CNA’S PREFERRED FUTURE: HEALTH FOR ALL

A DISCUSSION PAPER

OCTOBER 2008
Nurses have often been at the forefront of change. Today, they are setting the agenda to create a health-care system that truly serves and reflects the priorities of Canadians.

Although publicly insured health services have been available in Canada since the 1950s, the goal of achieving health for all has been a particularly vivid and growing part of Canadian thinking since the World Health Organization declaration of Alma Ata in 1978 (WHO, 1978). In response to the excitement that emanated from Alma Ata, Canada reoriented its approach to health care in Achieving Health for All, a clear and visionary document that states that health for all “can only be achieved if each of us can be assured of equitable access to health” (Health and Welfare Canada, 1986). The need for equitable access has not changed, nor has it been met. And we are also facing new challenges on many fronts: shifting demographics, growing and unmet health needs, human resources shortages, as well as the globalization of economies and diseases. Other trends have created new opportunities through partnerships, research, innovation and evolving technology.

The Canadian Nurses Association (CNA) accepts the challenge to re-frame and reinvigorate our approach to health care and human resources issues, from how nurses are educated and licensed to how their competencies are used to best advantage. Nursing education, job design and responsibilities must change as the country moves from the traditional model of treating illness to one that focuses on keeping people well, with both care and support for maintaining health delivered in the community. Making this model of health care a reality will require breaking down divisions within nursing as well as barriers between nursing and other professions.

Nurses are the largest group of health-care providers; nevertheless, their services are in short supply in some parts of today’s health system. If we maintain current delivery models and levels of demand, the existing shortages of nurses, physicians and other health-care professionals will remain irresolvable. Working collaboratively toward our preferred future will make that future possible. It will also make nursing a more rewarding profession that attracts and maintains a diverse, healthy and effective workforce.

1 For the purposes of this document, the term nurses is seen to include the three regulated nursing groups that exist in Canada at the time of writing: registered nurses, licensed practical nurses and registered psychiatric nurses. Unless otherwise specified, registered nurse refers to all registered nurses, including those in advanced practice, such as clinical nurse specialists and nurse practitioners. For a full definition of RN, see CNA 2007, p. 2.
CNA has a strong vision for the future of nursing, as expressed by its vision statement: “Registered Nurses: leaders and partners working to advance health for all.”

Building the preferred future for the Canadian health system requires a collective effort by registered nurses (RNs) and other health-care professionals, policy-makers and leaders who are tracking emerging trends and issues in social, political and economic sectors both nationally and internationally. Building an effective health system also requires the participation of the public, whose potential and desire for self-care must be fostered and appropriately integrated into the future system.

Over the last two years CNA has led the nursing community and others in exploring trends and imagining their impact on the future of health care. This work has been accomplished through research (Villeneuve & MacDonald, 2006), presentations, workshops and new learning tools (CNA, 2008a). In January 2008, the association provided an initial overview of its vision and announced its intention to “work with all levels of government, its many health partners and with Canadians who count on the health system to be there for them” (CNA, 2008b). In its next step in working with these partners, CNA is now elaborating further on its vision and inviting all those who are committed to collaboration to discuss, debate and describe the desired future of health care.

This discussion paper seeks to:

- stimulate dialogue among nurses that will promote a shared vision;
- stimulate dialogue between nurses, other health professionals and the public that will help create a shared vision;
- generate productive dialogue on optimizing the role of nurses in Canada’s future health-care system to achieve health for all in the context of national and international trends;
- set goals that will help individual CNA members work in their own communities and areas of practice to build the preferred future for Canadian health care;
- generate coordinated action by CNA members in the provincial and territorial jurisdictions, in our national associate and affiliate member organizations, and in national and international partnerships; and
- arrive at a clear understanding of the preferred future to guide CNA strategic directions and future initiatives.
The following pages describe CNA’s preferred future as seen in 2020. Key elements for health care and for nursing are outlined – both those from today’s system that need to be maintained and protected and those that need to be changed or created anew. These elements are divided into five sections: the health-care system, the practice of RNs, the regulation of health-care professionals, nursing human resources and nursing education. The sections are subdivided and numbered to assist in discussion.
1.1 Canada’s health system remains the pride of people everywhere in the country and a central value in our national identity.

1.2 Federal, provincial and territorial governments provide health services through a congruent, effective and sustainable health-care system for Canada based on a primary health care approach.

1.3 The primary health care approach adopted across the Canadian health system supports the principles of accessibility, public participation, health promotion, appropriate technology and intersectoral collaboration, and has the necessary resources for implementation (CNA, 2005a).

1.4 Broad social determinants of health are acknowledged to be critical drivers in achieving health for all (CNA, 2005b). Therefore, building on the idea of “health in all policies,” intersectoral collaboration predominates in Canada’s approach to health care. Intersectoral collaboration involves, but is not limited to, the health, education, natural resources, food, agriculture, industry, human resources, communications, housing and transport sectors; government and non-government organizations; voluntary organizations, community groups and their leaders; and policy-makers and program planners.

National strategies have produced significant ongoing programs of federal, provincial and territorial collaboration, with sustained coordination of activities in all jurisdictions. These programs have positioned Canada as a world leader in health promotion and productivity.

- The national housing program is providing universal access to adequate housing.
- The national anti-poverty program is putting structures in place to reduce economic disparities and eliminate poverty.
- The national child care program is ensuring that all children and families have access to appropriate early learning and child care that meets their needs.
- National programs for conservation and the protection of the environment are improving the quality of the air, water and land and are keeping the food chain safe and nutritious.
• The national Aboriginal youth program is enhancing cultural literacy, public and post-secondary education and skills development for First Nations, Inuit and Métis people.

• The national mental health program is reducing the impact of mental illness on Canadians, preventing mental disorders and promoting mental health and wellness.

1.5 Health is understood to be a human right, accessible to all. Health is a state of complete physical, mental, social and spiritual well-being and not merely the absence of disease or infirmity.¹

1.6 Every Canadian has equitable access to the resources of a comprehensive, publicly funded, publicly administered, not-for-profit health system that

• is client-centred³ and culturally appropriate;

• is based on the needs of clients no matter where they are in the continuum of wellness to illness;

• includes services for health promotion, disease prevention, curative care for illness, rehabilitation and palliative/supportive care, either in institutions or in community or home care settings;

• has included additions to insured services since 2008 (i.e., national pharmacare,⁴ home care, dental and vision care); and

• promotes and preserves the health of Canadians and prevents illness and injury.

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2 Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 2006). In March 2006, the CNA Board of Directors resolved to work toward including the concept of spiritual well-being within the WHO definition of health.

3 The client is the person, family, group, community or population that is the beneficiary of care from an RN. Individual clients are also referred to as patients or residents.

4 In October 2006, a coalition of five national organizations composed of the Best Medicines Coalition, Canadian Healthcare Association, Canadian Medical Association, Canadian Nurses Association and Canadian Pharmacists Association published a Framework for a Canadian Pharmaceutical Strategy and called on federal, provincial and territorial premiers to develop a coherent, holistic strategy for ensuring that all Canadians have access to safe and effective prescription drugs. See http://www.cna-aiic.ca/CNA/documents/pdf/publications/Framework_Pharm_Strategy_e.pdf.
1.7 A 100 per cent increase over 2008 funding levels is directed to the financial and human resources needed to improve the health of communities through health promotion and protection and disease and injury prevention.

1.8 All health-care providers work in remuneration models that pose no barriers either to access by Canadians to health care or to effective interprofessional collaboration.

1.9 All health and illness care is provided through health services organizations that are accredited by Accreditation Canada. National accreditation standards include measures of quality and safety for clients and for health-care providers in all categories. Annual public reports indicate a decrease in adverse events and an increase in the quality of the practice environment.

1.10 The quality of professional practice environments in Canada’s health system reflects leading practices and serves to attract and retain nurses.

1.11 Primary care services are delivered according to diverse models, some based on general needs and others on special population health needs. Service delivery models include interprofessional clinics led by RNs, physicians or other health-care professionals. The role of all RNs in primary care teams is greatly enhanced and collaborative practice is well developed, thereby creating access to primary care for all Canadians. Canadians no longer report having to go to emergency departments for a “minor health problem” or for “routine care” (Health Council of Canada, 2008, p. 6).

1.12 Personal, comprehensive, continuing care provided by an interprofessional team is the cornerstone of primary care in Canada. Every Canadian has access to a primary care team in a community health centre or affiliated satellite that uses the expertise of an RN, nurse practitioner, physician, social worker and other health-care professional, as appropriate, to meet his or her health needs.

- Self-care is the norm. Health-care professionals are partners and consultants with clients, families and communities in a “shared-care” model of responsibility and accountability for health. Health-care professionals do not carry out any tasks that can be accomplished safely by those receiving care who have the knowledge, ability, strength and will to do so.
• All primary care providers work within interprofessional teams, whether working in the same location or through video-telephone technology.

• A range of health professionals, including registered nurses, provide access to the health system according to client-identified needs. This group of care providers also makes referrals to the broader primary care system and to specialists.

• Licensed complementary and alternative practitioners (e.g., acupuncturists, naturopaths, homeopaths and massage therapists) are active, integral members of the health team; referrals to them are commonplace.

• Even the smallest communities have access to a full team of primary care providers through broadband Internet services and video-telephone technology, which links them with the nearest appropriate community health centre.

1.13 Every Canadian has a secure, private, portable and accessible electronic health record. A network of interoperable electronic health record solutions (similar to the global banking system) exists across Canada – linking clinics, hospitals, pharmacies, home care services, public health units and other points of care. With the pan-Canadian electronic health record,

• every Canadian has a unique identification number for health care;

• every Canadian is able to view her or his own health record and to add information;

• every regulated health-care professional has a unique provider identification number; and

• all authorized health professionals have access to accurate health histories, information on allergies, laboratory and other diagnostic test results, past treatments, prescription drug profiles and immunizations.

2.1 RNs are health professionals and knowledge workers who provide nursing care and lead nursing and health services in all types of settings in accordance with a legislated scope of practice and their code of ethics.

2.2 RN education and professional commitment to lifelong learning prepare RNs to provide direct care; lead nursing, health and social services; coordinate and collaborate with and lead teams in institutional and community settings; conduct and participate in research; educate nursing and other students; mentor less experienced nurses; develop health policy; and serve as health administrators. Regardless of setting, most registered nurses work in interprofessional teams.

2.3 RNs champion self-care and facilitate its integration across all health-care settings as appropriate, engaging citizens, families, groups and communities at every opportunity. Community-led health initiatives supported by registered nurses and other health professionals abound.

2.4 RNs in all settings recognize and incorporate into their practice knowledge of the impact of determinants of health on the health of individuals, families, groups, communities and populations. Registered nurses provide knowledge and support as clients identify health goals and seek to implement changes in their lives and in their environments.

2.5 RNs support individuals, families, groups, communities and populations by advocating, enabling and mediating through building healthy public policy, creating supportive environments, developing personal skills and strengthening community action.

2.6 All RNs assist clients to navigate the system and to increase control over and improve or maintain their health. RNs support individuals, families, groups and communities by helping clients to understand and acquire necessary information about their health status and treatment options. RNs assist clients in overcoming barriers to self-determination such as anxiety, fatigue, language difficulties or cultural differences so that they can make informed choices about their care. Some RNs work entirely as system navigators.

2.7 RN expertise in direct clinical care continues to be needed, particularly when health-care needs are acute, complex and rapidly changing and when outcomes are unpredictable.
2.8 RNs are also health educators, directing clients to credible resources and assisting them to develop health literacy. RNs support clients to develop the capacity to make informed health-care decisions for themselves and to develop the leadership capacity to support community action.

2.9 RNs in all settings provide care that responds to the changing demographics of Canadian society, including the needs of the growing number of older Canadians, Aboriginal Canadians and newcomers to Canada from all parts of the world.

2.10 RNs assess, plan, implement and evaluate the mental health needs of all clients, families, groups and communities with whom they work. Mental health is seen as essential to well-being. Related services have grown and are now integrated within insured services across the continuum of care, including health promotion and disease prevention.

2.11 The role for RNs in family practice has evolved to partner with and complement that of the family physician. RNs follow the client through all stages of growth and development, through degrees of wellness and illness, from one setting to another, collaborating with other registered nurses, physicians and expert providers in the various settings. The family practice nurse provides holistic assessments and creates linkages with appropriate community resources. The nurse continues to work with the client intermittently as needed to support self-care or to provide ongoing support during acute episodes of care or chronic disease management.

2.12 Community health nurses, in much greater numbers than in 2008, continue to work with individuals, families, groups, communities and populations to promote, protect and preserve health in diverse settings. They develop programs to that end in collaboration with professionals from other disciplines who have expertise in physical and mental health, sports, recreation, education, public safety and other areas. Community health nurses provide clinical care and treatment focused on promoting, restoring and maintaining health in the client’s home, school, workplace or neighbourhood. They successfully bring nursing and health services to vulnerable, at-risk populations. They also contribute to the prevention of disease and injury for whole communities and populations and play key roles in the national, provincial and territorial public health systems in the prevention and management of epidemics and emergencies of all kinds.
2.13 RNs continue to work in established roles and move into new roles that meet population health needs.

- They support and assist individual clients to prevent and manage chronic diseases.
- They provide triage for acute complaints in person or by telephone, webcam, e-mail or other communications technologies, as available. When it is appropriate, as determined by protocols, they also provide nursing treatment or advice and discharge, with follow-up instruction and documentation.
- They assess, diagnose and treat specified health conditions (e.g., providing contraception and immunization, suturing, and putting casts on non-complex injuries), including ordering medications and radiology and laboratory tests.

2.14 RNs develop, implement, evaluate and publish promising practices based on evidence. They identify research questions and use pertinent research findings in evidence-based nursing interventions.

2.15 RNs in advanced practice continue to work in established roles and move into new roles to meet population health needs, improve the quality of care provided and reduce wait times. They analyze and synthesize knowledge, interpret and apply nursing theory and research, and develop and advance nursing knowledge and the profession as a whole.

Clinical nurse specialists:

- provide system solutions; they initiate needs assessments, and then develop, implement and evaluate programs to meet identified needs across the continuum of care in collaboration with other health professionals and intersectoral partners; they play a leading role in the development of clinical guidelines and protocols;
- lead expert nursing care for specialized client populations with complex health issues; and
- promote the use of evidence, conduct research, teach, provide expert support and consultation, and facilitate system change.
Nurse practitioners:

- provide direct care that focuses on health promotion and on the treatment and management of a broad range of health conditions, whether potential, acute or chronic;

- support individuals and families in managing common illnesses through performing in-depth assessment, ordering and interpreting diagnostic tests, providing diagnosis, prescribing treatments (including pharmaceuticals) and performing specific procedures within their legislated scope of practice, referring to other health-care providers as needed; and

- collaborate in developing new advanced practice roles. For example, nurse practitioners working on anesthesia care teams conduct pre-anesthetic assessment and planning and post-anesthetic pain assessment and management. Some anesthetic care teams, in both urban and rural settings, include nurse practitioners who provide anesthesia for diagnostic procedures, labour and delivery, and minor surgeries.

2.16 RN practice continues to demonstrate positive outcomes for the client, the nurse and the system as a whole. RN practice is linked to:

- improved control or management of symptoms for individual clients such as fatigue, nausea and vomiting, dyspnea and pain

- improved infection control and reduced rates of infections acquired in hospital

- improved physical and psychosocial functioning and self-care

- fewer adverse events such as pressure sores, falls and patient mortality

- increased client satisfaction with nursing care and improved health outcomes

- improved child and maternal outcomes

- improved healthy lifestyles and reduction in chronic diseases

- improved immunization rates and reduced rates of communicable diseases

- improved access to health care for marginalized populations
2.17 The public in Canada thinks of registered nurses as a resource for everyday living.

2.18 RNs and CNA are recognized for their leadership and collaborative initiatives in reforming Canada’s health system and for their research and innovation in clinical practice, nursing education and new models of delivery for nursing and health services.

2.19 Canadian RNs and CNA are recognized for their equity-based approach to international partnerships that have strengthened health systems through the inclusion of registered nurses in national policy forums and through initiatives that develop community- and country-specific solutions.
3.1 Health professions, including registered nursing, continue to be self-regulated. The public demonstrates support for the self-regulation of health-care professions in the interest of the public.

3.2 The public is aware of the nursing profession’s responsibility to establish and enforce standards of education and practice for RNs and of its commitment to the regulation of registered nurses in the public interest. Individual members of the public participate in appropriate governance and disciplinary activities of provincial and territorial regulatory bodies.

3.3 RNs must be licensed in order to practise nursing. The assessment of eligibility for licensure is carried out nationally. Candidates apply to be licensed with the regulatory body of their place of residence. Upon licensing with the regulatory body, their names and unique, permanent identification numbers are entered into the national database of registered nurses, allowing them to move with ease between provinces and territories. RNs register annually with the provincial or territorial regulatory body to renew their licence.

3.4 As a condition of and prior to being licensed as an entry-level nurse, each RN and nurse practitioner is objectively measured by examination against a national standard that is valid, reliable and fair and that is based on nationally agreed upon competencies.

3.5 Provincial and territorial regulatory bodies and CNA collaborate to establish, promote and maintain national standards. Provincial and territorial regulatory bodies carry out annual registration based on the requirement that each nurse continue to practise according to those national standards and meet continuing competence requirements.

3.6 Each nurse knows, understands and practises according to the national standards and the *Code of Ethics for Registered Nurses*. When registered nurses fail to meet standards, regulatory bodies take action through professional conduct review.

3.7 Discipline issues are tracked using the nurse’s national identification number, and disciplinary decisions are entered within 24 hours into the national database and communicated to the relevant employer.
3.8 Each nurse, whether employed or self-employed, has the obligation to ensure that information regarding her or his jurisdiction of practice and employer (if applicable) is kept current in the national database.

3.9 The national database of regulated nurses is open to the public. Members of the public know how to verify a nurse’s credentials in the national database and which regulatory body to contact if they have a concern or a complaint about a nurse.
4.1 A sound, nationally coordinated health human resources plan is in place, making Canada as self-sufficient as possible in supplying its own needs. Formal agreements exist between the Canadian federal and provincial and territorial governments and their counterparts in developing nations to discourage unethical systematic recruitment from developing countries.

4.2 While self-sufficiency and sustainability remain the goals of health human resources planning, vacancies continue to be filled by both Canadian and internationally educated graduates. Support systems are in place across all regions to facilitate their licensure, integration and leadership in Canada's health system.

4.3 Nursing remains a career of choice. RN education programs continue to have more qualified applicants than available seats, as was the case in 2008. RN education programs meet the target for numbers of graduates set by the national coordinated health human resources plan.

4.4 All health-care partners agree that one goal of health human resources recruitment is to attract candidates from minority groups, in order to reflect the diversity of the Canadian population. To achieve this goal, active recruitment and retention programs, student-centred mentoring and professional development programs have been put in place, through consultations with the Aboriginal Nurses Association of Canada and nurses from minority communities. The interim targets listed below, which were set 10 years earlier, have been achieved. New targets are now needed to guide efforts of all stakeholders toward the goal of having a workforce that reflects the general population.

- At least 10 per cent of formal nursing leaders (registered nurses who are managers, executives, advanced clinicians, educators, deans and directors, policy leaders, and researchers) come from Canada's aboriginal population (no 2006 baseline is available).
- At least 10 per cent of formal nursing leaders come from visible minorities (no 2006 baseline is available).
- At least 15 per cent of the nursing workforce is composed of men, up from 5.6 per cent in 2006 (CNA, 2008c).

6 This diversity is reflected in race, culture, religion, ethnicity, age group, sex, sexual orientation, economic status, and physical and mental ability.
Workplace programs are in place to ensure appropriate accommodation and assignment for nurses who have a disability to increase their attachment to the workforce while protecting the public.

4.5 Recruitment and retention strategies have been successful in attracting health professionals to the workforce and retaining them. Accreditation by Accreditation Canada is awarded to institutional and community employers based on demonstration of healthy workplace strategies, retention and turnover rates that meet national benchmarks (as set out in the national coordinated health human resources plan). The following are examples of indicators of successful nurse recruitment and retention.

- Absenteeism and overtime rates among nurses are comparable to those of other Canadian workers.
- One hundred per cent of RNs have access to full-time positions.
- Seventy per cent of RNs are electing to work in full-time positions.
- Workloads have been adjusted such that utilization/productivity levels do not exceed 85 per cent.
- Annual national surveys of the health of nurses, begun in 2005, indicate lower levels of workplace stress each year.

4.6 The health-sector workforce is adequate to meet established, acceptable and appropriate standards regarding waiting times for care. The roles for nurses and the models of service delivery have been adapted to best meet demands with available human resources.

4.7 The changes to models of service delivery include the following:

- The use of technology is optimized in order to positively affect the number and deployment of health human resources. For example, electronic health records provide quick access to information and prevent duplication of lab tests; innovative clinical care supports and equipment design reduce the physical toll on nurses; programmed web cameras and voice prompts monitor for safety and guide people receiving care who are mentally confused or distracted through routine activities; robots track and deliver supplies.
• There is a significant shift in focus to health promotion and illness prevention, resulting in a reduced need for acute care interventions (Alliance for the Prevention of Chronic Disease – Manitoba, 2005, p. 1). For example, promotion of weight loss and exercise has reduced the need for joint replacement; fewer new cases of diabetes have resulted in a lower incidence of heart disease). As a result of this shift, 60 per cent of RNs now work in settings outside acute care hospitals, including public health, primary care, home care (acute and chronic), rehabilitation and long-term care facilities. This statistic is in direct contrast to that of 2006, when 59.1 per cent of RNs worked in hospitals (CNA, 2008c).

• More RNs work in specialty areas of nursing within institutional and community settings. Most employers require specialty certification for such positions, and 10 per cent of RNs now hold CNA certification – double the percentage in 2007, when approximately 14,500 registered nurses held CNA certification in one of 17 recognized specialty areas of nursing. The number of options for obtaining certification now includes nurse generalists in medical/surgical acute care.

• More RNs work in specialty programs for psychiatric care and mental health promotion. The increased focus on mental health promotion and disease prevention has reduced the number of affected clients progressing to acute emergencies and requiring in-patient care. Although mental health care is part of the holistic nursing services provided to all clients, the proportion of all RNs working in the speciality has doubled since 2006 to 26,000 (CNA, 2008d, p. 4). As with other specialty areas, employers generally require RNs in psychiatry and mental health programs to hold post-RN certification or a graduate degree in mental health and psychiatric nursing.

• Acute care organizations deliver nursing services primarily through the deployment of RNs. These RNs are highly specialized in their area of care, and they provide direct care, lead teams, coordinate care, and serve as managers, teachers and clinical experts. They work with other regulated and unregulated health-care providers to deliver nursing care. All non-nursing work is carried out by other personnel.
• In health services organizations offering rehabilitation and long-term care, the majority of nursing services for clients with stable conditions are delivered and supervised by nurses who are not registered nurses (e.g., licensed practical nurses) and by unregulated health-care workers. RNs continue to provide clinical expertise, and the number of those holding CNA certification in the specialties of gerontology and rehabilitation has doubled since 2008.

• There has been an increase in the use of telehealth services to provide timely access to health care and to enhance the coordination of services across the continuum of care. Telehealth services include health assessment, health promotion and disease prevention, provision of health information, teaching, and various kinds of counselling and support.

• The level of education within the RN workforce has been targeted for increase to meet the needs of the health-care system, based on health outcomes research and the need for faculty in nursing education programs. The proportion of RNs attaining each level of education has changed, as shown in the table below:

<table>
<thead>
<tr>
<th>EDUCATION LEVEL</th>
<th>2000</th>
<th>2005</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diploma</td>
<td>75.6% (175,801)</td>
<td>66.0% (166,004)</td>
<td>20%</td>
</tr>
<tr>
<td>Baccalaureate</td>
<td>22.7% (52,927)</td>
<td>31.5% (79,306)</td>
<td>73%</td>
</tr>
<tr>
<td>Master’s</td>
<td>1.6% (3,652)</td>
<td>2.4% (5,954)</td>
<td>5%</td>
</tr>
<tr>
<td>Doctorate</td>
<td>0.1% (186)</td>
<td>0.1% (394)</td>
<td>2%</td>
</tr>
</tbody>
</table>

(Data for 2000 and 2005 are taken from CNA, 2006)
5.1 Nursing is a practice-based discipline that exists to serve a societal need. To be relevant to society and the health system (see section 1), nurses must graduate with competencies for nursing roles needed by individuals, families, groups, communities and populations, as well as by health services organizations, to assist the people to whom they provide care to attain the best health outcome possible – health for all (see section 2).

5.2 To meet the needs of Canadian society, national competencies are developed and agreed to through a national consensus process. Employers, members of the general public and client groups are involved in determining competencies and curricular priorities. To ensure that nursing service demands are being met, nurse educators are fully engaged as partners in practice settings and are open to input from employers, members of the public and practising nurses.

5.3 Nursing is carried out by different categories of regulated nursing care providers, whose educational programs share many common elements. Education for nurses facilitates progression through educational levels without requiring repetition of previous learning.

5.4 Many nursing education programs take place in the context of interprofessional client-centred education, in which each professional school is accredited in part on the basis of interprofessional courses and clinical practice. All health-care providers are taught to listen, facilitate, accompany, teach self-care and provide care within their scope of practice to meet needs identified by the client. As part of learning interprofessional practices and values, nursing students continue to receive strong orientation with regard to the theories, goals, science and ethics of nursing. Whether or not the education program involves collaboration with other professional schools, all nursing students are prepared by various studies and experiences, such as public health and other sciences, for interprofessional practice.

5.5 Nursing schools develop and implement nursing curricula based on nationally determined competencies and in accordance with national accreditation standards for schools of nursing and regulatory requirements. Curricula can be modified quickly to respond to changing needs. For example, competencies for public health, mental health and primary care were quickly integrated into curricula across the country to respond to population health needs in the previous decade.
5.6 Schools of nursing develop program initiatives that facilitate the transition of internationally educated nurses into the Canadian workforce while maintaining professional standards for the protection of the public.

5.7 Curricula in schools of nursing reflect the diversity* of populations in Canada and the world and promote client-centred care that is appropriate to that diversity. Educational support programs are offered by most initial nursing education programs to provide individual and group assistance for students from minority communities.

5.8 Clinical practice, whether in Canada or in other countries, is designed and supported by nursing schools to ensure that adequate orientation and ongoing supervision promote safe, compassionate, competent and ethical care for clients.

5.9 Clinical practice for nursing students is supported by a partnership of health service organizations, community-based services, schools of nursing and individual RNs who act as preceptors and mentors for students and for nurses learning new roles. Regional databases of students in all health professions allow for the maximum use of available clinical space at all times.

5.10 All nursing education is structured to allow re-entry of graduates into the education system so that they can efficiently access programs leading to higher educational qualifications for general or specialized roles.

5.11 All educational pathways are available through a variety of educational delivery models, including on-site, online and tele- or video-conferenced learning, with a combination of virtual and real clinical practice experiences.

5.12 All nursing education streams articulate efficiently to reduce duplication of previous studies. A variety of fast-track programs (e.g., advanced standing, bridging, accelerated) are available to candidates who possess other nursing credentials or professional degrees.

5.13 Nurses are educated primarily by other nurses holding the next highest level of education. Given the needs of both the health-care system and nursing education programs, recruitment to doctoral programs has been increased, and one of the

7 See footnote 6.
recruitment strategies implemented is to offer degree options such as practice doctorate (e.g., DNP) and academic doctorate (e.g., PhD). Faculty members maintain competence in their area of teaching.

5.14 A national database of nursing education tracks information on admissions, attrition and graduation. Attrition rates for schools of nursing are based on a nationally standardized formula and meet national benchmarks.

5.15 All undergraduate and graduate nursing education programs are accredited.

5.16 Evidence-based criteria are used for recruitment and enrolment to ensure that students are well suited to the roles required of RNs as portrayed in the national competencies and changing health service delivery models. The student body is an accurate reflection of the diversity of Canada’s population.
Today, in 2008, Canadians love and need their health-care system and that is unlikely to change in the future. Even when politicians do not include health care in their election platforms, Canadians stand up and ask when their leaders will fix the health-care system. The public keeps putting health and health care back on the agenda.

In this regard, CNA is right in line with public priorities. CNA, too, wants to keep health on the agenda, and for a very specific purpose. The association sees health for all as an achievable goal. CNA recognizes that although political leaders are key partners in building Canadians’ shared dream, they do not have all the answers to building a 21st-century health-care system that will take Canadians to new levels of health.

“Be the change” was the watchword for the 2008 CNA convention during its centennial celebration, and CNA members were invited to accept that challenge. With this discussion paper, CNA invites others to join in a dialogue about the change all Canadians want to see, so we can work together more effectively to be that change.


