INFO NURSING

VOLUME 44 ISSUE 2 FALL 2013

MISSION POSSIBLE

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Nurses Association OF NEW BRUNSWICK

fall 2013

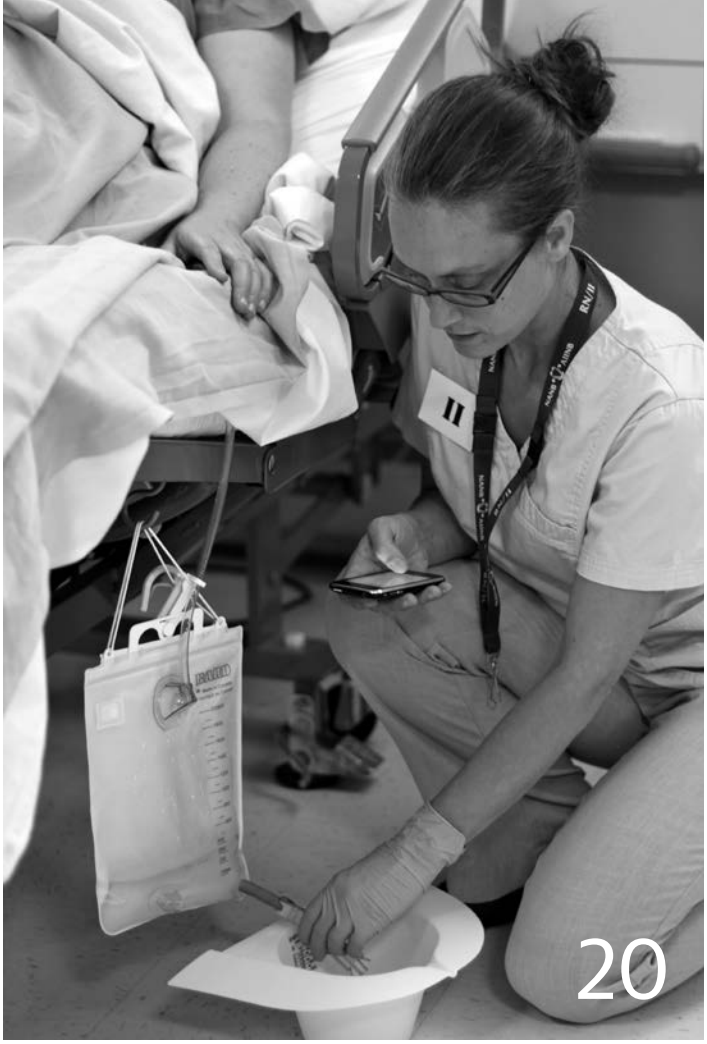
INSIDE

On May 28th, NANB recognized five outstanding nurses including (left to right):

Award of Merit: Education: Rose McCloskey;
Life Membership Award: Lucille Auffrey;
Award of Merit: Administration: Suzanne Robichaud;
Excellence in Clinical Practice Award: Sherry Gionet;
Award of Merit: Nursing Practice: Liette Mainville.

See additional photos of the Forum on page 47.

Cover
NANB hosted an Invitational Forum *The Changing Face of Professionalism* on May 29th at the Delta Hotel, Fredericton. Nurses participated in an opportunity to be on the cover of *Info Nursing* by completing the sentence 'I am a professional because…' A follow-up article and additional photos can be found on page 24.



the pulse

Nurses Association *of* New Brunswick

Nurses shaping nursing for healthy New Brunswickers. In pursuit of this vision, the Nurses Association of New Brunswick is a professional regulatory organization that exsits to protect the public and to support nurses by promoting and maintaining standards for nursing education and practice and by promoting healthy public policy.

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Submissions
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Change of address
Notice should be given six weeks in advance stating old and new addresses as well as registration number.

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Ancora Imparo—I am still learning...

A plaque bearing the expression ANCORA IMPARO hangs on my office wall as a constant reminder—*I am still learning*. What other profession would have given me such rewarding experiences and opportunities for personal and professional growth? My passion continues to be my patients; strangers who allow me to care for them and support them through life's challenges. What a privilege.

What does nursing mean to you? Do you remember how proud you felt when you graduated and received your degree or diploma? I wore my white uniform and nursing pin proudly! In recent months, I have had the opportunity to speak with nursing graduates as they look to enter this great profession and practice their craft, and this has caused me to reflect on my 36 years of nursing.

My career began as a staff nurse, followed by educator, nursing supervisor and most recently, nurse manager; always choosing to remain in positions where I interact with patients daily. A large part of what has shaped me "the nurse" has been my commitment to and participation in both the New Brunswick Nurses Union (NBNU) and the Nurses Association of New Brunswick (NANB).

As the unit representative for nurse managers/supervisors on the NBNU Executive, I participated in the first negotiations committee for the supervisors/managers contract. I was proud when unionized nurses agreed to adopt a new dues structure so NBNU would have the financial resources to advocate for fair nurses salaries and better working conditions.

Another significant challenge facing health professionals daily are escalating health costs to the system without improving health outcomes for our patients. NANB has been a strong advocate for primary health care reform for more than 30 years and will continue to highlight, through evidence-based research, the roles registered nurses and nurse practitioners will play in supporting this reform. I look forward to supporting NANB as it continues to collaborate with government in moving the recently announced Primary Health Care Framework forward and I look forward to your support during the 2014 provincial election to keep this initiative a top priority for all political parties.

For the next two years, I will be your national representative on the Canadian Nurses Association's (CNA) Board of Directors, developing by-laws that will help shape CNA's future governance structure. As you know, CNA has grown and changed over its 100-year history. This will be a new path, one that I look forward to learning, growing and helping to shape our nursing future together with my national colleagues.

With your continued support, I hope to ensure the continued financial stability of NANB so it can continue with a strong mandate of maintaining standards of nursing education and practice while promoting healthy public policy in the public's interest.

Nurses in New Brunswick continue to have the public's trust. You have the privilege of fostering a positive image for nursing. Represent your profession with pride. Like, Marilyn Quinn, President of NBNU, I encourage you to wear your RN pin and introduce yourself proudly as a registered nurse. I am a firm believer that all of us together can shape health care in New Brunswick.

I look forward to working with you, and for you, over the next two years. I have been so blessed; in my career, as a wife with a supportive husband and three sons who bring such joy. I am a Registered Nurse who is still learning from my colleagues and patients. I will continue to advocate for nursing, the profession, and our patients and look forward to this journey with humility and gratitude for the trust you have shown in me. ■

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Challenging Times Invoke Louder Voices

As summer comes to an end, and fall is just around the corner, this issue of *Info Nursing* always feels like the beginning of a new cycle. Since the Annual General Meeting (AGM) in May, the NANB team has been hard at work proactively planning the upcoming year leading to exciting projects and new initiatives for 2014. I would like to personally thank each of you who made attending our AGM a priority. Your presence is essential for NANB to advance its mandate. I also want to congratulate this year's five exceptional Award recipients, who are pictured on the inside cover of the journal. They were nominated by you, their peers, and the honour bestowed on them is certain to be a highlight of their professional life. Congratulations as well to the other nominees; there is no higher honour than being recognized by a colleague for your commitment to our profession. Thank you to those who attended NANB's Forum focused on Professionalism. When the NANB team identified Ros Moore, RN and Chief Nursing Officer with the Scottish Government, we knew we would have a dynamic and challenging discussion. We thank her immensely for accepting our invitation and the Scottish Government for supporting her participation. Presentations from the Forum are available for viewing on NANB's website (www.nanb.nb.ca); please take the time to watch them. Our work in this area will be ongoing; additional offerings of a webinar and face-to-face sessions around the province are planned. There is clearly no shortage of "professionalism" in our ranks; that was evident during our deliberations and together, we will make a difference.

In August John McGarry, CEO Horizon Health Network, met with the NANB nursing management team to discuss the challenges facing the health authority as it strives to achieve the fiscal targets set by government while maintaining and advancing the quality and safety of health services. This reality creates uncertainty both for the public, as it relates to their ability to access care, and for those employed within the system. Our health system was not created to provide jobs, it was created to provide essential health services to the people of New Brunswick; services that we expect to be of the same quality as those delivered elsewhere in Canada and the world. As tax payers and funders of the system, we expect nothing less.

A recent commentary from the Fraser Institute continues to question the efficiency, cost and outcomes of our system and to challenge the value of a public, not-for-profit system over privatization or a hybridized model. However, analysis that compares our Canadian system to others without including the social policy framework that supports and advances the determinants of health is incomplete and inaccurate.

As always, NANB supports a publically-funded, universal health system. Evidence continues to identify this model as being the most efficient and effective. Nursing professionals, both RNs and NPs, have demonstrated their essential contribution to the system when their knowledge and skills are optimized. NANB will continue to do its part in keeping the evidence front and center as we meet these challenges in New Brunswick.

Finally, I want to thank our outgoing President, France Marquis, for her leadership and commitment to the NANB and our profession. We wish you good health and success in your personal and professional life. We would also like to welcome our incoming President, Darline Cogswell. Your commitment to our profession and the NANB has been evident and we look forward to your leadership over the coming two years.

ROXANNE TARJAN
Executive Director

THE BOARD OF DIRECTORS MET ON MAY 27 AND 28, 2013, AT NANB HEADQUARTERS IN FREDERICTON.

Policy Review

The Board reviewed policies related to:

- Governance Process
- Executive Limitations
- Board-Executive Director Relationship

New Policy

The Board of Directors approved a new policy GP-16, Board Development.

Proposed By-law Revision

Amendment Resolution—The Board of Directors approved proposed revisions to the amendment of By-laws 12.01, 12.02, 12.06 and 13.07 to enable the Board to approve the use of other valid and reliable methods of voting to elect members to the Board to be presented at the Annual General Meeting for member consideration.

Organizational Performance

Monitoring—The Board approved monitoring reports for the Executive Limitations; Governance Process Policies; and Board-Executive Director Relationship.

Board of Directors & Committee Appointments

Election 2013—Elections were held for the President-Elect and Director—Regions 2, 4 and 6 positions. Election results were announced during the 2013 Annual Meeting. Terms of office for these newly elected Directors are effective September 1, 2013, to August 31, 2015, inclusive.

Congratulations and thank you to all candidates for letting your names stand. Elected Directors are listed below:

President-Elect
- Brenda Kinney

Directors
- Region 2—Jillian Lawson
- Region 4—Josée Soucy
- Region 6—Annie Boudreau

Public Director Vacancies

The Board of Directors is composed of 12 members, three of whom are members of the public. The role of the public director is to provide the Board with a public, non-nursing, consumer perspective on issues as they relate to nursing and health care in New Brunswick.

The term of one public director, Roland Losier, will expire August 31, 2013. This public director position is appointed by the Minister of Health from a list of candidates submitted by the NANB. The appointment is for a two-year term effective September 1, 2013.

The Board approved the following three nominees:

- Edward Dubé, Edmundston, NB
- Pauline Fournier, Petit-Rocher, NB
- Gérald Pelletier, Beresford, NB

Director Region 3 Appointment

The Board approved the following process for appointment: that RNs in Region 3 be informed of the vacant position on the Board and be asked to indicate their interest in filling the position by submitting a Nomination Form, résumé and a brief statement explaining their reason for submitting the nomination. A replacement would then be selected by the Board from the nominations submitted. The term of appointment would be from September 1, 2013, to August 31, 2014.

Executive Committee

The President and President-Elect are members of the Executive Committee, along with two region directors and one public director. The Board appointed the

following directors for a one-year term, effective September 1, 2013, to August 31, 2014:

- Chantal Saumure, RN
  Region 1 Director
- Linda LePage-LeClair, RN,
  Region 5 Director
- Wayne Trail
  Public Director

The Nursing Education Advisory Committee

- Dawn Haddad, Staff Educator, Miramichi Regional Hospital, Miramichi (new)
- France Chassé, Nurse Educator, Université de Moncton, Edmundston (new)
- Claudia McCloskey, Nurse Educator, University of New Brunswick, Moncton (new)
- Lynn Comerford, Experienced Clinical Nurse, Oromocto Public Hospital (re-appointment)

The Complaints Committee

- Michelle Cronin, Staff Nurse, Bobby's Hope House–hospice, Saint John (new)
- Solange Arseneau, Coordinator of New Products and Staff Attendance, Vitalité Health Network-Zone 6, Bathurst (new)
- Gail Dupéré, Supervisor/Coordinator Informatics, Campbellton Regional Hospital, Campbellton (new)
- Jeannita Sonier, Retired Educator, Neguac, Public Member (re-appointment)
- Albert Martin, Retired Educator, St-Basile, Public Member (new)

The Discipline/Review Committee

- Jenny Toussaint, Nurse Manager, Edmundston Regional Hospital, Edmundston (new)
- Claudette Finnigan, Public Health Nurse, Public Health, Bathurst (new)
- Marie Chase, Staff Educator, Dr. Everett Chalmers Regional Hospital, Fredericton (re-appointment)
- Cindy Crossman, Staff Nurse, Health Services Clinic, Mount Allison University (re-appointment)
- Monique Mallet-Boucher, Nurse Educator, University of New Brunswick, Moncton (re-appointment)
- Paul Rousselle, Nurse Manager, Chaleur Regional Hospital, North Tetagouche (re-appointment)
- Charles Flewelling, Retired Educator, Moncton, Public Member (re-appointment)

Nursing Education Advisory Committee (NEAC)

The Board approved the re-appointment of Janet MacDonnell and Lynne Theriault-Sehgal and the appointment of Martha Vickers to the Nurse Practitioner Therapeutics Committee for the term September 1, 2013, through August 31, 2015.

*For further information and to submit nominations for consideration, members can refer to the NANB website or call toll free 1-800-442-4417.

2013 NANB Awards

The Board accepted recommendations of the 2013 award recipients from the Awards Selection Committee. Awards were presented during the 2013 Gala Awards Banquet, May 29, 2013:

- Rose McCloskey
  Award of Merit: Education
- Suzanne Robichaud
  Award of Merit: Administration
- Liette Mainville
  Award of Merit: Nursing Practice
- Sherry Gionet
  Excellence in Clinical Practice Award
- Lucille Auffrey
  Life Membership Award

NANB Documents

The Board approved the following:

Document(s):

- *Entry-Level Competencies for Registered Nurses in New Brunswick* (2013, revised)
- *Continuing Competence Program* (2013, revised)

Position Statement:

- *Violence in the Workplace* (retired)

*All documents and position statements are available on the NANB website or call toll free 1-800-442-4417.

Nursing Education Advisory Committee (NEAC)

The Board approved the NEAC's recommendations that the University of New Brunswick baccalaureate of nursing program be granted an approval status for five (5) years; and that the University of New Brunswick baccalaureate of nursing program provide a progress report by May 31, 2014, outlining measures taken to address the recommendations identified in the Approval Review Team Report as requiring follow-up within one year.

Presentation(s)

Maurice Robichaud and Pamela MacKay of Connexions + provided an overview of recent public and member survey findings which focused on identifying member concerns and priorities and measuring the public's, as well as registered nurses, and nurse practitioners', understanding of NANB's regulatory role and the responsibilities of RNs and NPs as regulated health professionals. Findings will inform future NANB planning and initiatives.

The Canadian Nurses Association's (CNA) Barbara Mildon, President, and Rachel Bard, CEO, provided the Board with an overview of CNA's Governance Journey and how the proposed changes will affect who the members are at an AGM, as well as who votes and who sits at the Board table.

Chantal Léonard, Chief Executive Officer with the Canadian Nurses Protective Society (CNPS), provided an update to the Board on behalf of CNPS.

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F.Y.I.

NANB to Lauch a President's Blog

Want to hear from your President? NANB will launch a president's blog beginning this October that will provide highlights from the Association's Board meetings as well as regular updates from CNA's Board and other relevant happenings impacting nursing in New Brunswick. Check NANB's website (www.nanb.nb.ca) towards the end of October for Darline's first blog post.

NANB Welcomes New Staff

Dawn Torpe, RN, MN, Oromocto, has accepted the position of Nursing Practice Consultant with the Nurses Association of New Brunswick (NANB), effective June 17, 2013. Ms Torpe brings over 30 years of nursing experience in direct clinical and management roles. She joins NANB from Horizon Health Network. As a member of the Practice Department, she will provide consultation services, develop and promote standards for nursing practice, and support the strategic direction of the Association on nursing issues.

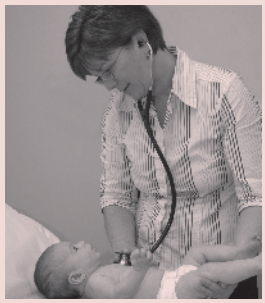
Coming This Fall: NCLEX Workshop for Educators

Later this fall, New Brunswick and PEI will be providing a regional workshop for educators who are preparing students to take the NCLEX-RN exam in 2015. This one-day, interactive workshop, presented by NCSBN (National Council of State Boards of Nursing) staff, will include the following topics:

- Evaluating curricular content against the detailed test plan
- Test plan categories
- Content distribution

Participants will also engage in item writing exercises and a review of different item types.

The session will take place on November 1, 2013 at the Delta Beauséjour Hotel, Moncton, NB. Information about registering for the session is available on NANB's website (www.nanb.nb.ca).



A New Series to Profile RNs & NPs

NANB IS EXCITED members want to learn and hear more from front-line nurses, so we will be launching a series in *Info Nursing* of RN/NP profiles. These profiles will showcase nurses at work in New Brunswick focusing on hands-on, more practical applications including roles and responsibilities of day-to-day nursing. In order for this to be successful, we need your support!

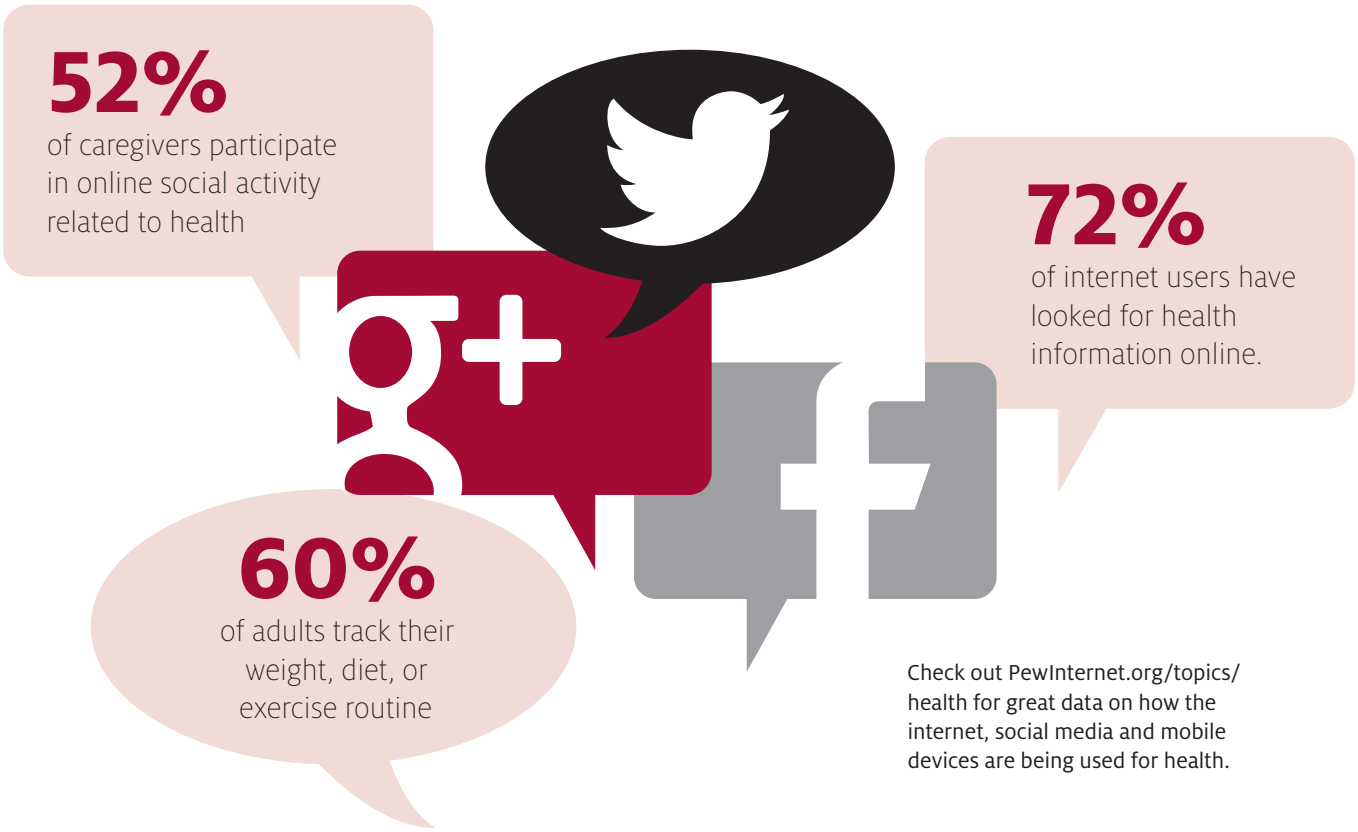
To jump start this initiative, we are calling on you to:

- submit suggestions to name this on-going series. Email submissions to nanb@nanb.nb.ca between now and October 31; and

- build a database of potential RNs/NPs to profile. Nurses would need to be informed and agree that their names be forwarded and contact information of the nurse to profile, including name, email and phone number, be provided to NANB (nanb@nanb.nb.ca).

NANB would then contact the RN/NP to profile and provide them information on what is expected, including draft interview questions publishing requirements, including deadlines and word count. The longevity of this series will depend on the interest expressed by members.

Please help NANB make this new series a success!



Check out PewInternet.org/topics/health for great data on how the internet, social media and mobile devices are being used for health.

Expanding Your Nursing Toolkit

Why Nurses Need to Know About Social Media and Digital Tools

By ROB FRASER

Social media is not a trend that nurses can ignore. Like any technology, it is an evolution. As our knowledge changes and expands so does technology. That is because all technology starts with an idea that is applied and tested. This allows us to learn and improve the technology. Today, no clinician doubts the utility of a sphygmometer, though we usually call it a blood pressure cuff. However, even this technology had pushback. One medical journal wrote, "the sphygmometer is one of the most silly and ridiculous babbles that was ever attempted to be foisted on the attention of the profession." Today that quote sounds absurd. At that time, devices were quite strange and not very accurate and their implications not fully known. Every technology starts somewhere. Even the computer mouse took years to develop and started as a bowling ball.

So where is social media in its evolution? An early understanding of social media could be tools for sharing and discussing information among human beings. This definition is easy to understand. It could even refer to books, however, the tools we are using are changing fast. So today's use of social media is better understood as Internet and mobile-based tools for sharing and discussing information.

That definition encompasses most web services and technology that jump to mind when people think about social media, which could be a long list. The term digital tool expands the category to computers, internet services, and mobile apps. Switching to thinking about digital tools can help make an important change in mindset. Tools are easy to relate to. We use different tools every day: pens, hammers, scissors, and the list goes on. Digital tools simply have different functionality and potential purposes. For example, *Facebook* and *LinkedIn* are social networks, while *SlideShare* and *YouTube* are meant to share content.

Thinking about function and

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CIVILITY FOR ALL!

Register Now!

NANB continues moving forward with its work on Professionalism in Nursing by offering a webinar which will focus on *Strategies for Embracing Civility* as put forward by RNs and NPs during the 2013 invitational forum. Join us on October 16 at 11:00am.

All New Brunswick RNs/NPs, as well as employers are invited to join this LIVE presentation by Susanne Priest, NANB Practice Consultant. Nursing students are also invited to join in by asking their educators' support for registration. The presentation will last approximately 45 minutes.

Registration is mandatory if you wish to participate and must be received before October 11. Register online at NANB's website, email to nanb@nanb.nb.ca or call 1-800-442-4417.

Previously Recorded Webinars

Leadership: Every Registered Nurse's Responsibility

Documentation: Why all this paperwork?

Safety First! Managing RNs with Significant Practice Problems

Visit our website (www.nanb.nb.ca) to view a recorded session.

potential purposes is important when shifting to the mindset of using digital tools. First, it prevents the overwhelming feeling that can happen when learning about another new website or app. Instead of adding another name to the long list of tools, focus on what it can do and if it could be useful. Second, focus on what you might learn from using it, not on whether it might change eventually. Very few people still use a typewriter, but typing is a useful skill. Changing perspective is critical to see how digital tools can create new opportunities. If providers don't see the opportunity others will, and someone else will be shaping the future of health and healthcare.

In 2010, we passed 2 billion Internet users, and a survey estimates 59% of adults have looked for health information in the past year. The world is going digital, which means nursing research, education and practice can evolve too, and they already have. Nurses are using crisis outreach through *Facebook*, supporting caregivers through *Twitter*, and sharing patient education materials with nurses at different organizations and in different countries.

Access to the Internet isn't limited to computers. Close to 85% of adults have a cellphone and 53% of those phones were smartphones. Smartphones can download health-related apps. In the last 2 years, the iTunes App Store went from 2,993 to 13,619 health related apps. Research found that 150 million fitness apps were downloaded in 2012. Clinical research on apps is also demonstrating that they can have an impact on health.

The trends all show an increasing interest in health-related digital tools. Unfortunately, healthcare providers have not been the majority of early adopters or innovators. Many apps in the health category are focused on daily nutrition, calculating Body Mass Index, or tracking an exercise routine. There are few that help manage chronic illness, or that integrate into healthcare practice. This is where nurses have the opportunity to change practice and create new opportunities using social media. Nurses have been doers, leaders, and innovators throughout history. Nurses could and need to begin to add their input to how these tools are being used and explore ways to impact on what matters most.

Any time tools are being used there is also risk. As nurses begin to use digital tools, it is critical that they think about ethical and professional issues as well. Unfortunately, there are stories of nurses being fired for breaching confidentiality or other regulations. This does not mean that nurses can't or shouldn't use social media. It simply means we need to discuss and learn about the potential harm in order to prevent it before it happens.

Nurses need to foster conversations about the opportunity and risks of using social media. The *Connecting Nurses* series will do both, providing more detailed information on professional issues, including what is out there and how to get started, as well as new insights into different social media. The focus will be on exploring how digital tools can improve health and healthcare. Hopefully, it can stimulate discussions around in the profession and help you consider how social media might fit into your nursing tool kit.

For a reference list, please visit: www.nanb.nb.ca/downloads/Rob Fraser References_E.pdf

AVOID THE LATE FEE. RENEW EARLY!

2014 ONLINE REGISTRATION RENEWAL

NOVEMBER 15
PAYROLL DEDUCTION DEADLINE

Members participating in employer payroll deduction of registration fees must renew online by November 15, 2013. After November 15, payroll deduction fees must be returned by NANB to the employer and members will have to use their debit or credit card to renew online.

DECEMBER 1
ADMINISTRATIVE DEADLINE

NANB has an administrative deadline of December 1, 2013, to renew registration. This deadline ensures the necessary time to assess and process all the renewal applications and to complete any follow-up prior to expiry on December 31, 2013.

JANUARY 1
REGISTRATION DEADLINE

Registrations that are renewed on or after January 1, 2014 will be subject to a late fee of $56.50. Any nurse who practises while not being registered is also in violation of the *Nurses Act* and may be charged an additional unauthorized practice fee of $250.00 plus tax.

Online registration renewal opens on October 1, 2013, and closes at 16:00 on December 31, 2013. In early October, members will receive an email reminder to renew their registration online. If your email address has changed, please contact Registration Services at 1-800-442-4417 or 1-506-458-8731.

NEW THIS YEAR

Revised Continuing Competence Program and Worksheets

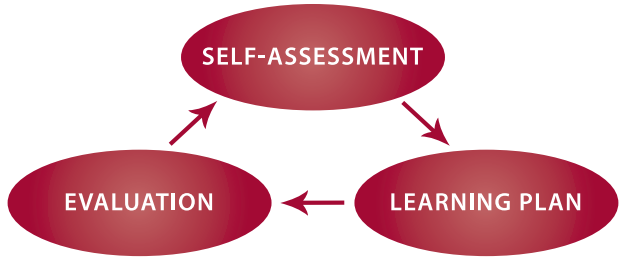
The Continuing Competence Program has been revised and is now available online. The revised RN CCP worksheets for 2014 reflect the 2012 NANB *Standards of Practice for Registered Nurses*.

New Payment Option Online

Members will have the option to pay their online registration renewal fee by debit.

Renew Online via Your *"My Profile"* Account

This year, members will be prompted to log in to their secured "*My Profile*" account using their username and password to access the online registration renewal module. If you did not create a profile last year, you may do so via the *Create my profile* link on the NANB home page and by following the instructions.



Continuing Competence Program (CCP)

To renew registration for the 2014 practice year you must have:

- completed a self-assessment to determine your learning needs;
  - RNs assess their practice based on the NANB *Standards of Practice for Registered Nurses*; and
  - NPs assess their practice based on the NANB *Standards of Practice for Primary Health Care Nurse Practitioners*;
- developed and implemented a learning plan that outlines learning objectives and learning activities;
- evaluated the impact of your learning activities on your practice; and
- reported on the registration renewal form that you have completed the CCP requirements for the 2013 practice year.

The CCP documents are available on the NANB website (www.nanb.nb.ca). New interactive CCP worksheets are currently under development and will be available in the coming months via your "*My Profile*" account.

CCP Audit

Compliance with the CCP is monitored through an annual audit process. In August 2013, a randomly-selected group of RNs and NPs received notification to complete a CCP Audit Questionnaire related to their CCP activities for the 2012 practice year. These members are required to complete the online questionnaire by September 30, 2013, prior to registration renewal.

Verification of Registration Status for Employers and Members

Employers are required under the *Nurses Act* to annually verify that nursing employees are registered with NANB. A quick and efficient way to verify the registration status of nurse employees is to go to the NANB website and access the registration verification system as follows:

1. go to the NANB website at www.nanb.nb.ca;
2. select *Registration* from the menu at the top of the screen;
3. select *Registration Verification*;
4. select *Option 1* in order to register as an employer if you have not *already* done so previously (this option will enable you to create a list of nurses later by using option 2);
5. select *Option 2* if you are already registered as an employer with NANB. Enter your password and verify the registration status of the nurse for the first time by entering their name and registration number. (If this has already been done, a list of names and registration status will appear automatically);
6. select *Option 3* to verify the registration status of an individual nurse without having to use a password.

Individual registered nurses can also use the registration verification system to verify their own registration status one business day after completing their online renewal.

2014 ONLINE REGISTRATION RENEWAL

Office Hours

The NANB office is open Monday to Friday, 08:30 to 16:30. Please note the office will be closed December 25, 26 and 27, 2013, and January 1, 2014.

For assistance with any registration issue, please contact NANB Registration Services at 1-800-442-4417 (toll free in NB) or 506-458-8731.

Health Literacy for a Service That Empowers the Client

By NATHALIE BOIVIN

The Canadian Council on Learning (2008) estimates that "60% of adults in Canada lack the capacity to obtain, understand and act upon health information and services and to make appropriate health decisions on their own" (p. 5). In a health care context where services are being streamlined and people are under increased pressure to manage their own health, how do we ensure the information provided to the clients allows them to play an active role in managing their health and make informed choices? Health literacy could be a key element for success. This article provides information on health literacy and suggests well-proven avenues for intervention.

Did you know that 60% of adults (16-65 years old) in Canada lack the capacity to obtain, understand and act upon health information and services and to make appropriate health decisions on their own? (Canadian Council on Learning [CCL], 2008, p. 5.) Health literacy refers to the capacity to find, assess and use health information in order to make decisions and navigate through the health system. In New Brunswick, especially in Francophone areas, statistics show that over 70% of the population has poor health literacy skills. If these results seem surprising, go to the health literacy map available at www.ccl-cca.ca/cclflash/healthliteracy. Looking at this map, one has to conclude that a majority of New Brunswick adults experience difficulty with reading, writing or understanding health information. Are health care providers aware of this? Did they receive the training required to work with clients who have literacy issues? Are there best practices that address working with clients presenting a low level of literacy?

Information Not Always Easy to Understand

Having access to information is a necessity for clients, not a choice. However, research shows that, in general, 50% of the information provided to a client during a visit with a health care provider is forgotten immediately or misunderstood (Kessels, 2003; Crane, 1997). Use of medical terms, worrying about one's health status, coldness of the care environment, a sense of inferiority before the health care provider and feeling embarrassed are all barriers to "provider-client" communication. When you throw a low literacy level in to the mix, combined with shame, it becomes even more difficult to understand the information and the messages conveyed.

Some Health Care Providers Overestimate the Literacy Skills of Their Clients

Health care professionals often overestimate the literacy skills of their clients. For example, in the United States, Kelly and Haidet conducted research where they assessed the ability of a group of 12 first-line physicians to estimate the literacy level of clients. A majority of these physicians, whose average work experience spanned 15 years, overestimated the literacy skills of their clients, and even more when these clients belonged to a visible minority (Kelly & Haidet, 2007). Furthermore, a survey by the Prince Edward Island Literacy Alliance (PEILA) of 99 Anglophone health care professionals showed that over half of them underestimated how low the literacy level of Islanders was (PEILA, 2008). As there is no data for health care professionals in New Brunswick, the health literacy team undertook research to inform the situation in the province. An online survey was sent out in the fall of 2010 and the spring of 2011. A total de 858 Francophone health care professionals, students and educators from New Brunswick and Prince Edward Island answered the self-administered survey. Table 1 presents the data collected and shows that the majority had overestimated the literacy skills of their clients. Among all health care professionals, students and educators, only 15% of them estimated correctly the prevalence of literacy challenges experienced by their clients.

When overestimating the literacy skills of their clients, health care professionals maintain a high-level language, using medical terms and written teaching tools unsuitable for clients. This is a barrier that interferes with the clients' understanding and taking ownership of the information and ultimately prevents them from using that information to manage their own health.

Health Care Professionals as a Preferred Source of Information

This is concerning, as the survey of Canadian attitudes toward learning conducted by the Canadian Council on Learning shows that Canadians obtain their health information from different sources, mainly family physicians (73%), other health care professionals (69%), family or friends (69%), newspapers or magazines (64%), internet (62%), or books and television (50%) (CCA, 2009). What can we do so these preferred sources of information (the health care professionals) can contribute to facilitating access to, understanding of and use of the information by clients?

Focus on Complex Interventions

Several stakeholders already use simple interventions to help clients understand the information. Using plain language written material, illustrations and

TABLE 1 *Estimation of the prevalence of low literacy level among clients per category of survey respondents, fall 2010 and spring 2011*

Percentage of low literacy level clients	Health care professionals	Students in health disciplines	Educators in health disciplines
Less than 15%	26	33	31
15–30%	35	34	36
31–45%	22	17	14
46–60%	10	9	8
61–75%	5	5	5
75% and over	1	1	3

Source: Boivin, Arsenault & Gaucher, 2011

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Canadian Nurses Protective Society

infoLAW®

Supervision

Vol. 20, No. 1, February 2012

Supervision entails initial direction, periodic inspection and corrective action when needed. It is the active process of directing, assigning, delegating, guiding, monitoring an individual's performance of an activity to influence its outcome. Supervision can be direct (being physically present or immediately available while the activity is being performed) or indirect (providing direction through various means of written and verbal communications).[1] Both health care institutions and nurses can have responsibilities for supervision.

Health Care Institutions

Health care institutions have an obligation to maintain safe systems for patients. Providing proper instruction and supervision to staff is one way in which they accomplish this. Case law has shown that health care institutions can be held directly and vicariously liable for failing to properly supervise those under their control, including nurses. Administrators may properly discharge their duty to supervise nursing staff by delegating this responsibility to front-line nurses, such as charge nurses or team leaders. This was clearly illustrated in a case where a nursing supervisor was informed of the struggles a recently graduated nurse was having in handling a normal patient assignment. The management supervisor of nursing consequently asked the team leader to keep a close watch on that new nurse. On a night shift, the team leader gave the nurse a heavy patient assignment. When the new nurse said she was having trouble coping, the team leader rebuked her. The team leader did not inquire about the extent of her difficulties or arrange assistance from more experienced colleagues. As a result, necessary patient intervention was delayed. The court commented on the conduct of the nursing supervisor and team leader. Given the weaknesses that had been reported, it identified the nursing supervisor as responsible "for ensuring the nursing assignment was carried out in such a way as to adequately maintain patient care."[2] It also found that the nursing supervisor's delegation of supervisory responsibilities to the team leader was reasonable and did not breach the standard of care.

Nurses

Nurses in Charge or Team Leader

The role of the charge nurse generally includes supervision of others. In the case mentioned above, the court found the team leader was a delegate of the nursing supervisor and was required to ensure the nursing assignments were carried out safely. The court held that contrary to this, the inexperienced nurse was "was pushed beyond her limit and was not appropriately supervised."[3] It found that the team leader breached the standard of nursing care by failing to perform her assigning and supervisory duties properly.

It may not be possible for a charge nurse to personally supervise and monitor nursing staff at all times. Other options exist, such as enlisting experienced staff to be a resource for certain staff members or procedures. Nurses in supervisory roles may also have to oversee other health care workers remotely, for example, when they are responsible for

A dawning reality:

registered nurses supervising health care providers at more than one site

More than liability protection

more than one site in a long-term care facility. Staying in touch by telephone is common in these circumstances and presents the same risks as any other telephone nursing. When contacted by phone, the charge nurse will consider whether she can gain sufficient information and understanding of the patient's status to provide direction remotely about patient care management. Good communication requires the collaboration of both parties to the call. It can be enhanced by conveying patient information in a structured way. This may consist of briefly outlining the current situation, providing background information about the patient, detailing the nurse's assessment of the situation, and stating what is being sought from the charge nurse.[4] The charge nurse should however be prepared to attend in person or take other appropriate and timely measures to assess the situation if an adequate understanding of the patient's condition cannot be gained over the phone.

Supervison of Students

Nursing school instructors are aware of the academic requirements and clinical skills to be acquired and honed during a clinical placement. Instructors carry their responsibilities to supervise students into the clinical setting, but there is commonly an additional designated person to supervise the student in the clinical setting: a preceptor who is a registered nurse. While students can be accountable for their actions and decisions, instructors and preceptors are responsible for supervising them to different degrees, depending on the circumstances. Good communication between instructors and preceptors will assist both of them in knowing what type and intensity of supervision is needed for each individual student.[5]

Risk Management Considerations

- As a supervisor, are you readily accessible? If not, do you have in place appropriate delegates? Do staff new to your unit or specialty know when and where to receive help? Do you understand the nature and extent of a problem that is reported to you before taking action?
- Do you seek guidance from a trusted colleague or from your supervisor if you are unsure of your assessment of the patient or how to proceed?
- Are you prepared to assist colleagues who need assistance, even if you are not formally in a supervisory role, in the interest of patient safety?
- Do you know to whom you report within the health care team or administrative chain of command when the limits of your authority have been met?

If you have any questions, please contact CNPS at **1-800-267-3390** or visit our website at **www.cnps.ca.**

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1. Saskatchewan Registered Nurses' Association, "The Practice of Nursing: RN Assignment & Delegation," 2004, online: http://www.srna.org/images/stories/pdfs/nurse_resources/2004_RN_assignment_delegation.pdf (accessed July 20, 2011) and College of Nurses of Ontario, The Standard of Care, "Practice Guideline: Authorizing Mechanisms," 2011, online: http://www.cno.org/Global/docs/prac/41075_AuthorizingMech.pdf (accessed December 2, 2011).
2. *Granger (Litigation guardian of) v Ottawa General Hospital*, [1996] OJ No 2129 (QL) at para 86 (Ont Gen Div).
3. *Ibid* at paras 83-88.
4. Institute for Health Care Improvement, "SBAR Technique for Communication: A Situational Briefing Model,"online: http://www.ihi.org/knowledge/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx (accessed October 13, 2011).
5. Ethyllynn Phillips, "Managing Legal Risks in Preceptorships," *Canadian Nurse* 98, 9 (October 2002): 25-26. Also available at www.cnps.ca.

Related infoLAWs of interest: *Delegation to Other Health Care Workers*, *Telephone Advice*. Available at www.cnps.ca.

N.B. In this document, the feminine pronoun includes the masculine and vice versa except where referring to a participant in a legal proceeding.

"Use of medical terms, worrying about one's health status, coldness of the care environment, a sense of inferiority before the health care provider and feeling embarrassed are all barriers to the "provider-client" communication. When you throw a low literacy level in the mix, combined with shame, it becomes even more difficult to understand the information and the messages conveyed."

audiovisual material are examples of simple interventions that facilitate clients' access to and understanding of the information. Although it's a step in the right direction, these interventions have a limited effectiveness. Clement, Ibrahim, Crichton, Wolf & Rowlands (2009) suggest instead to focus on complex interventions, which are a combination of simple interventions that are coordinated and organized in a way that is adapted to the needs and the characteristics of the client. This combination of simple interventions has to be supported by effective means of verifying if the client understands, for example through the "teach back" method. There is also health literacy training available for health care professionals. In the Francophone regions of New Brunswick and Prince Edward Island, the majority of the 858 respondents to the health literacy team survey stated they never had any training to identify literacy challenges among clients or to work with these clients (Boivin, Arsenault & Gaucher, 2011).

Implementation of universal measures

Rudd (2010), Wynia & Osborne (2010), Mancuso (2009) and the Canadian Public Health Association (CPHA, 2006) recommend implementing a universal approach to literacy. These authors state that such an approach is beneficial for all clients, whatever their literacy level. This means that health care professionals should presume their clients have difficulty understanding and using the information provided during an interaction with a health care provider. Mandated by the Agency for Healthcare Research and Quality (AHRQ), DeWalt, Callahan, Hawk, Brucksou, Hink, Rudd & Brach prepared a toolbox (Health Literacy Universal Precautions Toolkit) to facilitate the implementation of this universal approach. Several interventions backed by practical measures are suggested, such as taking health literacy training, making it a practice to encourage clients to ask questions, ensuring that clients have an appropriate understanding of the information, or organizing the facility's physical environment to facilitate access.

Health Literacy Training

Since April 2011, health literacy training has been offered online in French at no cost (www.alphabetismeensante.ca). Efforts are underway to translate this training into English for Anglophone stakeholders. The training is offered to all health care providers, students and educators. It was developed collaboratively with seven adult learners, the Department of Post-Secondary Education, Training and Labour, the Fédération d'alphabétisation du Nouveau-Brunswick (FANB) and the Université de Moncton Nursing Sector, Shippagan Campus, Bathurst Site (UMCS).

Currently, 11 lessons are offered online. Each lesson takes about one hour to complete. These lessons provide information, testimonies and tips to implement an approach that becomes a tool to help clients take ownership of the information. Users of this training can download a certificate indicating they have completed one or several training modules. Input from users show the training has a positive impact on their knowledge, attitudes and practices (Saintonge, 2011).

People who prefer social media (Facebook, Twitter) can receive information, quizzes and tips through those networks.

You are invited to take this training! What if New Brunswick became a Canadian leader in health literacy? Are you up to the challenge? It's up to all of us to meet it!

For a reference list please visit: www.nanb.nb.ca/downloads/Nathalie Boivin References-E.pdf. ■

By LIETTE CLÉMENT

What's WRONG With This Picture?

In May of this year, NANB hosted an invitational forum focusing on professionalism in the nursing profession. Evidence was presented showing a positive correlation between professionalism, client outcomes and an enhanced quality practice environment. The table top discussions involving some 250 forum participants confirmed that there is an expectation that RNs demonstrate and model professional behaviour in all they do and say.

One of the numerous situations originating from the practice setting that was shared during the discussions was the prevalence of personal communication devices actively in use in the workplace, during work hours. Most of us carry a personal communication device in our purse or pocket. This device allows us to be better connected to information and people than ever before. We can be reached anywhere, at any time, and we are never more than a few clicks away from our family and social network. However, there needs to be a balance between our personal life and our professional responsibilities. Consider the following:

Personal Communication at Work: Avoid Unprofessional Behavior!

Although technology use can be a valuable and critical tool in organizing your work and life, there are some issues you need to consider when using personal technology in the workplace. Answering personal calls, checking voicemail and texting during patient interactions is inconsiderate and unprofessional. Additionally, it may be against facility policy and can even put your position at risk. It can distract you from critical duties that may increase the potential for errors and increase your risk for liability and litigation. Patients who see or hear healthcare professionals using technology devices may have concerns about their own privacy (is that nurse communicating about me?) and there is a risk of a potential or real HIPAA violation *(retrieved July 2013 from: http://w3.rn.com/News/news_features_details.aspx?Id=31824).*

NANB, as the regulatory body for RNs and NPs in New Brunswick, does not regulate the use of electronic and communication technologies in the workplace. Evidence

shows that such technologies can be, and are being, used with positive client outcomes. But when the use of communication technologies for personal reasons competes with client care, RNs need to consider potential transgressions of their standards of practice, the code of ethics and employer policies.

NANB's standards state that RNs are expected to behave, interact and communicate in a professional manner and demonstrate professional presence at all times. In the practice setting, RNs engage in professional relationships with clients and clients' significant others which must be client-focused. RNs must build trustworthy relationships as the foundation of meaningful communication, recognizing that building these relationships involves a conscious effort to establish and maintain the relationship's therapeutic nature. When an RN interrupts her care to use a personal communication device for her own needs, she is in fact breaching the client's trust.

The Code of Ethics for registered nurses calls for RNs to engage in compassionate care through their speech and body language and through their efforts to understand and care about other's health-care needs. This includes being present for the client, demonstrating that she or he is focused on work-related issues during work hours, and is not distracted by personal concerns during this time.

Registered nurses must exercise reasonable judgement and demonstrate professional presence when interacting with clients. Choosing to answer a personal call or texting while interacting with clients or colleagues is projecting the wrong image, not to mention that interruptions not related to care can lead to errors, resulting in a risk to patient safety, as well as be against employer policies. So I ask you—what's wrong with this picture?

NANB is interested in hearing your comments on this subject. Please feel free to share your point of view by emailing us at nanb@nanb.nb.ca. All comments will be kept anonymous and will help inform NANB's future initiatives towards creating a culture of professionalism.

NB RN Recipients of the Queen Elizabeth II Diamond Jubilee Medal

A special ceremony was held in Ottawa on March 5, 2013 recognizing 30 registered nurses and nurse practitioners for their outstanding contribution to nursing and health care with Queen Elizabeth II Diamond Jubilee Medals.

NANB proudly acknowledges two New Brunswick recipients Lisa Guidry, RN, NP (Rothesay, NB) and Natalie Haché Losier, RN, (Dieppe, NB).

Your Feedback Fuels Changes in 2013-14

EDITOR'S NOTE: On behalf of the Association, we sincerely thank you for taking the time to respond to NANB's recent member survey and for sharing your opinions on areas we can improve. On average, the survey took approximately 19 minutes to complete, and NANB spent weeks to review and analyze all your comments. Congratulations to Pascale Losier, RN, winner of the random iPod draw.

In April 2013, NANB conducted a member survey to identify priorities and inform NANB's efforts to enhance registered nurses, and nurse practitioners understanding of our regulatory role and their responsibilities as regulated health professionals.

Surveys were sent to 6,615 RNs/NPs (all those who provided NANB with an email address) representing approximately 80% of NANB's total registered members. 1,225 (20%) participated, with the majority of respondents (41%) being between the ages of 45-54 with over 20 years nursing experience.

The survey was broken into three parts:

1. NANB's Mandate
2. NANB's Communications & Linkages
3. Demographics

91% of RNs/NPs believe that self-regulation is VERY or EXTREMELY IMPORTANT to the nursing profession and 85% responded to say they have a "pretty good" understanding of NANB's mandate.

Additionally, you ranked how effective NANB was in fulfilling our Ends/Goals based on this mandate.

- End/Goal 1:
  Protection of the Public
  97% effective
- End/Goal 2:
  Professional Self-Regulation
  95% effective
- End/Goal 3:
  Healthy Public Policy
  90% effective

A series of questions followed to determine RNs/NPs, awareness of NANB resources such as:

- Standards of Education and Practice;
- Nursing Education Program Approval Standards;
- Entry Level Competencies;
- Entry to Practice Requirements;
- Continuing Competence Program;
- Professional Conduct Review.

Surprisingly, only 52% RNs/NPs are somewhat or not at all aware of NANB's Professional Conduct Review process.

COMING SOON! NANB is planning to deliver a webinar to further explain the Professional Conduct Review Process… stay tuned for details in *Info Nursing*, via the e-bulletin *The Virtual Flame* as well as NANB's website.

Over 36% of RNs/NPs indicated they would be interested in becoming an NANB committee member but requested more information on the role and expectations as well as time commitment etc.

NANB will publish a re-occurring article in *Info Nursing* as well as add a permanent section to the website that will highlight the work of the committees, the role members play as well as expectations and time commitment.

Other comments included:

- Host meetings via teleconference;
- Hold meetings in more accessible locations; and
- Offer salary replacement.

87% of respondents have accessed these resources at least yearly or more. That said there is still over 13% who have never accessed any of the resources listed.

NANB recognizes a lack of awareness may be the cause for not accessing these resources and intends to optimize existing communications tools by:

- publishing regular reminders of resources that are available in both *Info Nursing* and e-bulletin, *The Virtual Flame*; and
- consider developing e-learning modules and or webinars to promote and explain how these resources support nursing practice.

Although few RNs/NPs have accessed NANB's e-learning modules, 49% did not know they existed but plan to look in to them. Many expressed difficulties accessing the modules or that the topics were of no interest.

Similarly, few RNs/NPs have accessed NANB's webinars due to timing, accessibility and or lack of interest in topics being covered. 30% offered suggestions for future presentations which included:

- Professionalism/civility
- Nursing and community health
- RN/LPN relationships - collaborating
- The Role of the NP

NANB'S NEXT WEBINAR on professionalism/civility, will highlight feedback received at NANB's Forum, scheduled for October 16, 2013. Details on how to register can be found on page 12.

COMING SOON! NANB is developing a webinar on Collaborative Care which will further identify the roles of the RN and LPN in the health care setting.

95% of RNs/NPs believe that NANB communicates effectively! An overwhelming 80% prefer direct email communication to any other method.

83% of respondents consider the *Info Nursing* journal to increase their awareness of nursing practice and the nursing profession.

While some RNs/NPs indicated they believe *Info Nursing* to be a 'a lot of wasted paper', NANB is continuously looking to improve the journal as it is our only guaranteed means of communicating with all 8,900 RNs/NPs as well as a wider audience of health stakeholders including: government, educational institutions, libraries and other jurisdictions. Over the past four years, NANB:

- has eliminated one issue of the journal and replaced it with four issues annually of the e-bulletin;
- has switched to FSC certified stock "recycled" paper; and
- offers electronic PDF copies, by request, of both the journal and the Annual Report.

Additionally, NANB will launch an ongoing series profiling front-line RNs/NPs. Details can be found on page 10.

Over 60% of RNs/NPs scan and look forward to NANB's e-bulletin, *The Virtual Flame*. That being said, a number of respondents indicated they have provided their email address but DO NOT receive it.

Efforts will continue to ensure the Department of Health as well as both Regional Health Authorities IT support teams recognize the NANB e-bulletin so that it is not filtered as SPAM.

Although we recognize that attendance at NANB's AGM and Forum/Conference has increased over the past few years, only 32% of RNs/NPs who responded have attended meetings in the last five years.

Suggestions to increase participation included:

- offering a more accessible location/time;
- not knowing or being invited;
- offering salary replacement; and
- not given permission to attend by employer/absence from work.

NANB intends to respond by:

- increasing awareness through a direct email invitation to all RNs/NPs one month prior to the AGM and Forum/Conference; and
- improving accessibility, piloting a three-year live stream of the AGM/Forum.

NANB's Board of Directors Election is now conducted by mail-in ballot. Although that increased participation to approximately 30%, the cost continues to increase year to year. Overwhelmingly, respondents supported NANB moving to electronic/online voting.

- Therefore NANB will launch an online and telephone election voting process to begin in 2014. Stay tuned for details.

This is a snapshot of the feedback received from NANB's survey. Once again, we thank you for sharing your opinions on areas we can improve. NANB acknowledges that we can and will continue to support ways to enhance nursing practice and regulate registered nurses and nurse practitioners, thus ensuring safe, competent and ethical nursing care for all New Brunswickers. ■

NANB hosted an Invitational Forum *The Changing Face of Professionalism* asking nurses to pose for the cover of *Info Nursing* by completing the sentence: "I am a professional because..."

MISSION POSSIBLE

CREATING A CULTURE OF CIVILITY

By SUSANNE PRIEST

NANB has been on a mission to facilitate discussion regarding professionalism in nursing. Some of NANB's initiatives to meet this objective included the publication of journal articles, face-to-face presentations, virtual forums and member surveys. To date, members have discussed professionalism in nursing as a global concept, as well as specific elements of professionalism including: professional presence, social media and civility.

Professionalism encompasses varied aspects of behaviour, appearance and communication and has been described as both a noun and a verb. We are expected to 'be' professional, 'look' professional and 'act' professional.

The term professionalism may be interpreted by some as an over-arching term, including everything from basic manners, education and appearance, to specifics like individual behaviour, job skills and job title. Some may consider professionalism as a way of being and acting "on-the-job" without considering the impact that one's personal behaviours can have on the profession of nursing (including social media and social lifestyles).

Regardless of how RNs and NPs define professionalism, there has been an overwhelming response to this initiative and nurses have shared that professionalism needs to be addressed. This article is a follow-up to the presentation given at the NANB Invitational Forum on May 30, 2013, titled *Mission Possible: Creating a Culture of Civility*. The purpose of this article is to share information on the topic of civility and to propel RNs and NPs forward into embracing strategies for creating a culture of civility in healthcare, and therefore improving professionalism in nursing.

What is Civility?

Civility is an awareness of being polite and it involves all those little sacrifices you make in living life respectfully with other humans. It does not depend on liking everyone, but on resolving to think before you speak and being respectful of those around you. Civility may mean agreeing to disagree; talking through differences; or providing civilized criticism that isn't blunt and harsh, but as factual and as objective as possible (Lower, 2012). Civility includes what is spoken, what is written and body language.

Why Be Civil?

Civility can be the foundation of relationships and relationships are the cornerstones of collaborative healthcare teams and therapeutic nurse-client relationships. A healthcare team that communicates effectively, respects each team member and works together, will be productive and innovative, enjoy working, and provide quality services to the clients entrusted, to their care. In other words, being civil could lead to increased productivity, healthier staff and safer clients.

The opposite is also true. Uncivil behaviour can result in trust issues amongst staff and a fear of repercussion. A lack of trust and a sense of intimidation could result in team members not voicing a valid opinion or not making a significant contribution to the healthcare team. It is easy to see how impaired communication as a result of incivility amongst healthcare professionals could result in unsafe client care, increased use of employee sick time to avoid the environment, and even resignation of positions to flee a toxic environment. There is no room in healthcare for condescending behaviour or rude remarks. The client is depending on a high-functioning, information-sharing team to provide safe, competent and ethical care.

Increased acuity of clients, staffing challenges, shift work and increased responsibilities are a reality for RNs on a regular basis. Working with multigenerational colleagues who have different values regarding work and social/familial time is also a reality. For example, communication styles vary from generation to generation and between males and females and societal norms include electronic communication and texting with less eye contact and human touch.

Stressors combined with a multigenerational workforce (with differing values and norms), create a potential battlefield of misunderstandings, hurt feelings, negative body language and impatient remarks. In other words, high stress and a kaleidoscope of healthcare workers can lead to incivility.

Research Findings on the Impact of Incivility

A few years ago, research on the generational difference in distress, attitudes and incivility among RNs was conducted in Nova Scotia and Ontario. Results from self-reporting in the form of a questionnaire, were analyzed and revealed the following (Leiter et al., 2010):

- Generation X reported greater incivility from co-workers and supervisors than Baby Boomers.
- Generation X reported greater distress which included exhaustion, cynicism, turnover intention and physical symptoms of stress.
- Exhaustion and thoughts of leaving a practice area were strongly correlated with incivility from a supervisor.
- Co-worker incivility was significantly tied to psychological withdrawal.

A follow-up study further focused on whether incivility at work exacerbated the relationship between stressors and work-related strain for hospital workers in Nova Scotia and Ontario (Oore, D. et al., 2010). The following points were reported from this research initiative:

- Incivility is linked to an array of physical and psychological effects.
- Decreasing respect is a symptom of an uncivil work environment.
- Co-worker incivility negatively impacts mental health.
- Supervisor incivility has a pronounced negative impact on staff members, with employees reporting strain on physical health.
- Workplace interventions targeting incivility lessen the impact of work stressors on the employee.
- Co-worker support and help when an employee is under pressure, is important.

Commit to Being Civil

Imagine a workplace in which each employee committed to being responsible for their actions, strived for excellence, listened actively and communicated respectfully. Imagine a workplace free of gossip but full of authentic congratulations or high-fives for personal or professional accomplishments. Imagine the time that would be saved if employees committed to sharing expert knowledge and working together, even offering to help without being asked. Sound too good to be true? Civility is "Mission Possible"!

Mission Possible: Civility for All!

Working in healthcare may mean spending holidays, weekends, and long shifts together at any given time of the 24 hour clock. If you work full time, you may see your co-workers more than family members. Therefore, from a personal perspective, it is worth every effort to make the workplace more enjoyable. Moreover, as regulated healthcare professionals, RNs have a responsibility to civility. The following standard indicators in the revised *Standards of Practice for Registered Nurses* (NANB, 2012), point to behaviour and actions that require civility:

- Indicator 3.2 states that the RN communicates effectively and respectfully with clients, colleagues and others.
- Indicator 3.7 states that the RN is to advocate for and contribute to quality professional practice environments.
- Indicator 4.1 addresses professional presence and states that the RN is to model professional behaviour.

In summation, becoming involved in making the workplace civil or "Mission Possible: Civility for All!", has personal and employer benefits and is required from a regulatory perspective. Most importantly, civility should lead to a more collaborative healthcare team in which information is shared, opinions are valued, and excellence in client care is the goal.

Strategies for Creating a Culture of Civility

- Identify triggers which zap your patience or cause a negative reaction from you.
- Don't jump to conclusions. Try to be objective. Be quick to listen and slow to speak.
- When gossip reaches you, remember to be a duck! Let the gossip roll off you, like water rolling off a duck's back. BE A DUCK!
- Practise praise: say thank you when someone deserves it and share the credit if someone gives you a compliment but someone else was also involved in helping.
- Agree to disagree (if clients are not at risk and employer policy, standards and legislation are adhered to).
- Speak out (respectfully, of course) when you witness uncivil behaviour. Practice a short but polite response to recall and speak in the heat of the moment.
- Advocate for civility to be addressed in your workplace.
- Apologize if you are uncivil in words or actions. Humans make mistakes and apologizing for your mistake shows commitment to civility in the workplace.

Aside from the fact that incivility is a stressor in an already stressed healthcare system, the results of incivility are never positive and often physically and mentally harmful. It behooves employers, managers, and front-line healthcare staff to take an active role to curb the spread of incivility. Civility is one way individuals can proactively impact themselves, the workplace environment and the recipients of care.

A webinar titled: *Mission Possible: Recommendations for Embracing Civility* is planned for October 16. Please register no later than October 11 to nanb@nanb.nb.ca.

Professionalism & Civility *Roadshow*

The NANB Practice team is currently planning a tour across the province with a live presentation on Professionalism and Civility in Nursing. This presentation is for RNs/NPs. To help us determine locations for these educational opportunities, we invite you to submit an electronic request form at:

www.nanb.nb.ca/index.php/practice/consultations.
Preference will be given to groups of 20 participants or more.

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RN Prescribing

By DAWN TORPE

Autonomous RN prescribing is gaining momentum in Canada. In June 2012, the report from the Canadian Nurses Association (CNA) National Expert Commission, *A nursing call to action*, recommended that the RN's scope of practice be expanded to include prescribing in an effort to support patient care and health-system sustainability. In an interview published in the *Globe and Mail* in December 2012, Barb Mildon, the president CNA, is quoted as saying "the evidence is clear and compelling—RN prescribing benefits patients and improves accessibility to health-care services." She pointed to evidence from the United Kingdom (UK) where RN prescribing began in the late 1990s with the granting of limited prescribing privileges to district and health visitor nurses. This has evolved today to independent prescribing by specially trained nurses with complete access to the British National Formulary.

In Canada and the USA, RN prescribing has been linked to the development of advanced practice roles and is primarily limited to NP practice. As well, in the USA there are CNSs, nurse midwives and nurse anesthetists who have prescribing authority. This is not the case in other countries that have introduced this practice as an added certification/qualification for RN practice. The most frequently cited drivers for RN prescribing have been: (1) the call for more efficient patient access to medications; (2) the need to make better use of nurses' skill and knowledge; (3) effective utilization of all health professionals' time; (4) reducing workload on physicians and (5) addressing physician shortages.

There is great variation in the prescribing legislation of different countries, which results in differences in the types of medications nurses can prescribe and the scope of prescribing privileges. Autonomous RN prescribing has been implemented in the UK, Ireland, New Zealand, Australia, Sweden, and a number of African nations. However, although RNs in these countries prescribe on an independent basis, their scope of practice or freedom to act varies considerably, depending on whether or not protocols and/or formularies are in place and if so, how restrictive these are.

In Canada the move to autonomous RN prescribing is taking different paths based on the health priorities and population needs.

- In Quebec, permission is being sought for RNs to prescribe preventative medications (e.g., oral contraceptives, tobacco cessation medication) and medications to treat minor health problems (urinary tract infections, sexually transmitted infections).
- In Manitoba, proposed RN prescribing will be focused on improving access in three distinct areas of nursing practice: sexually transmitted infections, reproductive health and travel health.
- In Alberta, changes are being sought for limited RN prescribing of Schedule 1 drugs in order to meet specific needs in particular populations. It is expected that prescribing decisions will be limited and clearly defined in a clinical support tool and be supported by collaborative practice relationships with either an NP or a physician.

Watch for NANB's next Virtual Discussion on RN Prescribing opening towards the end of November. Details will be shared in November's e-bulletin and on our website www.nanb.nb.ca.

- In Ontario, the RNAO released a report entitled *Primary Solutions for Primary Care* in June 2012. It outlines a two-phased approach to expanding the role of primary care RNs and recommends RN prescribing.

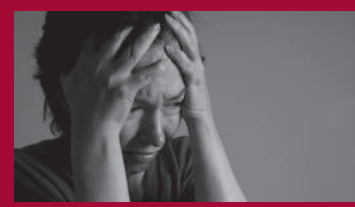
It's All About the Nurse-Client Relationship

available at www.nanb.nb.ca

The Therapeutic Relationship is the foundation on which nursing care is provided. RNs are committed to the development and implementation of best practice through the ongoing acquisition, critical application and evaluation of relevant knowledge, skills and judgment. This e-learning module will benefit both registered nurses and nursing students in their nursing practice and will familiarize them with all aspects of the nurse-client relationship, including how to:

- establish a therapeutic nurse-client relationship;
- set and define the limits of the relationship;
- recognize and deal with situations when boundaries that separate professional behaviour from non-professional behaviour are blurred;
- terminate the relationship in a professional manner; and
- maintain a professional relationship with the client and his significant others after the termination of the therapeutic nurse-client relationship.

As a member or nursing student in New Brunswick, you can access free e-learning modules via NANB's website (www.nanb.nb.ca) at your convenience, 24/7, with the ability to leave and return when the time is right for you.



ALSO AVAILABLE
Problematic Substance Use in Nursing

- In British Columbia, RNs who have become certified in one of three areas (Remote Practice, RN First Call and Reproductive Health) independently diagnose and treat their clients using decision-support tools.

In May of 2013, CNA facilitated a pan-Canadian roundtable discussion on the topic of autonomous RN prescribing. The goal of the event was to lay the groundwork for an actionable framework capable of supporting the education, regulation and deployment of RNs in Canada who are able to autonomously diagnose illnesses and injuries and to prescribe tests and treatments (including, but not limited to, medications).

NANB has been monitoring the initiatives and developments occurring across the country. Currently no steps have been made to introduce autonomous RN prescribing in the province. New Brunswickers are well served by our primary health care NPs who diagnose and prescribe for clients under their care. Their scope of practice is broad and extends well beyond the prescribed/limited scope proposed by other jurisdictions for RNs. The use of medical directives, although not considered prescribing, allows RNs in NB to support client care by providing timely, evidence-based interventions (e.g., immunizations, insulin dose adjustment).

Before considering any change to the RN scope of practice in NB, NANB believes that a thorough gap analysis is required to evaluate if positive health outcomes can be reached by introducing limited prescribing authority to RNs. Do we need RN prescribing now?

CANAC
ACIIS

Canadian Association of Nurses in AIDS Care

Position Statement: Cultural Safety for First Nations, Inuit and Métis people

Background

First Nations, Inuit and Métis people are central to Canada's history and future. Their resilience and diversity are evident in the many unique languages, cultures, practices, art and world views which collectively create the Aboriginal landscape on which Canada is built.

As nurses, we understand that culture is more than beliefs, practices and values. We understand it as a sociopolitical construct with underlying power relationships, which is enacted relationally through history. Lack of cultural safety between nurses and patients has been demonstrated to produce adverse outcomes, poor quality care and to disenfranchise patients. Cultural safety takes us beyond awareness and the acknowledgement of difference. Whilst cultural competency focuses on the skills, knowledge and attitude of health professionals, cultural safety focuses on the power differentials that are inherent in health care delivery, and redressing these inequities through education and changes to practice.

First Nations, Inuit and Métis people in Canada hold a unique social, economic and political position based on the historical antecedents that have contributed to the unequal power hierarchies that exist in Canadian society. Aboriginal health is a complex issue, reflecting historical disadvantages such as colonialism, racism, introduced diseases and the imposition of cultural and political institutions resulting in loss of land, loss of traditional food and lifestyle, residential schools and the forced separation of healthy families, poverty, unemployment and inadequate housing. CANAC recognizes the individual, family and community impacts of forced assimilation and Residential Schools and the escalation of child removal which occurred with the Section 88 amendment to the Indian Act.

HIV/AIDS nursing involves the care and treatment of a very diverse population of First Nations, Inuit and Métis, women, and children who have unique and multifaceted needs. Due to social, economic and political factors Aboriginal people make up a disproportionate percentage of all new HIV diagnoses. An important feature in shaping improved health outcomes for First Nations, Inuit and Métis peoples is the ability of health care professionals and organizations to provide culturally safe and competent care. In addition to requiring expert knowledge of the complex and continually emerging diagnostic and treatment modalities, nurses working in HIV/AIDS care must also be cognizant of racism, power relationships and negative impacts of social exclusion, negative stereotyping and victimization on the health of their clients.

Nurses must work from a strengths based approach with all clients and communities. Research, data and clinical care should be framed by the individual or community itself, and be presented in strengths based language to avoid further stigmatization.

To provide the expertise required for culturally safe HIV/AIDS care, nurses need more than the general knowledge and skills acquired in basic nursing education programs. It is generally accepted that nurses with specialized knowledge and skill are more efficient and provide safer, more competent and compassionate care. Culturally safe HIV/AIDS nursing care includes:

Strengths based approach: A strengths-based approach to nursing care offers a genuine basis for people taking control of their health and life in meaningful and sustainable ways. Nurses should focus on the positive basis of the person's resources and resilience. First Nations, Inuit and Métis people should be empowered to take a lead in their own care and draw upon their community and personal resources of motivation and hope.

Self reflection: nurses should reflect on their own cultural experiences, beliefs and attitudes and gain an understanding of privilege and how power is enacted, received and perceived in the nurse-client relationship.

Understanding of postcolonial theory: nurses should understand the relationship between colonization, residential school and historic/generational trauma and the impact this has on health disparities and inequities. Ideally, this education and exposure should be led by people with Aboriginal heritage.

Inclusive engagement and respect of First Nations, Inuit and Métis peoples and cultures that entails effective communication, inclusion of First Nations, Inuit and Métis peoples in the conduct of research and health care service planning and recognition of uniqueness and diversity in First Nations, Inuit and Métis communities. Research data and community level health data should be owned by, and framed by First Nations, Inuit and Métis people, to avoid the further stigmatization of communities.

Acknowledging indigenous knowledge. Nurses should understand Indigenous information systems as dynamic, continually influenced by internal creativity and experimentation as well as by contact with external systems. Indigenous knowledge is unique to each community, nation and family. Nurses should respect the practice and integration of traditional healing, medicine, oral narrative, oral knowledge and wisdom in health care.

Position

It is the position of the Canadian Association of Nurses in AIDS Care that:

- First Nations, Inuit and Métis people are a diverse, vibrant population who bring strength, fortitude and knowledge to our communities.
- First Nations, Inuit and Métis people experience unique barriers to health and well being due to a history of colonization and continued racism in both general society and within health care.
- Racism is a social determinant of health that must be addressed, explored, challenged and changed to ensure that all care is culturally safe.
- To provide optimal prevention, health promotion and care for First Nations, Inuit and Métis people, nurses require knowledge and skills about indigenous history, colonization, generational trauma and culturally safe practice.
- Nurses recognize that all interactions with clients are bi-cultural and nurses must understand their role as a 'bearer of culture' and examine their own realties, attitudes and beliefs.
- Nurses must acknowledge the power they posses as a nurse and its impact on others – cultural safety is determined by the person we are providing care to.
- Nurses should work with their organization to identify and address issues that may affect client's accessing services.
- Nursing care should be undertaken whenever possible, with the input of the client and/or whomever the client identifies as their community, family, significant other(s) and support structure.
- Nurses working in HIV/AIDS care must be committed to ongoing professional development to obtain and maintain cultural competency.
- To optimize client outcomes, workplaces and nursing education programs should make every effort to recruit and retain nurses with First Nations, Inuit and Métis heritage.

For a reference list, please visit: www.canac.org/Members/Positions/Cultural Safety PS.pdf

Boardroom Notes

Continued from page 9

Next Board

The next Board of Directors meeting will be held at the NANB Headquarters on October 16, 17 and 18, 2013.

Observers are welcome at all Board of Directors meetings. Please contact Paulette Poirier, Executive Assistant / Corporate Secretary at ppoirier@nanb.nb.ca or call 506-459-2858 / 1-800-442-4417.

97th Annual General Meeting & Invitational Forum

The 97th Annual General Meeting & Invitational Forum occurred on May 28 and 29, 2013, at the Delta Hotel, Fredericton. Approximately 250 RNs were in attendance over the two days of meetings. An overview of the Auditor's Report and highlights of activities current and future were presented.

For interested members, the 2012 Annual Report including the 2012 Auditor's Report is available on the NANB website under About Us / Annual Reports (www.nanb.nb.ca).

Invitational Forum:

The Changing Face of Professionalism

NANB hosted an Invitational Forum for members and stakeholders to remind registered nurses they are expected to demonstrate professional presence and model professional behaviour in the workplace. Discussions highlighted how professionalism can speak to multigenerational nurses and reflect on today's realities in the healthcare workplace. Video presentations can be accessed via NANB's website (www.nanb.nb.ca).

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Securing the Future of the Role of the Clinical Nurse Specialist in the Maritime Provinces

By ELEANOR KENNY, GLORIA SMITH, MALLORY DROST & MELISSA HILCHEY

The Clinical Nurse Specialist (CNS) is one of two advanced practice roles recognized in Canada. According to the Canadian Nurses Association (CNA, 2009), the CNS holds a Masters or Doctoral degree in nursing and is an expert practitioner in a nursing specialty. The responsibilities of the CNS incorporate the five key role components of clinician, consultant, educator, researcher, and leader (CNA, 2009). CNS practice impacts patient care by communicating and collaborating between the three spheres of patient/family, nurses and nursing practice, and organization/system (Lewandowski & Adamle, 2009; Montgomery & Steinke, 2006). The role of the CNS was first implemented in Canada in the 1970s (CNA, 2008) but its progression in the Maritime Provinces has been slow when compared to the rest of Canada. The practice of the CNS is characterized by autonomy and flexibility which allow for adaptation to meet the ever changing needs of the health care system (CNA, 2009); it is, however, the complex and dynamic nature of the role that makes it difficult to articulate. In order to better understand advanced practice and articulate the CNS role, the authors engaged, through graduate study at UNB during winter term 2013, with eleven CNSs employed throughout the Maritime Provinces. Observations and feedback from the CNSs were collaboratively synthesized with current literature and this analysis yielded several strategies that may support CNS practice in the Maritimes.

The evolution of the role of the CNS varies considerably in the three Maritime Provinces. There are currently no CNS positions in Prince Edward Island (PEI), nor are there immediate plans to introduce the role. According to the perceptions of CNSs in the Halifax area, the future of the CNS in Nova Scotia (NS) is bright; there has been a steady increase in the number of CNS positions in a wide range of clinical specialties over the past few years. In New Brunswick (NB), interviews with CNSs coincided with the ratification of a collective agreement between the New Brunswick Nurses Union and the Province of NB that included a new classification system. The agreement does not recognize the Masters or Doctoral education required by the CNS. Consequently, it threatens or risks the loss of recognition previously secured for CNS positions in the province. The only other advanced nursing role in the Maritimes is the nurse practitioner (NP), who is represented in a distinct and exclusive classification category of the collective agreements in both NB and NS. Despite the apparent absence of representation of CNSs in two provincial classification systems, Maritime CNSs recognize the need to enhance public understanding of their role and highlight the potential value they bring to patients, organizations, and the entire health care system.

There is a strong body of literature that well documents how CNSs operationalize their roles in advanced practice (Avery et al., 2006; Bailey, Murphy, & Porlock, 2011; Bergdahl, Benzein, Ternestedt, & Andershed, 2011; Charbachi, Williams, & McCormack, 2012; CNA, 2009; Darmody, 2005; Ingleton, Chatwin, Seymour, & Payne, 2011; Lewandowski & Adamle, 2009; Mayo et al., 2011). Engagement with CNSs in the Maritimes indicates clear similarities between these previous discussions of the CNS role and experience in the Maritime Provinces. Also consistent with this literature, it is important to note that the majority of Maritime CNSs reported the least amount of time was spent in the research role. Also consistent with previous discussions, many positive outcomes of CNS practice are recognized by CNSs, including improved health status, functional status, quality of life, and increased patient and family satisfaction (Bryant-Lukosius, DiCenso, Browne & Pinelli, 2004), shorter lengths of stay, lower rates of infection, the promotion of evidence-based and health promotion practice (Kleinpell, 2007), and the development of provincially and nationally adopted programs (Charbachi et al., 2012).

Observations and conversations with Maritime CNSs also agree with national and international literature concerning barriers to advanced practice; these barriers far outnumber facilitators. Barriers to CNS practice included: lack of understanding of the role; lack of support for the research component of the role; lack of support from key stakeholders, administration and the organization; invisibility of the role; financial restraints; and the organizational culture and agenda (Bryant-Lukodius, 2010; Charbachi et al., 2012; Gerrish et al., 2012; Krainovich-Miller et al., 2009; LaSala et al., 2007; Leary et al., 2008; Lewandowski & Adamle, 2009). Facilitators to CNS practice include: positive rapport with patients, nurses and other health care professionals; visibility among frontline nurses and patients; and support from administration and the organization in which they practiced (Avery et al., 2006; Charbachi et al., 2012; Darmody, 2011). Partnerships with individuals, groups, communities, organizations, administrators, and stakeholders were identified as

facilitators to practice both among the Maritime CNSs and in current literature (CNA, 2011; Interprofessional Education Collaborative, 2011; Charbachi et al., 2012).

A synthesis of CNS conversations, observations, and current literature resulted in suggestions for strategies that may enhance successful CNS practice in the Maritime Provinces:

- The creation of CNS positions that are based on evidence and that support the needs of the patient population and patient care setting (Bryant-Lukosius & DiCenso, 2004; Bryant-Lukosius et al., 2004). To promote optimal deployment of the CNS role the use of the PEPPA (Participatory, Evidence-based, Patient centered process for ANP role development) or other comparable framework is recommended.

- There is also a need for continuous evaluation and long-term monitoring of all CNS positions (Bryant-Lukosius et al., 2004). Consequently, those in current positions need to update job descriptions in collaboration with organizational leadership so that the goals of the role are mutually agreed upon and clearly defined.

- The research component of the CNS role must be strengthened to include research that is two-fold: research that demonstrates the value of the CNS position highlighting positive outcomes at the individual, nursing, organization and global level (Bryant-Lukodius, 2010); and research that integrates practice-based evidence to better support effective CNS practice (Bonis, 2009; Salmond, 2007).

- Strengthening partnerships with academic institutions, government stakeholders and nursing organizations will serve to enhance the research aspect of the role and help allocate appropriate funds needed for research (Dluhy et al., 2007).

- Policy processes that promote advanced nursing practice and policies that are shaped by the expertise of advanced practice nurses are also needed; the CNS is positioned to bring the patients' and nurses' voice to the policy table, creating a bottom-up approach to healthy public policy (Exworthy, 2008).

- Communication and education tools to inform the public, policy-makers, administrators, and other professions about the valuable contributions of the CNS role are needed. CNSs should consider engagement in campaigns aimed at improving the understanding of their role; an initiative, similar to the 2004 Canadian NP Initiative, would be of benefit. Through the initiative NPs were able to demonstrate their worth to governments, stakeholders and the general public; they gained support and firmly entrenched their role in the health care system (CNA, 2008).

- CNSs need to lobby for a CNS specific regulatory body that will help protect the future of the role as well as support and promote understanding of the role and its valuable contributions to health care.

In conclusion, the progress of the CNS has been slow in the Maritime Provinces and current political forces in the form of collective agreements and job classification systems threaten to reverse the progress that has been made. National and international literature

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The Institute for Safe Medication Practices Canada (ISMP Canada) is an independent national not-for-profit agency established for the collection and analysis of medication error reports and the development of recommendations for the enhancement of patient safety.

The Healthcare Insurance Reciprocal of Canada (HIROC) is a member owned expert provider of professional and general liability coverage and risk management support.

Volume 12, Number 7 **ISMP Canada Safety Bulletin** June 27, 2012

Identifying Knowledge Deficits Related to HYDROmorphone

Earlier this year, ISMP Canada undertook a survey to better understand the extent of healthcare professionals' knowledge deficits or gaps that could contribute to medication incidents with HYDROmorphone. The response to the survey was tremendous, with a total of 4399 respondents completing all or part of the survey, and 3476 respondents completing the knowledge assessment questions. Responses were received from every province and territory and represented healthcare disciplines involved in the prescribing, dispensing, preparation, administration, and/or monitoring of HYDROmorphone. This bulletin describes the context for the HYDROmorphone survey and provides an overview of the key findings.

Why a Survey about HYDROmorphone?

HYDROmorphone is 1 of the top 3 medications involved in incidents associated with harm that have been voluntarily reported to ISMP Canada.[1] As of June 30, 2011, the number of reported incidents involving HYDROmorphone with an outcome of harm or death totalled 160. Although the actual incident rate cannot be determined from voluntary reports, the number of harmful medication incidents involving HYDROmorphone warrants additional focus on this medication.

HYDROmorphone is a potent, centrally acting analgesic drug of the opioid class that is used to relieve moderate to severe pain.[2,3] Its adverse effects are similar to those of other potent opioid analgesics, such as morphine and fentanyl. Respiratory depression is the primary concern with these medications.

Available in oral and injectable forms, HYDROmorphone is about 4-7 times stronger than morphine;[2,3] therefore, any confusion between these 2 drugs can have devastating consequences for the patient, including death. A review of HYDROmorphone incidents that have been reported to ISMP Canada, including mix-ups between HYDROmorphone and morphine, suggested to ISMP Canada analysts that the difference in potency between these 2 drugs may not be well understood by all healthcare professionals.[4]

Background to the Survey

It was determined that an assessment of physicians', nurses', and pharmacists' knowledge related to the use and administration of HYDROmorphone was needed to identify potential knowledge gaps. Furthermore, it was felt that the types and magnitude of any gaps identified would assist in planning future interventions to decrease the potential for harm with this medication. An electronic survey format was selected as the approach that would support the widest dissemination of the survey and hence allow for the broadest reach across disciplines. Several expert advisors guided development of the survey, which was then field-tested by nurses in a regional health authority. The final survey consisted of 10 demographic questions, 19 knowledge assessment questions, and 1 question about how frequently HYDROmorphone was used in the respondent's practice setting. The survey questions covered the pharmacologic properties of HYDROmorphone, indications for use, adverse effects, usual dosage, dosing calculations, and difference in potency between HYDROmorphone and morphine.

The HYDROmorphone Knowledge Assessment Survey was launched via 2 national webinars presented in February 2012, one in English (February 9, 2012) and one in French (February 16, 2012). The online survey was open until March 4, 2012. After the survey closed, a link to the survey questions and answers was posted on the ISMP Canada website (available from http://www.ismp-canada.org/education/webinars/20120209_Hydromorphone/Answers.pdf).

Table 1: HYDROmorphone Knowledge Assessment Survey Results, by Discipline

Discipline	Number (%) of respondents	Average score on knowledge assessment questions (%)
Nursing	2169 (62.4)	72.5
Pharmacy	968 (27.8)	78.8
Medicine	299 (8.6)	81.7
Other	40 (1.2)	65.6
Total	3476 (100)	75

Survey Results: Overview

Of the 4399 respondents, 3476 (79%) provided answers to the knowledge assessment questions. Of these 3476 respondents, 2169 (62.4%) were from nursing, 968 (27.8%) from pharmacy, and 299 (8.6%) from medicine. An additional 40 respondents (1.2%) indicated that their primary role was in some other area (e.g., occupational therapy, social work, paramedic services) (Table 1).

Key Findings

- The majority of healthcare providers in the nursing, pharmacy, and medicine categories (3023 of 3436 or 87.9%), in responding to a question related to the *difference in potency*, correctly identified HYDROmorphone 1 mg as approximately equal to morphine 5 mg. An even larger proportion of respondents (3270 of 3436 or 95.2%) correctly indicated that morphine and HYDROmorphone are "both opioid medications used to treat pain but are dosed differently".

  However, incorrect answers provided by the remaining respondents (166 of 3436 or 4.8%) suggest that the relationship between morphine and HYDROmorphone is not universally understood. Specifically, 147 respondents (4.3%) answered "They are two completely different medications with different uses", 10 (0.3%) answered that "HYDROmorphone is 'watered-down' morphine", 6 (0.2%) answered that "Morphine is a brand name for HYDROmorphone", and 3 (0.1%) answered that "HYDROmorphone is a brand name for morphine". There was no apparent pattern to these incorrect responses in terms of disciplines: all disciplines were represented in these incorrect answers.
- For all disciplines, the lowest scores were obtained for questions related to the *pharmacologic properties* of HYDROmorphone, specifically, onset, peak effect, and duration of action of the various sustained-release and immediate-release formulations, as well as the relationship of these properties to patient monitoring and the use of rescue agents.
- The second lowest scores were obtained for a question involving *dosing calculations*. This knowledge deficit was greatest among respondents from nursing. Respondents were asked to calculate the volume of HYDROmorphone to be administered IV to a pediatric patient from the lowest-concentration parenteral formulation available in Canada (HYDROmorphone 2 mg/mL, 1 mL ampoule). This is an important question because the starting dose for an opioid-naïve individual, even an adult, is less than a full 2 mg ampoule. Interestingly, some respondents commented that they could not answer the question because they did not work with pediatric patients.
- Other areas where scoring was lower were related to:
  - ability to identify opioid tolerance (all disciplines);
  - recognition that obese patients do *not* require higher doses of HYDROmorphone (all disciplines);
  - recognition that patients with chronic obstructive pulmonary disease require lower doses of HYDROmorphone (all disciplines);
  - recognition that patients who are taking a benzodiazepine require lower doses of HYDROmorphone (nursing and pharmacy);
  - recognition that elderly patients require lower doses of HYDROmorphone (nursing and pharmacy);
  - conversion factor for changing an oral dose of HYDROmorphone to an equianalgesic parenteral dose of HYDROmorphone (nursing);
  - distinction between side effects and allergies (e.g., understanding that a side effect does not preclude the use of morphine) (all disciplines); and
  - recognition of the signs and symptoms of an overdose (medicine).

The responses to several of the questions were analyzed further to determine if there was any relationship between selection of the correct answer and a respondent's years of experience or area of practice. For most questions, no clear relationship could be established with either factor. For example, the number of incorrect responses was slightly higher for respondents working in long-term care, a group that might be anticipated to use HYDROmorphone less frequently than healthcare professionals working in acute care. However, the majority of respondents working in long-term care reported using HYDROmorphone more frequently than morphine or using it exclusively.

Next Steps

The level of participation in both the HYDROmorphone Knowledge Assessment Survey and the webinars used to introduce the project reflects strong interest in the safe management of HYDROmorphone across healthcare disciplines and settings. ISMP Canada has received many positive comments about the project. Several organizations have indicated their desire to incorporate use of the survey and resulting local findings into educational programs.

ISMP Canada is committed to working on strategies to enhance the safe use of HYDROmorphone and other opioid medications. An aggregate analysis of voluntarily reported incidents involving HYDROmorphone in which knowledge deficits were identified as contributing factors is in progress. Planning is also under way for a demonstration project to support and evaluate the implementation of specific strategies to enhance the safe management of HYDROmorphone.

Conclusion

It is hoped that sharing the key survey findings will assist Canadian healthcare facilities and individual practitioners to

examine processes in their organizations where knowledge gaps related to HYDROmorphone could increase the potential for error. ISMP Canada would be pleased to hear from individuals and organizations with ideas or results of work already done to further the understanding of identified issues and to enhance the safe use of HYDROmorphone and other opioids (by email at cmirps@ismp-canada.org or by telephone at 1-866-54-ISMPC [1-866-544-7672]).

The **complete survey report**, including a discussion of limitations, is available from: http://www.ismp-canada.org/download/miscpub/ISMPCanada_HYDROmorphoneKnowledgeAssessmentSurveyReport_2012June.pdf.

Acknowledgements

ISMP Canada gratefully acknowledges:

- All those who participated in the HYDROmorphone knowledge assessment survey—your responses are invaluable and will assist future efforts to enhance safety with HYDROmorphone.
- All the individuals who shared the HYDROmorphone knowledge assessment survey within their healthcare organizations and networks in an effort to widen distribution of the survey.

ISMP Canada also extends a special thank-you to the following individuals and groups for their contributions (in alphabetical order):

- Expert advisors: Jocelyn Brown RN BA BScN MN, Palliative Care Clinical Nurse Specialist, Princess Margaret Hospital, Toronto, ON; Paul Filiatrault RPh BSc(Pharm), Manager, Medication Safety, Interior Health Region, Kelowna, BC; Alex Ho MD FRCPC, Department of Anesthesia, St. Michael's Hospital, Toronto, ON; Sandra Knowles RPh, Drug Safety Pharmacist, Pharmacy Department, Sunnybrook Health Sciences Centre, Toronto, ON; Salima Ladak, Nurse Practitioner, Toronto General Hospital Acute Pain Service, and Coordinator, University Health Network Pain Advanced Practice Nurses Committee, Toronto, ON; Patti Madorin RPh ACPR BScPhm, Pharmacist, Patient Safety Service, Sunnybrook Health Sciences Centre, Toronto, ON.
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- Linda Poloway BScPharm FCSHP, Project Lead for this initiative; Lori Taylor RN BScN, Master of Nursing (MN) candidate and Project Manager, Corporate Nursing, University Health Network, Toronto, ON, and Ian Trimble BScPhm ACPR, Doctor of Pharmacy (PharmD) candidate, Vancouver Island Health Authority, Victoria, BC, both of whom worked on this initiative as part of their postgraduate studies.
- The nurses from Saskatoon Health Region who field-tested the survey.

ISMP Canada would also like to acknowledge special project funding support from Health Canada.

Knowledge is the Best Medicine: New Options Available to Help Patients Keep Track of Their Medications

The Canadian Medical Association, Canadian Nurses Association, Canadian Pharmacists Association, Victorian Order of Nurses, and Best Medicines Coalition have worked in partnership with Canada's Research-Based Pharmaceutical Companies (Rx&D) and ISMP Canada to create a new electronic version of the Rx&D product *Knowledge is the Best Medicine*. In recognition of the importance of engaging patients in their own healthcare, the new website provides innovative tools to help consumers and patients to keep track of information about their medications and vaccinations. For patients who prefer to use a portable electronic device, an iPhone software application called MyMedRec is available free of charge. Patients can choose how they store and carry their medication information and can easily communicate this information to their healthcare providers whenever they receive care. Communicating information about medications during transitions of care facilitates the process of medication reconciliation, and this innovation supports the National Medication Reconciliation Strategy. For more information on these tools, please visit www.KnowledgeIstheBestMedicine.org

Securing the Future of the Role of the Clinical Nurse Specialist in the Maritime Provinces

Continued from page 32

has proven the value of the CNS in other jurisdictions and can be applied to the Maritime Provinces since the role is operationalized in much the same way as in other parts of the country. The strategies outlined are designed to preserve and expand the role of the CNS in the Maritimes. Immediate action is required to protect the future of the CNS in the Maritime Provinces; the involvement of CNSs, provincial and national associations, organizational leaders, and government stakeholders is critical to establishing the CNS as a valuable leader in the health care system.

For a full list of references, please visit: www.nanb.nb.ca/downloads/Clinical Nurse Specialist References-E.pdf ■

Hours & Dates

The NANB Office is open Monday to Friday, from 08:30 to 16:30

NANB WILL BE CLOSED		DATES TO REMEMBER	
OCT. 14	Thanksgiving Day	OCT. 16–18	NANB Board of Director's Meeting
NOV. 11	Remembrance Day	DEC. 1	Registration Renewal Administrative Deadline
DEC. 25, 26 & 27	Christmas Holidays	DEC. 31	Registration Renewal Deadline
JAN. 1	New Year's Day		

CNA CERTIFICATION
for Nursing Specialties

Offered by the Canadian Nurses Association (CNA), the Certification for Nursing Specialties (competencies) is part of a respected national certification program that help registered nurses (RNs) stay current by testing their specialized knowledge and skills in their area of specialty. It is a voluntary program that allows RNs to build on the solid foundation of their RN registration and the clinical experience gained in their specialties.

The purpose of the certification is:

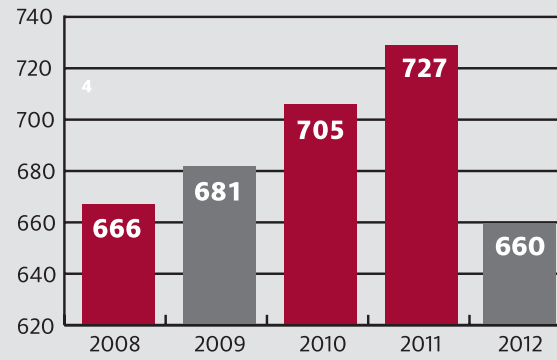
1. to promote excellence in nursing care through the establishment of national standards of practice in nursing specialty areas;
2. to provide an opportunity for practitioners to confirm their competence in a specialty; and
3. to identify, through a recognized credential, those RNs meeting the national standards of their specialty.

TABLE 1 *Number of RNs with CNA Certification in 2012*

Cardiovascular	60
Community Health	**
Critical Care	41
Critical Care-Pediatrics	0
Emergency	67
Enterostomal Therapy	*
Gastroenterology	10
Gerontology	57
Hospice Palliative Care	44
Nephrology	35
Neuroscience	29
Occupational Health	12
Oncology	58
Orthopaedic	26
Perinatal	55
Perioperative	55
Psychiatric-Mental health	60
Rehabilitation	11
Medical-Surgical	23
Total	**660**

* Information suppressed to protect privacy (1 to 4 records)
** Information suppressed to protect privacy (5 or more candidates)

FIGURE 1 *Number of CNA Certified NB RNs per Year*



The certification credential indicates to patients, employers, the public and professional licensing bodies that the certified registered nurse is qualified, competent and current in a nursing specialty. CNA offers 19 nursing specialty certifications.

As of July 2013, there were 660 valid CNA certifications in 19 different specialties/areas of nursing practice. Figure 1 demonstrates the numbers of certified RNs for the period of 2008–2012 in NB. Table 1 gives a breakdown of the number of valid CNA certifications and certification renewals by specialty for New Brunswick for 2012.

In order to get more information or to apply for the next CNA certification, visit the CNA website at www.cna-nurses.ca/CNA/nursing/certification/default_e.aspx or call 613-237-2133 / 1-800-361-8404.

The information in this article is provided by CNA's Department of Regulatory Policy (2013). www.cna-aiic.ca/en/professional-development/specialty-certification/what-is-certification/statistics

REFERENCES

Canadian Nurses Association (2013). *Department of Regulatory Policy*. Author: Ottawa.

Ask a
PRACTICE
CONSULTANT

By VIRGIL GUITARD

YOU'VE ASKED

As a registered nurse (RN), what do I need to consider before caring for one of my family members?

Entering into a therapeutic nurse-client relationship with one's family member can create challenges. The therapeutic nurse-client relationship differs from a non-professional or personal relationship in that the needs of the client always come first. By virtue of the nature of the nurse-client relationship, it is not recommended to maintain simultaneously a therapeutic and a personal relationship with the client. RNs should always disclose the existence of personal relationships with a client, to ensure alternative care arrangements are made and remove self from care. But, in some situations where no other alternative is available, an RN could be required to care for family members (such as when an RN works in a small community). In these situations, the RN must carefully reflect on whether she/he can maintain objectivity when deciding to enter into a therapeutic nurse-client relationship with a family member and whether the relationship could interfere with meeting the family member's care needs. It is also necessary to ensure that providing care for a family member will not interfere with the care of other clients or with the dynamics of the health care team. Before making the decision, the RN should discuss the situation with colleagues and the employer. Employers may have specific policies in place in relation to providing nursing care to family members.

NANB's *Standards of Practice for Registered Nurses* (2012) state that the RN *initiates, maintains and concludes the therapeutic nurse-client relationship*. Furthermore, NANB's document *The Therapeutic Nurse-Client Relationship: Practice Standards* outlines the specific requirements in relation to the nurse-client relationship. All of these expectations apply regardless of the situation. It is with this in mind that the decision of entering into a therapeutic relationship with a family member will be made. Finally, in deciding whether or not to offer nursing services to a family member, the RN must consider the following: *consent, boundaries, confidentiality* AND the *nurse-client relationship*.

Before providing nursing services to a family member, the RN must reflect carefully on whether she/he can maintain objectivity in caring for the family member and whether the relationship interferes with meeting other client's needs.

Consent

Consent protects the right of the client to be involved in an informed decision-making process about their own health care. Giving, refusing or withdrawing consent to care, treatment or research is an important step in the informed consent process. The RN must acknowledge that some clients (family member) may not be comfortable with receiving nursing services from someone with whom they are related. The client should be informed that all options have been explored and that at this time the only option available is to have the RN who is a family member, provide care.

Maintaining Boundaries

When entering into a therapeutic relationship with a family member, it may be particularly difficult for the RN to maintain professional boundaries. When a family member becomes a client, the RN must clarify the need to shift from a personal to a professional relationship in an open and transparent manner. Furthermore, the RN needs to consider how she/he will be able to maintain the boundaries either within the formal nurse-client relationship or, outside the therapeutic relationship (ex., at home or in social gatherings), once the episode of care has ended. The practice standard *The Therapeutic Nurse-Client Relationship* (NANB, 2010) outlines the expected professional behaviors of the RN in relation to maintaining boundaries with clients.

Confidentiality

An essential aspect to consider before deciding to care for a family member is confidentiality. The *Standards of Practice for Registered Nurses* (2012),state the RN must protect clients' privacy and confidentiality. Within the context of a therapeutic relationship with a family member, the RN will be privy to personal health information that she/he may not have been aware of as a family

member. The RN must maintain confidentiality and not share any of the information obtained in the context of a therapeutic relationship outside the health care team. An RN involved in the care of a family member needs to carefully reflect on how she will maintain confidentiality and not reveal information about the client to other family members, even after the therapeutic nurse-client relationship has ended. It's important to be aware of the legal and professional responsibilities as well as employer policies that address confidentiality of client information.

Nurse-client Relationship

A therapeutic nurse-client relationship ends when the episode of care has ended. It is important to explain to the client (family member) that once the episode of care ends, you will no longer be formally involved in providing nursing care. As well, all personal health information that has been acquired within the nurse-client relationship should not be discussed and the family member should be encouraged to consult with their primary health care provider if further care is needed.

For more information, contact NANB at 1-800-442-4417 or by email at nanb@nanb.nb.ca.

REFERENCES

Canadian Nurses Association (2008). *The Code of Ethics for Registered Nurses*. Ottawa: Author.

Nurses Association of New Brunswick (2011). *Consent: Practice Guideline*. Fredericton: Author.

Nurses Association of New Brunswick (2012). *Standards of Practice for Registered Nurses*. Fredericton: Author.

Nurses Association of New Brunswick (2011). *The Therapeutic Nurse-Client Relationship: Practice Standards*. Fredericton: Author.

TD Insurance
Meloche Monnex

Moving away from home for the first time? Don't forget your renter's insurance

Renter's (or tenant) insurance may not be at the top of people's minds as they prepare to move away from home for the first time. According to a survey by TD Insurance, 39% of Canadian renters under 35 don't have renter's insurance.

"Many recent graduates or young people assume they don't need renter's insurance, because what they own might not be valuable enough to insure," says Sylvie Demers, Chairman, Affinity Market Group, TD Insurance. "Even if you don't have expensive jewellery or furniture, consider the cost of replacing your laptop. Renter's insurance is a cost-effective way to ensure you have the right coverage in the event that the unexpected occurs." Sylvie provides her tips on what to consider when purchasing renter's insurance:

- **Look for deals and ways to cut costs:** Purchasing your auto and renter's insurance with the same insurance provider or through your student or alumni association can often yield attractive discounts. The cost of renter's insurance can be as little as the price of two movie tickets, and you will have peace of mind in the event that the unexpected occurs.

- **Ensure you're covered for liability:** What many people don't realize is that they may be liable if someone is injured on their property. If your landlord doesn't salt the walkway in the winter, and someone trips, negligence may fall with your landlord. But if they slipped inside your apartment because you didn't clean up a puddle, you may be liable for their medical bills, lost wages and damages for pain and suffering out of your own pocket.

- **Understand your coverage:** Make sure you understand and are comfortable with your renter's insurance deductible (how much you will have to pay if you have to make a claim) and if your policy offers 'actual cash value' or 'replacement cost' coverage for your belongings. You should also inform your insurer about items that are particularly valuable—like jewellery, computers or instruments—as these may require additional coverage.

- **Is it worth the chance?:** The chances of something actually happening are so small it's not worth the cost. There are a number of common incidences and simple mistakes that are generally covered under renter's insurance, including:

  - If there is a break-in at your home
  - If you have a party and you accidentally cause damage to your neighbour's property or your landlord's property
  - If you forget to turn off your water when you leave your home for the winter holidays, and one of your pipes freezes and bursts

SEPTEMBER 25–27, 2013

York Foundation

Excellence in Aging Care Symposium

- Journey Wesleyan Church, Fredericton, NB
- » http://yorkfoundation.ca/upcoming-events

OCTOBER 2–4, 2013

Canadian Association of Advanced Practice Nurses (CAAPN) Biennial Conference

- The Westin Nova Scotian, Halifax, NS
- » www.caapn.com/PDF/Biennial_Conference.pdf

OCTOBER 2–4, 2013

Canadian Federation of Mental Health Nurses 2013 National Conference

Mental Health Nursing...A Journey of Collaboration, Culture and Change

- Okanagan Grand resort Hotel, Kelowna, BC
- » http://cfmhn.ca/content/cfmhn-2013-national-conference

OCTOBER 3–4, 2013

5e Colloque sur le cancer du sein

- Four Point by Sheraton, Edmundston, NB
- » www.colloquecsnb.ca/conferenciers.htm

OCTOBER 4–5, 2013

Canadian Lactation Consultant Association Conference

Breastfeeding—It Just makes Good Science

- Delta Beauséjour Hotel, Moncton, NB
- » www.ilca.org/i4a/pages/index.cfm?pageid=3520

OCTOBER 16–18, 2013

NANB BoD Meeting

- NANB Headquarters, Fredericton, NB
- » www.nanb.nb.ca

OCTOBER 17–18, 2013

Atlantic Nursing Informatics Conference

Building Bridges—Making Connections

- Halifax Infirmary, Royal Bank Theatre, Halifax, NS
- » www.nsnig.ca/

OCTOBER 18, 2013

Canadian College of Health Leaders (NB Chapter) 2013 Annual Education Day

Critical Condition: Why Canada's Health System needs to be dragged into the 21st Century

- Ramada Inn, Moncton, NB
- » www.cchl-ccls.ca/default1.asp

OCTOBER 18–20, 2013

Canadian Association of Wound Care

Wound Care Learning Series

- Four Points by Sheraton Hotel, Halifax, NS
- » http://cawc.net/en/index.php/educational/institute/registration-information/

OCTOBER 28–29, 2013

National Reducing Hospital Readmissions & Discharge Planning Conference

- Hyatt Regency Vancouver, Vancouver BC
- » www.healthcareconferences.ca/healthcare-conference-events/national-reducing-hospital-readmissions-discharge-planning-conference

NOVEMBER 1, 2013

NCLEX- Workshops for Educators

- Delta Beauséjour, Moncton, NB
- » www.nanb.nb.ca/index.php/news/post/nclex_exam

NOVEMBER 9–10, 2013

Aboriginal Nurses Association of Canada (A.N.A.C.) National Forum

Honouring the Nursing Spirit at the Heart of Aboriginal Healing

- Marriott Vancouver Airport, Richmond BC
- » www.anac.on.ca/conferences.php

NOVEMBER 21–23, 2013

Canadian Association of Perinatal and Women's Health Nurses 3rd National Conference

Evolving Through the Mist of Change

- Sheraton on the Falls, Niagara Falls, ON
- » www.capwhn.ca/en/capwhn/News_p2469.html

NOVEMBER 28–29, 2013

National Correctional Services Healthcare Conference

- Ottawa Convention Centre, Ottawa, ON
- » www.healthcareconferences.ca/healthcare-conference-events/national-correctional-services-healthcare-conference

DECEMBER 2–3, 2013

National Operating Room Management Conference

- Hyatt Regency Vancouver, Vancouver, BC
- » http://cfmhn.ca/content/cfmhn-2013-national-conference

STAFF PROFILE

Supporting Members While Protecting the Public: NANB's Professional Conduct Review Process

Meet Lorraine Breau, NANB's Regulatory Consultant: Professional Conduct Review

Prior to joining the Association, what nursing career path did you follow and how did this prepare you for a position at NANB?

I have worked in a variety of settings such as Obstetrics and Gynecology, Public Health, Community Health, Nursing Education (RN, BN & LPN programs), Staff Education, Nursing Home and Correctional Services either in New Brunswick or Newfoundland. The experience I have gained from the various settings has helped me understand the documents and details we receive surrounding a complaint.

As the Regulatory Consultant: Professional Conduct Review, you have a very specific role to play at NANB. How would you describe your position?

My main responsibility as Regulatory Consultant: Professional Conduct Review is to oversee the Complaints and Discipline Process and to ensure the Process is fair for all involved. In this role, I coordinate, organize and support the Complaints, Discipline and Review Committees and also monitor the conditions imposed by the Discipline or Review Committees.

NANB's recently conducted member survey indicates that 52% of the respondents are only 'somewhat aware' or 'not at all aware' of the Professional Conduct Review (PCR) process. Why do you think this is?

The vast majority of nurses provide safe, competent and ethical care and therefore have no reason to think about or be familiar with the Complaints and Discipline Process. Generally speaking, a nurse becomes familiar with the Complaint and Discipline Process if she knows someone who has gone through the Process or if she has attended a Discipline or Review Committee hearing.

What would constitute a complaint as defined by the *Nurses Act*?

A complaint means: "…any complaint, report or allegation in writing and signed by the complainant regarding the conduct, actions, competence, character, fitness, health or ability of a member…" (*Nurses Act*, Section 27)

Complaints tend to be mostly related to:

Incompetence—medication administration and/or documentation errors, substandard documentation, failure to ensure patient safety.

Incapacity—problematic substance use and physical or mental health conditions or disorders affecting the practice of safe, competent and ethical nursing care.

Professional misconduct—a digression from the established standards of nursing such as: failure to assess, intervene/ take appropriate actions and ensure patient safety, unprofessional communication or behaviour, theft, breach of confidentiality.

Conduct unbecoming a member—is any conduct that might adversely affect the good standing or good name of the practice of nursing or the NANB such as: criminal convictions and theft.

Once a complaint is lodged with NANB, what happens next?

Once a formal written complaint is received, the Complaints and Discipline Process is activated and the nurse is promptly notified and provided with a copy of the written complaint and the supporting documents. A letter of acknowledgement is sent to the complainant with a request to provide any additional documentation as soon as possible.

All documents received from the complainant are shared with the nurse against whom the complaint was lodged and she has the opportunity to respond in writing before the matter goes to the Complaints Committee.

Are there trends in the nature of complaints received? If so, what are they and how is NANB addressing them?

In the last few years most of the complaints have been related to issues of incompetence such as medication and documentation errors, substandard documentation, and communication, a lack of knowledge, judgement and communication, and problematic substance use.

In relation to the issue of problematic substance use, NANB developed the document *Recognition and Management of Problematic Substance Use in the Nursing Profession* and delivered a number of presentations across the province on this topic. An e-learning module

REGISTRATION SUSPENDED

On January 28, 2013, the NANB Complaints Committee suspended the registration of registrant number 028109 pending the outcome of a hearing before the Discipline Committee.

SUSPENSION CONTINUED

On February 7, 2013, the NANB Discipline Committee found Kymberley Dawn Gillett, registration number 027907 to be suffering, at the time of the complaint, from an ailment or condition rendering her unfit and unsafe to practise nursing, and that the Member's conduct demonstrated professional misconduct, conduct unbecoming a member, dishonesty and a disregard for the welfare and safety of patients.

The Discipline Committee ordered that the suspension imposed on the Member's registration be continued until conditions are met, after which time, the member will be eligible to apply for a conditional registration.

REGISTRATION SUSPENDED

On February 19, 2013, the NANB Complaints Committee suspended the registration of registrant number 027964 pending the outcome of a hearing before the Review Committee.

REGISTRATION SUSPENDED

On March 11, 2013, the NANB Complaints Committee suspended the registration of registrant number 027992 pending the outcome of a hearing before the Discipline Committee.

SUSPENSION CONTINUED

On March 21, 2013, the NANB Review Committee found Guillaume Morin, registration number 028079, to be suffering from an ailment or condition rendering him incapable and unsafe to practise nursing when his ailment or condition is not adequately treated or controlled. The Committee also found that he failed to meet the standards of nursing practice, that he demonstrated professional misconduct, a lack of judgement and professional ethics, and a disregard for the welfare and safety of patients by not notifying his employer of his ailment or condition.

The Review Committee ordered that the suspension imposed on the Member's registration be continued until conditions are met. At that time, the Member will be eligible to apply for a conditional registration.

CONDITIONS LIFTED

The conditions imposed on the registration of registrant number 016562, have been fulfilled and are hereby lifted effective April 19, 2013.

REGISTRATION SUSPENDED

On April 22, 2013, the NANB Complaints Committee suspended the registration of registrant number 015334 pending the outcome of a hearing before the Review Committee.

REGISTRATION SUSPENDED

On May 6, 2013, the NANB Complaints Committee suspended the registration of registrant number 025947 pending the outcome of a hearing before the Review Committee.

REPRIMAND ISSUED

On May 16, 2013, the NANB Review Committee found that Emily Jane Victoria Sipprell, registration number 026149, had not adhered to conditions imposed on her registration by an order of the Review Committee dated December 7, 2011. The Committee also found the Member responsible for her conduct and actions and that she demonstrated professional misconduct, conduct unbecoming a member, dishonesty and a lack of judgement. Furthermore, the Committee reprimanded the Member for having breached her conditional registration.

The Member was ordered to pay a fine of $1,000 within 90 days of her return to the active practice of nursing. The member was also ordered to pay, within 24 months of her return to the active practice of nursing, a portion of the costs in the amount of $2,000 and the remainder of the portion of the costs in the amount of $4,500, ordered by the Review Committee, December 7, 2011. The Member is eligible to apply for a conditional registration. ■

Problematic Substance Use in Nursing is now available on the NANB website.

On average, how many complaints does NANB receive annually?

In the last two years, NANB has received an average of 10 complaints per year.

What is the importance of having a Professional Conduct Review process?

NANB is legally responsible for the regulation of the members of the nursing profession in NB. The professional Conduct Review Process, within a regulated nursing profession, makes its members accountable to the public for the delivery of safe, competent and ethical care.

What are some of the most rewarding and difficult aspects of your position?

The most rewarding aspect is seeing a nurse who was either suspended or revoked, being able to return to the practice of nursing in a safe, competent and ethical manner.

On the other hand, one of the most challenging situations is when the Review or Discipline Committee makes the decision that a member can no longer practice in order to protect the public.

How does this process support registered nurses while protecting the public?

Both nurses and the public are represented on the Discipline or Review Committees as they are composed of three nurses and one member of the public. By ensuring the process is fair for all involved, both the public and the nurse are protected. ■

NANB Documents

Recently Revised

The following NANB documents were recently revised and are now available on the website.

Standards for Nursing Education in New Brunswick

The *Standards for Nursing Education in New Brunswick* informs and supports the development and maintenance of high quality nursing education in the interest of public safety. The Standards' ultimate purpose is to provide guidance to nursing education programs in preparing registered nurses and nurse practitioners to practise effectively and competently within the present and future health care systems.

www.nanb.nb.ca/downloads/Standards for Nursing Education in NB English FINAL COPY.pdf

Entry-Level Competencies for Registered Nurses in New Brunswick

The *Entry-Level Competencies for Registered Nurses in New Brunswick* describes the knowledge, skills and judgement required of entry-level registered nurses to provide safe, competent, and ethical care in a variety of practice settings. The competencies also serve as a guide for curriculum development and for public and employer awareness of the practice expectations of entry-level registered nurses.

www.nanb.nb.ca/downloads/Entry level Competencies May 2013-E.pdf

Continuing Competence Program: Learning in Action

The *Continuing Competence Program* requires all New Brunswick registered nurses (RNs) and nurse practitioners (NPs) to demonstrate on an annual basis how they have maintained their competence and enhanced their practice. RNs and NPs reflect on their practice through self-assessment, the development and implementation of a learning plan, and the evaluation of the impact of the learning activities on nursing practice. The CCP applies to RNs and NPs in all domains of practice.

www.nanb.nb.ca/downloads/CCP Document August 2013_ English.pdf

Change, Challenges &

NANB's 97th Annual General Meeting was held on May 28, 2013 at the Delta Hotel, Fredericton.

France Marquis Reflects on Her Journey as President of NANB

By FRANCE MARQUIS

EDITOR'S NOTE: The following is an abridged version of France Marquis' presidential address delivered at the 2013 Annual General Meeting this past May.

The time has come for me to share with you my thoughts, my reflections and my dearest wishes. Several themes stand out throughout my term, so I choose what characterizes this social period: change and its associates, which are the challenges and the choices we must make to move forward.

First of all, I have to tell you that before undertaking my term at NANB, I too made a change that brought challenge and personal reflection. For several years, I had this great desire to surpass myself, physically and psychologically, by doing something that was way out of character for me. People who know me well, also know that I am far from being a fitness fan, even if I do have a healthy lifestyle and I am in good health. So, at the end of June 2011, I walked over 350 km, doing an average of 25 km per day, from Puy-en-Velay to Cahors in France on the Camino de Santiago. This journey, that I chose to do, brought all kinds of daily challenges (geographic, physical, psychological, etc.). Because of those challenges, I had to draw on my resources to find the required endurance, resilience, perseverance and ability to make decisions. Despite the challenges, I never thought of quitting, on the contrary; the more abrupt the hill or the more beset with obstacles, the more I wanted to go forward and further.

At first, I didn't make the connection with the position of President I was to assume two months later. But believe me, this life experience has been most useful in the last two years; I often drew from the same resources and, combined with the wise advice of Board Members and NANB staff, we were able to make the best decisions for our profession and the public. In fact, my reflection can be summed up this way: whatever the change, and whether this change is voluntary, desired or imposed, we must take the time to analyze the context and the issues and use our internal and external resources in order to move forward in the right direction. My changed philosophy is consistent with that of Mahatma Gandhi, who believed that one must embody the change that they want to see happen.

In several ways, it has been a rewarding term, but also a term marked by inner torments, uncertainty and hesitation. During my first year as President, I often asked myself why it had to be that a university nursing educator was leading NANB at a time where we had to decide whether to adopt a computer adaptive exam from the United States. I didn't find the answer, but I know that each President's term has its journey, and mine was tailor-made in some way.

During discussions around the exam issue, I sometimes felt I was losing my soul, but don't worry, I got over it, as the Board decided that we would be involved in the transition process in

& Choices. Moving forward . . .

order to be able to somewhat inform this change. Therefore, NANB's Executive Director is part of the planning committee which must ensure the competencies guiding nursing education in Canada are included and that the needs of the graduates from both linguistic communities in NB and throughout the country are respected. As an educator, I am in favour of a computer adaptive exam in a time where state-of-the-art technologies are everywhere, facilitating the assessment process and making it more effective and more efficient. For the future, we must trust in the ability of our representatives to see that the exam will meet the needs of the entry-level nurses starting their career in the Canadian context.

Beyond the exam, my dearest wish is to see NANB continue to grow long after its Centennial celebrations in 2016 through its regulatory mandate of promoting the profession and its members, and promoting public health policy that improves the well-being of all New Brunswickers. One hundred years of history, built upon the accomplishment of the pioneers who created this organization and those who advanced it. Therefore, I want to honour these young nurses in Saint John whose vision led, in 1916, to the creation of the New Brunswick Association of Graduate Nurses, established with the passing of the *Nurses Act*, with Reverend Sister Corrine Kerr as its first official President. Since then, 27 leaders have succeeded her and seen to the NANB's development and advancement. Allow me to acknowledge a few of those leaders: Katherine MacLaggan, Bernadette LeBlanc (the 10th President and 1st Francophone), Judith Oulton, Yolande Lepage-Cyr, Roxanne Tarjan, Sue Ness, Monique Cormier-Daigle and Martha Vickers.

To those who will succeed me for decades to come, I hope they will have the vision and the wisdom to preserve what we have and promote NANB's development as a regulatory body that carries on its commitment to promoting the profession and healthy public policy. Finally, I wish a very long life and a vibrant future to this organization that I profoundly respect and for which I feel a great deal of gratitude.

The Association's accomplishments and the services it offers its members make me proud. A lot was done in the last two years, and we succeeded in raising the profile of the profession significantly. The discussion forum scheduled tomorrow on *The Changing Face of Professionalism* is a perfect example, and the invitation extended to students to take part in the AGM activities is another. In the last two years, NANB has been closer to its members with its website and an increased presence in the various regions of the province in order to reach more and more members. As we know, current economic conditions have an impact on nurses participating in events like this. We must be clever and develop strategies that allow us to reach members where they are. The support by the primary health care framework and the development of national assessment nursing service for internationally trained nurses are other initiatives coming from NANB.

Nurses are full-fledged health care professionals who must optimize the use of their skills. This means you must mobilize and support the organizations that represent you–NANB, NBNU, CNA–in their efforts to help you develop professionally. You must demand the place that is yours, as there is no substitute for registered nurses. We must ensure that the registered nurse, the clinical nurse specialist and the nurse practitioner play a larger role within our health system. Evidence and best practices demonstrate that a smart use of nurses not only contributes to better services for clients, but also eases the fiscal pressure on the health system. Consequently, I urge you to continue demanding the space that is yours.

I will now take a few moments to tell you about the relationship we have with the Canadian Nurses Association (CNA). Later this morning, CNA's President Barb Mildon and Executive Director Rachel Bard will speak to the governance changes that are needed to maintain a prosperous national association. Historically, NB nurses have had and still have a very close relationship with CNA. This special relationship certainly results from the fact that several of our nurse leaders ended up at CNA, and even at the International Council of Nurses (ICN). We must strive to maintain and even reinforce this relationship. CNA is a federation that brings together close to 150,000 nurses throughout the country. This organization has a lot to offer, whether in terms of public health policies with, for example, the recent National Expert Commission, which advocates for the transformation of the health system to make it more effective and efficient in terms of population health, or the valuing of the profession through the nurse practitioner awareness campaign piloted with NANB, or the current campaign that puts forward the optimization of the registered nurse practice. However, CNA is currently at a crossroad. We will have to choose the path that will allow CNA to prosper and develop. This choice won't go smoothly, and we need to have the courage of our convictions and the political and professional courage to make the choices that seem the best ones to us. We need CNA to be a strong and prosperous national organization that will continue to be the best avenue for maintaining unity and professional visibility on a national and international level. I wish to acknowledge the recent election of outgoing CNA President Judith Shamian to the position of President of the INC, and I extend to her my warmest congratulations. I take this opportunity to thank my colleagues on the CNA Board and CNA staff, who diligently work for the success of the organization.

We are already into the second decade of not only a new century, but a

new millennium. History shows new centuries and new millennia are characterized by profound changes, challenges and choices which bring instability, uncertainty and confusion at all levels–sociopolitical, economic, climate, etc. But what we should remember is that, despite wars, cataclysms, corruption, abuse, or endemic, epidemic and pandemic diseases, populations were able to stand up and better embrace change and the challenges that come with it, and to progress. Resilience, audacity, determination and perseverance generate hope for a better future. Indeed, these periods were also marked by great discoveries and developments. As Mark Twain said, "Challenges make life interesting; however, overcoming them is what makes life meaningful".

Nursing is no exception. From Florence Nightingale to Virginia Henderson, to Helen Mussalem, to Judith Oulton, and to each nurse who, every day, fully embraces his or her role, nursing as a profession progresses and stands out. These leaders from yesterday and today nurture the aspirations of the next generations. To our leaders of tomorrow, who could be among the students with us today from both universities, I thank you for accepting NANB's invitation, and I encourage you to progress with certainty in your learning of this great and noble profession. With nursing, you will experience unforgettable moments and flourish as a person on all levels. During your studies and throughout your career, don't hesitate, take advantage of every possibility, provoke change, make the desired changes and learn to cope with the changes that are imposed. The ensuing challenges will bring you further and higher. Ask questions, advocate and, mostly, suggest innovative solutions. Be committed agents for change, proud of your career choice, and sustain the momentum throughout your career.

At this point, I would like to express my heartfelt thanks to the Board members, especially those who are completing their term, for their commitment to advancing the Association's mission. To those who are staying on the Board and those who will join you at the end of the day, I trust you will ensure continuity. Don't hesitate to embrace change, to question it, and to share your vision for the growth of the profession and its members.

I also want to thank all the nurses who were nominees at the 2013 election. Your initiative illustrates your commitment and your interest towards the profession and health care. I wish you every success.

To each member of NANB's staff, I wish to express my profound gratitude for the excellence of your work. I thank Lynda Finley, Director of Regulatory Services, Liette Clément, Director of Practice, Shelly Rickard, Manager of Corporate Services, and Jennifer Whitehead, Manager of Communications and Government Relations, for your initiative and your leadership. I thank Paulette Poirier, Executive Assistant, for her expertise and her great interpersonal skills. And last but not the least, I wish to convey my sincere gratitude to Roxanne Tarjan, Executive Director, for her leadership and her commitment of course, but also and mostly for her professionalism and her vision. Roxanne has a symbiotic relationship with NANB, having been member of the Board, President-Elect (1993-1995) and President (1995-1997), Nursing Practice Consultant, and finally, since 2001, Executive Director. Even if we didn't see things eye to eye every time, we worked together to meet the Association's mandates and ensure its development. Roxanne, please continue to advance NANB, and I sincerely thank you for your listening skills and your support during my two years as NANB's President.

I also want to thank my employer for its unfailing support of this responsibility that I held dear to my heart, and especially, Jacques Paul Couturier, Dean of Studies. I am extremely grateful to my work colleagues for their direct and indirect support during the many times I had to be away for reasons related to my responsibilities as President. You succeeded in holding the course, developing and implement a new curriculum while maintaining the quality of the curriculum still in place. I will be eternally grateful to you.

At last but not least, my family. Without their love and their unshakable support, I would not have been able to carry out this professional endeavour. My husband and I are very proud of our two daughters and their families, to whom I want to pay tribute. You have grown into exceptional human beings, and never forget that the sun will always rise on the horizon following winds and tides. Hold on to your values, as they will guide you and lead you where you need to go. You and our five grandchildren are my anchor, my fountain of strength and my inspiration.

In conclusion, I invite nurses, students, NANB and partners to pursue excellence in serving the public and promoting the nursing profession.

It was a great privilege to be NANB President, and it allowed me to meet and get to know many of you and to represent the public's and the profession's interests. Nursing is indeed a very demanding profession about which I am passionate, one that has nourished me and made me grow. I hope I was worthy of your expectations.

I take this opportunity to address my most sincere thanks to past president, Martha Vickers, for her advice during my two years as president-elect and beyond.

It is now time for me to transfer powers to president-elect Darline Cogswell, to whom I wish a calm and fulfilling mandate. Enjoy every moment of this experience, both good and challenging. They will make you stronger and wiser. Your past experience at different levels will serve you well. I take this opportunity to thank you for your support throughout my presidency. You are a good leader for the nurses of NB, the profession and the public. I leave reassured about continuity and I am confident you will carry out the activities of the Board and guide the destiny of NANB.

Finally, it is with pride that I share with you that I am celebrating this year not only 40 years of nursing, but also 40 years of marriage. I think I have every reason in the world to celebrate.

Thank you very much!

France Marquis, RN, MScN
President NANB, 2011–2013

The Changing Face of Professionalism

NANB's 2013 Invitational Forum

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