CRNBC

CELEBRATING THE EVOLUTION OF NURSING REGULATION IN BRITISH COLUMBIA

100 YEARS *of* NURSING REGULATION 1912-2012

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INTRODUCTION

One hundred years ago, 68 nurses met in a church basement in New Westminster. Their goal was to create a strong provincial association that could convince government to enact legislation requiring nurses to be registered. How far we have come!

In 2012 we celebrate the evolution of nursing regulation in British Columbia, and what that has meant to the women and men who choose to serve the public by providing competent and ethical nursing care, as well as the generations of British Columbians who have benefited from that care.

It is a proud history.

From 1912 to 1934, the Graduate Nurses Association of British Columbia fought hard for the Registered Nurses Act that established the statutory framework for the regulation of nursing in the province. Once that was achieved, the focus turned to developing standards for nursing education to ensure students received the appropriate education to qualify as registered nurses.

In 1935, legislation was revised to improve nursing education and the Graduate Nurses Association of B.C. was renamed the Registered Nurses Association of British Columbia. For the next 45 years, initial and on-going education remained a priority, with labour relations also becoming a major part of the Association's work. This was the era following the Second World War – a time of economic prosperity when salaries and benefits were increasing, and Canadians were turning their attention to social welfare issues such as pensions and the creation of a national health care insurance program.

By the 1970s, hospital-based nurse training programs were being replaced by diploma programs carried out by publicly-funded community colleges and universities. RNABC was given the legal authority to approve these programs that prepared individuals for nurse registration.

In the 1980s, labour relations became the responsibility of the B.C. Nurses Union, and RNABC turned its energies to elevating entry-to-practice education requirements, developing standards for nursing practice and laying the groundwork for mandatory registration.

The period from 1988 to 2005 was a time of great change and uncertainty. It began with a major accomplishment: at long last, the Nurses (Registered) Act was changed to make registration mandatory for B.C. nurses.

This was also the time when the Royal Commission on Health Care and Costs (Seaton Commission) was underway, and changes to the regulation of health professions in B.C. were expected. In preparation for these changes, RNABC adopted a regulatory framework of promoting good practice, preventing poor practice and intervening when practice is unacceptable. Continuing competence requirements for registration renewal were developed, an examination of the Professional Conduct Review Process was undertaken, and work began on implementing the nurse practitioner role.

In 2003, the registered nursing profession came under the Health Professions Act and the Nurses (Registered) and Nurse Practitioners Regulation. Two years later, on August 19, 2005, RNABC was dissolved, and the College of Registered Nurses of British Columbia, empowered by the Health Professions Act to regulate the practice of registered nurses and nurse practitioners in B.C., was established.

Helen Randal, Sharley Bryce Brown and the other nurses who met in that church basement 100 years ago could not have foreseen their fledgling Graduate Nurses Association of B.C. evolving into a bargaining unit, association and regulatory body for nurses, and then into an association and a regulatory body, and finally into a regulatory body only.

However, they certainly would have recognized the need for these changes. They would have marveled at the advances in the nursing profession and rejoiced at the changes in education to achieve registration. Above all, they would have taken great pride in knowing that for 100 years, protecting the public has been the mandate of B.C.'s registered nurse regulator – as it is for all health profession colleges in the province.

IN THE BEGINNING

To understand why Helen Randal and her colleagues were so concerned about nursing registration in the early 1900s, we need to understand the primitive state of health care at the time.

In the mid-1800s, British Columbia was a rugged land, home to First Nations and young men drawn by necessity, or adventure, or opportunities in fishing, mining, logging and fur trading. Then came two gold rushes – the first along the Fraser River in 1858, followed four years later with another in the Cariboo. In 1885, the transcontinental railroad was completed – linking British Columbia, which joined confederation in 1871, to the rest of Canada.

In those early days, Fort Victoria (later to become Victoria) was the supply base and outfitting centre for miners on their way to find their fortunes of gold. It was also the location of the Royal Hospital (now the Royal Jubilee Hospital), established in 1859 and the first hospital in British Columbia.

Three years later, a second hospital – the first on the mainland – was built in New Westminster, the capital of the colony. The Royal Columbian Hospital was designed to care for 30 male patients. Women, children, and "the incurable and the insane" were excluded. It was replaced in 1889 with a 50-bed hospital staffed by 10 people. In 1901, it amalgamated with the Women's Hospital of New Westminster, the maternity hospital organized by the Women's Christian Temperance Union.

It was not until 1886 that a hospital (of sorts) was established in Vancouver. The nine-bed tent, which was intended to treat Canadian Pacific Railway workers, was lost in the Great Fire that destroyed Vancouver on June 13, 1886. It was replaced by a small shack with only a few beds until the new 35-bed Vancouver City Hospital (now Vancouver General Hospital) opened in 1888. St. Paul's Hospital was opened in 1894 by the Sisters of Providence who had earlier established St. Mary's Hospital in New Westminster in 1887.

A challenge at each of these hospitals was the lack of trained nurses, so they began their own schools of nursing. Royal Jubilee Hospital appears to be the first hospital in the province to establish a training program, followed by Vancouver City Hospital's Training School for Nurses in 1899 and Royal Columbian's Nursing School in 1901. St. Paul's Hospital School of Nursing graduated its first class of 11 students in 1910.

Few women in those days worked outside the home, and those who did were most often employed as domestic help. Many "schools of nursing" did little more than provide the hospitals with cheap labour in the form of student nurses. These young women were immediately sent to work on the wards under the supervision of matrons and doctors, with their "education" considered incidental. Because the work was hard and the wages (and status) low, nursing tended to attract women with little education, mostly from poor families, who were desperately seeking ways to advance themselves.

Despite the onerous conditions, nursing continued to draw women committed to providing quality care, and with great pride in what nursing was and could become. They also began to see – perhaps influenced by the success of the suffragette movement – that more would be accomplished if they banded together to form a provincial nursing association that could speak for all of them. What they wanted was registration for nurses in British Columbia.

REGISTRATION

The movement for the registration of nurses began in Great Britain and quickly spread to Canada. In August 1909, Dr. Helen MacMurchy of the Canadian National Association of Trained Nurses (founded in 1908 and the forerunner of the Canadian Nurses Association) told the Victoria Nurses Club that while no women should be prevented from nursing, no one should be allowed to put on a uniform and call herself "trained" without first going through the necessary training.

The next year, the Graduate Nurses Association of Vancouver (GNAV) began working towards securing a registration act from the provincial government. A draft bill was written with the B.C. Medical Association and presented to the GNAV membership as well as to the Vancouver General Hospital Alumnae Association, the Victoria Trained Nurses Club and others. That first draft was never presented to government because it was apparent that a provincial association with strong leadership was needed if they were to be successful.

When the provincial association – the Graduate Nurses Association of British Columbia (GNABC) – was established in September 1912, the first order of business was nurse registration. A committee was struck to draft a bill, which was presented to Premier Richard McBride in December that year.

Despite organized efforts by GNABC members, the bill was laid over by the legislature's executive committee. With the outbreak of the First World War in 1914, the fledgling association turned its attention to donating money and materials for the war effort.

The bill was reintroduced in 1916 and met with resistance. Some believed nurses were seeking a monopoly. Some felt that by setting high nursing standards, a person of modest means could not afford to hire nurses (many of whom worked in private practice). Jo Ann Whittaker, author of *The Search for Legitimacy: Nurses Registration in B.C. 1913-1935*, wrote: "Doctors did not want nurses to be able to make their own rules but rather to continue to defer to them." When government proposed that nursing be controlled by the College of Physicians and Surgeons, GNABC withdrew the bill.

Finally, after a change in the provincial government and passing of the enfranchisement referendum giving women the right to vote and hold provincial office, the Registered Nurses Act was passed into law on April 23, 1918. In May of that year, Helen Randal was appointed as the first GNABC registrar.

A registration act was finally in place, but it would take another 70 years to achieve mandatory registration.

The next 10 to 12 years were dominated by debate over education standards and working conditions for nurses. It was the exploitation of student nurses by hospitals that eventually caused nurses to demand educational standards and prevent unlimited expansion of poor-quality schools, which in turn led to GNABC submitting, in 1934, proposed amendments to the Registered Nurses Act.

In 1935, the Registered Nurses Act became the Nurses (Registered) Act. The new act not only changed the name of the association to the Registered Nurses Association of B.C., but included amendments that helped elevate the stature of the nursing profession. For example, it prevented hospitals with less than 50 patients from having nursing schools, legalized the minimum age for student nurses at 19, and set junior matriculation as the minimum education requirement for entry to a nursing education program.

Despite the growing acceptance of the RN designation as a confirmation of professional competency, registration with RNABC was voluntary. Nurses went to school, got their diplomas and practiced. Unless they chose to become registered with the Association, there was no other body ensuring that graduates had the required qualifications to practice nursing.

In 1988, after years of consultation, deliberation and fine-tuning, RNABC was successful in having the Nurses (Registered) Act changed so that registration for practising registered nurses became mandatory. B.C. was one of the last provinces in Canada to enact mandatory registration legislation.

EDUCATION AND EXAMINATIONS

Few if any education and professional standards existed in the early 1900s. Within any group of nursing students, some had high school diplomas while others could barely read. Each education program was different and varied in length from six weeks to three years. Because nursing was not particularly valued as a career, most students came from poor families and had little education.

However, education was very much on the minds of the 68 women who met in 1912 to form the Graduate Nurses Association of B.C.

The First World War began to change young women's attitudes about nursing as a profession. Before the war, nursing was considered a dedication and a service to the community rather than a job, and nurses put up with long hours and poor wages. But during the war, women could earn good wages doing war work, and with other options available nursing lost some of its earlier appeal. Hospitals were crowded with the wounded from France and there were shortages of all supplies, including nurses.

After the Registered Nurses Act was passed in 1918, Helen Randal, as registrar of the Association, put her energies into conducting the first survey of hospital training schools in the province. Then she began carrying out annual school inspections.

In 1921, GNABC recommended that prospective student nurses be 19 years old and have at least one year of high school. Schools were urged not to accept younger students because it was felt that women of college age might not be attracted to nursing if the standards were too low.

In 1924, GNABC established standards for the approval of nursing schools and went on to create standards for admission, equipment, teaching methods and curricula. As standards increased, and the Great Depression took its toll, smaller training schools closed.

A pivotal moment in nursing education occurred when the *Survey of Nursing Education in Canada* by Dr. George M. Weir, head of the department of education at the University of British Columbia, was published in 1932. The Weir Report, as it was more commonly referred to, found that hospital-nursing schools turned out a disciplined workforce, but did not provide the quality of education necessary for highly

competent nurses. He concluded that nursing education should be placed within the general education system and the minimal education requirements for professional nurses should be four years of high school followed by three years of nurse training. Perhaps the most significant aspect of the report was that it enabled nurses and others to talk about nursing as a profession.

At the time, British Columbia had fewer training schools than other provinces in Canada, with the exception of Prince Edward Island. By 1939, with the combination of the economic impact of the Great Depression and RNABC's increased standards for approval, only seven schools were still open – in Victoria, Vancouver, Kamloops, New Westminster and Cranbrook.

The outbreak of the Second World War in 1939 meant that women were once again drawn to the better salaried jobs offered in the war industries. Nursing salaries in the early 1940s were well below these other salaries and still lower than pre-Depression nursing salaries.

As a result, nursing shortages were again growing – a situation that has been consistent from the turn of the 20th century and continues today. Attempts were made to counter the shortage by granting temporary licences, permitting married nurses to work and encouraging private duty nurses to work as general staff nurses. Student nurses were allowed to marry, but only to servicemen.

RNABC started sponsoring refresher courses for inactive nurses and later hired an instructor to update nurses returning from the war. This was the beginning of a more visible role in continuing education for RNABC.

The end of the Second World War ushered in the era of university education for nurses. Although the University of British Columbia had offered a degree program in nursing since 1919 – the first university in the British Commonwealth to do so – there were few baccalaureate programs in Canada in the 1950s. Most nurses were still receiving hospital-based training.

By the 1970s, radical changes in nursing education were being discussed. A RNABC survey in 1973 stated: "Education is suffering as a consequence of inordinate service demands." It was proposed that nurses be educated in the classroom rather than the traditional on-the-job apprenticeship.

The roots of that proposal went back to Helen Mussallem's 1962 report on nursing education for the Royal Commission on Health Services that said nursing education in Canada was in a "deplorable situation" and that "75 per cent of hospital school instructors are unqualified."

(Helen Mussallem trained at Vancouver General Hospital, and went on to receive a bachelor of nursing from McGill University and a doctor of education from Columbia University. She received numerous awards throughout her illustrious career, including being named a Companion of the Order of Canada.)

Although hospital nursing schools had done a credible job, it was clear that they were not situated to provide education for the future. These hospital-based schools were functioning where the first priority was patient care and not education. A component of these programs provided the services of nursing students for patient care in one setting, usually in the one hospital. This exposure did not provide sufficient breadth and depth of education to prepare nurses with the foundation required for specialized knowledge and skill to work in a variety of settings and outside hospitals. Nor did the educational preparation include the foundation for career progression into administration, education and research as well as clinical practice roles.

Hospitals began closing their schools of nursing, and community colleges started offering two-year programs with students' time focused on classroom instruction and practicums. RNABC remained responsible, through the Nurses (Registered) Act, for establishing standards for the education of nurses in British Columbia and approving nursing education programs in the province.

The final shift in advancing nursing education began in 1982, when RNABC delegates at the annual meeting resolved "that by the year 2000, minimum education requirements for entry into the practice of nursing in B.C. will be successful completion of a baccalaureate degree in nursing."

That goal was missed by just a few years. The B.C. government finally announced its support for the transition to baccalaureate programs in 2002, with the changes phased in over several years starting in 2003. The last non-baccalaureate program ended in 2007.

Today, the College of Registered Nurses of B.C. is responsible for assessing all nursing education programs in the province. The Education Program Review Committee reviews nursing education programs and courses required by applicants for registration, and makes recommendations about whether the Board should recognize them for the purpose of registration, and any terms or conditions of recognition.

The quality of nursing education in B.C. is borne out by the results of the Canadian Registered Nurses Examination – the pass rate for graduates from B.C. schools of nursing writing the exam for the first time consistently surpasses that of candidates who graduated outside of Canada.

PROFESSIONAL CONDUCT REVIEW

The privilege of a self-regulated profession that Helen Randal and her contemporaries fought so hard to establish was predicated on their belief it was the best way to protect the public. It was true 100 years ago and remains true today.

All registered nurses, nurse practitioners and licensed graduate nurses practising in British Columbia are required to adhere to a Code of Ethics that includes the assumption they will provide "safe, compassionate, competent and ethical care."

In the 1970s, RNABC's Committee on Social and Economic Welfare was responsible for much of what would become the domain of the Association's Labour Relations Division and eventually the B.C. Nurses Union. Within that committee was a sub-committee, the Committee to Hear Appeals of Nurses Dismissed from Their Positions.

In the mid-1970s, a process was established for receiving complaints about nurses. When a complaint was received, the nurse in question was interviewed by RNABC's employment referral director. A report was submitted to the Referral and Review Committee, which then made a recommendation to the Board of Directors. If the Board deemed it necessary, a hearing was ordered.

Writing about this new process in the 1975-76 annual report, Ann Sutherland, chairman of the Committee on Social and Economic Welfare, said: "I would like to assure you that the hearings have been very hard on all concerned. This is the first time that board members have had to face such a situation, assessment of peers. It is not an easy thing for any of us: 'Who am I to be judging another nurse? Do I understand all the facts?' The decisions are not taken lightly."

In the 1990s, a comprehensive examination of the RNABC's professional conduct review process was carried out, resulting in a number of recommendations to ensure the discipline process "continues to be fair, flexible and effective" and to make the process more participatory and less adversarial. Changes included the establishment of a staff position – the consumer relations representative – to handle complaints and, where possible, to resolve concerns through a consensual complaint resolution process without having to hold a formal discipline hearing.

Today's Professional Conduct Review process ensures there is a venue in place for receiving, investigating and dealing with complaints about nurses. All complaints, from whatever source, are taken seriously and reviewed to determine if the continued practice of the nurse poses a danger to the public. Some complaints are handled informally – helping people to address their concern by referring them to the most appropriate resource or agency, for example – while others are resolved using a formal process, which may involve CRNBC'S Consensual Complaint Resolution Process.

The most recent change to the process came about with the implementation of the Health Professions Act. It provides for a Health Professions Review Board that functions somewhat as an ombudsman when a complainant or a nurse is not satisfied with CRNBC's decision.

QUALITY ASSURANCE

Quality assurance can mean many things and varies according to industry, profession and even consumer product.

Before the 1970s, quality assurance in the nursing profession referred to the quality of nursing care provided. Today it is synonymous with reflecting on practice, assessing practice and professional growth – all of which are important aspects of registered nursing practice and an obligation of all registered nurses practising in British Columbia.

Although the need for nurses to upgrade their skills was recognized in the 1940s – driven by the combination of changes in patient care, the use of antibiotic drugs and the growing complexity of new medical and surgical techniques and procedures – continuing education came of age in the early 1970s.

For example, in the late 1960s RNABC began investing $5,000 a year in *continuing nursing education* through the University of British Columbia School of Nursing. In 1973, the Association published the Continuing Nursing Education component of an extensive plan for the development of nursing education in B.C. This document included a recommendation, among others, that individual nurses should "assume primary responsibility and accountability for maintaining competence in nursing practice (including recognition of the continuing financial investment necessary)."

In 1977, RNABC began implementing a five-year Safety to Practice program. The program represented a broad approach to assuring nursing competence and touched on nearly every aspect of the nursing profession. The program included evaluating registration procedures, promoting effective performance evaluation programs, helping nurses to ensure their work settings made competence possible, and continuing support of the RNABC Quality Assurance Program. The Quality Assurance Program was developed to evaluate and modify the quality of nursing care. A one-year pilot project at the Matsqui Sumas-Abbotsford Hospital demonstrated the program could be used to evaluate the outcome of nursing care as reflected in a patient's condition; nursing procedures performed; and the organizational structures necessary for the support of these practices.

By 1986, after 12 years of making significant contributions to the development of continuing nursing education in B.C., RNABC'S Continuing Education Approval Committee was disbanded. This was attributed, in part, to the "improved qualifications and planning capabilities of educators in the continuing education field."

In 1993, changes to the Nurses (Registered) Act required RNABC to "establish and maintain a continuing competency program to promote high practice standards amongst members" – a requirement of all provincial health regulatory bodies. In 1996, the Association distributed the discussion paper, *Continuing Competence: A Shared Responsibility*, to begin dialogue with nurses and other key stakeholders on various approaches to continuing competence.

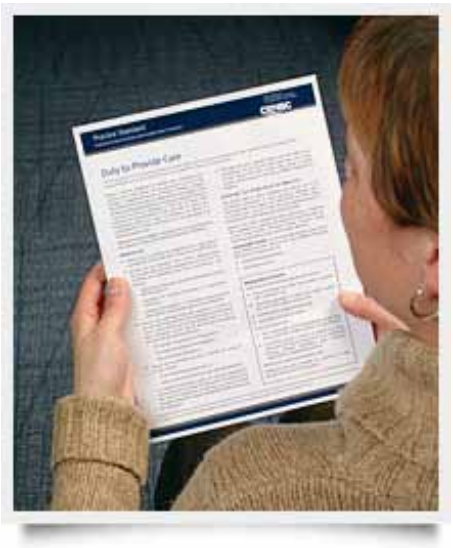
Following extensive consultation and a three-year implementation process, a personal practice review component of the continuing competence requirements for registration renewal went into effect in January 2000.

Due to downsizing and restructuring of the health care system in the 1990s, many nurses were unwilling to work in practice environments that put clients at risk. To help resolve the problem, in 2002 RNABC published *Guidelines for a Quality Practice Environment for Registered Nurses in British Columbia*. The guidelines were developed to assist registered nurses and their employers evaluate and improve practice environments in all practice settings in B.C. Considerable effort was made to bring this initiative to an actionable level through workshops to address issues of workload, nursing leadership, control over practice, professional development and organizational support.

The Quality Assurance Program we know today promotes high practice standards through a proactive approach to improving nursing practice. Its three parts — reflect, assess and grow — help registrants learn, study their own practice, and ultimately improve their practice. While the methods used for reflection, assessment and growth may change over time, CRNBC is committed to quality assurance as an important part of profession-led regulation and professional development.

NURSING STANDARDS

The concern that all registered nurses in British Columbia meet established professional and practice standards was, without doubt, on the minds of those who sought nurse regulation in 1912. But what they could not have imagined was the growing complexity and specialization of the profession over the past 100 years.



The need for established standards came into focus in 1973, beginning with a resolution that RNABC was "on record as supporting the principle that all practising members are required to provide evidence of keeping up-to-date in order to retain their professional standing."

That same year, a priority for the Association was "the development of standards of nursing care." Six task committees were established to address practice standards for extended care, intensive and coronary care nursing, obstetric, pediatric and psychiatric nursing, and emergency care.

It was almost 10 years before the *Standards for Nursing Practice in British Columbia* was published and distributed to all RNABC members. This document defined what the profession expected of its members. The Standards were considered "the criteria against which all registered nurses are measured by consumers, employers, colleagues and themselves."

Following a two-year trial, the Workplace Representative Program was established in 1989 as a provincial network of RNABC representatives who volunteered to be resources for their nursing colleagues and particularly in relation to the Standards for Nursing Practice. The program continued to expand to an increasing number of sites, and in 1998 a Student Representative Program was also developed. The Workplace and Student Representative Programs became part of CRNBC when it was established in 2005 and, five years later, the Workplace Representative Program was renamed the Professional Support Program.

Although standards for nursing care had been established, they remained guidelines and expectations. In the early 1990s, RNABC's legal requirement to "establish, monitor and enforce" standards of practice and standards of education was added as statutory objects under the Nurses (Registered) Act. Today, the Health Professions Act requires regulatory colleges to establish not only standards, but also limits and conditions for registrant's practice as well as standards for academic achievement and registration. In other words, the legislation gives CRNBC the authority to establish standards that are not subject to government approval.

CRNBC's Bylaws require registrants to "conduct themselves in accordance with the standards of practice and the standards of professional ethics."

In 2001, RNABC began working in partnership with the provincial government to implement the nurse practitioner role in British Columbia. The first nurse practitioners graduated in 2005.

Today, CRNBC's Standards of Practice assist nurses to provide competent and ethical care by setting the requirements for practice. There are three categories of nursing standards:

- Professional Standards guide and direct nurses' practice by setting out levels of performance that CRNBC registrants are required to achieve in their practice. They reflect the values of the nursing profession and clarify what the profession expects from nurses.
- Scope of Practice Standards set standards, limits and conditions related to the scope of practice of registered nurses and nurse practitioners under the Nurses (Registered) and Nurse Practitioners Regulation.
- Practice Standards set out requirements related to specific aspects of nurses' practice. They link with other standards, policies and bylaws of CRNBC and all legislation relevant to nursing practice.

ADVOCACY

Although we tend to think of social awareness and advocacy as something that grew out of the 1960s, nurses have been speaking out on health care issues since the turn of the 20th century. Nurses began advocating for their profession when they worked towards securing a registration act from the provincial government, and they were advocates for their patients when, in 1918, the Graduate Nurses Association of B.C. appealed to government to provide care for "mentally defective and delinquent children" and "aged men and women."

A more formalized role in B.C.'s health care system came in the 1970s, when RNABC began lobbying for and was finally included in number of provincial health care planning committees. In 1978, then RNABC president Stephany Grassett challenged nurses to enter the political arena to alter the future of nursing and improve the health care system. Nurses began actively lobbying the federal government to improve the proposed Canada Health Act.

In 1978, RNABC was embroiled in a dispute at Vancouver General Hospital (VGH) when the administration refused to allow the director of nursing access to policy-making on a level comparable to other major Canadian hospitals. The issue was really about how much control nursing should have over its practice, and the outcome was seen as precedent-setting. At the height of the dispute, 800 VGH nurses signed a petition calling for change. Major health and service organizations joined RNABC in supporting the nurses and news media focused attention on the problem. In the end, the health minister stepped in and replaced VGH trustees with a public administrator, changed the hospital's corporate structure and accepted virtually all requests made by RNABC.

RNABC's talent for advocacy reached a new level when provincial hospital budgets were slashed in 1979. Within weeks, nursing staff shortages reached the critical stage – a situation that was dangerous for patients – and nurses began to protest to their hospitals and the public. In 1981, RNABC prepared and published a report entitled, *Nurses: Are We at the Breaking Point?* It concluded that it was time B.C. nurses "threw off the 'slow, cautious and non-assertive approaches' that were part of their heritage."

During the 1980s, RNABC had achieved an increased profile for nursing in B.C., with stepped up political advocacy, public awareness campaigns and representation on numerous committees ranging from education institutions to provincial government advisory committees.

In 1989, RNABC developed the initiative, *New Directions for Health Care*, which articulated the Association's perspective on the future of the health care system. It espoused "registered nurses influencing changes in the health care system instead of merely reacting to them." The plan was based on shifts in nursing and the Canadian health care system, and the belief that "Nursing is moving away from a tradition of trained servitude to expert caring, and nurses themselves are ready for substantive changes in the environments and ways in which they practise." It promoted good practice and the effective use of nurses through activities that facilitate the application of primary health care principles in nursing practice and education. The impact of RNABC'S work was evident in the many aspects of the B.C. government's policy for health care reform, *New Directions for a Healthy British Columbia*, introduced in early 1993.

To show what nurses can do when they are allowed to practise to the full scope of their profession, RNABC established the Comox Valley Nursing Centre Demonstration Project, with a grant from the B.C. government. It was the first nursing centre of its kind in Canada, providing an alternative system of care delivery incorporating the principles of primary health care that allowed nurses to act as an entry point to the existing health care system. Following completion of the two-year project in 1996, the nursing centre changed locations and portfolios several times, and today functions within the Vancouver Island Health Authority.

Throughout the 1990s, RNABC continued to speak out and develop position statements on issues of concern to nurses and their patients.

As a regulatory body under the Health Professions Act, the College of Registered Nurses of B.C. has moved away from political advocacy, as have regulatory colleges throughout the province. Advocating on behalf of the profession is seen to be in conflict with CRNBC's mandate and its responsibility for regulating nurses in the public's interest.

LABOUR RELATIONS

Early nursing was hard work (certainly no different today) and often dangerous. It carried with it the stigma of low wages and relatively low status. Student nurses were worked to the bone and, when they graduated, left hospitals to find positions in private practice.

The first steps in elevating the status and compensation of nurses were registration and standards for nursing education, both important for demonstrating that registered nurses were trained and qualified professionals. But there was still a sense that these women were pursuing a calling and not a career.

Nurses began talking about shorter working hours in 1919, shortly after the Registered Nurses Act was passed, and at a time when the typical nurse was working 12 hours and more a day, six-and-a-half days a week.

In 1930, nurses finally achieved the 10-hour workday. The Canadian Commonwealth Federation (forerunner of the federal New Democratic Party) championed the nurses' cause, repeatedly pressing provincial governments to introduce the 48-hour workweek. In 1937, the government appointed a committee to examine labour conditions in B.C.'s hospitals. Among its recommendations, the committee recommended an eight-hour workday and 96-hour fortnight for nurses. The recommendations were never acted upon.

In 1946, with the Great Depression and the Second World War finally over, nurses' compensation had fallen behind women's salaries in many other occupations. RNABC stepped up to accept responsibility for bargaining on behalf of its members, becoming the first nurses' association in Canada to assist nurses in becoming unionized province-wide. A Charter of Rights for Nurses was established as well as a Labour Relations Committee.

In 1951, Evelyn Hood was appointed the Association's first full-time labour relations officer and collective bargaining for nurses came of age. Stretching its growing labour relations muscles, RNABC recommended strike action to its members after negotiations broke down between the Association and the hospitals in 1957. Strike votes were taken at three hospitals, but the B.C. government backed down at the eleventh hour and the strike was averted.

In 1959, eight B.C. hospitals again rejected a conciliation board report. After repeated refusals from government to meet, RNABC sent a letter stressing that nurses were prepared to strike because they "resented being used by hospitals to fight financial difficulties." The government provided the necessary funding just before the strike was to begin.

In 1976, an autonomous independently-funded labour relations division was created following a Supreme Court ruling that a nursing body could not be both a regulatory body for all nurses and the bargaining agent for staff nurses. The division ended all financial dependence on the Association and relied on income from dues paid by members through salary deductions to ensure there could be no question of management influence on labour relations activities, and no hint of conflict between nurses' economic and professional interests.

In 1980, a legal separation of the Association and the labour relations division was approved by RNABC and the Labour Relations Council of B.C., and the functionally-independent B.C. Nurses Union was founded.

LEGISLATION

The battle for the regulation of the nursing profession in British Columbia has been fought on two fronts: regulation and legislation. From the beginning, regulation was seen as the only way to protect the public by ensuring that nurses registered with the regulatory body of the time were qualified to practise their chosen profession. Legislation was required to enshrine regulation into provincial law.

From 1918 to 1988, legislation was in place that prohibited anyone from using the title "registered nurse" unless that person was registered with RNABC. However, there was nothing stopping a person who was not registered from practising as a nurse in B.C. That finally changed when the provincial government approved RNABC's proposed changes to the Nurses (Registered) Act to make registration with the appropriate regulatory body mandatory for all B.C. nurses.

Other changes to the Act required that nurses wishing to renew practicing membership would have to meet requirements designed to give reasonable assurance of their ability to competently practise nursing. Until then, nurses were only required to meet RNABC standards when they first registered.

In 1992, as the Royal Commission on Health Care and Costs (Seaton Commission) was winding down, and in anticipation of *New Directions for a Healthy British Columbia* issued by the government the following year, RNABC adopted a regulatory framework of promoting good practice, preventing poor practice and intervening when practice is unacceptable. This was done, in part, to provide a guide for the Association for the changes anticipated in professional regulation.


Government approves changes to Nurses act

At the 1993 annual meeting, delegates voted to accept an amendment to the Association's bylaws to permit one-third public representation on a restructured 24-person RNABC board of directors. Coincidentally the B.C. government had adopted a plan for health care reform that included greater public participation in regulatory boards. These public representatives were subsequently appointed by the minister of health and joined the RNABC Board of Directors in the fall.

In another demonstration of public accountability, the government introduced the Criminal Records Review Act in 1996. Designed originally to help protect children from individuals whose criminal record indicates they pose a risk of physical or sexual abuse, the Act was expanded in 2009 to help protect vulnerable adults from physical, sexual or financial abuse. CRNBC is one of many provincial regulatory bodies that require criminal record checks as a condition of registration.

In 1999, RNABC presented a joint submission with the B.C. Nurses Union to the Health Professions Council on the scope of practice for registered nursing in British Columbia. This too was in response to the Seaton Commission, which said that existing legislation governing health professions created "persistent jurisdictional disputes and a distinct lack of cooperation among the health professions" primarily because of its reliance on exclusive scopes of practice.

The Seaton Commission concluded that exclusive scopes of practice should be "narrowed to focus on preventing harm . . . (to provide) . . . more appropriate, cost-effective and timely health care to more patients."

The RNABC/BCNU joint submission included a proposed scope of practice definition that clarified that the purpose of services provided by registered nurses is to promote, maintain and restore health, provide palliation, and prevent illness and injury as well as a proposal that registered nurses be granted several reserved acts.

In March 2000, the Health Professions Council released *Safe Choices: A New Model for Regulating Health Professions in British Columbia*, which included recommendations arising from the legislative and scope of practice reviews of a number of B.C. health professions, including registered nurses. Among the proposed changes was the regulation of registered nurses who achieved competencies required for registration as a nurse practitioner.

On October 23, 2003, the Health Professions Amendment Act was passed in the British Columbia legislature creating a common regulatory framework for the governance of all health professions in the province. Once enacted for registered nurses, it repealed the Nurses (Registered) Act, bringing registered nurses under the Health Professions Act. A significant achievement was that the essence of profession-led regulation – having responsibility for establishing the standards for registered nursing practice and codes of ethics – was not subject to government approval.

On August 19, 2005, the Registered Nurses Association of British Columbia was dissolved and the College of Registered Nurses of British Columbia was established. The College was empowered, under the Health Professions Act, to regulate the practice of registered nurses, licensed graduate nurses, nurse practitioners and student nurses.

Through all the changes in the last decade, the most important aspects of profession-led regulation remain the same. CRNBC's mandate continues to be the protection of the public through regulation.

A new governance structure that came into effect in 2010 has resulted in a smaller Board, with nine elected registrants and five government-appointed members. All registrant board members are elected at large to a three-year term of office.

Restricted activities have been introduced for clinical activities that may present a significant risk of harm and therefore reserved for specified professionals only, such as diagnosing and managing labour. In addition, there are now College-certified practices, which are restricted activities that can only be carried out by registered nurses certified by CRNBC. Categories of certified practice include remote nursing, contraceptive management, sexually transmitted infections and RN First Call.

Unlike its predecessor RNABC, CRNBC does not have a dual role as a professional association and a regulatory body. With its establishment in 2005, CRNBC transitioned from an association to a regulatory college.

As history shows, changes in nursing and the regulation of nurses are more the norm than the exception.

The context of professional nursing has changed dramatically in B.C. over the last 100 years. Nurses are no longer the handmaidens of doctors, nor can they be treated and order about as domestics or servants. Nurses today have much more responsibility and are active participants in the development and delivery of health care services. They bring a strong nursing perspective to today's multidisciplinary approach to health care.

Recognizing that changes in regulation as well as in health care and its delivery will continue to occur, CRNBC continues to take a leading role in protecting the public by effectively regulating registered nurses and nurse practitioners. For example, CRNBC will soon add Multisource Feedback to its Quality Assurance Program. Similar to the onsite peer review process for nurse practitioners, multisource feedback will enable registrants to assess professional performance. It is just another way CRNBC supports nurses' professional growth so they can achieve high practice standards.

Today we live in an era where regulation is evolving perhaps faster than it has in any other time. In recognition of the need for a greater pan-Canadian focus and voice in nursing regulation, CRNBC became one of the founding members of the Canadian Council of Registered Nurse Regulators.

Advances in technology now enable the College to conduct much of its work online, including registration renewal and a comprehensive website housing a breadth of required information for registrants, supports for ongoing learning and development, and useful information for the public and employers.

As we acknowledge the centennial anniversary of the first gathering of nurses committed to legitimizing the nursing profession by achieving a registration act and setting standards to protect the public, today we take pride in being a leader in Canadian nursing regulation. We look forward to the opportunities and challenges ahead as we work to fulfill our public protection mandate.