In the UK, they do not hear that new graduates are not prepared to be clinically competent upon graduation. They do, however, on occasion, hear the complaint that university graduates are “too posh to wash.”

**Delegation Interview Results**

The interviewed regulators were asked three questions in related to RN delegation from the perspective of the RN acting as a delegatee, i.e., accepting delegations from other regulated health professionals. The first question was whether there was authority in their practice legislation to permit delegation from another regulated health professional. Of the 13 respondents, only two (15.4 %) had delegation specifically addressed in their legislation. These were CRNBC and CNO, both with umbrella health profession legislation and they have specific processes for delegation. CRNM noted that with their anticipated move to umbrella health profession legislation in 2015, delegation will likely be included in their RN Regulations. CRNBC reports that delegation is “alive and well” in
BC but it is very complex because not all pieces of the required HPA legislation are in place as yet. However, the process does involve at least two regulators to reach agreement on the process, the delegating College and the receiving College. CRNBC does have standards for delegation for registered nurses which have been developed in agreement with the BC College of Physicians and Surgeons. CRNBC also reports that there are actually few examples of delegation since government is enabling scopes of practice for all health professionals. However, where the RN Regulations do not permit a particular activity for RNs, then a delegation is required.

CNO reports that delegation is addressed in their Authorized Practices document (20) and it covers the RN as delegating to others and also accepting a delegation from another health professional. CNO has criteria for RNs who perform controlled acts that are delegated to them. RNs may accept a delegation when they have:

- The necessary knowledge, skill and judgment
- A nurse-client relationship with the client
- Assessed the appropriateness for them to accept
- Are satisfied there are sufficient safeguards and resources available
- No reason to believe the delegator is not permitted to delegate the controlled act
- Assurance if the delegation is subject to conditions, that these have been met
- Recorded the delegation appropriately in the client record.

It is significant to note that the Federation of Health Regulatory Colleges of Ontario has developed resources to facilitate collaboration among health care providers including delegation. The Nova Scotia Regulated Health Professions Network has also drafted a practice guideline for all regulated health professionals in NS on the Principles of Assignment and Delegation, which is based on a previously published CRNNS document Assignment and Delegation Guidelines for RNs (2012).

CARNA, although also under umbrella health legislation reportedly does not have delegation addressed in either the HPA legislation or the RN Regulations, and they do not have a policy statement on delegation. When there is a need for delegation between two or more health professionals, a formal agreement is needed between the respective Colleges.

The UK NMC does not have delegation in their legislation; however, it is included in their Standards document on Code of Conduct, but mostly from the perspective of the RN as delegator. Their current Code of Conduct document is under revision.

In relation to the second question related to whether they have a policy statement on delegation, 66.7 % (8/12) reported that they did. However, of the eight with policy documents, only four addressed the RN as both a delegator and delegatee (accepting a delegation) specifically, CRNBC, CNO, ARNNL and the Nursing and Midwifery Board of Australia. The remaining regulator policy documents only addressed the RN as a delegator mostly to unregulated care providers. The RNANT/NU includes delegation in their Scope of Practice document as part of the transferred functions framework for decision making. It requires a written agreement between nursing and the transferring health profession stating the transferred function is a shared responsibility as well as an employer policy.

Although SRNA has no legislative authority for delegation, the authority for delegation will be defined in new Medical Bylaws which are in development. SRNA reports they plan to develop standards for delegation and perhaps a delegation protocol.
NANB discusses delegation in their PELP document (2013). Delegated tasks are those that are performed by other health professionals and not within the RN scope of practice. A delegated task is always client specific and time specific (one client, one time) and cannot be applied to other clients. A delegated task does not become part of the scope of practice of a registered nurse.

ARNNL addresses the RN as both delegator and delegatee in their scope of practice document (2006). They describe three different delegation situations; provincial legislation, agency and client specific situations. Regarding provincial legislation, if a particular competency or activity is limited to a specific discipline by legislation, e.g., prescriptive authority, then delegation cannot occur at the agency/employer level. Any transference of authority must be done with government and the regulator with appropriate stakeholder input. With the agency/employer category, the competency is limited to a particular discipline by agenda policy or organizational bylaws and the decision to delegate can only occur at the agency/health authority level between the administration and nursing leadership with appropriate stakeholder input. For client specific situations, if the competency in question is not restricted by legislation, agency policy or bylaws, and has not previously been considered to be within the scope of nursing practice and there is a client need- the decision to delegate may occur at the level of the individual RN and the unit/agency level. This delegation requires both appropriate RN education and agency support and is considered to be both client specific and non-transferable. However, if the intervention or competency becomes common practice within the agency with numerous clients- then the employer should invoke the ARNNL scope of practice decision making framework and this is an important point.

The Nursing and Midwifery Board of Australia’s National Framework document (2010) defines a delegation relationship existing when one member of the multidisciplinary team delegates aspects of consumer care, which they are competent to perform and which they would normally do themselves, to another member of the health team from a different discipline or to a less experienced member of the same discipline. Delegations are done to meet consumer needs and to ensure the right person is available at the right time to provide the right service to the consumer. The document clearly makes a distinction between delegation and assignment. The document also defines specific responsibilities when delegating and when accepting a delegation.

The UK NMC Code of Conduct document mainly addresses the RN as delegator. However, the interviewee noted there is nothing in their legislation or documents that prohibit the RN accepting a delegation from another health care professional.

In relation to the third question which asked if the regulator had any alternative processes to delegation, all but two answered no to this question. NANB noted their alternative process was their Post Entry-level Procedure (PELP). Australia stated their alternative process was their decision making framework (2010) so perhaps this can be assumed to be true for the other regulators with decision making frameworks as well. The Nursing Council of New Zealand reported their alternative processes would be standing orders, protocols and algorithms. NCSBN also reported that standing orders are used in many US states to assist RNs expand their scope of practice. However, as Pringle discusses (2009), if nurses are going to assume responsibility for activities beyond their current scope, then “let nursing education prepare them for it and take responsibility for their actions.” Pringle goes on to say that extending the RN scope is more than just teaching a competency or skill- it impacts the process of clinical reasoning and clinical decision making.

To summarize, although two thirds of those interviewed have policy documents on delegation, only four of the 13 surveyed regulators (31%) have legislation or policy documents that address the RN as a delegatee. Several of the regulators believe that delegation in general may be more limited in the future as all health professions are encouraged to be working at optimal scope of practice and government is supportive of all health professionals working to optimal scope. The degree of regulatory oversight with delegation also varies with several requiring agreement between the delegating College and the accepting regulator. A number of regulators have developed decision making frameworks to allow RNs to add to their scope of practice or other alternative processes such as PELP (NANB) which becomes part of the permanent scope of practice of the individual registered nurse and no longer requires a delegation.
Interview with the National Council State Boards of Nursing

The interview with the representative from the National Council of State Boards in the US (NCSBN) did not provide much additional information specifically related to the interview questions since every state is responsible for regulating nursing practice. However, many of the IOM report “The Future of Nursing Leading Change, Advancing Health” (IOM, 2010) recommendations are recognized by NCSBN and are an important part of its strategic plan. (NCSBN, 2011). One of the IOM recommendations relates to removing scope of practice barriers especially for advanced practice registered nurses (APRNs) who should be able to practice to the full extent of their education and training.

NCSBN has not developed any specific documents related to scope of practice other than their participation in the 2009 consortium of six health professional regulators which produced a guide for assessing scope of practice proposals. The representative noted that most practice legislation in the US is fairly broad allowing for expansion to the RN scope of practice. Many states have developed decision trees to enable RNS and employers to make independent decisions regarding scope of practice (Kentucky Board of Nursing, 2011; Texas Board of Nursing, 2011) but it does vary by state. State regulators do receive numerous calls about scope of practice and it is handled differently depending on the state. She noted that some states use “standing orders” to assist registered nurses expand their scope of practice. The respondent made a clear distinction between what an NP can do in terms of diagnosis, treatment and prescriptive authority and a general practice RN. She also suggested interviewing a representative from the American Nursing Association as they are more involved regarding expansion of RN scope of practice.

Interview with the American Nurses Association

The writer interviewed Cheryl Peterson, Director of Policy at the American Nursing Association (ANA). The regulator interview questions were not appropriate for the ANA so the focus for the interview was on what are the current issues and initiatives in relation to scope of practice for the ANA. ANA reported they are currently working with the National Council of State Boards of Nursing (NCSBN), the American Association of Colleges of Nursing (AACN), the American Organization of Nurse Executives (AONE) and the National League for Nursing (NLN) in relation to scope of practice issues. One new project is the development of a standardized decision making tree to assist with decisions around RN scope of practice that can be used by all state Boards of nursing. She did note that some states have developed their own decision making framework but not all and there are differences in some of the developed ones. The interviewee noted that the decision tree has to meet multiple needs and it is very early in the joint process at present. They are currently just developing the background document which sets out the scope of the work. Ms Peterson was very interested in the scope of practice policy paper being developed by CRNNS and stated that CRNNS was further along in their process and thinking. The group is meeting in September, 2014 to review and refine the background document. Other joint work involves the development of a standardized criminal records check which will enhance RN mobility across US states. They are also currently discussing issues around the future of RN specialized practice.

Ms Peterson noted that ANA is very supportive of RNs working to “full” scope of practice, e.g., being fully utilized to their maximum education and experience but she also noted that she is not sure what this will “look like”. There is a professional issues panel at ANA in the fall of 2014 where this will be discussed. It is important to identify the challenges that prevent or impact RNs working to full scope of practice. ANA is in the process of revising their 2010 document on Nursing: Scope and Standards of Practice.

We also discussed the issue of new nursing graduates being “practice ready”. The US has also had issues where employers complain that new graduates are not fully clinically proficient and practice ready. Ms Peterson stated that this notion of full competence immediately after graduation is simply not a reasonable view, that it is important that new graduates have an appropriate orientation and transition period to allow them to be fully ready for practice given the many challenges of the current health care system.
Policy Analysis: Interpretation of scope of practice

Interpretation of scope of practice means the addition or incorporation of a new role, function or accountability to the scope of practice that is within the current legislated authority for the profession. An interpretation of scope of practice can be considered an interpretation when the role, function or accountabilities have not traditionally been within the practice of nursing but are consistent with or meet the definition of the practice of nursing in the enabling legislation. Based on the literature review and telephone interviews, best practice is for regulators to have a decision making framework or model to assist RNs and employers who are considering adding tasks or functions to the RN scope of practice make independent decisions. Even those who disagree with heavy handed regulation would see a public interest in some type of regulatory oversight. So the policy debate is not whether regulatory oversight should exist but, instead, around the way it should be structured, implemented and maintained.

In deciding the options for this policy paper regarding assisting stakeholders in making decisions regarding interpreting the registered nurse individual scope of practice, CRNNS needs to consider the degree of regulatory oversight that is realistic and cost effective but most importantly, what is appropriate for them to meet their mandate for ensuring public safety. Right-touch regulation is based on a proper evaluation of risk, is proportionate and outcome focussed; it creates a framework in which professionalism can flourish and organisations can be excellent (UK Government (2007) Trust, Assurance and Safety –The Regulation of Health Professionals in the 21st Century). With right touch regulation, the degree of regulatory oversight should be appropriate, simple and to the degree required to achieve the best result in the public interest.

**Policy Option #1**
The highest degree of self regulation by CRNNS in this instance would be for CRNNS to review and approve every request for a change in interpretation of the scope of practice by an RN, employer and/or other stakeholders. This has been the approach used in the past by some regulators (e.g. ARNNL) but was found to be expensive, time consuming and arguably, not necessary or practical in many instances. (However, please note that this approach is required when modifications to the scope of practice of the profession are contemplated).

The pros for this approach are:

1. College would have control and knowledge over all scope of practice change requests
2. Possibly highest degree of public protection

The cons for this approach:

1. Time consuming and expensive
2. Inconsistent with right touch regulation for interpreting scope of practice decisions in majority of cases
3. College does not have “on the ground” knowledge of clinical practice requirements

**Policy Option #2**
The lowest degree of regulatory oversight in this instance would be for CRNNS to allow the RN and employer to make independent decisions regarding additions to the scope of practice with no guidelines or consultation provided by CRNNS. However, most stakeholders including government would acknowledge that some form of College oversight is needed when issues as essential as patient health and safety are involved.

Pros

1. Most cost efficient for CRNNS in the short term
Cons

1. Degree of regulatory oversight insufficient to ensure public safety

2. Employers and RNs could be making decisions regarding scope of practice in isolation of each other and CRNNS

Policy Option #3
For additions of a new role, function or accountabilities to the RN scope of practice through an interpretation of the scope of practice, the policy recommendation is for CRNNS to introduce a decision making framework to assist RNs and employers make appropriate decisions.

The decision making framework provides a moderate degree of regulatory oversight in that written and clear guidelines are provided to employers and RNs. The RN and employer are required to use CRNNS’ decision making framework to decide the appropriateness of a new addition to the scope of practice of an RN. The greater the risk to client safety, the more regulatory oversight is required and CRNNS must be consulted. Factors such as the degree of client risk associated with the addition of a new task or activity; the introduction of a major or significant new competency which has not historically been in the scope of RN practice and the autonomy and support structure for the registered nurse must be considered in decisions whether to involve CRNNS. If the RN is self employed or works in an isolated environment with little practice or employer support, these are factors that must trigger at minimum a mandatory consultation and discussion with CRNNS. CRNNS can then assess the degree of regulatory involvement and stakeholder consultation required. This reflects, in my view, a moderate level of regulatory oversight as well as right touch regulation. The new addition to the RN scope of practice, once acquired and maintained, becomes part of the RNs individual scope of practice, for which he/she is accountable.

This framework assists RNs when assessing their own practice and also assists employers and other stakeholders in making decisions about interpreting the RN scope of practice to allow for additions to the individual scope of RN practice. The Framework consists of decision points which are organized into different areas for consideration.

Interpretation of Scope of Practice: Decision Making Framework: RNs and Employers

1. Legislation and Scope
   » Has the nursing profession evolved towards adding this new role/function?
   » Is the new role/function supported in the RN Act?
   » Does the new activity/task meet the definition of the practice of nursing as defined in the RN Act?
   » Is the new role/function supported in the CRNNS Standards for Nursing Practice?
   » Have you determined that there are no prohibitions in any other health profession legislation or policy (government, employer or other) against the RN performing the addition to scope?

   If yes, proceed.

2. Client
   » Is there a client need for this addition to RN scope of practice?
   » Will the client benefit from this addition to RN scope of practice?
» Has there been a client assessment to determine that it is appropriate for the RN to perform this new task/activity?

» Have you considered the consequences of not adding the new role/function in terms of client care?

» Have you considered and eliminated other options such as a care directive to meet the client need?

If yes, proceed.

3. Evidence
» Is there credible evidence (literature and best practice) to support this addition to the RN scope of practice?

» Have you determined that there is no evidence that refutes this addition to RN scope?

If yes, proceed.

4. Risk
» Has there been an assessment of risk to the client, RN and/or organization?

» Are you comfortable with the level of risk associated with the addition?

» Is there a plan and/or clinical support for the RN to manage any unexpected outcomes for this addition to the scope of practice?

» Would a reasonable and prudent RN implement the task/activity?

» Have you investigated possible implications with liability coverage with CNPS or the CRNNS?

» Have you assessed the need for the CRNNS to be consulted regarding this addition to the RN scope of practice?

» Is there a plan/mechanism for ongoing monitoring and regular evaluation for the addition to the RN scope of practice?

If yes, proceed.

(Please note that a modification to scope also might be required when the role, function or accountability may be considered within the scope of practice of nursing but the risk is significant enough to consider a legislative change to the scope of practice for the profession.)

5. Competency/Education
» Has your nursing education program prepared you to perform the new activity/task? If not, how will you be able to attain the necessary competencies?

» Do you have the competencies to support this addition to your scope of practice (knowledge, skill and ability)?

» If not, is there an appropriate plan to develop/attain the necessary competencies? e.g., appropriate education and supervision?

» Is there an appropriate plan/mechanism for the review and maintenance of competence and is the responsible person/organization identified?

If yes, proceed.
6. Consultation and Support

» Do you work in an area with the necessary employer and nursing support and supervision? E.g. DHA
» Are you self employed? (If yes, please consult the CRNNS for guidance)
» Does the employer support you to add this task to the individual scope of practice?
» Does the employer have the appropriate resources to support this addition to the RN scope of practice?
» Does the employer have clear policies and procedures to support the addition to scope of practice?
» Have the other disciplines/stakeholders potentially impacted by the addition been identified and have they been consulted?
» Does the organization have a quality practice environment with appropriate support for the RN?
» Will the organization culture and interdisciplinary team accept the change?

If yes, proceed

If all of the decision points in the decision making framework can be answered with a “yes”, the RN and employer have the necessary information to make an informed decision regarding incorporating a new role/function in the RN scope of practice. Answering negatively to any of the questions doesn’t necessarily mean the new role/function cannot be added, but it does mean a consultation with CRNNS. At any time in the process, the RN and employer may consult with CRNNS and should consult if they have any questions or concerns in answering the questions in the decision making framework or if the decision points indicate a significant risk to the client by proceeding. Alternatively, the CRNNS also has a number of decision points they need to consider if they are informed or consulted regarding an interpretation to the RN scope of practice.

CRNNS Decision Points
1. Is the planned addition to the RN scope of practice considered an interpretation of scope of practice requiring no legislative change?
2. What is the level of involvement necessary for CRNNS based on the employer and RN information and degree of risk?
3. Do regulatory tools need to be developed to support the change? E.g. standards, competencies, policies.
4. Is there a need for consultation and discussion with the Nova Scotia Regulated Health Professions Network or other stakeholders?

Policy Analysis: Modification of scope of practice

If the RN or employer wishes to add a new role, function or accountability that cannot be interpreted to be within the scope of practice of a registered nurse, CRNNS must always be consulted as this change may be a modification to scope of practice. A modification of scope of practice is a major proposed change in competencies or profession scope of practice requiring actual changes in the current legislation. A modification to the scope of practice may be required when 1) the role, function or accountability is not currently within the scope of practice of nursing 2) the new addition is restricted by a statute regulating the practice of another health profession. A modification also might be required when the role, function or accountability may be considered within the scope of practice of nursing but the risk is significant enough to consider a legislative change to the scope of practice for the profession. Examples of modification of scope are the registered nurse taking on broad prescriptive authority, conducting minor surgery or administering general anesthesia. Modification of scope is always within the authority of the regulatory body.
Modification of Scope of Practice: Decision Making Framework: RNs and Employers

1. Legislation and Scope
   » Does the new role, function or accountability meet the definition of the practice of nursing as defined in the RN Act?
   » Is the new role, function or accountability a major change to the RN scope of practice which has never been part of the RN scope?
   » Is the new role, function or accountability within the exclusive domain of another regulated health profession? If not, is the new role, function or accountability within the public domain?
   » Is adding the new role, function or accountability prohibited by any other health profession legislation, bylaws or policies?

2. Client
   » Is there a client need for this addition to RN scope of practice?
   » Will the client benefit from this addition to RN scope of practice?
   » Has there been a client assessment to determine that it is appropriate for the RN to perform this new task/activity?
   » Have you considered the consequences of not adding the new role/function in terms of client care?
   » Have you considered and eliminated other options such as a delegated function to meet the client need?

3. Evidence
   » Is there credible evidence (literature and best practice) to support or refute this addition to the RN scope of practice?

4. Risk
   » Has there been an assessment of risk to the client, RN and/or organization?
   » Are you comfortable with the level of risk associated with the addition to RN scope?
   » Is there a plan for nursing to manage any unexpected outcomes for this addition to the scope of practice?
   » Would a reasonable and prudent RN implement the task/activity?
   » Have you investigated possible implications for liability coverage with CNPS or the CRNNS?
   » Is there a plan/mechanism for ongoing monitoring and regular evaluation for the addition to the RN scope of practice including identification of who is responsible?
   » Is the new role, function or accountability consistent with public health policy and models of care?

5. Competence/Education
   » What new competencies (knowledge, skills and ability) are required for registered nurses to add this to their scope of practice?
   » What education programs (formal or otherwise) are needed to support this addition to the RN scope?
   » Is there an appropriate plan/mechanism for the review and maintenance of competence and is the responsible person/organization identified?
6. Employer support
   » What is required for the employer to support this addition to the RN scope of practice?
   » Does the employer have the appropriate resources to support this addition to the RN scope of practice?
   » Would new employer resources be required to support this addition to the RN scope of practice?
   » Are new policies and procedures required to support the addition to scope of practice?
   » Does the organization have a quality practice environment with appropriate support for the RN?
   » Will the organization culture and interdisciplinary team accept the change?

7. Consultation
   » Which other health professions will be impacted by the new addition to RN scope?
   » Has the proposed addition been discussed with the Nova Scotia Regulated Health Professions Network?

CRNNS Decision Points
1. Does this new role or function require a modification to the scope of practice for the registered nurse?
2. Has CRNNS considered an alternative to modification of scope such as a delegated function?
3. What is the risk/benefit analysis of adding this new role/function to the profession scope of practice?
4. What is the feasibility of seeking this modification at this time?
5. Does the modification require a change in Standards of Nursing Practice and Competencies?
6. What regulatory tools need to be developed or modified to support the change?
7. What education is required to support the modification to scope and will College approval be required?
8. What are the implications for formal nursing education programs at the undergraduate and/or graduate levels?
9. What are the current and future implications for RN licensure, if any?
10. Has the issue been referred to the NSRHPN to follow their defined process for discussion and consultation?

Modification of scope of practice by definition is adding to the scope of practice of the profession and always requires a great degree of regulatory involvement along with extensive consultation with government, employers, registered nurses, other health care professions and the public and ultimately requires government approval. The Nova Scotia Regulated Health Professions Network (NSRHPN) is the mechanism for review and discussion for proposed modifications to the RN scope of practice, as this will impact other regulated health professions. When agreement is reached within NSRHPN, consultation is then begun with other relevant stakeholders. However, the decision points in the decision making framework will assist RNs and the employer to decide if the addition should be considered an interpretation of scope or a modification to scope of practice and have them prepared to discuss the issue with CRNNS.

Part of the purpose for this paper was to include an assessment of whether there is a need for the framework to include competency development beyond entry-level competencies to address what employers are calling “advanced nursing skills”. As noted previously, the majority of regulators do not use the term advanced nursing skills. This has been replaced with specialty nursing practice (ARNNL; SRNA); post entry-level procedures (NANB);
expanded scope (Nursing Council of New Zealand) and expanded scope for certified practice (CRNBC). RNANT/NU does use the term advanced special nursing functions. This writer does not see a need for CRNNS to include any additional guidance in the decision making framework regarding competency development over and above entry level competencies. The decision making frameworks as defined in this policy document provides the appropriate regulatory direction and guidance required by employers.

**Delegation Policy Options**

Based on the literature review and survey interviews, there is considerable variation in the language used to discuss delegation. Even though only 31% of those regulators surveyed have a process for the RN to act in a delegatee role, delegation can still be considered a viable option to allow an RN to add a new activity or competency to their individual scope of practice if there is support in the regulatory body’s legislation and/or policy documents and no prohibition in the legislation of another health professional group. However, there are fewer delegated functions required today as the scope of practice of the registered nurse has been expanded in many jurisdictions. Generally, there is agreement that delegation is transferring the responsibility to perform a function or intervention to a care provider who would not otherwise have the authority to perform it (e.g., function/intervention is within the delegating provider’s scope of practice, but not within that of the care provider to whom it is being delegated). Delegation does not involve transferring accountability for the outcome of the function or intervention although the delegatee is responsible to successfully complete the intervention or tasks. Responsibility for delegation is shared amongst the employer, the regulated healthcare professional who determined the most appropriate healthcare provider with whom to delegate the intervention to, and the individual RN (CRNNS, 2012).

Previously, CRNNS had a formal Scope of Practice Committee with representation from CRNNS, CPSNS, DNS and the NSAHA (now Health Association Nova Scotia) whose function was to review and approve all requests for additions to the RN scope of Practice, mainly requests from medicine. This Committee was discontinued in 2009 as it was no longer considered necessary since more and more procedures/functions are now within the scope of RN practice. This is consistent with what many of the regulators were reporting in the interviews. In addition, employers now have clearly defined policies and procedures for the development of delegated medical functions. CRNNS developed a new document on Delegated Functions in 2012 and has been supporting RNs in accepting delegated functions in accordance with their new guidelines.

However, recently another issue in relation to the Nova Scotia RN Act (2006) and delegation has come up. In reviewing the RN Act, specifically, section 20(1) and (2), CRNNS legal Counsel believes that section could pose a potential problem for the RN acting in the delegatee role, i.e., accepting a delegated function from another regulated health professional (not for the RN acting as a delegator although the practice legislation for the delegatee accepting a delegation from an RN, if that legislation exists, may create a problem for them). Although that was never the intent of that section 20 to prohibit the RN accepting a delegation, it is perhaps an unintended consequence. However, legal counsel also said that since the CRNNS definition of the practice of nursing is quite broad, that an argument could be made that it covers the RN accepting a delegated function from another health professional. In other words, a broad interpretation of the “practice of nursing” suggests that RNs can accept delegated tasks from others, as their training and experience has indeed prepared them for the concept and function of delegation. However, legal counsel suggests a longer term solution would be to work toward a change to the scope of practice of each health profession, through the modification to scope of practice provisions that can be done by way of regulation through the Nova Scotia Regulated Health Professions Network. A general phrase would be added to the scope of practice of each profession to indicate something like: “and includes those matters delegated to the member from other regulated health professionals in accordance with guidelines approved by the Network” (Email Marjorie Hickey to Donna Denney, June 13, 2014). However, CRNNS’ ED has questions regarding this interpretation and has asked legal counsel for further discussion and clarification on this issue (Email D. Denney to M. Hickey, August 5, 2014).
In addition, the new NS Medical Act (2011) when it is proclaimed may be inconsistent with current College documents around delegation specifically, CRNNS Delegated Functions Guidelines for Registered Nurses (2012.) The relevant section of the new Medical Act reads:

27 Nothing in this Act applies to or prevents

(g) the practice of any health profession authorized pursuant to an Act of the Province, by a health professional authorized by such Act and practicing within the authorized scope of practice of that person’s profession and individual scope of practice, if such person does not describe their practice as “the practice of medicine”; or

(h) The performance of particular acts of the practice of medicine by another health professional if such acts are authorized by a process approved by the Council.

The CPSNS Regulations may clarify the intent of the language in the Act regarding the role of Council in approving delegated medical functions. It is beyond the authority of this writer to make the required interpretation in relation to delegation and the RN Act (2006) and CRNNS will have to work this out with legal counsel. Implications of the exemptions around delegation in the new Medical Act will have to be discussed with the CPSNS when their new Regulations are finalized. However, the decisions impact on the policy recommendations for this paper. If the current RN Act can be interpreted to allow for the RN accepting a delegation and/or the necessary changes can be made to the health profession regulations, the policy options below are viable. In the event, this cannot be done; CRNNS would have to consider prohibiting registered nurses from accepting a delegated function from other health professionals. In the view of this writer, this would be unfortunate since this has been a long standing and useful option in selected situations and would likely create confusion among registered nurses and employers and potentially negatively impact timely client care at least in the short term.

Recently, there has also been a great deal of discussion regarding whether the delegating health professional or delegator is required to be “on site” for the delegation or can they be available electronically- essentially delegation “in absentia”. Issues such as this for specific delegation requests do require discussion and agreement by the involved regulators so there is no inconsistency in policy guidance by the respective Colleges.

If the legislation authority can be worked out, CRNNS can consider four levels of regulatory oversight in terms of policy options regarding appropriate delegation.

**Policy Option #1**
This option would leave the decision totally to the RN and employer with no guidance or consultation with CRNNS.

Pros
1. Saves time and money

Cons
1. Degree of regulatory oversight insufficient to ensure public safety

**Policy Option #2**
Establish a regularly scheduled interdisciplinary review/approval committee for delegation requests with members from selected health profession regulators.

Pros
1. Similar to previous Scope of Practice Committee
2. Provides tight degree of regulatory oversight
Cons
1. Questionable regulatory overkill and not necessary in the majority of instances
2. Time consuming and expensive
3. Historically, very difficult to get regular attendees as all have multiple priorities

**Policy Option #3**
Rather than a regularly scheduled interdisciplinary review/approval committee, establish an “ad hoc” committee when necessary with selected health profession regulators to deal with specific delegation issue, especially for any high risk activities or those requests with potential impact on several or more health profession regulators.

Pros
1. Provides appropriate degree of regulatory oversight with an interdisciplinary group of involved health professional regulators and/or other stakeholders.
2. Reflects right touch regulation principles

Cons
1. May be time consuming

**Policy Option #4**
College provides written guidelines on the RN accepting a delegated function from another health professional and is available for discussion, consultation and guidance.

Pros
1. Essentially what CRNNS is currently doing
2. Reflects right touch regulation principles
3. Leaves considerable accountability to RN, employer and delegating health professional which is consistent with trends in the literature and reported practice.

Cons
1. Potential that the employer, RN and delegating professional not familiar with CRNNS Guidelines and would not consult if necessary.
2. Current College Guidelines may be outdated when new Medical Act is proclaimed and will have to be rewritten with appropriate consultation with the CPSNS as well as consultation with the Nova Scotia Regulated Health Professions Network.

It is the opinion of this writer that a hybrid of combining policy options 3 and 4 would offer the most appropriate degree of regulatory oversight in relation to RNs accepting a delegated function given that the legislative barriers can be solved.

To summarize, the two policy options to allow registered nurses to incorporate new roles, functions and accountabilities not within the scope of RN practice and/or where the new addition is restricted by a statute regulating the practice of another health profession are:

1. Modify the registered nurse scope of practice via legislative changes to the RN Act and Regulations. This requires regulatory oversight by CRNNS and consultation with all the other stakeholders via the mechanism established by the Nova Scotia Regulated Health Professions Network. It also must be recognized that changes to legislation can be a lengthy and labor intensive process.
2. Allow the RN to accept delegated functions with appropriate College written guidelines while allowing for the option to establish ad hoc working groups when necessary.

The distinction is that with delegation, the new activity does not become part of the scope of practice of the individual RN but remains a delegated function. With an interpretation and/or modification of the scope of practice for the RN, the new role/function becomes part of the permanent scope of registered nursing practice.

It should be noted here that a care directive can also be used to broaden the scope of registered nursing practice. A care directive is an order written by an authorized prescriber for an intervention or series of interventions to be implemented by another provider (e.g., RN) for a range of clients with identified health conditions or health needs when specific circumstances exist (CRNNS, 2012). However, in contrast to delegation, the actual interventions must be within the scope of practice of the RN who will be implementing the care directive. However, the care directive can provide a useful option in some circumstances.

**Conclusion**

The purpose of this paper was to inform CRNNS of the existing options that nursing and other regulators in North America use to determine what activities/tasks/interventions fall within the individual scope of practice of the registered nurse and to develop a regulatory framework for interpreting or modifying the registered nurse individual scope of practice. This policy paper provides direction in assisting the registered nurse, the regulator and the employer in making decisions to allow registered nurses to practice to their optimal scope of practice through the development of two decision making frameworks. The decision making frameworks provide decision points for additions to the RN scope of practice through interpretation that can be considered to be within the scope of nursing practice and for those not considered to be within current scope of nursing practice which require a modification to the RN scope of practice. A modification to the scope of practice may be required when 1) the role, function or accountability is not currently within the scope of practice of nursing 2) the new addition is restricted by a statute regulating the practice of another health profession. A modification also might be required when the role, function or accountability may be considered within the scope of practice of nursing but the risk is significant enough to consider a legislative change to the scope of practice for the profession. The paper also addresses the issue of delegated functions and finds that it is still a viable and reasonable option to allow RNs to add new activities to their individual scope of practice if concerns related to prohibitions in the RN Act can be resolved.
References


Association of Registered Nurses of Newfoundland and Labrador (2006). *Scope of Nursing Practice: Definition, Decision Making and Delegation*. St John’s, NL: Author.


Nursing and Midwifery Office Queensland (2005) *Strengthening Health Services through Optimizing Nursing Registered Nurse Professional Practice in Queensland*. Queensland, Australia: Author


Texas Board of Nursing (2011) *Six step Decision Making Model for Determining Nurses Scope of Practice*. Austin, TX: Author.


Appendix A

Interview Guide for Nursing Regulators

Interview Questions
1. Do you have a written policy statement or document on the Scope of Practice of a Registered Nurse?

2. Is it useful in making decisions about RN scope of practice issues? If no, why not?

3. Does your legislation address/define scope of practice for the profession of nursing and scope of practice for the individual registered nurse?

4. What are the legislative enablers and barriers in your legislation specific to scope of practice of the profession and individual scope of practice?

5. Do you have any regulatory tools, policies or decision making tools to assist in interpretation of individual scope of practice or to modifications to the scope of practice of the profession?

6. Do you have any regulatory mechanisms to approve or not approve the addition of tasks, activities or competencies to the individual scope of practice? To the scope of practice of the profession? If yes, please describe.

7. What criteria or mechanisms do you use in deciding whether a task, activity or competency is within the scope of the PROFESSION of nursing?

8. What criteria or mechanisms do you use in deciding whether a task, activity or competency is within the scope of practice of an INDIVIDUAL registered nurse?

9. As a regulator, do you have a mechanism to ensure competency on an initial and ongoing basis when tasks, competencies or activities are added to the scope of RN practice?

10. How do you decide if an activity, task or competency is NOT within the RN scope of practice?

11. What do you see as the advantages of adding to the scope of practice of a registered nurse? Disadvantages? Risks?

12. Is there interest from RNs, employers, government or other health professions to add tasks, activities or competencies to the profession scope of practice or to individual RN scope of practice?

13. Do you have the authority in your legislation to permit delegation from another regulated health professional to registered nurses?

14. Do you have a policy statement on delegation, i.e., RNs accepting a delegated function from another regulated health professional? If no, is one under consideration?

15. Do you have an alternative process to the delegation process to allow RNs to add tasks or activities to their individual scope of practice?

16. In your jurisdiction are the following terms used: Entry level skills advanced nursing skills, scope: full scope, advanced scope, expanded scope, optimal scope, certified acts, restricted acts? Which of the terms are rooted in your legislation?
17. An additional question was added as per direction of Donna Denney (email direction June 4, 2014) after several interviews had been completed. “Are you aware if the practice setting (employer) differentiates entry-level competencies and specifically entry-level skills from “advanced nursing skills”? As the regulator have you provided any guidance to the employer around determining what skills requires additional knowledge and supervision?”

18. Any additional comments you would like to make in relation to these issues?

Thank you for taking the time to do this interview. The CRNNS will share the results of the policy paper upon completion of the work.

Appendix B

Regulator Interviews

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<thead>
<tr>
<th>Regulatory Body</th>
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