HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

STANDING COMMITTEE

ON

HEALTH

Thursday, June 20, 2019

LEGISLATIVE CHAMBER

Nursing Potential Report

Printed and Published by Nova Scotia Hansard Reporting Services

STANDING COMMITTEE ON HEALTH

Hon. Gordon Wilson (Chair)
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[Hon. Margaret Miller replaced Hon. Gordon Wilson]

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Nova Scotia Nurses' Union

Janet Hazelton - President

Paul Curry - Researcher/Educator and
Government Relations Advisor

Coleen Logan - Communications Officer

House of Assembly
Nova Scotia

HALIFAX, THURSDAY, JUNE 20, 2019

STANDING COMMITTEE ON HEALTH

1:00 P.M.

CHAIR
Hon. Gordon Wilson

VICE-CHAIR
Suzanne Lohnes-Croft

SUZANNE LOHNES-CROFT (The Chair): Order, I call this meeting to order. This is the Standing Committee on Health. My name is Suzanne Lohnes-Croft. I am the MLA for Lunenburg and I am also the Acting Chair of the committee.

Today, we will hear from the Nova Scotia Nurses' Union regarding its report on nursing potential. I would like to remind everyone to turn your phones off or put them on vibrate. In case of an emergency, please exit through the back door to Granville Street and gather across the street.

I will ask the committee members to introduce themselves.

[The committee members introduced themselves.]

THE CHAIR: We will now turn it over to Ms. Hazelton for the introduction of her group and also for opening remarks.

JANET HAZELTON: Good afternoon, and thanks for having us. My name is Janet Hazelton, and I'm the President of the Nova Scotia Nurses' Union. We represent around 7,000 nurses in the province in 38 different hospitals, many of the long-term care facilities, and all the nurses in VON. We have a wide range of nurses that we represent: RNs, LPNs, and NPs as well.

With me is Paul Curry. He works in the research arm of our organization. He did a lot of the research and the focus groups with our nurses, with the communities, and with various stakeholders throughout the system. When the report was completed, it was circulated to nurse leaders, the Department of Health and Wellness, and many people to take a look to see if we are on the mark or not. A fair bit of work went into this report.

Working with him was Justin Hiltz, who also works for the Nova Scotia Nurses' Union, but he is on vacation today. Ashley Buckle is a current registered nurse who works in this province but was taking her master's. We hired her last summer to help Paul and Justin complete some of this work.

Also with me is Coleen Logan. She is the communications person who works for our organization and does all the work around getting the book together, the pictures, the social media, all of those. We had an ad that we also made to go along with the book to inform Nova Scotians about the important role of nurses within the primary health care system. That's our team.

For the most part, I'll be answering the questions, unless they are specific in nature, like, is this statistically significant, or how many people, and Paul will take those questions. For the most part, I'll be talking about the recommendations. We believe the recommendations in this report are doable. Some of them are doable easily and can be done quickly. Others, we'll need to talk to stakeholders, and we'll need to bring stakeholders together that are involved: What do we do to make this happen? I'll start with a little introduction, and then we'll talk about any of the recommendations that you want to dig deep into or ask us about, if you have questions or concerns or how we see this happening.

We all know that Nova Scotians are concerned about the health care system in this province. They have concerns about access to primary health care. They have concerns about whether or not they have a doctor, how long they're waiting in our emergency department. We have a focus in this province of keeping people in their homes as long as possible. How do they access care when they're home? How do they access care when they're sent home? If some of the reasons they can't be sent home are because they require care that they need to access, how can we do that better than we're currently doing it today?

We have heard from our nurses as well, their frustration in an emergency department, knowing that people are waiting too long, knowing that a lot of the people who are in that wait room just require primary health care. They don't require emergency care, but they don't have a choice because they have a urinary tract infection, and it's a Saturday. Whether they have a GP or don't have a GP, on a Saturday with a urinary tract infection, somebody needs to look at these people and prescribe medication and let them go on with their weekend. That's not possible in many cases in this province, so we wanted to talk to Nova Scotians and nurses about that.

So 18 months ago, the Nurses' Union and the board of directors that runs our organization, who are all practising nurses in this province, directed me and our staff - we want to do something that is looked at as positive; we want to be part of the solution. Nurses are the biggest group of workers in the health care system in this province, and our board said, we really think we have solutions, we know our nurses have the solutions, and we want you to talk to our nurses about that. That's what precipitated this work.

We all know that we need research in order to get anything done, in any kind of measure. Research has to be done - people want to see. I think if any of you have read this book, the amount of research in it is phenomenal. We all say that we have the sickest, oldest residents in this province. This research shows that we do. Nova Scotians are the sickest, oldest people in the country, and they have the most chronic illness: diabetes, heart failure, obesity - those kinds of issues. Again, not proudly, but we're ranking number one.

That research tells us that most of those issues can be dealt with through primary health care. Diabetes can be managed with a primary health care person - whether it's a nurse practitioner, a registered nurse, a licensed practical nurse, or a GP. All those health care workers are able to talk to, treat, ask people, teach people. Most of our chronic illness is just teaching people proper diet, how to control their insulin, how insulin and exercise go together - or not - or what they should and shouldn't eat.

Many of our diabetics just don't know that this is not good for you or that has too much sugar. Who knew that a half bottle of ketchup is full of sugar? People don't understand that. So a lot of it is just education to know that I shouldn't be using ketchup because you don't think that ketchup is full of sugar.

Those are the kinds of things that our nurses know, and they know that some of the patients they're seeing come through our emergency departments ought not to be there.

Asthma is another perfect example. Many people in our emergency departments are children with asthma attacks. We need to teach their parents the proper care on how to avoid an asthma attack. What do we do when their child has an asthma attack? Taking them in the shower, filling up the shower with steam. That often will subside it. That requires our nurses and health care professionals to have the time to talk and teach parents, to teach the children, to teach Nova Scotians how to look after themselves properly.

So far, I'm really sticking to the script so well. (Laughter) I don't think I've said one thing that's in the script.

The research advocates for reform along four main themes. The first one is system dysfunction. In order to build a better health care system, we need to build it on the foundations of a robust primary health care sector. We know that people need primary health care. Primary health care does not necessarily mean that everyone has to have . . .

THE CHAIR: Order. There are no photographs allowed while we're in session, except for the media. You must be sitting down and not hanging over the railings.

Sorry about that interruption - we have some tourists in our gallery. Ms. Hazelton.

JANET HAZELTON: We believe we need to break down the barriers that impede effective health care. In particular, we need to ensure that professionals in home care, hospitals, and collaborative practices are able to access and share information via the same electronic charts for One Patient One Record.

We're working on One Patient One Record in this province, but one of the things that was identified is - that's great if we're going from hospital to hospital, but how are we going to use that One Patient One Record in the community so that our VON nurses will be able to look at that One Patient One Record to see what happened to them while they were in the hospital, what care did they require, and what is the post-op or the post-discharge care? That needs to be at the fingertips of our community nurses. It isn't right now, and that's something that needs to happen.

The other thing is system design. We think, and our nurses think, our nurses and other health care workers are out there every single day working to the best of their ability to provide the best care they can. The unfortunate piece of it is that there's so much negativity around the work that they do. Many of you are probably in the same - you're working very hard to represent Nova Scotians, and oftentimes, people are very critical of the work you do and talk about it in a negative way. That's the same feeling that our nurses get. They understand there are problems and issues in the system, but they want to be part of the solution, and they want their work to be recognized as valuable and not "I'm waiting five hours in emergency." That's not the nurses' issue.

Our nurses are very proud, and I think that's the point I'm trying to make. We need to stop focusing on the negative and start looking at what we can do in a positive way to reassure Nova Scotians - our health care system has problems, there's no doubt, but it's still a good system. If someone was to have a heart attack or chest pain right here today, they could be taken to the QEII, have a stent put in, and have their X-ray done within hours. Do we have issues around wait times for cataracts and orthopaedic? Absolutely. We need to talk about how we fix them.

We also need to recognize that the people working in the system are working very hard, and when there is a true emergency, more often than not, people are getting seen to and seen to appropriately. That's the reason we have six-, seven-, eight-, and ten-hour waits in lots of our emergency departments - because behind the scenes, there's someone with a car accident or a heart attack or an amputation who is being treated, and all our nurses and physicians are busy dealing with that emergency patient. We can't go out and advertise that to the wait room - sorry, we have a really bad MVA. We're not permitted to have those kinds of conversations with the patients in the wait room, but that's exactly what's happening. So some of the recommendations deal with that.

I'll stop talking so you can ask questions if you like. Anyone who knows me knows I can talk for three hours. (Laughter)

THE CHAIR: No, please continue, Ms. Hazelton.

JANET HAZELTON: We came up with the recommendations that are in the book before you. I know the book is long, I get it. I'm not one to pay attention to a lot of detail, but I honestly did read it twice - no, more than twice. They read it eight, nine, or ten times. If you haven't read it, it really, truly is worth the read if health care interests you in this province. The data in this is amazing, and the ideas and the recommendations are coming from nurses, nurse practitioners, and the public. That's where these recommendations are coming from - we just coalesced it all. All of the data around our health or not-health population of Nova Scotians is all in there with the data.

It is an extremely important read, in my view. It really captures a lot of the issues that we have around health care in this province with our many, many recommendations on how we believe these can be fixed. You have it. This document here has all of the recommendations.

When I started nursing in 1984, if you wanted to see a nurse in your home, you called up VON, made an appointment, and the nurse came to your home - that's it. Now it's a cumbersome process, and you can't just do it. You have to be approved. You have to go through an approval process. There has to be someone assigned. There has to be a risk assessment. I'm not saying none of these things are important, but some of them just take too long and make us not nimble.

If I have a 92-year-old mom, and I'm looking at her ankles and saying, they look a little swollen - I wonder if something's going on there - our view is that you should be able to call up the VON and have a nurse drop by to say, yes, it looks like you're starting to have a little edema there. We need to call your doctor, and maybe we need to look at your Lasix.

What happens now is people wait three or four days until they're in congestive heart failure when a simple little visit by a nurse could have prevented not only that visit to emergency and admission to hospital, but what happened to that 92-year-old mom.

We had a system where the VON nurses would go in and do INRs; they would take blood. An INR is clotting for mostly seniors on warfarin. What happens is, they have to have a certain blood level. So they used to go in, prick a finger - just like a glucometer - and look at the reading. The VON nurses had a range that they could say, Mrs. MacDonald, take half a pill or take a pill and a half or don't take a pill or whatever, depending on the reading. If it was too low or too high, they'd call the GP looking after whomever and they'd get an order.

[1:15 p.m.]

Now, the same person has to go to a hospital, get their blood drawn, go back home - all requiring probably a family member - wait until the lab reads it, faxes it to the GP, the GP reads it, calls the patient, and tells them what to do. It has taken a whole day for what used to take 10 minutes. It makes no sense.

Those are some of the easy wins - having nurse practitioners in emergency makes perfect sense to us. We could have two streams of patients in our emergency departments. They're called fours and fives. Fours and fives would be your earaches, urinary tract infections, pneumonia, a broken bone - urgent, but not emergency.

We could have nurse practitioners in the next hallway seeing all those patients, ordering the X-ray, seeing if it's pneumonia, ordering the antibiotic, discharging them home - easy. Those things could happen.

As a matter of fact, in Digby they just hired a nurse practitioner in emergency. Originally, they felt that the nurse practitioner wouldn't be able to work unless there was a doctor there, but there are recent changes that you people voted on through the College of Registered Nurses that really allow the nurse practitioners - they were always able to practise autonomously; however, there were phrases in the Act that gave people the impression that they had to be in a collaborative practice. That's not so anymore. They can act independently. They always could, but with that word "collaborative" taken out, the notion is gone that there has to be collaboration.

All nurses have to collaborate. We don't have a choice. If I feel as a nurse that I'm over my head on whatever it is, I'm required under my licence to collaborate with a physician, a nurse practitioner because I'm a registered nurse - I'm not a nurse practitioner. The same applies to nurse practitioners. The same applies to GPs. They have to collaborate with a specialist if they can't deal with a complicated chest pain. They probably will consult a cardiologist. So everyone in the health care system is required to collaborate.

A lot of the stuff that we're hearing in the press about nurse practitioners is just not right. Nurse practitioners can see people independently. They have their own practices. They have their own client base. They look after Nova Scotians every day in this province. However, we believe that they could be utilized better, like in emergency. We believe that they should be in long-term care so that they can get under the covers of the numerous medications that some of our seniors are on in long-term care.

Instead of sending our long-term care resident out to the hospital, if there was a nurse practitioner assigned to - it wouldn't be one long-term care facility, it would be a whole host of long-term care. In Truro, I think there are five. So one nurse practitioner could do all five. Then the nurses could call up and say, could someone come and look at Mr. MacDonald? I think he's starting to get pneumonia. She could come, she could assess, and put the resident on antibiotics.

No, we put them in an ambulance and take them to emergency; they wait, they wait, they may or may not be admitted, and then they're sent back home. That's congesting our emergency department, but more importantly, there is no need of that resident necessarily going to the emergency department. So there's another area we think nurse practitioners are of value.

The third area is, our VON nurses tell us they have a lot of patients that started in their care, say, six or eight months ago and they had to get dressing changes or whatever it is, and in the meantime, their doctor retired or moved or is gone. Now, they don't have orders; they have to discharge the patient from their service because they have to have orders from somebody to continue with the dressings. There's another perfect role for our nurse practitioners.

We're starting RNs prescribing soon, I think January-ish. That is another huge step forward for nurses. Registered nurses in specific areas - I'm going to pick one because I don't think it's fully sourced exactly where they're going to go, I think some in mental health, but I'm not sure. I'll pick one: emergency. I was an emergency nurse.

If someone comes in with a urinary tract infection, we take the urine and send it to the lab. It comes back, and we can read the piece of paper that says they have a urinary tract infection. We can see that. RNs are going to be able to write a prescription for antibiotics because it says, this is the infection, and this is the antibiotic of choice. Again, it's a good utilization of our nurses, so they can discharge the patient home.

Now what we do is, we wait, we wait, and we wait until our emergency physician, who is so busy seeing emergencies, then he has to come out and see a whole bunch of these patients like urinary tract infections that could be home. We really believe that's a better utilization of our system. We have emergency nurses, too, who are better in trauma, and maybe others could be doing this other piece of work.

Does anyone have any questions? Yes, I can see. I am supposed to stop at some point, aren't I?

THE CHAIR: If you're finished your opening remarks, we will start questions.

JANET HAZELTON: Sure.

THE CHAIR: Thank you for your opening remarks. Please wait to be acknowledged so that the microphones can be turned on when you give your response.

We will start with the PC caucus for 20 minutes. Ms. MacFarlane.

KARLA MACFARLANE: Thank you so very much for your delivery of this report and for being here today. It's also a great opportunity for us to extend a shout-out to all levels of the nursing profession in Nova Scotia. Where would we be without them? I think as a province, we're very grateful for the work that they do and the commitment in particular during such difficult times when we know there are many gaps in our health care system.

I believe the report came out on May 7th, so we have had about a month and a half. I think a lot of Nova Scotians - and I know myself - look at the Department of Health and Wellness and the NSHA, and we wonder sometimes if opportunities have been missed where some of these recommendations could have immediately, and hopefully effectively, been implemented to improve patient care.

If you could elaborate on the conversations that have happened between yourself, the Nova Scotia Health Authority, and the Department of Health and Wellness. Have any recommendations been considered or implemented to date? Is there any formal process between you and those two bodies?

JANET HAZELTON: We are fortunate in this province to still have the Provincial Nursing Network. Many of the provinces across this country have eliminated that group of individuals. The Provincial Nursing Network is a group of nurse leaders from across both unions, St. F.X. and Dalhousie - all leaders from there - the Department of Health and Wellness, several nurse leaders from the Nova Scotia Health Authority, and also nurse leaders from long-term care and community care. We consulted with that group prior to even publishing this.

Some of the recommendations, like RNs prescribing - it's happening, and it's going to happen. We have been talking about it for a while for sure because they have been doing it in New Brunswick for quite a while. We have taken it to the table. They have done the research, and they have developed a program. Through monies, through the Provincial Nursing Network, nurses are going to be supported to take that, I believe starting in January. Some of these recommendations made it to the book, but we've been working with that group of nurse leaders from across the province.

The other ones that are more of a challenge - certainly the nurse practitioner in long-term care came out of the *Broken Homes* report. We are still waiting for that. There are a couple, maybe three, if I'm not mistaken, that are in long-term care - I think Cumberland County, Cape Breton, and at Northwood. Not quick enough and not soon enough, in our view, but it is happening.

The other exciting thing is that report requires us to have a significant number of nurse practitioners in the system. We have gone from about 30 to almost 200, so there has been significant investment in the nurse practitioners. What I like about the Provincial Nursing Network is it's not about politics. It's about nurse leaders coming together to get things done. One of the programs is for the nurse practitioner.

I don't know if you know this, for example, if the Health Authority is to identify for the Department of Health and Wellness where we have gaps in care - let's say Inverness has an issue. What we've worked on and has been successful is, if a registered nurse working in the hospital in Inverness gets into the NP program at Dal, she will continue her full salary and benefits the entire time she is studying to become a nurse practitioner, but the hook is that she has to go back to Inverness and work there for five years. In our view, she has already proven - she lives in Inverness and she has a family in Inverness, but she can't afford to go be an NP because she can't give up her full-time job for two years to go study. Those were initiatives that came out of the Provincial Nursing Network.

KARLA MACFARLANE: Thank you so much for that response. At the end of the day, I know that there were discussions prior to this report coming out with regard to RNs being able to prescribe. I know it's one of the recommendations, but we're aware that those conversations were happening before this report came out. Is it fair to say at this point - just a simple yes or no answer - that none of the 35 recommendations today have been considered for being implemented within, let's say, over the summer or any time quickly?

JANET HAZELTON: Yes, we're starting to work with the VON about what their nurses can do and what are the issues. We're working with VON, the employer, about the recommendations that involve them and what obstacles they see that we need to get around or through in order to make that work.

KARLA MACFARLANE: I look at some of these recommendations - there are a lot of good recommendations, but a lot of them can actually be implemented fairly quickly. It's somewhat disappointing to see that - my understanding, anyway, is that none of them have been implemented at this point. Congratulations, yes, in the new year - again, that is something that was being discussed prior to this report though.

I want to go to Page 74 in the report. We know it's indicated that 45 per cent of emergency department nurses feel the majority of patients seen in emergency departments - conditions are made worse possibly by insufficient primary health care in this province. Looking at the chart that you provided, out of that 45 per cent, 44 per cent of the emergency department were RN or LPN that you actually collaborated with to get this information. Was there any collaboration with the other levels of health care, like primary health care, home care? How did they feel about this?

JANET HAZELTON: The only people we discussed, the health care workers, were nurses obviously, because those are the only individuals we have access to. We have the ability to contact our nurses directly.

We did hear frustration from our community nurses and our long-term care nurses and others that they don't believe that people necessarily had to go to an emergency department. They could have dealt with it had they the ability. Does that answer your question?

[1:30 p.m.]

KARLA MACFARLANE: Just for clarification for everyone, you were able to work with nurses in your union but not beyond. Is that what you're saying?

JANET HAZELTON: Yes, except for the nurse practitioner community.

KARLA MACFARLANE: That clarifies that. Thank you. If we can just go through the overall picture for nurses in this province at all levels, since - let's say the last five years of this Liberal Government and perhaps since amalgamation. What is the impact and the stress on nurses with regard to Nova Scotians not receiving the proper basic care and having access to primary health care?

JANET HAZELTON: I think one of the obvious stressors - and we speak about that a fair bit as well - is violence. We have an unacceptable level of violence in our health care system, and we believe a lot of it is because we're in a McDonald's society where people come to emergency, and they expect to be back home within an hour. That's just not happening. They want home care, and it's going to take three months or whatever in certain areas of the province.

We think that those kinds of issues are creating an atmosphere in our health care facilities of aggression towards the nurses. We have had incidents where nurses who work in the emergency department have gone out and said, we're not going to be able to see Johnny, Joey, or little Susie for four hours, and the parent gets irate.

We're lucky if we're only getting verbally abused. It's never acceptable. It's not part of our job. It should never be part of our job. I think a lot of it is becoming worse because of the sometimes long waits for care.

KARLA MACFARLANE: I would agree with that. My concern is, what type of impact do you see and hear and witness, as in the amount of stress leave and sick time that nurses in emergency departments are taking?

JANET HAZELTON: It's not just nurses in emergency departments. The nursing population is mostly in the community, actually. The amount of sick time is higher than pretty much any other type of workers in the province. More importantly, the amount of violence is higher than a police officer. It's higher than a prison guard. One would think that a police officer would be the end of violence more than a nurse, and that's just not so.

The workers' compensation claims within the health care system are unacceptably high. Nurses and others are getting not just violence but getting hurt at work more than any other profession in the province. That's back strain, all of those kinds of soft-tissue injuries. We shouldn't have to go to work - come home tired, but we should come home safe. That's just not happening. It's not just Nova Scotia, obviously. It's across the country. There's an unacceptably high level of violence and injury within the nursing profession.

KARLA MACFARLANE: Would you say that that has increased in the last five years?

JANET HAZELTON: Yes, definitely.

KARLA MACFARLANE: Out of your recommendations, is there any one particular recommendation that could actually be implemented right now to somewhat alleviate those concerns?

JANET HAZELTON: The wait times in emergency. We are recommending a nurse practitioner, and what we're saying about that is, the Catch-22 of it is, most of our nurse practitioners are working. They have a big practice; they have hundreds of people they're seeing. If they move there to the emergency department, they're leaving hundreds of patients without. That's easy. Most of them are employees of the Health Authority, so let's offer them an extra four hours on a Saturday, an extra shift, at least try it. We know that one of our busiest emergencies is Colchester and another one is Cape Breton. The nurses in Cape Breton are saying - because we asked, do you think nurse practitioners working in this department would help? - yes, definitely, we need it. My thing is, let's just do it.

KARLA MACFARLANE: I know a number of nurse practitioners across this province right now that can't find work. Why do you think that is? We need them. What is the proverbial brick wall from allowing them to be able to work in the profession that Nova Scotians absolutely need right now?

JANET HAZELTON: I have no idea who these people are. Tell them to send me an email. I'm serious when I say that because my understanding is every nurse practitioner who wants work in this province has work. If that's not accurate - because one of the barriers is just what I mentioned.

Not every nurse practitioner will be able to work in emergency, but they are able to look after the fours and fives in emergency, for sure. If they're family nurse practitioners, they can work in emergency seeing all of those clients, for sure.

KARLA MACFARLANE: There's a recommendation to have a nurse practitioner in every emergency department in this province, but that's not fulfilled. That's one of your recommendations.

You're saying right now we have a shortage of nurse practitioners. If that's the case, what do you recommend this government do to change that?

JANET HAZELTON: My understanding is that there is a shortage - I understood that there are no nurse practitioners to spare. If that's inaccurate, then it's important knowledge for me, for sure. If not, we have to look at how many we are graduating. Is that enough? Are we graduating them in the right volume at the right time? Do we need to periodically bring them out at different times?

To go from an RN to an NP, especially if you're an RN with loads of experience, it's not that big a leap. It costs money and it costs time. The challenge is, if I'm an RN living in Truro with three children and I'm making whatever I'm making as an RN, I can't afford to give up my job to go to school for two years. If I do it part time, it's going to take me five years, and by the time I'm finished in five years, is it really worth it? It's very difficult to study and work at the same time.

Recommendation 33 is to increase the 200 to 500. I think we can employ every single nurse practitioner, and we should.

KARLA MACFARLANE: I'm concerned about the One Patient One Record, and I think a lot of Nova Scotians are as we look at different breaches that are happening with our most vulnerable and personal information. I think I used the expression the other day: there's a lot of information that we can't find out from this government, but a lot of this personal, vulnerable information is just blowing in the wind.

I've heard you several times mention the word "collaborative." It's very concerning to me to make sure that when this is implemented, that all allied health care professionals be consulted and communicated with. Could you elaborate on the discussions you have had in moving forward to ensure that you play a role and part in knowing that how this will be rolled out will be sufficient and effective with regard to the people you represent?

JANET HAZELTON: To date, I've been present for a meeting on the process about how they're going to go about it, how they're going to RFP it, what it's going to look like, and what the chart intends to do. That's the extent. We have electronic charting now in most, but they just don't talk to each other. The chart from Colchester hospital can't communicate if I'm going to the QEII, so it's very cumbersome the way it is now.

Other provinces have it, and hopefully, the people who are designing this are talking or collaborating - what were your pitfalls?

I also sit on the Workers' Compensation Board, and we're just going through a big transformation, going into electronic files for injured workers in this province. We just went live on June 1st. It's the same kind of issues: injured workers' personal information and personal health care. I've suggested to the individuals looking after this within the Department of Health and Wellness that they need to pair with the Workers' Compensation Board.

I've been on the subcommittee, so I'm intimately involved in all the issues that we have been going through around transforming Workers' Compensation. We've spent a lot of money at the Workers' Compensation Board to do this, and we have had a lot of expertise on it. My suggestion at that meeting was that they ought to team up with the folks at the Workers' Compensation Board who are now, in my view, experts on confidentiality, privacy, and all those kinds of issues.

KARLA MACFARLANE: Just a quick question: Quickly, when you say you had one meeting, who was it that you met with?

JANET HAZELTON: I can't recall. It was two individuals: one from the IWK and one from the Department of Health and Wellness. My understanding is that they're the ones leading One Patient One Record. On that issue though . . .

THE CHAIR: Order. Time has elapsed for the PC caucus. We'll move it over to the NDP caucus, and Ms. Martin, for 20 minutes.

TAMMY MARTIN: Thank you for being here. First of all, there's a tremendous amount of material here. We only have a short amount of time, so I'm just going to try to get right to the focus that we want to shine some light on. We would like to thank the NSNU, however, for the many great ideas that have been articulated. It certainly gives us lots to consider on what our health care system could look like if we paid closer attention to the people who deliver it and who should be organizing it.

That being said, I would like to focus on staffing in the next few minutes. The report notes that management practices of not backfilling vacation and sick time are, in the authors' words, an "ongoing problem." It goes on to say, "Working with reduced staffing levels jeopardizes the quality of patient care while overburdening the nursing workforce."

Two parts: Would it be fair to say that many nurses are suffering from burnout as a direct result of this practice; and do you believe that these practices are contributing to nurses leaving and/or dropping down to fewer hours?

JANET HAZELTON: That's an easy answer: yes. It's very difficult to work fully staffed. It's almost impossible to work if you don't have that.

As I describe to some people, when it comes to being a nurse - as the President of the Nurses' Union, I can wake up this morning not feeling all that great, but I'll manage. I'll get in my car, I'll do my job, I'll go home, and maybe go right to bed with a couple Tylenol. When you wake up as a nurse and you're about to go in for a 12-hour shift, you have to be at the top of your game. You can't say, I'll drag myself through the day. You can't drag yourself through the day as a nurse. It's just not possible. You have too much responsibility, and it's just too difficult. It's a very difficult job physically and emotionally as it is.

That's part of the reason our sick time is so high, because we don't work in offices. We work shift work. We work every other weekend. We work 12-hour shifts. We have to stay past 12-hour shifts, sometimes 16 hours, sometimes longer. It's difficult. When you get up, and if you don't know that you're not going to be expected to stay 16 hours - if I wake up, and I'm not feeling well, I know I'm off in eight hours. If I wake up and I'm not feeling well, I don't know for sure even that I'm going to be off in 12.

I agree. Nurses are reducing their status because they're burnt out, just as you worded it, for sure.

TAMMY MARTIN: As the mother of an emergency room nurse whose daughter just worked 17 hours, I completely agree. You go assuming you're going to come home in 12. But then it's 14, 16, or 17, and then you finally get to go home.

What justification do you think management offers for this? Is it that nobody is available? Why aren't they filling or calling in people when somebody's off sick? Is it that nobody's available or that nobody's willing to come in and do the work?

[1:45 p.m.]

JANET HAZELTON: Both. In some situations, especially in rural Nova Scotia, no one's available. There just isn't. When I started nursing in 1984, I think I was a year or more working casual before I got a job. We don't have casuals - I'm not saying there are no casuals, but there are very few casuals. Often, we don't get vacation because there's no one to work for us. If I want Saturday off, too bad. Unless there's someone to work for me, I can't have Saturday off. But when I started, there were people like me working casual who said, I'll work Saturday, sure.

There's a shortage, but also nurses just don't want to work any more than full time, and they shouldn't have to.

TAMMY MARTIN: I completely agree. We've heard though from many health care workers, many nurses that the NSHA cannot find enough nurses to fill the shifts. As you know, we're closing a lot of hospitals, especially Glace Bay and North Sydney, because we don't have enough nurses to fill the shifts. From your experience on the ground, is there a nursing shortage in Nova Scotia?

JANET HAZELTON: Registered nurses - we have a challenge. We're doing a bit better. About 600 new nurses are going to be entering our system between now and into the Fall, which is good.

We definitely have a shortage in pockets, more significant in some pockets than others. Cumberland County, for example, has a huge challenge recruiting and retaining nurses to work in that hospital. With others, it's not as much of an issue.

The problem with some new grads - and I'm not saying that it's a problem, but it's an issue - is they all want to work potentially in Halifax at the IWK or the QEII. They're young and this is the city, and they don't want to work necessarily in Port Hawkesbury or Pugwash or Parrsboro or Advocate. There are areas in the province that are increasingly challenged.

One of the good things that has happened in the last several years was extending the nursing program in the CBU. It was a brilliant move because most of the nurses who graduate from there stay and work there, which is awesome because we used to have a huge issue in Cape Breton as well.

To say we don't have a shortage is inaccurate, I think.

TAMMY MARTIN: Sadly, there's a nurse I know though who's travel-nursing right now because she can't get a job. She can't get a permanent job in Cape Breton. So it kind of flies in the face of (Interruption) Exactly, that's what I said when I heard that.

Is this shortage putting people at risk - staff and patients?

JANET HAZELTON: Any time you work short staffed, there's a risk. There's always a risk. Any profession - if you're not putting enough teachers in the classroom and one teacher is expected to look after two classes, that's a risk. So yes, but one of the things through this PNN that I've been talking about, one of the programs is - like the NP to RN - they're going to do it with LPN to RN.

We have an accelerated program at St. F.X. that an LPN can apply for, but she has the same problem: how is she going to leave her family and her children, quit her job, and go to school? They're going to start with nine LPNs to RNs through the PNN. Again, these ideas all come through PNN.

That might help because they're also going to look for hard-to-recruit areas like Canso. You know that Canso hospital had to close for the night shift because of a lack of RNs. It was a difficult day for the people in Canso. I was there. It was very difficult, very emotional. That was the first time that facility closed in 60-some-odd years and it's because of a lack of RNs, not because of a lack of physicians.

TAMMY MARTIN: In 2015, the Department of Health and Wellness did a report on the nursing strategy - and I'll table that document - and it showed that the RN gap in Nova Scotia would continue to grow to a shortage of more than 900 FTEs by 2024 if Nova Scotia did not put into place a number of measures including reducing turnover to national rates, hiring 90 per cent of new grads, increasing RN productivity by 1 per cent per year, and shifting 5 per cent more RNs to full-time hours.

So 900 RNs is a lot, and as of December 2018, we have 5,100 practising RNs and 1,516 practising LPNs - FTEs. Were you aware of this review, and how has that changed and/or what is the extent that we're still facing that challenge and it will continue to grow by 2024?

JANET HAZELTON: I was aware of the review. I was part of it. I've been sitting on PNN since I've been president; since 2002, I've been sitting on the Provincial Nursing Network. Since then, the seats have increased. The seats in universities have increased. It's a four-year degree program so it takes a while, and I think we're just starting right now to see the fruits of those kinds of decisions to increase the seats both at St. F.X. and Dalhousie.

The worry I have, and what I will continue, is just because we're seeing the results, we can't take our foot off the gas. We need to continue with those seats because now I'm happy to say we're having more significant issues with maternity leaves than we are with retirements, which is awesome - as long as all those children become nurses, we're golden. We have to make sure that whoever is in government, they do not touch those funds that have been earmarked for increased seats in NPs, increased seats for the RN program at St. F.X., CBU, and Dal.

We're starting to see a bit of light. This is the first summer that people are getting some vacation. It's not there yet, but 600 new grads this year is pretty good. Don't quote me, but I think the Health Authority has something like 400 or 350 job offers out. That's great, but still not enough.

TAMMY MARTIN: To that end, will that cover the vacancies? Do we know how many current or ongoing vacancies are under the NSHA or within the province? You're right - 350 offers is wonderful, but what will it take to get us up to balance zero?

JANET HAZELTON: I'm told somewhere around 500, but it's so hard to track this because nurse A goes on maternity leave, nurse B takes her job, and she leaves a job back here. For us trying to figure it out as a union, it's very, very difficult. Then all of a sudden, where did it go? We're not sure of that sometimes.

I do wish we had better data, but again, through PNN - my understanding is that they have an individual now who is going to look at the numbers and do some extensive calculations for us to take a look at where the vacancies are. We're only talking about the Health Authority here - we're not talking about the IWK, we're not talking about long-term care which has huge challenges, and VON is starting to get challenged, as well, to recruit into their positions. Many of these recommendations need to have full complements of staff in order to make it be. We can't add work to the VON if we have vacancies there that aren't filled. We have to make sure everything is marching along at the same time.

TAMMY MARTIN: Do you know what our current RN turnover rate is in Nova Scotia? In 2016, statistics had the outflow rate of 8.1 per cent.

JANET HAZELTON: I knew it was 8.1 per cent, but you're asking right now what it is? We get that from CIHI just like you got it from CIHI. We don't get any more current information than that. Adrian has been hired by the Department of Health and Wellness under the Provincial Nursing Network to dig deep about - not just nurses, but he's doing

nursing - but other health care professionals and what are the vacancy rates and what do we need and how many do we need. I understand he's working on that now.

TAMMY MARTIN: The report talks a lot about recruitment and retention, which is a huge issue. What factors do you think you could identify that would improve our rates of recruitment and retention? For example, in New Brunswick, an LPN is paid $30 per hour to start. In Nova Scotia, we are the lowest paid.

Well, salary being one because of course everybody wants to make a good wage or a comparable wage, but we're the lowest in the country, so what can this government do to recruit and retain the hundreds of health care providers we need?

JANET HAZELTON: I think one of the biggest challenges, other than compensation, is work/life balance. That's huge. Nurses have to get their vacation in the summer, and to be told that you're not going to your son or daughter's rehearsal party because we can't replace you is devastating - and it happens. Or no, you can't have that surgery because we can't replace you - and that's happening.

The work/life balance we have to get better at. Sometimes tough decisions are going to have to be made. If you can't staff your ICU wherever your ICU is, then maybe we need to do something about that - and nobody wants to hear that. Nobody wants to hear that maybe we have to reduce from 10 beds to 8 beds so that we can give a couple of people some vacation, but that's reality.

I think the big thing is that Nova Scotians have to understand, the fix for some of this is going to cost money and the only way we can get money is through taxes. That's the same for long-term care. If we're going to want and respect our seniors in long-term care, then we're going to have to figure out how to pay for it because the staffing in long-term care is worse than it is in acute care.

Work/life balance is hugely important to nurses. Most of them - 97 per cent or so - are female so 90 per cent of them are moms. They have children, they have challenges and kids graduating, and they have all kinds of things happening. They have to be able to attend them. It's just not fair that I can't go to my son's graduation. There's no other profession I know of that that happens.

TAMMY MARTIN: Sadly, I'm going to have to disagree with you, Janet, because I believe that the surplus the Liberal Government is sitting on is a way to fix the health care crisis. Right now, the government is more concerned with balancing the budget than making the investments we need into health care and into nurses and into long-term care.

To that end, I would think that Bill No. 148 has significantly impeded recruitment and retention for nurses. Would you agree?

JANET HAZELTON: Sadly, there are Bill No. 148s all over this country, unfortunately. I believe that interfering in collective bargaining is wrong. The whole strike discussion - we don't go on strike. We've had one strike in the history of the Nurses' Union. We try to get solutions at the table.

We're able to negotiate our wages and we're able to make decisions on our behalf. We don't need to be told. We're professionals. We understand the importance of our role. We understand the significance of withdrawing our service. We get it. We are nurses. We don't want someone in long-term care to die because we're on strike - absolutely not.

Before I was president - 1988 or so - I think it was Bill No. 68, whenever that was - when we provided services, we did our essential services, but it wasn't essential service legislation. We did it as an organization, as a union.

Tatamagouche hospital - the plan was they'd have the same staff during the strike as they would have before the strike. We understood that we only have two RNs on and two LPNs. We're not going down to one and one; we're not doing that. At the bigger hospitals, of course, we looked at elective surgeries.

[2:00 p.m.]

We had a solid plan for when we were going to go on strike that wouldn't jeopardize the health of Nova Scotians in our view. We had people on call who would come in if there was emergency surgery - we had it all. We don't believe essential service legislation was necessary or appropriate or certainly that Bill No. 148 was necessary or appropriate.

TAMMY MARTIN: I would agree. As a union leader and as a past employee of the NSHA doing staffing and payroll for surgical units, I can tell you that the inability to offer these benefits and services to nurses so that they can have work/life balance and they can have a decent wage is significant to the ability to properly run a hospital. I don't believe that there has ever been a strike by any health care union that has put patients or residents in harm's way. I think it was a disgrace of this government to think that grown professional people could not come to the table and negotiate a free and fair collective agreement.

JANET HAZELTON: I agree.

THE CHAIR: We'll now turn it over to the Liberal caucus for 20 minutes. Mr. Irving.

KEITH IRVING: Thank you to our guests here today. I want to first of all thank Ms. Hazelton for your work. You have become a great partner for government in us working to improve the system, and your work on the nursing network, I think, is very important to Nova Scotians and to the province as we work to improve the health care system.

I do also want to thank you for raising the issue that we do have a good system here. Those are your words, and I want to thank those health care professionals - doctors and nurses - who are doing the difficult job that they do each and every day even in the constrained system that we have, which is putting pressures on health care throughout the country, really.

I want to go back to looking forward rather than backwards here. Your report, I think, is of extreme value to us about the potential that nursing will play in solutions for the province. My first question is around - I think it's on Page 55 where you talk about reviewing high-performance health care systems - referring to Baker and Axler, 2015 - that envisions a health care system. It doesn't really call upon experiences in other jurisdictions. There's no references to - in B.C., they do this or that. I'm just wondering if some of the ideas that came here are tried-and-true tested ideas from other provinces or jurisdictions beyond Canada, or are these really coming from the ground up in terms of talking to your nurses? Or perhaps it's a combination of both. Have you exhausted the jurisdictional scan of good practices that we might be able to capture and put into practice here.

JANET HAZELTON: You're right, the majority is from the ground up. It's from talking to our nurses to say, if you could, what would you do? What are the problems, and what do you see are the solutions?

As the President of the Nurses' Union though, I also sit with the Canadian Federation of Nurses Unions with my colleagues across the country, and the CFNU has also produced many really great documents about best practice, about safe staffing, about just-in-time staffing. We're fortunate enough that we have access to the other nurse unions across the country, and we meet very regularly to talk about all of these kinds of issues.

When we hear a good idea - I'll give you an example. All of the nurse union presidents went to New Zealand a few years ago because they have very advanced safe staffing in their country. We looked at just-in-time staffing. What that means is it's not based on patients and nurses - it's based on the acuity of the patients. That might mean three nurses, or it might mean one nurse. It's just-in-time staffing. Right now, we have a very sort of rigid kind of - this many nurses.

One would argue that our patient ratios aren't good enough, but what this staffing model does is, there's a board that says, oh look, emergency is in red, so they're hurting down there. But look, obstetrics is in green. They may have the same number of patients, but the acuity level, based on the nurses' assessment in the obstetric unit is not as acute, so the management is able to move people appropriately - maybe call in staff or maybe move

staff around. It's called just-in-time, and they have huddles. I believe Newfoundland and Labrador is seriously looking at it, and we're having conversations about it. One Patient One Record, there could be something within that that might be able to be used to do the just-in-time.

To answer your question, it's sort of a conglomeration of what we get from our colleagues across the country. Most of it came from our nurses because often, the people at the bedside, the people in the community, the people in long-term care are the ones who know how to fix it. Sometimes they just need the tools.

KEITH IRVING: My next question is with respect to nurses prescribing. I think you said that's about to start in January. Can you explain to us how that's going to work? I believe you have some statistics here with respect to patients' acceptance and trusting nurses to give prescriptions. I'm just wondering if you could explain to us briefly how that might work. Are there limitations? Are you prescribing morphine? Are you prescribing antibiotics? Are there limitations on that? How would this work, as you see it?

JANET HAZELTON: Currently, nurses have limitations on the medications they give out, depending on the unit. For example, I might be able to push morphine in an ICU. I'm the same nurse, I go out to the floor, and I'm not able to push morphine because there aren't the controls in place on the floor that there are in the ICU. It's going to be similar to that.

I believe the program is through Dalhousie, and it starts in January, not the actual prescribing. Those nurses will be hand-selected by - I don't know the process - a process. The departments they're going to be working in will be hand-selected by the employer and the committee that's looking at that. Let's say it's emergency - I don't know the answer to that yet. If it's in emergency, it will be very prescriptive - pardon the pun - about what they're allowed to prescribe for what. They won't be just - here's your prescription pad, go and write prescriptions. It will be very, very - for UTIs, this and this; when you see this, this and this - very, very organized.

It's all going to be under the auspices of the College of Registered Nurses of Nova Scotia. That's our regulatory body. The course was developed. It has to be approved by the college, just like all education does. It has been approved, and now they're able to start rolling it out. In mental health, they'll have different abilities. I think they're talking about detox and those kinds of drugs. That nurse will have that ability, but she wouldn't be able to go to emergency and write an antibiotic necessarily. Everybody will be specialized within whatever department is decided.

KEITH IRVING: Are there any risks in terms of - I forgot the term - when two drugs interact with each other? Is that where the level of pharmacist comes in to track that? Are these low-risk prescriptions that we're not as at-risk with?

JANET HAZELTON: Currently in our facilities, we have pharmacists who would identify. Most of them would be low-risk antibiotics. The biggest risk with an antibiotic is if the patient is allergic to it. As long as the nurse has assured herself that there is no allergy, there should be no issue. I can't imagine it will ever be a controlled substance like a narcotic. It may be, but out of the gate, that's not going to be an issue.

We can't even give Tylenol to a patient in emergency. The X-ray is here, there's no break, he's got a strain or a sprain, we're going to wrap him up, it's 10:00 p.m., and he might need a Toradol, which is high-octane aspirin. We're not permitted to give him a Toradol to go home with. Those are the kinds of things I'm imagining that these nurses will be able to do.

KEITH IRVING: I'll sneak one more in before passing it along to my colleague. In terms of the VON nurses and providing more supports in the home by RNs, you talked about the importance of changing the communications around nurses and their work within the VON that goes beyond One Patient One Record, which might contribute to improving the communications and the support for patients in their home. What might that look like, those other forms of communication improvements with respect to VON?

JANET HAZELTON: Some of the challenges around the VON - I think the biggest challenge is the cumbersome process to get to them. The other issue that VON nurses have told us quite clearly is that sometimes they're not able to use their own nursing assessment to maybe increase the visits, prolong the visits, stop the visits, or change the visits. All of that has an approval process through care coordinators. I'm not trying to be disrespectful to care coordinators, but many of them may or may not be nurses.

Our view - and we clearly state it - is if a registered nurse says I think Mr. MacDonald needs another four days of dressings or whatever, then that should never be challenged. The VON nurses are highly, highly skilled nurses. The dressings they do in the home, often many of the nurses in our acute care facilities aren't doing. They are very, very skilled. We have over 120 or 130 in metro, in Cape Breton. They work 3:00 p.m. to 11:00 p.m. - they're on call.

I'm not sure then, and I was public about the whole paramedic home visits - I was saying, we have two nurses on call in Sydney - they're in Sydney. The problem is the doctor who is discharging the patient from the emergency in Sydney can't get approval for that nurse that evening to go in to see the patient. It takes a day or two. My view is that it shouldn't take any time. They should be able to send the referral off to VON. There are two of them on call. They don't have patient assignments. Go see the patient. There are some things, absolutely - they don't do EKGs in the home. If that's what the doctor wants, that's not going to happen.

There is an underutilization of the VON nurses in this province, without question. They could be doing so much more in the home if they were given the latitude to make those kinds of decisions.

KEITH IRVING: Thank you very much, Ms. Hazelton and Mr. Curry, for your report - very helpful. I'm going to turn it over now to my colleague.

THE CHAIR: Ms. Miller.

HON. MARGARET MILLER: Thank you for coming in today. I have to confess I haven't read this all yet, but I am going to this weekend, so we'll be good.

I want to mention a couple of things that were mentioned by the Opposition caucus here, but first, I want to say two months ago, I was also in the hospital, and I can't say enough about the great care I had. I didn't see a lot of RNs, but I didn't need to see RNs. I was coming out of surgery - my arm was just broken, so I was okay. The LPNs I saw did an amazing job. One was a young lady who was a newcomer to Nova Scotia. She was an RN in another country, and she was trying to become an RN here, but she was still at LPN status. I'm looking forward to at least seeing that she's going to be able to get into some kind of a program that's going to be able to bring her back to her RN status, because she was simply amazing. The nursing care was wonderful.

[2:15 p.m.]

I also want to mention the VON. My dad was able to die at home because of the VON. Thank you.

My colleagues here - I found it interesting that the PC caucus has suggested that the government move forward with all your recommendations. (Interruptions) I agree that a lot of the recommendations you had made are really great, but usually the narrative is extreme caution and collaboration, so I found that interesting.

Also, the NDP caucus had mentioned about the surplus of government. That's really funny. We spend up to $900 million a year on interest; $200 million of that alone is from the time of the interest on the money from the NDP expenditures during their short time. It doesn't feed, clothe, or provide health care to anybody, and I'd love to see that $200 million back in the system. We would certainly be able to use that.

I have to agree about your McDonald's expectation. I think we're dealing with the same thing in our constituency offices. I've even had to unfortunately put up a sign in my own office that said, if people are going to come in and be verbally or physically abusive, we won't help them. I know nurses can't do that, but we had to take drastic action because some people have the expectations that we can move the world, and oftentimes we can't.

My question finally - I gave you a little bit of a break here - we have the new nursing Act in the province, and I think that is a great Act. How do you see this supporting the implementation of some of the recommendations of your report, particularly as it relates to moving some of the barriers to optimal scope of practice?

JANET HAZELTON: I don't know why we can't have signs in our facilities that say, if you're going to be abusive, you're not welcome here. (Interruption) No, it just says it will not be tolerated. That's not, you will be discharged.

One of the issues is, absolutely there should be zero tolerance for abuse by a family member. The nurse in Moncton was choked for 11 minutes by a patient's husband. She'll probably never nurse again. She's traumatized completely. The issue was they were moving his wife to a different bed - that's it.

I think we have to get to a place where, you know what - go home. If you're going to treat us this way, if you're going to be abusive, if you're going to be hitting, slapping, and spitting on us - go home. But we're going to need support of people across from me to say, we agree with that. So when they go into your constituency office - you're never going to guess what they did to me at Dartmouth General. Well, you deserved it.

Violence really gets me going because it's very distressing to talk to a nurse. I was on a call-in show last week and someone called in and said, well, you nurses get paid a lot of money. So we have to change the attitude of Canadians and Nova Scotians. I shouldn't have to take self-defence courses to go to work. We need security in our buildings that actually get involved and remove the person or remove them off me.

Your question about the changes within the Act - a long time coming. One of the complaints I've always had about the College of Registered Nurses - and it was because of the Act - was their inability to be nimble. In order to get anything done, it had to go to change the Act, which as you all know, takes forever. There are some really good things in that Act like expanding the role of nurses, without having to change the legislation, bringing in new and different types of nurses like potentially psychiatric nurses - maybe, who knows - student nurses.

I don't understand why we can't license student nurses while they're student nurses and have them work with us as a student nurse. Not as a CCA or PCW - as a student nurse in her third year at St. F.X., and she can come with me and give injections and put in a catheter and do all those kinds of things. No, they're working at Tim Hortons or they're working in the tavern. It's because they don't have a licence. This new Act will allow that and, believe me, I'm all over that because I really think we're missing an opportunity with our brightest and best.

We need to get them into our facilities during their breaks, so they get to know the staff, get to feel comfortable on the 3 North of the Sydney hospital where - I think I want to come back and work here. My daughter is working for the Irvings, and for three summers, she worked for them. For her, it made sense - of course I'm going to work for them, I have been working for them for three summers, I know them all, and I'm happy here.

I think we need to get there with our students, but if you're going to take them into long-term care and make them work as a CCA, that's going to drive them away from nursing, not to nursing - really. They're not learning. I think that new Act is going to help with that. The biggest thing is the nurse practitioners, the ability to change what they're allowed to do and what they're allowed to prescribe, and all those things now don't have to be so cumbersome.

THE CHAIR: Ms. DiCostanzo. You have less than one minute.

RAFAH DICOSTANZO: My question was more about the scope of LPNs and the new legislation that we passed to join the schooling and how they can control the training for them. Actually, I had a very interesting question. You said you graduated in 1984. I was going to ask you, did you do just two years, or was your education four years? How did we get - it was four years at that time.

JANET HAZELTON: No, it wasn't at that time. Sorry, there were two programs then, the diploma and the degree. I wanted an X ring, so I went to St. F.X. to get a degree. Honest to God, that's the truth. I was accepted at St. Martha's and at St. F.X., and I went to St. F.X. because I wanted an X ring like my brothers and sisters.

THE CHAIR: Order. Time has expired. We'll move on to the PC caucus for nine minutes. Ms. Adams.

BARBARA ADAMS: We just have nine minutes, so I'm going to ask short questions, and hopefully we'll get short answers so we can get through as many as we can. I want to say that I am a physiotherapist, and I was on the VON board of directors for a while. I know that as the largest health professional group, nurses are the staple of our programs.

I wanted to ask when I was looking through the references, was the Nova Scotia Health Authority accreditation report reviewed? Were the items and issues that they identified considered when you prepared this report?

JANET HAZELTON: This will be short: No.

BARBARA ADAMS: I'm going to recommend it because there are some things in there specific to nurses, and I think that would be a good thing to match up.

The second thing is, in looking through the recommendations - I love the report. We're going to be able to reference a lot of information from here. Under the system dysfunction, I like a whole lot of it. I did have a question under Recommendation 5. It says, "The Nova Scotia government should ensure that team members in all settings are able to practice autonomously according to their scope of practice, and do not face arbitrary barriers . . ."

The nurses shortage is well known, and I'll reference something else a little bit. Nurses are already short staffed. They're already staying too long. How do they feel about expanding their scope of practice when there's already a shortage of them compared to, say, expanding the scope of practice of the pharmacist to do prescribing or physiotherapists to see back pain patients in emergency?

I'm just wondering how the profession feels about expanding the scope of practice when they're already feeling tremendous pressure to do things that are already within their scope of practice.

JANET HAZELTON: They're very excited. I'll take an emergency nurse for example. They have to look at that patient with a UTI for six hours knowing full well, if I could just write a prescription, they would be out the door and gone. They know how to do that now. When I worked in emergency, I know this is a UTI, I know all he needs is an antibiotic, if I could write it myself and give it to them - but I'm not allowed. They're excited because they know this is going to improve the care that they give.

BARBARA ADAMS: I agree that there are certain medications because pharmacists are allowed to prescribe those as well. I guess what I'm wondering is, where a pharmacist has a four-year degree in prescribing and we don't have a shortage of pharmacists, why we wouldn't be expanding their ability to prescribe where we have their expertise. They may not have the same assessment skills as nurses for sure, but does the union acknowledge that we should also expand and maximize the scope of practice of all of the other allied health professionals and that they may also be able to pick up some of the slack that the nurses just aren't able to do?

JANET HAZELTON: I really can't comment because I don't know all of what a pharmacist is taught; I have no idea the extent. But I do know that a pharmacist at Lawton's can't do a urinalysis. My worry would be if you have a UTI, go to the pharmacy and get this prescription, that's two stops when it could be one.

I absolutely think that pharmacists are doing a great job on flu shots and all those kinds of things and re-ordering, but I can't comment whether their scope should be - not every health care professional has a scope of practice. Some do and some don't. CCAs, for example, don't have a scope of practice - they have a scope of employment. In order to have a scope of practice, you have to be a regulated health care professional.

BARBARA ADAMS: I know you saw the look of surprise on my face, because as a health professional, we all have scopes of practice.

The pharmacists have a four-year degree and they have continuing education throughout their whole career, so what is the actual training going to be for an RN to be able to prescribe, and how does that compare to a pharmacist?

JANET HAZELTON: The actual writing of the prescription is the end result of the registered nurses already having extension education and training around medications. We have to know this to give the medications, so I have to understand what each medication is to do, and if I give this with this, what the results will be.

Our nurses already have a huge amount of education, and continuing education, on medications. If a doctor, for example, writes a prescription for something, it's my responsibility as a nurse to make sure that the dose was appropriate, that there was no allergy. Oftentimes, our nurses are calling to say, with this drug, you might want to think about this. Those kinds of conversations happen every single day all over this province in all our acute care.

The next step of actually writing the prescription, I'm not seeing it as that huge a jump because we already know what Amoxil's going to do, why the Amoxil is getting ordered, how often the Amoxil should be taken because we're the ones giving it if they're in the facility - like TID with meals. We know all this because that's what we do.

BARBARA ADAMS: There are thousands of medications, and I think physicians who are prescribing those medications and the pharmacists who took the four years of training may have different thoughts on where all this fits in and who is the best first point of contact for prescribing. I think that's a very significant conversation that needs to go on.

I want to move on to Recommendation 14. It says, "Given that nurse practitioners have an autonomous scope of practice, when population metrics or recruitment challenges warrant it, the Nova Scotia Health Authority should allow clinics to operate with a nurse practitioner as the highest level of provider."

Are you referring to publicly funded clinics or privately funded clinics?

JANET HAZELTON: Publicly funded clinics.

BARBARA ADAMS: Under Recommendation 16 it talks about, "To improve access, efficiency, and patient outcomes, the Health Authority should empower collaborative practices to book nurse-only visits, and visits with other professionals, based upon patients' individual needs."

Is this not already happening? To my knowledge, they are not also seeing a doctor when they come into those collaborative practices.

JANET HAZELTON: It's not just nurse practitioners. There are family practice nurses that are involved in this as well.

BARBARA ADAMS: I'll clarify. Are you suggesting that the patient who comes in to see a family practice nurse should not need to see a physician?

JANET HAZELTON: Where the nurse practitioner is working in a fee-for-service, she's working with a GP in clinic X, and the physician is a fee-for-service, she can see and she can treat. The physician currently has to sign off. They have to sign off if it's a fee-for-service.

[2:30 p.m.]

BARBARA ADAMS: The clinical nurse practitioner training program, does it include emergency department training?

JANET HAZELTON: Not typically. What we're referring to in the emergency department is the people who aren't emergency patients, so your fours and fives. Your fours and fives are probably - I'm guessing a large majority of the patients that are . . .

THE CHAIR: Order. Time has elapsed for the PC caucus. We'll move over to Ms. Leblanc for the NDP - nine minutes.

SUSAN LEBLANC: I'm going to move on to some questions about system design and dysfunction. I wanted to ask you about the nurse-only visits and how they are built. If I understand correctly, in a collaborative practice setting, even if a patient only needs to see the nurse and not a doctor for something - for instance, a wound redressing or whatever, changing the dressing - that patient is still slotted in to see the doctor so that the visit can be billed for. Is that correct?

JANET HAZELTON: In the fee-for-service ones, yes. In the others - I believe there's a clinic in Pictou, and I believe we have three nurse practitioners and two physicians, but the physicians are salaried. In that situation, the nurse practitioner sees, treats, and releases. If it's a fee-for-service, my understanding, what I'm being told, is the nurse practitioner in a fee-for-service has to have a sign-off by the physician.

SUSAN LEBLANC: It would be fair to say, then, when the province was implementing the collaborative practice model and began to integrate more nurses into primary health care settings and collaborative practice teams, someone essentially forgot to update the billing model to reflect this collaborative setting, or is the issue that nurse-only visits are not being embraced by the other practitioners on the team? Can you comment on that?

JANET HAZELTON: All of the newer collaborative practice ones, most recently, are all designed so that the nurse practitioner can see, treat, and release without having to be seen by the physician. There are still some that are out there where, as you suggest, the physician has to see them.

SUSAN LEBLANC: When you say newer, you're referring to the NSHA turnkey model where the NSHA is the employer of all of the folks in the clinic? Correct, okay. In the situation of collaborative practice teams, I understand that the nurses are, yes, employees of either the NSHA or the clinic and that their salaries are directly covered by the doctor operating the clinic - this is the fee-for-service kind - or the NSHA transfers a certain amount to cover the nurse's salary directly. That's correct in the fee-for-service?

THE CHAIR: Address the Chair, please.

SUSAN LEBLANC: Sorry.

THE CHAIR: Ms. Hazelton.

JANET HAZELTON: My understanding is if the nurse is being paid by the Health Authority, they're able to independently, without sign-off from a doctor. That's not just nurse practitioners. It might be a registered nurse, for example, who gives sex education. She could do it, and if she's in a clinic where she's not salaried by the Health Authority, she has to get that education signed off by the physician.

SUSAN LEBLANC: When you say address the Chair, do I say, "can the witness"?

THE CHAIR: You don't say "you."

SUSAN LEBLANC: I'm interested in hearing the witness' thoughts on this set-up and whether one way is better than the other or what generally works better for the nursing profession and the people of Nova Scotia.

JANET HAZELTON: My view is that nurse practitioners should be employees of the Health Authority. I think they need to stay in a publicly funded, publicly administered health care system. I would be disappointed if there came a time when they were able to charge for their services. They are in Newfoundland and Labrador, and it has become an issue, in that some of our most vulnerable people need to see - my view is they need to be because that provides some benefits for them as well, like medical, a pension plan, et cetera.

I think we're seeing the pushing and pulling and tugging now within the physician community. Some are going to a salary and some are staying fee-for-service. I think we should avoid all that with our nursing profession and just leave them all as employees of somebody.

SUSAN LEBLANC: Related to this, your report mentions the need for a dedicated stream of funding for chronic illness support and case management in primary care. This sounds to me like a great idea. How would you envision this working and are some clinics already funded to do this?

JANET HAZELTON: Yes, there are some clinics funded, but not enough and I think we need to look at all of our chronic diseases. Even some of the clinics that we talked about that are nurse-led clinics - that might be a nurse-led clinic in Truro, but we might look at - and I keep saying Cape Breton, but we might look at Cape Breton and say, Glace Bay may need a different kind of health care professional in that clinic, maybe a nurse practitioner or maybe a social worker or maybe whatever.

I think we have to look at the needs of every community in this province and say, if we're going to set up a clinic, who needs to be working in this clinic? If it's in a community that has a lot of challenges around addictions, well obviously, we need some specialists that deal with addictions. If we have a very senior population with chronic illnesses, maybe that clinic has to look at that.

I think we should have seniors' clinics all over this province where they could go, they could sit down, they could chat with a nurse, they could chat with physio. Just because you're 92 and you can't walk on a treadmill doesn't mean you don't walk - and how do you walk and how do you lift? What about nutrition - I can't eat like I used to. So let's make sure our seniors are eating the right foods.

I think that would be a huge bang for our buck. If we developed all these clinics with VON nurses - but not just nurses. There are all kinds of other health professionals - physiotherapists. Many seniors think they can't do certain exercises; physiotherapists would help. So I think we have a huge opportunity in this province.

SUSAN LEBLANC: After-hours care is obviously a huge issue. People are often unable to access primary care because they can't get out of work or because they work odd hours and are sleeping at that time or because they have caregiver responsibilities and the list goes on why we can't go to a clinic between 9:00 a.m. and 5:00 p.m. The nine-to-five schedule doesn't really accommodate everybody, but we need to ensure that when you work shouldn't affect or determine whether or not you get access to care.

Can you speak a little bit more about why nurses are uniquely positioned to help expand access to after-hours care?

JANET HAZELTON: Because that's what we do. We're 24/7 and that's what we do, and we're used to it. Ironically, after a certain hour we do it all. We do all the pieces of care that others would do maybe in the day shift, and nurses are keen. They're keen to do this. They're excited about the potential changes that they see happening. They want to be able to go see Mr. MacDonald with the swollen foot before Mr. MacDonald's swollen foot gets him in the hospital with congestive heart failure.

SUSAN LEBLANC: How much time?

THE CHAIR: Two minutes.

SUSAN LEBLANC: Nurse-to-patient education is another topic that I was glad to see come up in the report. Do you have any sense of how we can quantify the amount of time that's needed above and beyond what's currently available in order to provide adequate nurse-to-patient education and general counselling?

JANET HAZELTON: I think it depends on the individual. Everybody has different learning needs. Everybody learns differently. Our seniors learn differently than our younger people, so I think we have to look at the population, but it's a big gap.

Typically, in acute care in most of our units, we don't have a whole lot of time to teach anybody anything. That has to be kind of built in. The softer side of nursing sort of has disappeared because we're too busy doing the busy stuff that we have lost the, "How are you doing? How are you really doing?" We've kind of lost some of that.

SUSAN LEBLANC: Thank you so much for your comments. I really appreciate them.

THE CHAIR: Order, the time has elapsed. We'll turn it over to the Liberal caucus - Ms. DiCostanzo.

RAFAH DICOSTANZO: I'm really glad to go back to my question that we started. You graduated in 1984 and at that time, most nurses studied for two years. That was unusual - almost like a master's nowadays. If you can help me understand, within 30 years now, how did we get from a two-year program that was sufficient for nurses - that was really the standard - to a four-year program? Now we kind of went back with the last - when did LPNs start to become more - we're going back to the two-year program.

I know you said that 600 nurses are just graduating. Is that RN or LPN or a mixture of the two? How is the scope, and where do you see the vision for LPNs? How does what they can do compare to RNs? Would the RNs become the managers? It has become so much more paperwork that RNs are responsible for, and the LPNs are more the bedside nurses. Am I correct? What is the vision, and how do you see it?

JANET HAZELTON: You're not correct. Depending on the practice environment, it's the skill mix. Our ICUs and emergency departments, our highly acute individuals, are generally - 90 per cent or more of the time - looked after by registered nurses. Our more stable medical patients, depending, could and may be looked after by a licensed practical nurse. It depends on the patient.

Typically what happens in our acute care facilities is, the registered nurse most often will make a decision on who's going to look after who and why. They may look at patient X and say the skill set of - and let's be clear: every LPN doesn't necessarily have the same skill set, and every RN doesn't have the same skill set. I was an emergency nurse - don't put me in a CCU. It just depends on the skill set of the nurse.

The four-year program was a decision of the Canadian Nurses Association. The reason for it is because our patients are more complex. The skill set that we require is more advanced. It wasn't a decision of the unions, obviously. They believed that they required more education. They required at that point more university education, because at that point, there were schools of nursing, and a lot of their time was task oriented. The registered nurses were task-oriented in the two-year diploma.

Someone made the decision that we wanted them to have a more formal university education, like chemistry - university chemistry. We didn't have a lot to say about that decision, but it has been made, and it is what it is.

RAFAH DICOSTANZO: I just wanted to understand what the vision is for LPNs in their capacity and scope, according to you. Where do you see they can reach? What other things can they do? How far can they go? I'm excited about LPNs, as you can see.

JANET HAZELTON: Yes, we're excited about the increase of the LPN scope as well. When I first started nursing, the LPNs didn't give out medications, didn't do physical assessments, and now they are. The RNs didn't, and now they are. I'm sure physicians have increased their scope as well. I'm not 100 per cent sure of that.

In that, though, when we increase the skill sets, and we increase the expectations, we have to also have a conversation about compensation. There is an area there within the LPN - the difference between an LPN and a CCA is not very much, and the responsibility is significant. I think we have to be cognizant every time we increase the responsibilities and the expectations of any profession - not just nursing - that we appropriately compensate them for it.

RAFAH DICOSTANZO: Thank you. I leave it to my colleague, Ben Jessome.

THE CHAIR: Mr. Jessome.

BEN JESSOME: I just want to go back to the commentary around the challenges that are existent for - I forget the exact acronym. For a nurse to advance, Ms. Hazelton had indicated it was fairly straightforward if someone could afford the time to actually take the course to advance themselves, citing challenges around child care and proximity to our schools. I'm wondering if Ms. Hazelton could comment on whether there has been any exploration around a satellite program or anything of that nature, acknowledging that there are components, I would suspect, that are required to be onsite. If Ms. Hazelton could provide a response to that, that would be great.

[2:45 p.m.]

JANET HAZELTON: Currently, the LPN program at St. F.X. offers an accelerated program, where you actually physically go to St. F.X. Monday to Friday, but they also have an online program. They have that. The nurse practitioner program, they either started or they intend to start having that available at the Cape Breton University. It's hugely inconvenient for someone to leave a home that's three or three and a half hours away, especially if they have children. That's the reality of it. Yes, there are plans. I'm not sure about the nurse practitioner. Yarmouth has a satellite clinic out of Dalhousie. It is a satellite clinic from Dal, and I think it's 30 or 40 students in Yarmouth at Dal. It's called the Dalhousie campus.

BEN JESSOME: With respect to educating the public about the potential and the scope of nurses, and I'll cite a couple of different instances in your recommendations with respect to the suggestion around in-home checkups for patients who are more than 75 years old and the use of telemedicine and other formats. Dare I say that some people are fairly entrenched in the way that they have accepted health care? A requirement for us to morph into something more modernized is there. It has to be there. I'm wondering how important the public education component is to what we're trying to accomplish here.

JANET HAZELTON: I think that's why we did our TV ad, because it showed a nurse practitioner writing a prescription. That's what we're trying to impress upon Nova Scotians, that there's enough work in the system for all of us. There doesn't need to be competition between health care professionals. There's plenty to do. There's lots to do, and we just have to make sure that we're using the most appropriate health care professional depending on the client's needs or the patient's needs.

I think we do have to change, but there aren't many people under the age of 60 who don't have a smartphone. Granted, 60 to 80, we may find some. Those individuals are going to be 80 very soon. How can we utilize the technology that they're carrying around in their pocket to better our health care needs? Your Fitbit now can tell your blood pressure. I think we're going to get there one way or another. It's going to happen. People are going to start

demanding to know what their bloodwork is. They're not going to want to go see their doctor to see what their bloodwork is. Why should I have to? Email it to me. Text it to me. If we don't get ahead of this, they're going to go right over the top of us, and they're going to start demanding. We need to be leading this charge, not catching up.

THE CHAIR: Order. Time has elapsed. Thank you very much. Would you have any closing remarks, Ms. Hazelton?

JANET HAZELTON: Yes. I think it's important that no matter who we are, we're all Nova Scotians. We're all going to have to access this health care system that's being created at some point in our lives. If we haven't already, we're going to, or our parents are going to or somebody is going to. We need to find a way, everyone, to work towards some solutions to this health care issue that we find ourselves in. Everybody in the system needs to be involved. Everybody needs to have whatever piece of their world they need. We can't not do something.

I truly believe some of these recommendations - and many of you have the ability to make it happen, it has to happen - we need to do it now. I don't want to be back here five years from now saying, we had 35 and there's two done. These are doable. They're affordable. They need to happen to improve health care. If we want to keep our seniors in the home, then we have to make sure they have the supports in place to stay at home. Some of these things will allow our seniors to stay at home and be looked after at home. There's too much pressure on patients' families right now to provide the care that, quite frankly, I believe not just nurses, but others can provide within the homes.

THE CHAIR: Thank you very much, and thank you, Mr. Curry and Ms. Logan, for coming today. Thank you for the report.

Special thanks to our clerk, who went out of her way to try to find a date for us. I think this was probably the most challenging meeting date to set up that you were available, Ms. Hazelton, and your co-workers and members of the committee. I know there were some events going on that some members could not attend.

Thank you for being here. You may leave.

We have two items of committee business. If you look at your correspondence, we have a request from the Canadian Cancer Society to appear before the committee. We also have a request for the Nova Scotia Health Authority for additional witnesses.

We'll deal with the request from the Canadian Cancer Society. They have asked to appear. When is our next agenda-setting meeting; we're scheduled for how many more meetings?

JUDY KAVANAGH (Legislative Committee Clerk): Some time this Fall.

THE CHAIR: Can we add this topic, when we do have our agenda-setting, to have the Cancer Society be put on that list? Are we in agreement? We're in agreement.

Our next piece is a request from the Nova Scotia Health Authority for additional witnesses at the July 9th meeting. You all received correspondence. Dr. Dunbar did not make this request but has told the committee clerk he has no objection to these additions. Any comment, or are we in agreement with the extra witnesses? That's great. We will put them on.

Ms. MacFarlane.

KARLA MACFARLANE: I have a point of order. I just want to clarify that at no time during this presentation, when I spoke, that I said I endorsed the 35 recommendations. My colleague to the left of me from the Liberal caucus indicated that she was surprised that the PC Party endorsed all 35 recommendations. That is incorrect. I would ask that perhaps we go through Hansard and prove that I did not say that the PC Party endorses all 35 recommendations.

THE CHAIR: I would have to refer to Legislative Counsel about that. We'll take a short recess.

[2:53 p.m. The committee recessed.]

[2:54 p.m. The committee reconvened.]

THE CHAIR: Order. I have been told that it's not a point of order. It is just something that the committee can agree to do or not agree to do.

Ms. MacFarlane.

KARLA MACFARLANE: I would like to have a motion put forward to prove that I did not say that the PC Party endorses all 35 recommendations.

THE CHAIR: Mr. Jessome.

BEN JESSOME: If the honourable member would like to produce the transcript, we can look at it at the next meeting and whatever's in the transcript is what's there.

THE CHAIR: Okay, we will put on the agenda for the next (Interruption) No, she said "I would like to have a motion." She didn't say, I will make a motion.

Ms. Adams.

BARBARA ADAMS: I think it's really important that what we are saying is accurately reflected by other members, so I'm going to make a motion. The motion is that I would like the committee to bring to the next meeting a copy of the transcript of what Ms. MacFarlane said and what Ms. Miller said so that we can ensure that what our Party has said is accurately recorded and referred to.

We would like a recorded vote.

THE CHAIR: You're asking for a recorded vote. There's a motion on the floor. We will have a recorded vote.

YEAS	**NAYS**
Ms. Martin	
Ms. Leblanc	
Ms. Adams	
Ms. MacFarlane	
Ms. Miller	
Mr. Jessome	
Mr. Irving	
Ms. DiCostanzo	

THE CHAIR: The motion is carried.

We will have that prepared for the 9th. We'll all get a copy of the transcript anyway for our own viewing.

There being no further business, our next meeting will be July 9th from the hours of 1:00 p.m. to 3:00 p.m. Our witness will be Dr. Michael Dunbar, orthopaedic surgeon at the QEII Health Sciences Centre.

The meeting is adjourned.

[The meeting adjourned at 2:57 p.m.]