



# Framework for the Practice of Nursing

Quebec First Nations



**Developed by:**

Denise Paul, B. Sc.  
Nursing Consultant

## Aknowledgments

The FNQLHSSC wishes to thank Health Canada for their financial support in this project.

Finally, we wish to express our sincere gratitude towards the Ministère de la santé et des services sociaux - Direction générale de la planification stratégique, de l'évaluation et de la qualité, as well as l'Ordre des infirmières et infirmiers du Québec for their support in this project.

## TABLE OF CONTENTS

---

Introduction	5
Background	7
Geo-demographic elements	11
Classification of communities	12
Inter-professional committee	14
Contextual elements related to the practice of nursing in the Quebec First Nations communities	15
Particular situation of healthcare organizations	20
Collective prescriptions	20
Position of the Ordre des infirmières et infirmiers du Québec (OIIQ)	21
Recommendations	22
Recognition of advanced nursing practice	23
Conclusion	24
Implementation plan	25
Bibliography	34
Appendix A – Non-exhaustive list of health problems affecting the populations of the Quebec First Nations	37
Appendix B – Non-exhaustive list of emergency situations that can occur in the remote communities of the Quebec First Nations	39
Appendix C – Summary of the meeting with the OIIQ - February 9, 2007	41
Appendix D – OIIQ / Comments on the final report: Framework for the practice of nursing in the Quebec First Nations	43
Appendix E – MSSS / Comments on the final report: Framework for the practice of nursing in the Quebec First Nations	45





## INTRODUCTION

---

In May 2002, after a long and sustained process spanning a little more than six years, the First Nations of Quebec Nursing Directors Committee (FNQNDC) presented the Quebec First Nations Caucus with the conclusions of its reflections on the problems surrounding the framework for medical acts performed by nurses in the Quebec First Nations communities. At this meeting, the FNQNDC recommended the creation of a First Nations Autonomous Inter-Professional Health Committee (FNAIHC) under the direct responsibility of the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC).

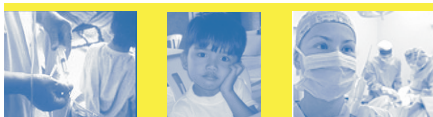
This recommendation was approved by way of Resolution 06-2003, which was sent to the First Nations and Inuit Health Branch (FNIHB). The FNIHB acknowledged in a letter dated April 26, 2006 that “(...) *the situation of nurses working in transferred communities is not in compliance with the laws and regulations in effect and the creation of an inter-professional committee could offer a solution to consider as a means for resolving this problem.*”

On several occasions, the FNQLHSSC indicated to Health Canada its desire for the two parties to establish an agreement for funding the creation of an inter-professional committee.

To address the situation as adequately as possible, the FNQLHSSC requested the work described in this document, which consisted in demonstrating the need to implement a structure and mechanisms that would ensure protection of First Nations members and legalize nursing in the First Nations communities in a manner that took into account the specific context of each community, i.e., whether it was remote, semi-remote or non-remote.

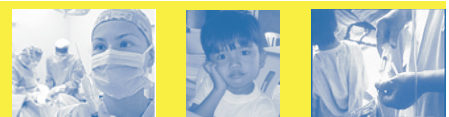
The first part of this document describes certain historical aspects surrounding this issue, followed by geo-demographic data and a brief description of the make-up of the inter-professional committee.

The second part gives a portrait of the context surrounding the practice of nursing in the First Nations communities, followed by the conclusion.



The third part presents an implementation plan giving the steps involved in creating a mechanism to guarantee a framework for the practice of nursing in the Quebec First Nations' health-care organizations with regard to medical acts coming under other health professionals' fields of practice.

It is important to note that this document is not intended as an in-depth scientific study of the practice of nursing in the Quebec First Nations communities. Instead, it serves to demonstrate the need for and feasibility in creating a structure which, through its mandate, should resolve in large part the problems related to nursing in the First Nations healthcare organizations in Quebec.



## BACKGROUND

---

In the mid-1980s, several First Nations communities in Quebec region indicated to Health Canada that they wished to sign transfer agreements giving them control of the management and delivery of health services for their members. At the time, it appeared that the issue concerning medical acts performed by nurses that went beyond their normal duties would not be included in the discussions on this matter, nor was it mentioned in any way in the transfer agreements signed by the First Nations' political organizations with Health Canada.

Although these transfer agreements gave the band councils full autonomy in the delivery of health services to the members of their communities, the nurses working for the band councils were required to comply with the legislation governing their profession in keeping with their obligation to be entered on the roll of the *Ordre des infirmières et infirmiers du Québec (OIIQ)*. Therefore, in accordance with their civil liability and their ethical duty, the nurses working for the Quebec First Nations must always have the skills recognized as being necessary for carrying out their professional duties. They must also agree to upgrade their skills in order to provide care and treatment based on generally-accepted nursing standards.

It has been known for several years that the nurses in Quebec's remote regions are daily called upon to perform certain professional actions that are not within their field of practice. The nurses in the First Nations communities are no exception here. Furthermore, the vast majority of such actions performed by these nurses, as employees of the band councils, are not approved by the *Conseils des médecins, dentistes et pharmaciens (CMDP- advisory boards of physicians, dentists and pharmacists)* under collective prescriptions in accordance with section 39.3 of the *Professional Code*, which defines 'prescription' as follows:

*“the word ‘prescription’ means a direction given to a professional by a physician, a dentist or another professional authorized by law, specifying the medications, treatments, examinations or other forms of care to be provided to a person or a*



*group of persons, the circumstances in which they may be provided and the possible contraindications. A prescription may be individual or collective.”<sup>1</sup>*

The previous decade saw numerous actions, discussions, debates, consultations and searches for solutions to rectify this situation.

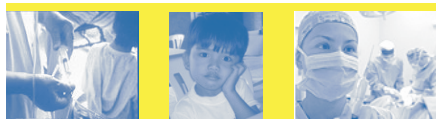
- 1996: Creation of the First Nations of Quebec Nursing Directors Committee (FNQNDC). Since the inception of this committee, the issue of delegated medical acts has been a constant concern of the committee's members. Today, the committee is made up of the nursing directors for 17 healthcare organizations in the Quebec First Nations. It has undertaken many actions and established several collaborations, in particular with the FNQLHSSC and the Ordre des infirmières et infirmiers du Québec (OIIQ), concerning the practice of nursing in the communities of the Quebec First Nations.
- 2001: Presentation of a brief by the OIIQ to the Groupe de travail ministériel sur les professions de la santé et des relations humaines (departmental working group on health and helping professions). This brief proposed modifying the *Nurses Act* in order to legalize the practice of nurses in remote regions.
- 2002: The *Act to amend the Professional Code and other legislative provisions as regards to the health sector* was sanctioned and adopted by the National Assembly (S.Q. 2002, c 33). The coming into effect of this Act entailed the redefinition of the fields of practice for 11 professional orders, including the Ordre des infirmières et infirmiers du Québec and the Collège des médecins du Québec. One of the modifications brought about by the Act involved replacing the notion of permanent prescription by the notion of collective prescription.

---

<sup>1</sup> *Professional Code: Act to amend the Professional Code and other legislative provisions as regards to the health sector*, S.Q.2002, c. 33, sect. 39.3



- 2002: Creation by the OIIQ of the consultative committee on recognition of the specificity of the practice of nursing in remote regions, particularly those in which First Nations are located. The brief produced on the basis of this committee's work included recommendations, some of which are presented below.
- 2002: Presentation by the FNQNDQ at a meeting of the Quebec First Nations Caucus of the results of its reflections about the problems surrounding the practice of nursing in the Quebec First Nations communities.
- 2003: At the annual meeting of the First Nations Caucus, a resolution was adopted and presented to the First Nations and Inuit Health Branch (FNIHB). This resolution recommended the creation of a First Nations Autonomous Inter-Professional Health Committee (FNAIHC), which would have the following mandate:
- Identify the medical acts performed by nurses working for the First Nations.
  - Develop clinical protocols and directives concerning these medical acts.
  - Develop mechanisms for evaluating the application of these protocols and directives.
  - Continue the work being carried out with the involved corporations.
  - Ensure training of nurses who are required to apply collective prescriptions.
- 2005: The FNIHB, through its nursing manager, Chantale Renaud, acknowledged the creation of the FNAIHC as one of the means to be considered for resolving the problems related to the practice of nursing in the First Nations communities. Ms. Renaud sent the FNQLHSSC a letter on April 26, 2005 to that effect.
- 2006: The Report on the First Nations Socio-Economic Forum, which was held in Mashteuiatsh, highlighted the fact that nurses working for the First Nations are regularly required to perform acts that go beyond the legal framework of their professional practice. The need to provide a framework for certain act that



nurses in the First Nations communities performed outside their field of practice was stressed at the Forum.

The report's synthesis of the discussions concerning health reads in part:

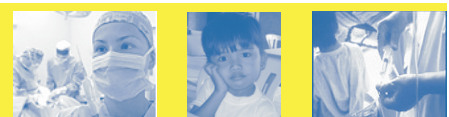
*“Nurses play a key role in the healthcare systems of the communities, the remote ones in particular. This role therefore requires a well-defined legislative framework that will allow these nurses to provide certain forms of treatment in compliance with the legislation, the main purpose of which is to ensure protection of the health system's users.”<sup>2</sup>*

OIIQ president Ghyslaine Desrosiers also attended the Forum and offered her organization's collaboration *“to ensure that progress could be made in this issue.”*

2006: In December 2006, the FNQLHSSC assigned the mandate to develop a work plan for implementing an appropriate mechanism that would ensure the legality of nursing in the First Nations communities.

---

<sup>2</sup> Report on the First Nations Socio-Economic Forum, Mashteuiatsh, October 25-27, 2006



## GEO-DEMOGRAPHIC ELEMENTS

In 2005, the First Nations and Inuit population in Quebec stood at 66,500, with 70% of members living in the communities. The First Nations and Inuit account for approximately 1% of Quebec's total population. The demographic distribution of their members differs sharply from that of the Quebec population overall. Quebec's non-Aboriginal population is aging, but the situation is entirely different for the First Nations and Inuit, whose younger members account for a very high percentage of their populations. Table 1 shows that in 2005, the average age of the First Nations and Inuit population was approximately 29 for men and approximately 30 for women, giving an average of 29.4 for both sexes combined.

**Table 1**

### Demographic distribution of the Quebec First Nations population

Age group	Male	Female	Total	%
0-4	2006	1808	3814	7.9 %
5-9	2427	2364	4791	9.9 %
10-14	2716	2559	5275	10.9 %
15-19	2303	2222	4525	9.4 %
20-24	2009	1933	3942	8.2 %
25-29	1799	1724	3523	7.3 %
30-34	1893	1824	3717	7.7 %
35-39	1793	1767	3560	7.4 %
40-44	1715	1683	3398	7.0 %
45-49	1390	1537	2927	6.1 %
50-54	1084	1124	2208	4.6 %
55-59	849	928	1777	3.7 %
60-64	653	764	1417	2.9 %
65+	1429	1929	3358	7.0 %
<b>Total</b>	<b>26 058</b>	<b>28 529</b>	<b>54 587</b>	<b>100 %</b>

Indian and Northern Affairs Canada, Registered Indian Population (On-Reserve) by Sex and Residence, Ottawa 2005



The above statistics show that the First Nations and Inuit population is very young; 69% of their members are younger than 40. The under-20 age groups account for 38.1% of the total population, while the 65 and older group accounts for just 7%.

The work described in this document potentially covers the Quebec communities that are **not under agreement**<sup>3</sup>, as follows:

- Wolinak and Odanak, located on the south shore of the St. Lawrence River
- Pikogan, Kitcisakik, Lac Simon, Kitigan Zibi, Témiscaming, Eagle Village, Wolf Lake, Winneway and Barrière Lake, whose traditional territories extend from Lac des Deux-Montagnes to Abitibi-Témiscamingue
- Wemotaci, Opitciwan and Manawan, with territories in the Centre-du-Quebec region (Lanaudière, Haute-Mauricie)
- Wendake, the Huron-Wendat community, located near Quebec City
- Essipit, Betsiamites, Mingan, Uashat Mak Mani Utenam, Unamen Shipu, Natashquan, Matimekush, Mashteuiatsh and Pakua Shipi, located on the North Shore, in the Lac Saint-Jean region and near Schefferville
- Akwesasne, Kahnawake and Kanesatake, located in the Montreal region
- Gespapegiag, and Listuguj, located on the Gaspé Peninsula

## CLASSIFICATION OF COMMUNITIES

---

The communities of the Quebec First Nations are located at varying distances from the services available through the Quebec health system. Depending on their location, they are classified as being remote, semi-remote or non-remote. The following table gives the populations of the communities and their respective classifications.

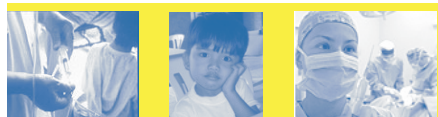
---

<sup>3</sup> *James Bay and Northern Quebec Agreement*



<b>Tableau 2</b>			
<b>Classification des communautés des Premières Nations et leur population (2005)</b>			
<b>Classification</b>	<b>Communautés</b>	<b>Population</b>	<b>Total population</b>
<b>Isolée</b>	Unamen Shipu / La Romaine	928	
	Natashquan	850	
	Matimekush	715	
	Pakua Shipi	277	
	Winneway / Long Point	352	
	Wemotaci	1190	
	Opitciwan	1903	
	Manawan	1915	
	Barrière Lake / Lac Rapide	497	
<b>Semi-isolée</b>	Kitcisakik	329	
	Mingan / Ekanitshit	499	
	Betsiamites	2673	
<b>Non isolée</b>	Wolinak	69	
	Odanak	299	
	Pikogan	546	
	Lac Simon	1207	
	Wendake	1276	
	Essipit	178	
	Uashat Mak Mani-Utenam	2766	
	Mashteuiatsh	2026	
	Kitigan Zibi	1491	
	Témiscaming / Notre dame Nord	544	
	Kipawa / Eagle Village	263	
	Wolf Lake	11	
	Listuguj	1908	
	Gesgapegiag	541	
	Akwesasne	4843	
	Kahnawake	7330	
Kanesatake	1347	<b>26 645</b>	

On-reserve population: Source: Secrétariat aux affaires autochtones du Québec, 2005



---

## INTER-PROFESSIONAL COMMITTEE

The First Nations Autonomous Inter-Professional Health Committee (FNAIHC) would be made up of nurses<sup>4</sup>, physicians, a pharmacist, a dentist and a FNQLHSSC representative. The committee would call on experts for advice as required.

Coming under the responsibility of the FNQLHSSC, the FNAIHC will have the mission to provide nurses working in the Quebec First Nations with the expertise and the legal framework necessary for their professional practice, in a continually evolving context. The responsibilities of the FNAIHC will be to:

- Identify activities which are reserved for other professionals (physicians, pharmacists and dentists in particular) but which nurses working for the First Nations carry out, the context in which they perform these activities, the category or categories of the target clientele(s), the associated professional responsibilities, and the tools necessary for ensuring compliance and quality in the performance of these activities.
- Develop the collective prescriptions, clinical protocols and directives associated with the application of these activities.
- Ensure the implementation of a training program for medical activities targeted by collective prescriptions.
- Approve and implement the collective prescriptions and various tools that are developed.
- Monitor the application of prescriptions, in accordance with the protocols, concerning activities and the use of the tools that are developed.
- Identify difficulties encountered in applying collective prescriptions and, where necessary, find solutions to those difficulties or make the appropriate adjustments.
- Develop and strengthen collaborations with partners in the health system and guide ac-

---

<sup>4</sup> Tout au long du texte, le féminin est employé seulement pour alléger le texte.



tions to guarantee the best healthcare services possible for First Nations members.

## CONTEXTUAL ELEMENTS RELATED TO THE PRACTICE OF NURSING IN THE QUEBEC FIRST NATIONS COMMUNITIES

*“Even though, all populations in principle have the right to the same level of health care, some categories of people do not benefit from that right as much as others do. The Romanow Report<sup>5</sup> notes that in Quebec, the people living in rural areas and remote regions are not as healthy as the people living in urban centres” (translation).<sup>6</sup>*

Healthcare equity is one of the key elements in any public healthcare system. The concept of equity can encompass several aspects, i.e., it refers to health itself, the use of healthcare services, and accessibility to these services. In relation to the concept of equity, any healthcare system must ensure that all persons are equal and thus treated equally. In the issue that concerns us, this concept is one of the main elements justifying the creation of a structure that will ensure the effective, efficient and equitable delivery of healthcare services to the First Nations in Quebec.

The members of the First Nations are affected by numerous health problems (physical, social or psychological in nature). The First Nations Regional Longitudinal Health Survey for Quebec Region, conducted by the FNQLHSSC in 2002, clearly illustrates the situation regarding diabetes, high blood pressure, heart disease, lung problems, cancers, traumas and injuries, and infections of all kinds, to name just some of the common health problems affecting the First Nations’ populations. To these physical problems we must add those with a social aspect, such as blood-borne and sexually transmitted infections, violence, neglect, sexual abuse, addictions and alcoholism, distress, and poor psychological well-being. In remote and semi-remote

<sup>5</sup> *Recognition of the Practice of Nursing in Remote Regions. Brief by the Consultative Committee on Recognition of the Specificity of the Practice of Nursing in Remote Regions, 2002, p. 7 (see bibliography entry no. 15).*

<sup>6</sup> *Ordre des infirmières et infirmiers du Québec, Recognition of the Practice of Nursing in Remote Regions, position statement by the Ordre des infirmières et infirmiers du Québec, Adopted by the OIIQ at its meeting of February 20, 2004, p. 5 (see bibliography entry no. 15).*



comes to carry out his or her own evaluation of the patient.

In an emergency situation, the nurse will provide medical care while waiting for the patient to be transferred by road or air to the nearest hospital. However, the at-times difficult weather conditions and the unavailability of the most appropriate means of transportation may force the nurse to continue giving the required care until the medical resources at the hospital where the patient is being transported actually take charge of the patient.

The work of nurses employed by First Nations in non-remote regions differs from the work of their colleagues in remote and semi-remote regions. Nevertheless, they are all required to provide services and to apply programs comparable to the ones offered by the CSSS network (CLSC mission) and they will inevitably have to perform certain medical acts. Examples here include screening at-risk clients, performing clinical follow-up on patients receiving treatment (includes adjustment of medications), following up on perinatal clients, initiating therapeutic measures such as treating wounds and administering emergency medication, providing primary health care related to contraception and BBSTI, and giving anti-coagulant treatment.

Under the homecare programs in the communities, all nurses employed by the First Nations must work with a variety of clientele, including elders who require assisted-living services, people in the post-operative phase, and people requiring palliative care.

Whatever region they are in, nurses in the communities of the Quebec First Nations are every day taking on responsibilities that exceed the legal framework for their nursing activities. Given the number of consultations that nurses provide each day, we can easily see that it would be impossible for them to refer all clients requiring medical consultation for common health problems. Furthermore, we must remember that the costs involved in medical transportation of patients represent a very high expense, for emergency and elective cases alike.

The work done by the nurses in the First Nations communities represents an enormous challenge. Often called upon to provide front-line services in a clinic-based environment and normally in the absence of a physician, they are the primary healthcare professional for the communities. Available 24 hours a day, seven days a week, they must regularly cope with certain organizational factors, including the absence of physicians, the non-recognition of their work in



legal terms, and the absence of standardized protocols by way of collective prescriptions.

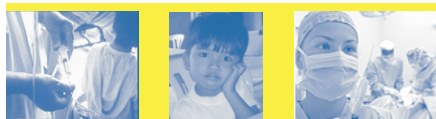
To do their work, these nurses must possess tremendous rigour, strong analytical skills, and excellent clinical judgement. Not only are they regularly subjected to stressful situations, they must also perform their duties without a legal framework for their practice. In addition, the training they receive is often insufficient and poorly adapted, and in far too many cases, they are not evaluated for the skills required to perform medical acts which do not come within their field of practice, but which they perform anyway.

According to statistics obtained by the consultative committee on recognition of the specificity of nursing in remote regions, the First Nations healthcare organizations experienced important difficulties in the past in their efforts to obtain approval for the delegation of medical acts under the regulation in effect at the time. These difficulties were due to the absence of medical resources, the hesitancy and even refusal to approve this delegation on the part of some physicians or physician councils, dentists and pharmacists working for establishments in the Quebec health system, and the turnover rate of physicians who visited the communities and who had varying perceptions of the skills of nurses working for the First Nations.

These nurses are concerned about the fact that they are doing their work in an illegal context. Further to the professional insecurity that it creates, this situation runs counter to the main principle of all health legislation, namely the obligation to ensure public protection.

In most First Nations healthcare organizations, the medical acts that nurses are called on to perform do not comply with the standards set out in Bill 90. In this regard, collaborations or agreements that are established with establishments in the provincial system often depend on the good will of certain doctors and establishment administrators. When such agreements concerning medical acts carried out by nurses exist, they are never the object of a collective prescription, nor are they supported by planned and structured training programs intended to give nurses the necessary skills involved. Furthermore, the skills and abilities associated with the application of these agreements are not evaluated. Finally, the head nurses or nursing directors who monitor the quality of medical acts do not have the tools necessary for assuming this responsibility.

Obviously, the range of medical acts carried out by nurses working for the First Nations varies,



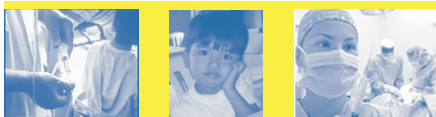
depending on whether the community is remote, semi-remote or non-remote. But in all cases, the First Nations healthcare organizations are required to ensure that these medical acts are performed in compliance with a legal framework to protect their members and the professionals who are working for them, and even to ensure protection of the political organizations that oversee the delivery of services.

To summarize, the main elements identified in the problems regarding the practice of nursing in the First Nations communities are as follows:

- As members of the OIIQ, the nurses working for the First Nations are required to comply with the *Nurses Act*.
- The First Nations communities are categorized as being in remote, semi-remote or non-remote regions.
- The band councils, as political entities with autonomous administrations, do not have the infrastructures allowing them to provide a legal framework covering the specificity of nursing with regard to medical acts.
- The nurses working for First Nations in remote and semi-remote regions are performing their duties in a context where other medical resources are often absent.
- The nurses working for First Nations in non-remote regions are called upon to deliver services and programs comparable to those offered by the Quebec CSSS network (CLSC mission) and are inevitably asked to perform the same medical acts that the CSSS network provides.
- The nurses working for the First Nations are called upon to perform medical acts that go beyond their field of practice.
- The medical acts performed by the nurses working for the First Nations are not supported by collective prescriptions.
- The reference tools currently being used by the First Nations' nurses are limited to clinical directives or treatment protocols which are often not standardized and are not legally recognized by way of collective prescriptions.
- The remote and semi-remote communities are experiencing genuine problems regarding health care accessibility.



Therefore, it is vital that we take concrete actions for ensuring that the practice of nurses in the Quebec First Nations communities is governed by a framework which meets all of the conditions set by legislation.



## PARTICULAR SITUATION OF HEALTHCARE ORGANIZATIONS

---

The brief on recognition of the specificity of nursing in remote regions stresses that nurses in several communities are seen as the professionals providing access to the health system.

Each First Nation community has a nursing station<sup>8</sup> or a health centre offering a wide range of healthcare services and programs, with components in promotion, prevention, screening, treatment and rehabilitation. The semi-remote and remote communities also have the obligation to give front-line care in a clinic-based environment, often without a doctor present or without clear protocols that are recognized and approved by the CMDP of an establishment in the Quebec system.

Lastly, we cannot leave aside the question of the special legal status of the healthcare organizations in the Quebec First Nations communities. They come under neither the jurisdiction of the federal government nor that of the provincial government. The First Nations healthcare services are administered in their entirety by the band councils and are considered under provincial legislation to be organizations, not establishments.

---

## COLLECTIVE PRESCRIPTIONS

In its brief concerning recognition of nursing in remote regions, the consultative committee described collective prescriptions as being a completely new legal instrument particularly necessary for allowing nurses to perform medical acts reserved for other professionals (physicians, pharmacists and dentists in particular).

Regarding this same issue, the Ordre des infirmières et infirmiers du Québec, in its guide con-

---

<sup>8</sup> Dispensaries



cerning application of the new *Nurses Act* and the *Act to amend the Professional Code and other legislative provisions as regards to the health sector*, describes a collective prescription as “a very flexible tool because it is not restricted to a list of medical acts. It is associated with reserved medical acts which, in themselves, have a much broader scope. It allows nurses to carry out diagnostic tests, administer and adjust medications, provide medical treatment to specific groups and initiate diagnostic and therapeutic measures, without having to wait for an individual prescription. The collective prescription is no longer limited to establishments in the healthcare system. The door has been opened for its use in other settings, e.g., by industries, family doctor clinics, dispensaries, and so on. The healthcare establishments will also set their own rules for developing and adopting collective prescriptions” (translation).<sup>9</sup>

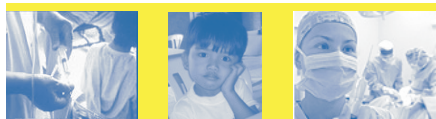
It is therefore necessary to fully legalize the practice of nursing in the First Nations communities with regard to the medical acts reserved for other professionals, including physicians, through the establishment of collective prescriptions and the implementation of a structure designated by the First Nations that will allow the development and adoption of standardized prescriptions to guarantee better continuity of health care and to facilitate the mobility of nurses among the communities.

---

## POSITION OF THE ORDRE DES INFIRMIÈRES ET INFIRMIERS DU QUÉBEC (OIIQ)

---

<sup>9</sup> Ordre des infirmières et infirmiers du Québec, *Guide for application of the Nurses Act and the Act modifying the Professional Code and other legislative provisions as regards to the health sector*, April 2003, p. 10 (see bibliography entry no. 12).



For several years, the OIIQ has shown its concern for the situation of nursing in remote regions. In 2002, it created a consultative committee on the specificity of nursing in remote regions, which involved consulting the nurses in these regions. Following these consultations, the committee produced a brief in which it formulated 13 recommendations. More specifically, the recommendations, given below, confirm and support the various elements brought up with regard to the problems identified in this document.

## RECOMMENDATIONS

To allow nurses to perform the greatest possible number of reserved medical acts listed under section 36 of the *Nurses Act*, the consultative committee recommended the following:

- Collective prescriptions should be developed and implemented by a regional or supra-regional entity (for example, the Ministère de la Santé et des services sociaux, the Public Health Branch in each region, or an entity designated by the First Nations).

For purposes of the above, a consultative committee should be created. This committee would be made up of physicians, nurses, pharmacists and dentists who know the nursing specificities involved and would be given the mandate to formulate recommendations concerning the development and implementation of collective prescriptions.<sup>10</sup>

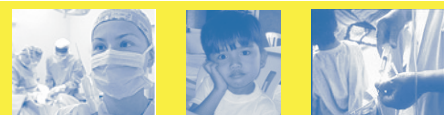
To ensure that nurses in remote regions maintain the required level of knowledge and skills adapted to this context for their practice, the consultative committee recommended the following:

- Work experience programs of 12 weeks should be required for nurses in remote regions.
- Nurses in remote regions should receive at least 20 days of ongoing training each year.

To ensure that the populations in remote regions have access to quality healthcare services that take account of the regions' specific characteristics, the consultative committee recommended the following:

---

<sup>10</sup> *Recognition of the Practice of Nursing in Remote Regions: Brief by the Consultative Committee on Recognition of the Specificity of Nursing in Remote Regions*, 2002, p. 17 (see bibliography entry no. 15)



- The expanded duties currently being performed by nurses in remote regions should be legalized.
- The role of nurses should be developed and legalized.

To obtain recognition of the practice of nursing in remote regions, the committee recommended the following:

- The experience of nurses now performing expanded duties in remote regions should be recognized in the transition phase leading to the creation of the role of nurses providing front-line services in remote regions.
- ~~A training program or work experience program should be created for nurses who require additional training.~~

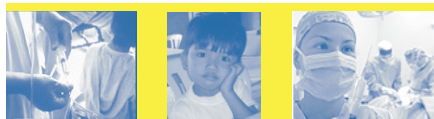
## RECOGNITION OF ADVANCED NURSING PRACTICE

In its brief concerning recognition of nursing in remote regions, the consultative committee on recognition of the specificity of nursing in remote regions concluded by affirming that “*it is necessary to recognize and legalize what is currently being done in the regions*” (translation). Recommendations 4 and 5, presented above, deal with this matter.

The committee added the following: “*It is necessary to recognize the scope of activities carried out by nurses, so that they can perform, on a fully legal basis, the activities essential to their specific practice. New modifications to the legislation governing the current practices of nurses in remote regions are thus justified in order to better define and control this role and to ensure greater public protection*” (translation).<sup>11</sup>

---

<sup>11</sup> Ibid, p.19 and p. 20



## CONCLUSION

---

The difficulties facing the First Nations' healthcare organizations concerning the process for the development and approval of collective prescriptions are firmly entrenched. They are due to the fact that certain professional activities in the practice of nursing in the First Nations communities are reserved for other professionals and that the communities' nurses are working in an illegal context.

It is therefore clear that the problems related to nursing in the First Nations communities represent a situation which is cause for strong concern and which can be resolved only by concerted, long-term actions.

In consideration of the elements presented throughout this document, we recommend the following:

- Create a First Nations Autonomous Inter-Professional Health Committee (FNAIHC).
- Appoint nurses, physicians, a dentist and a pharmacist as the committee's members.
- Place the committee under the governance of the First Nations of Quebec and Labrador Health and Social Services Commission.
- Assign the following mandates to the FNAIHC:
  - Develop collective prescriptions and activities related to their implementation in the First Nations' healthcare organizations.
  - Ensure a framework for the practice of nursing regarding collective prescriptions.
  - Develop professional expertise regarding collective prescriptions.
  - Develop an adapted training program.
  - Ensure clinical and practical evaluation of nurses regarding the application of collective prescriptions.
  - Develop all other activities deemed necessary for the project.

The following implementation plan gives the main actions necessary for carrying out and guiding the process to create the First Nations Autonomous Inter-Professional Health Committee.



## IMPLEMENTATION PLAN 2007-2010

---

### Underlying premises

- Protect the health of the members of the First Nations in Quebec.
- Legalize the practice of nursing within the healthcare organizations of remote, semi-remote and non-remote First Nations.
- Provide a framework for the practice of nursing within the healthcare organizations of remote, semi-remote and non-remote First Nations.
- Ensure the delivery of quality and effective services by the healthcare organizations of remote, semi-remote and non-remote First Nations.
- Harmonize the professional practices within the healthcare organizations of remote, semi-remote and non-remote First Nations.

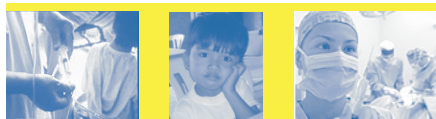
### Objective

Implement a permanent structure ensuring a legal framework for the practice of nursing in the communities of the Quebec First Nations and ensuring the necessary supervision and training of the nurses in the communities.

### Implementation plan

The work plan is made up of seven components and lists the activities for each one, along with an approximate work calendar for completion of the activities. These components are as follows:

1. Administration
2. Human resources
3. Development of collective prescriptions and protocols
4. Communication
5. Monitoring
6. Training
7. Operationalization



<b>1. COMPONENT: ADMINISTRATION</b>				
<b>Objective</b>	<b>Actions</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>
<p>Implement administrative procedures for governing the organization and functioning of the FNAIHC.</p>	<p>The actions in this component are the first ones to be completed in the implementation plan.</p> <ol style="list-style-type: none"> <li>1. Define the mandate of the FNAIHC.</li> <li>2. Determine the conditions for remuneration of resources.</li> <li>3. Determine the conditions for contracts of all resources (physicians, pharmacists, dentists, nurses).</li> <li>4. Identify the work location of the FNAIHC.</li> <li>5. Establish preliminary annual budgets for the first five years.</li> <li>6. Define collaborations with the Ordre des infirmières et infirmiers du Québec, the Collège des médecins du Québec, the MSSS, the Ordre des pharmaciens du Québec, the Ordre des dentistes du Québec, and Health Canada.</li> <li>7. Present the results to the FNQLHSSC for approval.</li> <li>8. Present the final project to all First Nations health directorates and to the First Nations of Quebec Nursing Directors Committee (FNQNDC).</li> </ol>	<p><b>Month 1 &amp; 2</b></p> <p><b>Month 1 &amp; 2</b></p> <p><b>Month 1 &amp; 2</b></p> <p><b>Month 1 &amp; 2</b></p> <p><b>Month 1 &amp; 2</b></p> <p><b>Month 1 &amp; 2</b></p> <p><b>End (year 1)</b></p> <p><b>End (year 1)</b></p>		



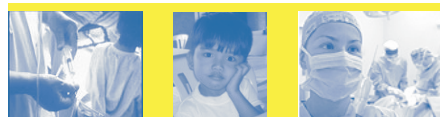
<b>2. COMPONENT: HUMAN RESOURCES</b>				
<b>Objective</b>	<b>Actions</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>
Determine the human resources necessary for carrying out the project	1. Determine the real needs in terms of time for the following human resources: nurses, physician, pharmacist and dentist.	<b>Month 1 &amp; 2</b>		
	2. Define the roles and responsibilities of the members of the FNAIHC.	<b>Month 1 &amp; 2</b>		
	3. Define the profile for the responsibilities and skills of the required human resources: nurses, physician, pharmacist, dentist.	<b>Month 1 &amp; 2</b>		
	4. Establish a list of candidates (known or possible) to form the membership of the FNAIHC.	<b>Month 1 &amp; 2</b>		
	5. Select and hire nursing resources.	<b>Month 1 &amp; 2</b>		
	6. Select and hire other resources: physician, pharmacist, dentist.	<b>Month 3</b>		
	7. Validate the roles and responsibilities of all members of the FNAIHC and make adjustments where necessary.	<b>Month 3</b>		
	8. Draw up a regional portrait of the nurses working in the First Nations communities.	<b>X</b>		



<b>3. COMPONENT: DEVELOPMENT OF COLLECTIVE PRESCRIPTIONS AND PROTOCOLS</b>				
<b>Objective</b>	<b>Actions</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>
Carry out all activities required to make collective prescriptions and the related tools available .	1. Develop and define the standards (all technical prescriptions applied to guarantee the proper functioning and safety of a method) and rules (all legislation and precepts governing the professions involved) associated with the use of the required collective prescriptions.	<b>Month 3 &amp; 4</b>		
	2. Establish the calendar for validation meetings by the FNAIHC.	<b>Month 3 &amp; 4</b>		
	3. Develop the framework for elaborating protocols and procedures.	<b>Month 3 &amp; 4</b>		
	4. Inventory the needs regarding collective prescriptions.	<b>Month 3 &amp; 4</b>		
	5. Draw up the collective prescriptions and protocols.	<b>X</b>		
	6. Where necessary, ensure validation in collaboration with the relevant legal entities (OIIQ, Collège des médecins, MSSS, etc.).	<b>End (year 1)</b>		
	7. Define, validate and confirm the roles and responsibilities of the various partners (band councils, local nursing directors, healthcare personnel).		<b>Beginning (year 2)</b>	
	11. Establish a follow-up calendar.	<b>X</b>		



<b>4. COMPONENT : COMMUNICATION</b>				
<b>Objective</b>	<b>Actions</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>
Ensure communication at all steps of the process to promote adherence at all organizational levels.	<u>Initial step</u>	<b>Month 1</b>		
	1. Present the project to all health services directorates in the member communities of the FNQLHSSC.			
	<u>Throughout the process:</u>			
	1. Inform the band councils of the FNQLHSSC member communities concerning each step.	<b>X</b>	<b>X</b>	<b>X</b>
	2. Inform the members of the First Nations of Quebec Nursing Directors Committee.	<b>X</b>	<b>X</b>	<b>X</b>
	<b>Second year of operation</b>			
	1. Members of the First Nations of Quebec Nursing Directors will keep the directors of the First Nations health services directorates informed of the results obtained during deployment.		<b>X</b>	
	2. Provide an evaluation of the results following the first year of operation and afterwards, as required, at the AGM of the FNQLHSSC.			<b>End (year 3)</b>



<b>5. COMPONENT: MONITORING</b>				
<b>Objective</b>	<b>Actions</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>
Implement tools to monitor the quality of medical acts performed according to the established standards and rules.	1. Develop a top-to-bottom algorithm for monitoring collective prescriptions.	X		
	2. Identify the professional who will ensure local monitoring of the application of medical acts.	X		
	3. Develop a program and tools for monitoring medical acts.	X		
	4. Identify a professional resource liaison at the FNQLHSSC for the nurses in the communities.	X		
	5. Identify a professional resource liaison at the regional CSSS in each of the First Nations communities.	X		
	6. Develop an evaluation tool (measurement indicators) for the ongoing revision and adaptation of all developed tools, collective prescriptions and protocols.	X		



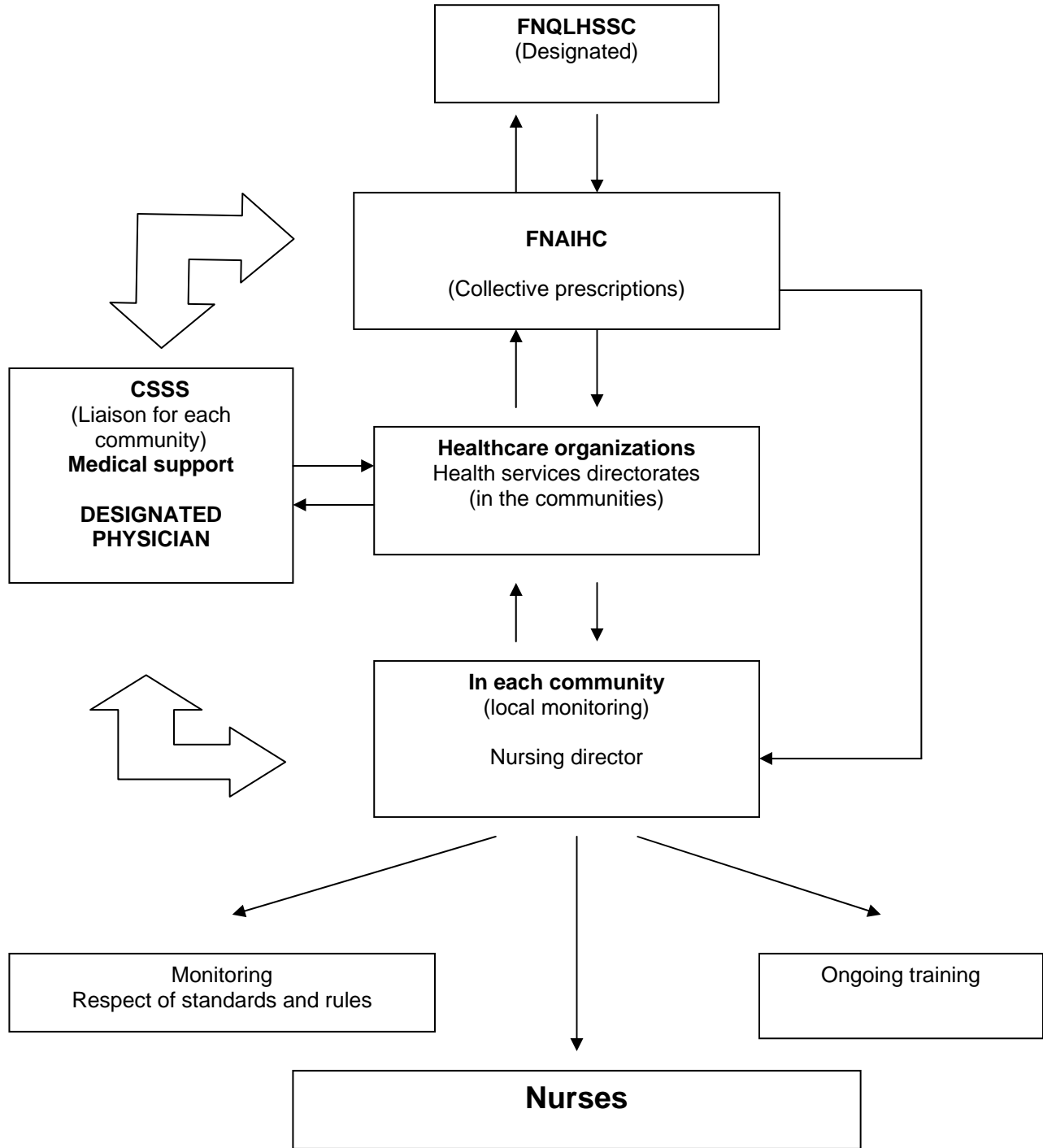
<b>4. COMPONENT : TRAINING</b>				
<b>Objective</b>	<b>Actions</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>
Implement a training program to provide nurses with the skills necessary for carrying out medical acts related to collective prescriptions according to the established standards and rules.	1. Implement a training program for medical acts covered by collective prescriptions. Training will be provided to: <ul style="list-style-type: none"> <li>- Nurses</li> <li>- Existing healthcare personnel</li> <li>- New nurses who are hired</li> </ul>	<b>X</b>		
	2. Establish the skills profile of nurses already working in the communities and adapt the training accordingly (it is essential to obtain information about the knowledge and skills possessed by the nurses).	<b>X</b>		
	3. Identify the trainers.	<b>X</b>		
	4. Establish the training calendar.	<b>X</b>		
	5. Coordinate logistics required to give the training.	<b>X</b>		
	6. Determine an ongoing training process.			<b>X</b>
	7. Develop partnerships with training institutions and organizations.	<b>X</b>		



7. COMPONENT: OPERATIONALIZATION				
Objective	Actions	Year 1	Year 2	Year 3
Operationalize collective prescriptions in all the health centres and nursing stations of the Quebec First Nations.	<ol style="list-style-type: none"> <li>1. Establish an implementation calendar.</li> <li>2. Initiate the training program.</li> <li>3. Deploy the work tools in the healthcare organizations.</li> <li>4. Implement the monitoring plan.</li> <li>5. Ensure technical support services for implementation.</li> <li>6. Follow up with the First Nations of Quebec Nursing Directors Committee three times a year.</li> <li>7. Analyze the results after one year of operation and revise, if necessary, the different implementation elements (collective prescriptions, protocols, training, reference tools, etc.).</li> <li>8. Establish a calendar for updating all tools that are developed (collective prescriptions, protocols, monitoring tools, quality control tools)</li> </ol>	<p>X</p>	<p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p>	<p><b>Beginning (year 3)</b></p>



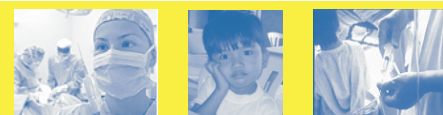
### ALGORITHM FLOW CHART FOR COLLECTIVE PRESCRIPTIONS



## BIBLIOGRAPHY

---

- (1) Association québécoise d'établissement de santé et des services sociaux, *Améliorer l'accessibilité, la continuité et la qualité des services*, May 2005.
- (2) *Bill 90: An Act to amend the Professional Code and other legislative provisions as regards to the health sector*, sanctioned on June 14, 2002, Explanatory guide, version no. 5.
- (3) Collège des médecins du Québec, *L'exercice de la médecine et les rôles du médecin au sein du système professionnel* (position statement by the Collège des médecins du Québec), April 2002.
- (4) Collège des médecins du Québec, *Les ordonnances faites par un médecin: Guide d'exercice du Collège des médecins du Québec*, May 2005.
- (5) Collège des médecins du Québec, *Partage des activités dans le secteur de la santé*, pp. 1-9. (on-line at: [www.cmq.org](http://www.cmq.org))
- (6) Colloque Conseil de la famille et de l'enfance, *Le réseau familial, la fratrie et le cousinage : la réalité des Premières Nations*. (on-line at: <http://agora.qc.ca/colloque/cfe2005> (6))
- (7) First Nations of Quebec and Labrador Health and Social Services Commission, *First Nations Regional Longitudinal Health Survey- Quebec Region*, 2002.
- (8) Indian and Northern Affairs, *The burden of ill health*. (on-line at: [www.ainc-inac.gc.ca](http://www.ainc-inac.gc.ca) )
- (9) Indian and Northern Affairs Canada, *Registered Indian population by sex and residence 2004*, Ottawa, 2005.
- (10) *Medical Act: Regulation respecting the standards relating to prescriptions made by a physician*, 2005, pp. 1-3.
- (11) National Assembly, *Bill 90: An Act to amend the Professional Code and other legislative provisions as regards to the health sector*, 2002, version no. 5. (on-line at: [www.publicationduquebec.gouv.qc.ca](http://www.publicationduquebec.gouv.qc.ca))



(12) Ordre des infirmières et infirmiers du Québec, *Guide d'application de la nouvelle Loi sur les infirmières et infirmiers et de la Loi modifiant le Code des professions et d'autres dispositions législatives dans le domaine de la santé*, April 2003.

(13) Ordre des infirmières et infirmiers du Québec, *Notre profession prend une nouvelle dimension*, April 2003.

(14) Ordre des infirmières et infirmiers du Québec, *Rapport du groupe de travail OIIQ/FMOQ sur les rôles de l'infirmière et du médecin omnipraticien de première ligne et les activités partageables*, October 2005.

(15) Ordre des infirmières et infirmiers du Québec, *La reconnaissance de la pratique infirmière en région éloignée*. Prise de position de l'Ordre des infirmières et infirmiers du Québec, *Mémoire du Comité consultatif sur la reconnaissance de la spécificité de la pratique infirmière en région éloignée*, 2002.

(16) Ordre des infirmières et infirmiers du Québec, *Règlement sur les activités visées à l'article 31 de la Loi médicale qui peuvent être exercées par des classes de personnes autres que des médecins*. (on-line at: [www.oiiq/infirmieres/lois\\_reglement\\_pdf/M-9-r-1.2.pdf](http://www.oiiq/infirmieres/lois_reglement_pdf/M-9-r-1.2.pdf))

(17) Ordre des infirmières et infirmiers du Québec, *Tableau de concordance entre les actes visés par l'article 31 de la Loi médicale et l'article 36 de la Loi sur les infirmières et infirmiers et les activités réservées dans le cadre de la Loi modifiant le Code des professions et d'autres dispositions législatives dans le domaine de la santé (Loi 90)*, 2003.

(on-line at: [www.oiiq.org/infirmieres/lois\\_reglements\\_pdf/tableaux\\_de\\_concordance](http://www.oiiq.org/infirmieres/lois_reglements_pdf/tableaux_de_concordance))

(18) *Report on the First Nations Socio-Economic Forum* (held at Mashteuiatsh), October 25-27, 2006.

(19) Secrétariat aux affaires autochtones Québec, *Aboriginal population in Quebec: 2005*.





## APPENDIX A

### Non-exhaustive list of health problems affecting the populations of the Quebec First Nations

<p><b>Respiratory, cardiovascular and vascular problems</b></p> <ul style="list-style-type: none"> <li>- Laryngitis</li> <li>- COPD</li> <li>- Bronchitis, pneumonia</li> <li>- Acute lung oedema</li> <li>- Cardiac insufficiency</li> <li>- Angina</li> <li>- Retrosternal pain</li> <li>- Cardiac arrhythmia</li> <li>- High blood pressure</li> <li>- Cerebral vascular accident</li> <li>- Hemorrhage and epistaxis</li> <li>- Asthma</li> </ul> <p><b>Neurological problems</b></p> <ul style="list-style-type: none"> <li>- Cephalagia, migraines</li> <li>- Convulsions (including febrile convulsions)</li> <li>- pilepsy</li> <li>- Cranial trauma</li> </ul> <p><b>Gastro-intestinal problems</b></p> <ul style="list-style-type: none"> <li>- Appendicitis</li> <li>- Gastric ulcers</li> <li>- Gastric and intestinal hemorrhages</li> <li>- Constipation and diarrhea</li> <li>- Gastro-esophageal reflux</li> <li>- Hepatic colic</li> <li>- Hemorrhoids</li> <li>- Dehydration</li> <li>- Gastro-enteritis</li> </ul> <p><b>Infectious diseases</b></p> <ul style="list-style-type: none"> <li>- Influenza</li> <li>- Tuberculosis</li> <li>- Rabies</li> </ul>	<p><b>Urological, gynecological and nephrological problems</b></p> <ul style="list-style-type: none"> <li>- Cystitis</li> <li>- BBSTI</li> <li>- Pelvic infections</li> <li>- Kidney stones</li> <li>- Pyelonephritis</li> <li>- Bleeding during pregnancy</li> <li>- Miscarriage</li> <li>- Premature labour and delivery</li> <li>- Breast cancer and cervical cancer</li> <li>- Dysmenorrhea</li> <li>- Mastitis</li> <li>- Renal insufficiency</li> </ul> <p><b>Endocrine problems</b></p> <ul style="list-style-type: none"> <li>- Diabetes</li> <li>- Hypoglycemia</li> <li>- Gestational diabetes</li> <li>- Hypo/hyperthyroidism</li> </ul> <p><b>Skin conditions</b></p> <ul style="list-style-type: none"> <li>- Cellulitis</li> <li>- Skin abscess</li> <li>- Eczema</li> <li>- Urticaria</li> <li>- Skin burns/frostbite</li> <li>- Chilblain</li> <li>- Lesions</li> <li>- Impetigo</li> <li>- Scabies</li> <li>- Pediculosis</li> </ul>	<p><b>Musculoskeletal and articular problems</b></p> <ul style="list-style-type: none"> <li>- Tendinitis</li> <li>- Strains</li> <li>- Lumbago</li> <li>- Fractures</li> <li>- Injuries to joints and conjunctive tissue</li> </ul> <p><b>Mental health problems</b></p> <ul style="list-style-type: none"> <li>- Depression</li> <li>- Aggression (including towards women and children)</li> <li>- Psychosis</li> <li>- Schizophrenia</li> <li>- Substance poisoning (medication, drugs or alcohol)</li> <li>- Attempted suicide</li> <li>- Suicide</li> <li>- Personality disorders</li> </ul> <p><b>Immune system problems</b></p> <ul style="list-style-type: none"> <li>- Inflammation</li> <li>- Allergies</li> </ul> <p><b>Ophthalmologic problems</b></p> <ul style="list-style-type: none"> <li>- Foreign matter in the eye</li> <li>- Conjunctivitis</li> </ul> <p><b>Otorhinolaryngological problems</b></p> <ul style="list-style-type: none"> <li>- Otitis (externa, media)</li> <li>- Sinusitis</li> <li>- Laryngitis</li> <li>- Pharyngitis</li> <li>- Dental abscess</li> <li>- Tonsillitis</li> </ul>
---	---	---





## APPENDIX B

### Non-exhaustive list of emergency situations that can occur in the remote communities of the Quebec First Nations

#### Traumatisms

- Firearms accident (injury caused by a bullet)
- All-terrain vehicle or snowmobile accident
- Work accident
- Suicide attempt
- Fractures (open and closed)
- Burn
- State of shock

#### Obstetrics

- Spontaneous abortion and hemorrhaging
- Emergency delivery
- Post-partum hemorrhaging

#### Cardio-respiratory

- Cardio-respiratory resuscitation of a newborn baby, a child, an adult or an elder
- Pneumothorax
- Acute lung oedema
- Bronchospasm
- Infarction
- Unstable angina
- Anaphylactic shock
- Hypovolemic shock
- Cerebral vascular accident (ACV)

#### Neurology

- Convulsion
- Epilepsy
- Cranial trauma

#### Psychiatry

Acute psychosis

#### Social crises

- Suicidal person
- Violence (against child, spouse, elders, etc.)
- Sexual abuse
- Substance poisoning (medications, drugs or alcohol)
- Others





## APPENDIX C

**Summary of the meeting with the OIIQ  
February 9, 2007**

**Summary of the meeting with the OIIQ  
February 9, 2007**

### **ORDRE DES INFIRMIÈRES ET INFIRMIERS DU QUÉBEC**

#### **Persons in attendance:**

Madeleine Lauzier- Council Director and Director of Training  
Suzanne Durand, Director of Professional Development and Support  
Ginette Thériault, Director of External Affairs and Personnel Statistics

### **FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION**

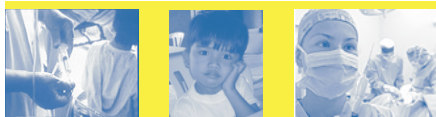
#### **Person in attendance:**

Denise Paul, Consultant

**Subject:** Creation of a *Committee of Physicians, Dentists, Pharmacists and Nurses* (CPDPN) allowing for the development of collective prescriptions to meet the needs concerning this specific aspect of nursing in remote, semi-remote and non-remote regions.

#### Information submitted to the OIIQ representatives regarding the above-mentioned subject:

- Brief summary of the mandate assigned to Denise Paul, as follows:
  - The main objective of this process is to provide First Nations nurses with the necessary framework and expertise to fully guide the practice of nursing in the current context.
  - This mandate consists in developing an adapted work plan for implementing an appropriate mechanism that will ensure the legality of nursing in the First Nations. To achieve this goal, we propose the following activities:
- Background of the issue regarding nursing in the First Nations communities.
- Reference to the brief submitted in 2002 by the consultative committee on nursing in remote regions.
- Information on the desire of the First Nations to create a CPDPN under the governance of the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC).



- Information on the model for the structure in terms of:
  - Make-up of the CPDPN
  - Types of collective prescriptions and reserved and non-reserved medical activities
  - Training component during implementation of practices and annual thereafter
  - Monitoring component – on-site (nursing directors) and distance (physicians)
  - Skills evaluation component – theory and practical
  - Establish links with the CSSS which will serve as reference regions for each Aboriginal community
  
- Advantages in creating a CPDPN under the governance of the FNQLHSSC:
  - Ensure public protection.
  - Establish a framework for the practice of nursing.
  - Ensure standardized administration of nursing.
  - Allow standardization of nursing practices for all First Nations' healthcare organizations.
  - Ensure better control of nursing quality.
  - Allow better monitoring of nursing practices.
  - Establish a standard for training.
  - Allow all band councils to join the process at all levels.
  - Allow the development and signing of collective prescriptions.
  
- The OIIQ representatives agreed that the creation of a CPDPN under the governance of the FNQLHSSC was an interesting solution that could lead to a framework for collective prescriptions.
  
- The OIIQ representatives suggested that the document should stress the importance of nurses as part of the healthcare teams in remote and semi-remote communities, and that human resources planning should take this importance into account.
  
- The OIIQ representatives agreed to read the document, to provide comments on it, and to propose any necessary additions, amendments or deletions.
  
- The OIIQ representatives offered their association's support for the implementation of the CPDPN and to provide advice concerning specific activities with regard to collective prescriptions as well as with regard to any discussions necessary in the future with the Collège des médecins du Québec.



## ANNEXE D

**OIIQ – Comments on the final report:  
Framework for the practice of nursing in the Quebec First Nations**

**Letter dated April 18, 2007**

---

Ordre des infirmières et infirmiers du Québec

April 18, 2007

Ms. Denise Paul  
Centre Tshishemishk  
1823 Amishk Street  
Mashteuiatsh, Quebec G0W 2H0

**Subject: Comments on the work document concerning the First Nations Autonomous  
Inter-Professional Health Committee**

Dear Ms. Paul,

I read with great interest the above-mentioned work document.

It bears directly on the concerns we discussed at our meeting this past February 9 and is in keeping with the avenues for action that were brought up.

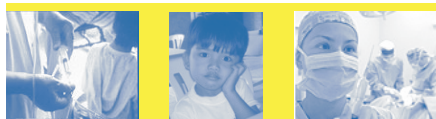
I have only positive comments on the document. Congratulations for the high quality of your work.

I hope this project will come to fruition. Please be assured that I am available if you require additional information.

Yours sincerely,

Madeleine Lauzier, M. Sc. in Nursing, M.B.A.  
Council Director  
External Affairs and Personnel Statistics

ML/Im





## ANNEXE E

**MSSS – Comments on the final report:  
Framework for the practice of nursing in the Quebec First Nations**

**Letter of May 2, 2007**

Dear Ms. Paul,

We have read your document in which you present the project for implementing a Quebec First Nations autonomous inter-professional health committee. We understand that the elements given in the document stem from reflections held by the First Nations over a period of several years to resolve the problems concerning the framework for nursing in the Aboriginal communities, the remote communities in particular.

Overall, it appears to us that the solutions you are proposing are in compliance with the Quebec legislation that governs the practice of nursing. Furthermore, we believe it is necessary to implement a process that will bring about a better framework for nursing in the communities. Apart from the comments we have provided to you on specific points, we note that your project appears able to meet the needs of the nurses in the Aboriginal communities. We hope that it will take concrete shape in the near future.

Please do not hesitate to contact us if our expertise can contribute to the development of your project concerning a framework for the practice of nursing in the Aboriginal communities.

Yours sincerely,

Sylvie Hains and Natalie Rosebush  
Evaluation and Quality Strategic Planning Branch - MSSS

