IN THE MATTER OF: **A determination by the *ad hoc* Chair of the Joint Steering Committee (JSC)**

- and -

IN THE MATTER OF: **The Grievance of Roberta Banfield et al (LPNs)**

BETWEEN:

NOVA SCOTIA GOVERNMENT AND GENERAL EMPLOYEES UNION

(hereinafter called the "UNION")

- and -

NOVA SCOTIA HEALTH AUTHORITY

(hereinafter called the "EMPLOYER")

Counsel:

Gordon Forsyth, Q.C.
Mary Burnet
for the Union.

Tom Groves
for the Employer.

***ad hoc* Chair of the JSC:**

Bruce Outhouse, Q.C.

Hearings held at Halifax, on December 6, 7 and 8, 2017.

DATE OF DECISION: September 23, 2019.

DECISION

This matter has a rather convoluted history. On March 17, 2014, the Union requested a classification review on behalf of five licensed practical nurses ("LPN"s) under Article 42.03 of the collective agreement. The Employer rejected the request for review on the ground that it was not sufficiently documented.

On October 7, 2014, the Union filed a grievance on behalf of the five LPNs alleging that the Employer's refusal to refer the review to the Job Evaluation Committee violated Article 42. The parties subsequently submitted the grievance to me as mediator-arbitrator and a hearing took place on June 3, 2015. Mediation was successful to the extent that the parties were able to reach agreement on a process for resolving their differences with respect to the issue of how the Job Evaluation Committee ("JEC") and the Joint Steering Committee ("JSC") would evaluate changes to existing positions and determine when such changes occurred. The operative paragraphs in resulting Memorandum of Settlement dated July 9, 2015 ("MOS #1") are set out below:

> "1. The parties will establish a committee comprising of Janie Richardson, Dave Collins and Grant Vaughan (the "Committee");

2. The Committee will meet and make best efforts to reach an agreement on what process the Job Evaluation and Joint Steering Committees would use under Article 42 in evaluating substantial changes to the duties and/or responsibilities of a position and how to determine the effect of such changes;

3. If the Committee is unable to reach an agreement under paragraph (2) above, the parties will refer the matter to Bruce Outhouse to develop such a process, after hearing evidence and representations from the parties;

4. The parties agree that the process developed pursuant to either paragraphs (2) or (3) above shall be used in all subsequent classification appeals under Article 42 of the collective agreement;

5. The current LPN classification appeal will be addressed as follows:

a. The Union members shall make a bona fide attempt to particularize the five LPNs' claim of how the duties and/or responsibilities of the position have changed, including the effective date of the changes;

b. The appeal shall then be held in abeyance pending the development of the process described in paragraphs (3) and (4) above;

c. Once a process has been developed, it shall be applied to the current LPNs' classification appeal;

d. In the event that there is a dispute between the five LPNs and their managers regarding their duties and/or responsibilities, such dispute shall be resolved by the Committee through meetings with the LPNs and the managers."

The Committee was established pursuant to paragraph 1 above and subsequently reached agreement on the process for handling requests for review under Article 42.03 of the collective agreement. The process was set out in Memorandum of Settlement #2 ("MOS #2") as follows:

> "1. All requests for review pursuant to Article 42.03(a) of the collective agreement shall include job fact sheets along with a separate, written explanation of how the duties and/or responsibilities have changed, including the effective date of the change(s) (the 'Change Documents');
>
> 2. All employees requesting the review shall approve and sign the Change Documents;
>
> 3. The manager of each employee described above in paragraph 2 shall be given an opportunity to review and either approve or contest the factual allegations contained in the Change Documents prior to the Human Resources Department's decision pursuant to Article 42.03(a) of the collective agreement;
>
> 4. In the event the Human Resources Department rejects a request for review pursuant to Article 42.03(a) because it decides that there has not been a substantial change in the duties and/or responsibilities during the term of the collective agreement and the Union disagrees with that decision, the Employer representative and Union representative of the Joint Steering Committee shall meet and attempt to resolve the disagreement;
>
> 5. In the event that the Employer representative and Union representative are unable to resolve the disagreement, the Union may refer the matter to the Chair of the Joint Steering Committee for a final determination of whether there has, in fact, been a substantial change in the duties and/or responsibilities during the term of the collective agreement;

6. In the event that the Human Resources Department or the Joint Steering Committee determines that there has been a substantial change in the duties and/or responsibilities during the term of the collective agreement, the matter will be referred to the Job Evaluation Committee pursuant to Article 42.03(b) of the collective agreement to determine whether any wage adjustments are warranted;

7. The Job Evaluation Committee shall evaluate the substantial changes against the original factor assessments to determine whether any adjustment to the factors are warranted that would result in an adjustment to the pay rate of the classification;

8. If the Job Evaluation Committee is unable to reach agreement on whether any adjustment to the factors are warranted, the Union may refer those specific issues on which agreement has not been reached to the Joint Steering Committee pursuant to Article 42.03(b) of the collective agreement;

9. This agreement is intended to be used in conjunction with Article 42.03 of the collective agreement, not amend it; and

10. The Union shall withdraw the Grievance."
[emphasis added]

On November 26, 2015, the Union submitted detailed information to the Employer about changes in the job duties and responsibilities of LPNs and the timing of those changes. On March 17, 2016, the Human Resources Department sent an equally detailed rebuttal to the Union and declined the request for review. The Union disagreed with that decision and referred the matter to the JSC. The Employer representative and the Union representative of the JSC subsequently met

in an attempt to resolve the disagreement but were unable to do so. The Union then referred the matter to the Chair of the JSC for final determination in accordance with paragraph 5 of MOS #2. The parties then agreed that I would serve as Chair of the JSC for the purposes of determining "whether there has, in fact, been a substantial change in the duties and/or responsibilities [of the LPNs] during the term of the collective agreement". Thus, my jurisdiction is rooted in paragraph 5 of MOS #2 as *ad hoc* Chair of the JSC and not as a rights arbitrator under the collective agreement.

The JSC's role under Article 42 is to resolve disputes related to "the ongoing administration of job evaluation issues" within the bargaining unit. Because of the fundamental importance of Article 42 to the present case, it is reproduced in full below:

> "**ARTICLE 42 – PAY PLAN MAINTENANCE**
>
> **42.01 Overall Process**
>
> (a) The pay plan process outlined in this provision is intended to provide mechanism for the ongoing administration of job evaluation issues within this bargaining unit. Such issues shall be addressed through the application of the Aiken (Watson Wyatt) job evaluation system.
>
> (b) The parties will maintain a Joint Evaluation Committee as a forum to review job evaluation issues raised through this process and to facilitate their resolution. The

Committee shall be comprised of three representatives from each of the Employer and the Union.

(c) Unresolved issues under this process may be referred to a Joint Steering Committee for binding resolution. The Joint Steering Committee shall include one representative of the Union, one representative of the Employer and a chair to be mutually agreed to by the parties.

42.02 Issues Subject to Review

The following process shall be applied when a new position has been created or where the Employer has initiated a substantial change to an existing position during the term of the collective agreement.

(a) Where a new position is created the Employer may provisionally rate the position pending a review by the Human Resources Department. If both parties are not in agreement with the provisional rate, the matter may be referred for determination through the review process.

(b) Where an employee or either party to this agreement believes that the duties and/or responsibilities of a bargaining unit position have substantially changed during the term of the collective agreement, they may file a request for review. If the parties are unable to agree on a resolution of the matter it may be referred for determination through this review process.

42.03 Review Process

(a) All requests for review shall initially be submitted to the Human Resources Department in Capital Health for determination. Such requests shall include job fact sheets and an explanation of how the duties and/or responsibilities of the position have changed, including the effective date of the change(s). The Union will be provided with copies of any material submitted for the review. The Human Resources Department will issue a decision within 30 days of receipt of the request for review and all other necessary material.

(b) Where a party disagrees with the decision of the Human Resources Department the issue may then be referred to the Job Evaluation Committee for review and decision. The Job Evaluation Committee shall meet within 30 days of

the request to consider the matter. If the committee is unable to reach complete agreement, a party may refer those specific issues on which agreement has not been reached to the Joint Steering Committee for review for a final and binding determination. The Joint Steering Committee shall have 60 days in which to render a decision. Such issues shall be addressed through the application of the Aiken (Watson Wyatt) job evaluation system. When a decision on the issues in dispute has been issued it shall then be referred back to the Job Evaluation Committee for implementation.

(c) Where issues are referred to the Joint Steering Committee for resolution, the Employer and Union representatives shall first meet, before engaging the Chair, and attempt to resolve the referred issues between themselves. Any decisions reached by agreement at this stage shall be considered a decision of the Joint Steering Committee. Only those issues which cannot be resolved by the representatives of the parties may be referred on for resolution with the participation of the Chair.

(d) Any new pay rate arising as a result of a review of a newly created position or a substantially altered position pursuant to paragraph 8 shall be effective from the date the position was created or, in the case of substantially altered positions, the first day of the bi-weekly period immediately following the date of receipt by the Employer of the employee's request for review.

(e) A position may not be the subject of a request for review more than once in any one year period."

[emphasis added]

Historical Evolution of LPN Role

It is common ground that the LPN scope of practice has expanded very considerably in recent years. As a result of their expanded scope of practice, the duties and responsibilities of LPNs have substantially changed. Under the *Licensed Practical Nurses Act* of 2001, it was a requirement that LPNs could "only practice

practical nursing under the general direction of a duly qualified medical practitioner or a registered nurse." However, this requirement was dropped in the 2006 *Licensed Practical Nurses Act* which contains the following definition of practical nursing:

> "2 (ah) 'practice of practical nursing' means the provision of nursing services
>
> (i) independently, for clients considered stable with predictable outcomes; and
>
> (ii) under the guidance or direction of a registered nurse, medical practitioner or other health care professional authorized to provide such consultation, guidance or direction, for clients considered unstable with unpredictable outcomes;"

The 2006 *Act* was not proclaimed until April 14, 2009 and came into force May 1st of that year. In the meantime, the Model of Care Initiative in Nova Scotia ("MOCINS") was launched in March 2008 through a partnership of the Department of Health, the District Health Authorities and IWK. MOCINS designed what came to be referred to as the "Collaborative Care Model" which, among other things, emphasizes the importance of all health care providers working collaboratively within inter-professional teams to their optimal scope of practice.

In the spring of 2008, the parties were in collective bargaining. Some changes in the duties and responsibilities of LPNs had already been implemented

by this time and higher licensure standards were being put in place. In recognition of these changes, the parties agreed to move LPNs to a higher classification effective April 1, 2009 which translated into a wage increase of approximately 6%. This agreement was set out in Memorandum of Agreement #10 ("MOA #10") dated April 23, 2008 which includes the following provisions:

> "The Union agrees to withdraw all requests for review under Article 42 of the collective agreement involving the classifications listed above and that no such requests for review involving these classifications will be initiated during the life of this agreement.
>
> A request for review involving these classifications initiated following the expiry date of this agreement shall only consider changes to the classification made following April 1, 2009."

MOA #10 was not renewed in the 2009-2011 collective agreement for the obvious reason that its effect was spent as of March 31 of 2009. No reviews were requested by LPNs during the term of that agreement. However, as will subsequently be discussed, there were some changes in the duties and responsibilities of LPNs during that two-year period.

Evidence – Changes in Duties and Responsibilities

By agreement of the parties, the hearing was conducted in a mediation-arbitration format. No witnesses gave formal testimony and I met

separately with the parties. Many documents were exchanged and both sides were given the opportunity to explain their respective positions including oral submissions by counsel on the third day of the hearing. Subsequently, both parties filed additional documents and comments, first by the Employer on December 18, 2017 and in response by the Union on January 23, 2018. It should be noted at this point that both parties approached the issue from the perspective of the LPN classification as a whole rather than focusing specifically on the five positions held by the five individuals who initially requested that their positions be reviewed.

I will not attempt to set out in this decision all of the oral and written information that was provided to me in connection with this matter. The written material alone exceeds 2,000 pages. The Union's letter of November 26, 2015 and the Employer's reply of March 17, 2016 contain a useful statement of the respective positions of the parties as they stood at that time. The letters are reproduced below without attachments.

NSGEU
NOVA SCOTIA GOVERNMENT & GENERAL EMPLOYEES UNION

nsgeu.ca
inquirygnsgeu.ca

Mail & Email: Dave.Collinsnshealth.ca
November 26, 2015

Mr. Dave Collins
Manager Labour Relations
Nova Scotia Health Authority
Victoria General Site
1st Fl, Rm 119 Bethune Building
1276 South Park Street
Halifax NS B3H 2Y9

Dear Mr. Collins:

Please accept this as the information regarding timing of changes to be read in conjunction with the previously submitted LPN Job Fact Sheet.

The role of the Licensed Practical Nurse has evolved dramatically over the past decade. In the earlier years the more basic care roles (like feeding, and taking vital signs) were transferred out to non-licenced staff. This set the stage for the LPN to acquire many more nursing skills and for the increasing independence and accountability that is commensurate with the new scope of practice. During the term of the collective agreement that ran from November 1, 2011 to October 31, 2014 the LPN practice was greatly enhanced. Now, in many day to day aspects on the units, the work of the RN and LPN has become interchangeable. There are still distinctions, but those distinctions have been lessening in extent and scope for years, under the direction of the Employer.

Please see the directive from Mary Ellen Gurnham confirming the requirement of both medication and physical assessments skills by end of 2013 (attachment 1). This signaled the compulsory requirement that LPNs execute most of the full nursing protocols right across all the CDHA units and floors.

Throughout 2012, 2013 and 2014, the vast majority of nursing protocols accorded equivalent responsibility to RNs and LPNs in most nursing procedures and accountabilities. There are dozens of examples; here are a few. The Tunnelled Hemodialysis Catheter Learning Module has been revised with the addition of the role of the LPN or RN in assisting the physician. The RN or LPN implements the Target Body Weight (TBW) protocol (attachment 2). All Nurses (RN and LPN) are responsible for mental health protocols, and on 8.2 the LPNs perform cognitive assessments (attachment 3). Only RN and LPN can manage restraints for mental health patients (attachment 4). In the sensitive role of accountability for narcotics, the Medication Reconciliation policy now reads that: The RN/LPN completes the

modules... (attachment 5). Peripheral IV therapy and maintenance came on stream in 2012 and are now considered a basic entry level for RNs and LPNs (attachment 6). LPNs began regularly assisting physicians with bone marrow biopsies and drawing blood cultures. A huge range of Post Entry Level Competencies (PELCs) were now fully expected of LPNs.

Primary Nursing assignments became the norm. This means that the LPNs independently care for own assignment with RN support only if needed rather than assisting an RN. Please see this explicitly verified by a Nurse Manager (attachment 7). All LPNs for example became responsible on unit 8.2 to reference the clinical portal program daily to review lab results and act on any findings that create concern (attachment 3 again).

It was throughout the years of 2012 and 2013 that LPNs gradually began to take on responsibility for maintenance of NG tubes, trach care, and in Neurosurgery, care of the small bore feeding tubes. LPNs own the skill sets inherent in these invasive protocols along with the RNs.

LPNs as College professionals must engage in and demonstrate their continuous learning. See the attachment on LPN Brenda MacDonald's extensive ongoing certifications and training during the period in question (attachment 8). See also, the accreditations of LPN Debbie Henshaw's continuous professional development — Epilepsy education, Stroke workshop, Wound care training, as only a few examples (attachment 9).

The leadership role of the LPN crystalized during the period 2011 to 2014. During these years the LPNs on some units began to function as Charge Nurses, assigning roles to other staff, taking the Charge Nurse Orientation programs (attachment 10). On some shifts RN became only "available" from a distance, not present on site/unit (attachment 11).

LPNs have for a few years now been fully responsible for acting as preceptor for new staff including LPNs and RNs new to floor (attachment 3 again). Public Health LPNs are an Education Resource for all other Health Professionals on the Immunization Line. LPNs during these years became formally responsible for monitoring work of Personal Care Workers, Care Team Assistants, Renal Assistants, LPN students, RN students, and Unit Aides and Orderlies.

RNs and LPNs during this period commenced to be full partners in unit Practice Committees including Orthopedics and Geriatrics for example, and to do chart audits for nursing quality control.

Many CDHA policies demonstrate the increased practice required of LPNs during these years. Three examples...Falls Prevention Programs were rolled out to many LPNs in the autumn of 2012 (attachment 12), Policy CC 55 080 came into effect in August 2013 regarding Negative Pressure Wound Therapy becoming one of many now required competencies. As noted in CDHA Policy CC-03-020, the LPN became one of those responsible for completing the Discharge Summary which is the foundation upon which the receiving facility develops a plan of care. The Transfer of Accountability shows the ultimate responsibility for properly receiving and sending patients can now rest with an LPN (attachment 13).

Attached is a timeline from the LPN College demonstrating the evolution of the scope of practice (attachment 14).

Yours truly,

Odette MacLeod, BA LLB
Employee Relations Officer
/rld
Attachments (14)

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nova scotia
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March 17, 2016

Grant Vaughn
Employee Relations Officer
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255 John Savage Avenue
Dartmouth, Nova Scotia
B3B 0J3

Dear Mr. Vaughn:

Re: LPN Appeal

Further to our meeting of Feb. 12, the following is our response to the Unions' appeal in relation to the substantial changes as reflected in your letter of Nov. 26/2015;

Following is an itemized list of the substantial changes which the union maintains has occurred within the life of the Agreement (since Nov. 1/2011). Our response is listed below the itemized changes with attachments where appropriate;

1. Requirement of medication and physical assessment skills required by the end of October 2013. (Union Attachment 1)

The Union attachment refers to a 2013 memo from Mary Ellen G reminding LPN's of their responsibility to maintain their License by completion of medication and physical assessment competency as required by CLPNNS. The requirement itself was mandated by CLPNNS as part of licensure requirements in 2007. The LPN's who did not have these courses as a part of their program were required to obtain these courses through a five year period (ending Oct 31, 2013). (Employer Attachment #1 LPN Skills Policy dated 2010)

2. The RN or LPN implements the Target Weight protocol (union attachment #2).

The Target Body Weight Adjustment policy was rolled out on April 8, 2009. It included at that time both RNs and LPNs in the hemodialysis satellites only (Employer Attachment #2 Policy dated April 2009)

3. 8.2 LPN's now perform cognitive assessments (union attachment #3)

As confirmed in our meeting that the cognitive assessment has been in place for many years. In this example, it is simply to ask the patient to remember three words Apple, Penny, Watch and then ask them to draw a clock with the hands showing ten past 11. Once they do that they ask them to repeat the three words and based on their response a cognitive score is given. There is an algorithm to follow.

4. Only RN and LPN can manage restraints for mental health patients. (union attachment #4)

The email attachment from the Union refers to a reminder to maintain competency in this practice. The practice itself has been in effect for many years. (this in Emerald Hall)

5. In the sensitive role of accountability for narcotics, the Medication Reconciliation policy now reads that the RN/LPN completes the modules. (union Attachment #5)

While the LPN may have a role in collecting the medication history data the expectation would be the RN review all data assessment findings and determine the next steps/plan of care for a newly admitted patient. As well, the NP and Physician still retrain responsibility to reconcile the medications. This is a long standing practice and the Policy dated 2013 is an update to a prior policy dated 2010 (Employer Attachment #3 Medication Reconciliation)

6. Peripheral IV therapy and maintenance came on stream in 2012 and now are considered basic entry level for RN's and LPN's. (union attachment #6)

Depending on the patient population many LPN's may not perform this function. This became an entry level competency for LPN's and was added to their curriculum in May 2012. (Employer Attachment #4)

7. Primary nursing assignments became the norm. This means that the LPN's independently care for own assignment with RN support only if needed rather than assisting an RN. Please see this explicitly verified by a Nurse Manager (union Attachment #7).

Independent practice in relation to LPN role is not that they are assigned to patients independently; it is that the LPN's can independently execute identified care interventions (within their individual scope of practice) for a patient,-For this to occur, certain parameters need to be met i.e, patient is meeting expected outcomes, patient has an established plan of care and status and anticipated care needs remain anticipated/predictable.- If these parameters are not met there is significant and active RN role required in which the RN will either direct the care interventions the LPN is required to provide or at a minimum the LPN will be responsible to collaborate with the RN. In both situations, the RN is responsible to provide the required oversight and direction and may need to assume the care assignment for the patient.

The specific competencies identified in the email (not-dated) by the Union referring to LPN, J. Christie, have been a part of LPN competency skill set. These skills were referred to in the original LPN appeal of March 28/2007. (see Employer Attachment #5 and JFS dated Feb., 2008, Attachment #6)

8. All nurses (RN and LPN) are responsible for mental health protocols

9. The Tunneled Hemodialysis Catheter Learning Module has been revised with the addition of the LPN or RN in assisting the Physician.

The tunneled CV policy was updated in May 2014 and at that time it was laid out in the learning module what the specific tasks were that the RN and LPN could do to assist the Doctor. This policy has existed for many years as part of the RN and LPN learning. (Employer Attachment #1 LPN skills dated December 2010 page 5 Policy #CCO2-008)

10. LPN's began regularly assisting physicians with bone marrow biopsies and drawing blood cultures.

Assisting with procedures has always been within the role and scope of the LPN. It is important to highlight the role of an LPN in assisting with this is to: position patient, pass items to the physician, label and send the specimen and observe the patient for any bleeding from the small puncture site post procedure (all within scope of practice of an LPN and would not be considered an advanced procedure as it is the physician who is performing the intervention).

11. All LPN's for example became responsible on unit 8.2 to reference the clinical portal program daily to review lab results and act on any findings that create concern (attachment 3).

LPNs do look in the clinical portal to review lab results. Certain LPN's may use the manual method however in other units the process has become computerized. Many lab results impact medication administration which is part of their role so they need to know the normal/abnormal results and notify either the RN they work collaboratively with or the physician. It has always been the expectation on all units to review lab data daily. Not all units use the portal which is the most up to date information.

12. 2012 and 2013 LPN's gradually began to take on responsibility for maintenance of NG tubes, trach care, and in Neurosurgery, care of small bore feeding tubes. LPN's own the skill sets inherent in these invasive protocols along with the RN's.

It is important to specify that the LPN do not own the skill sets as care of one of these tubes or devices is a shared competency between RN and LPN and the delivery of associated care by an LPN is based on an RN assessment of patient acuity/complexity and LPN competency. The actual insertion of NG tubes and small bore feeding tubes rests mainly with a RN scope of practice. Care and maintenance of a new trach would require an RN assessment to determine who (RN or LPN) is the appropriate provider. As well, the practice of LPN providing trach care would only occur in specific units. These functions have been part of the LPN skill set since at least 2007 (see attachment # 1 page 5)

13. LPN's as college professionals must engage in and demonstrate their continuous learning (Attachment 8) see also accreditations

Continuous learning has always been a constant and ongoing job requirement. Reference to JFS (2002 page 2 JFS attachment #7)

14. The leadership role of the LPN crystallized during the period of 2011 to 2014. During these years the LPN's on some units began to function as charge nurses, assigning roles to other staff, taking the Charge Nurse Orientation Programs. On some shifts the RN's became only available from a distance, not present on the site or unit.

Generally speaking LPN's do not function as Charge Nurses on any units. This is typically the role of the RN. The one example referred to by The Union (Emerald Hall) has an RN/LPN model of care. This particular unit has a formal dedicated Charge Nurse who works M-F Days. In exceptional circumstances there may be a 4 hour overlap which the LPN is acting charge nurse. They receive charge pay premium as per collective agreement. There also needs to be an RN on shift in close proximity in case a patient's status changes.

15. LPN's for a few years now have been acting as a preceptor for new staff including LPN and RN's new to the floor.

They could be acting as a resource to demonstrate a clinical skill to a new RN but they do not precept RNs. It is a long standing practice that all employees are expected to precept for new staff as part of the orientation process and as part of their professional responsibility. This has been a constant feature referenced within old Job fact sheet as far back as 2002 (Employer Attachment #7)

16. Public Health LPN's are an Education Resource for all other health professionals on the immunization line.

LPNs triage the immunization intake line, so all calls are answered by an LPN in Public Health. When the calls are related to a change in the plan of care for a client, the LPN is required (by scope) to consult with a Public Health Nurse (RN designated under the Health Protection Act) for recommendations to the plan of care. LPNs must work within their scope of practice and

consultation has been clearly outlined as part of the process of responding to calls from all health care providers who administer publicly funded vaccines. They work within a collaborative practice model, as outlined by both the CLPNNS, and CRNNS in the guidance document: http://cipnns.ca/wp-content/uploads/2013/05/EffectiveUtilizationofRNsandLPNs.pdf

17. LPN's during these years became formally responsible for monitoring work of personal care workers, care team assistants, renal assistants, LPN students, and unit aides and orderlies.

They are not solely or primarily responsible to monitor the work of these individuals. It is a long standing practice that they would be responsible to provide direction and to delegate care aspects/duties within their scope of practice and to communicate effectively with these team members. If there was a gap or issue in performance they would be expected to bring the issue to the employee's attention and inform the IBM as would any licensed professional would be expected to do so according to their standards of practice. (2008 JFS Attachment #6 page 8)

18. RN's and LPN's during this period have commenced to be full partners in unit Practice Committees including Orthopedics and Geriatrics for example, and to do chart audits for nursing quality control.

It has always been standard practice and job description for LPNs to be involved in quality improvement. A component of which is to report inconsistencies in charts in relation to documentation gaps, missing information etc.

19. Many CDHA policies demonstrate the increased practice required of LPN's during these years. Three examples are Falls Prevention Program rolled out to many LPN's fall of 2012; Negative Wound Therapy Policy became one of many now required competencies. Policy CC 03 020, the LPN became of those responsible for completing the Discharge summary which is the foundation upon which receiving facility develops a plan of care. The transfer of accountability shows the ultimate responsibility for properly receiving and sending patients can now rest with an LPN (union Attachment 13).

The ToA document specifically references and defines when an LPN can perform ToA (which depends on patient and patient status) it is not all patients. As well, providing a ToA is an ROP and if the LPN is providing care for a patient would be expected to contribute to the information that needs to be conveyed to another nurse/provider to ensure quality, safe care. (see Employer Attachment # Policy CH30-060 dated December 2010)

20. Attached is a timeline from the LPN College demonstrating the evolution of the scope of practice. (union Attachment #14)

The timeline indicates an evolving LPN scope of practice since 1996. It is clear that the functions referred to by the union as significant changes occurred well before Nov 1, 2011.

Prior LPN Appeal (2007)

It is significant to note that LPN's filed an appeal in 2007 (Attached) That appeal reflects many of the duties which the Union now claims to form part of this new appeal. The prior appeal was

ultimately addressed in the Nov./06–Oct/09 round of bargaining in the form of an MOA 10 (Attached) This resulted in a 6% pay adjustment for all LPN's in order to recognize the increased scope of LPN practice

2002 JFS/2008 JFS

A comparison between these documents and the most recent IFS submitted by the LPN's reflect very little if any difference in actual job function. While it is fair to say that the LPN scope of practice has itself evolved over the years, these evolutionary changes have all been incorporated into the role well before Nov./2011as part of the licensure change in 2007.

LPN group Appeal

It is our understanding that all NSGEU LPN's are represented by this Appeal. This means that in order for a substantial change to be eligible for review by the Committee, all LPN's must have experienced the change within the life of the Agreement (since Nov/2011). That is clearly not the case. Once again, this has been an evolutionary process within the LPN scope of practice which began in 2007. Depending on the specific work unit and patient population, LPN competencies and job functions were added to the role at various points in time over the years. The Appeal does not identify any such function which occurred after Nov., 2011. If there are any duties which did arise after 2011, they would at best be no more than a variation of a prior function which in itself would not be considered a substantial change for the purposes of this exercise.

In order for the Committee to consider an Appeal, all employees who form part of the Appeal must identify substantial changes which have occurred during the term of the agreement (since Nov. 2011). In consideration of the above, we are of the view that no such changes have been identified.

Further to the protocol that was agreed within your email of Aug. 7, please advise how you wish to proceed.

Sincerely,

Dave Collins
Manager, Labour Relations and HR Consulting
Nova Scotia Health Authority
cc: Janie Richardson
Mary Ellen Gurnham

At the outset of the hearing, the Union circulated a four-page "Timeline of Changes" consisting of 26 separate items. This document was the central focus of discussion throughout mediation. Consequently, it is appropriate to use it as a template for summarizing the relevant factual background and the sometimes conflicting positions of the parties with respect to the timing and significance of changes in the duties and responsibilities of LPNs. Generally speaking, the Employer did not take the position that the changes in the Timeline document had not occurred but, rather, it questioned their incremental significance and when they occurred. The Timeline is reproduced below with comments by the Employer and responses by the Union inserted on an item-by-item basis where applicable.

Timeline of Changes

1. **May 1, 2009** – *Licensed Practical Nurses Act, 2006, c. 17, and Licensed Practical Nurses Regulations*, NS Reg 197/2009 *come into force, increasing licensed practical nurses' (LPNs) scope of practice to allow them to provide nursing services* independently for clients considered stable with predictable outcomes. Under the 2006 *Act*, LPNs are required to complete Continuing Competency Programs (CCPs) by performing ongoing self-assessments of their competency, identifying learning needs and/or goals, and developing, implementing and evaluating a plan of action to meet their learning needs or goals. The College of Licensed Practical Nurses of Nova Scotia (CLPNNS) becomes responsible for auditing LPNs' CCPs.

Employer Comments: None

2. **September 2009** – "Patient Support Worker Skills," CC 02-009 is issued by CDHA/NSHA (reissued as "Care Team Assistant (CTA) Skills (formerly Patient Support Worker Skills)," CC 02-009 in March 2012). Policies specify that PSWs (CTAs) assist and are supervised by LPNs and RNs.

Employer Comments: None

3. **October 2009** – "Initial Management of Anaphylaxis Following Immunization," MM 20-005 is issued by CDHA/NSHA, specifying that this is a post-entry level competency (PELC) for registered nurses (RNs) and LPNs in specifically approved practice settings.

Employer Comments: The documents and original rollout relating to the enhanced role of LPNs in the Immunization program began in 2008. This particular change was not mentioned in the Union's letter of November 26, 2015.

Union Response: The LPNs did start doing school immunizations in 2008 but RNs were also involved and the LPNs reported to the RNs until 2013 when the RNs were assigned to other duties and the LPNs now run the program and are responsible for the initial management of anaphylasis.

4. **October 2010** – "Enteral Nutrition, Administration of," CC 25-021 is issued by CDHA/NSHA, specifying that administration of enteral nutrition via a nasogastric, orogastric, gastronomy or jejunostomy tube is a basic nursing procedure for RNs and LPNs.

Employer Comments: LPNs commenced doing tube feeds at the Rehab Centre in 2008 and tubes feeds are included in the list of PELCs issued in February of 2008.

Union Response: The Eating Disorders Clinic tube feeds were performed by one RN and one LPN until 2011 after which they were performed by two LPNs for a period of approximately 5 years. Starting in 2012, the LPNs no longer worked alongside an RN but directly with the physician, planning admissions and developing care plans.

5. **October 2010** – "Medication Reconciliation, MM 50-003 is issued by CDHA/NSHA (reissued March 2015). LPNs are included as team members involved in the care of the patient in implementing the policy.

Employer Comments: Participating in medication reconciliations is tied to LPNs giving medications which they began doing prior to 2009. The 6% increase which the LPNs received covered the performance of this particular duty although it was perhaps granted "a little early" (i.e., before LPNs actually started giving medications).

Union Response: LPNs started doing medication reconciliations in 2010. However, the rollout was phased in and some LPNs did not start doing them until 2013.

6. **December 2010** – "Transfer of Health Information Between Facilities," CH 30-060 is issued by CDHA/NSHA (reissued October 2013 and July 2015 as "Transfer of Patient's Health Information (Facility to Facility, Unit to Unit, Shift to Shift & Episodic Care

Transfers)," CH 07-060), specifying that LPNs may be the transferring and/or accepting care provider, depending on patient circumstances.

Employer Comments: This is not a change. LPNs have been doing the documentation required to support the Transfer of Accountability (TOA) process. Discharge planning is one of the work activities included in the LPN job fact sheet submitted by LPNs for review dated February 26, 2008.

Union Response: TOA is not part of discharge planning. It's a transfer from service to service. Prior to the change in 2010, LPNs did not accept or receive transfers.

7. **December 2010** – "LPN Skills," CC 02-008 is issued by CDHA/NSHA (revising January 2008 version). In December 2010 version, several changes are made to LPN skills, including:

- Added as PELC: Hemodialysis Access – various skills
- Added as PELC: Infusion Therapy – insert peripheral IV access device
- Added as PELC: Medications – Administer vaccinations or inoculations
- Added as PELC: Specimen Collection – Troponin testing (Point-of-care testing)
- Added as PELC: Wound Care – Insert and remove packing to surgical or deep wounds with established treatment regimes

Employer Comments: Hemodialysis access was a PELC in the January 2008 version of "LPN Skills". While it is true that administering vaccinations or inoculations was added as a PELC in 2010, the practice did not change in 2010. With respect to specimen collection, troponin testing was added as a PELC in 2010. Wound care was added as a PELC in 2010 but it was not previously on the "do not do list" and it is a gray area.

Union Response: The LPNs' scope of practice with respect to hemodialysis has increased considerably. Since 2012 LPNs troubleshoot problems with central venous catheters rather than relying on RNs to solve the problem. In the satellite dialysis clinics they also do initial needling. With respect to wound care, LPNs were previously restricted to caring for wounds up to 2 centimeters. Now they insert and remove packing in surgical and deep wounds with established treatment regimes. They can also care for larger wounds once they have achieved competency in Advanced Wound Care.

8. **2012** – *CLPNNS informs LPNs that* peripheral IV insertion, initiation of IV therapy, administration of IV medications (both intermittent bolus and in limited circumstances, direct IV push), and blood therapy competencies have become ELCs for LPNs.

Employer Comments: Agreed that these are new ELCs for LPNs.

Union Response: IV therapy has become an ELC for LPNs and the LPNs' role in infusion therapy is increasingly independent of RN participation. LPNs are now required to have blood therapy competencies as a basic skill but the Employer is not utilizing them.

9. **April 2012** – "Suicide Watch – Offender Health Services," CH 65-036 is issued by CDHA/NSHA (reissued February 2015), specifying that LPNs are to assess offenders who have been identified as requiring enhanced rounds/a special watch to ensure against the potential of suicide, and that following assessment, LPNs are to determine if the offender requires a suicide watch until further assessment can be completed by a psychiatrist.

Employer Comments: LPNs do not assess offenders for suicide risk but monitor patients who are put on suicide watch. The February 26, 2008 LPN job fact sheet doesn't specifically mention suicide watch for offenders but does refer to observation of confused patients in other areas to prevent self-injury as well as participation in weapon and drug searches.

Union Response: None

10. **September 2012** – CLPNNS releases a new Continuing Competency Profile (revising 2008 version) with the following changes:

Competency / Requirement	**2008 CP**	**2012 CCP**
"Performing an ongoing self-assessment of their competency in their current context of practice; identifying learning needs and/or learning goals; and developing, implementing *and evaluating* (using critical reflection) a plan of action to meet their learning needs or goals."	--------	Required (p. xii)
"Intradermal medication administration"	Advanced (p. 205)	Entry-Level Competency (ELC) (p. 194)
"Initiate, flush, monitor and discontinue heparin and saline locks in established peripheral infusion sites"	Advanced (p. 218)	ELC (p. 207)
"Identify common IV puncture sites	Advanced (p. 219)	ELC (p. 208)
"Provide medications and fluids via hypodermoclysis"	Advanced (p. 222)	ELC (p. 211)
"Initiate hypodermoclysis infusion"	Advanced	--------

	(p. 222)	
"Initiate, assess, monitor, maintain, regulate, and evaluate hypodermoclysis infusion"	--------	ELC (p. 211)
"Monitor and regulate administration of blood or blood products"	ELC (p. 225)	--------
"Initiate, assess, monitor and regulate administration of blood or blood products"	--------	ELC (p. 214)
"Compare actual assessment findings to expected findings" and "consult appropriate care provider when assessment findings: are not as anticipated, changed or new; client is not achieving intended outcomes; status is becoming variable or less predictable"	--------	Required (pp. (pp. 16, 54, 70, 80, 81, 85, 86, 89, 91, 94, 97, 100, 102, 105, 108, 109, 112, 119, 132, 139, 142, 143, 157, 164, 168, 173, 187, 188, 199 x2, 214, 262, 266, 270, 287, and 297)

Employer Comments: Despite the above changes in ELC requirements, LPNs do not prepare patient care plans.

Union Response: LPNs must meet the ELC standards in order to maintain their license. They have changed very significantly since 2009 and after the MOCINS report came out in the fall of 2010.

11. **October 2012** – "Falls Prevention Program" memorandum is sent by CDHA/NSHA to Satellite Dialysis Clinics, specifying that LPNs are to complete fall risk assessments.

Employer Comments: This doesn't require any particular training and should have always been part of the LPN role in providing patient care.

Union Response: Under the new policy LPNs are required to fill out a Fall Prevention form on a daily basis and attach it to the patient's chart. Previously, LPNs only prepared post-incident fall assessment reports and they had to be signed off by an RN.

12. **November 2012** – "Oxygen Cylinders," CC 06-085 is issued by CDHA/NSHA, specifying that the use of oxygen cylinders, including the adjustment of flow rate as per the physician's order, is an ELC for LPNs.

Employer Comments: The new policy simply describes a method and procedures for handling oxygen cylinders.

Union Response: LPNs check the SAT levels of patients and can increase oxygen flow if needed without consulting the physician. There is a significant safety issue with the use of oxygen and the handling of oxygen cylinders.

13. **2013** – CLPNNS Standards of Practice document is released, emphasizing increased leadership and accountability of LPNs.

Employer Comments: None

14. **August 2013** – "Negative Pressure Wound Therapy (NPWT)," CC 55-080 is issued by CDHA/NSHA, specifying that this is a PELC for LPNs.

Employer Comments: This is not a new policy or change in duties/responsibilities for LPNs. Negative Pressure Wound Therapy was previously known as Vacuum Assisted Closure Therapy (VAC Therapy). A very similar policy covering VAC Therapy was issued in June of 2009.

Union Response: The VAC Therapy policy was issued after the new* Licensed Practical Nurses Act *and associated Regulations came into effect on May 1, 2009 increasing the LPN scope of practice to allow them to provide nursing services independently for clients considered stable with predictable outcomes. Thus, the Negative Pressure Wound Therapy policy can be seen as a newly-codified policy for the purpose of the present review request.

15. **October 2013** – "Venipuncture for Blood Specimen Collection," CC 85-079 is issued by CDHA/NSHA, specifying that this is a PELC for LPNs.

Employer Comments: Venipuncture for Blood Specimen Collection was listed as a PELC for LPNs in CC 02-008 and CC 02-010 which were issued in January 2008 and February 2008 respectively.

Union Response: Venipuncture is now an ELC for LPNs and they collect blood specimens on a regular basis.

16. **October 31, 2013** – Deadline by which LPNs must complete mandatory upgrades in Medication Administration and Physical/Health Assessment as a condition of licensing and employment.

Employer Comments: None

17. **November 2013** – "Care of Peripherally Inserted Central Catheters (PICC)," CC 80-018 is issued by CDHA/NSHA, specifying that identified components are PELCs for LPNs.

Employer Comments: The dressing change for a PICC line is relatively simple. It was identified as a PELC for LPNs in policies CC 02-008 and CC 02-010 issued in January 2008 and February 2008 respectively.

Union Response: None

18. **January 2014** – "Central Venous Access Device (CVAD) – Umbrella Policy," CC 80-021 is issued by CDHA/NSHA, specifying that this is a PELC for LPNs.

Employer Comments: Care of CVADs was listed as a PELC for LPNs in policies CC 02-008 and CC 02-010 which were issued in January 2008 and February 2008 respectively. The LPNs working in hemodialysis clinics do use CVADs to give meds as part of the normal standard of care.

Union Response: There is a high risk with the drug used in hemodialysis and a new one (Fragmin) was added on October 30, 2017. Care of CVADs is now an ELC for LPNs but not all do it, depending on where they work, and only LPNs working in the ICU, ECU and Hemodialysis do "IV push".

19. **October 2014** – "Medicinal Marihuana - Use of by Authorized Users as inpatients in Capital Health Facilities," MM 20-021 is issued by CDHA/NSHA. LPNs implement the policy as members of the healthcare team.

Employer Comments: LPNs and other hospital staff are not permitted to become involved in the handling or administration of medicinal marihuana. The patient has to be able to self-administer the drug.

Union Response: LPNs need to be aware of their role and are accountable for administering the policy. They also have to educate themselves on the interaction of medicinal marihuana with other drugs.

20. **January 2015** – "Peritoneal Dialysis (PD); Care of the Patient Receiving," CC 50-065 is issued by CDHA/NSHA, specifying that components of the policy are PELCs for LPNs.

Employer Comments: Peritoneal Dialysis was listed as a PELC for LPNs in CC 02-008 and CC 02-010 which were issued in January 2008 and February 2008 respectively. Some patients in the Veterans Building are on long-term dialysis and the LPNs are trained for that function.

Union Response: Previously, LPNs were only involved in the administration of peritoneal dialysis on Floor 6B. Now it is being done on many units.

21. **March 2015** – "Medication Orders," MM 15-003 is issued by CDHA/NSHA. Health Care Providers, including LPNs, follow the policy.

Employer Comments: None

22. **March 2015** – "Peripheral I.V. Therapy Initiation and Maintenance," CC 80-019 is issued by CDHA/NSHA, specifying that an LPN may insert a peripheral I.V. with an authorized prescriber's order, and may initiate I.V. infusions with standard maintenance I.V. hydration solutions without added medications or electrolytes. This is a revision of the January 2007 version of the policy, which specified that this was a PELC for RNs only.

Employer Comments: LPNs are now involved in initiating I.V. Therapy and the program is still being rolled out across the system. Initiation of I.V. Therapy was previously done by RNs.

Union Response: None

23. **September 2015** – "Skin and Wound – Assessment, Prevention & Documentation," CC 55-045 is issued by CDHA/NSHA, specifying that the assessment and documentation of all patients' risk of developing pressure ulcers is to be performed by LPNs, and that the assessment and documentation of patients' wounds is to be performed by LPNs.

Employer Comments: This policy prescribes the Braden Scale for predicting ulcer (bedsore) risk. LPNs are required to be trained in its use as a basic competence.

Union Response: In addition to doing the assessments using the Braden Scale, LPNs also initiate skin care plans.

24. **September 2015** – "Post-Entry Level Competencies" CC 02-010 is issued by CDHA/NSHA (revising February 2008 version). The 2015 version newly lists "Transfusion – Blood and Blood Products" as an ELC for LPNs, and no longer lists "Transcription of Medications – 7.3 QEII" as a PELC, as it is encompassed by the mandatory competency of Medication Administration.

Employer Comments: None

25. **January 18, 2016** – "Blood Transfusions: Administration of Blood, Blood Components and Blood Products," CC 75-005 is issued by CDHA/NSHA, specifying that verification of blood, blood components and blood products can be performed by LPNs.

Employer Comments: LPNs cannot sign off for (verify) blood, blood components or blood products. The policy clearly states that verification can only be performed by two Health Care providers as long as one of those signing is the transfusionist. The policy further states that an LPN may be a verifier but not a transfusionist.

Union Response: Two LPNs can now do the typing and crossmatch. They also get everything ready for the transfusion and monitor the patient for reaction once the transfusion is in progress.

26. **March 6, 2017** – "Licensed Practical Nurses (LPN) Administration of Intravenous (IV) Medication," CL-AP-015 is issued by CDHA/NSHA, specifying that the administration of IV medication is an ELC for LPNs.

Employer Comments: The administration of IV medication by LPNs is new and is still being rolled out. This is just a different way of giving medications.

Union Response: LPNs possess the required competence and the Employer's change of policy allows them to better fulfill their scope of practice.

Following the hearing, the Employer submitted three additional documents – the initial VAC Therapy policy dated June 2009; Head Count of LPNs in the Various Units of NSHA's Central Zone; and a High Level Summary of LPN Work on Various Units. The latter document is reproduced below:

Prepared by Interprofessional Practice & Learning, Central Zone (December, 2017)

LPN Practice

	LPN Practice (Inpatient Units)		
Unit	**Service/Focus**	**Some Examples of Context/**Typical Skills**	**Other** (example: staffing model)
38	ENT	**Typical Optimized Skills:** IV Therapy, Blood draws, Trach Care (not cuff care, corking or instillations), VAC (negative pressure wound therapy) dressings.	*RN/LPN Trach Care: RN needs to determine if appropriate for LPN based on RN assessment. Trach policy in effect since 2007 or longer VAC: Only RN can determine the pressure setting for this therapy. RN most perform initial wound assessment & perform dressing. Then LPN can perform once treatment plan established. VAC dressing skill has been in place for LPN for over 10 years.
48	**Transitional Care**	This subacute unit has an RN Charge and an RN (24/7) as part of the planned staffing. While there may be an occasion where the LPN may have to assume "administrative charge duties' such as fire warden when the RN is from External Agency there is always an RN for oversight, collaboration and direction for patient care needs. Typically, the majority of the patient population requires an RN/LPN collaborative assignment. **Typical Optimized Skills:** Collaborating	RN/LPN/CTA Approximate Budget FTEs: RN=6.20 LPN=10.0

Prepared by Interprofessional Practice & Learning, Central Zone (December, 2017)

		with RN in Care of Patients with Responsive Behaviors & Required Behavioral Plans	
5A	Gynecology/Oncology	**Typical Optimized Skills:** IV Therapy, blood draws, may get some VAC dressing	*RN/LPN VAC: same as above
5B	Urology	**Typical Optimized Skills:** IV Therapy, blood draws, may get occasional VAC dressing	*RN/LPN VAC: same as above
6A	Thoracic Surgery	**Typical Optimized Skills:** IV Therapy, blood draws, PIC line dressing, Chest Tubes	*RN/LPN Chest Tubes: Basic competency- dressing change and document drainage only other duties fall to RN
7A	Palliative	Many of the Typical Optimized Skills would not be applicable or infrequent given the focus of care for this unit.	*RN/LPN/CTA
9A	GI	**Typical Optimized Skills:** IV Therapy, blood draws, PIC line dressing, VAC dressings, care of NG tube but not insertion	*RN/LPN VAC: same as above
4.1	Vascular/Gen Surgery	Typically, the care needs for this patient population are complex and acute. The post-op period can at times be unpredictable. As such the care model on this unit requires a higher number of RNs as part of the planned staffing model. Typically 60% of patients require an RN assigned and others would require frequent RN oversight and collaboration when LPN is assigned. There is also an IMCU attached to this unit that is staffed with RNs only. **Typical Optimized Skills:** IV Therapy, blood draws, PIC line dressing, may get some VAC dressings	*RN/LPN VAC: same as above Approximate Budget FTEs: RN=38.0 LPN=10.0

Prepared by Interprofessional Practice & Learning, Central Zone (December, 2017)

7.2	Ortho	**Typical Optimized Skills:** IV Therapy, PIC Line dressing, blood draws, may get some VAC dressings	*RN/LPN VAC: same as above
7.3	Neuro-Surgery	**Typical Optimized Skills:** IV Therapy, blood draws, PIC line dressing, perhaps the occasional small bore feeding tube	*RN/LPN Feeding tubes: LPN NG tube insertion is restricted to only small bore feeding tubes and can only be performed in approved practice settings where this is a frequent patient need. This has been in effect for over 10 years.
7.4	Neurology	**Typical Optimized Skills:** IV Therapy, blood draws, occasional PIC line dressing, perhaps the occasional small bore feeding tube	*RN/LPN Feeding Tube: same as above
8.1	Ortho	**Typical Optimized Skills:** IV Therapy, PIC Line dressing, blood draws, may get some VAC dressings	*RN/LPN VAC: same as above
8.2	Medicine Teaching Unit	The majority of patients on the unit on a typical day either require an RN (approx. 50%) or an RN/LPN (approx. 40%) collaborative assignment. Majority of patients are admitted from ED setting and so significant role for RN to help interpret initial assessment findings, determine appropriate nurse provider and determine initial plan of care. **Typical Optimized Skills:** IV therapy, blood draws, PIC dressing, may get some VAC dressings.	*RN/LPN VAC: same as above Approximate Budget FTEs: RN=35.0 LPN=16.0

Prepared by Interprofessional Practice & Learning, Central Zone (December, 2017)

8.3	Ortho/Medicine	**Typical Optimized Skills:** IV Therapy, blood draws, occasional PIC line dressing, may get some VAC dressings	*RN/LPN VAC: same as above
8.4	Hospitalist Medicine Unit	**Typical Optimized Skills:** IV Therapy, blood draws, occasional PIC line dressing, may get some VAC dressings	*RN/LPN VAC: same as above
9Lane	Subacute	**Typical Optimized Skills:** IV Therapy, blood draws, occasional PIC line dressing, may get some VAC dressings	RN/LPN
GRC	Subacute	**Typical Optimized Skills:** occasional PIC line dressing, may get some VAC dressings, may get some care of feeding tubes (LPNs do not insert)	RN/LPN
Veterans	Long Term Care	**Typical Optimized Skills:** occasional PIC line dressing, may get some VAC dressings, may get some care of feeding tubes (LPNs do not insert)	RN/LPN/CTA VAC: same as above
Rehab Inpatient Units	Rehab Medicine (sub-acute)	Many of the patients could be assigned to the LPN for the delivery of care interventions, however, the RN would be responsible to develop the initial plan of care, provide interventions that are outside LPN scope (such as care of an occluded PIC line) and provide consultation and direction if patient experiences a change in status. **Typical Optimized Skills:** Blood draws, may get some VAC dressings	RN/LPN/CTA VAC: same as above Approximate Budget FTEs for 5th Floor Rehab: RN=11.50 LPN=8.80
Mental Health	Acute and Sub-acute units	Many of the skills listed above would not be applicable. If patient requires restraints or seclusion it is the RN who is accountable to take the lead with the team and collaborate with the physician. It is the RN role to debrief with staff. Suicide Risk or Imminent Risk assessments are in scope for RN.	Acute: RN/LPN Subacute: RN/LPN/Support Role
NRT	Nursing Resource Team	Contingent upon which unit the LPN staff are being deployed	RN/LPN (predominantly RN compliment)

*Planned RN/LPN staffing mix allows for a higher planned RN staffing complement within the models given the acuity/complexity and care needs of the patient. Examples have been highlighted in comment section. ** Typical Skills: Routine Medication Administration (oral, subcut etc.) would be required of the LPN in all of the practice settings. IV Therapy (insertion of an IV) is the most recent skill added to LPN scope of employment and has been in effect since **2015.**

The Union responded to the Employer's supplemental filing by letter dated January 23, 2018. The section of the letter which deals with the Employer's high level summary of LPN work is set out below:

3) The "high level summary" of LPN work on various hospital units

The Union submits that it is not appropriate within the context of this review to consider changes to the LPN position by individual hospital unit. Rather, changes to the LPN position should be considered as a whole.

The Union submits that LPN competencies, responsibilities, and accountability are not limited to the "Typical Optimized Skills" listed in the Employer's document. As set out by the Union at the hearing and supported by documents included in the Union's Books of Documents, many competencies and responsibilities have been newly required of LPNs by the College and the Employer, or codified by the Employer for the first time as individual detailed policies, since the coming into force of the *Licensed Practical Nurses Act, 2006, c. 17,* and *Licensed Practical Nurses Regulations,* NS Reg 197/2009 on May 1, 2009.

These competencies and responsibilities include:

- VAC / Negative Pressure Wound Therapy dressing changes following initial dressing application as a Post Entry Level Competency ("PELC");
- Initial Management of Anaphylaxis Following Immunization as a PELC;
- Administration of Enteral Nutrition as a "basic nursing procedure," which is administered via a nasogastric
- (NG), orogastric, gastrostomy, or jejunostomy tube;
- Medication Reconciliation;
- Transfers of Patient Health Information;
- Infusion Therapy as a PELC;
- Wound Care as a PELC;
- Medication Administration as a mandatory competency;
- Physical/Health Assessment as a mandatory competency;
- Comparing actual assessment findings to expected findings and consulting appropriate care provider(s), constituting a significant increase in LANs' requirements for critical thinking, independence, accountability and leadership in relation to practical competencies;
- Intradermal medication administration as an Entry Level Competency ("ELC");
- Initiating, flushing, monitoring and discontinuing heparin and saline locks in established peripheral infusion sites as an ELC;
- Identifying common IV puncture sites as an ELC;
- Peripheral IV insertion and administration of IV medications (both intermittent bolus and in limited circumstances, direct IV push) as an ELC;

- Providing medications and fluids via hypodermoclysis as an ELC;
- Initiating, assessing, monitoring, maintaining, regulating, and evaluating hypodermoclysis infusions as an ELC;
- Initiating, assessing, monitoring, and regulating administration of blood or blood products as an ELC;
- The use of oxygen cylinders, including the adjustment of flow rate as an ELC;
- Suicide watch in Offender Health Services;
- Falls risk assessments;
- Venipuncture for Blood Specimen Collection;
- Care of Peripherally Inserted Central Catheters (PICC lines);
- Care of Central Venous Access Devices (CVADs);
- Implementing the Medical Marihuana Policy;
- Components of Care of Patients Receiving Peritoneal Dialysis, including:
  - Collaboration with the RN about patient fluid assessment data, PD prescription orders and cycler programming prior to performing the procedure;
  - Ongoing assessment of the CAPD/CCPD procedure and reporting to the RN of any complications or abnormal findings during the procedure, and
  - Documentation of completed procedures performed, patient outcomes and data from the CAPD or CCPD exchange on the CAPD/CCPD record sheet;
- Recognizing and flagging any inaccuracies on Medication Orders;
- Insertion of a peripheral I.V. and initiation of IV infusions with standard maintenance IV hydration solutions;
- Skin and Wound Assessment, Prevention & Documentation for bed sores;
- Transfusion of blood products as an ELC, and verification of blood, blood components and blood products; and
- Administration of IV Medications.

When a competency is newly designated as an ELC, all LPNs who have already graduated from the LPN program and are in practice are expected to update their competency to align with these new basic expectations for their practice. For example, to achieve the new ELCs of initiation of IV therapy, administration of IV medication, and blood therapy competencies, LPNs were required to:

1) Complete an accredited/approved post-graduate IV/Blood therapy program, such as one at the Nova Scotia Community College; or
2) Complete an employer-based educational program consisting of a learning module and clinical learning opportunity.

When a competency is newly designated as a PELC and the Employer requires an LPN to perform it, LPNs must undergo training. Though not all PELCs will be required of all LPNs working on all units, the Union submits that the addition of multiple PELCs that LPNs may be required to train for and perform contributes significantly to the substantial change the LPN position has undergone.

As well, when all LPNs became required to be competent in Medication Administration and Physical/Health Assessment, this meant that practicing LPNs had to complete an approved Medication Administration and/or Physical/Health Assessment course where required as a condition of licensing and employment.

While not every LPN working on every unit will be required to perform each of the above-listed competencies on a daily basis, many of these competencies are performed by LPNs daily. The fact that all LPNs must become competent to perform new ELCs and new mandatory competencies, and that LPNs must update their competency to perform new PELCs whenever required by the Employer to do so, constitutes a substantial change to the LPN position.

The Union agrees that LPNs practice the listed "Typical Optimized Skills" (among many others) in each of the named units in the Employer's "high level summary", with the caveat that these skills should not be limited by language such as "may get some VAC dressings", "perhaps the occasional small bore feeding tube", or "occasional PIC [sic] line dressing". Pursuant to College documents and Employer policies submitted by the Union at the hearing, the practice of these competencies may be required of LPNs at any time. The Union submits that the frequency with which LPNs practice these competencies, as determined from time to time by patient need, is irrelevant to the consideration of whether there has been a substantial change to the LPN position.

The Union specifically disagrees with the following representations in the Employer's "high level summary":

- The Employer fails to include the following Typical Optimized Skills for LPNs in unit 3B: ENT: care and monitoring of NG tubes, medication reconciliation, and verification of blood products;

- The Employer fails to include the following Typical Optimized Skills for LPNs in unit 5A: Gynecology/Oncology: care of NG tubes, verification of blood products, medication reconciliation, and application of PICC line dressings;

- The Employer fails to include the following Typical Optimized Skills for LPNs in unit 5B: Urology: care of NG tubes, verification of blood products, and application of PICC line dressings;

- The Employer fails to include the following Typical Optimized Skills for LPNs in unit 6A: Thoracic Surgery: VAC dressing changes, insertion and care of NG tubes, medication reconciliation, verification of blood products, insertion and maintenance of IVs, and application of MCC line dressings;

- The Employer states that in unit 7A: Palliative, "Many of the Typical Optimized Skills would not be applicable or infrequent given the focus of care for this unit." The Union submits that this is not accurate. LPNs in the Palliative Care unit: insert and maintain IVs, care for NG tubes, apply PICC line dressings, administer medication including methadone and high dose pain medication, perform medication reconciliation, verify blood products, and apply complex dressings for wound care;

- The Employer states that in units 9A: GI, GRC: Subacute, and Veterans: Long Term Care, LPNs care for but do not insert NG tubes. Though the Union has not been able to verify whether LPNs in these units insert NG tubes in practice, policy CC 25-021: Administration of Enteral Nutrition (Union's Book of Documents, Vol. III, Tab 33)

states that administration of enteral nutrition via a nasogastric (NG), orogastric, gastrostomy, or jejunostomy tube is a "basic nursing procedure" for RNs and LPNs. LPNs may therefore insert NG tubes when necessary.

- The Employer's statement that in units 7.3: Neuro-Surgery and 7.4: Neurology, "LPN NG tube insertion is restricted to only small bore feeding tubes" acknowledges that LPNs do insert NG tubes when necessary. Regarding the alleged restriction to small-bore tubes, the Union notes that this is not a limitation on LPN competencies, but rather a procedural preference for using small-bore NG tubes, regardless of the health care practitioner inserting the tube. The Administration of Enteral Nutrition policy states at page 3 under "General Procedures":

  2. Avoid using large-bore nasogastric tubes as feeding tubes as they carry an increased risk of aspiration and are more irritating to the nasopharyngeal and esophageal mucosa.

     2.1 Small-bore nasogastric feeding tubes (ten to twelve French gauge) are preferred.

- The Employer fails to include the following Typical Optimized Skills for LPNs in unit 5A: Gynecology/Oncology: care of NG tubes, verification of blood products, medication reconciliation, and application of PICC line dressings;

- The Employer fails to include the following Typical Optimized Skills for LPNs in unit 7.2: Orthopedics: care of NG tubes, medication reconciliation, and peritoneal dialysis care;

- The Employer fails to include the following Typical Optimized Skills for LPNs in unit 7.3: Neurosurgery: VAC dressing changes and verification of blood products;

- The Employer fails to include the following Typical Optimized Skills for LPNs in unit 7.4: Neurology: VAC dressing changes, peritoneal dialysis care, medication reconciliation, and verification of blood products;

- The Employer fails to include the following Typical Optimized Skills for LPNs in unit 8.2: Medicine Teaching: daily wound and skin assessments and complex wound care, medication administration, medication reconciliation, verification of blood products, and care and monitoring of NG tubes;

- The Employer fails to include the following Typical Optimized Skills for LPNs in unit 8.4: Hospitalist Medicine: insertion and care of NG tubes, peritoneal dialysis care, medication reconciliation, and verification of blood products;

- The Employer fails to include the following Typical Optimized Skills for LPNs in unit 9Lane: Subacute: care of feeding tubes, medication reconciliation, and verification of blood products;

- The Employer also states that in Mental Health units, many of the optimized skills listed for other units in its "high level summary" would "not be applicable." The Union submits that this is not accurate. LPNs in Mental Health units: care for NG tubes, perform suicide risk assessments, perform medication reconciliation, and are independently responsible for clients considered stable with predictable outcomes;

- The Employer fails to include the following clinics, units, and offices that employ LPNs in its "high level summary":

    - Cardiology Clinic at the QEII Health Sciences Centre;
    - Dermatology Clinic at the QEII Health Sciences Centre;
    - Nephrology Clinic at the QEII Health Sciences Centre;
    - In-patient Holding Unit — Diagnostic Imaging at the QEII Health Sciences Centre;
    - Endoscopy Unit at the Victoria General Hospital;
    - Public Health Office;
    - Berwick Satellite Dialysis Office;
    - Liverpool Satellite Dialysis Office;
    - Pictou Satellite Dialysis Office;
    - Port Hawkesbury Satellite Dialysis Office; and
    - Springhill Satellite Dialysis Office.

- LPNs in the Cardiology Clinic, which the Employer fails to include in its "high level summary", employ the following Typical Optimized Skills: medication reconciliation; transfers of patient health information; infusion therapy; wound care; medication administration; intradermal medication administration; physical/health assessment; initiating, flushing, monitoring and discontinuing heparin and saline locks in established peripheral infusion sites; identifying common IV puncture sites; peripheral IV insertion and initiation of IV infusions with standard maintenance IV hydration solutions; use of oxygen cylinders including adjustment of flow rate; falls risk assessments; venipuncture for blood specimen collection; care of PICC lines; care of Central Venous Access Devices (CVADs); and recognizing and flagging inaccuracies on medication orders.

Reasons for Decision

The first issue to be determined is whether I am limited to considering only those changes in the job duties and responsibilities of LPNs which occurred during the term of the collective agreement commencing November 1, 2011 (the

"2011-14 agreement"). For convenient reference, Article 42.02(b) is reproduced again below:

> **"42.02 Issues Subject to Review**
>
> The following process shall be applied when a new position has been created or where the Employer has initiated a substantial change to an existing position during the term of the collective agreement.
>
> (b) Where an employee or either party to this agreement believes that the duties and/or responsibilities of a bargaining unit position have substantially changed during the term of the collective agreement, they may file a request for review. If the parties are unable to agree on a resolution of the matter it may be referred for determination through this review process."

The Employer argues that this language clearly rules out consideration of any changes in the job duties and responsibilities of LPNs which were implemented under preceding collective agreements. It emphasizes the word "initiated" and asserts that only changes which "began" or "started" during the 2011-14 agreement can be taken into account in applying Article 42.02(b). Accordingly, the Employer rejects the "accretion" approach which has been adopted by arbitrators in this province and elsewhere when dealing with similar though not identical contractual language. For the reasons which follow, I do not accept the Employer's argument.

The most recent case on point between these parties is ***Nova Scotia Public Service Commission and NSGEU*** 2011 CarswellNS 1004, 106 C.L.A.S. 30 (Richardson). In his decision, arbitrator Richardson reviewed the relevant arbitral authorities and concluded that the accretion approach was valid. He reasoned as follows:

> "120 Art. 41.01(a) commences with the introductory words '[*w*]*hen* a new or substantially altered classification covered by *this* Agreement *is introduced*' (emphasis added). Did the parties intend by these words to create a right to negotiate a rate of pay in respect of new classifications, or substantially altered classifications, regardless of when those changes arose? Or did they mean to deal only with those changes that happened during the term of 'this' collective agreement. In my opinion the latter is the right interpretation.
>
> 121 The word 'when' in its conjunctive sense (the sense used here) means 'at the time that, or any occasion that:' *Oxford Canadian Dictionary* (Toronto, 1998). The same dictionary includes the following definitions for 'introduce:' 'insert; place in … bring in; usher in; bring forward; … begin; occur just before the start of.' These words in my view point to a particular and specific trigger date: the date the change happens. Second, the change is tied to a particular 'thing:' a classification 'covered by *this* Agreement' – that is, the current agreement. Taken together these words can only mean that the parties agreed that if the Employer introduced a new or substantially altered classification during the term of the collective agreement it was required to enter into negotiations with the Union over the new or altered classification's rate of pay. What this means, in other words, is that Art. 41.01(a) is triggered only when the introduction of a new classification, or a substantial alteration to an existing classification, occurs during the term of the collective agreement. There is no right to negotiate rates of pay for new or substantially altered classifications that were introduced *before* the collective agreement came into effect.
>
> 122 There is another reason for interpreting Art. 40.01(a) [sic] in this way. To be effective collective

bargaining requires a degree of finality. Once the terms and conditions of employment have been agreed upon and reduced to writing in a collective agreement the parties may turn to the management of that agreement secure in the knowledge that the terms and conditions themselves will remain fixed and certain until the next round of bargaining. However, as a practical matter, there may be events or developments during the terms of a collective agreement – not known or contemplated at the time of the collective bargaining – that may require adjustment of those terms and condition [sic]. The need for such flexibility is especially important when particular job duties and classifications are involved. Employers have and need the right to adjust work duties to suit operational requirements – but employees should be entitled to be paid an appropriate rate for what they do when that happens.

123 It is this context that underlies the use of re-opener clauses like Art. 41.01(a). They provide employers with the necessary flexibility to make changes to job duties, while at the same time entitling unions to negotiate new wage rates to compensate employees affected by those changes. But precisely because they exist as, 'in effect, an adjunct to the collective bargaining process,' they make sense only if their intent is 'to afford parties the opportunity to adjust wages where something *new* – the creation of a new or substantially new classification – occurs *between* bargaining sessions, *i.e.* during the term of a given agreement:' *Four Counties Hospital and ONA (2008-01550)* (2010) 196 LAC (4th) 253 (Goodfellow) at para. 27. To come to a different interpretation, one that permitted a party to insist upon negotiating changes 'based entirely on events that predated the current agreement, [would mean that] the certainty and stability of the wage bargain would be defeated:' *ibid*; see also *Selkirk and District General Hospital and CUPE, Local 1601* [1993] MGAD No. 9 (Hamilton).

124 While such an interpretation is easy to state it is on occasion difficult to apply in practice. Not all changes to a job are sudden, dramatic and significant. Sometimes the change is gradual and stretches over years. Taken individually the changes seem insignificant, mere extensions or re-arrangements of existing duties. But there may come a day when a particular change changes everything, and the job becomes, finally, something that is substantially different from what it started out to be. Is the Union in such a case to be precluded from arguing that there has been a substantial

alteration just because some of the changes upon which it relies to prove its case predates the collective agreement under which the grievance is filed? The answer in the arbitral jurisprudence tends to be 'no'.

125 In such cases, arbitrators and adjudicators have tended to the opinion that where the last change in an 'accretion' or series of changes occurs during the term of the collective agreement then the timing requirements of a clause like Art. 41.01(a) can be satisfied. So long as it can be said that the substantial alteration 'crystallized' during the term of the collective agreement it does not matter that some of the new or changed elements of that job predated the collective agreement. This was the approach of Arbitrator Veniot in *Cape Breton (Regional Municipality) v CUPE, Local 933* (unreported) and discussed by Cromwell, JA (as he then was) in *Cape Breton (Regional Municipality) v CUPE, Local 933* 2006 NSCA 80. As described by Cromwell, JA at para. 4, Arbitrator Veniot when dealing with a similarly-worded clause concluded that he could grant relief 'if there were sufficient changes since the signing of the agreement to 'crystallize' the substantial change.' His Lordship added that this might be called 'the 'accretion' approach because it recognizes that there may have been a gradual accretion of duties over time;' see also the *Deputy Sheriffs Decision*, para. 7.

126 It remains the case, however, that while the evidence 'can show a course of conduct or an accretion of duties, there still must be a finding that the substantial change in duties arose or crystallized during the term of the Agreement itself:' *Selkirk and District General Hospital and CUPE, Local 1601* [1993] MGAD No. 9 (Hamilton) at p. 19 of 29; see also the *Deputy Sheriffs* decision of Adjudicator Archibald at paras. 7-8.

127 Such an interpretation of Art. 41.01(a) and its application to changes that span the current and previous collective agreements makes sense to me and I would adopt it here. Change is always measured by and against what went before. To refuse to consider the past context (and past changes) simply because they happened under a prior collective agreement could render Art. 41.01(a) meaningless. Take for example a series of small changes in a classification that took place over the course of two years. The last change that 'crystallizes' what the union says is a substantial alteration occurs two months after the start of a new

> collective agreement. To refuse to consider those earlier changes in such a case would make it impossible to prove (or even 'see') the changes alleged. It seems to me then that in agreeing to the wording of Art. 41.01(a) the parties must have intended and meant that prior changes could be considered, so long as they were part of a rationally related series of changes, and so long as the last one – the crystallizing change – occurs in the current collective agreement."
> [emphasis added]

I concur with arbitrator Richardson's analysis of the authorities and his observation that refusing "to consider the past context (and past changes) simply because they happened under a prior collective agreement could render Art. 41.01(a) [42.02(b)] meaningless."

In this connection, I note that arbitrator Wallace expressed the same view in ***Shaw Media Inc. and CEP (Ramsey)*** (2012) 223 L.A.C. (4th) 289, a case cited by the Employer. After reviewing the authorities, including arbitrator Richardson's decision, he stated at para. 27:

> "In my opinion, this 'accretion' approach is analytically sound. It preserves the efficacy of classification clauses like Article 59 of this Agreement while still observing the fundamental jurisdictional principle that grievances must aim at an alleged violation of the agreement under which the grievance is filed…."

The Employer did not provide me with any authorities which rejected the accretion approach. However, it took the position that arbitrator Richardson's decision and the authorities on which he relied were made on the basis of contractual provisions which were not as clear as Article 42.02(b) in ruling out consideration of changes made under prior collective agreements. However, in my opinion, while there is some variation in wording, the effect of the provisions considered by arbitrator Richardson, and in the other authorities cited, is virtually identical to Article 42.02(b). In the case of arbitrator Richardson's decision, the provision in question read as follows:

> "When a new or substantially altered classification covered by this Agreement is introduced, the rate of pay shall be subject to negotiations between the Employer and the Union. The Employer may implement a new classification and attach a salary to it, providing that the Union is given ten (10) business days' written notice in advance."
> [emphasis added]

In my view, there is no difference in meaning between the words "initiated" and "introduced". More importantly, it is readily apparent from paragraphs 120-123 of arbitrator Richardson's decision, as previously quoted, that he interpreted the above provision to mean that it only applied when there was substantial change to an existing position during the term of the current collective agreement. Notwithstanding that interpretation however, he endorsed the accretion

approach just as other arbitrators had previously done. His reason for doing so was not based on any perceived vagueness or ambiguity in the governing contractual language. Rather, it was based on arbitral precedent and the practical reality that jobs evolve and can be substantially altered over time as the result of an accumulation of relatively small changes.

I would add that the express purpose of Article 42, as indicated by the title "Pay Plan Maintenance", is to provide for ongoing administration of job evaluation issues through the application of the Aiken (Watson Wyatt) job evaluation system. The maintenance of modern pay plans through an established job evaluation system is now quite common in the public sector, especially for large bargaining units. The integrity of such systems could easily be undermined if, as the Employer contends, the evaluation process was strictly limited to changes in job duties and responsibilities which occurred during the life of the collective agreement in place at the time the request for review was made.

Having said this, the accretion approach has a contractually-limited reach in the circumstances of the present case. As previously discussed, the parties agreed in MOA #10 to move LPNs to a higher classification level effective April 1, 2009 which resulted in a wage adjustment of approximately 6%. The parties

further agreed that no requests for review of the LPN classifications would be initiated during the life of the collective agreement to which MOA #10 was appended, the expiry date being March 31, 2009. Importantly, for present purposes, the parties further agreed that any request for review involving the LPN classifications initiated after the expiry date "shall only consider changes to the classification made following April 1, 2009". Consequently, in my opinion, it is clear that the parties agreed that the current classification which became effective on April 1, 2009 was intended to compensate LPNs for all changes to the classification made prior to April 1, 2009 and any future requests by LPNs for review of their classification would only be considered on the basis of changes made following April 1, 2009.

The second issue to be determined is what constitutes a substantial change in the duties and/or responsibilities of an existing bargaining unit position within the meaning of Article 42.02(b) of the collective agreement. The parties appear to be in agreement that the "substantial, qualitative change" test applies in such circumstances. As I stated in a prior decision (***NSGEU v. Nova Scotia (Department of Human Resources)*** (Buyers Grievance)) July 5, 2019, unreported:

> "Turning, then, to the pivotal issue of whether the Buyer 3 and Buyer 4 classifications have been substantially altered, the authorities cited by both parties are much to the same

> effect. The proper test to be applied is whether there has been a substantive qualitative change. Minor changes in job content or increased workload do not satisfy the test. There must be real and significant change in core functions or responsibilities...."

In the Employer's letter to the Union of March 17, 2016, the Employer took the position that, in order to establish a substantial change in the LPN classification, the onus was on the Union to demonstrate that "all LPNs must have experienced the change". The letter states, in part:

> "It is our understanding that all NSGEU LPN's are represented by this Appeal. This means that in order for a substantial change to be eligible for review by the Committee, all LPN's must have experienced the change within the life of the Agreement (since Nov/2011). That is clearly not the case....In order for the Committee to consider an Appeal, all employees who form part of the Appeal must identify substantial changes which have occurred during the term of the agreement (since Nov. 2011)."

I disagree with these statements for two reasons. First, as I have already found, changes prior to November of 2011 can be considered provided they occurred after April 1, 2009. Second, it is not necessary, in my opinion, that all LPNs must have experienced a substantive and qualitative change in their duties or responsibilities. LPNs in this bargaining unit work in a wide variety of health care settings. Job duties and special skills vary quite considerably from unit to unit. Another complicating factor is that changes in duties and responsibilities are

usually rolled out gradually rather than being implemented simultaneously on a system-wide basis. Consequently, for the purpose of determining whether there has been a substantive and qualitative change in the LPN classification, one must examine those duties and responsibilities which are prevalent and not those which only exist in a highly specialized unit. In the latter circumstance, LPNs working on such a unit might well be able to demonstrate a substantive and qualitative change in their positions but not the entire classification. Likewise, some LPNs may work on units where their job duties and responsibilities do not include duties and responsibilities which are prevalent on many other units. However, such a situation would not warrant lowering the LPN classification. In short, whether there has been a substantive and qualitative change in the duties and responsibilities of LPNs does not depend upon whether there is a small group of LPNs who work in positions or units where the job duties and responsibilities are at the very high end of the scale or, conversely, at the very low end.

Turning to the evidence, it is readily apparent that there have been many changes in the duties and responsibilities of LPNs over the years. Some of those changes are relatively minor while others are of a substantial, qualitative nature. When considered on a cumulative basis, they undoubtedly constitute a substantial change to LPN positions and the LPN classification. The parties have

already dealt with the changes which took place prior to April 1, 2009 in MOA #10. The real issue here is whether a further substantial change occurred after April 1, 2009 which crystallized after November 1, 2011. For the reasons which follow, I am satisfied that it did.

I will deal first with the changes which the Union alleges were made during the period from April 1, 2009 to October 31, 2011. In discussing these changes, as well as those which occurred later, I will follow the order in the Union's "Timeline of Changes" document reproduced earlier herein. In doing so, I omit reference to those changes where I am satisfied that they were either made before April 1, 2009 or are not significant.

1. May 1, 2009 – *Licensed Practical Nurses Act, 2006, c. 17, and Licensed Practical Nurses Regulations*, NS Reg 197/2009 *come into force, increasing licensed practical nurses' (LPNs) scope of practice to allow them to provide nursing services* independently for clients considered stable with predictable outcomes....

Proclamation of this new legislation and associated regulations expanded the LNP scope of practice and allowed LPNs to provide nursing services independently for certain clients.

2. September 2009 – "Patient Support Worker Skills," CC 02-009 is issued by CDHA/NSHA (reissued as "Care Team Assistant (CTA) Skills (formerly Patient

Support Worker Skills)," CC 02-009 in March 2012). Policies specify that PSWs (CTAs) assist and are supervised by LPNs and RNs.

CC 02-009 is the first official recognition of LPNs' supervisory authority over Patient Support Workers (now known as Care Team Assistants).

3. October 2009 – "Initial Management of Anaphylaxis Following Immunization," MM 20-005 is issued by CDHA/NSHA, specifying that this is a post-entry level competency (PELC) for registered nurses (RNs) and LPNs in specifically approved practice settings.

While the rollout relating to the enhanced role of LPNs in the immunization program began in 2008, it was not until 2013 that LPNs started running the program without RNs and they are responsible for the initial management of anaphylaxis.

4. October 2010 – "Enteral Nutrition, Administration of," CC 25-021 is issued by CDHA/NSHA, specifying that administration of enteral nutrition via a nasogastric, orogastric, gastronomy or jejunostomy tube is a basic nursing procedure for RNs and LPNs.

I accept that LPNs were doing tube feeds at the Rehab Centre as early as 2008 and tube feeds were included in the February 2008 list of PELCs for LPNs. However, policy CC 25-021 establishes that tube feeds of various types are "a basic nursing procedure for RNs and LPNs within CDHA". Subsequent to the issuance

of this policy, LPNs started performing tube feeds in the Eating Disorders Clinic without the assistance of an RN.

5. October 2010 – "Medication Reconciliation, MM 50-003 is issued by CDHA/NSHA (reissued March 2015). LPNs are included as team members involved in the care of the patient in implementing the policy.

While the LPNs started giving medications prior to 2009, they did not start doing medication reconciliations until 2010. There was a phased-in rollout and some LPNs did not start doing the reconciliations until 2013.

6. December 2010 – "Transfer of Health Information Between Facilities," CH 30-060 is issued by CDHA/NSHA (reissued October 2013 and July 2015 as "Transfer of Patient's Health Information (Facility to Facility, Unit to Unit, Shift to Shift & Episodic Care Transfers)," CH 07-060), specifying that LPNs may be the transferring and/or accepting care provider, depending on patient circumstances.

Prior to this policy, LPNs did not transfer or receive patients to or from other services.

7. December 2010 – "LPN Skills," CC 02-008 is issued by CDHA/NSHA (revising January 2008 version). In December 2010 version, several changes are made to LPN skills, including:

- **Added as PELC: Hemodialysis Access – various skills**
- **Added as PELC: Infusion Therapy – insert peripheral IV access device**
- **Added as PELC: Medications – Administer vaccinations or inoculations**
- **Added as PELC: Specimen Collection – Troponin testing (Point-of-care testing)**

- **Added as PELC: Wound Care – Insert and remove packing to surgical or deep wounds with established treatment regimes**

The Employer agrees that all of the above were added as PELCs in 2010 with the exception of hemodialysis access which was listed as a PELC in 2008.

This completes the discussion of the changes made between April 1, 2009 and October 31, 2011. I find that the changes are significant on a cumulative basis; however, it is unlikely, in my view, that they would be sufficient to demonstrate that the duties and/or responsibilities of LPNs had been substantially changed within the meaning of Article 42.02.

I will now deal with changes which the Union says were made after November 1, 2011.

8. 2012 – *CLPNNS informs LPNs that* peripheral IV insertion, initiation of IV therapy, administration of IV medications (both intermittent bolus and in limited circumstances, direct IV push), and blood therapy competencies have become ELCs for LPNs.

The Employer agrees that these are new ELCs for LPNs. Although the Employer has apparently not as yet made general use of LPN blood therapy

competencies, the LPNs' role with respect to IV therapy has become increasingly independent of RN participation.

10. September 2012 – CLPNNS releases a new Continuing Competency Profile (revising 2008 version) with the following changes:

Competency / Requirement	2008 CP	2012 CCP
"Performing an ongoing self-assessment of their competency in their current context of practice; identifying learning needs and/or learning goals; and developing, implementing *and evaluating* (using critical reflection) a plan of action to meet their learning needs or goals."	--------	**Required (p. xii)**
"Intradermal medication administration"	**Advanced (p. 205)**	**Entry-Level Competency (ELC) (p. 194)**
"Initiate, flush, monitor and discontinue heparin and saline locks in established peripheral infusion sites"	**Advanced (p. 218)**	**ELC (p. 207)**
"Identify common IV puncture sites	**Advanced (p. 219)**	**ELC (p. 208)**
"Provide medications and fluids via hypodermoclysis"	**Advanced (p. 222)**	**ELC (p. 211)**
"Initiate hypodermoclysis infusion"	**Advanced (p. 222)**	--------
"Initiate, assess, monitor, maintain, regulate, and evaluate hypodermoclysis infusion"	--------	**ELC (p. 211)**
"Monitor and regulate administration of blood or blood products"	**ELC (p. 225)**	--------
"Initiate, assess, monitor and regulate administration of blood or blood products"	--------	**ELC (p. 214)**
"Compare actual assessment findings to expected findings" and "consult appropriate care provider when assessment findings: are not	--------	**Required (pp. (pp. 16, 54, 70, 80, 81, 85, 86, 89, 91, 94, 97, 100,**

as anticipated, changed or new; client is not achieving intended outcomes; status is becoming variable or less predictable"		**102, 105, 108, 109, 112, 119, 132, 139, 142, 143, 157, 164, 168, 173, 187, 188, 199 x2, 214, 262, 266, 270, 287, and 297)**

The Employer does not dispute the above changes in ELC requirements.

11. October 2012 – "Falls Prevention Program" memorandum is sent by CDHA/NSHA to Satellite Dialysis Clinics, specifying that LPNs are to complete fall risk assessments.

Under this new policy, LPNs are required to fill out a fall prevention form on a daily basis and attach it to the patient's chart. This was a new duty.

12. November 2012 – "Oxygen Cylinders," CC 06-085 is issued by CDHA/NSHA, specifying that the use of oxygen cylinders, including the adjustment of flow rate as per the physician's order, is an ELC for LPNs.

This policy establishes a new ELC for LPNs with respect to the use of oxygen cylinders.

14. August 2013 – "Negative Pressure Wound Therapy (NPWT)," CC 55-080 is issued by CDHA/NSHA, specifying that this is a PELC for LPNs.

This policy was preceded by the VAC Therapy policy issued in June of 2009. Both policies are very detailed and require very similar PELC certification requirements. Under both policies, the role of LPNs is the same – patient care. In my opinion, both policies represent a significant change in LPN duties and responsibilities. However, it appears that change occurred, for the most part at least, in the period between April 1, 2009 and October 31, 2011. Policy CC 55-080 is an update of the VAC Therapy policy and did not, in and of itself, represent a substantive change post-November 1, 2011.

15. October 2013 – "Venipuncture for Blood Specimen Collection," CC 85-079 is issued by CDHA/NSHA, specifying that this is a PELC for LPNs.

As the Employer points out, venipuncture for blood specimen collection was listed as a PELC for LPNs as early as January 2008. Consequently, policy CC 85-079 did not represent any change. However, venipuncture for blood specimen collection subsequently became an ELC for LPNs and they collect blood specimens on regular basis.

18. January 2014 – "Central Venous Access Device (CVAD) – Umbrella Policy," CC 80-021 is issued by CDHA/NSHA, specifying that this is a PELC for LPNs.

Again, as pointed out by the Employer, care of CVADs was listed as a PELC for LPNs as early as January 2008 and, thus, policy CC 80-021 did not make any change in this respect. However, care of CVADs is now an ELC for LPNs and includes infusion/medication delivery.

19. October 2014 – "Medicinal Marihuana - Use of by Authorized Users as inpatients in Capital Health Facilities," MM 20-021 is issued by CDHA/NSHA. LPNs implement the policy as members of the healthcare team.

This is a new policy. While LPNs and other health care providers are not permitted to be involved in the handling or administration of medical marihuana, LPNs are responsible for administering the policy and educating themselves on the possible interaction of medicinal marihuana with other drugs.

20. January 2015 – "Peritoneal Dialysis (PD); Care of the Patient Receiving," CC 50-065 is issued by CDHA/NSHA, specifying that components of the policy are PELCs for LPNs.

Peritoneal dialysis was listed as a PELC for LPNs as early as January 2008. At that time, however, LPNs were only involved in the administration of peritoneal dialysis on one floor. Now LPNs administer peritoneal dialysis on many units.

22. March 2015 – "Peripheral I.V. Therapy Initiation and Maintenance," CC 80-019 is issued by CDHA/NSHA, specifying that an LPN may insert a peripheral I.V. with an authorized prescriber's order, and may initiate I.V. infusions with standard maintenance I.V. hydration solutions without added medications or electrolytes. This is a revision of the January 2007 version of the policy, which specified that this was a PELC for RNs only.

LPNs now initiate I.V. Therapy which is a new duty for them. At the time of the hearing, the program was in the process of being rolled out across the system.

23. September 2015 – "Skin and Wound – Assessment, Prevention & Documentation," CC 55-045 is issued by CDHA/NSHA, specifying that the assessment and documentation of all patients' risk of developing pressure ulcers is to be performed by LPNs, and that the assessment and documentation of patients' wounds is to be performed by LPNs.

For all patients admitted for greater than 24 hours, this policy requires the assessment and documentation of their risk of developing pressure ulcers by an LPN or RN using the Braden Scale. This was a new duty for LPNs and they are required to be trained in the use of the Braden Scale as a basic competence. The policy also requires LPNs to assess and document patient wounds as well as the preparation of individualized care plans.

24. September 2015 – "Post-Entry Level Competencies" CC 02-010 is issued by CDHA/NSHA (revising February 2008 version). The 2015 version newly lists "Transfusion – Blood and Blood Products" as an ELC for LPNs, and no longer lists "Transcription of Medications – 7.3 QEII" as a PELC, as it is encompassed by the mandatory competency of Medication Administration.

The Employer does not dispute that the transfusion of blood and blood products is added as an ELC for LPNs. However, the evidence indicates that the Employer is not presently utilizing this competency in many areas.

26. March 6, 2017 – "Licensed Practical Nurses (LPN) Administration of Intravenous (IV) Medication," CL-AP-015 is issued by CDHA/NSHA, specifying that the administration of IV medication is an ELC for LPNs.

The express purpose of this policy was to guide and support LPNs to work to their full scope of practice in reference to IV medication. As previously mentioned, this was a new duty for LPNs and was still being rolled out across the system at the time of the hearing.

Based on the foregoing, I am satisfied that there were very significant changes in the duties and responsibilities of LPNs after November 1, 2011. These changes are reflected by the addition of approximately a dozen new entry level competencies for LPNs as well as several post-entry level competencies. The ELCs are particularly important because all LPNs are expected to attain and utilize them as required in the performance of their regular duties. It goes without saying, of course, that not each of the new ELCs are of equal significance. For example, the ELC relating to the use of oxygen cylinders would carry little weight from a classification perspective. On the other hand, the ELC related to I.V. therapy is

very significant. The other new ELCs and PELCs fall between these two extremes. Taken together, I find that they represent a substantive and qualitative change in the duties and responsibilities of LPNs. They now play a more independent and advanced role in patient care than they did in November 2011, and even more so than they did in March of 2009. In the parlance of the authorities, the post-November 1, 2011 changes "crystallized" the substantial change which has occurred in the LPN position since April 1, 2009. Indeed, unlike in some of the cases referred to earlier, the majority of the changes here have been implemented since November 1, 2011.

In the result, pursuant to the authority conferred on me by paragraph 5 of MOS #2, I find that there has been substantial change in the job duties and/or responsibilities of LPNs during the term of the collective agreement.

DATED at Halifax, Nova Scotia, this 23rd day of September, 2019.



BRUCE OUTHOUSE, Q.C.
ad hoc Chair of the Joint Steering Committee