



Strengthening BC's Health Care Backbone:

Oversight of the Work of Health Care Assistants



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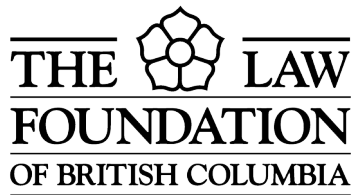
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ABOUT THE CCEL

The CCEL conducts research, and develops reports and educational tools about legal and policy issues related to aging. The CCEL collaborates with community stakeholders and organizations to identify and address subjects that impact older people.

The CCEL is part of the British Columbia Law Institute, British Columbia's non-profit independent law reform agency.

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EXECUTIVE SUMMARY

In British Columbia and most other jurisdictions in Canada, health care assistants (HCAs) perform the vast majority of day-to-day, hands-on, paid health and personal care provided to older people, adults living with disabilities, and people with complex health needs. This is true regardless of who is funding the services, and where the person lives—for example, a private home, an assisted living residence, or a long-term care facility.

The tasks HCAs perform range in intimacy from heating a meal in a microwave to providing intimate perineal care. The varied complexity of HCA work includes grocery shopping, wound care, and tube-feeding. They may get all their training on the job, have completed certified educational programs, or immigrate to Canada with a background in nursing. HCAs do their work with very limited and sometimes no onsite supervision. Although HCAs are increasing performing nursing tasks, unlike most other health care workers, their practice remains unregulated, they are not licensed to do their work, and they have no ongoing continuing education requirements.

Although BC was the first jurisdiction in Canada to develop a body to oversee aspects of the work of HCAs, BC is no longer in the vanguard. The BC Care Aide & Community Health Worker Registry (the BC Registry) was developed in 2010 by way of a letter of agreement between the Health Employers Association of BC, the Facilities Bargaining Association, and the Community Bargaining Association. Twelve years later there is still no legislation governing the BC Registry's work and the contract underlying the BC Registry's existence is not publicly available.

Over the years researchers, non-profits, and others have expressed concerns regarding the limited capacity of the BC Registry to properly oversee HCA competence and fitness to practice. These concerns include problems related to BC Registry's limited mandate (registration is only required for HCAs working in publicly funded positions; it can only investigate practice complaints related to abuse or neglect), issues related to lack of legislative framework (investigators cannot access critical information due to privacy), loop holes in the letter of agreement (HCAs can avoid BC Registry intervention by quitting before they are disciplined or terminated), and lack of transparency with the general public (a member of the public cannot look up an HCA on the BC Registry).

In 2012 the Government of BC commissioned a review of the BC Registry. Key informants identified many concerns. The writers made four recommendations for improving the model. The government further identified numerous actions for addressing the recommendations. However, in the last ten years BC has made no progress in addressing the four

recommendations. In the meantime, new legislation is in various stages in Ontario, Alberta, and Nova Scotia to enhance oversight of the work of HCAs.

The work of HCAs raises challenging questions about how to properly oversee their increasingly complex and staggeringly diverse work without producing unintended consequences that erect barriers to accessing much-needed care. Does BC's approach adequately protect the public? Should HCAs be brought under the *Health Professions Act* or the proposed *Health Professions and Occupations Act*? What are the appropriate options between these axes? What kind of regulatory approach fits an occupation that includes, on the one hand, complex technical tasks delegated by regulated health professions, and on the other hand, basic housework? Developing a better framework for oversight is critical because HCA work involves both vulnerable workers (the majority are immigrant women of colour) and vulnerable recipients of care.

This study paper provides a foundation for BC to consider further law reform. We explain how BC has approached oversight of HCAs through the BC Registry, discuss the broader provincial health professional regulatory framework, and summarize criticisms that have been made of BC's approach to HCA oversight and health professional regulation more generally. We review approaches taken in other jurisdictions and with other categories of workers to identify options for reform. We conclude with seven possible pathways.

We hope this paper will support BC to move forward to enhance oversight of the work of HCAs and better protect both workers and the public. This research was largely an academic exercise. We strongly encourage consultation prior to any law reform. In this case we recommend engaging the people most directly impacted by possible reform, namely, the HCAs doing this critical work, and the members of our community who rely on HCAs for care.

UPDATE ON NEW HEALTH PROFESSION LEGISLATION IN BC

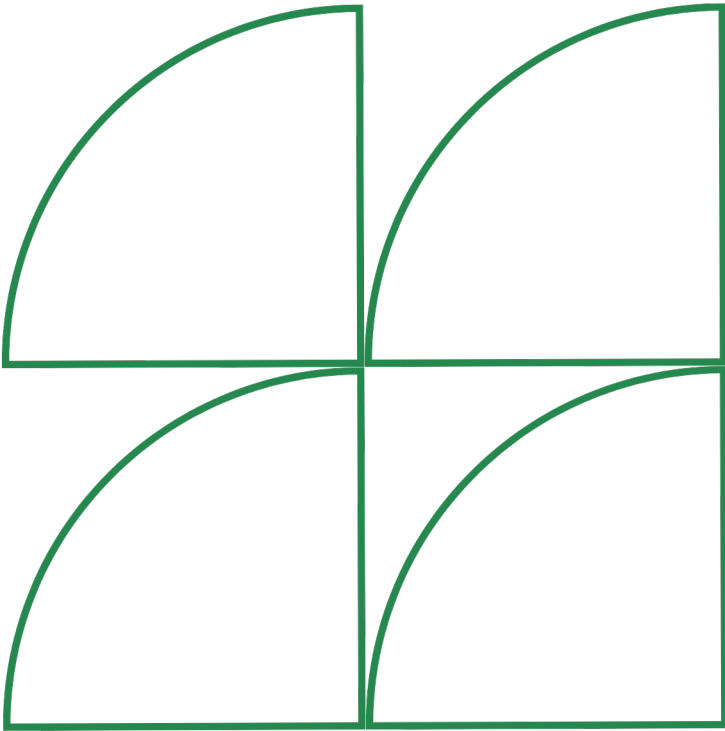
On October 19, 2022 the BC government introduced new legislation to replace the *Health Professions Act (HPA)*, bill 36 - *Health Professions and Occupations Act* [3rd Sess, 42nd Parl, British Columbia, 2022 (first reading 19 October 2022) - *HPOA*].

This bill creates a new type of regulated health care worker, called a health occupation, which is an approach that could be used for regulating HCAs. This bill was introduced shortly after we wrote the study paper, and just before our publication date. Section 5.4 of the study paper describes the regulated health profession framework at the time of publication, the *HPA*. CCEL will provide details on the proposed *HPOA* in our blog and other communications.

The term health profession is used in both the *HPA* and the proposed *HPOA*. Health professionals determine the course of care for patients. They must have a professional level of knowledge and abilities. Health professional regulation is necessary to protect the public from harm. In contrast, a person practicing a health occupation does not direct the course of care for patients. Therefore occupations may poses a lower level of risk to the public.

Under the *HPOA* a person in a health occupation must be either supervised by a health profession licensee, or have a level of knowledge and ability to protect the public from harm. A health occupation would be governed by a director, not a college. The Minister would choose what type of regulations and rules are appropriate to govern each health occupation. These rules could include qualifications to join the occupation such as education, examinations, practical experience, and evidence of good character. The Minister may require a person to be credentialed or authorized to practice, limit who can use a particular title, or require a public register listing those authorized to practice. A health occupation would be subject to the same complaints, investigation, and discipline process as a health profession.

This bill is not yet law, and there are no regulations or policies providing details. The rules and regulations for each health occupation may vary. Given those limitations and uncertainties, it is too early to analyze the health occupation framework. Regulation of a health occupation shares characteristics of a licensing scheme, title registration, self-regulation, and certified non-registrant status, described in chapter 5. The benefits and drawbacks of these regulatory schemes, discussed in section 7.3, are applicable to the proposed *HPOA* framework.



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LIST OF ABBREVIATIONS

Abuse Registry (the)	The Manitoba Adult Abuse Registry
BC HCA Provincial Curriculum	Health Care Assistant Program: Provincial Curriculum
BC Registry (the)	BC Care Aide & Community Health Worker Registry
CDA	Certified dental assistant
CCA	Community care assistant
CCALA	<i>Community Care and Assisted Living Act</i>
ECE	Early childhood educator
EHSA	<i>Emergency Health Services Act</i>
EMA	Emergency medical assistant
HCA	Health care assistant
HEABC	The Health Employers Association of BC
HPA	<i>Health Professions Act</i>
LPN	Licensed practical nurse
NCAS	Nursing Community Assessment Service
Program Recognition Guide (the)	BC Health Care Assistant Program Recognition: Guide for Educators
NP	Nurse practitioner
PSW	Personal support worker
PSW Registry (the)	Personal Support Worker Registry of Ontario
RN	Registered nurse
RPN	Registered psychiatric nurse



1.1 The Ubiquitous Work of Health Care Assistants

Health care assistants (HCAs) are critical to health care delivery in Canada and many other countries. They are often described as the backbone of various health care environments.¹ Their ever-presence is subtle because they go by different titles depending on the health care setting and jurisdiction in which they work.² In British Columbia (BC), HCAs working in long-term care are called care aides; in Ontario, they are known as personal support workers. In home and community care, HCAs go by titles such as community health worker or home support worker. In Quebec, HCAs are referred to variously as nurse aides, orderlies, and patient attendants, depending on the care environment.

Health care assistants have a regular presence in the lives of many people who are living with complex disabilities or frailty, and they provide support whether a person is aging semi-independently in their long-time home, in assisted living, or in a long-term care facility. HCAs provide the vast majority of day-to-day hands-on health and personal care that is not provided by family and friends.³ In BC, this is true whether or not the care is publicly funded and delivered through a health authority, or accessed via a private home and community care agency. Long-term care facilities rely on care aides to provide a majority of direct care hours in both for-profit and not-for profit contexts.⁴ In terms of BC home and community care, home support is

delivered almost exclusively by HCAs,⁵ and home support makes up approximately 90% of the home and community care services provided to British Columbians.⁶

HCAs perform many different kinds of tasks which require diverse skills. They assist with bathing, feeding, dressing, grooming, and toileting (activities which are characterized in health policy as activities of daily living). Their work includes some of the most intimate of activities, such as perineal care. They also perform tasks that are outside of HCA training—to the extent that standardized training exists—which have been delegated by nurses and other regulated health professionals.⁷ Examples of typically delegated nursing tasks include tube-feeding, medication administration, wound care, administration of suppositories, catheter care, oxygen equipment maintenance, and bowel care.

HCAs working in home support assist with activities that require little or no training, like meal preparation, banking, shopping, and housekeeping.⁸ Although increasingly, at least in BC, these sorts of activities are not funded by public health care, and instead often accessed through privately operated home and community care providers, and non-profit agencies funded through the Better at Home Program,⁹ the work is still performed by HCAs. A minority of people in BC receive funding through BC's self-direct care program, Choices in Supports for Independent Living, which helps them to hire HCAs and others to provide the care they wish to receive.¹⁰

In all environments HCAs communicate with clients, patients, and residents, providing social connection and emotional support to people who are often socially isolated.

These circumstances reflect significant change in policy and practice over time. Historically HCAs performed a more limited range of tasks. They did some personal care, and provided assistance with mobility, housekeeping, transportation, and shopping.¹¹ Over the years many complex tasks previously performed by nurses and other regulated health professionals have been shifted to HCAs. Average life expectancies have increased, and medicine has advanced in recent years; consequently people are living longer lives with increasing frailty and complexity in their care needs whether they are aging at home or in a facility. Researchers speculate that with "[w]ith growing pressures to find cost savings in care delivery, it is likely that the role of UCPs [HCAs] will continue to expand."¹²

1.2 Regulation and Oversight of HCA Work in BC

Practically speaking, HCAs often do their work with minimal supervision. In BC there is no legal requirement to have a registered nurse on duty 24/7 in long-term care facilities and the ratios of nurses to care aides have declined in recent years.¹³ In home and community care HCAs provide care with no onsite supervision by nurses.¹⁴

Regardless of the care setting and the complexity of their work, HCAs remain unregulated in BC and most other jurisdictions. This means that unlike nurses, physicians, and other health care professionals, HCAs are not licensed to practice by a regulatory college.¹⁵ No agency supervises their competency or fitness to practice, and no public body accepts and investigates complaints about their work.

As an alternative to regulation, BC has one of the only HCA registry systems in Canada. HCAs must register with the BC Care Aide & Community Health Worker Registry (the BC Registry) in order to work in positions that are publicly funded. The BC Registry is a creature of contract: a letter of agreement between the Health Employers Association of BC, the Facilities Bargaining Association, and the Community Bargaining Association established the BC Registry in 2010.¹⁶ Twelve years later, there is still no legal framework governing its work.

The BC Registry does not govern practice broadly in the manner of a College. Rather, it receives and investigates reports of abuse and neglect by registrants. Some HCAs will lose their BC Registry status as a result of an investigation. In this sense the BC Registry oversees a narrow aspect of fitness and competency to practice for HCAs.

Over the years many Canadian researchers have raised concerns regarding lack of standardized training and competencies for HCAs, the inadequacy of their training, and the absence of continuing education requirements.¹⁷ Some HCAs have no formal training; others receive training in Canada and abroad through a variety of programs. The breadth of expertise among HCAs includes foreign-trained nurses and individuals who have received minimal on-the-job instruction.

At time of writing, a new working group facilitated by Health Canada has begun to explore the possibility of developing national core competencies for HCAs.¹⁸ In BC, one component of the BC Registry's mandate is to establish the provincial curriculum for HCA education and maintain the program standards its delivery; however, only a select part of the HCA population has taken these short training programs. One researcher who interviewed HCAs working in long-term care in BC writes that HCAs report they are “unprepared for the work” and “going in blind.”¹⁹

In terms of the employers of HCAs, some sectors are regulated. Long-term care facilities and hospitals are regulated by provincial legislation.²⁰ Home support remains a completely unregulated area that one health policy expert has referred to as a “wild west”.²¹

1.3 CCEL Project Scope and Methods

In the face of increasing reliance on HCAs to provide care to both older people and younger people living with disabilities, current limited and spotty practice oversight of HCAs, and multiple calls for greater standardization of competency and education, the Canadian Centre

for Elder Law embarked on research into possible law and policy approaches to overseeing HCA work. In late 2019 we approached the Law Foundation of BC about this study. Months later BC was deep into a pandemic in which over-worked HCAs employed in under-staffed long-term care facilities had become a primary spreader of illness in long-term care.²² Very quickly BC developed health policy to top-up HCA pay, enhance their access to sick leave, and limit their work to single facilities. Suddenly the work of these ubiquitous but invisible health care workers was making headlines.

Increased regulation or other oversight of the work of HCAs is important because both HCAs and the people they care for represent vulnerable groups. HCAs deliver the majority of care provided to older adults and people living with disabilities. A significant majority of HCAs were born outside of Canada, speak English as a second language, and are precariously employed casual labourers.²³ 90% are women;²⁴ many are people of colour.²⁵

This study paper explores options for enhancing oversight of the work of HCAs in BC. Chapter 2 describes the work of HCAs and the populations doing this work. Chapter 3 explains the approach BC has taken to oversight of the work of HCAs. We describe the work of the BC Registry, including the accreditation of HCAs with the BC Registry and its role in curriculum development and program recognition for HCA education programs. We also clarify how HCA oversight works on a practical level through delegation and assignment by professions covered by the *Health Professions Act* (generally nurses), and the limited oversight provided through facility regulation under the *Community Care and Assisted Living Act*.

Chapter 4 summarizes critical reflections to date on the BC Registry model, identifying recommendations that have been made on how to improve its effectiveness. Chapter 5 discusses health care professional regulation in BC. We review the why and how of regulation, describe the *Health Professions Act* framework in BC, identify different approaches to oversight that might be suitable to the work of HCAs, and summarize guidance on health care professional regulation found in recent law reform work. Chapter 6 identifies how other select jurisdictions have approached credentialing HCAs and overseeing their work. We examine Alberta, Ontario, Manitoba, Nova Scotia, the United Kingdom, and Australia. Chapter 7 concludes with an analysis of various approaches BC could take to enhance oversight of HCA practice, ranging from expanding the BC Registry model to self-regulation.

Although HCAs work in many health care settings, this paper focuses on long-term care and home and community care—two of the sectors most critical to supporting people as they age. Excellent research has been published over the last decade, coming out of health policy, gerontology, and labour. This paper brings this work together in one place to lay a foundation for the Province of BC to develop a more robust law and policy response to address both the needs of HCAs and the people for whom they provide care.

To support our research we interviewed a very small number of academics and agencies with expertise related to training, credentialing, supporting, and managing HCAs. These were high level conversations aimed at helping us to identify the appropriate issues to research and capture in our paper. Occasionally we mention their feedback. Many aspects of the HCA oversight question are polarizing and complex, and we have left comments anonymous. If BC embarks on further reform we encourage comprehensive consultation with everyone who will be impacted by change, but particularly with HCAs themselves. The social and workplace dynamics that limit the capacity of HCAs to lead organization of their sector will also create barriers to their participation in law reform. However, their experiences should be considered.



2.1 Overview

This chapter describes the work of HCAs and the populations doing this work, including demographics. We discuss the precarity of HCA work and vulnerability of the workers, including lessons from the COVID-19 pandemic. We highlight some of the issues unique to home and community care versus long-term care, as the variability of HCA work in different environments contributes to the challenge of developing a framework for comprehensive oversight of their work.

2.2 The Work of HCAs

2.2.1 Work Environment

In BC HCAs work in a variety of care environments. The settings include acute and extended care hospitals (including mental health facilities, hospice houses, and substance use treatment centres), long-term congregate housing (assisted living, long-term care, and group homes), and day programs serving diverse populations (including dementia care and programs supporting adults with intellectual disabilities.²⁶ HCAs also provide support and assistance in people's private homes.

HCAAs working in facilities typically work shifts ranging from 8 to 12 hours. HCAAs may work full time, equivalent to around 40 hours per week. Often they are casual employees working part-time, and for multiple employers. HCAAs can work at any time of day or night, and any day of the week.²⁷ They are typically supervised by a registered nurse (RN) or licensed practical nurse (LPN). A 2021 study of 89 nursing homes found that 44.5% of HCAAs reported to an RN, 53.3% reported to an LPN, and 2.2% reported to a facility care manager.²⁸

In the long-term care context, many HCAAs work at multiple facilities. Studies have estimated this number to be around 30%.²⁹ Doan conducted a study in BC examining how many HCAAs work in multiple facilities. She found that 26.5% of study participants worked in more than one long-term care home.³⁰ Some long-term care HCAAs worked at more than two long-term care facilities: 2.3% worked at three long-term care facilities; 0.3% worked four at long-term care facilities; and 0.1% worked at five long-term care facilities.³¹ If an HCA worked in more than one long-term care facility they were likely working more hours than HCAAs working at a single facility. Doan found that HCAAs working at only one long-term care facility averaged 65.4 hours within a two-week period. HCAAs working in more than one facility averaged 83.5 hours within a two-week period, which would be full-time hours.³²

Home and community care workers typically visit multiple clients a day. Home and community care workers may work for a few hours at a time, or for full days.³³ They may be in and out of a person's home in 20 minutes and provide care in many homes per day.³⁴ They spend a lot of time driving.³⁵

2.2.2 Work Duties

HCAAs deliver most of the direct care provided to long-term care residents. Estimates of how much care HCAAs provide range from 70 to 90% of care provided to older adults.³⁶ HCAAs perform a wide variety of duties in all work environments.

HCAAs assist clients with activities of daily living, including:

- Bathing
- Dressing
- Personal grooming
- Assisting with feeding
- Lifting, turning, and repositioning
- Toileting
- Transporting clients via wheelchair³⁷

HCAAs assist clients with some instrumental activities of daily living, including:

- Planning, preparing, and serving meals
- Cleaning the patient's home or room
- Washing dishes
- Making the bed
- Cleaning laundry
- Transporting a patient by vehicle
- Running errands
- Organizing a schedule
- Helping to manage the home³⁸

HCAAs perform medical-related activities requiring technical training, including:

- Providing first aid
- Measuring blood pressure, temperature, pulse, and breathing
- Recording fluid intake and output
- Collecting specimens
- Organizing medications
- Giving medications
- Administering suppositories
- Administering enemas
- Monitoring a patient's condition
- Reporting information to nursing or medical staff
- Documenting information and activities
- Changing dressings
- Providing end-of-life care³⁹

HCAAs assist with other health-related tasks, including:

- Engaging in infection prevention and control activities
- Supervising exercise routines
- Assisting clients with indoor and outdoor activities
- Assisting clients with therapeutic recreation programs
- Providing social and emotional support
- Helping with prosthetics or assistive devices, such as hearing aides⁴⁰

Home and community care tasks delivered by HCAs

Margaret Saari et al conducted a review of home and community care client charts to examine the most common care activities performed by home and community care HCAs.⁴¹ The most common tasks were:

- Personal care – 99.4%
- Housekeeping – 54.2%
- Mobility assistance – 51.5%
 - Added skill: Range of motion/home exercise program – 9.3%
 - Added skill: Transfer with equipment – 5%
- Assistance with elimination – 33.5%
 - Added skill: bowel/ostomy care – 1.4%
 - Added skill: Catheterization: 0.2%
- Assessment and monitoring – 29.8%
- Nutrition and meal support – 22.8%
 - Added skill: Tube feeding – 0.4%
- Medication assistance – 9.9%
 - Added skill: Cueing/monitoring/assistance – 8.3%
 - Added skill: Applying medicated creams – 1.7%
 - Added skill: Oxygen administration – 0.2%
 - Added skill: Assisting with inhalants – 0.2%
 - Added skill: Assistance with eye/ear drops – 0.2%
- Foot care – 2.7%
- Wound care – 1.7%
- Applying braces or prostheses – 0.4%⁴²

2.2.3 Demographics

The number of HCAs in BC

As of April 1, 2022 there are 42,749 HCAs actively registered with the BC Registry.⁴³ The WorkBC job profile states that, as of the 2016 census, there are 30,100 nurse aides, orderlies, and patient services associates in the province, and 12,900 home support workers and housekeepers working in BC.⁴⁴

Most HCAs work in the lower mainland, on Vancouver Island, and in the interior BC. WorkBC

lists the following number of nurse aides in the province by region:

- Mainland/Southwest: 21,930 nurse aides and 8,630 home support workers
- Vancouver Island/Coast: 8,400 nurse aides and 3,740 home support workers
- Thompson-Okanagan: 6,280 nurse aides and 1,800 home support workers
- Cariboo: 1,370 nurse aides and 580 home support workers
- Kootenay: 1,360 nurse aides and 380 home support workers
- North Coast & Nechako: 480 nurse aides and 230 home support workers
- Northeast: 440 nurse aides and 280 home support workers⁴⁵

The BC Registry's *Spring Updates Report 2022* provides the following breakdown of registered HCAs across the last five years. The total number of registered HCAs in 2021 was 5,263, which reflects an increase of 33% from the previous year. The number of BC HCA graduates in 2021 was 3,441, which is an increase of 58% from the previous year. The number of internationally educated HCPs in 2021 was 249, which is an increase of 64% from the previous year.⁴⁶ Based on these numbers, roughly 12% of HCAs are registered in BC.

Table 1: Registered BC HCAs 2017-2022, Broken Down by Credentialing Pathway

CALENDAR YEAR	BC HCA Program Graduates	Canada HCA Program Graduates / HCA Equivalant	Internationally Educated Health Care Professionals (IEHCPs)	Nursing Students	Nurses (Current or Recent Canadian Registration)	Total
2017	2283	171	135	893	160	3642
2018	2186	80	123	966	116	3471
2019	2405	99	179	931	96	3710
2020	2174	262 - 204 Expedited Pathway - 58 NCAS Competency Assessment	152	1279 - 1048 Full - 231 Temporary Emergency Registration	91	3710
2021	3441	312 - 273 Expedited Pathway - 39 NCAS Competency Assessment	249	1210 - 801 Full - 409 Temporary Emergency Registration	51	5263

Source: BC Care Aide & Community Health Worker Registry, *Spring Updates Report 2022*, by Sarina Corsi & Lara Williams (May 10, 2022) at 5. Reprinted with permission.

By way of comparison, although the exact number of HCAs in Ontario is unknown,⁴⁷ in 2015, it was estimated to be around 90,000.⁴⁸ 50% of HCAs work in home and community care, and 36% work in long-term care.⁴⁹

Wages and work opportunities

The salaries of HCAs vary. According to WorkBC, the median annual salary of nurse aides is \$47,447, with hourly rates ranging from \$18.30 to \$25.33 per hour.⁵⁰ For home support workers, the median annual salary is lower: \$41,712, with hourly rates ranging from \$15.20 to \$24 per hour.⁵¹ In 2020 the Seniors Advocate of BC reported a significant difference between the hourly rates of HCAs working in for profit and not-for profit long-term care (starting wages of \$16.85 versus \$23.48).⁵²

The median wages for HCAs across Canada also varies significantly. The median wage across the entire country is \$20.88 per day. In BC, the median wage is \$22.75 per hour. The median range in other jurisdictions varies from \$16 per hour to \$37.64 per hour. The amounts for each jurisdiction are listed Table 2 below.

Table 2: HCA Median Wages across Canada⁵³

Jurisdiction	Median Wage
Yukon	No Data
Nunavut	No Data
New Brunswick	\$16.00
Newfoundland & Labrador	\$17.55
Nova Scotia	\$18.00
Manitoba	\$19.40
Quebec	\$20.56
Ontario	\$20.82
Canada	\$20.88
Alberta	\$21.00
Prince Edward Island	\$21.00
Saskatchewan	\$22.00
British Columbia	\$22.75
Northwest Territories	\$37.64

WorkBC considers HCA work to be a high opportunity occupation. For nurse aides, the data suggests there will be a 2.4% job growth between 2026 and 2031, with 18,430 new job openings within the next 10 years. 55.1% of the job openings are projected to be from replacing retiring workers, and 44.9% will be new jobs due to economic growth.⁵⁴ For home support workers, the data suggests there will be a 1.7% job growth between 2026 and 2031, with 7,410 new job openings within the next 10 years. 59.1% of the job openings are projected to be from replacing retiring workers, and 40.9% will be new jobs due to economic growth.⁵⁵

Gender and age

HCAs are primarily women. WorkBC states that in BC, 85% of nurse aides are women.⁵⁶ For home support workers, 87% are women.⁵⁷ Other studies examining HCA work across Canada have found the number of women to be in the similar range, between 89 and 93%.⁵⁸

HCAs range in age, but most are middle aged.⁵⁹ According to the 2016 census data, in BC home support workers are distributed in the following age groups:

- 15-24: 7% for nurse aides and 4% for home support workers
- 25-44: 39% for nurse aides and 32% for home support workers
- 45-64: 50% for nurse aides and 57% for home support workers
- 65+: 4% for nurse aides and 7% for home support workers⁶⁰

Language

Many HCAs do not speak English as their first language. Studies have found the number of HCAs who speak English as a second language to range from 50% to 68%.⁶¹ The number of HCAs in BC who speak English as a second language differs depending on the region. In BC, most of the HCAs in the lower mainland spoke English as a second language; however, in Interior Health, most HCAs spoke English as their first language.⁶²

By way of comparison with other parts of Canada, one Manitoba study concluded that many HCAs spoke English as a second language: 32% spoke English, 34% spoke Tagalog, and 13% spoke Filipino.⁶³ In Alberta 64.8% spoke English as a second language.⁶⁴

Immigration

Many people working in Canada as HCAs were not born in Canada. Studies place the number of HCAs born outside of Canada in the range of 25% to 69%.⁶⁵ For example, one

study found that in Ontario, 42% of HCAs were not born in Canada. 27% of the HCAs were from Latin America, 18% were from Europe, and 40% were from Asia.⁶⁶

Nova Scotia is an outlier. Only 27% of community care assistants (CCAs) were a visible minority.⁶⁷ Nova Scotia has a smaller population and fewer economic opportunities, which can create strain regarding hiring foreign workers to fill the gaps.⁶⁸ Researchers found there is resentment towards foreigners who are perceived to be taking economic opportunities.⁶⁹ Researchers have speculated that these conflicting issues have made it more difficult for foreign workers to find success in Nova Scotia. Rather, employers prefer to hire locally trained CCAs wherever possible.⁷⁰

Continuing education

We discuss variations across jurisdictions in terms of education and credentialing in Chapter 6. More generally, it appears that HCAs often do not have time to complete additional training once they start working. For example, Estabrooks et al found that 50% of surveyed HCAs had not attended any type of training or learning during the past year.⁷¹ Gauthier et al studied how HCAs sought out information, and made the following observations:

- They first rely on steps or procedures they have memorized and what their past experiences have taught them;
- They seek out information when they need it to avoid mistakes, to provide better care, if the resident has a change in condition, to better prepare themselves for the job at hand, when they are feeling job stress, and when they want to provide safe care;
- They identified time as biggest obstacle to getting information;
- They do not often rely on printed information; they preferred to obtain verbal information;
- They say power dynamics with other health care professionals impact their ability to obtain information; and
- They use printed information generally only as quick reference tools or for residents' daily living sheets.⁷²

Job entry

One meta-analysis examined why HCAs entered the job. The most common reasons for entering the HCA workforce were:

- Wanting to help people
- Wanting to work with people
- Wanting to work in health care
- Seeking job security
- Seeking a job with good benefits⁷³

Sheila Novek studied HCAs from the Philippines who worked in long-term care. The reasons they provided for immigration included poverty, unemployment, and underemployment.⁷⁴ Among the HCAs in the study, none of them had intended to work as HCAs in Canada. Many had completed university education in the Philippines, but could not qualify to work in their profession in Canada. The two primary barriers HCAs identified to gaining work in their chosen profession were accreditation challenges and English language proficiency. HCAs reported they had learned about being an HCA through their social networks.⁷⁵ Reasons cited for becoming an HCA included job security, improving their English skills, and flexible hours.⁷⁶

2.2.4 The Changing Experience of Working in Long-Term Care

Long-term care residents typically have the highest acuity. The needs of residents living in long-term care have changed in recent years.⁷⁷ More people are aging at home in the community, and entering long-term care once their care needs are more complex. Older adults may also live in assisted living or seniors independent living residences which can support them with moderate levels of care before moving to long-term care.

In BC, the eligibility for long-term care has changed. A person must require round the clock nursing care in order to be an appropriate candidate.⁷⁸ This means long-term care residents are coming in with medical and chronic conditions, and increasingly, cognitive impairments such as Alzheimer's Disease.⁷⁹ Chamberlain et al point out: "[r]esidents routinely enter nursing homes with multiple chronic conditions and in later states of dementia with accompanying heavy care needs that can contribute to care aide burnout."⁸⁰

The composition of the care teams in Canada's health care system has also changed. Over time, there has been an increase in lower-trained health care professionals, such as HCAs and LPNs, and a decrease in the number of RNs.⁸¹ Dahlke and Baumbusch have studied how the mix of care staff impacts care. Study participants reported conflicts between the different types of health care workers. The writers identified workload issues for RNs, who must focus on the highest acuity patients. An important factor in terms of how well the team functioned was communication. The study noted that other staff often left HCAs out of care team discussions.⁸² Other studies confirm this finding.⁸³

In long-term care the roles of LPNs and RNs are becoming more similar. LPNs are

increasingly supervising HCAs and delegating tasks to them.⁸⁴ The research is mixed on whether having an RN or LPN as supervisor increases the quality and effectiveness of care.⁸⁵

With increased resident acuity in long-term care, more residents are dying within long-term care. Just et al found that in developed countries “33%-50% of their older adult populations will die in [long-term care].”⁸⁶ Just et al studied HCA roles for end-of-life-care in long-term care. They found that HCAs were very involved in end-of-life care. HCAs reported performing other care actions outside their normal role behaviour to help residents. Normal roles for an HCA in end-of-life care include reducing pain, making residents comfortable, treating the person with dignity and respect, helping the person be at peace, and providing support and encouragement to the resident’s loved ones. This aspect of work takes a significant emotional toll on HCAs: they develop relationships with their patients and therefore negotiate constant grief and loss as part of work.⁸⁷

HCAs also report providing higher levels of physical care, providing more care than usual, performing care at a more cautious pace, encouraging loved ones to ask nursing staff for pain medication, staying with the resident so they are not alone, being emotionally close to the resident, and standing in for loved ones if the resident is alone.⁸⁸ A number of key informants reported to us that HCA work is highly relational and inter-personal, rather than being strictly task-based.

2.3 Precarity and Vulnerability

2.3.1 Precarious Employment

In Canada there is a growing body of work examining precarious employment.⁸⁹ Precarious employment contrasts with standard permanent employment positions characterized by full-time hours that are consistent across the year. Precariousness is multi-dimensional and related to the conditions of work rather than the person.⁹⁰ Cranford et al identify four dimensions of precarity in relation to work. They are the degree of:

1. job security;
2. control over the way the work is done and rewarded, for example, job “conditions, wages and pace of work”;
3. regulatory protection (union, regulatory college, legislation); and
4. financial security through work (income, health benefits, pension).⁹¹

HCA work is precarious.⁹² As noted earlier, most of the positions are casual, and many HCAs must work multiple jobs to earn an adequate income. Further, the pay is usually low. HCAs often have inconsistent hours, and experience job insecurity. There are limited opportunities to advance in the job without obtaining a higher education level.⁹³

The BC Seniors Advocate, in reviewing COVID-19 outbreaks in long-term care, found that many HCAs were casual, and so lacked sufficient sick time.⁹⁴ The Seniors Advocate found that 61% of staff were regular staff, either full or part-time, and 39% were casual.⁹⁵ While 96% of the regular staff had paid sick leave, only 10% of facilities provided casual staff with sick time.⁹⁶ HCAs receive the least amount of sick time of all the direct care employees in long-term care.⁹⁷ For regular staff, HCAs who worked in long-term care run by health authorities received the greatest number of sick days, followed by not-for-profit long-term care facilities.⁹⁸ The number of sick days are of concern because facilities which permitted few sick days were more likely to have larger outbreaks during the pandemic.⁹⁹

Some researchers have found there is a shortage of HCAs. However, other research indicates the problem is likely recruitment and retention of HCAs, since the positions typically offer low wages and casual employment. The practice of HCAs working multiple jobs can create staff scheduling problems.¹⁰⁰ There is a high rate of turnover among HCAs.¹⁰¹

2.3.2 Discrimination

HCAs who are Black, Indigenous, or people of colour experience racism in the course of their employment. The racism is perpetrated by co-workers, clients, and family or friends of clients, residents, and patients, and is highly systemic in nature.¹⁰² Experiences of racism have been found to be highest for unregulated care providers and home and community care workers than for regulated health professions, such as nurses and doctors.¹⁰³

In the BC health care system, indigenous-specific racism is a major area of concern. In 2020, BC conducted a review of systemic racism against Indigenous peoples in the BC health care system.¹⁰⁴ The review found widespread stereotyping, racism, and discrimination. Half of the Indigenous health care workers who participated in the review reported experiencing stereotyping and racism in the course of their work. Indigenous health care workers reported that the racism had limited their career, and led to negative personal outcomes. Many Indigenous health care workers stated they could not safely report the racism to their supervisor or employer. In health care, the culture does not promote speaking up about racism; instead, racism is largely ignored or tolerated.¹⁰⁵ Health care workers identified the following needs:

- More Indigenous health care workers in the system;
- A safer learning environment for students to learn in;
- More systemic efforts to recruit, train, and retain health care workers;
- Increased education and training on reducing racism; and
- Improving the health care culture so people feel comfortable speaking out when

experiencing or witnessing racism.¹⁰⁶

2.3.3 Burnout

The increase in a resident acuity in long-term care has heightened HCA workloads. Larger and more challenging workloads mean that HCAs have a greater risk of burnout.¹⁰⁷ HCAs report exhaustion and cynicism.¹⁰⁸ They also experience organizational factors that can increase the risk of burnout, such as increased workload, obstacles, and time pressures.¹⁰⁹

Burnout can be mediated by several factors. One of these is job satisfaction. Many studies have found that HCAs have a high level of job satisfaction¹¹⁰ at least partly because they consider the work important.¹¹¹

2.3.4 Work Safety and Work Injuries

HCAs face a number of risks in the job. SafeCare BC is a non-profit that develops occupational health and safety training for the long-term care and home and community care sectors.¹¹² They indicate that HCAs have the highest injury rate across province per occupation, even compared with police and firefighters.¹¹³ HCAs working in long-term care had a higher injury rate than HCAs in home and community care or acute care.¹¹⁴ HCAs do physically demanding work, have large workloads, and have insufficient time to perform tasks.¹¹⁵ They experience psychological and emotional stress.¹¹⁶ HCAs can experience many different types of injuries, including:

- Musculoskeletal injuries;
- Stress;
- Fatigue;
- Infectious or contagious diseases;
- Physical violence;
- Verbal abuse;
- Bullying;
- Allergens and irritants;
- Psychological injuries; and
- Scratches, cuts, bruises, punctures, or bites.¹¹⁷

2.3.5 Challenges in Long-Term Care

HCAs experience a great deal of frustration with the work. Booi et al conducted qualitative interviews with HCAs working at a long-term care facility in rural BC to examine how HCAs perceived their job. The researchers, whose paper was titled “I wouldn’t Choose this Work Again”, found several concerning themes.¹¹⁸

Gaps in education and training

- Their education did not prepare them for the job. They had to learn a lot on the job.
- They were not taught how to develop relationships with clients even though the work was very relational and intimate.

Exclusion from care team

- HCAs were rarely included in the care decisions, despite knowing the residents or patients the best.
- Other care providers higher up in the care hierarchy dismissed the HCA role.
- HCAs reported feeling powerless.

Staffing and structural issues

- HCAs worked short-staffed most of the time.
- HCAs lacked the ability to control how they spent their care time.
- HCAs were often made to work through a busy checklist that did not reflect the needs of the residents.
- Some HCAs saw the long-term care system as failing residents and families, and felt unable to take action to provide better care.

Stigma and discrimination

- The HCA is quite stigmatized by the public, being reduced to toileting tasks.
- Bullying and discrimination from their fellow HCAs and other care team members is common.

2.3.6 Challenges in Home and Community Care

Increased need for HCAs

More adults are aging in place. Consequently care is moving from institutions to the community. With this shift, the need for home and community care has grown.¹¹⁹ Sims-Gould and Martin-Matthews note that from 2000 to 2010, home and community care costs in Canada doubled, and the number of care recipients increased by 24%.¹²⁰ Macdonald et al found that between 2008 and 2011 home and community care services increased by 55%,

and there is still unmet need.¹²¹

Home and community care includes a range of services aimed to support people to stay in their own homes for as long as possible, rather than receiving care in long-term care or hospital.¹²² HCAs, LPNs, RNs, and others participate in home and community care. Home support makes up approximately 90% of the home and community care services provided to British Columbians,¹²³ and home support is delivered almost exclusively by HCAs in BC.¹²⁴

Increase in work complexity

Home and community care can include personal care, health-related tasks, food preparation, and housekeeping. Home and community care tasks are increasingly being delegated to HCAs from nurses, or allied health professionals like physiotherapists or occupational therapists.¹²⁵ Commonly delegated tasks include “transfers...simple wound care, exercises, medication management, catheterization, colostomies, compression stockings, G [gastro-intestinal]-tube feeding, continence care, blood sugar monitoring, eye drops, and injections.”¹²⁶ Home and community care HCAs also may provide specialized tasks, such as palliative care and rehabilitation tasks.¹²⁷

A study by Barken et al found that when HCAs are performing delegated tasks, they are developing a base of more complex skills and knowledge. This increased skill level can allow HCAs to feel that they have more control of their work, and feel more autonomy and mastery. In turn, HCAs find more meaning and reward from their work, even if the monetary rewards are not increased.¹²⁸ However, there is some concern that home and community care HCAs often lack adequate time to learn these delegated skills.¹²⁹

Training gaps

Some BC home support staff have no training.¹³⁰ Although training gaps are not unique to home and community care, home support HCAs work without on-site support and supervision, and so this lack of training can be particularly concerning, depending on the nature of their assigned tasks.

Some home and community care HCAs work in rural areas, which present some unique difficulties. Zena Sharman’s research identifies the following challenges related to rural care:¹³¹

Table 3: Challenges Identified by Home and Community Care HCAs¹³²

Safety-related issues	
Having sole responsibility for their health and safety on the job	
Difficulty reporting problems to supervisors	
Unpredictable working conditions	
Staying in unsafe environments because of a duty to provide care	
Inadequate health and safety training	
Lack of onsite help if they experience an injury or violence	
Task-specific issues	
Inflexible task lists for clients	
Inadequate time to perform all client tasks	
Inter-personal issues	
Managing clients' expectations regarding tasks outside of the work scope	
Having a client's family members around during the home and community care visit	
Trying to fulfill clients' needs for companionship when not part of usual duties	
Responding to requests for activities which are not in the care plan or not safe	
Infrastructural issues	
Extensive travel required between clients' homes	
Personalizing care in a rushed and regimented environment	
Extra expenses incurred because they must use their own car and phone for work	
Challenges related to specific home environments ¹³³	
Dirt and clutter	Pets
Hoarding	Poor driving or weather conditions
Smoking	Tripping hazards

Table 4: HCA Work—Challenges related to Rural Care

Travel
Long driving distances between clients
Poorly-maintained roads
Insufficient compensation for travel
Severe weather
Limited public transit
Service, workload, and skill
Broad range of duties
Lack of local training programs
Inadequate community health or social services to support the client
Staff shortages that increase workload
Safety
No cell phone reception, so the HCA cannot call for help
Encounters with wild animals, farm animals, or pets while on the job
Income
High cost of living
Too few home support clients to provide a predictable and sufficient income
Other
Lack of privacy or separation from clients due to the small community size

2.4 The Impact of the COVID-19 Pandemic

The COVID-19 pandemic had a disproportionate effect on older people and people living and working in long-term care. Long-term care residents are particularly vulnerable to COVID-19 due to their health conditions and age. During the first year of the pandemic, 80% of the COVID-19 deaths were long-term care residents,¹³⁴ half of long-term care facilities experienced an outbreak, and 96% of the outbreaks involved a staff member.¹³⁵ The Seniors Advocate found that those working and living in long-term care were 3.3 times more likely to contract COVID-19. If the first case of COVID-19 in the facility was a staff member, half of

these cases were in an HCA.¹³⁶

The pandemic has highlighted and exacerbated long-term care issues that existed beforehand. For example, during the pandemic, staff shortages became worse. Staff shortages can increase the risk of infection, abuse, and other safety issues.¹³⁷

2.4.1 BC Provincial Health Orders

On March 25, 2020, the BC Provincial Health Officer announced that people working in long-term care and assisted living would be restricted to working at one facility. However, the single site order did not prevent a person from working in another job outside of long-term care or assisted living, such as acute care or home and community care.¹³⁸

As previously described, many HCAs work multiple jobs. To deal with the loss of a second income for those HCAs that worked at multiple long-term care or assisted living facilities, the province enacted a health care labour adjustment. Any person who was impacted by the single site order had their hourly wage matched to the rate recognized in the Health Employers Association BC collective agreement for their job type.¹³⁹

To help manage labour shortages flowing from the single site rule, the Provincial Health Officer also required long-term care facilities to provide information about health employees to the Ministry of Health.¹⁴⁰ For one month, the Provincial Health Officer also put in an order prohibiting personal service providers from entering long-term care or assisted living for activities such as haircuts.¹⁴¹ In 2020 the BC Provincial Health Officer also issued orders limiting visitor access in long-term care and assisted living.¹⁴²

2.4.2 The Impact of Provincial Health Orders on the Work of HCAs

Researchers and government have examined the impact of the COVID-19 pandemic and the PHO orders. While some of the policies did succeed in reducing COVID-19 infections, there were many negative impacts on both older people and those caring for them.¹⁴³

Both the single site order and visitor restrictions helped to reduce the transmission of COVID-19 in long-term care, but at a cost to residents and staff.¹⁴⁴ The single site policy reduced the number of staff working in facilities, especially for contracted and private long-term care facilities. This was problematic because long-term care facilities were already facing staffing difficulties. Some staff left private and contracted facilities to work at health authority run facilities, which offered better salaries and benefits. Although the wage levelling was critical to attracting staff, communication about it was lacking.¹⁴⁵

A report commissioned by the Ministry of Health to evaluate its response to the pandemic noted that staff shortages increased pressure on existing staff. Some staff members were concerned about bringing COVID-19 home to their families. Many staff reported increased stress, anxiety, and burnout. The impacts on mental health led to further staffing challenges.¹⁴⁶

Researchers have noted the impacts that COVID-19 outbreaks had on HCAs. These impacts include:

- Concerns about infecting family or residents;
- Worsened mental health;
- Less time off work;
- Working with too few staff members due to single site orders and illness;
- Feeling pressure to come into work sick;
- For overnight staff, not receiving sufficient support or training;
- Increased risk of burnout;
- Lost income due to single site order; and
- Increased anti-Asian racism.¹⁴⁷

Lack of sick time for HCAs combined with work pressures resulted in long-term care staff coming into work sick. 40% of respondents to the Seniors Advocate's survey on Covid-19 outbreaks reported coming into work sick. Their reasons for coming in sick included not wanting to leave co-workers short staffed, feeling pressure from their employer, and losing earnings.¹⁴⁸



3.1 Overview

The BC Care Aide & Community Health Worker Registry (the BC Registry) oversees HCAs on behalf of the Ministry of Health.¹⁴⁹ In the context of day-to-day practice, it is generally nurses—including registered nurses (RN), registered psychiatric nurses (RPN), and licensed practical nurses (LPN)—who oversee the work of HCAs.

In this chapter we explain:

1. The role of the BC Registry;
2. The BC program recognition requirements for HCA educational programs;
3. The BC registration requirement for HCAs;
4. Key features of the BC HCA Provincial Curriculum (more details can be found in appendices to this study paper);
5. The BC HCA core competency profile;
6. Delegation and assignment of nursing tasks to HCA; and
7. Oversight through the *Community Care and Assisted Living Act*.

3.2 The BC Care Aide and Community Health Worker Registry

3.2.1 History Leading to the BC Registry's Creation

In 2006 and 2007, the Ministry of Health recognized that there was no legislation covering HCAs, no regulatory body, and no legally defined scope of practice.¹⁵⁰ To identify occupational competencies for HCAs, the province funded the 2007 Care Aide Competency Project. This work resulted in the creation of HCA competencies, the 2008 BC HCA Provincial Curriculum, and the BC Registry. The BC Registry also formed part of the Minister of Health's commitment to track and address abuse by unregulated health care workers in BC.¹⁵¹

The Ministry of Health created the BC Registry in 2010.¹⁵² The BC Registry was not created by legislation. Contract law and health policy form the legal basis for the BC Registry. Publicly funded employers have a contract with the Ministry of Health or a health authority to provide care. These contracts require any employer receiving public funding in BC to hire HCAs who are on the BC Registry and to report any allegation of abuse or neglect towards a client by an HCA. This requirement includes employers who have a contract with a health authority.¹⁵³

3.2.2 The BC Registry's Mandate

The BC Registry's website lists three mandates under which it operates:

1. "To protect vulnerable patients, residents and clients"
2. "To establish and improve standards of care in the care aide and community health worker occupation"
3. "To promote professional development for care aides and community health workers and to assist these workers in identifying career opportunities"¹⁵⁴

1. The BC Registry fulfills its public protection role by:

- Maintaining a registry of HCAs which can be accessed by publicly funded employers;
- Creating a process for reporting and investigating abuse or neglect by a HCA; and
- Suspending or removing HCAs from the BC Registry if they have engaged in abuse or neglect.¹⁵⁵

2. The BC Registry addresses standards of care by:

- Establishing a “standard, provincially mandated Health Care Assistant Training Program” (BC HCA Provincial Curriculum);¹⁵⁶
- Maintaining the program standards for delivery of the BC HCA Provincial Curriculum;
- Ensuring registrants complete training that follows the BC HCA Provincial Curriculum or equivalent training;
- Communicating the BC HCA Provincial Curriculum to education programs;
- Developing the BC Health Care Assistant Program Recognition: Guide for Educators (the “Program Recognition Guide”), which sets out HCA Program Standards; and
- Assessing and recognizing educational programs.¹⁵⁷

3. The BC Registry promotes continuing education by providing resources on its website, including the Core Competency Profile for HCAs.¹⁵⁸

3.2.3 Scope of the BC Registry

There are several groups of people or organizations that participate in BC Registry processes:

1. Health employers who receive public funding and employ HCAs;
2. HCAs who are or wish to work for a publicly funded employer; and
3. Educational institutions who have or wish to have an HCA education program recognized by the BC Registry.

1. Employers: The BC Registry applies to employers who receive public funding. A publicly funded employer must confirm an HCA is registered with the BC Registry before that person is hired as an HCA. A publicly funded employer must also report any HCA who is suspended or fired for allegedly abusing or neglecting a client, resident, or patient. If a health employer who employs HCA does not receive any public funding, then the BC Registry does not apply to them.¹⁵⁹

2. HCAs: An HCA who wants to or is working for a publicly funded employer must be registered with the BC Registry.¹⁶⁰ The full requirements for becoming a registrant, including for those HCAs who were educated outside of BC or Canada, are discussed in section 3.2.5 below.

3. Institutions and programs: The BC Registry website lists all HCA educational programs which have been recognized by the BC Registry, which means they follow the BC HCA

Provincial Curriculum and meet the program standards set out in the Program Recognition Guide (the “Program Standards”).¹⁶¹

3.2.4 Registry Governance and Staffing

The Health Employers Association of BC (HEABC) runs the BC Registry.¹⁶² The BC Registry has a manager who reports to HEABC, who then reports to the Ministry of Health, and five additional full-time staff.¹⁶³

The BC Registry has an advisory committee that meets three times a year. The advisory committee is made up of unions, employers, education institutes, and the BC Registry’s program manager.¹⁶⁴ As of 2012, there were 13 members:

- 4 union members;
- 4 employer members from the Health Authorities and the community services sector;
- 2 education institution members;
- 1 Health Match BC member; and
- 2 home support sector members.¹⁶⁵

The BC Registry has four investigators.¹⁶⁶ The investigators are contracted, and work when they are needed. The investigators are appointed every three years by the advisory committee. Most of the investigators have law degrees, and have experience in labour relations and mediation or arbitration. There is no formal procedure for investigations. Each investigator can create their own process.¹⁶⁷

As of 2012, the annual budget for the BC Registry was \$478,000, to cover staff costs, development, and other operating expenses. In 2022, the BC Registry’s budget was \$759,719.¹⁶⁸ The costs of investigations when the HCA is a union member are split between the union and the employer. When the HCA is not in a union, the BC Registry pays the investigation costs. The mean cost of an investigation in 2022 was \$5,976.80.¹⁶⁹

3.2.5 Registration Requirements for HCAs

Registration requirements depend on where the HCA obtained their education. The following categories of people can be registered:

- Graduates of an approved BC HCA program;
- Graduates of other Canadian HCA or HCA equivalent programs;
- Canadian-licensed or trained LPNs, RNs, and RPNs;
- Nursing students in Canada; and

Table 5: BC Registry Registration Requirements¹⁷⁰

Application Category			Documentation	Practice Experience	Additional Training	Skills Assessment
BC HCA Program Graduates			Graduation certificate, official transcript, or official letter of completion	Is part of BC curriculum	None if program approved by the BC Registry	Maybe if training completed more than 3 year ago
Canadian HCA Program Graduates	Expedited Pathway	Category 1	<ul style="list-style-type: none"> - Graduation certificate or official transcript - proof of English language competency - Resume - Satisfactory HCA Nurse Manager Competency Reference Form 	1125 practice hours in the last 3 years or 450 practice hours in the last year	HCA Standardized Orientation Program	None
		Category 2	<ul style="list-style-type: none"> - Graduation certificate or official transcript - Proof of English language competency - Practice hours verification form - Resume - HCA Clinical Instructor Competency Reference Form 	None	HCA Standardized Orientation Program	None
	Competency Assessment Pathway		<ul style="list-style-type: none"> - Graduation certificate or official transcript (within the last 2 years) - NCAS* Consent Referral Form and report 	None	None	NCAS HCA Assessment
Canadian-Licensed or Trained LPNs, RNs, RPNs		Licensed BC nurse	Current or recently expired LPN, RN, or RPN license	None	None	None
		Licensed out of province nurse	<ul style="list-style-type: none"> - Current or recently expired LPN, RN, or RPN license - Resume showing past 5 years of nursing work 			
		Canadian nursing graduate	Proof of graduation from a nursing program which is approved by a Canadian nursing regulatory body			
Nursing Students in Canada (current or recent)			<ul style="list-style-type: none"> - Official transcript from Canadian nursing program approved by a Canadian nursing regulatory body; - Competency reference letter from a nursing program; - Character reference 	None	None	None
Internationally Trained HCAs			<ul style="list-style-type: none"> - Graduation certificate, diploma, or degree - Official transcript - Proof of English service language competency -World Education Services or International Credential Evaluation Service evaluation 	None	Remedial education if required by NCAS	NCAS HCA Assessment

*NCAS is the Nursing Community Assessment Service

- Internationally educated health care professionals.¹⁷¹

HCAs must verify their account with the BC Registry annually. The BC Registry will only list current verified registrants. If an HCA does not verify their account, they will be archived and not displayed on the BC Registry.¹⁷²

There is no cost to be registered.¹⁷³ Any HCA who meets the BC Registry's requirements can be listed with the BC Registry, even if they are currently not working or are working for a private employer.¹⁷⁴

3.2.6 Abuse and Neglect Process

An employer who receives public funding and hires HCAs is eligible to register as an employer and gain access to the BC Registry database.¹⁷⁵ These employers must report to the BC Registry if an HCA has been suspended or fired because they have allegedly abused or neglected a client, patient, or resident. The employer must make the report in writing within 7 calendar days of suspending or firing the HCA.¹⁷⁶

An employer's report must list who the employee is, and the nature of the allegation.¹⁷⁷ Upon receipt of a report, the BC Registry will suspend the HCA until a determination can be made on the allegation of abuse and neglect. The HCA can be suspended from their employment without pay for up to 21 calendar days. If after 21 days the determination cannot be completed, the employee must be suspended with pay.¹⁷⁸ Other aspects of the process depend on whether an HCA is a part of a union or not, and whether a grievance is filed.

Definitions of abuse or neglect

The BC Registry uses the definitions of abuse and neglect found in the *Residential Care Regulation*. Abuse includes physical, emotional, financial, and sexual abuse.¹⁷⁹

Schedule D

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"emotional abuse" means any act, or lack of action, which may diminish the sense of dignity of a person in care, perpetrated by a person not in care, such as verbal harassment, yelling or confinement;

"financial abuse" means

- (a) the misuse of the funds and assets of a person in care by a person not in care, or
- (b) the obtaining of the property and funds of a person in care by a person not in care without the knowledge and full consent of the person in care or his or her parent or representative;

“neglect” means the failure of a care provider to meet the needs of a person in care, including food, shelter, care or supervision;

“physical abuse” means any physical force that is excessive for, or is inappropriate to, a situation involving a person in care and perpetrated by a person not in care;

“sexual abuse” means any sexual behaviour directed towards a person in care and includes
 (a) any sexual exploitation, whether consensual or not, by an employee of the licensee, or any other person in a position of trust, power or authority, and
 (b) sexual activity between children or youths,
 but does not include consenting sexual behaviour between adult persons in care;¹⁸⁰

Abuse and neglect statistics

The BC Registry released its latest update report on May 10, 2022. This update covers the COVID-19 emergency measures, data on reports of abuse and neglect, data on program recognition, and data on HCA applications. This report provides data from 2017 to 2021.¹⁸¹ The numbers each year are fairly consistent, apart from a small drop in number of reports during 2021. The chart below shows the data from 2017 to 2022, taken from page 2 of the *Spring Updates Report 2022*.¹⁸²

Table 6: Abuse and Neglect Reports to the BC Registry, 2017-2022

	2017	2018	2019	2020	2021	Total
Alleged abuse cases reported to the Registry	92	110	98	88	75	463
HCAs returned to the Registry (allegation withdrawn, grieved and/or not substantiated) without a Registry appointed investigation	54	65	58	55	41	273
Terminated HCA employees removed from Registry without a dispute request for a Registry appointed investigation	10	21	24	11	6	72
Terminated HCA employees with Registry appointed investigations	28	24	16	22	28	118
HCAs removed from the Registry by an Investigator (2017 to 2021)						15
HCAs reinstated to the Registry with or without conditions by an Investigator (2017 to 2021)						101
Ongoing investigations (2017 to 2021)						2

Source: BC Care Aide & Community Health Worker Registry, Spring Updates Report 2022, by Sarina Corsi & Lara Williams (May 10, 2022) at 2. Reprinted with permission.

During the 2017-2021 period, there were 463 cases of alleged abuse reported to the BC Registry. Of these 463 reports, 273 were reinstated without an investigation by the BC Registry. This includes when the allegations were withdrawn, the grievance was not substantiated, or there was a suspension that was not contested.¹⁸³ These situations represent 59% of the reported cases of alleged abuse.

Of the reports of alleged abuse, 72 HCAs were terminated, and there was no request for the BC Registry to appoint an investigator. The HCAs were removed from the BC Registry.¹⁸⁴ These reports represent 15.5% of the reported cases of alleged abuse.

The remaining 118 reports were for HCAs who were terminated, and a BC Registry investigation was requested.¹⁸⁵ This represents 25.5% of the reported cases of alleged abuse.

Of the 118 reports that resulted in investigations, the outcomes were as follows:

- 15 investigations resulted in removal from the BC Registry (12.7% of investigations);
- 101 investigations resulted in reinstatement to the BC Registry, either with or without conditions (85.6% of investigations); and
- 2 investigations were still ongoing (1.7% of investigations).¹⁸⁶

Process when no union or no grievance

The process is simplest when an HCA is suspended, but the union does not file a grievance and the HCA wishes to serve their suspension and return to work. In this case, the HCA will be suspended from the BC Registry while they are suspended from their employment. When the HCA returns to work, their BC Registry status is restored.¹⁸⁷

If the HCA is fired and they are not a member of union, or the union chooses not to grieve the matter, the HCA can ask the BC Registry to appoint an investigator. The HCA must request an investigator within 30 days of termination. The investigator will collect evidence and information, talk with the parties, and may conduct a hearing. The investigator will provide a written report.¹⁸⁸ The report can recommend:

- Whether the HCA should be reinstated or stay suspended from the BC Registry;
- What length of suspension the HCA should serve; or
- What conditions should be placed on the HCA's reinstatement.¹⁸⁹

Process when there is a grievance

If the HCA is a member of the union, and the union grieves the suspension or termination, the process is more complex. If the grievance is resolved through the method specified in the collective agreement, then the HCA will either be reinstated to the BC Registry or remain removed from the BC Registry. When the HCA is reinstated to employment through the grievance process, the HCA will be reinstated to the BC Registry. However, the BC Registry requires assurance from the employer that the HCA does not pose a risk to the public in cases where the grievance has been resolved with a resignation.¹⁹⁰

If the grievance is not resolved, and the HCA was fired, the union can request an investigator be appointed. The investigator will gather evidence and try to help the union and employer resolve the matter. The investigator will provide a written report.¹⁹¹ The report can recommend:

- Termination;
- Reinstatement, with or without other conditions;
- A period of suspension from the BC Registry; or
- Whether the suspension should be permanent (removal from the BC Registry).¹⁹²

If the investigator recommends reinstatement without conditions, they will be put back on the BC Registry. Where there are conditions for reinstatement, these must be fulfilled prior to being put back on active status on the BC Registry. If both parties accept the recommendations, then the matter will be resolved. If one or both of the parties rejects the recommendations, the matter can proceed to arbitration as determined by the collective agreement.¹⁹³

3.2.7 Continuing Education for HCAs

One of the BC Registry's mandates is to promote continuing education for HCAs. The BC Registry does not impose any continuing education or skill development requirements on HCAs but rather lists education modules that are available on its website.¹⁹⁴ In comparison, continuing education is typically required for a regulated health professionals as part of their continuing registration each year.¹⁹⁵ The courses currently listed on the BC Registry website can be found in Appendix 2. The BC Registry's website is updated periodically when courses are added or removed

Occupational health and safety

SafeCare BC provides ongoing education and training for HCAs who work in long-term care and home and community care. Employers in the long-term care, home and community care, or community health sector are automatic members of SafeCare BC, with the exception of HCAs directly employed by a health authority.¹⁹⁶ Educators and service providers can purchase a membership.¹⁹⁷

SafeCare BC's goal is to reduce workplace injury and enhance workplace safety.¹⁹⁸ SafeCare BC's programming supports health care workers, educators, and employers. They offer:

- Training on safety, injury prevention, and violence protection;
- Professional development;¹⁹⁹
- Information on relevant legislation and policies;²⁰⁰
- Tailored outreach to organizations on health and safety matters;²⁰¹
- Training for in-house educators on violence prevention, dementia care, safety leadership, and safe client handling;²⁰²
- A peer resource network;²⁰³
- Mental health resources;²⁰⁴ and
- Resources on violence prevention, dementia care, musculoskeletal injury prevention, infection control, and bullying and harassment.²⁰⁵

3.3 HCA Education in BC

This section will outline HCA education.²⁰⁶ We will describe:

- The BC Registry's role in HCA education;
- The BC HCA Provincial Curriculum;
- Current BC HCA education programs; and
- The HCA Core Competency Profile.

3.3.1 The BC Registry and HCA Education

Part of the BC Registry's mandate is to standardize HCA training. The BC Registry ensures HCA education programs are following the BC HCA Provincial Curriculum, meeting the Program Standards, and graduating HCAs who are competent and eligible to be registered.²⁰⁷ The BC Registry does the following activities in regard to HCA education:

- Reviews and recognizes HCA programs to ensure compliance with BC HCA Provincial Curriculum and Program Standards;
- Reviews HCA programs to ensure continued compliance with BC HCA Provincial

- Curriculum and Program Standards;
- Reviews changes to HCA programs; and
- Develops various resources for educators on the BC HCA Provincial Curriculum.²⁰⁸

The Program Recognition Guide sets out the Program Standards that must be met in order for a program to be recognized.²⁰⁹

3.3.2 Recognized HCA education programs in BC

As of May 2022, there are 36 BC HCA education programs in BC. These programs are offered at 78 locations. Of these programs, half are at public education institutions, and the other half at private institutions. 32 of the programs have full recognition status. One program has interim recognition, and three are new programs who have not yet completed the compliance assessment.²¹⁰

Currently, 17 HCA programs are approved to have a combined delivery format. This means that some theory work is done remotely or online, and the lab and practical components are done in person. In 2021, 16 HCA programs requested to change their program delivery to be combined. Five applications are still under review.²¹¹

The HCA program recognition process was initiated in 2013. The first review cycle of BC HCA programs took place from 2014-2017 and the second cycle was from 2019-2022.²¹² With the second review cycle coming to an end, the BC Registry is considering updates to program recognition processes. The HCA Program Recognition Guide, 2nd Edition (2018), which outlines these processes, is currently under review. A third edition is expected to be released in Spring 2023.

Appendix 3 lists current (as of the publication date) BC HCA programs. The list of programs is subject to change. The BC Registry website provides more up to date information.²¹³

3.3.3 Requirements for HCA Program Approval

If an HCA education program wishes to meet the requirements of the BC Registry and be an approved program, they must apply to the BC Registry. The application process involves five steps for the initial program recognition.²¹⁴

The **first step** is to submit a Notice of Intent. The Notice of Intent asks for the education institute information, program contact information, and hours for the different parts of the education program.²¹⁵ In the Notice of Intent, the program must meet the following requirements to move to the next stage:

- Follow the BC HCA Provincial Curriculum;
- Include at least 475 hours of theory and laboratory courses;
- Include at least 270 hours of practice experience; and
- Have the program length be at least 745 hours total.²¹⁶

The **second step** is to have an educator orientation meeting. The BC Registry staff will meet with the new program staff to discuss the program approval process. The program must have a subject matter expert in place who can help them develop a program that meets the Program Standards.²¹⁷

The **third step** is to complete the online application for recognition. The program must provide information to prove they meet the Program Standards.²¹⁸

The **fourth step** is to complete the new program recognition submission. The program must prove they meet all the Program Standards and the BC HCA Provincial Curriculum. If the BC Registry is concerned about the submission, they may conduct an initial site visit to see if they have sufficient facilities and resources. Once the institution meets this fourth step, they can be added to the list of recognized programs on the BC Registry's website.²¹⁹

The **fifth step** is the program compliance assessment, which involves the site visit. At this stage, the program must submit their pre-visit compliance assessment report. A site visit will be scheduled later. The site visit is usually a one day visit.²²⁰ This visit will include:

- A tour of the program facility;
- A document review, including student files, instructor resumes, and program policies;
- Interviews with current students; and
- Interviews with program instructors, admissions staff, and student services personnel.²²¹

At the end of the visit, the BC Registry staff will provide preliminary feedback. The draft compliance report is given three to four weeks after the site visit. A final compliance assessment report is released within three months of the draft report, at which time the program's status on the website will be updated.²²² There are three possible statuses for a program after the site visit: recognition withdrawn, interim recognition with conditions, or five-year recognition.²²³

3.3.4 Ongoing Program Compliance

There are requirements for maintaining good standing. The institution must submit online

annual training profiles. This allows the institution to notify the BC Registry about any minor updates to their HCA program. If the BC HCA Provincial Curriculum has changed, institutions must confirm they have made the necessary changes to their HCA program. If an institution wants to make substantive changes, they must request to do so.²²⁴

Programs go through periodic reassessments. Six months before their recognition status is set to expire, institutions will be contacted to set up their compliance reassessment. The institution must submit a compliance report form three months before the expiration date. A site visit will be conducted to ensure the program is graduating competent HCAs and is meeting the Program Standards. This site visit will occur one month before expiry of registration status. Prior to the site visit, the BC Registry will interview recent graduates, practice education partner sites, and the program advisory committee. One to two weeks prior to the site visit, the program must submit a pre-visit compliance reassessment report.²²⁵ The site visit will include:

- A tour of the program facility;
- A document review, including student files, recent graduate files, instructor resumes, practice education evaluations, and program policies;
- Interviews with current students; and
- Interviews with program instructors, admissions staff, and student services personnel.²²⁶

At the end of the visit, the BC Registry will provide preliminary feedback. The draft compliance report is provided three to four weeks after the site visit. A final compliance assessment report is released within three months of the draft report. Afterwards, the program's status on the website will be updated.²²⁷

3.3.5 Program Changes

If an education program wants to make a substantive program change, the institution must notify the BC Registry and receive approval before this change is made. A substantive change is defined as more than a 15% change to the program, or a change in how the program is delivered.²²⁸

3.3.6 Instructor Qualifications

The guide sets out the minimum instructor qualifications. For theory courses, the instructors must:

- be registered with the BC College of Nurses and Midwives as an LPN, RN, or RPN, with their full or non-practicing registration;

- have experience teaching adults; and
- have at least two years of full-time nursing experiences, or equivalent. This work experience must include work with older adults with complex health needs, and work or orientation in home support or multi-level / complex care.²²⁹

For lab and practice experience courses, the instructors must meet the above criteria; however, their registration status must be full practicing registration

3.3.7 Alternate Program Formats

There are a few alternative ways to deliver the HCA education program. Institutions may seek approval to deliver a combined HCA ESL program. Students admitted to this program variation would be able to enter at a different language proficiency level than students entering the regular HCA program. In addition to HCA coursework, HCA ESL program students would complete an additional 300 hours of targeted English skills instruction designed to bring them to the same minimum level of English language proficiency as graduates of the regular HCA program.²³⁰

The HCA program can be delivered partly online or via videoconference. Only the theory courses can be offered online or via videoconference. The lab and practice components of the program must be conducted in person. The HCA Program Recognition Guide provides standards for delivering programs online or via videoconference.²³¹

3.3.8 HCA Program Entry Requirements

Minimum Program Entry Requirements

The HCA Program Recognition Guide sets out the minimum admission requirements for students of HCA programs. Prior to acceptance, students must prove they have completed Grade 10 or are a mature student. Students must also meet the English language requirements (set out below).²³²

Prior to the HCA's first practice education component, they must also meet the following requirements:

- Prove vaccination status, or have a signed vaccine exemption;
- Provide proof of a criminal record check, with clearance to work with vulnerable adults;
- Provide proof of First Aid completion;
- Provide proof of CPR level C completion;

- Provide proof of FoodSafe Level 1 completion; and
- Complete the Provincial Violence Prevention Curriculum E-learning Modules.²³³

English Language Competence Requirements

To maintain compliance with Program Standards, recognized BC HCA programs must ensure that HCA applicants meet the English Language Competency Requirements before they are admitted to the program.²³⁴ The purpose of the English language requirements are to protect the public:

Students must be able to communicate effectively in English in order to be successful in their studies and to be capable of providing safe and competent care to patients/clients/residents in the work environment. Teamwork and communication failures are a primary cause of patient safety incidents in healthcare; the ability to communicate effectively is one of the fundamental safety competencies identified by the Canadian Patient Safety Institute (CPSI).²³⁵

If an applicant's first language is English, the following metrics meet the requirements for English language competency:

- Grade 10 English completion;
- College courses equivalent to Grade 10 English or higher; or
- A sufficient score on the Canadian Adult Achievement Test, the Language Placement Index, or Accuplacer.²³⁶

If an applicant's first language is not English, they must achieve an adequate score on an English language proficiency test.²³⁷ If an applicant was educated in Quebec and the instruction was not in English, they must also meet the English language proficiency requirement.²³⁸

3.4 BC HCA Provincial Curriculum

3.4.1 Introduction

The BC HCA Provincial Curriculum was last revised in 2015 and is currently under review.²³⁹ The curriculum sets out the following information:

- Background to the curriculum;
- Values underlying the curriculum;
- Organizing concepts;
- Program learning outcomes;
- Required courses; and
- A list of required courses that includes course descriptions, learning outcomes,

and course consent.²⁴⁰

There is also a Supplement to the Provincial Curriculum Guide (2015). The supplement provides additional content for HCA programs in developing their course content.²⁴¹

For each course, the Supplement provides:

- Suggested learning strategies, including in-class activities, student handouts, strategies for teaching concepts, and case studies;
- Suggested approaches to assessment, including examples of how to assess the learning outcomes; and
- A list of resources, learning tools, and textbooks to support the course materials.²⁴²

The Supplement also includes:

- Suggested learning activities to promote computer literacy skills;
- Added content about HCAs in the acute care sector;
- Orientation materials for clinical instructors and preceptors; and
- Sample evaluation tools, including assignments, lab skills assessments, and skill checklists.²⁴³

3.4.2 Values and Concepts

The BC HCA Provincial Curriculum sets out the values, beliefs, and principles that underlie the curriculum.²⁴⁴ Some of the values, beliefs, and principles of note include:

- “All people have unique perceptions of themselves and others that shape their experiences, responses and choices. Factors that may influence a person’s perceptions include one’s life experiences, values, socio-cultural/ethnic background, gender, abilities, resources and developmental level.”²⁴⁵
- “As we age, our abilities, potentials, possibilities and goals can be expected to change. Nevertheless, each person’s potential for growth and development exists throughout life.”²⁴⁶
- “As adults move into their later years, they do not become a homogenous group... Older adults have a wide variety of interests, life experiences, backgrounds and values. Each older person must, therefore, be viewed and valued as a unique individual.”²⁴⁷
- “Health... is seen as a resource for everyday living, not an objective of living.

It is a positive concept which emphasizes psychological, cognitive, social and spiritual resources as well as physical capacity."²⁴⁸

- "People have the right and responsibility to be full participants in making decisions about and looking after their own health and the health of their family. The health care practitioner serves to facilitate the individual and family's ability to make informed choices and be actively involved in decision-making related to health care options."²⁴⁹
- "Care providers must be sensitive to and respectful of the language, culture, values and preferences of the families with whom they interact. Health care practitioners must recognize the socio-cultural and economic influences on the family, and respect the means by which the family is attempting to cope with increased stress."²⁵⁰

The BC HCA Provincial Curriculum has several organising concepts that guide it:

- Caring;
- Safety;
- Critical Thinking;
- Problem-Solving;
- Decision-Making; and
- Professional Approach to Practice.²⁵¹

3.4.3 Program Learning Outcomes

The BC HCA Provincial Curriculum was set up with nine learning objectives for graduates. These outcomes are:

1. Provide person-centred care and assistance that recognizes and respects the uniqueness of each individual client.
2. Use an informed problem-solving approach to provide care and assistance that promotes the physical, psychological, social, cognitive and spiritual well-being of clients and families.
3. Provide care and assistance for clients experiencing complex health challenges.
4. Provide care and assistance for clients experiencing cognitive and/or mental health challenges.
5. Interact with other members of the health care team in ways that contribute to effective working relationships and the achievement of goals.
6. Communicate clearly, accurately and in sensitive ways with clients and families within a variety of community and facility contexts.
7. Provide personal care and assistance in a safe, competent and organized manner.
8. Recognize and respond to own self-development, learning and health enhancement needs.
9. Perform the care provider role in a reflective, responsible, accountable and professional manner.²⁵²

3.4.4 Courses included in the BC HCA Provincial Curriculum

The BC HCA Provincial Curriculum has four courses which provide foundational theory. These courses are:

- Health and Healing: Concepts for Practice
- Health 1: Interpersonal Communications
- Health 2: Lifestyle and Choices
- Health Care Assistants: Introduction to Practice.²⁵³

The course descriptions, learning outcomes, and course content are detailed in Appendix 4.

The BC HCA Provincial Curriculum include three additional courses which provide specialized theory and skills. These courses are:

- Healing 1: Caring for Individuals Experiencing Common Health Challenges
- Healing 2: Caring for Individuals Experiencing Cognitive or Mental Challenges
- Healing 3: Personal Care and Assistance²⁵⁴

The course descriptions, learning outcomes, and course content are detailed in Appendix 4.

Healing 1 and 2 are particularly relevant to work with older people and people living with disabilities. Healing 1 addresses bodily changes linked to aging and person-centred care including in relation to end-of-life. The BC HCA Provincial Curriculum states that Healing 2 focuses on “supporting clients with dementia, recognizing responsive behaviours and identifying person-centred intervention strategies.” Healing 2 also addresses abuse. Healing 3 focuses on the development of personal care and assistance skills within the parameters of the HCA.

3.4.5 Practical Experience Courses

The BC HCA Provincial Curriculum includes two practice education courses. All program students are required to complete:

1. One or more practice placement(s) in Multi-level or Complex Care, which must include experience supporting clients with dementia.
 - Minimum hours: 210 hours
2. One or more practice placement(s) in a Home Support, Assisted Living, and/or Group Home setting.
 - Minimum hours: 60

After the successful completion of a minimum 150 hours of instructor-led clinical in multi-level or complex care, programs may have students complete remaining hours in a Practicum or Preceptorship format.²⁵⁵

3.5 BC HCA Core Competency Profile

3.5.1 What is the Core Competency Profile?

The BC HCA Core Competency Profile identifies required competencies for HCAs, as there is no legally defined scope of practice for HCAs.²⁵⁶ These competencies clarify the role of HCAs and what the public, employers, and other staff, including other HCAs, can expect of them.²⁵⁷ Competencies are the measure against which the health care system can ensure HCAs are proficient and safe in how they practice.

The Ministry of Health is responsible for reviewing HCA competencies on a regular basis. The HCA Competency Framework (2007) formed the basis for the HCA Core Competency Profile (2014).²⁵⁸ The Core Competency Profile was last updated in 2014.²⁵⁹

The 2014 update was guided by the following principles:

- Core competencies will support entrance to practice in all health care settings;
- Best practices will be reflected in the core competencies;
- Recognition of an interdisciplinary approach and health care team collaboration;
- Consideration for:
 - Acute care settings
 - Integration of Aboriginal health
 - Safe feeding techniques
 - Client communication/conflict resolution abilities
 - Recognition of elder abuse
 - Diverse Populations – dementia, mental health and palliative clients.²⁶⁰

3.5.2 Current HCA Competencies

The BC HCA Core Competency Profile lists six categories of competency. It “does not list specific tasks or procedures as these can quickly become out-dated as a result of health care system changes.”²⁶¹

The first competency is health and caring.

1.0 Competency: Health and Caring

An essential practice requirement for HCAs is to promote and maintain health in a caring manner. One of the primary functions is to provide care and support that promotes the physical, emotional/psychological, cultural, social and spiritual well-being of clients and their families.²⁶²

The second competency is plan of care. This competency includes tasks related to medication administration, and working with people with dementia.

2.0 Competency: Plan of Care

An essential practice requirement for HCAs is the provision of care in a manner that recognizes and supports the unique needs, abilities and backgrounds of clients. Care activities are directed to supporting, promoting and maintaining the health, safety, independence, comfort and wellbeing of clients in all care settings.

...

2.6 In accordance with the plan of care assists with specific tasks related to medication administration as delegated by a nurse

...

2.8 Demonstrates an ability to care for individuals with cognitive and or mental health challenges including dementia and delirium:

2.8.1 Demonstrates knowledge of the effect of the environment on individuals with cognitive and mental health challenges.²⁶³

The third competency is communication skills.

3.0 Competency: Communication Skills

An essential practice requirement for HCAs is the ability to communicate effectively with clients, families and other team members. As front-line workers, it is critical that HCAs are able to develop and maintain effective caring relationships with clients and families.²⁶⁴

The fourth competency is interdisciplinary team care.

4.0 Competency: Interdisciplinary Team Care

An essential practice requirement of the HCAs practice is the ability to work collaboratively with all members of the health care team to reach a common goal in the provision of safe, competent and ethical care to clients and their families.²⁶⁵

The fifth competency is safety.

5.0 Competency: Safety

An essential practice requirement for HCAs relates to providing care and services that promote and maintain the safety and well-being of clients and families in addition to attention to personal safety and job stressors.²⁶⁶

The sixth competency is responsibility, accountability, and ethical behaviour. This competency category includes understanding legal rights, ethical standards, and legal requirements of care, continuing education, self-evaluation, knowing best practices, and seeking help.

6.0 Competency: Responsibility, Accountability and Ethical Behaviour

An essential practice requirement for HCAs is to perform their job in an ethical, responsible and accountable manner. Since HCAs are neither licensed nor monitored by a regulatory body they do not have a legally defined scope of practice. It is imperative, therefore, that HCAs have a thorough understanding of the expectations and parameters of their job roles

6.1 Understands own values and attitudes and their effect on client's rights to establish successful client-caregiver relationships.

- 6.2 Understands and applies principles and guidelines to respect the rights of clients (e.g. privacy, confidentiality and legislation).
- 6.3 Demonstrates an understanding of the ethical standards and legal requirement, expected in the provision of care.
- 6.4 Takes responsibility for their own performance and actions.
- 6.5 Demonstrates the ability to self-evaluate on the basis of “best practices” and make improvements in own practice as needed.
- 6.6 Incorporates new knowledge into client care and shares knowledge with others.
- 6.7 Understands the need for and values continued learning.
- 6.8 Demonstrates an awareness of and maintains appropriate boundaries in provider-client and provider-family relationships.
- 6.9 Educates others about the roles and contributions of HCA.
- 6.10 Recognizes current abilities and seeks guidance as appropriate.
- 6.11 Demonstrates the ability to evaluate the effectiveness of own actions.²⁶⁷

3.6 Assignment and Delegation of Nursing Tasks to HCAs

3.6.1 Introduction

The BC *Health Professions Act* restricts certain activities to designated professions.²⁶⁸ Some restricted activities can be performed by a person who is not a designated health professional provided the person does the task while supervised by an appropriate health professional.²⁶⁹

A college determines what activities can be delegated or assigned to a person who is not a registrant of that college and sets out which tasks must be performed under supervision of a registrant, and which tasks can be delegated without supervision.²⁷⁰

Most of the delegated and assigned tasks performed by HCAs in BC are nursing tasks. The BC College of Nurses and Midwives sets out the rules for delegation and assignment in two documents:

- *Delegating Tasks to Unregulated Care Providers* (“RN/NP Practice Standard”);²⁷¹ and
- *Assigning and Delegating to Unregulated Care Providers* (RN/NP Delegation Booklet”).²⁷²

These documents refer to working with unregulated care providers, which include HCAs.²⁷³ Other unregulated care providers include mental health workers, community health representatives, assisted living workers, rehabilitation assistants, and teaching assistants.²⁷⁴ The RN/NP Delegation Booklet and the RN/NP Practice Standard apply exclusively to the practice of RNs or NPs.²⁷⁵

3.6.2 Assignment versus Delegation

RNs are often the clinical supervisors of HCAs. RNs are permitted to assign or delegate tasks to an unregulated care provider. They may assign or delegate tasks, not functions. A function and a task are distinguished as follows:

Function: A client care intervention. Performing a function includes assessing when to perform the function, planning and implementing the care and evaluating and managing the outcomes of care.

Task: Part of a client care function. The task has clearly defined limits.²⁷⁶

Typically, a function is something which requires a nurse to assess a patient, conduct care planning, or apply nursing judgment. A task is a specific action that would be part of a care plan. For example, a nurse may assess a patient's breathing and determine that they need supplemental oxygen. The task of administering oxygen may be assigned or delegated to an HCA.

A task is assignable when it is within both the HCA's job description and the nurse's scope of practice. A task is considered delegable when it is usually performed by a nurse, it is not in the HCA's job description, and the HCA has not been trained on the task.

Assignment: Allocation of clients or client care activities among care providers in order to meet client care needs. Assignment occurs when the required care falls within the employing agency's policies and role descriptions and within the regulated health care provider's scope of practice. Assignment to unregulated care providers occurs when the required care falls within the employing agency's policies and role description.

Delegation: Sharing authority with other health care providers to provide a particular aspect of care. Delegation among regulated care providers occurs when an activity is within the scope of one profession and outside the scope of the other profession (includes both the right to order a restricted activity and carrying out the restricted activity). Delegation to unregulated care providers occurs when the required task is outside the role description and training of the unregulated care provider.²⁷⁷

A task could be considered an assignable task in one situation, but a delegable task in another. For example, in long-term care, all tasks given to HCAs are considered assignment, not delegation, as all the tasks they would typically perform in long-term care would generally fall within their job description and they will have been trained to perform these tasks. In contrast, in home and community care, tasks are commonly delegated to an HCA and so will require training and supervision.²⁷⁸

Ultimately, the legal responsibility for the practice of nursing remains with the nurse, and cannot be assigned or delegated. A nurse is "responsible for the overall assessment, determination of client status, care planning, interventions and care evaluations when tasks

are delegated to an unregulated care provider.”²⁷⁹

3.6.3 Assignment

A nurse can assign a task to an HCA under the following circumstances:

- The task is within the HCA’s job description, as set out by the HCA’s employer;
- The HCA has received training on the task;
- The HCA’s supervisor provides ongoing supervision of the HCA’s performance;
- The HCA’s employer has made the HCA job description available to the nurse;
- The nurse remains responsible for the client assessment and care planning;
- The nurse provides any needed guidance to the HCA; and
- The nurse intervenes if something unsafe is occurring.²⁸⁰

The RN/NP Delegation Booklet sets out a nurse’s responsibility to intervene if the HCA is acting unethically or is not providing safe care, which “may include guidance, teaching and direction, clarification of the care plan and, if necessary, reporting to the appropriate authority.”²⁸¹

3.6.4 Delegation

Principles for Delegating Tasks

The BC College of Nurses and Midwives Practice Standard sets out the principles for delegating tasks to an HCA. These principles include ensuring the delegation is in the client’s best interests, and that the HCA has received adequate training on the task.²⁸² The RN/NP Delegation Booklet identifies two aspects to delegating a task to an HCA: the decision to delegate and the process of delegating the task.

The Decision to Delegate

When a nurse is deciding whether they will delegate a task to an HCA, they must consider the client, the task, the care environment, and the HCA.²⁸³ Within each of these four factors, there are considerations that would make the delegation lower risk or higher risk. However, generally delegation requires the client to be stable and the circumstances connected to the task to be fairly predictable.²⁸⁴

If a nurse finds that the factors point to lower risk—the HCA has enough previous training, there is enough supervision and support, it is in the client’s best interests, and the client is stable—then the nurse may delegate the task.

Client Decision-Making

The RN/NP Delegation Booklet highlights that, when making the decision about delegation, the nurse should always consider the best interests of the client, which include what the client's goals and perspectives are on their care.²⁸⁵ If the client has decision-making capacity for this decision, the nurse must respect their decision. If the nurse cannot eliminate all risks to the client, the nurse must provide information to the client so they can make an informed decision.²⁸⁶

The Process of Delegation

Once the nurse decides they can and should delegate the task to an HCA, they can proceed with the delegation. The RN/NP Practice Standard and the RN/NP Delegation Booklet set out what must be done to ensure the client is safe during this delegation:

Once the decision to delegate has been made, nurses delegate safely by:

- determining agency policy regarding delegation (e.g., what nurses are permitted to delegate)
- establishing that the unregulated care provider has the necessary knowledge and skill to perform the task
- establishing supervision and support mechanisms
- establishing the type and amount of ongoing nursing care required by the client
- clarifying the responsibility and accountability of all parties
- evaluating care outcomes.²⁸⁷

Supervision of the Task by a Nurse

Supervision does not require the nurse to be present. The supervision requirement is met if the nurse is available to the HCA when needed. Supervision includes follow-up by the nurse, regular reporting to the nurse, periodic observance by the nurse, and education by the nurse as needed.²⁸⁸

Delegation when the Nurse and HCA have Different Employers

In some cases, the HCA and the delegating nurse will have different employers, particularly in the home and community care context. These circumstance are subject to additional considerations, including requiring the HCA's employer to develop policies regarding delegation and agree to accept the delegated task.²⁸⁹

If two employers are involved, they must coordinate the delegation. Although the employers' policies or role descriptions may differ, there must be mechanisms to resolve any disagreement. Each person's roles and responsibilities should be set out in writing. The nurse, or other professional delegating a task, remains responsible for making a decision about whether delegation is appropriate and safe, and must provide supervision. The delegating professional may still need to provide education or guidance if the HCA does not have adequate training.²⁹⁰

Table 7: Delegation by Nurses—Factors to Consider

Client care needs²⁹¹
Stability and acuity of client
Complexity of care needs
Ability and willingness of client to direct care
Task issues²⁹²
Risk of harm
Predictability that client will need the task performed
Consistency in how the client will react to the task
Predictability in outcome of the task
Number of steps required to complete the task
Skill required
Frequency with which the HCA will likely perform the task
Variability in how the task must be performed
Care environment²⁹³
Need and capacity for ongoing assessment and care planning
Training time
Written procedure
Supervision and support
Onsite nursing support for clinical consultation or intervention
Organizational supports, including policies, procedures
RN competency to delegate
HCA issues²⁹⁴
Number of care providers needed
Staff turnover versus consistency
Whether task is part of standard HCA skill set
Learning curve for the task
How commonly would the task be delegated to HCAs

Responsibilities of Each Party During Delegation

The RN/NP Delegation Booklet summarizes the responsibilities of each party in the delegation process, including the agency or health authority, the RN, and the HCA. The provision of safe care is considered a shared responsibility.²⁹⁵

Agencies and health authorities that permit delegation of tasks to unregulated care providers are responsible and accountable for:

- providing a clear unregulated care provider role description based on the training program completed by the unregulated care provider;
- developing policies and procedures for delegation which include a clear description of each person's role, responsibility and accountability;
- ensuring adequate time for registered nurses to carry out client assessment and provide ongoing client care;
- ensuring adequate time for registered nurses to train unregulated care providers and provide ongoing supervision including support to unregulated care providers; and
- providing educational opportunities for registered nurses to develop the competence* to delegate. In addition, consultation should be available from registered nurses who can provide expert clinical consultation on delegation.²⁹⁶

Unregulated care providers who carry out delegated tasks are responsible and accountable for:

- knowing what tasks they can perform through assignment;
- not performing any delegated tasks until they have authorization from a registered nurse;
- completing the delegated task as taught; and
- reporting to the registered nurse as specified in the care plan and the policies of the agency.²⁹⁷

Employers must ensure that unregulated care providers are aware of their responsibilities in delegation.²⁹⁸

3.6.5 The Relationship between LPNs and HCAs

LPNs may assign tasks to HCAs if the tasks fall within the LPN's scope of practice and the HCA's job description, the tasks form part of the patient's care plan, and the HCA is trained to perform the task.²⁹⁹

The LPN Practice Standard sets out the following principles for delegating tasks to HCAs and other unregulated care providers. They are similar to the principles that apply to RNs:

Principles

1. LPNs are responsible for assessing clients, making a nursing diagnosis, planning care and assigning care appropriately to HCAs.
2. LPNs are responsible for knowing the HCA's role description in their practice setting.
3. LPNs only assign care to HCAs when the care is:
 - a. within the LPN scope of practice,
 - b. within the LPN's individual competence,
 - c. permitted within employer policy,
 - d. within the HCA core competency profile,

- e. within the HCA's role description and training, AND
 - f. set out in a client's care plan.
4. Before assigning care to an HCA, the LPN assesses the client's needs, makes a nursing diagnosis, determines the activity is within the HCA's job description and identifies any potential risks.
 5. LPNs may provide training and ongoing support and guidance to HCAs if it is an employer expectation set out in the LPN's job description.
 6. After an LPN assigns care to an HCA, the LPN continues to be responsible for assessing the outcomes of the care and for updating the overall plan of care.³⁰⁰

3.7 Other Legislative Reporting Requirements

The *Community Care and Assisted Living Act*³⁰¹ creates requirements for reporting certain incidents that occur in assisted living or long-term care to a government official. Assisted living reportable incidents are set out in the *Assisted Living Regulation*.³⁰² Long-term care reportable incidents are set out in the *Residential Care Regulation*.³⁰³ The requirements in each regulation are very similar.

These provisions apply to the work of HCAs and so provide some oversight for HCA work. If the incident involves abuse or neglect by an HCA, the reportable incident triggers the employer's responsibility to report to the BC Registry. An incident could also reveal other deficiencies in the work of an HCA.

Assisted living

The list of reportable incidents for assisted living includes abuse, neglect, and other occurrences. The full definition includes incidents involving:

- choking of a resident requiring first aid, emergency care, or transfer to a hospital;
- death of a resident;
- disease outbreak;
- a fall requiring emergency care or transfer to a hospital;
- food poisoning requiring emergency care or transfer to a hospital;
- a medication error adversely affecting a resident or requiring emergency intervention or transfer to a hospital;
- a missing resident;
- a serious unexpected illness requiring emergency care or transfer to a hospital;
- an overdose requiring the administration of naloxone, emergency intervention, or transfer to a hospital;
- poisoning of a resident; and
- any other injury requiring emergency care or transfer to a hospital.³⁰⁴

The definition also includes:

- Emotional, financial, physical, or sexual abuse of a resident;
- Neglect of a resident;
- Any situation requiring a request for police to attend the residence; and
- Any condition or event that could reasonably be expected to impair the ability of the registrant or the registrant's employees to provide a hospitality service or assisted living service, or that affects the health or safety of residents.³⁰⁵

The various types of abuse and neglect covered by the Regulation are listed in Schedule E and apply the same definitions used by the BC Registry. These definitions are discussed in Section 3.2.6 above.

For something to be a reportable incident, a resident must be the subject of, or a witness to, the incident.³⁰⁶ If the incident is abuse or neglect, the incident is reportable if abuse or neglect of a resident is alleged or suspected.³⁰⁷ The abuse or neglect need not be confirmed before it is reported.³⁰⁸

If a reportable incident occurs, the residence operator must:

- respond to the situation immediately;
- report the incident to the Assisted Living Registrar;
- inform the resident's contact person; and
- make a record of the incident.³⁰⁹

Long-term care

In long-term care, a reportable incident includes:

- choking requiring first aid, emergency care, or transfer to a hospital;
- death of a person in care;
- disease outbreak;
- a fall requiring emergency care or transfer to a hospital;
- food poisoning requiring emergency care or transfer to a hospital;
- a medication error adversely affecting a resident or requiring emergency intervention or transfer to a hospital;
- a missing or wandering resident;
- a serious unexpected illness requiring emergency care or transfer to a hospital;
- an overdose requiring the administration of naloxone, emergency intervention, or transfer to a hospital;

- poisoning of a resident; and
- any other injury requiring emergency care or transfer to a hospital.³¹⁰

The definition also includes:

- Emotional, financial, physical, or sexual abuse of a resident;
- Neglect of a resident;
- Any emergency use of a physical or chemical restraint protect the person in care or others from imminent serious physical harm; and
- “any condition or event which could reasonably be expected to impair the ability of the licensee or his or her employees to provide care, or which affects the health, safety or dignity of persons in care”.³¹¹

if a reportable incident occurs, the facility operator must notify:

- the resident’s contact person;
- the doctor or nurse responsible for the patient’s care; and
- the medical health officer.³¹²

For something to be a reportable incident, the resident must be the subject of, or a witness to, the reportable incident.³¹³ If the incident is abuse or neglect, the incident is reportable if abuse or neglect of a resident is alleged or suspected.³¹⁴ The abuse or neglect need not be confirmed before it is reported.³¹⁵



4.1 2012 Review by Foerster and Murtagh

In 2012 the Ministry of Health hired Vicki Foerster and James Murtagh to conduct a review of the first years of the BC Registry's work, covering January 2010 to October 2012.³¹⁶ They interviewed key stakeholders and examined information provided by the Ministry of Health, such as data from the first two-three years of the BC Registry's operation.³¹⁷ Their report, titled *British Columbia Care Aide & Community Health Worker Registry: A Review (BC Registry Review)*, identifies the strengths and weaknesses of the system and makes recommendations to the Ministry of Health for improving the BC Registry.

4.1.1 Analysis of BC Registry Data from 2010-2012

Over the first two years, approximately 44,000 people registered with the BC Registry. While exact numbers were not available, approximately 25,000 of those HCAs worked for public facilities. The government had not expected so many HCAs working in private facilities to register voluntarily.³¹⁸

BC Registry data included 123 reports of abuse by an HCA. Of these 123 reports, 47 were HCAs who were suspended, had returned to work, and were reinstated with the BC Registry.³¹⁹ These

suspensions represent 38.2% of the reports.

The remaining 76 reports concerned HCAs who were terminated by their employer.³²⁰ Of the initial terminations:

- 23 did not request an investigation. They were removed from the BC Registry (18.7% of the total reports).
- 10 were resolved during the grievance process between the union and the employer. The HCA was reinstated to the BC Registry (8.1% of the total reports).
- 43 proceeded to a BC Registry-appointed investigation (35% of the total reports).³²¹ Nearly all (98%) of these investigations were initiated by a union.³²²

Of the 43 BC Registry investigations, the outcomes were as follows:

- 6 investigations confirmed the abuse. The HCA was removed from the BC Registry (13.9% of investigations).
- 15 investigations found no proof of abuse. The HCA was reinstated to the BC Registry (34.8% of investigations).
- 13 found proof of abuse. However, the HCA completed training or provided medical documentation, and the HCA was reinstated to the BC Registry (30.2% of investigations).
- 5 investigations required the HCA to complete training. Their reinstatement was pending completion of the training (11.6% of investigations).
- 4 investigations were still underway (9.3% of investigations).³²³

Following most of these investigations, the HCA was reinstated to the BC Registry. In total, from both streams, 29 HCAs were permanently removed (23.5% of all reports of abuse). 90 HCAs were reinstated (73.1% of total reports).

4.1.2 Themes from Interviews with Stakeholders Groups

The authors conducted over 50 interviews with stakeholders. The stakeholders came from several groups, including people who were involved with the creation of the BC Registry, BC Registry staff members, Ministry of Health staff, members of the BC Registry's advisory committee, health care managers who employ HCAs, BC Registry investigators, and managers at sites where investigations had been completed.³²⁴

BC Registry Architects, Overseers, and Staff Members

The report authors conducted interviews with about 25 people who were involved in creating the BC Registry, staff members of the BC Registry, Ministry of Health staff, and advisory committee members.³²⁵

Among this group, most believed the BC Registry was meeting its objectives. All stakeholders in this group thought the model should be retained. They identified the following benefits of the approach:

- Obtaining assurance when an HCA is hired that they have the required skills;
- Providing data on abuse;
- Creating standards for training and educating for HCAs;
- Providing a timely and fair investigation process for abuse; and
- Providing a more cost-effective way to resolve disputes than labour arbitration.³²⁶

Stakeholders were asked to provide information on how the BC Registry could be improved. The stakeholders' answers covered several different areas: BC Registry scope, design and implementation, the investigation process, uptake of the BC Registry, and governance.³²⁷

Managers at Investigated Sites

The BC Registry authors spoke with managers at 12 investigated sites, including both Health Authority and contracted sites. These 12 sites accounted for 28% of investigations. The investigations took an average of three to eight weeks to complete. Some of the investigations which involved mediation took up to a year to complete. Most managers found the process was not smooth, and about half said the investigators were intimidating. Most were happy with the speed of the investigation.

In 10 out of the 12 investigations, the investigators confirmed that abuse had occurred, but all 12 HCAs had been reinstated to their employment and the BC Registry. The managers expressed concern about reinstatement following abuse. They recommended zero tolerance of abuse.³²⁸

Managers identified ways to improve the BC Registry. They requested more education on the BC Registry, in particular, greater clarity on privacy issues, the investigation process, including timelines, and relationship between BC Registry status and employment status. All managers thought disciplinary decisions should be available to the public.³²⁹

Facility Managers not using the BC Registry

The report authors conducted 21 interviews with facility and Health Authority managers at locations where there had not yet been a BC Registry investigation. Most were aware of the BC Registry and its primary objective of protecting the public. Managers named two benefits to the BC Registry: recognition for HCAs and standardization of training. The facility

managers suggested developing a legislative framework for the BC Registry, and possibly moving to a regulatory college model. No people from this group suggested dispensing with the BC Registry; however, half the stakeholders felt the approach was not working well. The major area for concern was the investigation process.³³⁰

Investigators

The report authors interviewed five investigators. Each had their own process, but all used a similar method. The investigators said they relied on arbitration jurisprudence to provide guidance on “assessing the severity (scale) of abuse”.³³¹

Some investigators felt that the authority for the BC Registry was unclear. Some had concerns about privacy, particularly sharing the details of their investigation reports, or sharing information between investigators. Some investigators noted that it was sometimes challenging to access critical information, such as licencing reports and witness names. They indicated that some employers were unwilling to cooperate with the investigation.³³²

Investigators suggested creating more clarity about the BC Registry’s legal authority, such as by legislation. They stated that the Letter of Understanding between HEABC and the bargaining associations which created the BC Registry was not sufficiently clear.³³³

4.1.3 Summary of Critical Feedback

This section summarizes critical feedback in five areas: scope, design, investigations, uptake, and governance.

Scope

There were two key concerns. The BC Registry’s scope:

- does not cover private facilities; and
- only covers abuse, and does not address other issues such as competence to practice.³³⁴

Design

Stakeholders expressed general concern regarding the lack of a legislative foundation for the BC Registry. They pointed to the following specific issues:

- There is no statute requiring people to participate in investigations.
- Some facilities will not provide confidential or private information to

investigators without a statutory ability to do so.

Other areas of ambiguity include:

- Disciplinary decisions and changes to BC Registry status are not shared broadly with all HCA.
- If HCAs resign before they are fired, then the BC Registry has no power to conduct an investigation or remove them.
- The BC Registry does not require a criminal record check prior to registration.³³⁵

Investigations

Ambiguity of roles and process:

- There is no deadline for completion of the investigation.
- The investigator's roles as investigator and mediator are conflated.
- The investigation process conflates BC Registry status and employment status.
- Investigations are very time-intensive for facility managers and they are not given adequate help navigating the process.

Cost and resource-related concerns:

- Who pays for the investigation depends on whether a union is involved.
- The BC Registry's investigation process can be more expensive than arbitration.
- BC Registry investigations add to, rather than conserve, costs because terminations for abuse typically go to arbitration.
- BC Registry costs discourage managers from reporting.
- HEABC advisors lack sufficient knowledge to support managers with investigations.³³⁶

Outcome of investigation:

- Findings can conflict with other co-occurring regulatory processes, such as by facility licensing.³³⁷
- Investigators consider the 'scale of abuse', which leads to abuse being treated less seriously. Instead there should be zero tolerance of abuse.³³⁸
- Reinstatement through the grievance process means the HCA remains on the BC Registry regardless of whether or not they have abused someone, which undermines trust in the system.
- The process adds on another step which can conflict with collective agreements.

Investigator skills:

Facility managers expressed concerns regarding whether investigators were:

- impartial; or
- skilled at interviewing vulnerable people.³³⁹

Uptake

A number of concerns called into question the sector's use of the BC Registry:

- Some HCA employers were not aware of the BC Registry.
- Some employers were not reporting abuse, or were requiring HCAs to quit in order to retain their BC Registry status.
- Some unions were helping HCAs to quit so they could retain their BC Registry status.³⁴⁰

Governance

Some stakeholders expressed concerns about governance, in particular:

- The unclear role of the advisory committee;
- The contractual and negotiated nature of the BC Registry is problematic.

4.1.4 Analysis of the Registry's Performance

The report considers the model, including governance, the public protection role, and the investigation process, and identifies the following strengths and challenges.

The BC Registry model is a novel and effective approach

The report authors found the BC Registry system to be novel and generally effective. They determined that most stakeholders preferred a college regulatory structure because they held the mistaken belief that the BC Registry was not functioning well. The authors concluded that a regulatory college would not better protect the public because colleges frequently fail in ensuring registrants are competent, deal inadequately with public complaints, and are both inefficient and costly. The BC Registry model was superior by virtue of being the simplest, most flexible, and least costly form of regulation that enables sanctions when an HCA has committed a serious offence. A different regulatory model might have stronger enforcement methods, but it would likely be more complex and

rigid.³⁴¹

The report authors identified the following potential improvements:

- Create a way to compel employers to participate;
- Address the unclear aspects of the BC Registry contract;
- Clarify the sources of the BC Registry's authority;
- Clarify the identified privacy issues; and
- Provide guidance for the public and stakeholders on the BC Registry and its procedures.³⁴²

BC Registry governance requires more structure

The report authors did not receive a lot of feedback on governance. The area of concern was the advisory committee. The authors found the advisory committee was acting in a purely advisory role, only discussing issues of concern and then tabling them. The advisory committee could not act proactively, or make any needed changes to the BC Registry. The only practical role of the advisory committee was appointing investigators.

The writers concluded that so long as the BC Registry remained based in contract law, it would be difficult to create a more structured governance scheme. However, at a minimum, a more clear procedure should be developed for the advisory committee to pass on concerns and suggestions about the BC Registry to the Ministry of Health.³⁴³

The Public protection role can be enhanced in three ways

The most critical function of the BC Registry is public protection. In this respect, the BC Registry has been generally successful because there is now a database of HCAs and a method to remove HCAs from the database. However, there are three areas where public protection could be expanded.³⁴⁴

1. The BC Registry's jurisdiction is limited to publicly funded employers. The authors noted that in 2012, 40% of HCAs worked for purely private employers. Although some private employers require their HCAs to be registered, they are not a part of the reporting and investigation scheme. This dynamic is problematic because HCAs working for a private employer can commit abuse and yet retain their BC Registry status because the abuse would not be reported.³⁴⁵

2. The BC Registry's oversight role is limited. The BC Registry can only act if an HCA is terminated and they are asked to investigate. Roughly half of the abuse cases are resolved without an investigation, and there is no information available to the public or the BC

Registry on these cases. The authors raised concerns that involved parties are negotiating resolutions that allow HCAs to retain their status regardless of abuse concerns.³⁴⁶

3. BC Registry decisions are not reported. There is no way to share changes to BC Registry status or investigation decisions with all HCA employers, which occurs with other professions. As a result, if an HCA is working for multiple employers, which is common, and commits abuse at one facility, the manager at the other facility may not be aware of this unless they are regularly checking the database. The report authors identified this issue as the one of highest concern.³⁴⁷

The investigation process is generally effective

The report authors were not particularly concerned with the investigation process in spite of stakeholders comments. The authors found the investigators applied the process well and were qualified. The biggest area of concern was the ambiguous language of the contracts and agreements underlying BC Registry's role, in particular that the framework conflates employment and BC Registry status.³⁴⁸

The authors did not recommend changing the cost-sharing structure with respect to BC Registry investigations; however, they expressed concern regarding the higher costs for facilities outside the Lower Mainland, which results of the investigators residing in the Lower Mainland.³⁴⁹

4.1.5 Recommendations

The report outlines four recommendations:

1. Review the legal framework for the BC Registry to enhance clarity and require employers cooperate in investigations.
2. Create a stronger governance structure.
3. Address gaps in the BC Registry, including the applicability to the private sector and closing loopholes.
4. Review the funding model to ensure it is sustainable and equitable.³⁵⁰

Recommendation 1: The MOH should review the suitability of the enabling framework under which the Registry exists/operates (i.e., the Letter of Understanding and 'Appendix A') with particular attention to mandate clarity/focus; implications for the Registry's scope (e.g., inclusion of private sector employers/employees); and ability to ensure the participation of employers and HCAs.

Recommendation 2: The MOH should ensure an appropriate governance structure exists for the Registry and that, within the context of the Registry's enabling framework, it is vested with the necessary authority to pursue the Registry's objectives and to establish a management structure charged with implementing strategic direction, developing operating policy/

procedure, etc.

Recommendation 3: The MOH should take steps to redress current gaps in the Registry's protection mandate. Minimally this would include: addressing the exclusion of private sector HCAs; establishing an oversight role related to abuse accusations handled outside the Registry's investigation process; eliminating loopholes (e.g., resignation of an accused HCA) that frustrate the Registry's ability to investigate; broadcasting Registry suspensions to employers; and compelling HCA registration as a condition of employment and employer participation in Registry investigations, etc.

Recommendation 4: The MOH should review the Registry's funding model with a view to ensuring a sustainable funding base as well as an equitable allocation of expenses. Given that the Registry's intent parallels, in some dimensions, the function of a regulatory college, and given that the Registry's creation is in part a response to failed human resource processes, charges to registrants and employers cannot be precluded. Existing inequities related to investigation costs (e.g., higher costs for facilities geographically distant from investigators and no costs for non-union facilities) should also be addressed.³⁵¹

4.2 BC Government Action Plan

Following the 2013 BC Registry Review, the BC government released an Action Plan. The Action Plan identifies specific steps to address the four recommendations made in the BC Registry Review and additional actions to continue implementation of the BC Registry.³⁵² In the last nine years the BC government has made no progress on the four recommendations. It has completed the additional four tasks it set for itself. The actions and tasks are listed below with status updates where progress has been made.

4.2.1 Actions Identified to Address Recommendations by Foerster and Murtagh

Recommendation 1: The BC Registry's enabling framework

1. "Implement [a] strategy that will mandate private sector participation in all aspects of the Registry."³⁵³
2. "Implement changes to the Registry's enabling framework and clarify the roles and responsibilities of all parties to ensure alignment so that the protection mandate is being met."³⁵⁴
3. "Where feasible, disentangle employment status from Registry status, except where individuals are permanently removed from the Registry"³⁵⁵
4. "Develop a process to make necessary changes to the Registry framework documents, procedures, and employer requirements to ensure that no loopholes impede the Registry's abuse prevention mandate."³⁵⁶
5. "Implement changes to the Registry consent form that will allow the Registry to collect adequate registrant information."³⁵⁷

Recommendation 2: Governance

6. "Launch a public campaign to inform HCAs, employers, educators, and members of the public regarding the purpose and role of the Registry"³⁵⁸
7. "Implement procedural standards for the Registry's investigation process"³⁵⁹
8. "Add a Ministry representative to the Registry Advisory Committee, and revisit the Committee's Terms of Reference to ensure a mechanism to bring forward the issues it raises"³⁶⁰

Recommendation 3: Gaps in the BC Registry's protection mandate

1. "If deemed feasible, implement criminal records checks as part of the Registry application process"³⁶¹

Status: A criminal record check is not part of the BC Registry application process. However, an admission requirement for a BC HCA program is a criminal record check for working with vulnerable adults. The loophole in the current system is an HCA who received their education anywhere other than BC may not have been subject to a criminal record check.

2. "Review privacy assessment and engage unions to discuss options for sharing HCA's Registry status with employers in cases of abuse"³⁶²
3. "Develop an appropriate mechanism to inform employers when an HCA has been removed from the Registry for abuse"³⁶³

Recommendation 4: Funding model

1. "Determine short-term solutions for resolving investigations costing inequities for geographically isolated employers"³⁶⁴
2. "Assess the financial implications of expanding the Registry's mandate to include the private sector"³⁶⁵
3. "Review funding model options and implement the most equitable approach to covering operational and investigative costs"³⁶⁶

4.2.2 Ongoing BC Registry Implementation

The BC government listed the actions they intend to take to continue implementing the BC Registry.

1. "Launch the new Registry website and database to meet the needs of the current volume of Registrants"³⁶⁷

Status: Complete

2. "Continue development activities for the Registry's education recognition process"³⁶⁸

Status: The HCA Program Guide is currently in its second edition, dated 2018. Additionally, there is a BC HCA Provincial Curriculum and supplement available to education programs. See section 3.4 for more details.

3. "Implement all education recognition processes to ensure the minimal training requirement mandate is fully met"³⁶⁹

Status: There are currently many streams for applicants who have received training outside of BC. This includes a process for graduates of an HCA program in Canada, Canadian-licensed nurses, nursing students in Canada, and internationally educated health care

professionals. For Canadian or internationally trained HCAs, there is a competency assessment pathway to become recognized in BC. See section 3.2.5 for more details.

4. "Implement professional development and career opportunity resources for registrants on the Registry website"³⁷⁰

Status: Continuing education opportunities are listed on the BC Registry website. The BC HCA Program Curriculum stresses the need for continuing education. One of the courses teaches about how to succeed in the HCA job market. See Appendix 2 for a list of courses.

4.3 2012 Ombudsperson's Best of Care Report

In 2012 the BC Ombudsperson completed a significant evaluation of seniors care, which culminated in the two-part report *The Best of Care: Getting it Right for Seniors in British Columbia*. The BC Registry is discussed briefly in Part 2 of the report.³⁷¹

The Best of Care Report identified two gaps in the BC Registry. First, the BC Registry does not include HCAs working for private facilities, even though the government states it was intended that the BC Registry would eventually be extended to private employers. This is a gap that fails seniors.³⁷²

Second, HCAs do not have to disclose whether they have ever been disciplined for abuse or neglect in past employment when they apply to the BC Registry.³⁷³

The Ombudsperson states that these two gaps are particularly concerning because HCAs do not have a college or association which governs professional standards or ethics.³⁷⁴ The Ombudsperson made two recommendations to close these gaps. The second recommendation has now been addressed.

Recommendation R24: "The Ministry of Health, by January 2013, require care aides and community health workers at all home support agencies, assisted living residences and residential care facilities to register with the BC Care Aide & Community Health Worker Registry."³⁷⁵

Status: The BC Registry still only applies to HCA employers who receive public funding. See section 3.2.3 for more details.

Recommendation R25: "The Ministry of Health require applicants to the BC Care Aide & Community Health Worker Registry to disclose whether they have ever been disciplined or terminated by a health care employer on the grounds of abuse, and establish a process for evaluating whether it is appropriate to allow registration."³⁷⁶

Status: Key informants shared with us that HCAs who apply to the BC Registry must now disclose past disciplinary history. The BC Registry has the ability to check with

other health profession regulatory bodies to investigate if the HCA has a disciplinary history with that regulatory body.



5.1 Overview

Researchers and policy analysts advocate for a “right-touch” approach to professional regulation. This approach cautions governments to choose a type of regulation that will best balance the risks and benefits. Regulation should mitigate the risks to the public at a level that is greater than the costs associated with the approach to regulation. If the costs of regulation are high, the regulatory scheme should substantially reduce or mitigate serious risks.³⁷⁷

The costs of regulation include:

- Increased costs to administer the regulatory scheme or fees for the professional to pay, which are typically passed on to the consumer or patient;
- Reduced number of individuals able or willing to meet entry requirements for the profession (resulting in fewer professionals);
- Reduced competition among providers, which can drive up the price of services; and
- Risks of the profession acting in their own self-interest.³⁷⁸

5.2 Professional Regulation

There is no set definition of professional regulation. In general, professional regulation occurs when the government creates legislation to govern professions and occupations. Professional regulation can apply to any type of profession or occupation. The government regulates a profession when there is a need to protect the public.

Professional regulation can take many forms. Governments often regulate a profession by determining what qualifications a person needs to become licenced or certified, and by developing processes to make sure professionals are acting ethically, professionally, and competently. The government may limit the ability to engage in certain restricted activities to licensed professionals.³⁷⁹

Professional regulation focuses on regulating the individual practitioner. Health care is increasingly provided by multi-disciplinary teams. However, the way health care is regulated does not regulate the team. Professional regulation cannot regulate problems or harm that come from team, organization, or system issues.³⁸⁰

5.2.1 Goals of Regulation

The primary purpose or goal of regulation is to protect the public.³⁸¹ Public protection is particularly important in professions where there is a difference in knowledge between the professional and the client or patient, the patient is vulnerable, or there is a fiduciary relationship. For some areas, such as medicine, a layperson may not know what skills a doctor should have, what the practice standards should be, or what good practice looks like. In this case, a person would have difficulty choosing an appropriate medical services provider. Additionally, when obtaining some medical or care services, a consumer may not have a choice as to who their doctor is.³⁸²

Professional regulation protects the public by trying to prevent or reduce harm by professionals. While the aim of professional regulation is to reduce risks, all risks and harms cannot be eliminated or prevented. In this case, a discipline process may occur.³⁸³ Harm can occur because a health professional:

- Made an error;
- Acted recklessly;
- Failed to follow practice guidelines;
- Failed to exercise appropriate clinical judgement;
- Acted unethically;
- Was impaired by drugs or alcohol;
- Is unfit to practice because of a physical or psychological illness;

- Did not have the basic competence to practice;
- Did not have the skills to complete the activity;
- Received inadequate training;
- Engaged in misrepresentation or fraud; or
- Breached confidentiality.³⁸⁴

5.2.2 Approaches to Regulation

When setting up professional regulation, the government can use many tools to help protect the public and minimize the risk of errors or harm. Some of these tools include:

Table 8: The Tools of Regulation³⁸⁵

Law	Practice Standards
Acts and regulations Rules under which Colleges or other regulatory bodies must operate Statutory investigation and discipline procedures	Codes of ethics Standards of practice
Credentialing	Fitness & discipline
Mandatory education or training Admission tests Continuing professional development Re-testing and audits of practice	Mandatory counselling Mandatory medical treatment Disciplinary actions, such as fines, suspensions, or removal of licences Mandatory reporting of other members
Practice & member support	Public communication & accountability
Assistance programs Professional consultation on practice or ethical concerns	Published discipline decisions Complaints process for members of the public

5.3 Types of Health Care Professional Regulation in BC

If the government wishes to regulate a profession, they can use many different types of regulation. The types of regulation sit on a scale from complex to least restrictive. The most common ways for the government to regulate a profession or occupation are

self-regulation, or direct government regulation, usually through an appointed board. Frameworks for self-regulated professions are on the most complex end of the scale. Direct government oversight is less restrictive.

5.3.1 Self-Regulation

Self-regulation allows governments to delegate some or all of the responsibility of oversight to the profession.³⁸⁶ Self-regulation is typically used when a profession has specialized knowledge. In such circumstances lay people would generally not know the appropriate practice standards or how to address misconduct.³⁸⁷ However, members of the public usually sit on college boards to offer the public perspective on professional governance and discipline matters.³⁸⁸

Self-regulation models generally delegate regulatory powers to a college required to act in the public interest. A profession may have a professional advocacy organization or union that acts to further the interests of the profession. A college will occasionally work with the union or advocacy organization, but must act only in ways that are in the public interest.³⁸⁹ Examples of self-regulated professions include nurses, doctors, and lawyers.³⁹⁰ See section 5.4, below, for a description of how BC's self-regulated health professions function under the *Health Professions Act*.

Supervised self-regulation is similar to full self-regulation, but the government supervises the regulatory colleges, usually through an oversight body or a tribunal.³⁹¹ This is an approach BC has not yet implemented. BC's plan for modernizing professional regulation, which is discussed in section 5.6.2, includes creating an oversight body to oversee self-regulating health professions.

5.3.2 Government Regulation

Government regulation occurs when the government directly oversees a profession or occupation. The government usually appoints a board for this purpose.³⁹² An example of this approach is the BC Financial Services Authority. The Authority directly governs the financial services sector, including credit unions, trust companies, registered pension plans, insurance companies, mortgage brokers, and realtors, without the involvement of a college.³⁹³ Paramedics are also another example: a board oversees paramedics, as set out in the legislation, and the government appoints the members.³⁹⁴ We discuss this approach in section 5.5.1 below.

Other forms of government regulation include:

Title registration: This approach does not limit who can practice in that profession;

instead it limits who can describe their work using a specific title. A restricted title regime might require individuals to register with a governing body, which could in turn require completion of an approved training or education program.³⁹⁵ We discuss title regulation in section 5.5.3 below on early childhood educators.

Licensing and certification schemes: This approach shares most of the features of professional regulation; however, the system it is run by the government, not the profession.

Occupational regulation: Under this approach the government regulates an occupation, typically through a regulatory body. Occupational regulation is typically used for skilled trades.³⁹⁶

Below in section 5.5 we discuss three example of government regulation in BC:

- Paramedics, which are regulated via mandatory licensing by a board created by provincial legislation;
- Certified dental assistants, who are certified by the College of Dental Surgeons of British Columbia; and
- Early childhood educators, who must be certified by, and registered with, a BC Registry administered by the provincial government and governed by legislation if they care for more than two children at a time.

5.3.3 Other Forms of Government Oversight

The government could also oversee a profession without creating governing legislation. For example, current government oversight of HCAs occurs via contract law and policy. Similarly, in BC counsellors are not regulated and do not need a formal designation to practice—although they can receive a formal designation by joining a provincial or national association self-regulation.³⁹⁷ Current government oversight exists via contract law when government agencies contract for private counselling services.³⁹⁸

The government may choose to regulate the employer or service provider, instead of or in addition to regulating the individual professional. For an example of regulation of service providers, see section 6.7.3 (Australia).

5.4 Regulation under the *Health Professions Act*

In BC, most health care providers are regulated. The *Health Professions Act (HPA)*³⁹⁹ governs designated health professions in BC, including both self-regulated health professions (also

known as registrants, or college members) and certified non-registrants. HCAs currently fall into neither category under the *HPA*. This paper discusses the *Health Professions Act* because self-regulation is an option for enhancing oversight of the work of HCAs.

5.4.1 Self-Regulated Health Professions in BC

The *Health Professions Act* defines a health profession in the following way:

“health profession” means a profession in which a person exercises skill or judgement or Provides a service related to
(a) the preservation or improvement of the health of individuals, or
(b) the treatment or care of individuals who are injured or sick, disabled or infirm”⁴⁰⁰

The health professions that are regulated under the *HPA* are:

- Acupuncturists;
- Audiologists;
- Chiropractors;
- Clinical perfusionists;
- Dental hygienists;
- Dental technologists;
- Dentists;
- Denturists;
- Dietitians;
- Doctors;
- Hearing instrument dispensers;
- Licensed practical nurses;
- Massage therapists;
- Medical laboratory technologists;
- Midwives;
- Naturopathic medicine practitioners;
- Nurse practitioners;
- Occupational therapists;
- Opticians;
- Optometrists;
- Pharmacists;
- Physical therapists;
- Podiatrists;
- Psychiatric nurses;
- Psychologists;
- Radiation therapy technicians;
- Registered nurses;

- Respiratory therapists;
- Speech-language pathologists; and
- Traditional Chinese medicine doctors.⁴⁰¹

A self-governing health profession under the *HPA* is governed by a regulatory college.⁴⁰²

As discussed earlier, registered nurses, registered psychiatric nurses, nurse practitioners, and licensed practical nurses generally supervise the work of HCAs. All four professions are regulated by the BC College of Nurses and Midwives.⁴⁰³

Purpose and objects of self-regulation in the health sector

The main duty of a college is to protect the public.⁴⁰⁴ To protect the public, a college must create:

- Education or training requirements for professionals to become a member of the college;
- Other conditions or membership requirements;
- Standards of practice;
- Requirements for conduct and ethics of college members;
- Continuing education requirements for members; and
- A patient relations program.⁴⁰⁵

A college must also monitor and enforce standards of practice and conduct requirements, including through “inquiry and discipline procedures that are transparent, objective, impartial and fair.”⁴⁰⁶ A college also has duties specifically related to protecting patients’ privacy rights. The Act requires colleges:

- (h) to require registrants to provide to an individual access to the individual’s health care records in appropriate circumstances;
- (i) to inform individuals of their rights under this Act and the Freedom of Information and Protection of Privacy Act⁴⁰⁷

Protecting the public: inquiries and discipline

One of the primary ways a college protects the public is by creating and enforcing standards of practice, ethics, and character requirements. If a member of a college is suspected of breaching codes of conduct, standards of practice, or ethics, a college may investigate, conduct an inquiry, and discipline the member.⁴⁰⁸

A college can become aware of a problem with a registrant in several ways.

- **A member of the public** can report a registrant to the college ⁴⁰⁹

- A **registrant** must report another registrant to the college
 - if they believe the person is a danger to the public;⁴¹⁰
 - if they have fired, put restrictions on, or dissolved a partnership with another registrant because that person might be a danger to the public;⁴¹¹
 - if they were about to fire, impose restrictions, or dissolve a partnership with a registrant, but that registrant quits before this can be done;⁴¹² or
 - if they believe the person has engaged in sexual misconduct. ⁴¹³
- A **medical professional** must report a registrant is to the college:
 - If the registrant is admitted to a hospital for psychiatric treatment and is unable to practice;⁴¹⁴ or
 - If the registrant is getting treatment for addiction and is unable to practice.;⁴¹⁵

A college may create a quality assurance program. These programs assess the professional performance of a registrant. If a quality assurance committee believes there are problems in the registrant's practice, they can require the registrant to undertake remedial activities, such as education or training.⁴¹⁶

If the college receives a complaint against a registrant, the inquiry committee can:

- Dismiss the matter if it is trivial, frivolous, or made in bad faith;
- Conduct an investigation;
- Direct the matter to go to a discipline committee hearing; or
- Resolve the matter through an agreement with the registrant.⁴¹⁷

If there is an urgent need to protect the public before the investigation and inquiry can be completed, the inquiry committee can put limits or conditions on the registrant's practice, or suspend the registrant's college registration.⁴¹⁸

At the discipline committee hearing, the committee can dismiss the matter, or find that the registrant has:

- Committed professional misconduct;
- Engaged in unprofessional conduct;
- Been incompetent;
- A physical illness, mental illness, or addiction which impairs their ability to practice; or
- Not followed the *HPA*, a regulation, or a college bylaw.⁴¹⁹

If the discipline committee finds the registrant has done any of the above, they can take

disciplinary action, including:

- Issue a reprimand;
- Issue a fine;
- Impose limits or conditions on the registrant's practice;
- Suspend the registrant's registration;
- Cancel the registrant's registration.⁴²⁰

Becoming a Designated Health Profession under the *HPA*

If a health profession such as HCAs want to become designated as a health profession under the *HPA*, the profession must make an application to the Minister of Health.⁴²¹ The Minister can refuse the application, make a determination if designation is in the public interest, or conduct an investigation to see if it is necessary to make this determination. In conducting an investigation, the Minister can:

- Require the profession to provide further information or examine its directors and officers.
- Seek the advice of other associations and organizations or hold hearings.
- Examine the scope of the services provided by the profession and the degree of risk they may pose to public health and safety.
- Evaluate the degree of supervision necessary for practitioners of the profession, and the degree of supervision practitioners receive or will be likely to receive.
- Determine what education programs exist for the proper training of the profession and evaluate the content of those programs.
- Do other things that they consider necessary or incidental in considering the application.⁴²²

The Minister must decide if it would be in the public interest for a profession to be designated as a health profession under the *HPA*.⁴²³ In doing so, the Minister must consider the degree to which the health profession's practice poses a risk to the public.

Criteria for designation of health professions

6 (1) For the purposes of section 10 (1) of the Act, the minister must consider the extent to which the practice of a health profession may involve a risk of physical, mental or emotional harm to the health, safety or well-being of the public, having regard to the following:

- (a) the services performed by practitioners of the health profession;
- (b) the technology, including instruments and materials, used by practitioners of the health profession;
- (c) the invasiveness of the procedure or mode of treatment used by practitioners of the health profession;
- (d) the degree to which the health profession is practised
 - (i) under the supervision of another person who is qualified to practise as a member of a different health profession, or

(ii) in a currently regulated environment.⁴²⁴

In addition to the risk to the public, the Minister can also consider other factors, including whether there is a body of knowledge providing standards of practice for the profession, there is a certificate or degree program, and whether the profession needs their competence to be assessed on an ongoing basis.

- (2) The minister may also consider the following criteria:
- (a) the extent to which the health profession has demonstrated that there is a public interest in ensuring the availability of regulated services provided by the health profession;
 - (b) the extent to which the services of the health profession provide a recognized and demonstrated benefit to the health, safety or well-being of the public;
 - (c) the extent to which there exists a body of knowledge that forms the basis of the standards of practice of the health profession;
 - (d) whether practitioners of the health profession are awarded a certificate or degree from a recognized post-secondary educational institution;
 - (e) whether it is important that continuing competence of a practitioner of the health profession be monitored;
 - (f) the extent to which there exists within the health profession recognized leadership which has expressed a commitment to regulating the profession in the public interest;
 - (g) the likelihood that a college established under the Act would be capable of carrying out the duties imposed by the Act, having regard to factors that may affect the viable operation of the college;
 - (h) whether designation of the health profession is likely to limit availability of services contrary to the public interest.⁴²⁵

5.4.2 Certified Non-Registrants

The *HPA* allows for the creation of a class of people under a college called certified non-registrants. The *HPA* defines a certified non-registrant in the following way:

“certified non-registrant” means a non-registrant to whom registrants of a college may delegate aspects of practice or who may be authorized to provide or perform aspects of practice in accordance with a bylaw of the college made under section 19(1)(k.1) and who is certified by the college in accordance with a bylaw of the college made under section 19(1)(l.2)⁴²⁶

A college can designate a class of non-registrants to whom they can delegate tasks. The college can also create education or training requirements, standards of practice, and requirements for how to become and remain certified. Certified non-registrants can also be elected to the board and vote in elections.⁴²⁷

Currently in BC, the only certified non-registrants are certified dental assistants, who are regulated by the College of Dental Surgeons of British Columbia.⁴²⁸ BC Certified Dental Assistants are discussed below in section 5.5.2.

5.4.3 Regulation of Nursing in British Columbia

The BC College of Nurses and Midwives regulates LPNs, RNs, RPNs, NPs, and midwives.⁴²⁹ The College sets out standards of practice, some of which involve working with HCAs, including assigning or delegating tasks to HCAs (discussed in section 3.6).⁴³⁰

Under the *HPA*, there are three regulations which apply to the practice of nursing: the *Nurses (Registered) and Nurse Practitioner Regulation*,⁴³¹ the *Nurses (Registered Psychiatric) Regulation*,⁴³² and the *Nurses (Licensed Practical) Regulation*.⁴³³

The BC College of Nurses and Midwives was established in 2020 through the amalgamation of the BC College of Nursing Professionals and the College of Midwives of BC.⁴³⁴ The BC College of Nursing Professionals was created in 2018 when the three previously existing nursing colleges (the College of Licensed Practical Nurses of BC, the College of Registered Nurses of BC, and the College of Registered Psychiatric Nurses) were amalgamated into a single regulator.⁴³⁵ Nursing (including both RNs and NPs) has been regulated in BC since 1918 under the *Nurses (Registered) Act*.⁴³⁶ Nursing became a designated profession under the *HPA* in 2005, following psychiatric nursing and practical nursing, which became designated under the *HPA* in 1965 and 1996 respectively.⁴³⁷

Scope of practice

The titles nurse, registered nurse, licensed graduate nurse, nurse practitioner, registered nurse practitioner, registered psychiatric nurse, psychiatric nurse, licensed practical nurse, and practical nurse are all considered reserved titles that can only be used by registrants.⁴³⁸

Nursing, as conducted by registered nurses and nurse practitioners, is defined by the regulations:

“nursing” means the health profession in which a person provides the following services:

- (a) health care for the promotion, maintenance and restoration of health;
- (b) prevention, treatment and palliation of illness and injury, primarily by
 - (i) assessing health status,
 - (ii) planning, implementing and evaluating interventions, and
 - (iii) coordinating health services;
- (c) medical assistance in dying;⁴³⁹

Licensed practical nursing is defined by the regulations:

“practical nursing” means the health profession in which a person provides the following services:

- (a) health care for the promotion, maintenance and restoration of health, with a focus on stable or predictable states of health;
- (b) prevention, treatment and palliation of illness and injury, with a focus on stable or

predictable disorders and conditions, primarily by
(i) assessing health status,
(ii) planning, implementing and evaluating interventions, and
(iii) coordinating health services;

“Psychiatric nursing” is also defined.⁴⁴⁰

Restricted activities

For NPs, RNs, RPNs, and LPNs, there is a similar list of restricted activities that only a registrant nurse can perform. Restricted activities that do not require an order from a doctor to perform include to:

- Make a nursing diagnosis;
- Suture skin;
- Administer oxygen or humidified air;
- For the purposes of a nursing activity, put a device, hand, or finger in a bodily opening past a prescribed location;
- Place a hearing instrument into the ear canal; and
- Apply ultrasound for bladder or blood flow monitoring.⁴⁴¹

In terms of medical drugs, the restricted activities depend on the type of registered nurse. An RN or NP can prescribe, compound, dispense, or administer a Schedule I drug by any method to treat anaphylaxis, cardiac dysrhythmia, opiate overdose, respiratory distress in a person with asthma, hypoglycemia, post-partum hemorrhage, or influenza-like illness. For Schedule II drugs, an RN or NP can prescribe, compound, dispense, or administer the drug by any method, with no restrictions on the type of illness it is being used for.⁴⁴² With a doctor’s orders, an RN or NP can compound, dispense, or administer any Section I or IA drug by any method.⁴⁴³ These activities can only be performed by a registrant.⁴⁴⁴ An RPN may perform similar activities.⁴⁴⁵

An LPN can compound, dispense, or administer a Schedule I or II drug by any method if it is done to treat anaphylaxis, respiratory distress in a person with asthma, or hypoglycemia. For Schedule II drugs, LPNs can only administer a drug orally, intranasally, or through a transdermal, transmuscular, or subcutaneous injection. An LPN cannot prescribe any drugs.⁴⁴⁶ With a doctor’s order, an LPN can compound, dispense, or administer a Schedule I, IA, or II drug by any method.⁴⁴⁷ These activities can only be performed by a registrant.⁴⁴⁸

5.5 Alternatives to Self-Regulation—BC Examples

In this section we discuss how BC has approached regulation and oversight of three types

of workers: emergency medical assistants (paramedics and first responders); certified dental assistants; and early childhood educators (ECEs) and ECE assistants. Each of these approaches bears considering because they use licensing or certification as opposed to self-regulation, which might be appropriate for HCA oversight.

5.5.1 BC Emergency Medical Assistants

The oversight model for emergency medical assistants working in BC (EMAs) includes:

- Regulation through a licensing board created by legislation;
- Mandatory licensing through the Board;
- Six levels of license, which must be renewed periodically;
- Recent criminal record checks concurrent with the licensing application;
- Successful completion a recognized training program;
- Examinations administered by the Board;
- Practice oversight through a complaints and investigation model that covers all aspects of competency to practice;
- Ongoing professional development; and
- A registry open to the public.

The Emergency Medical Assistants Licensing Board

EMAs include both paramedics and first responders. They have been regulated under BC legislation since 1975.⁴⁴⁹ EMAs are regulated through the Emergency Medical Assistants Licensing Board (the Board), under the *Emergency Health Services Act (EHSA)*.⁴⁵⁰

The Board operates in accordance with the *EHSA*, the *Emergency Medical Assistants Regulation*, the *Emergency Medical Assistants Licensing Board Regulation*, and the *Emergency Health Services Regulation*.⁴⁵¹ The Board, which is composed of three members, (one must be a licensed EMA, and another must be a medical practitioner), is responsible for examining, registering, and licensing all EMAs in BC.⁴⁵² The Board also sets the terms and conditions for licences and can investigate complaints.⁴⁵³ Under the *EHSA*, the Board can also create policies governing its own procedure.⁴⁵⁴

Credentialing: six levels of license

Anyone who calls themselves an EMA must be licensed through the Board.⁴⁵⁵ The regulation states that to be licensed as an EMA a person must:

- Successfully complete a recognized training program;
- Pass the approved Board examinations no later than 12 months after

- completing the training program; and
- Be of good character and fit to work as an EMA.⁴⁵⁶

Applicants are required by regulation to pay examination fees ranging from \$50 to \$550.⁴⁵⁷ They are also required by Board policy to undergo a criminal record check within 12 months of submitting their licensing application.⁴⁵⁸ The Board may grant licences to EMAs who were licensed in another jurisdiction if it determines that their authorization to practise is equivalent to the requirements in BC.⁴⁵⁹ If the Board determines that the qualifications, examinations, or training required are not equivalent, they may require an applicant from another jurisdiction to complete additional examinations or training.⁴⁶⁰ This review process for applicants from other jurisdictions can take up to one year.⁴⁶¹

There are six levels of licences, with each level increasing the services an EMA can provide.⁴⁶² The categories include:

- First responder;
- Emergency medical responder
- Primary care paramedic
- Advanced care paramedic
- Critical care paramedic; and
- Infant transport team.⁴⁶³

EMAs can hold a licence in only one category at a time.⁴⁶⁴ Licences are valid up to five years, except for the first responder category, which is valid for up to three years, and student licences, which are valid for up to one year.⁴⁶⁵ Each of these categories requires different education and exams.

Education based on the National Occupational Competency Profile

Under regulation, the Board has the authority to recognize training programs and examinations leading to EMA licensure.⁴⁶⁶ The Board's education and examination requirements are outlined through its policies as opposed to statute or regulation. Training programs are recognized initially for two years and then for five years, and are reviewed against the criteria contained in the Training Program Recognition Application Package.⁴⁶⁷ The criteria are based on the standards outlined in the EMA Regulations and the 2011 National Occupational Competency Profile.⁴⁶⁸

The National Occupational Competency Profile was created by the Paramedic Association of Canada, which develops blueprints for national standards for education programs.⁴⁶⁹ Examinations are administered by the Board and can include a jurisprudence exam, a

written exam, and/or a practical exam depending on the category of EMA licence.⁴⁷⁰ The jurisprudence exam covers components of EMA regulations and licensing policies, and legislation, including the *EHS Act*, the *Good Samaritan Act*, and the *Gunshot and Stab Wound Disclosure Act*.⁴⁷¹ The written and practical exam requirements are outlined in the BC Provincial Examination Guidelines for primary care paramedics and emergency medical responders, which also references the National Occupational Competency Profile.⁴⁷²

Practice oversight provided by the Board

The Board provides oversight by investigating complaints about EMAs and by ensuring continuing competency requirements. After receiving a complaint, or on its own motion, the Board may determine (following a hearing) that an EMA has incompetently performed their duties, has breached a condition of their licence, or is materially impaired (either physically or emotionally) to be act as an EMA.⁴⁷³ The Board can then impose conditions of a licence, suspend or revoke a licence, or bar someone from being licensed for a period.⁴⁷⁴ The Board can also take urgent action on a licence before a hearing if necessary to protect the public.⁴⁷⁵ Complaint investigations and their outcomes are published in the Board's Annual Report.⁴⁷⁶

Under the *EMA Regulation*, all EMAs (except for first responders and EMAs with student licences) are required to ensure continued competency by completing 20 continuing education credits and 20 patient contacts every year.⁴⁷⁷ Regulation requires EMAs to report continuing competence activities using the electronic Emergency Medical Assistants Continuing Competence System.⁴⁷⁸ The Board maintains a list of educational activities that have been pre-approved for credits.⁴⁷⁹

Registration

All licensed EMAs are included in a register which includes their name, address, licence number, place of employment, and any terms or conditions on their licence.⁴⁸⁰ The EMA register is accessible to the public from the office of the Licensing Board; however, the Board can refuse access to a person when it could threaten the safety of an EMA or when it is for commercial purposes.⁴⁸¹ There is also an EMA Licence Status Report online, but this list does not include EMAs' personal information, only their licence number and status.⁴⁸²

5.5.2 BC Certified Dental Assistants

There are two levels of dental assisting in BC. Dental assistants require no formal training, are not regulated, and do not need to be certified. Certified dental assistants (CDAs) must complete an approved CDA program and be certified by the College of Dental Surgeons of British Columbia.⁴⁸³

CDAs are qualified to carry out some procedures on patients under the direction of the dentist. The duties performed by dental assistants are more limited.⁴⁸⁴

The oversight model for certified dental assistants working in BC (CDAs) includes:

- Certification by the College of Dental Surgeons of BC;
- Credentialing through the National Dental Assisting Examining Board, which develops national standards and administers examinations;
- Practice oversight by a college governed by the *Health Professions Act*, through a complaints and investigation model that covers all aspects of competency to practice;
- Annual renewal of certification, which requires completion of professional development; and
- A registry open to the public.

Regulation

Under the *Health Professions Act (HPA)* and the *Dentists Regulation*, the College of Dental Surgeons of BC has the authority to regulate the practice of CDAs, dental therapists, and dentists in BC.⁴⁸⁵ The College is empowered by the *HPA* to create its own bylaws, which outline the qualifications for registration and the regulation of professional conduct, among others.⁴⁸⁶ The *HPA*, the *Dentists Regulation*, and the College's bylaws should all be read together.⁴⁸⁷ The College of Dental Surgeons of BC also has a Code of Ethics and Standards of Practice.⁴⁸⁸ Although these documents are not embedded in the act and are separate documents, they can still be applied in investigations, as outlined below.⁴⁸⁹

Credentialing based on national standards

The College of Dental Surgeons of BC certification requirements for CDAs are based on the national standards created by the Commission on Dental Accreditation of Canada and the National Dental Assisting Examining Board.⁴⁹⁰ The Commission on Dental Accreditation of Canada accredits post-secondary programs that provide training on a set of core skills for level II dental assistants, the level required to practice as a CDA in BC.⁴⁹¹ These programs generally take nine months to one year.⁴⁹² The National Dental Assisting Examining Board is responsible for examining CDAs, providing them with certificates after the successful completion of written and/or clinical exams.⁴⁹³

There are four classes of CDA certification.

Practising CDAs must graduate from an accredited dental assisting program within ten years of their application and have a National Dental Assisting Examining Board or National Dental Examining Board (NDEB) certificate (according to the Bylaws).⁴⁹⁴ However, the

College can certify applicants when it determines that a program meets the Level II CDA education standards, and when applicants complete a clinical exam with the National Dental Assisting Examining Board or other BC specific educational requirements.⁴⁹⁵ If an applicant's graduation date was more than three years before the date of their application, they must also meet the College's Quality Assurance requirements by completing a minimum of 600 hours of practice as a CDA and a minimum of 36 credit hours in approved continuing education activities.⁴⁹⁶ The College can also make exceptions to the educational or exam requirements where it determines that an applicant's knowledge, skills, and abilities are equivalent to the regular standards.⁴⁹⁷

Temporary CDA status is available where dental assistants have graduated from an accredited CDA program but not yet written the National Dental Assisting Examining Board exam. They must provide proof that they have applied to write the exam.⁴⁹⁸ Temporary certification lasts only one year, and can only be renewed once under extenuating circumstances.⁴⁹⁹ There are certain activities that temporary CDAs cannot perform.⁵⁰⁰

Limited CDAs are graduates of dental assistant programs outside of BC who are working towards the BC CDA certification requirements.⁵⁰¹ Like temporary CDAs, there are some activities that limited CDAs are not entitled to perform.⁵⁰² **Non-practising CDAs** are eligible to hold practising certification but are currently not practising.⁵⁰³

Professional development

CDAs must renew their certification with the College each year in order to practice.⁵⁰⁴ Renewal is contingent on the completion of continuing education and practice requirements under the Quality Assurance Program.⁵⁰⁵ CDAs must complete a minimum of 36 credit hours in an approved educational activity.⁵⁰⁶ CDAs are also required to complete a minimum of 600 hours of practice, and if they do not have the required hours, must successfully complete assessments such as by the National Dental Assisting Examining Board to demonstrate competency.⁵⁰⁷

Practice oversight by the College of Dental Surgeons of BC

The College of Dental Surgeons of BC is responsible for reviewing and investigating complaints made about CDAs.⁵⁰⁸ The framework for complaints and investigations is the same for all health professions regulated under the *HPA*.⁵⁰⁹

Anyone can make a complaint about a CDA.⁵¹⁰ The College can also investigate CDAs on its own motion on issues including a contravention of the *HPA* or the bylaws, conviction for an indictable offence, professional misconduct, competency, or physical and/or emotional inability to practice.⁵¹¹ Investigations can result in a reprimand, imposing conditions on

a CDA's practice, suspending or cancellation registration, or a fine up to a maximum of \$50,000.⁵¹²

CDAs have a duty under the *HPA* to report any unsafe practice or professional misconduct of any other regulated health practitioner.⁵¹³ CDAs must report other members of other health professional colleges if they believe their continued practice puts the public at risk.⁵¹⁴ There also required to report sexual misconduct.⁵¹⁵ If the College determines that a CDA presents a risk of physical or sexual abuse to children, or a risk of physical, sexual or financial abuse to vulnerable adults, they may suspend, cancel, or impose conditions on their certification.⁵¹⁶

Registry

The College of Dental Surgeons of BC maintains a public registrar containing the names and the class of certified CDAs.⁵¹⁷ The registrar is required under the *HPA* to publicly disclose the outcomes of disciplinary proceedings that result in actions against CDAs.⁵¹⁸

5.5.3 Early Childhood Educators

In BC early childhood educators (ECEs) and ECE assistants work with children from birth to age 5 and are hired in a variety of licensed facilities, including group childcare, multi-age childcare, or preschool settings.⁵¹⁹ ECEs and ECE assistants working in licensed childcare facilities are regulated by the ECE Registry.⁵²⁰

The oversight model for ECEs and ECE assistants working in BC includes:

- Regulation through an ECE Registry created by legislation;
- Mandatory certification through the ECE Registry;
- Two levels of certification, which must be renewed after either one year or five years;
- Successful completion of a training program recognized by the ECE Registry, and proof of work experience;
- Practice oversight by the ECE Registry through a complaints and investigation model that covers all aspects of competency to practice;
- A registry open to the public (although currently unavailable, recent legislation will make the ECE Registry public).

Certification under the Early Childhood Educator Registry

The ECE Registry oversees the certification of ECEs and ECE assistants, the investigation of complaints, and the recognition of ECE education programs.⁵²¹ The ECE Registry is

administered by the Ministry of Children and Family Development, which is responsible for licensed childcare support and programs, and is governed by the *Community Care and Assisted Living Act (CCALA)* and the *Child Care Licensing Regulation*.⁵²² Because providers require a licence when caring for more than two children, the ECE Registry's scope is broad.⁵²³ The recently passed *Early Childhood Educators Act*, although not in force, will make changes to the ECE Registry.⁵²⁴ The law combines the relevant provisions from the CCALA and the CCLR into a new statute dedicated solely to the ECE workforce.⁵²⁵ Although the legislation is not yet available, key changes made by the Act to the ECE Registry are identified in the below sections.⁵²⁶

Under the existing CCLR requirements, ECEs can be certified to work for either one year or five years.⁵²⁷

Five-year certification requires:

- Completion of an ECE training program in a program recognized by the regulations.⁵²⁸
- Proof of completion of at least 500 hours of relevant work experience within the last 5 years, or proof of sufficient childcare experience within the last 5 years.⁵²⁹
- A written reference from an educator who supervised their work experience, testifying to the applicant's competency in areas such as child development and health, their ability to develop and implement a curriculum, and their ability to foster positive relationships with children, their families, and co-workers.⁵³⁰
- Demonstration of the good character, the personality, ability and temperament necessary to work with children, and have the necessary training and skills to be an educator.⁵³¹

ECEs may also be certified for a one-year period once they have completed a recognized early childhood education program.⁵³² The one-year certificate can only be renewed once.⁵³³ ECEs may also apply to the ECE Registry for specialized infant and toddler and/or special needs certification. These require completing specific special needs and/or infant and toddler education in a recognized program.⁵³⁴

ECE assistants can apply for certification through a similar process. They must complete at least one course in child development, child guidance, or child health, safety, and nutrition in a recognized program.⁵³⁵ The ECE Registry also allows for flexibility in certifying applicants who have completed a program or course in qualifying for another profession and/or in a program that is not recognized in BC.

Exemptions can be made when the ECE Registry director considers a program to be at least

equivalent to a required program.⁵³⁶ The new legislation will allow the ECE Registry to issue temporary certifications to ECEs who completed their education outside of BC, so they can work while completing any outstanding requirements.⁵³⁷

Title protection

The new legislation provides title protection for ECEs and ECE Assistants—only those registered with the ECE Registry can use those titles.⁵³⁸ There is currently no publicly available database containing the names of persons who are certified by the ECE Registry. However, the new *Early Childhood Educators Act* will make the ECE Registry public.⁵³⁹

Curriculum

Certification is based on standards outlined in the *Child Care Sector Occupational Competencies*, which are used by the ECE Registry in deciding which education programs should be recognized, and by educational institutions in developing ECE programs.⁵⁴⁰ The *Competencies* have not been reviewed since 2004, and as such, the Government is working to develop ECE Standards of Practice.⁵⁴¹ ECE programs in BC are also guided by the Early Learning Framework, which does not impose a fixed curriculum, but is designed to guide and support early childhood educators, primary school teachers, and college and university education programs, among others.⁵⁴² The Framework also draws on the standards outlined in the *Competencies*.⁵⁴³ The *Early Childhood Educators Act* promises to provide clarity on how post-secondary programs are recognized for ECE certification.⁵⁴⁴

ECE Registry investigations

Anyone can complain to the ECE Registry about the “character, skills, or conduct” of a certified ECE or ECE assistant.⁵⁴⁵ If the ECE Registry director has reasonable grounds to believe there is an immediate risk to the health, safety or well-being of a child, they may suspend a certificate, or vary and/or attach terms to a certificate.⁵⁴⁶ Otherwise, the ECE or ECE assistant is notified of the details of the complaint and the ongoing investigation process, which can include contacting witnesses, interviewing the ECE or assistant, and conducting reference checks, among others.⁵⁴⁷

Following the investigation, the ECE or assistant receives a report containing all the evidence considered and the investigation findings.⁵⁴⁸ Where there are identified practice gaps, the ECE Registry can include remedial steps for the ECE or ECE assistant.⁵⁴⁹ The ECE Registry can also take action on a certificate when the ECE or assistant does not meet the character of skill requirements outlined in the CCLR, or their conduct has, or could have, caused harm to a child.⁵⁵⁰ The ECE Registry can require professional development or supervised work hours, suspend a certificate until legal requirements are met, or cancel a

certificate where there is a high risk to the health, safety or well-being of children should the ECE continue to practice.⁵⁵¹ If action is taken on a certificate, the matter may be taken to the CCALA Board or be handled as a criminal matter.⁵⁵² The new legislation will give the ECE Registry authority “to get the information needed to review complaints and complete investigations more quickly.”⁵⁵³

5.6 Modernizing Health Professional Regulation in BC

This section summarizes the current process to modernize the BC health profession regulatory framework.

5.6.1 Background to Law Reform: Findings from the Cayton Report

In 2018 the BC Ministry of Health launched an investigation into the College of Dental Surgeons of BC and the *Health Profession Act* when concerns were expressed regarding the College’s ability to function effectively and protect the public. The province appointed Harry Cayton to conduct a review of both the College and the *HPA* framework.⁵⁵⁴

In alignment with findings from the 2003 Ombudsperson’s report on self-regulation of health professions,⁵⁵⁵ the Cayton Report found that the College was not acting in the public interest and instead acting for the benefit of dentists.⁵⁵⁶ The College collected the fees for the BC dental association, which confused the regulatory role of the College and the advocacy role of the professional association.⁵⁵⁷ Cayton concluded that the College’s governance was ineffective, and there were many conflicts between staff and board members, a lack of trust, and a lack of openness, transparency and record-keeping.⁵⁵⁸

Cayton identified five factors that may have contributed to confusion regarding the true purpose of a regulatory college and the inability to focus on protection of the public:

1. The objects and duties of a regulatory college as stated in the legislation are not sufficient;
2. The fact that college members elect the board members confuses membership with registration. Board members felt obligated to act in the interests of their electors;
3. The dental college was reluctant to create unequivocal standards for fear they would have to hold fellow dentists accountable to them;
4. The complaints process was too complicated, and long negotiations were common; and
5. The college focused on voluntary consent orders and remediation, which does not protect the public.⁵⁵⁹

The Cayton report was critical of unlimited self-regulation, noting that: “[u]nlimited self-regulation has in general proved itself unable to keep patients safe or to adapt to changing healthcare provision and changing public expectations. Professional regulation needs to be shared between the profession and the public in the interests of society as a whole.”⁵⁶⁰

The Cayton report sets out 28 Standards for Good Regulation.⁵⁶¹ Cayton found that the College had failed to meet 11 of them.⁵⁶² He identified problems in the following areas:

- Developing standards and guidelines for professional practice and making the information accessible to the public;
- Investigating complaints; and
- Governing the profession.

Recommendations for improving BC’s health regulatory framework

The Cayton Report makes several recommendations for improving BC’s professional regulation framework and bringing it into alignment with his standards.

1. Cayton suggests replacing the *HPA* with new legislation because the current legislation is not sufficient to protect the public, and major structural reform is needed. He concludes that the current framework is slow to respond to changes, and does not fit the new model of team-based medical care.⁵⁶³ Cayton describes the objects of health professional regulatory reform as follows:

- To protect the safety of patients, to prevent harm and to promote the health and well-being of the public
- To provide a framework for safe, competent and ethical professional practise
- To have the trust of the public and the confidence of regulated occupations
- To be able to adapt to change and respond to new risks and opportunities
- To be efficient and cost effective in the interests of all citizens⁵⁶⁴

Cayton recommends several changes to the regulatory framework, including:

- Make colleges responsible for setting standards, monitoring competence, providing practice guidance, and issuing licences;
- Develop a single code of ethics for all professions; and
- Empower colleges only to investigate complaints, not to conduct the discipline stage.⁵⁶⁵

2. Cayton recommends creating a single registrar for all health professionals and that registration be mandatory. This registrar would conduct all discipline proceedings.⁵⁶⁶

3. Cayton suggests creating an oversight body for all colleges responsible for matters such

as shared standards for ethics and conduct, regulatory performance standards for the colleges and registration and adjudication body, and performance reviews of colleges.⁵⁶⁷

The full list of functions is:

- Approval of shared Standards for Ethics and Conduct and imposition of that Standard if all colleges are unable to agree
- Approval of the range (although not the content) of Standards for professional practice developed by colleges to ensure they cover all the necessary areas of practice
- Approval of a revised and more flexible arrangement for colleges to change their rules and bylaws
- Establishment of performance Standards of Good Regulation to be applied to both the colleges and to the registration and adjudication body
- Establishment of the dataset to be reported on by all colleges and for the compilation, analysis and publication of that information with the purpose of comparing performance, improving patient safety and reducing harm.
- Encouragement and support for the voluntary amalgamation of colleges
- Absorbing the functions of the HPRB to review on request certain registration decisions by the colleges and Inquiry Committee dispositions by the adjudication body
- Conducting reviews and investigations into the performance of colleges at the request of the Minister
- Advising, but not directing, colleges and the Minister on improvements in regulatory practice
- Assessing the risk of harm to patients and the public of healthcare occupations and to make recommendations to the Minister as to whether or not statutory regulation is necessary and if it is which college should be responsible
- Creating and overseeing an independent appointment process for both professional and public members of college boards based on open competition, published competencies and relevant experience and to make recommendations to the Minister⁵⁶⁸

4. Cayton recommends that decisions about which professions should be regulated be based on risk. He suggests creating an evidence-based occupational risk assessment process. He states a profession should only be regulated if no other type of oversight is sufficient to manage risk.⁵⁶⁹

5.6.2 BC's Modernization Process

Following the publication of the Cayton Report, the Government of BC created a Steering Committee on Modernization of Health Professional Regulation to consider how to update the *HPA* and health profession regulation.⁵⁷⁰ From May to June 2019, the Steering Committee conducted public consultations.⁵⁷¹ It published a consultation paper in November 2019,⁵⁷² and conducted a second round of consultation from November 2019 to January 2020.⁵⁷³ In August 2020, the Steering Committee released the *What We Heard Report* summarizing the consultation feedback,⁵⁷⁴ and a set of *Recommendations to Modernize the Provincial Health Profession Regulatory Framework*.⁵⁷⁵ At the time of publication of this study paper the Government of BC has introduced new legislation to replace the current *Health*

Professions Act, entitled the *Health Professions and Occupations Act*.⁵⁷⁶

The most pressing concern articulated by the Steering Committee, the Cayton report, and the Ombudsperson report was colleges are not sufficiently protecting the public. There is inadequate accountability and transparency, and a general lack of information on members and their work.⁵⁷⁷

Steering Committee Recommendations

The Steering Committee made six recommendations to improve the health professional regulatory framework.

1. The updated regulatory framework must embed cultural safety and humility.⁵⁷⁸
2. College governance must be improved, including changing the composition, appointment, and size of college boards.⁵⁷⁹
3. Colleges must be more efficient and effective, which will be accomplished through reducing the number of colleges from 20 to six.⁵⁸⁰
4. Oversight of colleges must be strengthened, which will be accomplished by creating a new oversight body and increasing accountability of colleges.⁵⁸¹
5. The complaints and adjudication process must be updated, including separating the investigation and discipline steps and increasing transparency.⁵⁸²
6. Colleges must share information between each other and with other agencies to improve patient safety and trust.⁵⁸³

One of the key recommendations of the Steering Committee is that an independent oversight body should be created. The oversight body would:

- Collect and analyze performance data on colleges;
- Audit colleges;
- Investigate the performance of colleges;
- Conduct systemic reviews of health profession regulation;
- Publish suggested policy and practice for colleges;
- Recommend minimum standards of practice, the specific content of which would be developed by colleges;
- Create consistent standards for ethics and conduct of registrants;
- Review college standards and bylaws and suggest where changes are needed;
- Appoint board members;
- Assess if new health professions should be regulated;
- Assess if existing health professions not governed by the *HPA* should fall under the *HPA*, such as social workers and emergency medical assistants; and

- Provide annual reports to the Ministry of Health.⁵⁸⁴

To make the colleges more effective and efficient, the Steering Committee suggests reducing the number of colleges to six, and developing the rest of the college landscape in the following way:

- Maintain the consolidated BC College of Nurses and Midwives;
- Amalgamate the dental colleges (currently in progress). Shift dental assistants from certified non-registrants to full registrants under the dental college;
- Maintain the BC College of Physicians and Surgeons (which has merged with the College of Podiatric Surgeons) and the College of Pharmacists of BC; and
- Create two new umbrella regulatory colleges – the Regulatory College of Allied Health and Care Professionals, and the Regulatory College of Complementary and Alternative Health and Care Professionals.

The Steering Committee also recommends:

- Create a streamlined process for new regulated health professions to join one of the six colleges;
- Prioritize bringing social workers, counselling therapists, and emergency medical assistants into the *HPA* framework; and
- Consider regulating unregulated diagnostic and therapeutic professions (such as respiratory therapists, radiation therapists, and medical laboratory technicians) under the *HPA* framework.⁵⁸⁵

5.6.3 How this Project Fits into These Changes

Currently, the process to modernize BC's health profession regulation does not include HCAs; however, HCAs could be designated a health occupation under the new *Health Professions and Occupations Act* framework. While there have been past reports examining HCA regulation (see section 4.1), these have been separate from the general health profession regulation discussions.

The Steering Committee has recommended changes to how new professions are considered for regulation, and has started a push to bring all health professions under the new health professional regulatory framework. This work will likely include professions that are regulated differently, such dental assistants (who are currently certified non-registrants), and paramedics (who are currently licensed under the Emergency Medical Assistant Licensing Board). The province has also indicated it wants to bring in currently unregulated professionals like counsellors and social workers. While these four professions appear to be the priority, it is possible if HCA oversight is updated, the province may want to bring them under the new *Health Professions and Occupations Act*. Any changes to how HCAs are regulated should consider this large-scale regulatory reform happening in BC.



6.1 Overview

The only Canadian jurisdictions in which HCAs are subject to any form of regulation are Alberta, Ontario, and Nova Scotia. This chapter describes law and policy in Alberta and Ontario, as their approaches are somewhat similar to BC's. They both have a type of education program curriculum or standard and a registry or association where some HCAs may be listed. Nova Scotia is included in this chapter because it has the most comprehensive HCA regulatory regime in Canada. In Nova Scotia all HCAs must be licensed and pass a certification exam no matter where they work. We also describe Manitoba's Adult Abuse Registry, which has some impact on HCA practice.

Internationally, we examine the United Kingdom and Australia. We chose these two countries because they are both commonwealth countries with very similar legal and health care systems. Canada and Australia's legal system were built off UK's legal system. Both countries also publish legal information in English.

6.1.1 Naming Conventions

HCAs go by different titles in different jurisdictions and working environments. Below is a chart

listing what HCAs are commonly called in each province and territory, and in the other comparative jurisdictions we review in this study paper.

Table 9: Naming Conventions for HCAs

Jurisdiction	HCA Names
British Columbia	Care aide Community health worker
Alberta	Health care aide
Saskatchewan	Continuing care assistant
Manitoba	Health care aide
Ontario	Personal support worker
Quebec	Nurse aide Orderly Patient attendant
New Brunswick	Personal support worker
Nova Scotia	Continuing care assistant
Prince Edward Island	Resident care worker
Newfoundland & Labrador	Home support worker Personal care attendant
Yukon	Health care assistant
Northwest Territories	Personal support worker Resident care aide
Nunavut	Home and continuing care worker
United Kingdom	Healthcare assistant Assistant practitioner Healthcare support worker Clinical support worker
Australia	Health care assistant Personal care worker Assistant in nursing

6.2 Ontario

Ontario had an HCA registry from 2011-2016. The Government of Ontario shut the registry down because it did not effectively oversee practice competency. In recent

years it announced plans to put in place a new HCA registry but the work stalled and implementation plans are currently uncertain. The 2021 legislation which would have created the new voluntary registry and authority, gives the authority a mandate to develop and maintain competencies and codes of ethics for HCAs, establish visual markers for credentialed HCAs, educate employers, registrants and members of the public, investigate complaints about practice, and discipline registrants.

Ontario's current oversight approach includes:

- An HCA educational program standard featuring placements in long-term care
- Mandatory credentialing to work in long-term care

6.2.1 Ontario's First Personal Support Worker Registry (2011-2016)

In Ontario, health care assistants are called personal support workers (PSWs). This name was adopted in 1997 by the *Ministry of Health and Long-Term Care* to standardize this group (which included "care aide[s], home support worker[s], attendant care worker[s] and respite worker[s]").⁵⁸⁶

In 2011, this Ministry created a registry for PSWs (PSW Registry).⁵⁸⁷ The Personal Support Worker Registry provided employment and educational history on registrants and created a complaint process. The Ministry closed the PSW Registry in 2016 because they determined that it did not thoroughly regulate registrants. For example, many registrants had criminal records or poor employment histories.⁵⁸⁸ In 2018, the province announced that a new registry was being developed in cooperation with the Michener Institute, scheduled for completion in December 2019.⁵⁸⁹ However, since the Conservative party formed the subsequent Ontario government in 2018, plans to implement this registry are unclear.⁵⁹⁰

6.2.2 Education: Ontario's Personal Support Worker Standard (2014)

In 2014, Ontario's Ministry of Training Colleges and Universities released the "Personal Support Worker Standard (Program Standard)." This approved standard for PSW programming delivered in Ontario includes:

- vocational learning outcomes and associated performance expectations;
- essential employability skills; and
- an optional general education requirement.⁵⁹¹

The vocational learning outcomes include the ability to:

1. work in line with legislative standards, policies, procedures and guidelines;
2. act as a professional, by demonstrating self-awareness, time management, team skills etc;
3. work collaboratively with other professionals to deliver client centered care;
4. provide care attuned to ethics, and in line with client's diverse backgrounds and needs;
5. create relationships with clients that are respectful, professional, and honor legislative, policy and employer requirements;
6. identify information relevant to the client, and document said findings;
7. develop safe environments (e.g., infection prevention methods, other applicable standards per legislation, policy, or employer requirements);
8. have a foundation of knowledge that allows for support of clients across the lifespan;
9. provide medication as directed by the employer and applicable legislation;
10. aid in household management to promote safety and comfort;
11. aid family caregivers, with consideration for the particular patient and family;
12. report and respond to "potential, alleged, suspected or witnessed" abuse per the legislative requirements;
13. support end of life care which is culturally and spiritually safe;
14. provide safe and client centered care to individuals with cognitive impairments and mental health concerns.⁵⁹²

The Program Standard does not include a curriculum.⁵⁹³

Educational programming is offered by several different institutions, including:

- community colleges,
- career colleges,
- board of education adult learning programs, and
- not for profits.

The majority of PSWs graduating from PSW Certificate Programs are educated at career colleges or board of education adult learning programs.⁵⁹⁴

Different providers require different time commitments, both for in class and practical learning components, as set out below:

- Community college programs: 384 in-class hours and 386 practicum hours;

- Private career college: 285 in class hours and 255 practicum hours; and
- Board of Education adult learning programs: 540 in class hours and 270 practicum hours.⁵⁹⁵

Most practicum placements are in long term care settings, leaving gaps in training for home and community care.⁵⁹⁶

As with most educational programs, research conducted on 1746 PSWs in Ontario points to gaps between the educational instruction and the realities of the work.⁵⁹⁷ Many of these gaps related specifically to the home and community care setting. These gaps included an understanding of “safe body mechanics for moving clients, managing client aggression, infection control, CPR/First Aid, mental illness, and basic health and safety.”⁵⁹⁸

6.2.3 Credentialing of PSWs Working in Long-Term Care

PSWs must have completed an educational program to work in long-term care.⁵⁹⁹ However, this requirement applies only to new PSWs and not those employed before the Program Standard was introduced.⁶⁰⁰ There is currently no central database of employed PSWs; therefore, the number of PSWs working since the Program Standard was implemented is unknown.⁶⁰¹ Those working in home and community care are also not required to complete an educational program. Rather, individuals may be trained on the job by the employer without government screening or oversight.⁶⁰²

Some programs in Ontario advertise themselves as being licensed by the National Association of Career Colleges, which has created a PSW program that is based on the Program Standard.⁶⁰³ The National Association of Career Colleges offers a certification exam for those who complete these programs. The Association’s website allows employers to verify whether an individual has completed one of their programs.⁶⁰⁴

The Program Standard does not mention an exam or test for certification.

6.2.4 Law Reform to Enhance Oversight via Voluntary Registration (2021)

In 2021, Ontario introduced the *Health and Supportive Care Providers Oversight Authority Act*.⁶⁰⁵ The statute creates an authority and registry for PSWs and related workers. Much of the act is not yet in force.

The authority’s mandate includes developing and maintaining competencies and codes of ethics for registrants. It will also interface with the general public by developing ways they can recognize credentialed registrants and by educating registrants, employers and

members of the public about the authority and registry. The Act includes the following objects:

- (b) to establish and maintain educational and skills-based qualifications for each class of registrants;
- (c) to establish and maintain one or more visual marks or identifiers for use by registrants that can identify registrants to members of the public;
- (d) to promote the provision of safe, competent, ethical and high-quality health services and supportive care services by registrants to members of the public;
- (e) to establish and maintain codes of ethics applicable to each class of registrants in relation to the health services or supportive care services they provide to members of the public;
- (f) to educate registrants, employers and members of the public about matters relating to this Act and the regulations;⁶⁰⁶

At present it appears the authority board is in the process of being appointed.⁶⁰⁷ The Government indicates that the authority “will be established in a manner similar to other delegated administrative authorities (‘DAAs’) in Ontario, such as the Retirement Homes Regulatory Authority and numerous other consumer protection DAAs.”⁶⁰⁸

Registration will be voluntary for PSWs.⁶⁰⁹ Individuals wishing to register as PSWs or related workers must meet certain criteria, which have not yet been established.⁶¹⁰ Once a PSW is registered, they are subject to the act and its regulations.

The legislation includes requirements to:

- A registrant must self-report to the Authority if they have been charged with an offence, or if they have been found guilty of an offence.⁶¹¹
- A registrant must report another registrant to the Authority if they have reasonable grounds to believe they sexually abused a person who receives health or supportive care services.⁶¹²
- Every person must cooperate fully with information requests if the authority receives a complaint about a registrant.⁶¹³
- Every person must cooperate fully with investigators.⁶¹⁴ Investigations may be conducted in relation to complaints or when the Chief Executive Officer has reason to believe that a registrant may have acted contrary to the Act, the regulations, or the Code of Ethics.⁶¹⁵ Investigators can enter places where registrants provide health or supportive care services, but must obtain a warrant and the consent of any occupier to enter a dwelling.⁶¹⁶
- Registrants must submit to a disciplinary process, including requirements to mediate a complaint or taking further education.⁶¹⁷ Registrants may also have their registration suspended or conditions imposed.⁶¹⁸

The act also creates offences. For example, it is an offence for a person to fail to report sexual abuse or if a non-registrant pretends they are registered under the authority.⁶¹⁹ Any person found guilty of offences under the Act is liable to fines up to \$25,000.⁶²⁰

The general public will be able to access the PSW registry.⁶²¹

6.3 Alberta

6.3.1 Introduction

Alberta has made some important strides in the oversight and regulation of health care assistants (known as health care aides in the province). The government has:

- Set educational requirements by developing the Health Care Aide Program curriculum;
- Created HCA provincial exams which are the primary way HCA are credentialed in Alberta; and
- Developed a Health Care Aide Directory (the Directory).⁶²²

All health care aides working at publicly funded institutions must be enrolled in the Directory. Further developments for oversight are in progress. Current plans are to regulate HCAs by bringing the Directory under the auspices of the LPN college. Law reform is required to effect this change and the legislation has not yet been developed.

6.3.2 Education: Alberta's Health Care Aide Program

The province of Alberta created and owns a curriculum for training health care aides.⁶²³ In this fashion, the government has been able to tightly control which institutions are able to provide the program. In 2017, the government stopped licensing additional institutions to offer the Program.⁶²⁴

PPre-requisites to the Health Care Aide Program include digital literacy, language arts (namely, high school English), and English language proficiency.⁶²⁵

Once these elements are established, a candidate can apply to an approved institution to attend the Health Care Aide Program.⁶²⁶ Upon completing the program, the candidate may take the provincial exam. Once they pass the exam they become as a certified health care aide.⁶²⁷

The educational curriculum follows the provincially created Health Care Aide Competency

Profile (Profile). The original version of the Profile was developed in 2001, and later updated in 2018. The Profile “outlines the knowledge, skills, behaviours, and attitudes required by all HCAs who deliver care in Alberta.”⁶²⁸ This is achieved through reference to six key areas:

- “1. HCA Role and Responsibility
2. Provision of Care
3. Collaborative Care
4. Communication
5. Health Across the Life Span
6. Safety.”⁶²⁹

These different aspects seek to:

- outline the competencies necessary for the job;
- create a foundation for the Provincial Health Care Aide Curriculum;
- inform competency assessment tools and methods; and
- establish terms of reference for developing health care aide job descriptions.⁶³⁰

One study found that a vast majority of health care aides had completed both high school and a health care aide certification program.⁶³¹

6.3.3 Credentialing

As outlined above, the primary way to obtain the health care aide certificate in Alberta is to complete an approved program and take the provincial exam. However, other methods include:⁶³²

- People with substantially similar education may undergo an evaluation called the Prior Learning Assessment and Recognition and then challenge the Alberta Examination.
- People with similar education or experience may complete a Substantial Equivalence Assessment.
- Employers may hire an individual with appropriate education who is not certified. The employer provides the necessary education following the Provincial Competency Assessment Profile tool. These health care aides are ‘deemed competent’.

Individuals from the above groups can seek to join the Health Care Aide Directory, subject to different requirements to demonstrate competency.⁶³³

With respect to those already working in the field, all health care aides listed in the

Directory who received their training prior to 2013 are required to complete a bridging program to ensure their skills match the new requirements. This education must be completed by June 30, 2022.⁶³⁴

6.3.4 Oversight via Alberta's *Health Professions Act* (2021)

Alberta regulates health care professions via the *Health Professions Act*.⁶³⁵ The statute covers a broad range of professionals including acupuncturists, naturopaths, opticians, dentists, physicians, and nurses. These professions are governed by various colleges.⁶³⁶ In Alberta colleges are responsible for setting up codes of ethics, enforcing regulations, and overseeing standards of practice. Part of this role extends to managing complaints and discipline for members.⁶³⁷

The colleges have authority to oversee the professionals working in that field. Some colleges are exclusive to one profession, while others oversee several.⁶³⁸ Historically, health care aides in Alberta were not part of a self-governing health profession. They provided health care services under the supervision of a regulated health professional.⁶³⁹

In April 2021, certain amendments to the *Health Professions Act* paved the way to regulation of health care aides. HCAs will be added to the portfolio of the *College of Licensed Practical Nurses of Alberta* (who already oversee the Directory).⁶⁴⁰ However, the necessary legislative framework does not yet exist. Regulations must be drafted before the *College of Licensed Practical Nurses of Alberta* can begin oversight.⁶⁴¹

Once this process is completed, health care aides will be subject to the same processes discussed above. For example, they will presumably be required to adhere to code of ethics and standards of practice utilized by the nursing college.⁶⁴² Further, where a health care aide fails to meet the standards and obligations set out by the regulations and other documents, they will be subject to a complaint and possible disciplinary process.⁶⁴³ The recent amendments will also include health care aides within a centralized public registry of regulated health professionals.⁶⁴⁴

This approach contrasts with Ontario, which has created a registry, but not brought HCAs under a college.

6.4 Nova Scotia

6.4.1 Introduction

In Nova Scotia, HCAs, called continuing care assistants (CCAs), were not regulated until very recently. However, Nova Scotia began the work of oversight nearly 20 years ago. Starting

in 2006, new CCAs entering the field required certification to work in “nursing homes and homes for the aged, and in agencies providing home support services to Continuing Care’s home care clients.”⁶⁴⁵ A voluntary registration scheme was put in place in 2010.⁶⁴⁶ Starting in February 2022, a mandatory registry created by new legislation, the *Continuing Care Assistants Registry Act*, has been in place.⁶⁴⁷

The Department of Seniors and Long-Term Care, the Department of Health and Wellness, and the Continuing Care Assistant Program Advisory Committee work together to manage the existing framework for CCAs. These entities oversee education, certification, and the CCA Registry.⁶⁴⁸ Concerns related to public interest and governance are managed largely by employers.⁶⁴⁹

6.4.2 Education

At present, there are seven recognized continuing care assistant training programs in Nova Scotia.⁶⁵⁰ Most programs are a minimum of 30 weeks in duration and require high school graduation and a clear criminal record check for entry.⁶⁵¹ Following completion of the program, an exam is required (discussed below under “Credentialing”).

In 2019, Nova Scotia Health and Wellness released a Scope of Practice and Competency Framework for continuing care assistants. The goal of this document was to:⁶⁵²

- provide basic expectations and structure for educational programs;
- inform employers and the public of expected skill levels for continuing care assistants;
- ensure that continuing care assistants are being trained to meet the needs of the industry;
- support effective hiring (provide focus for job descriptions, screening questions etc.);
- inform people seeking to enter the practice about what is expected, and the scope of the work.

The competency framework is conceived as a pyramid, with foundational skills providing a basis for further skills development.⁶⁵³ The manual defines each of the competencies and lists key behavioural expectations. For example, part of integrity is respecting client confidentiality.⁶⁵⁴ Skill development is unique to areas of practice and learning is expected to continue into a place of employment.

6.4.3 Credentialing

The simplest way to become certified is to complete an approved program and the

Continuing Care Assistant Exam.⁶⁵⁵ Eligibility for the exam depends on completing a program that meets certain educational requirements.⁶⁵⁶ In addition, candidates must have other certifications, including standard first aid and the Workplace Hazardous Materials Information System.⁶⁵⁷ However, as will be discussed below, there are exemptions to this rule. The candidate must apply for certification within 12 months of passing the exam.⁶⁵⁸

Like other jurisdictions, Nova Scotia offers alternative routes to certification for candidates with similar education or experience. For example:

- “Prior Learning Assessment and Recognition” reviews a person’s skills and level of competency acquired from previous training and life experience. This assessment results in an individualized learning plan for the person to complete prior to writing the exam.⁶⁵⁹
- “Course Recognition” reviews a person’s educational history. This assessment results in an individualized learning path for the person to complete prior to writing the exam.⁶⁶⁰

The Nova Scotia Department of Health and Wellness requires a person to be a Certified Continuing Care Assistant in order to become employed in publicly “funded nursing homes and home support agencies and most hospital settings.”⁶⁶¹

The Nova Scotia Department of Seniors and Long-Term Care has an ongoing policy with respect to educational requirements for non-licensed care staff (Entry to Practice Policy). The most recent update was November 9, 2021.⁶⁶² This policy applies to nursing homes and home support agencies, setting out requirements for employers hiring CCAs.⁶⁶³ The policy specifically applies to new hires, and requires one of the following certifications:

- Continuing care assistant or equivalent
- Personal care worker
- Home health provider
- Home health aide
- Home support worker⁶⁶⁴

These different designations have unique educational and certification requirements per the policy. There are, however, exceptions:

- for certain individuals hired prior to the policy coming into force (April 1, 2006) subject to several parameters for work experience;
- where a qualified person is not available for hire;
- where a person is trained internationally, and

- where a person was formerly a nurse.⁶⁶⁵

The recently passed *Continuing Care Assistant Registry Act* directs an administrator to “certify a person as a certified continuing care assistant” where they have:

- “successfully completed the certification program,” or
- “qualifications...training and experience equivalent to completion of the certification program.”⁶⁶⁶

A person must undergo this credentialing process to be called a CCA, which has title protection under the new legislation.⁶⁶⁷

6.4.4 2010: Voluntary Registration

In 2010, the Department of Wellness and Health created the CCA Registry, which recorded information including the employment status of CCAs, and the sector of employment (Acute, Long Term Care, Home Support, Residential Care Facilities, Private).⁶⁶⁸ However, registration was voluntary, and efforts to encourage CCAs to register, such as waiving registration fees, were unsuccessful.⁶⁶⁹ Because registration was optional, less than 10 per cent of CCAs working in Nova Scotia are included in the CCA Registry.⁶⁷⁰ In 2016, the voluntary registry had 1,261 members, and in 2018, the CCA Registry had 1,047 members.⁶⁷¹

6.4.5 New Oversight Mechanism: 2021’s *Continuing Care Assistants Registry Act*

Nova Scotia has since turned the voluntary registry into a new mandatory CCA Registry. Under the CCARA, registration is mandatory for all CCAs working in the field starting June 20, 2022, and must be updated annually.⁶⁷² Health Association Nova Scotia will run the CCA Registry on behalf of the Department of Health and Wellness.⁶⁷³

As with the voluntary registry, the CCA Registry is designed to collect workforce data, for example: where a person works, whether they work full time, part time or casual.⁶⁷⁴ Some of this information will be available to the public, including the individual’s name, registration, and compliance.⁶⁷⁵

The requirement to register extends to the following:⁶⁷⁶

- Certified continuing care assistants who have completed the Continuing Care Assistants Program and passed the examination;
- Certified home support workers who have completed a Home Support Nova Scotia Certification;

- Home health care providers/home health aides who are certified by Nova Scotia Community College;
- Personal care workers, certified through Nova Scotia Department of Health or Department of Community Services;
- Retired or inactive nurses who wish to work as continuing care assistants, who can prove good standing with the nursing college;
- International Educated Nurses who wish to work as a continuing care assistant, who have a report from the National Nursing Assessment Service indicating equivalency; and
- Others who fail to fall into the above categories but who are working in a continuing care assistants' akin role (for example those in training, or who are 'grandfathered in'.)

The new registry borrows considerably from the Entry to Practice Policy.

6.5 Manitoba

6.5.1 Introduction

In Manitoba, many terms are used for health care assistants, with the most common being health care aide. Manitoba has not made advances in regulation or oversight as compared with the other Canadian jurisdiction discussed in this chapter.⁶⁷⁷ It does not have a registry, educational standards, or legislation dedicated to regulating health care aides. We include Manitoba in this chapter because it operates an Adult Abuse Registry (discussed in section 6.5.5).

6.5.2 Education

Manitoba does not have a set program standard for care aide education. In 2012, the Association of Canadian Community Colleges and its affinity group, the Canadian Association of Continuing Care Educators, undertook an environmental scan of educational standards across Canada for personal care providers.⁶⁷⁸ They noted that "Manitoba does not have a provincial curriculum governing health care aide programs, however the public colleges have collaborated to utilize similar learning outcomes."⁶⁷⁹ The scan reported Manitoba's programming as slightly below average in terms of program length and required hours.⁶⁸⁰

At present, a general search reveals that care aide programs are offered by a variety of institutions ranging from school districts to colleges, to trade and technology institutes.⁶⁸¹

Most programs are from five months to one year in length, with most requiring a six-to-eight-week practicum.

In November 2020, the Government of Manitoba paired with Red River College to create a one-week “condensed, high-intensity training program that will train students to work as uncertified health-care aides (UHCAs) and create immediate employment opportunities for Manitobans including students currently enrolled in a health sciences faculty or program.”⁶⁸²

At the same time the Association of Canadian Community Colleges created the environmental scan of educational programs across Canada, they also released a reference guide on National Educational Standards for Personal Care Providers.⁶⁸³ These standards are “intended to be used voluntarily as a framework for comparing and/or enhancing existing curricula, standards, or curricular frameworks.”⁶⁸⁴

6.5.3 Credentialing

Prior to the 1990s, certification was not required to work as a care aide.⁶⁸⁵ After this time, employers began requiring a Care Aide Certificate for employment. However, there is no standardization of HCA education in Manitoba. Some care aide educational programs refer to being a “[Winnipeg Regional Health Authority] recognized Health Care Aide certificate”.⁶⁸⁶ However, it not clear that the Winnipeg Regional Health Authority recognize HCA programs in any formal way. Despite these limitations, the 2019 Study found that 96% of care aides surveyed had a Care Aide Certificate.⁶⁸⁷

6.5.4 Oversight

At present, there is no legislation, policy, group, or framework which oversees care aides in Manitoba. Only one piece of legislation references care aides.⁶⁸⁸ Further, “there is no registration examination for health care aides to enter practice and there is no regulating body for graduates.”⁶⁸⁹

Those working in the field see advantages and disadvantages to this vacuum. The complete lack of structure within the province creates disadvantages such as:

- Vast differences in the quality of educational programs;
- Workers lacking key knowledge or skill sets required by their employment;⁶⁹⁰
- Lack of value placed on the work of care aides because they are unregulated;⁶⁹¹
- Lack of standards, which is perceived as feeding to the lowest common denominator.
- People entering the field because of its accessibility rather than because of aptitude.

However, there are also advantages, namely:

- Low barriers to entry, making the field accessible to migrants;⁶⁹²
- Flexibility for employers to fill in the gaps and ensure a sufficient workforce.⁶⁹³

6.5.5 The Manitoba Adult Abuse Registry

The Manitoba Adult Abuse Registry (the “Abuse Registry”) is a database of persons who have been found to have abused or neglected adults protected by the *Vulnerable Persons Living with a Mental Disability Act* or *The Protections for Persons in Care Act*.⁶⁹⁴ Created through the *Adult Abuse Registry Act* in 2013, the Abuse Registry aims to help protect vulnerable adults by allowing employers to screen potential employees and volunteers.⁶⁹⁵ Manitoba is the only province in Canada with an adult abuse registry.

Scope of the Abuse Registry

The Abuse Registry protects adults designated as “vulnerable persons” and “patients” as defined by the *Vulnerable Persons Living with a Mental Disability Act* and *The Protections for Persons in Care Act* respectively. What is considered abuse or neglect differs depending on whether the adult is considered a patient or a vulnerable person.⁶⁹⁶

- “Vulnerable person” means “an adult living with a mental disability who is in need of assistance to meet his or her basic needs with regard to personal care or management of his or her property.”⁶⁹⁷
- “Patient” means an adult who is “a resident or an in-patient in a hospital, personal care home or Selkirk Mental Health Centre or is receiving respite care in such a facility, is receiving services in a geriatric day hospital that is managed by a hospital designated by regulation under *The Health Services Insurance Act*, or is receiving services in an emergency department or urgent care centre of a hospital.”⁶⁹⁸

The wide scope encompassed by these definitions means that the Abuse Registry covers multiple health and social care sectors, including public facilities and long-term care and personal care homes run by licensed private service providers.⁶⁹⁹

Abuse Registry process

A name **must** be placed on the Abuse Registry when a person has been found or pleaded guilty to an offence involving the abuse or neglect of vulnerable adult.⁷⁰⁰ If a court convicts someone of such an offence, they must report the person’s name and the particulars of the abuse and the neglect to the Abuse Registry.⁷⁰¹ Peace officers and designated officers must also report to the Abuse Registry when a person has been convicted of an offence covered by the Abuse Registry (in any jurisdiction), and is, or is likely to be, present in Manitoba.⁷⁰²

A name **may** be placed on the Abuse Registry when the Abuse Registry Committee (the Committee) receives a report from a designated officer and determines, through its own process, that a person has abused or neglected a vulnerable adult and that the person's name should be placed on the Abuse Registry.⁷⁰³

Only specific government officials who are responsible for investigating suspected cases of abuse and neglect (referred to as "designated officers") can make reports to the Committee in this context.⁷⁰⁴ Designated officers are required by legislation to provide a report to the Committee if they believe a person has abused or neglected a vulnerable adult.⁷⁰⁵ Regulations further specify that designated officers should only report:

- if the suspected person can work or volunteer, or may be able to in the future, and
- the abuse/neglect did not occur because the person was not properly trained.⁷⁰⁶

The Committee then reviews the report and any further information provided by a designated officer regarding the person suspected of abusing or neglecting an adult. They must decide whether abuse or neglect occurred and whether that person's name, and the particulars or the situation, should be registered.⁷⁰⁷ If a person's name is registered, the Committee must notify:

- The designated officer who made the report, and the person whose name is being listed (who can object to the entry of their name by filing a court application).⁷⁰⁸
- The current or former employer of the person, and/or the professional body of the person.⁷⁰⁹

Access to the Abuse Registry

All information in the Abuse Registry is confidential.⁷¹⁰ Access is restricted to the following circumstances:

1. Any person may apply to see if their own name is listed on the Abuse Registry.⁷¹¹
2. Designated officers, when conducting protection investigations.⁷¹²
3. Peace officers, when it is necessary for them to carry out their duties.⁷¹³
4. Employers and others, when it is necessary to assess the suitability of a person who would work directly with vulnerable adults.⁷¹⁴ As a matter of practice, the Abuse Registry requires the written consent of the person whose name is being checked. However, consent is not required by legislation.⁷¹⁵

The Committee publishes an annual report with data on the number of checks, referrals made, and names registered.⁷¹⁶ In 2015 and 2016, legislation was introduced that would have permitted information sharing about elder abuse between the Abuse Registry and government officials responsible for *The Protections for Persons in Care Act* and the *Vulnerable Persons Living with a Mental Disability Act*.⁷¹⁷ However, the Bills did not proceed for several reasons, including the challenge of coordinating several government departments and the resources required.⁷¹⁸

How does the Abuse Registry impact HCAs?

The Government of Manitoba website specifies that Abuse Registry “checks will be required for staff on a go-forward basis.”⁷¹⁹ However, checks are not required by legislation. Colleges require applicants for membership to undergo an Abuse Registry check, a criminal record check, and child abuse check. Individuals must also undergo an Abuse Registry check in order to obtain a license for long-term care.

Within the public sector, employees working with vulnerable adults are generally required to get an Abuse Registry check. Within the private sector, long-term care and home support service providers working with vulnerable adults are required to get an Abuse Registry check when they renew or apply for a license through Family Services.⁷²⁰ However, private service providers are only required to obtain Abuse Registry checks for new employees, including health care assistants, if they are receiving government funding.⁷²¹

The Abuse Registry annual reports do not include any specific data related to health care assistants.

6.6 United Kingdom

6.6.1 Introduction

In the United Kingdom (UK), various titles are used to refer to HCAs. These titles include roles within England’s National Health Service, such as healthcare assistants, assistant practitioners, healthcare support workers, clinical support workers, and others.⁷²² The terms “care support worker” and “personal assistant” are often used to describe HCAs working in adult social care.⁷²³

In the UK there is very limited oversight of HCAs and educational standardization. However, England’s Care Quality Commission, which regulates various registered health and social care services, requires providers to ensure appropriate training, qualifications, and professional standards for staff, including for HCAs. The Care Certificate has been widely adopted as a national standard for HCA training. Providers registered with the Care Quality

Commission must offer this training to their non-regulated staff and must demonstrate that their staff are competent in the standards.

HCAs may become voluntary members of the Royal College of Nurses, which provides guidance, expectations, and recommendations for practice. Some unregistered HCA roles, such as assistant practitioners, work under specific regulated health professionals and have educational requirements.

6.6.2 Oversight by the Care Quality Commission and the Royal College of Nurses

In the UK, no professional body or registry is directly responsible for HCAs.⁷²⁴ However, there are a few regulators and professional bodies that provide some oversight over their work. In England, this includes the Care Quality Commission.

The Care Quality Commission is an independent regulator for various registered health and social care services in England.⁷²⁵ Wales, Scotland, and Northern Ireland are governed by their own health care regulators.⁷²⁶ While some services are regulated by the Care Quality Commission, such as the provision of residential accommodation, other activities, such as supported living services, are not regulated.⁷²⁷ Under Regulation 18 (Staffing) and Regulation 19 (Fit and proper persons employed), the Care Quality Commission requires providers to ensure appropriate training, qualifications, and professional standards for staff, including for HCAs.⁷²⁸

In England, HCAs can also become members of the Royal College of Nurses.⁷²⁹ The Royal College of Nurses provides guidance, expectations, and recommendations for HCA members. For example, the Royal College of Nurses provides a guide on relevant principles for both nurses and HCAs in giving and receiving delegated tasks.⁷³⁰ However, HCAs can only become members if they provide health or social care under the guidance and supervision of a registered professional, such as a nurse.⁷³¹

6.6.3 Education and Credentialing

England, Northern Ireland, and Wales share a qualification framework designed to promote consistency and skill transferability.⁷³² However, for most roles under the HCA umbrella, there are no specific credentialing or education requirements. For example, the National Health Services website indicates that for the roles of “healthcare assistant” and “healthcare support worker,” there are no set entry requirements.⁷³³ Instead, the system relies on staffing requirements and induction training set by employers.

In England, the Care Certificate is the widely adopted national standard for HCA training.⁷³⁴

Wales and Northern Ireland have a similar national induction program; in Scotland there is no national induction program.⁷³⁵ The Care Certificate was implemented by Skills for Care, Skills for Health, and Health Education England in 2015 following the *Cavendish Review*, which recommended consistent training and education for HCAs.⁷³⁶ The Certificate is available as an online course through eLearning for Healthcare and contains fifteen distinct standards, ranging from the duty of care to safeguarding children.⁷³⁷

All health and social care providers registered with the Care Quality Commission must offer this training to their non-regulated staff and must demonstrate that their staff are competent in the standards.⁷³⁸ Employers are not legally required to ensure their staff have completed the Care Certificate, but the Care Quality Commission can take regulatory action if their staff do not follow the Care Certificate standards.⁷³⁹ The current framework has been criticized for creating inconsistencies because employers are responsible for the delivery of the Care Certificate.⁷⁴⁰

Assistant practitioners

While there are no education requirements to become a health care assistant or health care support worker in England, outside of the non-mandatory Care Certificate, some unregistered roles under the HCA umbrella have more stringent educational requirements. For example, “assistant practitioners” are required to have a level 3 healthcare qualification, delivered by a vocational training provider and involving both a theoretical component and supervised practice.⁷⁴¹ Assistant practitioners have been cited as a success in supporting nursing staff and providing development opportunities for healthcare assistants.⁷⁴²

6.7 Australia

6.7.1 Introduction

As with other jurisdictions, in Australia, HCAs go by a number of names and roles, including “health care assistant”, “personal care worker”, and “assistant in nursing”. Regulated health practitioners are governed through a National Registration and Accreditation Scheme (national scheme) which came into effect in 2010.⁷⁴³ HCAs are not regulated under the national scheme.

The national scheme sets out education, practice, and ethics standards for registered health practitioners, and registered health practitioners must renew their registration with the national scheme each year. The scheme applies to health practitioners using protected titles.⁷⁴⁴ The regulation is run at the state level. Each state had to enact their own version of the legislation.⁷⁴⁵

There is work in progress in various Australian jurisdictions which aims to enhance oversight and regulation of HCAs. The federal government is leading this work, including:

- *A National Code of Conduct for Health Care Workers* for unregulated health care workers, which has not yet been implemented by all jurisdictions
- Regulation of government-provided Aged Care, which must meet national quality standards monitored by Aged Care Quality and Safety Commission

A national non-profit organization, the Australian College of Care Workers, provides some oversight for HCAs by setting educational requirements and practice standards for members.

In 2021 the *Royal Commission into Aged Care Quality and Safety* recommended Australia develop a national personal care worker registry which would set standards for training and professional development, and enforce a code of conduct. This approach has not been implemented due to concerns about cost and the burden on workers.

6.7.2 Practice standards for HCAs

In 2015, the Council of Australian Government's Health Council established the *National Code of Conduct for Health Care Workers* across Australia for unregulated health care workers.⁷⁴⁶ The National Code also applies to de-registered health practitioners and registered health practitioners who provide services unrelated to their registration.⁷⁴⁷ The goal of this process was to create a low cost, low administration mechanism for protecting the public against unethical or incompetent practice.⁷⁴⁸

The provisions of this code range from respecting privacy to not engaging in sexual misconduct.⁷⁴⁹ The Code must be displayed at a workplace so that individuals have the opportunity to make a complaint about an unregulated health care worker.⁷⁵⁰ This approach creates a negative licensing scheme, whereby incompetent or unethical HCAs can be removed from practice.⁷⁵¹ Academics have criticized the approach for placing a high threshold on what constitutes a serious risk to public health and safety, "meaning that breaches of the Code of Conduct that are less serious are unlikely to be prosecuted."⁷⁵²

The National Code of Conduct includes mechanisms for mutual recognition of state and territory prohibition orders and a national register of prohibition orders.⁷⁵³ However, it is up to states and territories to determine how the Code is implemented, including determining a suitable body to receive and investigate breaches of the Code and issue prohibition orders.⁷⁵⁴ Currently, not all jurisdictions have enacted the Code via statute and roll out and enforcement has been inconsistent.⁷⁵⁵ The current status of implementation of the Code

across Australia is:

- New South Wales, Queensland, and South Australia have enacted the Code. Mutual recognition of prohibition orders is possible between these jurisdictions.⁷⁵⁶
- Victoria is developing legislation to enact the Code.⁷⁵⁷
- Public forums were held in Northern Territory on the implementation of the National Code.⁷⁵⁸
- National Code legislation was scheduled to be introduced in Australian Capital Territory's Legislative Assembly in 2019; however, this not yet been implemented.⁷⁵⁹
- In Western Australia, a bill enacting the National Code was passed in May 2022 but has not yet been implemented.⁷⁶⁰
- There are currently no plans to implement the National Code of Conduct in Tasmania.⁷⁶¹

6.7.3 Regulation of Government Employers Providing Aged Care

Australia also has a specific framework for regulating government-provided Aged Care with implications for HCAs. Aged care is governed by the *Aged Care Act 1997*, which outlines the approval process for residential care, home care, and flexible care, and the *Aged Care Quality and Safety Commission Act 2018*, which covers the accreditation, quality review, and complaint process for government subsidised programs.⁷⁶² Both these Acts also interact with the Australian Health Practitioner Regulation Agency, and the health and safety regulators in each state and territory, as described above.

The *Aged Care Act* requires Aged Care providers to “maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met.”⁷⁶³ However, the Act does not articulate in detail what specific skills are required to meet such needs.⁷⁶⁴ Under the *Aged Care Act*, providers are also expected to comply with the Quality Standards within the *Aged Care Quality and Safety Commission Act*.⁷⁶⁵ The Aged Care Quality Standards were introduced in 2019 after criticisms that the previous Accreditation Standards focused on compliance with minimum levels rather than on quality of care. The standards cover issues ranging from consumer dignity to organisational governance.⁷⁶⁶ The Aged Care Quality and Safety Commission assesses and monitors quality of care and services against the Quality Standards and publishes their results.⁷⁶⁷ To this end, the Aged Care Quality and Safety Commission can receive and respond to complaints about the quality of care delivered by HCAs; however, its disciplinary powers target the providers

rather than individual HCAs.⁷⁶⁸

6.7.4 Recommendations by Royal Commission into Aged Care Quality and Safety

In 2018, the Australian government established a Royal Commission to investigate aged care.⁷⁶⁹ The *Royal Commission into Aged Care Quality and Safety* carried out extensive consultation. In 2021 it published a final report which included several recommendations pertaining to education and credentialing of personal care workers, as well as oversight of their practice.⁷⁷⁰

The Commission recommended a national personal care worker registry, requiring registrants meet the following criteria:

- a. a mandatory minimum qualification of a Certificate III
- b. ongoing training requirements
- c. minimum levels of English language proficiency
- d. criminal history screening requirements
- e. a code of conduct and power for a registering body to investigate complaints into breaches of the Code of Conduct and take appropriate disciplinary action.”⁷⁷¹

Mandatory education

The Commission recommended that this new National Board for Personal Care Workers develop, review, and assess educational requirements for personal support workers.⁷⁷² As noted above, they recommended that completion of a Certificate III be mandatory for personal support workers. This qualification level is set out by the *Australian Qualifications Framework* and represents a level of training below a diploma.⁷⁷³

Parliament has stated that it would not “mandate the Certificate III as the minimum mandatory qualification for a personal care worker.”⁷⁷⁴ Rather, the budget for 2022-2023 included further subsidized training places for individuals to allow them to achieve their Certificate III voluntarily. Parliament also stated that it will not establish a registration scheme under the National Registration and Accreditation Scheme due to concerns that the “requirements would be disproportionately burdensome for personal care workers and present a significant ongoing cost.”⁷⁷⁵ However, the government has agreed to:

- Establish a single care and support sector code of conduct across aged care, veterans’ care and disability support sectors for implementation by July 1, 2022. The Aged Care Quality and Safety Commission will be responsible for the enforcement of the Code for aged and veterans’ care workers.
- Deliver a nationally consistent centralised pre-employment screening check,

with a register of cleared and excluded workers in the aged and veterans' care sectors, by July 1, 2022.⁷⁷⁶

Some states have moved forward with policies to oversee assistants in nursing. For example, Western Australia's Department of Health has a mandatory policy directive under its *Health Services Act 2016*.⁷⁷⁷ The policy sets out educational standards for the employment of students and non-students working in this role,⁷⁷⁸ for example, mandatory completion of the above-mentioned Certificate III in Health Services Assistance-Acute Care.⁷⁷⁹ The policy also sets out parameters for practice of assistants in nursing. These parameters limit the scope of practice and require oversight of the worker by a nurse or midwife.⁷⁸⁰

6.7.5 Oversight by the Australian College of Care Workers

The Australian College of Care Workers provides some oversight for HCAs. This not-for-profit organization describes itself as a "national registration and professional association that has been established for individuals working in aged care, mental health, disability, community services and other care related areas to benefit its members and the public."⁷⁸¹ Membership is voluntary.

This registry has specific requirements for membership and offers different kinds of membership ranging from student to corporate. The organization sets out certain expectations for its members, for example:

- Certain educational requirements specific to specific areas of practice;⁷⁸²
- Continuous professional development (minimum of 20 hours per year);
- Adherence to the Code of Conduct and Ethics for Care Workers.
- Adherence to the National Code of Health Care Workers, Code of Conduct for Unregistered Health Practitioners, and voluntary industry code of practice.
- Meeting requirements pertaining to "Professional Indemnity Insurance; Recency of Practice; Criminal History; English Language Skills; Complaints Handling and Compliance; Notification; Privacy and Information Technology policy."⁷⁸³



7.1 Overview

This final chapter brings together our research to identify:

1. Key limitations of the current BC approach to oversight of HCA practice;
2. Possible approaches to enhancing oversight applying different regulatory models; and
3. Related research questions to explore that were beyond the scope of our study paper.

We conclude with some final thoughts on how to approach reform in BC.

7.2 Key Limitations of the Current BC Approach to HCA Practice Oversight

This section outlines 11 key limitations of the current BC approach:

1. Exclusion of private facilities and employers from the BC Registry's mandate
2. Process loopholes that allow HCAs to avoid removal from the BC Registry

3. Lack of public access to the BC Registry
4. Lack of defined scope of practice for HCAs
5. Lack of standards of practice and codes of ethics
6. No means of addressing overall competency and fitness to practice
7. Lack of professional development requirements
8. Safety issues
9. Education approach that does not address the diversity of HCA roles
10. Lack of transparency in the BC Registry approach
11. Privacy barriers to effective investigation of abuse and neglect

7.2.1 Private Facilities

The most significant gap in the BC Registry is that it does not apply to fully private employers. A private employer of HCAs that does not receive any public funding can hire an HCA who is not registered. These employers do not have to report abuse by the HCA to the BC Registry. An HCA who works exclusively for private employers also does not have to be registered with the BC Registry—although many have registered voluntarily. Private employers would include an assisted living or long-term care facility whose beds are entirely private, or a home and community care agency where clients pay directly for their own care.⁷⁸⁴ This gap in the BC Registry has been highlighted by our key informants, the Ombudsperson report, the 2012 Registry Review, and other research and policy work as very problematic.⁷⁸⁵ This is not a simple gap to resolve as it raises questions about the breadth of private employers to include.

7.2.2 Avoiding Removal from the BC Registry

A design flaw in the BC Registry framework allows an HCA to avoid removal by quitting before they are suspended or fired.⁷⁸⁶ In the 2012 review of the BC Registry, and in our key informant interviews, it was noted that employers sometimes bargain with an HCA who is suspected of abuse or neglect that if the HCA voluntarily quits then the employer will not report the suspected abuse or neglect to the BC Registry. Unions may also facilitate allowing the HCA to quit so they can retain their BC Registry status.⁷⁸⁷

In other health professions, this gap is closed. The *HPA* requires registrants of any college to report other college registrants if they believe “the continued practice of a designated health profession by the other person might constitute a danger to the public.”⁷⁸⁸ This requirement applies regardless of whether a registrant quits their job or relinquishes their registration.⁷⁸⁹ The *HPA* provision could serve as a model for closing the gap in the BC Registry.

7.2.3 Public Access to the BC Registry

Currently, only registered employers can access BC Registry data to clarify whether an HCA is registered. Any employer of HCAs can apply to view the BC Registry, including government, health authority, or private employers who provide home support, community care, hospital care, or long-term care. However, if a private individual hires an HCA to provide care, that individual cannot check the BC Registry to see if the HCA is registered.⁷⁹⁰ Key informants noted this aspect of the BC Registry's work has run into further challenges: registration of employers is not always timely and so a private may be able to access BC Registry data based on a past contract with a public provider.⁷⁹¹

The fact that the BC Registry is not publicly accessible is a critical gap because private individuals cannot confirm that the HCA they are hiring has the correct skills and education to perform personal care. This gap poses safety issues because private individuals often do not know what education or skills an HCA should have, or how to evaluate whether the HCA is providing safe and competent care.⁷⁹²

This gap does not exist for regulated health professionals. The *HPA* requires regulatory colleges to publish their list of registrants on the college website. Members of the public can search the list of registrants to confirm whether a health care provider is in good standing with the college, and review the care provider's disciplinary history.⁷⁹³

7.2.4 Role Definition and Scope of Practice

HCAs do not have a defined scope of practice. The only guidance on an HCA's role and their scope of practice is the HCA education program they completed, and the BC HCA Core Competency Profile that is used to determine the skills HCAs should possess in order to be registered with the BC Registry. Each employer of HCAs can develop their own HCA job description, and these descriptions vary significantly across employers. This inconsistency matters in part because it is the employer's job description that determines whether a nursing task is being assigned or delegated. HCAs working in the different sectors (long-term care, home and community care, acute care) may have very different jobs, depending on the employer.⁷⁹⁴

The fact that HCAs do not have a defined role or scope of practice can leave both HCAs and the people receiving care vulnerable to harm.⁷⁹⁵ Studies on HCA roles and experiences have found that HCAs are often asked by clients and their families to do tasks that are outside of their training, their job description, or the client's care plan. HCAs come under a great deal of pressure because they want to help their clients. However, if HCAs do tasks for which they are not trained, this can place the client or the HCA at risk of injury or harm. This dynamic can also enhance job and time stress by increasing an HCA's already significant

workload.

7.2.5 Standards of Practice & Codes of Ethics

The BC Registry does not develop any standards of practice or code of ethics for HCAs. The only existing standards are the requirements of the BC HCA Provincial Curriculum, the HCA Core Competency Profile, and the risk that HCAs will be removed from the BC Registry if they abuse or neglect a client or patient.⁷⁹⁶

One of the reasons why the lack of standards or code of ethics poses a problem is these can be a mechanism for requiring anti-discrimination training, ethical standards when interacting with clients and co-workers, and protocols for addressing discriminatory behaviour. As noted above in section 2.2.3, HCAs are predominantly women of colour, many of whom immigrated to Canada or speak English as a second language. HCAs who are Black people, Indigenous people, or people of colour face discrimination in the workforce.⁷⁹⁷ While ethics and practice standards would not eliminate discrimination or poor practice, they could provide a starting point for effort to reduce discrimination.

7.2.6 Fitness and Competence to Practice

Flowing from the lack of practice standards and codes of ethics, there is no way to address fitness and competence issues among HCAs, outside of abuse and neglect issues. As discussed earlier, the only behaviours the BC Registry can address are abuse or neglect of a patient, resident, or client. The BC Registry's mandate does not allow it to address general competency to practice, fitness to practice, or unprofessional conduct. Key informants told us that the BC Registry does receive reports of matters outside of abuse and neglect but there is no authority to address them.⁷⁹⁸

In BC, there are mechanisms for addressing fitness and competency issues among other health professionals. Under the *HPA*, colleges can receive complaints about a registrant, and will conduct investigations and discipline processes. A college can deal with any fitness, competence, or unprofessionalism issues, including but not limited to abuse or neglect. The public can report these issues, and other registrants are required to report any competence or fitness issues to the appropriate college.⁷⁹⁹ Several key informants and the 2012 Registry Review have suggested expanding the BC Registry to include competence and fitness concerns.⁸⁰⁰

7.2.7 Ongoing Education

One of the BC Registry's stated goals is to promote continuing education among HCAs. The BC Registry lists available ongoing education on the website. However, the BC Registry does

not require any ongoing education.⁸⁰¹ Key informants stressed areas where HCAs require better ongoing training, such as dementia education.

Continuing education can be a challenge for HCAs. Studies have found that HCAs do not have time when they are working on the floor with patients to do any ongoing education. HCAs are also not given any time off the floor or paid time to complete continuing education. Nurses do not have a lot of time to train HCAs on delegated tasks or oversee the performance of delegated or assigned tasks.⁸⁰² HCAs often work multiple jobs and so it would be problematic to require them to complete professional development in their free time.⁸⁰³ Further, as HCAs earn a significantly lower wage compared with other health care workers, it may not be practical or reasonable to impose unpaid continuing education requirements. Staffing backfill for periods when HCA are off for continuing education can be a barrier due to labour shortage issues. SafeCare BC previously had funding through WorkSafe BC to cover the costs of staffing backfill but they found there was not substantial interest in the program.

Other health professionals are required to engage in continuing education. The *HPA* allows a college to make bylaws requiring registrants to complete continuing education or competence.⁸⁰⁴ For example, RNs are required to complete a professional development plan each year, and evaluate how they succeeded in achieving their goals. The BC College of Nurses and Midwives does not designate a specific number of professional development per year.⁸⁰⁵ Family doctors are required to complete 250 credits of CPD in a five-year cycle, and specialist doctors are required to complete 400 credits in a five-year cycle.⁸⁰⁶

Continuing education helps health care workers keep up with new knowledge in medicine and best practices. Continuing education can help keep patients and clients safe in a context of increasing acuity where HCAs are providing more medical care and delegated nursing skills. Continuing education approaches for regulated professionals could offer a model to consider; however, policy development should bear in mind potential unintended consequences. Given HCA labour shortages and the significant variety in the complexity of tasks performed by HCAs, it is critical that continuing education requirements do not push out of the sector HCAs who are competent for the lower skilled tasks. Policy must recognize the variability of HCA work.

7.2.8 Safety Concerns

HCAs work in environments where there are safety risks. As discussed in Chapter 2, HCAs often work alone with little help or supervision, particularly in home and community care. HCAs must manage physical and psychological risks in their work environment, often with little support or guidance on how to manage risk.⁸⁰⁷ The scope of the BC Registry does not allow it to address safety risks unrelated to a report of abuse or neglect by an HCA. There

are no safety or practice standards that address how an HCA should practice in order to minimize injury, illness, or other harm.⁸⁰⁸ SafeCare BC provides occupational health and safety training for the long-term care and home and community care sectors, and has a strong focus on injury prevention.⁸⁰⁹ Its work addresses this gap to some extent. However, there appear to be gaps in current HCA training connected to safety: as one key informant noted “everyone benefits from good training”, and HCAs need to be better prepared for the actual work.

Another safety issue is that the BC Registry cannot perform vulnerable adult criminal record checks on HCAs applying to register. The *Criminal Record Review Act* allows employers or educators whose employees or students are working with vulnerable adults or children to conduct a criminal record check for working with vulnerable adults. Colleges constituted under the *HPA or Social Workers Act* can also check for criminal records. However, no other college or oversight body can check for criminal record checks.⁸¹⁰ The system relies on employers to conduct criminal record checks on a regular basis. Additionally, a private person hiring an HCA would not be able to verify if an HCA has no criminal record, nor have any way to confirm with the BC Registry that the HCA has no relevant criminal record.

7.2.9 Education

The BC HCA Provincial Curriculum is a general program which outlines HCA skills in general terms, without including specific training appropriate for different practice sectors, such as long-term care or acute care. The only special training HCAs receive relate to the requirements to have practice experience in both complex care and in home and community, assisted living, or group homes. There are no specialization education available for HCAs to expand their training in a formal way.⁸¹¹

Some key informants expressed an interest in a change to HCA education whereby HCAs could receive training specific to different roles they may have, and achieve a rank of HCA certification corresponding to their level of knowledge and skill. The skill rating could indicate whether an HCA has experience and knowledge related to certain delegated skills or what level of medical and care skills they have.⁸¹² The United Kingdom has a skills rating system that could serve as a model for considering skill rating for HCAs.⁸¹³ In BC, RNs can be certified by the BC College of Nurses and Midwives to perform certain restricted skills that would normally require a doctor’s order, such as in reproductive health and remote practice. These RNs are called Certified Practice nurses.⁸¹⁴

Additionally, there are no formal bridging programs for HCAs to become LPNs or RNs. Many HCAs who immigrate to Canada hold higher level nursing or medical designations in their country of origin, but are unable to become licensed in that profession in Canada.⁸¹⁵ A bridging program could help cover this gap and allow HCAs to transition back to their

former profession once they had met certain criteria. This approach might also help address staff retention issues among the occupation.

7.2.10 Transparency

The BC Registry lacks transparency to the public in several areas. It does not publish information that clarifies:

- Who is on the advisory committee;
- What process or procedure the investigators use when conducting investigations into abuse or neglect;
- Whether an HCA is credentialed;
- What discipline findings are made following a finding that an HCA committed abuses or neglect; and
- When an HCA has been suspended or removed from the BC Registry.⁸¹⁶

The BC Registry is not subject to the same transparency requirements as colleges under the *HPA*.⁸¹⁷ For regulated health professions, transparency is key to achieving the trust of the public in their ability to act in the public interest.⁸¹⁸ Some of these transparency issues may be difficult to address without legislation.

7.2.11 Privacy Laws

The BC Registry investigation faces privacy hurdles. Investigators must follow the privacy laws, and there are no exceptions built in for investigators to receive or compel information relevant to an abuse investigation. In particular, investigators are unable to obtain the name of, or information about, the patient who experienced abuse. Facility operators are also hesitant to provide information to investigators out of fear of breaching confidentiality and privacy laws.⁸¹⁹

For regulated health professions under the *HPA*, colleges are given investigation powers that allow them to obtain information that is subject to confidentiality and privacy, to enter premises, to speak to people involved, and to obtain records.⁸²⁰ BC Registry investigators have no such powers. Legislation would be required to overcome privacy law hurdles related to BC Registry investigations.

7.3 Enhancing HCA Oversight in BC—Possible Alternative Approaches

This section outlines options for reforming BC's approach to oversight of the work of HCAs. These options include:

1. Retaining and expanding the BC Registry model;
2. Developing a legislative basis for the BC Registry;
3. Developing a licencing scheme;
4. Creating a title registration scheme;
5. Designating HCAs certified non-registrants under the *HPA*;
6. Bringing HCAs under the *HPA* or the proposed *Health Professions and Occupations Act* as a profession or an occupation;
7. Regulating the service providers.

7.3.1 BC Registry Reform: Filling Gaps in the Current Model

BC can retain the BC Registry model under contract law and policy mechanisms, and fill in some of the gaps that have been identified. Gaps that could be filled without fundamentally altering BC's approach to HCA oversight through the BC Registry include:

- Making the BC Registry apply to all employers who hire HCAs;
- Adding provisions to prevent an HCA from quitting to retain their BC Registry status;
- Allowing the public to access the BC Registry when they are hiring an HCA;
- Adding a scope of practice for HCAs;
- Adding a standard of practice or code of ethics for HCAs;
- Allowing the BC Registry to address competence and fitness to practice issues; and
- Adding requirements for ongoing education for renewal of BC Registry status.

Key informants indicated that the government had previously intended to move control of the BC Registry from the Health Employers Association of BC to the BC College of Nurses and Midwives.⁸²¹ As of the publication of this report, it is not clear if the government still intends to change who is responsible for administering the BC Registry.

Benefits of a reform approach that retains the basic structure of the BC Registry model include:

- Does not require any legislation;
- Does not require structural changes to how HCAs are regulated; and
- Does not increase costs to patients, HCAs, or government.⁸²²

The drawbacks of keeping the current BC Registry model are:

- Does not substantially enhance patient protection;
- Does not add protections for HCAs;

- Does not address the current lack of transparency; and
- Does not integrate HCAs with other health professionals under the same regulatory umbrella.

One key informant said to us that in its current form, the BC “Registry is a resource, not a source of protection for the public.” A critical question to consider is whether the BC Registry system can be adequately modified in order to meet its public protection mandate.

7.3.2 Law Reform to Develop a Legislative Basis for the BC Registry

Legislation could be created to underpin the BC Registry. This approach would be similar to how early childhood educators are regulated in BC.⁸²³ See section 5.5.3 for a description of how ECEs are regulated in BC.

In addition to addressing gaps in the BC Registry noted above, backing the BC Registry up with legislation would allow some other gaps to be filled:

- Provisions could be created to give investigators the power to investigate, receive or compel information, and gain access to people and records;
- Transparency provisions could be added to support greater public trust and confidence;
- The BC Registry could become accessible to the public; and
- The BC Registry could be given the power to conduct criminal record checks.

The key downsides of keeping the BC Registry, but backing it with legislation, include the risk that increased regulation will add costs for the client or patient.⁸²⁴ Additionally, keeping HCAs under a BC Registry model means that they remain regulated in a manner that is substantially different from how BC is approaching other health care team members. HCAs would continue to be left out of any attempts to create common and consistent practice and ethical standards between health professions. Concerns about HCAs being treated as lesser health care team members would likely persist.⁸²⁵ This dynamic is increasingly problematic because HCAs are working more independently and performing nursing tasks.

7.3.3 Developing a Licensing Scheme

HCAs could be regulated through a comprehensive licensing scheme, similar to how paramedics are regulated. See section 5.5.1 for a description of how paramedics are licensed in BC.

A mandatory licensing scheme could support greater consistency in oversight across all employers. The approach opens up other options such as the ability to:

- License HCAs for different skill levels;
- Require criminal record checks;
- Create additional entry requirements, such as examinations;
- Create competence and fitness requirements;
- Require ongoing professional development;
- Develop a discipline process that covers all areas of competence and fitness.⁸²⁶

Legislation can also enhance transparency as information on oversight becomes more publicly available.

The downsides of creating a licensing scheme include:

- Potential increased costs associated with maintaining a licensing scheme; and
- Potential decrease in service providers due to the increased entry requirements for the profession, especially in rural or remote areas.⁸²⁷

7.3.4 Creating Title Registration

HCAs could be regulated through a title regulation scheme. In title registration, the government would create a title which is a reserved title. Title registration means only people who meet certain requirements are allowed to use the title. Other people could practice in the same area, but would not be able to use the title. Under title regulation, the government creates education and entry requirements associated with the restricted title.⁸²⁸ Title registration is part of the new BC legislation for ECEs and ECE assistants and Nova Scotia's new *Continuing Care Assistant Registry Act*.

Benefits of title regulation include:

- The title offers the public a signal that an HCA had received an approved education program;
- There would be a standardized job scope for HCAs using the reserved title; and
- Other HCAs could continue to practice without using the reserved title—this would limit unintended consequences such as reducing the likelihood that increased oversight would:
 - result in the costs of oversight being passed on to patients or clients;⁸²⁹ and
 - exclude lower skilled HCAs from practicing in more limited settings.

Drawbacks of using title regulation are that it will not address many of the problems

identified earlier in this chapter.⁸³⁰ Further, the concept of reserved title may be more challenging to explain to a lay population. Depending on how broadly the title is used, the system may not increase the ability of private employers to confirm whether a staff person or contractor has adequate training and skills. There may remain challenges in enforcing competence and ethical requirements broadly across the sector. Under the proposed *Health Professions and Occupations Act*, the category of certified non-registrants would be removed/

7.3.5 Making HCAs Certified Non-Registrants

HCAs could become a certified non-registrant under the *HPA* framework within the BC College of Nurses and Midwives. Section 5.4.2 discusses certified non-registrants. Under the proposed *Health Professions and Occupations Act*, the category of certified non-registrants would be removed.

The benefits of HCAs becoming certified non-registrants lie with coming under the rich regulatory framework that currently governs nurses and midwives. This approach provides the ability to create:

- practice standards for HCAs;
- a code of ethics for HCAs; and
- a scope of practice for HCAs.

As certified non-registrants, HCAs also could be brought under the discipline process in place for fitness and competence issues.

Further, nurses are aptly positioned to create HCA standards, as nurses typically supervise HCAs and understand what HCAs do and what makes good practice. Further, sharing standards of practice and ethics with nurses and other health professionals could facilitate communication, collaboration, and consistency.⁸³¹

The key drawback of a plan hinged on HCAs becoming certified non-registrants is that this category may or may not exist once the *HPA* is overhauled. Further, as discussed in section 5.6.1, the current certified non-registrant profession, certified dental assistants, faces challenges. CDAs lack a voice within the college and are treated as a lesser profession within the college by virtue of not being full registrants. HCAs already face similar challenges among health care teams. The certified non-registrant approach risks further entrenching their low status and inequality.

7.3.6 Bringing HCAs under the *HPA* or the proposed *Health Professions and Occupations Act* as a profession or an occupation

HCAs could become a designated health occupation under the proposed *Health Professions and Occupations Act*.

Bill 36 was introduced months after we wrote this study paper and just before our publication date. As a result this paper does not summarize the *Health Professions and Occupations Act*. However, there are benefits to bringing HCAs within a robust regulatory framework—whether it be the *HPA* or the *Health Professions and Occupations Act*. The approach would:

- address many of the gaps in the BC Registry;
- enhance transparency to the public; and
- provide legal rules of procedural fairness that would apply to actions of the HCA college, including addressing many of the issues identified in relation to investigations and privacy.

Joining the regulated health professions under the framework could:

- increase the ‘buy-in’ of the occupation to comply with standards and rules;
- better support a team-based approach, including improved communication; and
- enhance the status of HCAs as an occupation.⁸³²

The drawbacks of coming under a health professional regulatory framework include:

- The increased cost of regulation may mean an increase in cost to the client or patient; and
- The number of HCAs may decrease due to the increased cost and requirements to become an HCA, especially in rural or remote areas;

Some key informants raised concerns over whether self-regulation would be feasible in the absence of HCAs being organized for self-advocacy outside of the current role provided by trade unions.

Scholars advocate for an approach to professional regulation that balances risks to the public with the costs of regulation. When considering whether self-regulation is appropriate for HCAs, the government should consider whether the value associated with further oversight of HCA performance is worth the money and other costs associated with self-

regulation.⁸³³ See the insert for more detail on the proposed legislation.

7.3.7 Regulating the Service Provider

One option for increasing public protection and HCA work oversight is to regulate the service providers who employ HCAs. This topic is outside the scope of this study paper; however, it does merit consideration. Future research and policy analysis could examine how employers could be meaningfully regulated and identify the potential benefits and unintended consequences of this approach. Australia has regulated service providers, as described in section 6.7.3

Regulation of service providers would not provide a direct mechanism for addressing competence and fitness issues in individual HCAs. However, the approach might be helpful in creating standards with respect to the services HCAs may provide, and imposing safety measures that would protect both HCAs and their patients. Given some of the demographics and work challenges discussed in chapter 2 of this paper, a focus on employers might be more in tune with the power dynamics and the practical issues impacting HCA work.

7.4 Further Questions to Explore

This study paper was funded by a small research grant from the Law Foundation of BC. In the course of our research many topics have emerged that are beyond the scope of this project but still relevant to the needs of HCAs and the recipients of their care. In this section we summarize some of these questions.

Other approaches to regulation

This study paper considers options for overseeing or regulating HCAs. We did not examine regulatory options for addressing worker and patient vulnerability that are outside of regulating a profession. Other questions worth exploring include:

- What are the options for regulating employers of HCAs?
- What are the options for creating standards for home and community care?
- What are the options for regulating individual skills, instead of regulating a profession?
- What are the options for creating levels of education, training, or licensing for HCAs?

Investigation processes

Some information was difficult to gather under the scope and time restrictions because it was not readily available to the public. Further research could explore:

- Do BC Registry investigator criteria lead to a fair and strong investigation, and what changes may be needed?
- Should severity of abuse be used in investigations, given the remedies available through the BC Registry process? Further research could consider whether a more nuanced approach to investigations and remedies is needed, considering the current lack of transparency and legislative controls.

Practice issues

This project did not explore the adequacy of BC's current approach to training and competency for HCAs. Further work could consider:

- What kind of ethical standards, practice standards, and codes of conduct should there be for HCAs?
- Is the education curriculum sufficient as is, or are there changes needed? Based on research and key informant interviews, training seems to focus more on long-term care. This approach does not align with the reality that many HCAs work in home and community care and fails to properly prepare HCAs working in home support.
- Are there changes needed to the core competency profile? Does the core competency profile reflect what actually is done by HCAs and what skills they need? Does the core competency profile need to be tailored to the different environments in which an HCA works? For example, home and community care versus long-term care work involve very different tasks and levels of supervision.

Privacy issues

A number of privacy issues could be further explored, such as:

- Should the public have access to the BC Registry? What would this look like? What protections need to be in place to protect the workers from invasion of privacy and other potential problems?

- How can BC increase transparency and better address privacy issues? What legislation is needed to overcome these problems?

Structural issues

This study paper examined the possible models for HCA oversight. Given the scope constraints of the study paper, we could not examine how law or policy could be used to enhance safety, improve the work environment, and address workforce issues. Further research projects could structural issues impacting HCA work, such as:

- How can law and policy be used to reduce the precarious nature of their employment? Can any of the COVID-19 policies be used as a model for wage levelling and reducing the need for HCAs to work multiple jobs? Or were the COVID-19 policies too flawed?
- How can potential regulation address the fact that health care is increasingly being provided by a multi-disciplinary team of health care professionals? How can regulation address exclusion of HCA from case-planning and health care decision-making?
- How can regulation or policy be used to increase workplace safety, prevent injury, prevent violence, and improve working conditions?
- Can regulation be used to create bridging programs for HCAs to become LPNs or RNs? Can regulation better address the circumstances of HCAs who immigrated to Canada with higher nursing or medical degrees and are facing barriers in becoming a registrant in their field?

7.5 Conclusion

In 2010 BC was the first jurisdiction in Canada to develop an organization to oversee the work of HCAs. However, while other provinces (including Ontario, Alberta, and Nova Scotia) are implementing new legislation to enhance oversight of the work of HCAs, the BC framework has not changed after twelve years. The legal foundation for the work of the BC Registry remains based in contracts not available to the public, and there is no legislation governing the BC Registry's work.

One key informant described the BC Registry as a “work in progress”. A 2012 review of the BC Registry approach commissioned by the Government of BC outlined actions for improvement; however, ten years later no progress has been made in addressing these recommendations. This stall exists despite evidence that HCAs operate with little support in complex work environments where there are safety risks, and that HCA practice can include

both vulnerable workers and vulnerable recipients of care. The work of HCAs has become increasingly complex over the years. Pandemic labour shortages have put extra pressures on HCAs and shined a spotlight on their critical work.

Limitations of the current BC approach

This study paper outlines the limitations of the existing BC Registry framework to oversee HCA practice. Although the BC Registry has collaborated with the Ministry of Health and others to make important sector enhancements in areas such as curriculum development, educational program certification, and voluntary continuing education, the current BC Registry model has significant limitations and gaps. They include:

- The BC Registry does not apply to fully private employers. HCAs working exclusively with private employers do not have to be credentialed with the BC Registry. These employers do not have to report abuse by HCAs to the BC Registry.
- HCAs can avoid removal from the BC Registry by quitting before they are suspended or fired.
- The BC Registry is not accessible to the public. Currently, only registered employers can access the BC Registry to verify an HCA's credentials.
- HCAs do not have a defined scope of practice, and HCA employers are free to develop their own job descriptions.
- The BC Registry does not have any standards of practice or code of ethics for HCAs.
- The BC Registry's mandate prevents it from addressing general competency to practice, fitness to practice, or unprofessional conduct.
- The BC Registry does not require any ongoing education or professional development.
- The BC Registry's scope does not allow it to address safety risks unrelated to a report of abuse or neglect by an HCA. There are no safety or practice standards that could address how an HCA should practice in order to minimize injury, illness, or other harm. Additionally, the BC Registry cannot perform vulnerable adult criminal record checks on HCAs applying to be credentialed.
- The BC HCA Provincial Curriculum does not include specific training for different practice sectors. There are also no formal bridging programs for HCAs to become LPNs or RNs.
- The BC Registry is not subject to the same transparency requirements

as colleges under the *HPA*, and does not publish information clarifying investigation procedures, disciplinary findings, and the composition of the advisory committee.

- BC Registry investigators do not have the same investigation powers as professions designated under the *HPA*, and cannot obtain the name of, or information about, a patient who experienced abuse.

These limitations have been criticized by key informants and scholars for creating inconsistencies ranging from how HCAs are trained, credentialed, hired, investigated, disciplined, and supported, to discrepancies in the actual practice of their work. These inconsistencies generate potential for harm for both HCAs and the people they care for.

Options for reform

We have outlined seven possible pathways for law reform to address these limitations. The Government of BC could:

1. Retain the BC Registry model under contract law and policy mechanisms while working to fill the identified gaps.
2. Develop a legislative basis for the BC Registry.
3. Develop a comprehensive licensing scheme to regulate HCAs.
4. Develop a title regulation scheme.
5. Designate HCAs as certified non-registrants within the BC College of Nurses and Midwives, under the *HPA* framework.
6. Bring HCAs under the *HPA* or the proposed *Health Professions and Occupations Act* as a profession or an occupation.
7. Regulate service providers employing HCAs.

All of these options contain key benefits and drawbacks that encompass the following considerations, among others:

- Structural overhaul;
- Procedural and legal considerations;
- Cost efficiency;
- Protection for HCAs;
- Patient protection;
- Impacts on service providers;
- Public transparency;

- Ability to join HCA occupation and the overall status of the profession;
- Risks of over and under regulation; and
- The status of HCAs within the overall *HPA* framework regulating health care professionals.

There is no one size fits all approach to professional regulation, and legal experts have cautioned against the dangers of over-regulation. However, as the work of HCAs becomes increasingly complex, their separation from the health professional regulatory framework is becoming increasingly untenable. The Cayton Report confirms that BC's approach to health professional regulation is flawed and in need of much repair. Both the *HPA* framework and the BC Registry approach have been criticized for failing to adequately protect the public, which is the foundational goal of regulation in the health care sector. As BC embarks on reform of its health professional regulatory framework, we caution against leaving HCAs behind.

Whether or not HCAs belong under the new *Health Professions and Occupations Act*, their work is equally deserving of reflection and oversight. For older people and others living with complex health needs, HCAs will be the health care provider from whom they will receive the most day-to-day care. Reform of our approach to HCA oversight could significantly impact the lives of people living in BC. That said, enhancing oversight raises questions regarding the workers that ought to be captured within any framework. The current BC Registry approach excludes many categories of HCAs, but who should be included if the net is broadened? There are many HCAs working in home support performing tasks that require minimal if no training. Many key informants expressed concern that over-regulation could have negative consequences on access to care and work.

We hope that the information we provide in this paper about approaches taken in other jurisdictions and options for reform will help BC move forward in enhancing HCA oversight and better protecting both HCAs and the public. Of course, regulation is not a panacea and many of the structural conditions under which HCAs work present problems that cannot be solved by law reform.

We strongly encourage the BC Government to consult with those who would be the most impacted by any law reform, including both HCAs and the members of our community who rely on HCAs for care. Their expertise is paramount in speaking to the power structures and practical considerations of navigating such intimate care environments. It is this expertise that should be centered in delineating the scope of HCA work in BC and how best to support and oversee their work.

Appendix 1. Program Standards found in the BC Health Care Assistant Program Recognition: Guide for Educators

The program recognition guide sets out the standards that must be met in order for a program to be recognized. These standards are divided into area, standard, and assessment criteria.⁸³⁴

Area 1: Facilities and Institutional Resources

Standard 1.1 – Program resources are adequate to meet the learning outcomes

1.1a The physical infrastructure is adequate.

1.1b Appropriate learning resources are available.

Interpretation: It is expected that the program students will receive adequate learning resources (textbooks/supplies) and supplemental resources will be available. The program will provide students with computer and internet access.

1.1c The lab equipment includes all items on the minimum laboratory equipment checklist.

Interpretation: It is expected that the all lab equipment is appropriately maintained, in working order and that appropriate quantities are in place for student practice.

1.1d Students have sufficient access to laboratory equipment/supplies.

Interpretation: Depending on available resources, it is understood that students may be scheduled into separate lab groups. It is essential that a minimum of 65% (78 hours) of the 120-hour Personal Care and Assistance course consists of the supervised application of hands-on skills to ensure students are deemed safe and competent in performing personal care.⁸³⁵

Area 2: Instructional Staff and Program Personnel

Standard 2.1 – The program has an appropriate number and type of instructional staff and program personnel to fulfil their role in supporting student learning to the level required to meet the learning outcomes

2.1a The program has personnel with documented responsibilities for overall program delivery, curriculum development/revisions, and instruction for theory, lab and practice experiences.

2.1b The program has sufficient numbers of instructional staff to sustain effective instruction/facilitation, adequate supervision and timely assessments of student learning.

Interpretation: It is expected that the program will not exceed ratios of 1:18 for lab instruction and 1:10 for Clinical Practice Experiences.

Standard 2.2 – The qualifications and experience of instructional staff enable quality delivery of the program

2.2a All instructors meet the established minimum HCA instructor qualifications.⁸³⁶

Area 3: Program Entry Policies

Standard 3.1 – The program entry requirements and the requirements prior to starting the first practice experience are appropriate and applied consistently

3.1a All students meet the established minimum HCA program entry requirements.

3.1b A reliable process is in place to verify program entry and pre-practice experience requirements are met.

Interpretation: It is the responsibility of the educational institution to develop a process which will confirm HCA Program applicant status (as either a speaker of English as a first language or not). Once status has been correctly identified, appropriate admissions documents need to be supplied.⁸³⁷

Area 4: Program Outcomes, Delivery and Assessment

Standard 4.1 – The program meets the learning outcomes identified in the HCA Program Provincial Curriculum

4.1a Learning outcomes and content align with the HCA provincial curriculum.

4.1b The program is appropriately sequenced.

Interpretation: Course theory, lab skills and practice experiences are well-paced and logically sequenced. There is a clear delineation of course and/or lab work that must be successfully completed prior to applying the knowledge/skills in a practice setting. Students may not practice a skill within the context of resident/client care (does not involve real life clients/residents) until he/she has been sufficiently instructed and appropriately assessed by an instructor as being able to provide that skill safely.

4.1c Learning outcomes are delivered and assessed using a variety of strategies.

Interpretation: The program applies the principles and best practices in the design and delivery of adult education. Learning strategies engage learners and provide them with opportunities for interaction and reflection. A variety of suggested assessment strategies are used in each course (i.e. minimum of three). The program demonstrates that it uses appropriate assessment tools to confirm students can perform personal care safely and competently [via lab skill procedure checklists (formative evaluation) and scenario-based practical skills testing (summative evaluation)]. Competency-based tools should use a pass/fail scoring systems (vs. percentile scoring) to indicate acceptable performance level(s) have been met in requisite competency areas prior to clinical practice.

4.1d The program can demonstrate students have met learning outcomes.

Interpretation: The program can demonstrate that students have met all required program learning outcomes, through application in the clinical practice environment.

Standard 4.2 – The practice education experiences are effectively integrated into the program and the roles and responsibilities of all parties are clear

4.2a Practice education experiences are effectively organized.

4.2b Affiliation agreements are in place.

Interpretation: It is expected that affiliation and/or work experience training agreements are in place with all partner sites.

4.2c Policies and procedures governing program specific practice experiences are clearly documented.

4.2d Personnel at the practice education sites are provided with information about the HCA program, practice education experiences outcomes and their roles/responsibilities.

4.2e Students are aware of their role/responsibilities while on practice education experiences.
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Area 5: Stakeholder Consultation

Standard 5.1 – A Program Advisory Committee (PAC) with appropriate representation is in place

5.1a Program has a PAC with terms of reference which meets a minimum of annually.

5.1b PAC membership includes a minimum of three (3) external representatives which may include employers, practice education partners, graduates and/or practitioners.

5.1c PAC meetings follow an established agenda with a list of attendees and minutes are taken.

Standard 5.2 – Key stakeholders (students, instructors, practice experience partners, employers and program graduates) have appropriate opportunities to provide feedback on the program

5.2a There are formal mechanisms in place to gather feedback from key stakeholders.

Interpretation: At a minimum, it is expected that students will complete end of course surveys, practice experience sites/personnel will be surveyed after placements and graduate and employer surveys will be conducted. Faculty meetings should also be held to gather input.

Standard 5.3 – Timely improvements are made to the program based on stakeholder consultation

5.3a Evidence exists that concerns arising within feedback are being addressed.⁸³⁹

Appendix 2. Courses Listed on the BC Registry Website

Health Care Assistant Practice in British Columbia
PACE for PSWs: Palliative Care Education for Personal Support Workers
Strategies and Actions for Independent Living
Core Indigenous Cultural Safety Health Training
Body Mechanics and Client Mobility
Infection Prevention
Medication Basics for Health Care Assistants
Planning, Time Management & Organization for HCAs
Health Care Assistant – Introduction to Practice Course
Dementia Care
SafeCare BC Courses
Suicide and Alertness Training
Mental Health First Aid
Medication Management for Health Care Assistants
Certificate in Medication Administration for Health Care Assistants
Long-term Care management
End of Life Doula
Mindfulness Based Stress Reduction
North Island College Activity Assistant Certificate Program
Vancouver Island University Activity Assistant Certificate⁸⁴⁰

Appendix 3. Recognized BC HCA Programs⁸⁴¹

Educator	Program	Locations	Recognition Status
Cambria College	Health Care Assistant, Health Care Assistant (Combined Delivery)	Richmond, Surrey, Victoria, Vancouver	Full Recognition *program under review
Camosun College	Health Care Assistant, Health Care Assistant – ESL, Health Care Assistant – Indigenous	Victoria	Full Recognition
Capilano University	Health Care Assistant, Health Care Assistant (Combined Delivery)	North Vancouver, Sechelt	Full Recognition
CDI College of Business, Technology & Health Care	Health Care Assistant, Health Care Assistant (Combined Delivery)	Richmond, Surrey	Full Recognition
Coast Mountain College	Health Care Assistant, Health Care Assistant (Combined Delivery)	Terrace, Smithers *regional program delivery may be available	Full Recognition
College Educacentre College	Health Care Assistant in French-Préposé aux soins de santé (Combined Delivery)	Vancouver	Full Recognition
College of New Caledonia	Health Care Assistant	Prince George, Quesnel, Vanderhoof *regional program delivery may be available	Full Recognition
College of the Rockies	Health Care Assistant, Health Care Assistant (Combined Delivery)	Cranbrook, Creston, Fernie, Golden, Invermere	Full Recognition
Discovery Community College	Health Care Assistant, Health Care Assistant (Combined Delivery)	Campbell River, Courtenay, Maple Ridge, Nanaimo, Parksville, Surrey	Full Recognition
Douglas College	Health Care Assistant, Health Care Assistant (Combined Delivery)	Coquitlam	Full Recognition
Drake Medox College	ESL – Health Care Assistant (Combined Delivery), Health Care Assistant (Combined Delivery), ESL – Health Care Assistant Health Care Assistant	Courtenay, Victoria	Full Recognition

Excel Career College	Health Care Assistant, Health Care Assistant (Combined Delivery)	Courtenay, Victoria	Full Recognition
First College	Health Care Assistant Program	Kelowna	Full Recognition
Gateway College	Health Care Assistant, Health Care Assistant – Accelerated, Health Care Assistant – Access, Health Care Assistant & Communication Year 2 (recognized as an HCA ESL Program), Health Care Assistant (Combined Delivery), Health Care Assistant – Accelerated (Combined Delivery), Health Care Assistant – Access (Combined Delivery), Health Care Assistant & Communication Year 2 (recognized as an HCA ESL Program (Combined Delivery)	Vancouver	Full Recognition
Heritage Community College	Health Care Assistant, Health Care Assistant (Combined Delivery)	Surrey	Full Recognition
Kwantlen Polytechnic University	Health Care Assistant, Health Care Assistant (Combined Delivery)	Langley, Surrey	Full Recognition
Langara College	Health Care Assistant	Vancouver	New Program Site Visit Pending
NEC Native Education College	Health Care Assistant, Health Care Assistant (Combined Delivery)	Vancouver	Full Recognition
Nicola Valley Institute of Technology	Health Care Assistant	Merritt	Full Recognition
North Island College	Health Care Assistant, Health Care Assistant (Combined Delivery)	Comox Valley, Port Alberni, Campbell River	Full Recognition
Northern Lights College	Health Care Assistant, Health Care Assistant (Combined Delivery)	Dawson Creek, Fort St. John	Full Recognition
Okanagan College	Health Care Assistant	Kelowna, Penticton, Salmon Arm, Vernon	Full Recognition
Pacific Coast Community College	Health Care Assistant, Health Care Assistant (Combined Delivery)	Langley	Interim recognition

Selkirk College	Health Care Assistant, Health Care Assistant Access (within Post-Graduate Diploma in Gerontological Nursing), Health Care Assistant (Combined Delivery), Health Care Assistant Access (within Post-Graduate Diploma in Gerontological Nursing) (Combined Delivery)	Trail, Castlegar	Full Recognition
Sprott Shaw College	Health Care Assistant, Health Care Assistant Upgrade (Combined Delivery), Health Care Assistant Access (within Post Graduate Certificate in Nursing Program), Health Care Assistant Internationally Educated (recognized as an HCA ESL Program), Health Care Assistant (Combined Delivery), Health Care Assistant Access (within Post Graduate Certificate in Nursing Program) (Combined Delivery), Health Care Assistant Internationally Educated (recognized as an HCA ESL program) (Combined Delivery)	Abbotsford, Kelowna, Chilliwack, Kamloops, Maple Ridge, New Westminster, Nanaimo, Penticton, Surrey, East Vancouver, Vancouver, Victoria, Osoyoos	Full Recognition
Stenberg College	Health Care Assistant, Health Care Assistant – International (recognized as an HCA ESL Program), Health Care Assistant Access (within Post Graduate Diploma in Canadian Nursing), Health Care Assistant Access International (within International Post Graduate Diploma in Canadian Nursing)	Surrey	Full Recognition
Thompson Rivers University	Health Care Assistant	Kamloops Williams Lake	Full Recognition
Thompson Rivers University - Open Learning Division	Health Care Assistant (Combined Delivery)	Multiple Locations in British Columbia	Full Recognition
Universal Learning Institute	Health Care Assistant	Richmond	Full Recognition

University of Fraser Valley	Health Care Assistant	Chilliwack	Full Recognition
Vancouver Career College	Health Care Assistant , Health Care Assistant (Combined Delivery)	Abbotsford, Burnaby	Full Recognition
Vancouver Community College	Health Care Assistant , Health Care Assistant – ESL, Health Care Assistant (Combined Delivery)	Vancouver	Full Recognition
Vancouver Island University	Health Care Assistant, Health Care Assistant (Combined Delivery)	Duncan, Nanaimo, Powell River	Full Recognition
Western Community College	Health Care Assistant, Health Care Assistant + ESL, Health Care Assistant – Access, Health Care Assistant (Combined Delivery), Health Care Assistant ESL (Combined Delivery)	Abbotsford, Surrey	Full Recognition
Westminster College	Health Care Assistant Program	Surrey	Full Recognition

Appendix 4. BC HCA Provincial Curriculum, Foundational Courses

Health and Healing: Concepts for Practice

Course Description

This course provides students with the opportunity to develop a theoretical framework for practice. Students will be introduced to the philosophical values and theoretical understandings that provide a foundation for competent practice as a HCA. The course focuses on concepts of caring and person-centred care; basic human needs and human development; family, culture and diversity as they relate to health and healing. Students will also be introduced to a problem-solving model that will be critical to their practice.

Minimum course hours: 70

Learning Outcomes

1. Display an understanding of person-centred care that recognizes and respects the uniqueness of each individual
2. Discuss basic human needs and common characteristics of human development as these concepts relate to person-centred care
3. Use an informed problem-solving approach to provide care and service
4. Contribute to the safety and protection of self and others within a variety of work environments
5. Display an understanding of the role of family, culture, diversity and life experiences in aging, health and healing

Course Content

- Characteristics of caring and person-centred practice
- Basic Human Needs
- Human Development
- Family in Health and Healing
- Multiculturalism and Diversity
- Critical Thinking and Problem-Solving
- Protection and Safety in Health and Healing⁸⁴²

Health Care Assistants: Introduction to Practice

Course Description

This course provides an introduction to the role of the HCA within the British Columbia health care system. Students will be introduced to the health care team and the roles and functions of HCAs within the team. Students will also have opportunities to develop self-reflective skills required for competent practice and will be introduced to effective job-finding approaches

Minimum course hours: 30

Learning Outcomes

1. Display an understanding of the roles and responsibilities of HCAs within the health care system in British Columbia
2. Contribute to the effective functioning of the health care team
3. Function in a responsible, accountable fashion recognizing legal and ethical parameters of the HCA role
4. Apply self-reflection and self-appraisal processes in order to recognize and respond to own self-development needs as a care provider

5. Confidently conduct a job-search process

Course Content

- Workplace Settings and Contexts
- Teamwork in Health care Settings
- Legal and Ethical Issues
- Professional Approaches to Practice
- Self-reflective Practice
- Employability Skills⁸⁴³

Health 1: Interpersonal Communications

Course Description

This course focuses on the development of self-awareness, increased understanding of others and development of effective interpersonal communication skills that can be used in a variety of care-giving contexts. Students will be encouraged to become more aware of the impact of their own communication choices and patterns. They will have opportunities to develop and use communication techniques that demonstrate personal awareness, respect and active listening skills.

Minimum course hours: 50

Learning Outcomes

1. Identify the characteristics and qualities of effective interpersonal communications
2. Discuss the interrelationship between self-awareness, self-esteem and perception as these relate to communication choices and patterns
3. Demonstrate effective, caring interpersonal characteristics with clients, colleagues and others
4. Apply self-reflection and self-appraisal process in order to increase own effectiveness in interpersonal contexts

Course Content

- Introduction to Interpersonal Communication
- Knowledge of Self
- Non-Verbal Communication
- Responding to Others
- Conflict Management and Resolution⁸⁴⁴

Health 2: Lifestyle Choices

Course Description

This course introduces students to a holistic concept of health and the components of a health-enhancing lifestyle. Students will be invited to reflect on their own experience of health, recognizing challenges and resources that can impact lifestyle choices. Students will be introduced to a model that can be applied in other courses to understand the multi-faceted aspects of health and healing.

Minimum course hours: 30

Learning Outcomes

1. Discuss the interrelationship of physical, social, cognitive, emotional and spiritual dimensions and the Determinants of Health

2. Display an understanding of how lifestyle choices and behaviours contribute to physical, psychological, social, cognitive and spiritual health
3. Display an understanding of the complexity of the change process in relation to health promotion

Course Content

- Understanding Health
- Components of Health: physical, psychological/emotional, cognitive, social, and spiritual
- Lifestyle Changes⁸⁴⁵

Appendix 5. BC HCA Provincial Curriculum, Specialized Care Courses

Healing 1: Caring for Individuals Experiencing Common Health Challenges

Course Description

This course introduces students to the normal structure and function of the human body and normal bodily changes associated with aging. Students will explore common challenges to health and healing in relation to each body system. Students will also be encouraged to explore person-centred practice as it relates to the common challenges to health and, in particular, to end-of-life care.

Minimum course hours: 115

Learning Outcomes

1. Display an understanding of the structure and function of the human body and normal changes associated with aging
2. Display a sound understanding of common challenges to health and healing
3. Discuss nutrition as it relates to healing
4. Describe ways to organize, administer and evaluate person-centred care and service for clients experiencing common health challenges
5. Demonstrate an understanding of the components of person-centred, end-of-life care for clients and families

Course Content

- Medical Terminology
- Structure and function of the human body
- Challenges to health and healing
- Nutrition and Healing
- End-of-Life Care⁸⁴⁶

Healing 2: Caring for Individuals Experiencing Cognitive or Mental Challenges

Course Description

This course builds on content from other courses to assist students to explore concepts and care-giving approaches that will allow them to work effectively with individuals experiencing cognitive or mental challenges. The emphasis in this course is on supporting clients with dementia, recognizing responsive behaviours and identifying person-centred intervention strategies.

Minimum course hours: 60

Learning Outcomes

1. Describe ways to organize, administer and evaluate person-centred care and assistance for clients experiencing cognitive health challenges (dementia)
2. Describe ways to organize, administer and evaluate person-centred care and assistance for clients experiencing mental health challenges (other than dementia)
3. Demonstrate an understanding of effective approaches to disruptive or abusive behaviours

Course Content

- Cognitive Challenges in Older Adulthood
- Abuse
- Mental Health Challenges⁸⁴⁷

Healing 3: Personal Care and Assistance**Course Description**

This practical course offers students the opportunity to acquire personal care and assistance skills within the parameters of the HCA role. The course is comprised of class and supervised laboratory experiences which assist the student to integrate theory from other courses to develop care-giver skills that maintain and promote the comfort, safety and independence of individuals in community and facility contexts.

Minimum course hours: 120

Learning Outcomes

1. Perform personal care skills in an organized manner ensuring the comfort and appropriate independence of the client
2. Apply an informed problem-solving process to the provision of care and assistance
3. Provide personal care and assistance within the parameters of the HCA
4. Provide care and assistance in ways that maintain safety for self and others in a variety of contexts

Course Content

- Problem-solving when carrying out care-giving procedures
- Asepsis and prevention of infection
- Promoting comfort and rest
- Moving, positioning and transferring a client
- Bedmaking
- Promoting exercise and activity
- Promoting healthy nutrition and fluid intake
- Promoting urinary and bowel elimination
- Measuring vital signs
- Heat and cold application (usually delegated task)
- Assisting with oxygen needs (may be delegated task)
- Assisting with medication for clients able to direct own care (may be delegated task)
- Home management⁸⁴⁸

Endnotes

- 1 See generally Laura Booi et al, “I wouldn’t choose this work again: Perspectives and experiences of care aides in long-term residential care” (2021) 77:9 *Journal of Advanced Nursing* 3842 at 3850; Frank Gunn, “Personal support workers are the backbone of health care but the bottom of the power structure” (2 September 2020), online: the Conversation <theconversation.com/personal-support-workers-are-the-backbone-of-health-care-but-the-bottom-of-the-power-structure-144648>; Margo H Schmiederer, “Home Health Aids: The Burgeoning Backbone of the Health Care System” (2021) 4:2 *Ohio J Public Health* 3.
- 2 See Sarah J Hewko et al, “Invisible no more: a scoping review of the health care aide workforce literature” (2015) 14:38 *BMC Nursing* 1.
- 3 See Arsalan Afzal et al, “The role of unregulated care providers in Canada – A scoping review” (2018) 13:3 *Int J Older People Nursing* 1 (e12190); See also Carole A Estabrooks et al, “Restoring Trust: COVID-19 and the Future of Long-Term Care on Canada” (2020) 5 *Facets* 651 [Estabrooks et al, “Restoring Trust”].
- 4 See Margaret J McGregor et al, “Staffing levels in non-for-profit and for-profit long-term care facilities: Does type of ownership matter?” (2005) 172:5 *CMAJ* 645 at 647; Estabrooks et al, “Restoring Trust”, *supra* note 3.
- 5 “Home Care” (last visited 5 July 2022), online: *British Columbia* <www2.gov.bc.ca/gov/content/family-social-supports/seniors/health-safety/health-care-programs-and-services/home-care> [BC, “Home Care”].
- 6 See Marcus J Hollander & Neena L Chappell, “A Comparative Analysis of Costs to Government for Home Care and Long-term Residential Care Services, Standardized for Client Care Needs” (2007) 26:1 *Can J on Aging* 149.
- 7 See “Practice Standard for Nurse Practitioners and Registered Nurses: Delegating Tasks to Unregulated Care Providers” (last visited 5 July 2022), online: *British Columbia College of Nurses & Midwives* <www.bccnm.ca/NP/PracticeStandards/Pages/delegating.aspx> [BCCN&M, “RN/NP Delegation Practice Standard”].
- 8 See “Home Support: We Can Do Better” (June 2019) at 6, online (pdf): *Office of the Seniors Advocate of BC* <www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/06/Report-Home-Support-Review_web.pdf> [Seniors Advocate, “Home Support”].
- 9 *Ibid* at 7; “Better at Home” (last visited 8 July 2022), online: *United Way* <betterathome.ca>.
- 10 Seniors Advocate, “Home Support”, *supra* note 8 (the Seniors Advocate report estimates 1000 people BC receive funding from CSIL at 40).
- 11 Afzal et al, *supra* note 3 at 13; *Ibid*.
- 12 Afzal et al, *supra* note 3 at 2.
- 13 See Margaret J McGregor et al, “Trends in Long-term care staffing by facility ownership in British Columbia, 1996-2006” (December 2010) at 4, online (pdf): *Statistics Canada* <www150.statcan.gc.ca/n1/en/pub/82-003-x/2010004/article/11390-eng.pdf?st=6cS69crX>.
- 14 See generally Margaret Saari et al, “The role of unregulated care providers in home care: A scoping review” (2018) 26:7 *J Nurs Manag* 782 [Saari et al, “Scoping Review”]; Margaret Saari et al, “The evolving role of the personal support worker in home care in Ontario, Canada” (2018) 26:2 *Health Soc Care Community* 240 [Saari et al, “PSW in Home Care”]; Christine Kelly, “Exploring experiences of personal support worker education in Ontario, Canada” (2017) 25:4 *Health Soc Care Community* 1430.
- 15 Afzal et al, *supra* note 3.
- 16 See Vicki Foerster & James Murtagh, “British Columbia Care Aide & Community Registry: A Review” (1 February 2013) at 2, online (pdf): *Ministry of Health* <www.health.gov.bc.ca/library/publications/year/2013/bc-care-aide-registry-report.pdf> [Foerster & Murtagh, “BC Registry Review”].
- 17 Afzal et al, *supra* note 3; See also Stephanie A Chamberlain et al, “Who is (Still) Looking After Mom and Dad? Few Improvements in Care Aides’ Quality-of-Work Life?” (2019) 38:1 *Can J Aging* 35; Carole Estabrooks et al, “Who Is Looking After Mom and Dad? Unregulated Workers in Canadian Long-Term Care Homes” (2015) 34:1 *Can J on Aging* 47 [Estabrooks et al, “Who is Looking”].

- 18 The Personal Support Workers Working Group.
- 19 Booi et al, *supra* note 1 at 3845.
- 20 See generally *Community Care and Assisted Living Act*, SBC 2002, c 75 [CCALA]; *Hospital Act*, RSBC 1996, c 200.
- 21 Anonymous key informant interview.
- 22 See “Review of Covid-19 Outbreaks in Care Homes in British Columbia” (October 2021) at 14, online (pdf): *Office of the Seniors Advocate of BC* <www.seniorsadvocatebc.ca/app/uploads/sites/4/2021/10/Outbreak-Review-Report.pdf> [BC Seniors Advocate, “Covid Outbreak Review”].
- 23 Afzal et al, *supra* note 3; Kelly, *supra* note 14.
- 24 Afzal et al, *supra* note 3; Estabrooks et al, “Who is Looking”, *supra* note 17.
- 25 See Naomi Lightman, “Caring during the COVID- 19 crisis: Intersectional exclusion of immigrant women health care aides in Canadian long- term care” (2021) 30:4 Health & Social Care in the Community 1343.
- 26 See “Nurse aides, orderlies and patient services associates (NOC 3431)” (May 25, 2022), online: WorkBC <www.workbc.ca/careers/3413#view-full-profile> [WorkBC, “Nurse Aide”]; “Home support workers, housekeepers and related occupations (NOC 4412)” (last modified 25 May 2022), online: *WorkBC* <www.workbc.ca/Jobs-Careers/Explore-Careers/Browse-Career-Profile/4412> [WorkBC, “HSW”]; Afzal et al, *supra* note 3 at 3.
- 27 WorkBC, “Nurse Aide”, *supra* note 26.
- 28 Laura D Aloisio et al, “To whom health care aides report: Effect on nursing home resident outcomes” (2021) 6 Int J Older People Nursing e12406 at 2, 3, 6.
- 29 Chamberlain et al, *supra* note 17 at 40.
- 30 Hong Helen Doan, *Care Aides Working More Than One Job in Long Term Care* (Master of Nursing Thesis, University of Alberta, 2021) [unpublished] at 50.
- 31 *Ibid* at 50–51.
- 32 *Ibid* at 50.
- 33 WorkBC, “HSW”, *supra* note 26.
- 34 Key informant interview.
- 35 *Ibid*.
- 36 Chamberlain et al, *supra* note 17 at 36; Estabrooks et al, “Who is Looking”, *supra* note 17 at 48; Aloisio et al, *supra* note 28 at 2; Afzal et al, *supra* note 3 at 2; Doan, *supra* note 30 at 2. See also Yuting Song et al, “Characteristics and Work Life Quality of Nursing Home Care Aides in Canada” (2020) 3:12 JAMA Network Open 29121 at 1; Renee Gauthier et al, “The Information-seeking patterns of care aides who work in nursing homes” (2019) 27 J Nursing Management 1604 at 1605; Sara L Cooper et al, “Burnout in the nursing home health care aide: A systemic review” (2016) 3 Burnout Research 76 at 77.
- 37 WorkBC, “Nurse Aide”, *supra* note 26; WorkBC, “HSW”, *supra* note 26; Booi et al, *supra* note 1 at 3843; Gauthier et al, *supra* note 36 at 1605; Afzal et al, *supra* note 3 at 2–3; Doan, *supra* note 30 at 2; See also Canada, “Support Services Assistant – Medical in Canada” (5 May 2022), online: *Job Bank* <www.jobbank.gc.ca/marketreport/summary-occupation/15798/ca> [Canada, “SSA Medical”].
- 38 WorkBC, “Nurse Aide”, *supra* note 26; WorkBC, “HSW”, *supra* note 26; Canada, “SSA Medical”, *supra* note 37; Afzal et al, *supra* note 3 at 3; Doan, *supra* note 30 at 2.
- 39 WorkBC, “Nurse Aide”, *supra* note 26; WorkBC, “HSW”, *supra* note 26; Gauthier et al, *supra* note 36 at 1605; Afzal et al, *supra* note 3 at 2, 11; Doan, *supra* note 30 at 2; Canada, “SSA Medical”, *supra* note 37 ; See also Danielle T Just et al, “Expanding the Concept of End-of-life Care in Long-term Care: A Scoping Review Exploring the Role of Healthcare Assistants” (2021) 16:2 Int J Older People Nursing 12353 at 1.
- 40 WorkBC, “Nurse Aide”, *supra* note 26; WorkBC, “HSW”, *supra* note 26; Canada, “SSA Medical”, *supra* note 37; Gauthier et al, *supra* note 36 at 1605; Afzal et al, *supra* note 3 at 11; Doan, *supra* note 30 at 2.
- 41 Saari et al, “PSW in Home Care”, *supra* note 14 at 245.
- 42 *Ibid* at 245.

- 43 See BC Care Aide & Community Health Worker Registry, *Spring Updates Report 2022*, by Sarina Corsi & Lara Williams (Vancouver: BC CACHW Registry, 10 May 2022) at 1 [BC CACHW Registry, *Spring Updates Report 2022*].
- 44 WorkBC, “Nurse Aide”, *supra* note 26; WorkBC, “HSW”, *supra* note 26.
- 45 WorkBC, “Nurse Aide”, *supra* note 26; WorkBC, “HSW”, *supra* note 26.
- 46 BC CACHW Registry, *Spring Updates Report 2022*, *supra* note 43 at 5–7.
- 47 See Catherine Brookman et al, “Community-based personal support workers’ satisfaction with job-related training at the organization in Ontario, Canada: Implications for future training” (2022) 5:478 *Health Sci Rep* 1 at 5.
- 48 See Christine Kelly & Ivy Lynn Bourgeault, “The Personal Support Worker Program Standard in Ontario: An Alternative to Self-Regulation?” (2015) 11:2 *Healthcare Policy* 20 at 21.
- 49 Marie Y Savundranayagam, Susan Maureen Docherty-Skippen & Shalane R Basque, “Qualitative Insights into the Working Conditions of Personal Support Workers in Long-Term Care in the Context of a Person-Centered Communication Training Intervention” (2021) 14:5 *Res Gerontol Nurs* 245 at 246.
- 50 WorkBC, “Nurse Aide”, *supra* note 26.
- 51 WorkBC, “HSW”, *supra* note 26.
- 52 See “A Billion Reasons to Care: A Funding Review of Contracted Long-Term Care in B.C.” (February 2020) at 27–28, online (pdf): *Office of the Seniors Advocate of BC* <www.seniorsadvocatebc.ca/app/uploads/sites/4/2020/02/ABillionReasonsToCare.pdf>.
- 53 Table created with data from Canada, SSA Medical, *supra* note 37 at Wages.
- 54 WorkBC, “Nurse Aide”, *supra* note 26.
- 55 WorkBC, “HSW”, *supra* note 26.
- 56 WorkBC, “Nurse Aide”, *supra* note 26.
- 57 WorkBC, “HSW”, *supra* note 26.
- 58 Chamberlain et al, *supra* note 17 at 40; Estabrooks et al, “Who is Looking”, *supra* note 17 at 48; Booi et al, *supra* note 1 at 3843; Song et al, *supra* note 36 at 3; Cooper et al, *supra* note 36 at 78; Aloisio et al, *supra* note 28 at 6; Afzal et al, *supra* note 3 at 2; Doan, *supra* note 30 at 2, 50; Savundranayagam, Docherty-Skippen & Basque, *supra* note 49 at 245; See also Joanie Sims-Gould & Anne Martin-Matthews, “Strategies Used by Home Support Workers in the Delivery of Care to Elderly Clients” (2010) 29:1 *Can J on Aging* 97 at 100; Donna M Dill, *Factors Influencing Recruitment of Continuing Care Assistants to Home Care in Nova Scotia* (Master of Arts Thesis, Mount Saint Vincent University, 2009) [unpublished] at 59.
- 59 Chamberlain et al, *supra* note 17 at 40; Aloisio et al, *supra* note 28 at 6; Doan, *supra* note 30 at 2, 50; Sims-Gould & Martin-Matthews, *supra* note 58 at 100; Brookman et al, *supra* note 47 at 7, 2; Dill, *supra* note 58 at 19.
- 60 WorkBC, “Nurse Aide”, *supra* note 26; WorkBC, “HSW”, *supra* note 26.
- 61 Chamberlain et al, *supra* note 17 at 40; Estabrooks et al, “Who is Looking”, *supra* note 17 at 48; Booi et al, *supra* note 1 at 3843; Song et al, *supra* note 36 at 3; Aloisio et al, *supra* note 28 at 6; Afzal et al, *supra* note 3 at 2.
- 62 Chamberlain et al, *supra* note 17 at 45.
- 63 *Ibid* at 41.
- 64 *Ibid* at 36.
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87 Key informant interview.

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178 "Reporting Alleged Abuse" (last visited 5 July 2022), online: BC CACHW Registry <www.cachwr.bc.ca/About-the-Registry/Ensuring-Public-Safety/Reporting-Alleged-Abuse.aspx> [BC CACHW Registry, "Reporting Alleged Abuse"].

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- 266 *Ibid*.
- 267 *Ibid* at 10.
- 268 HPA, *supra* note 195, ss 12(2), 13–14, & 55; *Nurses (Registered) and Nurse Practitioners Regulation*, BC Reg 284/2008, ss 6–9.1 [RN & NP Regulation]; *Nurses (Registered Psychiatric) Regulation*, BC Reg 227/2015, ss 6–8 [RPN Regulation]; *Nurses (Licensed Practical) Regulation*, BC Reg 224/2015, ss 6–8 [LPN Regulation].
- 269 HPA, *supra* note 195, s 13. If the *Health Professions and Occupations Act* becomes law, it may alter some of the regulatory framework for delegation. See Bill 36, *Health Professions and Occupations Act*, 3rd Sess, 42nd Parl, British Columbia, 2022, s 74.
- 270 *Ibid*, s 19(1) (k.1).
- 271 BCCN&M, “RN/NP Delegation Practice Standard”, *supra* note 7.
- 272 See British Columbia College of Nurses & Midwives, “Registered Nurses and Nurse Practitioners: Assigning and Delegating to Unregulated Care Providers” (March 2021), online: BCCN&M <www.bccnm.ca/Documents/learning/RN_NP_Assigning_Delegating_UCP.pdf> [BCCN&M, “RN/NP Delegation Booklet”].
- 273 *Ibid* at 2; BCCN&M, “RN/NP Delegation Practice Standard”, *supra* note 7 at 2; BCCN&M, “RN/NP Delegation Booklet”, *supra* note 272 at 6.

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- 275 BCCN&M, “RN/NP Delegation Practice Standard”, *supra* note 7; BCCN&M, “RN/NP Delegation Booklet”, *supra* note 272
- 276 BCCN&M, “RN/NP Delegation Booklet”, *supra* note 272 at 25.
- 277 *Ibid.*
- 278 *Ibid* at 20–21.
- 279 BCCN&M, “RN/NP Delegation Practice Standard”, *supra* note 7 at 1.
- 280 BCCN&M, “RN/NP Delegation Booklet”, *supra* note 272 at 6–7.
- 281 *Ibid* at 7.
- 282 BCCN&M, “RN/NP Delegation Practice Standard”, *supra* note 7 at 1–2.
- 283 *Ibid* at 2–3.
- 284 *Ibid.*
- 285 BCCN&M, “RN/NP Delegation Booklet”, *supra* note 272 at 14.
- 286 *Ibid* at 15.
- 287 *Ibid* at 16.
- 288 BCCN&M, “RN/NP Delegation Practice Standard”, *supra* note 7 at 1, 3.
- 289 *Ibid* at 3.
- 290 BCCN&M, “RN/NP Delegation Booklet”, *supra* note 272 at 20–21.
- 291 *Ibid* at 17.
- 292 BCCN&M, “RN/NP Delegation Booklet”, *supra* note 272 at 11.
- 293 *Ibid.*
- 294 BCCN&M, “RN/NP Delegation Practice Standard”, *supra* note 7 at 3; *Ibid* at 18–19
- 295 *Ibid* at 12.
- 296 *Ibid.*
- 297 *Ibid* at 13.
- 298 *Ibid.*
- 299 See British Columbia College of Nurses & Midwives, “Practice Standard for BCCNM Licensed Practical Nurses: Working with Health Care Assistants” (November 2020), online: BCCN&M <www.bccnm.ca/LPN/PracticeStandards/Pages/WorkingWithHealthCareAssistants.aspx#footnotes> [BCCN&M, “LPN Practice Standard”].
- 300 *Ibid* at 1–2.
- 301 CCALA, *supra* note 20.
- 302 See *Assisted Living Regulation*, BC Reg 189/2019 [Assisted Living Regulation].
- 303 *Residential Care Regulation*, *supra* note 181.
- 304 *Assisted Living Regulation*, *supra* note 302, Sch E, s 1.
- 305 *Ibid*, Sch E, s 1.
- 306 *Ibid*, s 51(1).
- 307 *Ibid.*
- 308 *Ibid.*
- 309 *Ibid*, s 51(2).
- 310 *Residential Care Regulation*, *supra* note 181, Sch D, s 1.
- 311 *Ibid.*
- 312 *Ibid*, s 77(2).
- 313 *Ibid*, s 77(1).
- 314 *Ibid*, s 77(1)(a)(ii).
- 315 *Ibid*, s 77(1).
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- 317 *Ibid* at 5–6.
- 318 *Ibid* at 10.
- 319 *Ibid.*
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336 *Ibid* at 15, 18.
337 *Ibid* at 14.
338 *Ibid* at 18.
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341 *Ibid* at 19–20.
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- 371 Office of the Ombudsperson, *The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)*, vol 1, Public Report No 47 to the Legislative Assembly of British Columbia (Ombudsperson, February 2012), online: <bcombudsperson.ca/investigative_report/the-best-of-care-getting-it-right-for-seniors-in-bc-part-2/> [Ombudsperson, *Best of Care*].
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- 378 Manitoba Law Reform Commission, Report #84, *supra* note 377 at 15; Priest, *supra* note 377 at 254, 272.
- 379 See William W Shores, QC, “Vavilov and the Regulation of the Professions” (2020) 33 can J Admin L & Prac 195 at 196–197; Merrilee Rasmussen, “Umbrella Professions Legislation: A “Made in Saskatchewan” Approach” (2010) 73 Sask L Rev 285 at 294–295; Harry Cayton, *An Inquiry into the Performance of the College of Dental Surgeons of British Columbia and the Health Professions Act* (London, UK: The Professional Standards Authority for Health and Social Care) at 59, 73 [Cayton Report].
- 380 CRNBC, *supra* note 377 at 3–4, 8, 12
- 381 HPA, *supra* note 195, s 16(1); CRNBC, *supra* note 377 at 3, 7; Rasmussen, *supra* note 379 at 294–295; Priest, *supra* note 377 at 253–254; Cayton Report, *supra* note 379 at 8–12, 57–59, 73.
- 382 Manitoba Law Reform Commission, Report #84, *supra* note 377 at 13–14; Priest, *supra* note 377 at 253–254.
- 383 CRNBC, *supra* note 377 at 3–4, 14; Manitoba Law Reform Commission, Report #84, *supra* note 377 at 68–9.
- 384 CRNBC, *supra* note 377 at 3–4, 14–15; Manitoba Law Reform Commission, Report #84 *supra* note 377 at 11–12.
- 385 For the information provided in the above table, see generally CRNBC, *supra* note 377 at 14; Shores, *supra* note 379 at 196; Manitoba Law Reform Commission, Report #84, *supra* note 377 at 11–12, 33–34, 37, 68–70; Priest, *supra* note 377 at 252.
- 386 Manitoba Law Reform Commission, Report #84, *supra* note 377 at 46; Priest, *supra* note 377 at 237, 251.
- 387 Shores, *supra* note 379 at 198–199; Manitoba Law Reform Commission, Report #84, *supra* note 377 at 48; Priest, *supra* note 377 at 238, 251.
- 388 Shores, *supra* note 379 at 198–199; Cayton Report, *supra* note 379 at 74–75.
- 389 Manitoba Law Reform Commission, Report #84, *supra* note 377 at 46; Priest, *supra* note 377 at 238, 251; Cayton Report, *supra* note 379 at 8–12, 47–55.
- 390 Some professions are regulated under the *Professional Governance Act*, SBC 2018, c 47, e.g. professional engineers, professional biologists, and agrologists; others are regulated by a statute addressing that profession alone, e.g. *Legal Profession Act*, SBC 1998, c 9, *Notaries Act*, RSBC 1996, c 334, and *Architects Act*, RSBC 1996, c 17.
- 391 Priest, *supra* note 377 at 259–261; Cayton Report, *supra* note 379 at 74–75, 83–84.
- 392 Manitoba Law Reform Commission, Report #84, *supra* note 377 at 46.
- 393 See *Financial Services Authority Act*, SBC 2019, c 14.

- 394 See *Emergency Health Services Act*, RSBC 1996, c 182 [EHSA].
- 395 Kelly & Bourgeault, *supra* note 48 at 21–22.
- 396 *Ibid* at 22; See e.g. *Industry Training Authority Act*, SBC 2003, c 34 (the ITA is a Crown agency that coordinates BC's skilled trades system).
- 397 See "Family, marriage and other related counsellors (NOC 4153)" (last modified 25 May 2022), online: *WorkBC* <www.workbc.ca/careers/4153#job-requirements>.
- 398 See e.g. "Find the support you need" (last modified 7 September 2021), online: *British Columbia* <www2.gov.bc.ca/gov/content/careers-myhr/all-employees/safety-health-well-being/health/efas/short-term-counselling>.
- 399 HPA, *supra* note 195. At the time of publication of this study paper the Government of BC has just tabled Bill 36, which proposes legislation to replace the current *Health Professions Act* and address many of the concerns identified in the Cayton Report. See Bill 36, *supra* note 269.
- 400 *Ibid*, s 1.
- 401 *Health Professions Designation and Amalgamation Regulation*, BC Reg 270/2008, s 2 [HPDA Regulation]. Other health professions regulated under different Acts include Emergency Medical Assistants (Paramedics) under the *Emergency Health Services Act*, *supra* note 395, and social workers under the *Social Workers Act*, SBC 2008, c 31.
- 402 HPA, *supra* note 195, s 15.
- 403 HPDA Regulation, *supra* note 401, s 9; See also "British Columbia College of Nurses and Midwives" (last visited 6 July 2022), online: *British Columbia College of Nurses and Midwives* <www.bccnm.ca/Pages/Default.aspx>.
- 404 HPA, *supra* note 195, s 16(1).
- 405 *Ibid*, s 16(2), 20(2).
- 406 *Ibid*.
- 407 *Ibid*, s 16.
- 408 *Ibid*, ss 16, Part 3
- 409 *Ibid*, s 32.
- 410 *Ibid*, s 32.2(1).
- 411 *Ibid*, s 32.2(2).
- 412 *Ibid*, s 32.2(3).
- 413 *Ibid*, s 32.4.
- 414 *Ibid*, s 32.3(1).
- 415 *Ibid*.
- 416 *Ibid*, s 26.1.
- 417 *Ibid*, ss 33, 36, 37, 37.1, 38.
- 418 *Ibid*, s 35.
- 419 *Ibid*, s 39(1).
- 420 *Ibid*, s 39(2).
- 421 *Ibid*, s 7.
- 422 *Ibid*, s 9(2).
- 423 *Ibid*, s 10.
- 424 HPDA Regulation, *supra* note 401, s 6(1).
- 425 *Ibid*, s 6(2).
- 426 HPA, *supra* note 195, s 1.
- 427 *Ibid*, s 19(1).
- 428 See "Certified Dental Assistants" (last visited 6 July 2022), online: *College of Dental Surgeons of British Columbia* <www.cdsbc.org/registration-renewal/certified-dental-assistants>.
- 429 See "Home" (last visited 6 July 2022), online: *British Columbia College of Nurses & Midwives* <www.bccnm.ca/Pages/Default.aspx>.

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- 431 *RN & NP Regulation*, *supra* note 268.
- 432 *RPN Regulation*, *supra* note 268.
- 433 *LPN Regulation*, *supra* note 268.
- 434 “Nursing Professions” (last visited 6 July 2022), online: *British Columbia* <www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/professional-regulation/nursing>.
- 435 *Ibid.*
- 436 *Ibid.*
- 437 *Ibid.*
- 438 *RN & NP Regulation*, *supra* note 268, s 3; *RPN Regulation*, *supra* note 268, s 3; *LPN Regulation*, *supra* note 268, s 3.
- 439 *RN & NP Regulation*, *supra* note 268, s 1, 4.
- 440 *RPN Regulation*, *supra* note 268, s 1, 4.
- 441 *RN & NP Regulation*, *supra* note 268, ss 6, 9.1; *RPN Regulation*, *supra* note 268, ss 6, 8; *LPN Regulation*, *supra* note 268, ss 6, 8.
- 442 *RN & NP Regulation*, *supra* note 268, s 6(1)(k), (l).
- 443 *Ibid.*, s 7.
- 444 *Ibid.*, s 9.1.
- 445 They may prescribe, compound, dispense, or administer a Schedule I drug by any method to treat anaphylaxis, opiate overdose, respiratory distress in a person with asthma, hypoglycemia, or influenza-like illness. For Schedule II drugs, an RPN can prescribe, compound, dispense, or administer the drug by any method, with no restrictions on the type of illness it is being used for: See *RPN Regulation*, *supra* note 268, s 6. With a doctor’s order, an RPN can compound, dispense, or administer any Section I or IA drug by any method: *RPN Regulation*, *supra* note 268, s 7.
- 446 *LPN Regulation*, *supra* note 268, s 6.
- 447 *Ibid.*, s 7.
- 448 *Ibid.*, s 8.
- 449 See “Emergency Medical Assistants” (last visited 16 June 2022), online: *Emergency Medical Assistants Licensing Board* <www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/professional-regulation/emergencymedicalassistants#:~:text=Emergency%20medical%20assistants%20have%20been,Emergency%20and%20Health%20Services%20Commission> [EMALB, “Emergency Medical Assistants”].
- 450 *EHSA*, *supra* note 394, s 6.
- 451 EMALB, “Emergency Medical Assistants”, *supra* note 449; See generally *Emergency Medical Assistants Regulation*, BC Reg 210/2010 [EMA Regulation]; *Emergency Medical Assistants Licensing Board Regulation*, BC Reg 145/2013 [EMALB Regulation]; *Emergency Health Services Regulation*, BC Reg 471/74 [EHS Regulation].
- 452 *EHSA*, *supra* note 394, ss 6 (2), 6 (5) (a).
- 453 *Ibid.*, s 6 (5) (b)-(c).
- 454 *Ibid.*, s 6 (7).
- 455 *Ibid.*, s 12.
- 456 *EMA Regulation*, *supra* note 451, s 2.
- 457 *EHS Regulation*, *supra* note 451, s 5.
- 458 See “Licence Applications”(last visited 16 June 2022), online: *Emergency Medical*

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462 *EMA Regulation*, *supra* note 451, s 8.

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- 504 *Ibid*, s 7.13.
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- 508 HPA, *supra* note 195, Part 3.
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- 510 HPA, *supra* note 195, s 32 (1).
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- 521 “See Become an Early Childhood Educator (ECE)” (last visited 14 June 2022, online: *British Columbia* <www2.gov.bc.ca/gov/content/education-training/early-learning/teach/training-and-professional-development/become-an-early-childhood-educator> [BC, “Become an ECE”].
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- 523 ChildCareBC, “Different Types, *supra* note 519.
- 524 See “New child care legislation will build stronger B.C. for families” (29 October 2021), online: *Children and Family Development* <news.gov.bc.ca/releases/2021CFD0070002070#:~:text=The%20Early%20Learning%20and%20Child%20Care%20Act%20confirms%20government's%20ongoing,improve%20oversight%20and%20help%20the> [MCFD].
- 525 *Ibid*.
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teach/training-and-professional-development/become-an-early-childhood-educator/ece-profession>; See also “BC Child Care Sector Occupational Competencies” (last visited 14 June 2022), online (pdf): *British Columbia* <www2.gov.bc.ca/assets/gov/education/early-learning/teach/ece/bc_occupational_competencies.pdf>; See also Childcare BC, *Investing in our Early Childhood Educators: Early Care and Learning Recruitment and Retention Strategy* (ChildCareBC, 4 September 2018) at 13, online (pdf): <www2.gov.bc.ca/assets/gov/family-and-social-supports/childcare/6337_earlycareandlearningrecruitment_andretentionstrategy_report_web.pdf> [ChildCareBC, *Recruitment Strategy*].

541 ChildcareBC, *Recruitment Strategy*, *supra* note 540 at 13.

542 See *British Columbia Early Learning Framework* (4 September 2018) at 6, online (pdf): <www2.gov.bc.ca/assets/gov/education/early-learning/teach/earlylearning/early_learning_framework.pdf>.

543 *Ibid* at 39.

544 MCFD, *supra* note 524.

545 See “Make a Complaint” (last modified 4 February 2022) , online: *British Columbia* <[//www2.gov.bc.ca/gov/content/education-training/early-learning/teach/training-and-professional-development/become-an-early-childhood-educator/complaints](http://www2.gov.bc.ca/gov/content/education-training/early-learning/teach/training-and-professional-development/become-an-early-childhood-educator/complaints)> [BC, “Make a Complaint”].

546 *CCL Regulation*, *supra* note 522, s 33 (5).

547 See “Investigation process” (last modified 4 February 2022) , online: *British Columbia* <[//www2.gov.bc.ca/gov/content/education-training/early-learning/teach/training-and-professional-development/become-an-early-childhood-educator/investigations](http://www2.gov.bc.ca/gov/content/education-training/early-learning/teach/training-and-professional-development/become-an-early-childhood-educator/investigations)> [BC, “Investigation Process”].

548 *Ibid*.

549 *Ibid*.

550 *CCL Regulation*, *supra* note 522, s 33 (5).

551 BC, “Investigation Process”, *supra* note 547.

552 BC, “Make a Complaint”, *supra* note 545.

553 MCFD, *supra* note 524.

554 Cayton Report, *supra* note 377.

555 Office of the Ombudsman of British Columbia, *Acting in the Public Interest? Self-Governance in the Health Professions: The Ombudsman’s Perspective*, Special Report 24 (Victoria: Office of the Ombudsman, 2003) [Ombudsperson Public Interest Report].

556 Cayton Report, *supra* note 377 at 8.

557 *Ibid* at 47–55.

558 *Ibid* at 8, 10–12, 17, 20–21.

559 *Ibid* at 57–59.

560 *Ibid* at 74.

561 *Ibid*, at Appendix 2

562 *Ibid* at 23–24.

563 *Ibid* at 85–86.

564 *Ibid* at 73.

565 *Ibid* at 85–86.

566 *Ibid* at 86–87.

567 *Ibid* at 87–88.

568 *Ibid* at 88.

569 *Ibid* at 89.

570 Steering Committee on Modernization of Health Professional Regulation, *Recommendations to modernize the provincial health profession regulatory framework* (Victoria: British Columbia, August 2020) at 3 [Steering Committee Report].

571 *Ibid* at 5.

- 572 *Ibid* at 6.
- 573 *Ibid*.
- 574 *Regulating Health Professions What We Heard: Engagement Summary Report* (Victoria: British Columbia, August 2020) [What We Heard Report].
- 575 Steering Committee Report, *supra* note 570.
- 576 See *supra* note 399. The Bill began first reading on October 19, 2022.
- 577 *Ibid* at 14–17; Cayton Report, *supra* note 379 at 82–84.
- 578 Steering Committee Report, *supra* note 570 at 6.
- 579 *Ibid* at 7–9.
- 580 *Ibid* at 9–14.
- 581 *Ibid* at 14–18.
- 582 *Ibid* at 18–24.
- 583 *Ibid* at 24.
- 584 *Ibid* at 14–18.
- 585 *Ibid* at 9–14, 16–17.
- 586 See Keira Anne Grant, *The Design and Content of Personal Support Worker Training Programs* (Master of Science Thesis, *University of Toronto*, 2016) [unpublished] at 5.
- 587 Kelly & Bourgeault, *supra* note 48 at 22–23.
- 588 See Katerina Kalenteridis, “Caring About Home Care: A Framework for Improvement in Ontario” (November 2017) at 26, online (pdf): *University of Toronto* <[tspace.library.utoronto.ca/bitstream/1807/82732/1/Kalenteridis_2017_Caring%20About%20Home%20Care](https://space.library.utoronto.ca/bitstream/1807/82732/1/Kalenteridis_2017_Caring%20About%20Home%20Care)>.
- 589 See “Ontario Launching First Phase of the Personal Support Worker Registry” (22 February 2018), online: *Ontario Ministry of Health and Long-term Care* <health.gov.on.ca/en/news/bulletin/2018/hb_20180222.aspx>.
- 590 See Pamela Hopwood & Ellen MacEachen, “Policy and Practice Note: Policy, Safety, and Regulation with Regard to Ontario Home Care Clients and Personal Support Workers” (2021) *Can J on Aging* 1 at 4.
- 591 See Ontario, *Personal Support Worker Standard* (Ministry of Colleges and Universities, January 2022).
- 592 *Ibid* at 7.
- 593 Brookman et al, *supra* note 47 at 3.
- 594 *Ibid*.
- 595 *Ibid*.
- 596 See *supra* note 269. The Bill began first reading on October 19, 2022.
- 597 *Ibid* at 12.
- 598 *Ibid* at 10.
- 599 Grant, *supra* note 586 at 11.
- 600 Hopwood & MacEachen, *supra* note 590 at 4.
- 601 *Ibid* at 4.
- 602 Brookman et al, *supra* note 47 at 4.
- 603 See e.g. “How to become a PSW in Ontario” (last modified 22 April 2022), online: *Cestar College* www.cestarcollege.com/blog/how-to-become-a-psw-in-ontario; “NACC Curriculum: Personal Support Worker” (last visited 7 July 2022), online: *National Association of Career Colleges* <nacc.ca/curriculum/personal-support-worker/>.
- 604 See National Association of Career Colleges “NACC Graduation Certificate Verification” (last visited 7 July 2022), online: *National Association of Career Colleges* <nacc.ca/resources/nacc-graduate-certificate-verification/>.
- 605 See *Health and Supportive Care Providers Oversight Authority Act*, 2021, SO 2021, c 27, Sched 2 [HSCPOAA].
- 606 *Ibid*, s 12 (b)–(f).
- 607 *Ibid*.

608 See “Health and Supportive Care Providers Oversight Authority”(last visited 7 July 2022), online: *Government of Ontario Public Appointments Secretariat* <www.pas.gov.on.ca/Home/Agency/673> .

609 See Bill 283, *Advancing Oversight and Planning in Ontario’s Health System Act*, 1st Sess, 42nd Leg, Ontario, 2021 (assented to 3 June 2021), SO 2021, c 24.

610 *HSCPOAA*, *supra* note 605 at s 30 (the criteria are not yet specified).

611 *Ibid* at s 33, s 34 (1).

612 *Ibid* at s 35 (1). The name of the person who was alleged to have been sexually abused cannot be included in the report except with that person’s written consent: s 35 (6).

613 *Ibid* at s 38 (1).

614 *Ibid* at s 43 (2) (a).

615 *Ibid* at s 39 (1) (a) (b).

616 *Ibid* at s 40

617 *Ibid* at s 44

618 *Ibid* at s 45 (1)

619 *Ibid* at s 55

620 *Ibid* at s 56 (1)

621 *Ibid* at s 32

622 See “Health Care Aide Program” (last visited 7 July 2022), online: *Alberta* <www.alberta.ca/health-care-aide-program.aspx> [Alberta, “HCA Program”].

623 *Ibid*.

624 *Ibid*.

625 *Ibid*.

626 *Ibid*.

627 *Ibid*.

628 See “Alberta Health Care Aide Competency Profile: Health Workforce Planning and Accountability” (April 2018) at 3, online (pdf): *Alberta Health* <open.alberta.ca/dataset/e1fbd562-1571-40b8-bc17-71687dab444c/resource/9e34d246-c389-4753-bda4-f53a77e02f80/download/ah-hca-core-competency-profile-2018.pdf> [Alberta Health, “Competency Profile”].

629 *Ibid*.

630 *Ibid*.

631 Chamberlain et al, *supra* note 17 at 35 (93.9% and 86.7% respectively)

632 *Ibid*.

633 See “Core Competencies” (last visited 7 July 2022), online: *Alberta Health Care Aide Directory* <www.albertahcadirectory.com/for-employers/core-competencies/>.

634 Alberta Health, “Competency Profile”, *supra* note 628 at 3.

635 See *Health Professions Act*, RSA 2000, c H-7.

636 See “Regulated health professions and colleges” (last visited 7 July 2022), online: *Alberta* <www.alberta.ca/regulated-health-professions.aspx> [Alberta, “Regulated Health”].

637 *Ibid*.

638 *Ibid*.

639 Alberta Health, “Competency Profile”, *supra* note 628 at 3.

640 See “Alberta moves to regulate health care aides: CLPNA to be regulator” (5 November 2020), online: *College of Licensed Professional Nurses of Alberta* <www.clpna.com/2020/11/alberta-moves-to-regulate-health-care-aides-clpna-to-be-regulator/>.

641 Alberta, “Regulated Health”, *supra* note 636 (the regulation on the government website was only current to February 2020, and thus appears to be awaiting update).

642 *Ibid*.

643 *Ibid*.

644 *Ibid*.

- 645 Dill, *supra* note 58 at 5.
- 646 Estabrooks et al, "Who is Looking", *supra* note 17 at 49.
- 647 See "CCA Registry Information" (last visited 15 June 2022), online: *Nova Scotia Continuing Care Assistant Registry* <www.novascotiacca.ca/cca-registry-information/#:~:text=New%20legislation%2C%20the%20Continuing%20Care,part%2Dtime%2C%20or%20casual> [CCA Registry, "CCA Registry Information"]; See also *Continuing Care Assistants Registry Act*, SNS 2021, c 4 [CCARA]; *Continuing Care Assistants Registry Regulations*, NS Reg 15/2022 [CCAR Regulations].
- 648 See "CCA Career" (last visited 15 June 2022), online: *Nova Scotia Continuing Care Assistant Registry* <www.novascotiacca.ca/careers/education-options/recognized-program/> [CCA Registry, "CCA Career"].
- 649 See "Governance Structure" (last visited 15 June 2022), online: *Nova Scotia Continuing Care Assistant Registry* <www.novascotiacca.ca/about-us/governance-structure/>.
- 650 CCA Registry, "CCA Career", *supra* note 648.
- 651 See e.g. "Continuing Care Assistant Progressive Education Plan" (last visited 15 June 2022), online: *CBBC Career College* <www.cbccareercollege.ca/programs/healthcare/continuing-care-assistant-progressive-education-plan/>.
- 652 See Nova Scotia Department of Health and Wellness, *Continuing Care Assistant Scope of Practice and Competency Framework* (Halifax: DHW, May 2019) at 11, online (pdf): <novascotia.ca/dhw/ccs/documents/Scope_of_Practice_CCA.pdf>.
- 653 *Ibid* at 13.
- 654 *Ibid* at 14.
- 655 "Becoming a certified CCA" (last visited 15 June 2022), online: *Nova Scotia Continuing Care Assistant Registry* <www.novascotiacca.ca/careers/becoming-a-certified-cca/> [CCA Registry, "Becoming CCA"].
- 656 "Continuing Care Assistant: Exam Certification Handbook" at 4, online (pdf): *Nova Scotia Continuing Care Assistant Registry* <2o51wue20ve158d5y15v9uun-wpengine.netdna-ssl.com/wp-content/uploads/2021/11/Certification-Exam-Handbook-November-2021.pdf>.
- 657 *Ibid*.
- 658 *Ibid* at 15.
- 659 "Recognition of Prior Learning Program" (last visited 15 June 2022), online: *Nova Scotia Continuing Care Assistant Registry* <www.novascotiacca.ca/careers/education-options/recognize-prior-learning/>.
- 660 *Ibid*.
- 661 CCA Registry, "Becoming CCA", *supra* note 655.
- 662 Department of Seniors and Long-Term Care, *Educational Requirements for Entry to Practice of Non-Licensed Care Staff* (policy) (Nova Scotia: Seniors and LTC, 9 November 2021) [NS Seniors & LTC].
- 663 *Ibid*.
- 664 *Ibid* at 5.2.1.
- 665 *Ibid* at 5.2.2.
- 666 CCARA, *supra* note 647, s 8.
- 667 *Ibid*, s 11.
- 668 See "Rising to the Challenge: Responding to Increasing Demands in Home Care" (June 2014) at 24, online (pdf): *Health Association Nova Scotia* <<file:///C:/Users/Owner/Downloads/6%20Home%20Support%20-%20Responding%20to%20increased%20demands%20-%20%20FINAL%20July%207%202014.pdf>>.
- 669 *Ibid*; See also Katherine Fierlbeck, *Nova Scotia: a health system profile* (Toronto: University of Toronto Press, 2018) at 113.
- 670 See "Frequently Asked Questions: CCA Registry" (last visited 15 June 2022 online), online: *Nova Scotia Continuing Care Assistant Registry* <www.novascotiacca.ca/cca-registry-

information/cca-registry-faq/> [CCA Registry, “Frequently Asked Questions”].

671 See Sara Torres, Simone Parniak & Christine Kelly, *Community Health Workers and Personal Support Workers*, ed by Ivy Bourgeault (Ottawa: Canadian Health Workforce Network, 2021) (loose-leaf updated 2021) at 9.

672 CCA Registry, “CCA Registry Information”, *supra* note 647; CCAR Regulations, *supra* note 647, s 6.

673 CCA Registry, “CCA Registry Information”, *supra* note 647.

674 CCAR Regulations, *supra* note 647, s 3 (1).

675 CCARA, *supra* note 647, s 10 (1).

676 *Ibid*, s 13 (1) (g); CCA Registry, “Frequently Asked Questions”, *supra* note 670; NS Seniors & LTC, *supra* note 662 at 3.

677 Chamberlain et al, *supra* note 17 at 37.

678 See “Canadian Educational Standards for Personal Care Providers Environmental Scan” (June 2012), online (pdf): *Colleges and Institutes Canada* <www.collegesinstitutes.ca/wp-content/uploads/2014/05/Canadian-Standards-Environmental-Scan.pdf>.

679 *Ibid* at 11.

680 *Ibid* at 25 (Manitoba’s programs were on average 25 weeks, requiring 700 hours of instruction. Conversely, the national average was 28 weeks, requiring 755 hours of instruction).

681 See e.g. “Manitoba institute of Trades & Technology” (last visited 7 July 2022), online: MITT <mitt.ca/>; “RB Russell Vocational Highschool” (last visited 7 July 2022), online: *Winnipeg School Division* <www.winnipegssd.ca/rbrussell>; “Academy of Learning Career College” (last visited 7 July 2022), online: AOLCC <www.academyoflearning.com/>.

682 See “New Provincial Training Program to Address Workforce Challenges at Personal Care Homes” (19 November 2020), online: *Manitoba* <news.gov.mb.ca/news/index.html?item=49866>.

683 See “Promoting Mobility and Recognition: National Educational Standards for Personal Care Providers” (June 2012) online (pdf): *Colleges and Institutes Canada* <www.collegesinstitutes.ca/wp-content/uploads/2014/05/Reference-Guide_Canadian-Educational-Standards-for-Personal-Care-Providers_ACCC.pdf>.

684 *Ibid* at 2.

685 Novek, *supra* note 65 at 410.

686 See e.g. “Health Care Aide” (4 February 2021), online: *RB Russell Vocational Highschool* <www.winnipegssd.ca/rbrussell/page/4167/health-care-aide>.

687 Chamberlain et al, *supra* note 17 at 41.

688 See generally *The Testing of Bodily Fluids and Disclosure Act*, CCSM c T55; *Testing of Bodily Fluids and Disclosure Regulation*, Man Reg 151/2009.

689 Novek, *supra* note 65 at 79.

690 *Ibid* at 81.

691 *Ibid* at 30.

692 *Ibid* at 35.

693 *Ibid* at 83.

694 See “Adult Abuse Registry” (last visited 7 July 2022), online: *Manitoba* <www.gov.mb.ca/fs/adult_abuse_registry.html> [MB, “Adult Abuse Registry”].

695 See generally *The Adult Abuse Registry Act*, SM 2011, c. 26, s 21(1) [AARA].

696 *Ibid*, s 1; MB, “Adult Abuse Registry”, *supra* note 694.

697 See *The Vulnerable Persons Living with a Mental Disability Act*, SM 1993, c 29, s 1(1) [VPA].

698 See “Adult Abuse Registry Questions and Answers” (last visited 7 July 2022), online: *Manitoba* <www.gov.mb.ca/fs/pwd/adult_abuse_registry_faq.html> [MB, “Questions and Answers”]; See *The Protection for Persons in Care Act*, CCSM c P144, s1 (1) [PPCA].

699 These private services providers are licensed through the Residential Care Facilities

Licensing Regulation or Family Services (see generally MB, “Questions and Answers”, *supra* note 698).

700 AARA, *supra* note 695, s 34, 35, 36 (1).

701 *Ibid*, s 34.

702 *Ibid*, s 35–37.

703 *Ibid*, s 12, 21(1).

704 *Ibid*, s 1 (this includes the Executive Director under the VPA).

705 PPCA, *supra* note 698, s 8.2(1); VPA, *supra* note 697, s 25.3(1).

706 See *Protection for Persons in Care (Adult Abuse Registry) Regulation*, Man Reg a 21/2013, s 3; *Vulnerable Persons Living with a Mental Disability Regulation*, Man Reg 208/96, s 1.1.

707 AARA, *supra* note 695, s 21(1).

708 *Ibid*, s 21(1.1) (a)(d), 26, 27.

709 *Ibid*, s 21(1.1) (b)(c).

710 *Ibid*, s 41(1).

711 *Ibid*, s 42.

712 *Ibid*, s 41(2).

713 *Ibid*, 41(4).

714 *Ibid*, s 41(1).

715 *Ibid*; MB, “Questions and Answers”, *supra* note 698.

716 See Department of Families, *Annual Report 2020-2021* (Winnipeg: Families, 2021) at 130.

717 See Bill 213, The Seniors’ Rights and Elder Abuse Protection Act, 4th Sess, 40th Leg, Manitoba, 2015, Explanatory Note (first reading 9 June 2015).

718 “Elder Abuse and Neglect in Manitoba Consultation Paper” (June 2021) at 26, online (pdf): *Manitoba Law Reform Commission* < www.manitobalawreform.ca/pubs/pdf/elder_abuse_consultation.pdf >.

719 MB, “Questions and Answers”, *supra* note 698.

720 *Ibid*.

721 See generally Community Living disABILITY Services, “Service Definitions and Funding Models” (last visited 7 July 2022), online: *Manitoba* < www.gov.mb.ca/fs/clds/service-definitions.html > (the service definitions for private services indicate they do not require AAR checks for new hires but agency support services do).

722 See *National Minimum Standards and Core Curriculum for Immunisation Training of Healthcare Support Workers* (London: PHE, 2015) at 3; Camilla Cavendish, “The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings” (July 2013) at 13, online (pdf): *National Health Service* < www.gov.uk/government/publications/review-of-healthcare-assistants-and-support-workers-in-nhs-and-social-care > [Cavendish Review].

723 Cavendish Review, *supra* note 722 at 13; See also Dr Lydia Hayes, Dr Eleanor Johnson & Alison Tarrant, “Professionalisation at work in adult social care” (Report to the All-Party Parliamentary Group on Adult Social Care, July 2019) [unpublished] at 1.

724 Felicity Hasson et al, “Protocol for a mixed methods exploratory investigation into the role and contribution of the healthcare assistant in out-of-hours palliative care” (2021) 20:55 BMC Nursing at 2; See also “GP mythbuster 57: Health Care Assistants in General Practice” (last modified 24 May 2022) online: *Care Quality Commission* < www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-57-health-care-assistants-general-practice >.

725 “About us” (last visited 7 July 2022), online: *Care Quality Commission* < www.cqc.org.uk/about-us >.

726 “Register as a new provider” (last visited 7 July 2022), online: *Care Quality Commission* < www.cqc.org.uk/guidance-providers/registration/register-new-provider >.

727 See Kavanagh et al, “Improving health care for disabled people in COVID-19 and beyond: Lessons from Australia and England” (2021) 14:2 Disability and Health J at 3.

- 728 See *Health and Social Care Act 2008* (UK); “Regulation 18: Staffing” (last modified 26 November 2021), online: *Care Quality Commission* <www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-18-staffing#guidance> [CCQ, “Regulation 18”]; “Regulation 19: Fit and proper persons employed” (last modified 26 November 2021), online: *Care Quality Commission* <www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-19-fit-proper-persons-employed> [CCQ, “Regulation 19”].
- 729 See “Assistant practitioner” (last visited 7 July 2022), online: *National Health Service* <www.healthcareers.nhs.uk/explore-roles/wider-healthcare-team/roles-wider-healthcare-team/clinical-support-staff/assistant-practitioner> [NHS, “Assistant practitioner”]; “Membership for Nursing Support Workers” (last visited 7 July 2022), online: *Royal College of Nursing* <www.rcn.org.uk/membership/nursing-support-worker-join>.
- 730 See “Accountability and delegation” (last visited 7 July 2022), online: *Royal College of Nursing* <www.rcn.org.uk/professional-development/accountability-and-delegation>.
- 731 *Ibid* (unless it is a register held by the Scottish Social Services Council or the Northern Ireland Social Care Council); NHS, “Assistant practitioner”, *supra* note 729.
- 732 See “What qualification levels mean” (last visited 7 July 2022), online: *United Kingdom* www.gov.uk/what-different-qualification-levels-mean/list-of-qualification-levels [UK, “qualification levels”].
- 733 See generally “Healthcare assistant” (last visited 7 July 2022) online: *National Health Service* <www.healthcareers.nhs.uk/explore-roles/healthcare-support-worker/roles-healthcare-support-worker/healthcare-assistant>; “Healthcare support worker” (last visited 7 July 2022) online: *National Health Service* <www.healthcareers.nhs.uk/explore-roles/healthcare-support-worker/roles-healthcare-support-worker/healthcare-support-worker>.
- 734 Sarah Jane Palmer, “Career progression from HCA to nurse: bridging the gap” (2020) 14:7 *British J Healthcare Assistants* at 351.
- 735 Hayes, Johnson & Tarrant, *supra* note 723 at 22.
- 736 Cavendish Review, *supra* note 722 at 5; See also “Care certificate” (last visited 7 July 2022), online: *Health Education England* <www.hee.nhs.uk/our-work/care-certificate>.
- 737 See “The Care Certificate” (last visited 7 July 2022), online: *eLearning for Healthcare* <www.e-lfh.org.uk/programmes/care-certificate/>; Health Education England, *supra* note 736.
- 738 CCQ, “Regulation 18”, *supra* note 728, 18(2)(a); CCQ, “Regulation 19”, *supra* note 728, 19 (1), 19 (2).
- 739 Hayes, Johnson & Tarrant, *supra* note 723 at 21 and Enforcement Policy” (2015) at 12, online (pdf): *Care Quality Commission* <www.cqc.org.uk/sites/default/files/20150209_enforcement_policy_V1-1.pdf>. See also “Care Certificate Health and Social Care Professionals Questions and Answers” (2020) at 3, online (pdf): *Health Education England* <www.skillsforhealth.org.uk/wp-content/uploads/2020/11/Care-Certificate-FAQ-for-Health-and-Adult-Social-Care-Nov-20.pdf>.
- 740 See Elaine Argyle et al, “Introducing the Care Certificate Evaluation: Innovative practice” (2020) 19:2 *Dementia* 513 at 515.
- 741 See NHS, “Assistant practitioner”, *supra* note 729.
- 742 See Ian Kessler & Vandana Nath, “Re-evaluating the assistant practitioner role in NHS England: Survey Findings” (2019) 27:3 *J Nurs Manag* 625 at 631.
- 743 See “About the National Scheme” (last modified 21 January 2022), online: *Ahpra & National Boards* <www.ahpra.gov.au/about-ahpra/what-we-do/faq.aspx>. See also Belinda Bennett et al, “Australia’s National Registration and Accreditation Scheme for Health Practitioners: A National Approach to Polycentric Regulation” (2018) 40:2 *Sydney L Rev* 159 at 160.
- 744 *Ibid*.
- 745 See “Legislation” (last modified 15 May 2022), online: *Ahpra & National Boards* <www.ahpra.gov.au/about-ahpra/what-we-do/faq.aspx>.

ahpra.gov.au/About-Ahpra/What-We-Do/Legislation.aspx>; *Health Practitioner Regulation National Law Act 2009* (Qld), 2009/45; See generally *Health Practitioner Regulation National Law* (NSW) 2009/86a; *Health Practitioner Regulation National Law* (Victoria) Act 2009 (Vic) 2009/79; *Health Practitioner Regulation (National Uniform Legislation) Act 2010* (NT) 2010/2; *Health Practitioner Regulation National Law (Tasmania) Act 2010* (Tas) 2010/2; *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA) 2010/5; *Health Practitioner Regulation National Law (WA) Act 2010* (WA) 2010/35.

746 Council of Australian Governments Health Council, *A National Code of Conduct for health care workers: Final Report* (17 April 2015) [COAG, *National Code of Conduct*].

747 *Ibid* at 16; See also Fiona Bogossian & Dana Craven, “A review of the requirements for interprofessional education and interprofessional collaboration in accreditation and practice standards for health professionals in Australia” (2021) 35:5 *J Interprof Care* 691 at 692.

748 COAG, *National Code of Conduct*, *supra* note 746 at 15 and 16.

749 *Ibid* (see page 32 for start of discussion on code provisions).

750 See e.g. “The National Code of Conduct for Health Care Workers (Queensland)” (last modified 13 June 2022), online: *Queensland Health* <www.health.qld.gov.au/system-governance/policies-standards/national-code-of-conduct> [Queensland Health, “National Code of Conduct”].

751 See Rebekah Winter, “Regulation of unregistered birth workers in Australia: Homebirth and public safety” (2018) 31:2 *Women Birth* 134 at 135.

752 *Ibid* at 140.

753 COAG, *National Code of Conduct*, *supra* note 746 at 8.

754 *Ibid* at 12

755 See Australian College of Nursing, “Regulation of the Unregulated Health Care Workforce across the Health Care System – A White Paper by ACN 2019” at 9, online (pdf): ACN <www.acn.edu.au/wp-content/uploads/white-paper-regulation-unregulated-health-care-workforce-across-health-care-system.pdf>.

756 Queensland Health, “National Code of Conduct”, *supra* note 750; See generally “Code of Conduct” (last modified 10 March 2022), online: *Health Care Complaints Commission* <www.hccc.nsw.gov.au/health-providers/unregistered-health-practitioners/code-of-conduct> ; “Code of Conduct” (last visited 27 June 2022), online: *South Australian Health and Community Services Complaints Commissioner* <www.hcsc.sa.gov.au/code-of-conduct-for-unregistered-health-practitioners/>.

757 See “Regulation of unregistered health professions” (last modified 23 November 2021), online: *Victoria Department of Health* <www.health.vic.gov.au/health-workforce-regulation/regulation-of-unregistered-health-professions#victorian-national-code-of-conduct>.

758 See “National Code of Conduct for Health Care Workers NT” (last visited 27 June 2022), online: *Northern Territory Government* <www.hcsc.nt.gov.au/home/national-code-of-conduct-for-health-care-workers-nt/>.

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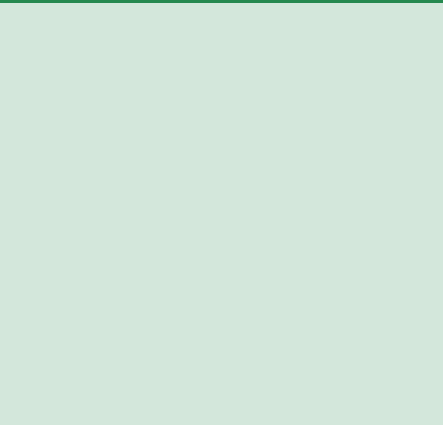
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