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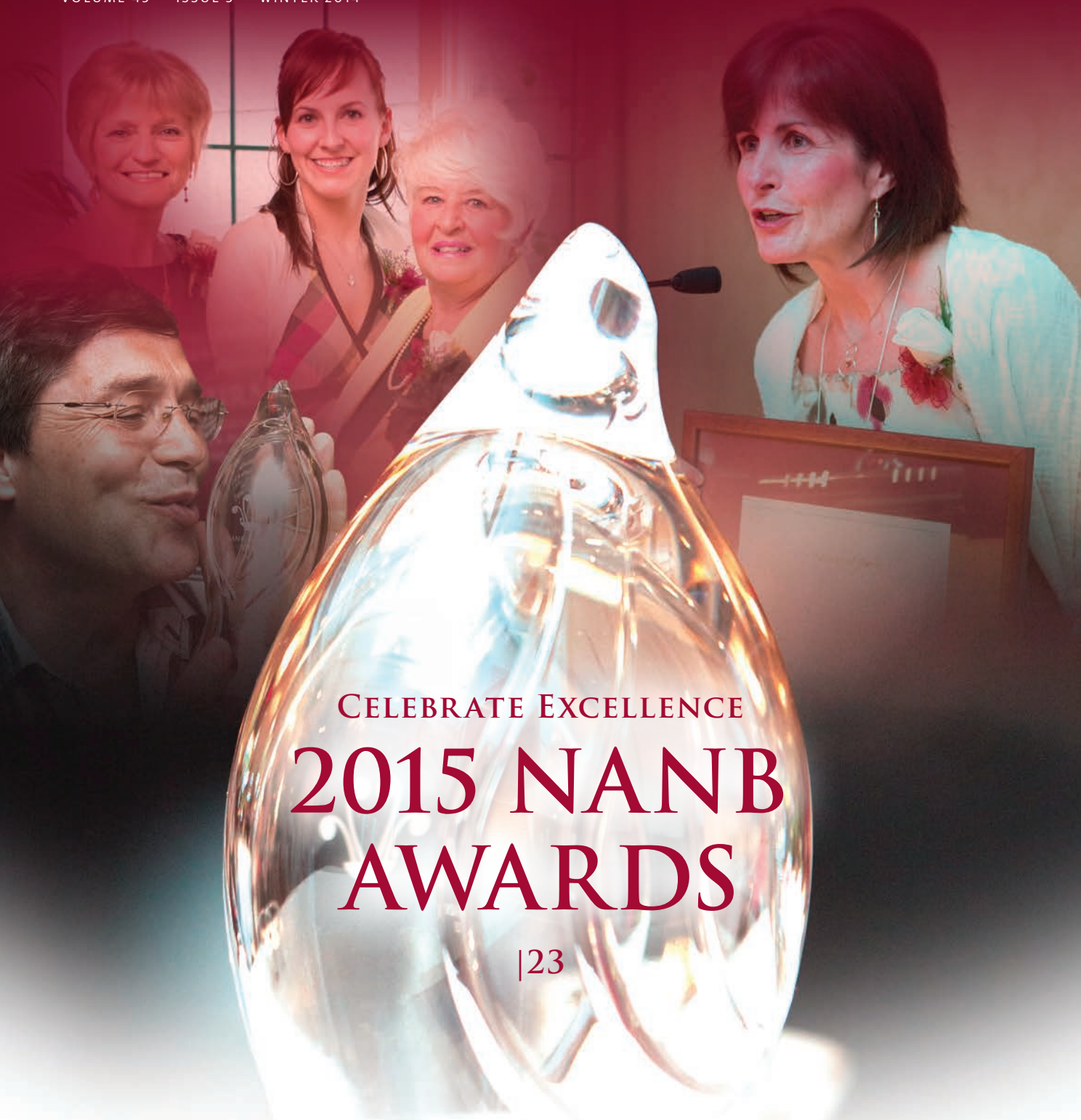

Celebrate Excellence

2015 NANB AWARDS

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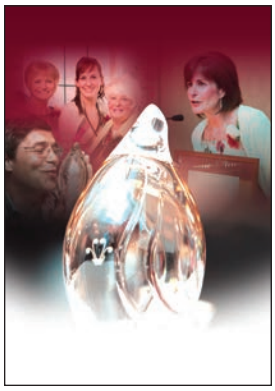
Nurses Association OF NEW BRUNSWICK

winter 2014

INSIDE

A voice for healthcare, a representative for your region, a contributor to the future of nursing in New Brunswick... *be a nursing leader.* See information on page 25 for the 2015 NANB Elections Call for Nominations.



Cover
Celebrate Excellence: 2015 NANB Awards. Nominate a nurse colleague deserving of recognition for their contribution to the profession and healthcare in New Brunswick.
See page 23.

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
Articles submitted for publication should be sent electronically to jwhitehead@nanb.nb.ca approximately two months prior to publication (March, September, December) and not exceed 1,000 words. The author's name, credentials, contact information and a photo for the contributors' page should accompany submissions. Logos, visuals and photos of adequate resolution for print are appreciated. The Editor will review and approve articles, and is not committed to publish all submissions.

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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Challenges and Changes

For some time we have been highlighting the impacts of globalization on our clients and our profession. The recent presence of Ebola in North America underlines its global impact, bringing awareness of health challenges around the world and its importance to us as health professionals. Having an Ebola patient in New Brunswick may continue to be identified as a limited possibility that would only occur if a number of circumstances and events aligned, but it is not impossible. The health system, government and health professions are prepared to respond. Learning from these challenges and continuously improving by maintaining our focus on professionalism is evident, something to be noted and applauded. Clearly, our careers in nursing and healthcare will bring many challenges; focusing on evidence, established best practices and bringing our commitment to the quality and safety of nursing practice and sound public policy to the forefront will ensure an optimal outcome for everyone.

With health care challenges, the Association is also faced with internal staffing changes. In August, the Board of Directors received a one year notice of retirement from our Executive Director, Roxanne Tarjan, to take effect in August 2015. On behalf of the members and the Nurses Association of New Brunswick, we thank Roxanne for her 20 years of commitment to the Association and its evolution, and for her dedication to the nursing profession. Celebrations will happen closer to her retirement! However, the NANB has a full work plan for the coming months which will continue to benefit from her direction until that time. In 2016, the Association will celebrate its Centennial - 100 years of exemplary work under the leadership of New Brunswick nurse leaders.

The NANB is an organization with a proud history, held in high regard by members and stakeholders and well positioned to continue its leadership in professional self-regulation and advancement of the profession and health policy in the public interest for all New Brunswickers.

Are you NANB's next Executive Director? Official recruitment will begin in March 2015. Today's announcement is to provide you, NANB members, the necessary time to reflect on your role in NANB's future. For more information on how to be considered for this position, please contact Shelly Rickard, Manager of Corporate Services, at 1-800-442-4417 or srickard@nanb.nb.ca.

Finally, on behalf of the Board of Directors and myself, we would like to extend our best wishes during the upcoming holiday season and hope for a new year of good health and professional success.

DARLINE COGSWELL
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Accomplishments and Opportunity

As we approach the end of 2014, taking a moment to consider the events of the past year in our personal and professional lives is important. This time of year also affords the opportunity to look forward to 2015 and consider what will and might be ahead for us individually and collectively.

While work at NANB during the past year focused on enhancing our regulatory capacity and supports to quality professional nursing practice, staff members were also engaged in a number of significant national projects with those same goals.

In August, the National Nursing Assessment Service was launched; culminating a 10-year journey for our discipline and registered nurse, licensed/registered practical nurse and registered psychiatric nurse regulators across Canada. The project would not have been realized without the financial support of the federal government. We thank them for their commitment to our vision. International applicants seeking recognition in Canada in any of the three nursing roles now apply through a common portal and are assessed using a common framework and tools established through the service and supported by our partner, the Commission on Graduates of Foreign Nursing Schools, recognizing their decades of competence and expertise in this area.

Transition to a new "entry to practice exam" continued in 2014; communication with stakeholders, education and development opportunities and the development and implementation of technology to support regulatory processes related to exam delivery, student registration for the exam, regulator authorization to write and the menu of result and reporting requirements as we transition to the NCLEX-RN exam in February of 2015 were completed. October 2014 saw the last cohort of New Brunswick writers of the Canadian Registered Nurse Exam. We sincerely thank the Canadian Nurses Association and Assessment Strategies, Inc. for their support, collaboration and commitment to this work over the years.

NANB is also undergoing a significant facility renovation at this time. Full access to our offices has been achieved through the installation of an elevator. As we are health professionals, your Board of Directors supported the importance of ensuring that everyone, regardless of mobility challenges, is able to access NANB facilities. This also supports and contributes to our regulatory mandate. This major upgrade also facilitated improvements to our office space in general; ensuring heating and lighting is up to date as well as general design and finishing refurbishments following almost 25 years of occupancy. We anticipate completion of the work early in the New Year and look forward to welcoming you all to an "open house" during our Annual General Meeting in June 2015.

There are exciting and jam-packed work plans in 2015, which include planning and preparations for our 2016 Centennial celebrations where NANB will host the Canadian Nurses Association Biennial Convention in Saint John, June 2016. The Board of Directors has committed to reaching out to nurses across the province in order to facilitate optimal member participation in joint celebrations. We encourage you to stay tuned for details in upcoming issues of *Info Nursing* and for updates via the website and e-bulletin. We will be recruiting nurse volunteers, so please think about stepping forward.

As noted in the President's Column, I have submitted my notice of retirement. I am so grateful of the opportunity and privilege to have worked for the NANB and the nurses of New Brunswick over the past 16 years; be assured of my continued commitment to our Association and our mandate over the coming months. Please consider this leadership opportunity for yourself. New Brunswick nurses have a proud heritage and one that you can be privileged to contribute to for years to come.

Finally, I wish to extend to each and every one of you best wishes for the coming holiday season and health and happiness in 2015!

ROXANNE TARJAN
Executive Director
rtarjan@nanb.nb.ca

THE BOARD OF DIRECTORS MET ON OCTOBER 15-17, 2014, AT NANB HEADQUARTERS IN FREDERICTON.

The meeting commenced with an afternoon orientation session welcoming the following four elected region directors and two reappointed public directors effective September 1, 2014:

- Joanne LeBlanc-Chiasson, *Region 1 Director*
- Amy McLeod, *Region 3 Director*
- Thérèse Thompson, *Region 5 Director*
- Lisa Keirstead Johnson, *Region 7 Director*
- Wayne Trail, *Public Director*
- Fernande Chouinard, *Public Director*

Policy Review

The Board reviewed and approved the 2014–15 Board Planning Cycle, as well as policies related to:

- *Governance Process*
- *Executive Limitations*

New and Amended Policies

The Board approved amendments to these policy:

- *GP-16 Board Development*;
- *GP-6.2 Nominating Committee Terms of Reference*;
- *EL-3 Financial Planning*;
- *EL-8 Communication and Support to the Board*;

and one new policy:

- *EL-18 NANB Document Nomenclature*.

New and Amended Rules: Nominating Committee

The Board approved a Rule amendment to enable the appointment of three RN Directors to the Nominating Committee instead of two RN Directors and the past president.

Electronic Voting

The NANB Bylaws were amended at the June 2013 Annual General Meeting to enable the implementation of electronic voting (internet or telephone) to elect members to the Board of Directors.

The first e-voting took place in April 2014. The NANB Rules were amended to concur with the bylaw amendments.

Short-Term Education Courses

A Rule amendment was approved by the Board to enable Registered Nurses (RNs) and Nurse Practitioners (NPs) from other Canadian jurisdictions to

participate in a clinical practicum related to a short-term course (e.g., foot care) without having to establish registration in New Brunswick.

Organization Performance: Monitoring

The Board approved monitoring reports for the *Executive Limitations; Governance Process* policies and Board Evaluation.

Call for Nominations for Public Director

The term of appointment of Edward Dubé, public director on the Board, will expire on August 31, 2015. Mr.Dubé has served only one term and has agreed to let his name stand for a second term. In order to appoint one public director, NANB must submit three nominees to the Minister of Health.

National Council of State Boards of Nursing (NCSBN) Associate Membership

The NANB's application to the NCSBN for Associate Membership was approved by the Delegate Assembly at their annual meeting in August 2014.

NCLEX Registration Examination

In preparation for the transition to the new entry to practice exam, the Board approved the recognition of the NCLEX from 1982 to the end of 2014 as an entry to practice examination for the purpose of registration of international applicants after January 1, 2015.

The first NCLEX will be offered in New Brunswick in February 2015.

Registered Nurses Professional Development Centre (RNPDC)

Re-entry Program

English and French international and domestic applicants who are required to take a re-entry program in order to meet registration requirements will be referred to the Registered Nurses Professional Development Centre (RNPDC) Re-Entry Program in Halifax, Nova Scotia. This will replace the previously utilized MacEwan University Nurse Refresher Program.

National Nursing Assessment Service (NNAS)

The purpose of the National Nursing Assessment Service (NNAS) is to provide a single portal of entry for applications for registration from internationally educated nurses (IENs) and to harmonize the application process by centralizing document collection and assessment of applicant files. The NNAS was launched on August 12, 2014.

UNB and UdeM Baccalaureate Program Interim Reports

Based on the recommendations of the Nursing Education Advisory Committee, the Board of Directors accepted interim progress reports from the UNB and UdeM Baccalaureate of Nursing Programs which responded to recommendations from the BN Program Approval Reports of February 2013 and November 2011 respectively.

Committee Appointments

The Board of Directors approved the following appointments:

- Nominating Committee members are: Brenda Kinney, President-Elect; Thérèse Thompson, Director Region 5 and Amy McLeod, Director Region 3.
- Sharon Hall-Kay, RN, York-Sunbury Chapter, was reappointed Chief Scrutineer for the 2015 Election and Annual Meeting.
- Nursing Education Advisory Committee Chairperson: Marjolaine Dionne Merlin, nurse educator, Université de Moncton (effective immediately to August 2016).

New and Revised Documents

The Board approved the following:

Revised:

- *Standards for Infection Prevention and Control*—a revision of Practice Guideline: *Infection Prevention and Control* (2009)
- *Professional Conduct Review: Complaints and Discipline Process*—a revision of *Complaints and Discipline Process* (2004)
- The 2010 *Accountability during a job action*: Practice Guideline document was retired and the content was republished as a Frequently Asked Question in the FAQ section of NANB's website.

New:

- *Cosmetic Medical Procedures:* Position Statement

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

Infrastructure Update

In 2013, the Board approved a capital construction project to enhance accessibility and update the NANB premises. The Board received an update on the current capital project underway. The building is being upgraded and an elevator is being installed to make the building fully accessible. This construction is proceeding on schedule and on budget to be completed by mid-December. Other upgrades to the premises

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NANB 2014 Social Committee Update

NANB's Social Committee raised approximately $800 last year through Casual Fridays. Proceeds went to: the Fredericton Food Bank; Emergency Shelter; Transition House; and the SPCA. Additionally, fundraising was done for the 'Dress Red' for the Heart and Stroke Foundation in February.

Again this past holiday season, NANB sponsored a deserving family through the Salvation Army. The committee organized the annual Silent Auction and raised funds in the amount of $500 to give this family a Christmas to remember. Plans are already undergo for this year's auction to raise more money for this wonderful cause.

Thank you to NANB staff for their continued support and cooperation!

Did You Know?

Every edition of NANB's e-bulletin, *The Virtual Flame*, is immediately posted on the NANB website after it has been distributed by email. If you have provided NANB with your current email address and are still not receiving *The Virtual Flame*, it could be blocked by your security settings or filtered to SPAM/junk folders. To receive notification and a direct link to the latest NANB e-Bulletin, forward your email address to **nanb@nanb.nb.ca** to be added to *The Virtual Flame* notification distribution list.

The President's Brief
Find it online at
www.nanb.nb.ca

Flu prevention begins with you. *Have you had your flu shot?*

Flu prevention resources available on NANB's website (www.nanb.nb.ca):

- NANB Position Statement: *Influenza Immunization for Registered Nurses*
- Immunize Canada: Influenza Immunization Awareness Campaign 2014–2015
- Government of New Brunswick: Influenza

Hours & Dates

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

NANB WILL BE CLOSED		DATES TO REMEMBER	
December 24, 25, 26	Christmas Holidays	December 31	Registration Renewal Deadline
January 1	New Year's Day	January 30	Deadline for NANB Election Nominations
		January 30	Deadline for NANB Awards Nominations
		February 17, 18	NANB Board of Director's Meeting

MARK YOUR CALENDARS

2015 NANB AGM & Forum

June 3 & 4, 2015

This is your opportunity to provide input and guidance to the Association. Stay tuned for more information and registration details in the spring issue of *Info Nursing*.

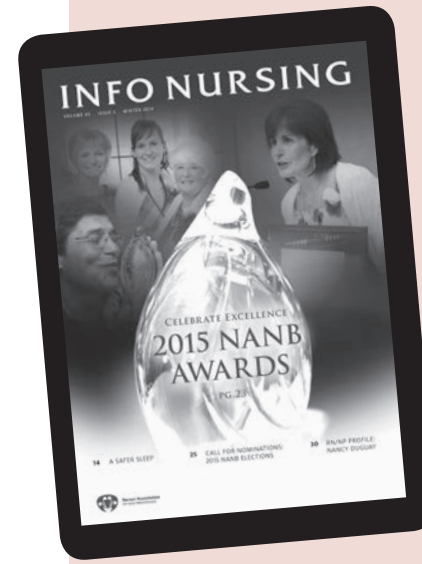
NANB Makes Greener Choices!

The Nurses Association of New Brunswick in shaping nursing for healthy New Brunswickers is pleased to inform you we have adopted greener policies and energy efficient processes for the health of it! By working together to protect our environment, we can all make a difference.

In an effort to become more environmentally responsible we:

- **transitioned** to 100% paperless registration renewal in 2012;
- **provide** new and out-of-province applicants with USB paperless packages since 2011 which include all necessary support materials to assist them in preparing for the NCLEX exam;
- **converted** to paperless Board of Director meetings providing director's and staff a secure section on the website to access necessary meeting information and reference materials;
- **made** significant changes to *Info Nursing* in 2009/10 which included:
  - introducing an electronic bulletin *The Virtual Flame* which replaced one issue of *Info Nursing* reaching members in a more timely manner, saving money and trees;
  - offering RNs/NPs the opportunity to receive *Info Nursing* electronically;
  - sending government MLAs, media and stakeholders *Info Nursing* electronically;
- **print** *Info Nursing*, all NANB documents and day-to-day paper needs using only 100% recycled Canadian Stock since 2009;
- **promote** new standards and documents available on the website instead of printing and mailing copies to all members since 2010;
- **discontinued** printing and mailing the Annual Report in 2008 to all members and stakeholders replacing with an electronic publication available on the website;
- **utilize** online surveys since 2009 to receive member feedback including NANB's annual CCP Audit process;
- **participate** in the Shred-it program, as a result the Association saved 6.1 trees in 2014;
- **installed** water coolers replacing bottles and installed energy efficient storm entrance doors to the building in 2010; and
- **NEW** in 2014, NANB's Election to the Board of Directors was conducted online or by telephone replacing paper ballots. ■

Do you want to receive *Info Nursing* electronically?



NANB offers members the opportunity to receive *Info Nursing* electronically. In a continuous effort to be an environmentally friendly Association, NANB currently emails stakeholders and members a direct link to your nursing journal. Please email **stobias@nanb.nb.ca** indicating you would prefer to receive future issues of *Info Nursing* electronically.

Victoria Public Hospital Nurses Alumnae Bursary

The VPH Nurses Alumnae bursary is awarded each year to a VPH nursing graduate or relative of same. Brenda (Blaney) Haney, VPH graduate of the Class of 1972, received a $2000 bursary to continue education in her specialty. Brenda has her CNA certification in Hospice Palliative Care and shares her expertise in this field with patients and staff at Extramural.

To apply for the bursary, please contact us with info about your nursing studies and your VPH connection at gtuttle@unb.ca or sheila.currie8@gmail.com.

NANB E-Learning Modules

Available at www.nanb.nb.ca

Committed to Professionalism, Committed to Care

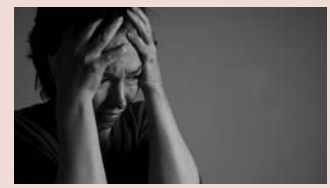
Nursing Standards require RNs and NPs to provide safe, competent and ethical care while being professional. This e-learning module discusses what professionalism entails, why RNs and NPs need to be professional, and the impact of unprofessionalism, and it provides strategies for making professionalism a part of everyday nursing practice.

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

Cultural Awareness for Preceptors and Mentors of Internationally Educated Nurses (IENs)

It's All About the Nurse-Client Relationship

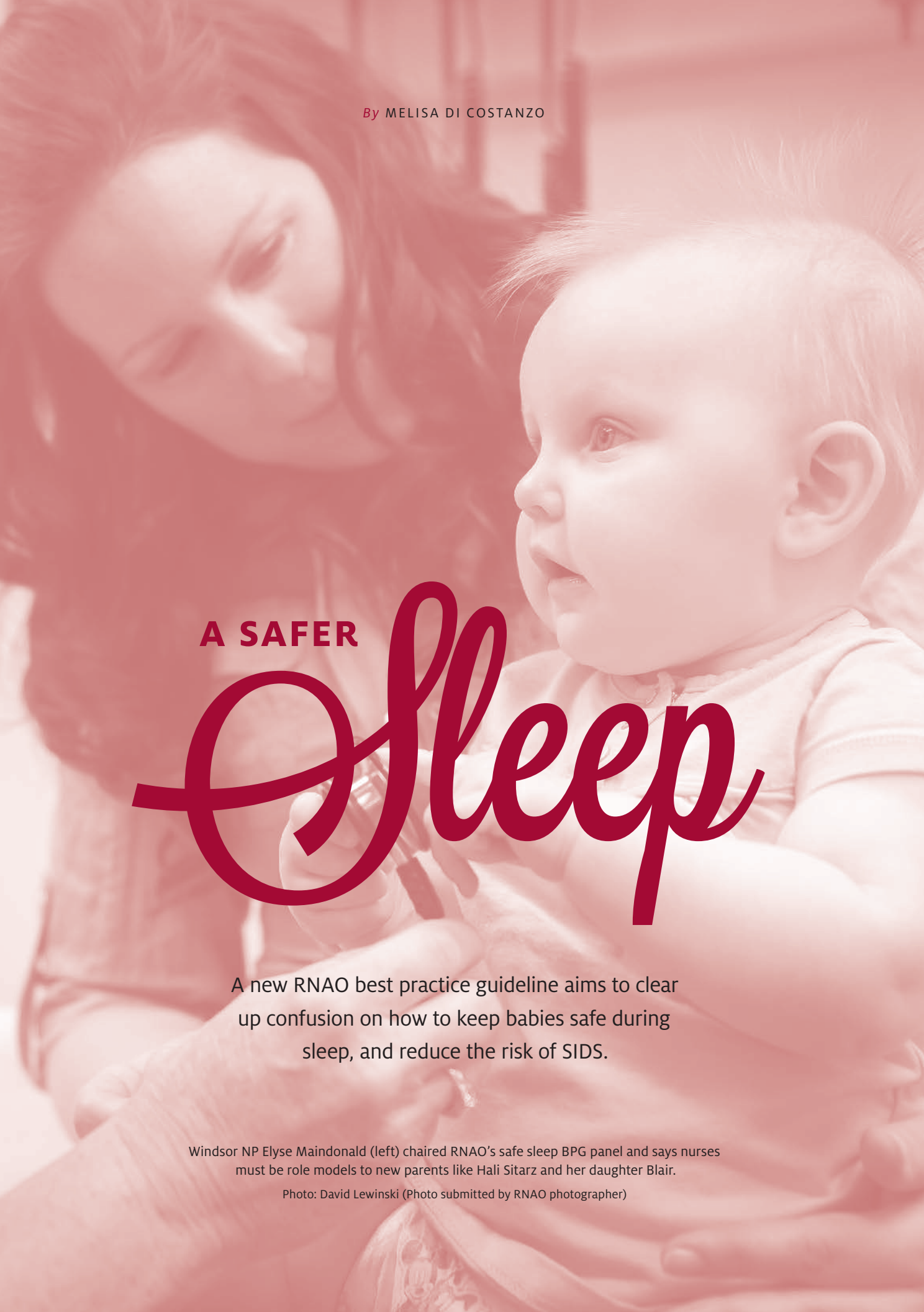


Problematic Substance Use in Nursing

By MELISA DI COSTANZO

A SAFER Sleep

A new RNAO best practice guideline aims to clear up confusion on how to keep babies safe during sleep, and reduce the risk of SIDS.



Windsor NP Elyse Maindonald (left) chaired RNAO's safe sleep BPG panel and says nurses must be role models to new parents like Hali Sitarz and her daughter Blair.

Photo: David Lewinski (Photo submitted by RNAO photographer)

Reprinted with permission. Originally published in the May/June 2014 issue of *Registered Nurse Journal*, the bi-monthly publication of the Registered Nurses' Association of Ontario (RNAO).

It was early morning on June 17, 2004, when Yolanda Guitar and her husband, John, boarded a plane bound for Las Vegas. The couple was looking forward to their four-day vacation, leaving their two kids—Emily, then two-and-a-half-years-old, and John Dylan, four months—in the hands of the babysitter they trusted with their eldest child since she was 10-months-old. Even before they stepped onto the jet, Yolanda admits: "I had a feeling… something was going to go wrong."

By early afternoon, the pair reached the MGM Grand, checked in, and poked around the slot machines until a security guard approached them. He was clutching a phone. A Toronto police officer wanted to speak to John, who was led into a back room. Yolanda, meanwhile, frantically dialed the babysitter, who didn't pick up. Instead, a police officer answered.

She doesn't remember why she asked this (a mother's instinct, maybe), but Yolanda blurted: "Did my son, did John Dylan, die?" There was a pause. "I'm sorry to tell you that yes, he did," came the response.

"The whole casino just closed in on me," she recalls.

Before leaving for their mini-holiday, Yolanda remembers the babysitter explaining that she was going to put John Dylan, a colicky baby, to rest on his tummy. "Babies sleep better on their stomachs, and are more comfortable," she said. Yolanda had "no reason not to trust her."

Twenty-four hours later, the Guitars found themselves at Toronto's Hospital for Sick Children holding their lifeless son, who was wearing only a diaper. He died of Sudden Infant Death Syndrome, or SIDS, during a nap. The Public Health Agency of Canada (PHAC) describes the phenomenon as "the sudden death of an infant less than one year of age, which remains unexplained after a thorough case investigation," including an autopsy, an examination of the death scene, and a review of the baby's clinical history.

For Yolanda, the term is synonymous with a bad dream. Sadly, she and her husband are not the only parents who have faced this unthinkable tragedy. John Dylan was one of 84 infants who died of SIDS in 2004 across Canada, according to Statistics Canada. In Ontario, he was one of 12. Fast-forward eight years to 2012 and the number of infant deaths attributed to SIDS in Ontario was only one. According to Ontario's Office of the Chief Coroner, roughly nine years ago, it decided to more strictly define SIDS, and require very specific circumstances in order to concretely say a death was the result of SIDS. The coroner's office admits it's possible this change resulted in the dip in numbers.

Meanwhile, PHAC says between 1999 and 2004, Canada saw a 50 per cent plunge in the rate of the syndrome. The national organization says the nosedive "may be attributable, in part, to changes in parental behaviour such as placing infants on their backs to sleep, and decreasing maternal smoking during pregnancy." Efforts to raise awareness over the past decade likely contributed to these changes. The *Back to Sleep* campaign, announced by the federal government in 1999, encouraged parents to put their babies to sleep on their backs. Six years prior to that movement, Canada, in tandem with other organizations across the globe, recommended infants be placed on their backs to sleep.

Evidence suggests SIDS can occur as a result of a combination of genetic, metabolic and environmental factors, including an unsafe sleep space. Although PHAC acknowledges the actual cause(s) of SIDS is unknown, the most important, modifiable risk factors are maternal smoking during pregnancy and infants sleeping chest-down (both are discouraged).

That nap 10 years ago was the only time John Dylan was put to sleep on his belly, Yolanda says. The Toronto resident always put her children to bed on their backs. In fact, just after giving birth to Sarah, the child she had after John Dylan, she noticed her newborn had been placed on her side. Recovering from a caesarean section, Yolanda pressed a call button, and asked another nurse to put Sarah face up. "What's the hospital policy…should babies be put to sleep on their backs, sides or chest?" the new mom remembers asking the nurse, who replied: "We don't really have one. Babies should be on their back, but some nurses will do what they think is best."

This kind of inconsistency, which still exists today, was the catalyst behind RNAO's best practice guideline (BPG), *Working with Families to Promote Safe Sleep for Infants 0–12 Months of Age*. The BPG's panel of experts sifted through and analyzed years of research to create the document. "Parents will do what they see and not always what they hear," Yolanda says. The mother of three (she had two more children after John Dylan died) was on the guideline's advisory committee, a group to which the panel of experts looks for feedback and insight. "(That's why) modelling of behaviour is critical in the hospital."

Nurse practitioner (NP) Elyse Maindonald agrees, adding nurses at all levels of the health system should be aware of best practices. The chair of the BPG panel says an essential piece of the guideline urges nurses to model safe sleep practices by placing infants on their back for every sleep, unless there are medical reasons for doing otherwise. The guideline also advises nurses to reflect on their knowledge, judgement, perceptions, practices and beliefs when it comes to safe sleep environments.

"Nurses are closest to babies and mom(s)," Maindonald says. "People look up to nurses." And evidence has found nurses are key when it comes to modelling safe sleep practices.

The BPG recommends that, when it comes to sleep, babies should be snoozing alone, on their backs, in a crib that meets Canadian safety standards. The "back is best" approach applies to children under the age of 12 months. Cradles and bassinets with sides that allow air flow are also considered safe

spaces. Sleep surfaces not recommended? An adult's bed, sofas, couches, armchairs, playpens, swings, strollers, slings and car seats.

Caregivers are also encouraged to avoid using blankets, pillows, positioning devices, head coverings and soft toys because all can obstruct an infant's airway. "Anything that improves the infant's access to good-quality air and nothing to block the intake of that air is what (nurses) want to get across," says Maindonald. A firm mattress and fitted sheet are all that's needed, according to the guideline. Breastfeeding is also recommended as a protective factor against SIDS; smoking (before, during and after pregnancy) is not.

Maindonald reinforces the BPG's aim is to "clarify myths and misconceptions (to help) give parents the very best information that's available at this time," so they can make informed decisions.

A Windsor primary care NP, Maindonald has spent the last 25 years researching SIDS, an interest born out of personal experience: her cousin and mother-in-law each lost a child. She has worked in emergency departments and intensive care units over four decades in the profession, and says it's impossible to forget the babies who have died while she's been on shift. "It's gut-wrenching," she says. "Even as a nurse, you wonder: what could I have done differently to save that baby, to save that family from that pain?"

Maindonald anticipates RNAO's BPG will help with just that. She's optimistic its recommendations will be incorporated into nurses' daily practice, nursing school curriculums, and hospital policies.

The safe sleep BPG was officially released in February 2014, but the topic has been on the minds of nurses for a number of years. Many RNs have expressed concerns with the conflicting messages parents receive about creating a safe sleep environment for their babies.

Waterloo RN Jan Levesque was one of those nurses. Some parents told her that, when they attended prenatal classes, they were told to put infants on their backs, whereas at the hospital, they saw nurses placing babies on their sides. She felt there was a strong need for clear and consistent guidelines to support safe sleep practices.

At a time when parents are vulnerable to differences in messaging, and aren't fully aware of all the challenges of caring for a new child, Levesque says: "It's really important everybody (is) on the same page and (is) consistent."

Levesque advocated for this kind of uniformity through a variety of means, including a resolution at RNAO's 2007 annual general meeting. A working group was established to help change practices and raise awareness among providers and caregivers. RNAO also identified safe sleep practices as a guideline topic priority, establishing an expert panel in 2010 that dug into the research.

Former public health nurse Helen Tindale (she retired in 2013) sat on the BPG's panel of experts. Tindale, an early advocate for clear messaging to parents and providers, worked with moms and babies for the better part of almost 40 years. For the last 25, she worked as a public health nurse in Waterloo Region. One crucial part of her role was conducting home visits. She saw blankets, pillows and stuffed toys crowding babies' sleep space, and talked to parents about the dangers these products can pose.

She'd watch as grandmothers put their tiny grandchildren to sleep on their stomachs, using the opportunity to explain how things have changed. "There were no car seats when your kids were little, right?" Tindale would ask. "This is the same kind of thing. Evidence has shown car seats prevent death.

We now know that…back is best for babies."

Another practice that many parents struggle with is swaddling. RNAO's guideline concludes: "there is currently no evidence on the "safe way" to swaddle an infant, and hence caution regarding swaddling should be expressed with parents/caregivers."

This traditional technique to keep infants warm can be associated with risks. For instance, wrapping babies tightly in blankets can cause overheating, which can put infants at greater risk of SIDS. A blanket can also become unravelled and cover the baby's face, increasing the risk for suffocation. If it's too tight, it can cause hip dysplasia and limit chest expansion.

During home visits, Tindale often advised parents to spend 10 minutes burping after each feeding, holding the child upright, against the chest. Then, cradle the baby and after he/she drifts off, place them on their back in the crib. "Parents need to learn how to read their baby's cues…they need practical, hands-on support…" from public health nurses and peer support groups, says Tindale.

Patricia Maddalena remembers when she began her nursing career 32 years ago. "Swaddling in the delivery room was something we all practised," she says. Now, the pediatric NP at Toronto's Sunnybrook Health Sciences Centre says "…overall, we try to impart (to caregivers) that our recommendation is not to swaddle." A member of the safe sleep expert panel, Maddalena admits educating those who have been doing it for years, or who have witnessed or heard about swaddling's perceived benefits, can be challenging.

When she encounters caregivers who are committed to swaddling, she asks: "When are you going to discontinue this practice?" She reviews the associated risks of loose blankets, especially when infants start to become more mobile. Some parents wonder how they're going to keep their youngster warm, so she recommends layers of clothing. If a sleep sack is used, it must be properly fitted. "It's imperative for families to understand what the risks are," she says. Adopting a collaborative approach is equally important, Maddalena adds, as opposed to telling parents "this is what you have to do."

"That's why she likes the title of the BPG: working with families to promote safe sleep. Maddalena is thrilled the BPG also addresses immunizations and breastfeeding. Both have an impact on safe sleep, but can have consequences "beyond that context, as well. It's an excellent document framed in the context of safe sleep that actually helps to optimize overall development and health."

Every June 17, Yolanda Guitar and her family visit John Dylan's grave, a 15-minute drive from home. They stop by throughout the year, too, sometimes bringing food for a picnic. In the spring, they plant white daises. Not a day goes by that Yolanda isn't thinking about her son. "He was only on earth for four months," she says. "I never want him to be forgotten."

"There's a lot of guilt (and) what-ifs," she adds. "I don't want anyone else to go through this."

Make it happen.

Maya • age: 4 • condition: Leukemia • wish: be a ballerina

MAKE-A-WISH.
Atlantic Provinces Canada

Make-A-Wish® Atlantic Provinces was pleased to connect with the Nurses Association of New Brunswick and be a "tool in your toolkit" for the benefit of your patients. For a child you know, you can provide a respite from illness, medical treatments and worry, allowing a family to come together and focus on happiness and child battling a life threatening illness just be a kid again.

An international charity spanning the globe, Make-A-Wish® is the largest wish-granting organization in the world with a wish granted globally every 38 minutes. With the help of over 30,000 volunteers world-wide, we've made dreams and wishes come true for more than 330,000 children since 1980.

Wish children come through a referral process which is as simple as a phone call. Here is what you need to know!

What is a wish?

A wish can teach a sick child that anything is possible – even the future. Wishes come in four main categories: I wish to have, I wish to be, I wish to go and I wish to meet. Whether it fulfills a fantasy, creates an adventure or includes a celebrity or sports hero, there is one common goal in the granting of each individual wish. That is to bring hope and joy to a child with a life-threatening medical condition.

Every wish is personal, involves the family and is free from financial worries. We ask the family to be a part of the wish experience, knowing that parents and siblings need these magical moments just as much as the wish child. A child's condition does not have to be terminal to qualify for a wish. Many of the children with life-threatening medical conditions who qualify for a wish go on to lead healthy, happy lives. It is the child's physician who makes the determination of whether a child has a life-threatening medical condition.

Who is eligible for a wish?

- A child must be between the ages of 3 and 17 at the time of referral.
- The child's current medical condition must be considered life-threatening.
- The child has not received a wish from Make-A-Wish or any other wish-granting organization.
- The child has the ability to identify, comprehend and appreciate a wish.

What steps are involved in granting a wish?

REFER: It all starts with a phone call or an email to Make-A-Wish

ELIGIBILITY: Make-A-Wish will determine the child's eligibility with help from their qualified healthcare professional and our medical advisor.

WISH VISIT: Wish Grantors meet the child to learn his or her one true wish and the magic begins to make that wish come true.

WWW.MAKEAWISH-ATL.CA | 1.877.466.9474 | ATLANTICCHAPTER@MAKAWISH.CA

Who can I refer a child to Make-A-Wish?

Make-A-Wish is dedicated to granting the wish of every eligible child. Anyone can contact Make-A-Wish at any time.

Knowing it can be difficult for families to think beyond the daily routine of hospital visits, treatments, and medication when their child is seriously ill, friends, extended family or members of their patient care team can become an important referral source.

We welcome your inquiry at any point and value your input and assistance in helping us continue to make wishes come true for children battling life-threatening medical illness.
Just call 1.877.466-9474.

How do I empower parents to refer their child?

If a family would like to take time to consider referring their child to Make-A-Wish, you can encourage them to visit www.makeawish.ca **or call 1-877-466-9474.**

Who do I contact for more information?

Lisa Mills, Manager Development
Make-A-Wish Atlantic Provinces
Suite 605, 5991 Spring Garden Road
Halifax, NS B3H 1Y6

1.877.466.9474 | infoatlantic@makeawish.ca | **www.makeawish-atl.ca**

MAKE-A-WISH
Atlantic Provinces Canada

WHY A WISH?

89%
Of health care professionals surveyed say they believe that the wish experience can influence wish kids' physical health.

96%
Of parents said that the wish strengthened their families.

74%
Of wish parents observed that the wish marked a turning point in their children's response to treatment.

81%
Of parents observed an increased willingness by their wish kids to comply with treatment protocols.

97%
Of wish families observed increases in their wish kids' emotional health.

99%
Of parents reported that the wish experience gave their children increased feelings of happiness.

* Make-A-Wish® America survey of the Make-A-Wish "community", including health care professionals, wish families and volunteers conducted by TCC Group from 2010 through 2011.

BPG Breakdown

All of RNAO's best practice guidelines (BPG) offer evidence-based recommendations that are grouped into three categories. The safe sleep BPG is no exception, and we explore in this full-length feature those categorized under the broad areas of practice and education. Following are further recommendations related to organization and policy changes. These provide some of the broader steps RNAO is recommending:

- advocate for education, training and resources for alternate caregivers regarding safe sleep practices for infants
- participate in research regarding morbidity and mortality as it relates to infant sleep
- advocate for improved systems for reporting and monitoring of morbidity and mortality related to infant sleep
- develop policies that support the implementation of safe sleep practice recommendations in all organizations involved in prenatal, postnatal, and community based family care.

Test Your Knowledge

Safe Sleep

True or False

A. My baby is more likely to choke while on his/her back.

B. Babies don't need to be wrapped tightly to stay warm.

C. My baby's head must be stabilized.

D. A soft sleeping surface will provide a lower risk for my baby.

E. My baby's head and arms are going to get caught in between the crib's rails.

F. Sharing the same sleep surface with my infant is safe because it's warm, calm, and he/she sleeps longer.

Answers

A. *False:* When facing up, babies are able to turn their heads to the side, which allows regurgitated food to flow out of the mouth.

B. *True:* It's true that babies (up to one month old) need to stay warm because their thermal regulators haven't stabilized. Parents can put their babies to sleep wearing layers, while being careful not to overheat the baby. If using a sleep sack, it must be properly fitted. Blankets and swaddling are not recommended.

C. *False:* Pillows can inhibit a baby from turning his/her head to the side, which is vital if there is a need to regurgitate food or milk.

D. *False:* Parents tend to equate soft surfaces with love and warmth. However, firm surfaces have a lower risk of SIDS. Babies can sink into a soft surface if the sheet is not pulled firm.

E. *False:* Heads cannot fit through the rails of a crib that meets Canadian safety standards.

F. *False:* This can lead to unintentional injury, such as asphyxiation or even unexpected death. Parents and caregivers should be supported to find alternative ways to soothe an unsettled infant, and encouraged to always place the infant on his/her own sleep surface.

YOUTH

RESEARCH **HOW** DEPENDANCE

QUIT TOBACCO **SHOULD** **VAPOR**

FLAVOURS **ELECTRONIC** NICOTINE

CIGARETTES TEENS

TOBACCO ACT **BE REGULATED?**

ADVERSITING E-LIQUID

By ANICK PERREAULT-LABELLE

E-cigarettes are popular, very popular. This keen interest creates a serious debate: are e-cigarettes a good tool to fight against tobacco use, a step backwards in terms of public health...or a bit of both? For now, there is no clear-cut answer...

Translated from Info-tabac.ca, No 102, September-October, 2014

E-cigarette manufacturing, sales and use remain very poorly regulated in Québec and Canada. How should we regulate this new technology?

There are hundreds of different models of e-cigarettes on the market. The mist they produce raises as much fear as hope. Experts agree on one thing though: it is urgent to regulate these new devices to ensure a better use of them while avoiding the dangers they may pose. For now, Canadian and Québec laws do not meet this need. But, in the European Union and the United States, regulation has progressed. Could Québec learn from them?

European Directive

In the spring of 2014, the EU adopted a new directive on tobacco and related products. This directive, which applies to e-cigarettes with nicotine, will become effective in 2016 and require, among other things, that:

- advertising of the device in print media and on the radio be prohibited;
- selling the device to minors be prohibited;
- a health warning covers 30% to 35% of the packaging (as opposed to 65% for traditional tobacco products);
- the label must, among other things, indicate the ingredients contained in the e-cigarette, its health effects and the addiction it creates.

THE NEW EU DIRECTIVE WILL PROHIBIT, AS OF 2016, THE ADVERTISING OF E-CIGARETTES IN PRINT MEDIA AND ON THE RADIO.

The European directive also regulates nicotine-containing liquids (e-liquids); these are mixtures of propylene glycol and/or glycerine, flavour and nicotine which are heated, then inhaled by the e-cigarette user. As of 2016, refills will have to be child-proof. Furthermore, the nicotine concentration will not be allowed to exceed 20 mg per millilitre. The researchers that authored the work, on which the EU directive is based, were critical of this limit. They say that 20 mg of nicotine will not be enough to meet the needs of heavy smokers. Finally, no later than May 2016, the EU requires the European Commission to present a report on the potential public health risks related to the use of refillable e-cigarettes.

United States: A Proposal From the FDA

E-cigarettes with nicotine regulations are also progressing in the United States. Last spring, the Food and Drug Administration (FDA) published a proposal aimed at extending the Family Smoking Prevention and Tobacco Control Act to new tobacco products, including e-cigarettes. If the proposal is accepted, makers of e-cigarettes with nicotine will have to meet the same requirements as traditional cigarette makers, such as:

- disclosing the ingredients contained in their products;
- obtaining a pre-market authorization for the sale of their products, which means documenting the benefits and the risks for the public;
- adding a health warning to their products.

Selling e-cigarettes to minors will also be prohibited, although, in the short term, advertising of e-cigarettes will not be affected.

Other initiatives

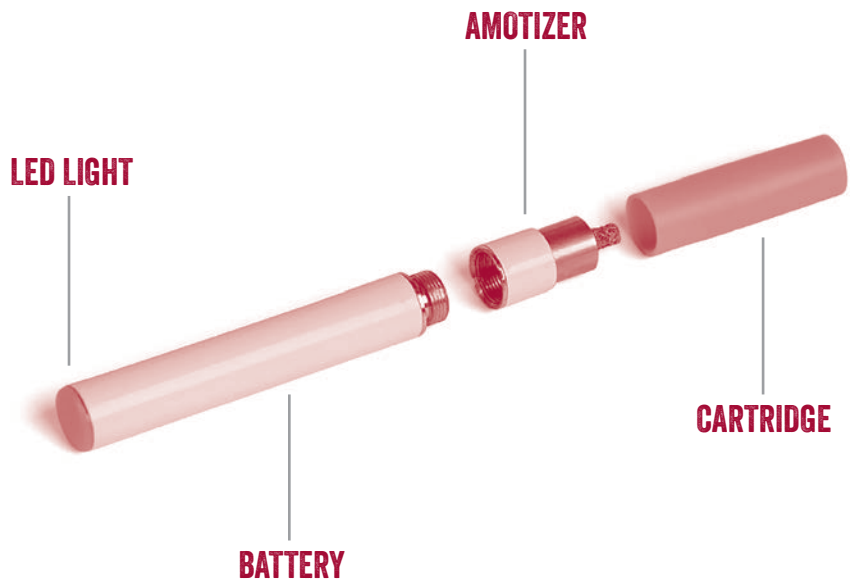
In the United States, about 40 States have already prohibited the sales of e-cigarettes to minors. Three States and 170 cities, including New York City, prohibit the use of e-cigarettes where tobacco products are also prohibited. In Canada, Red Deer, Alberta and Hantsport, Nova Scotia, are two municipalities which have done the same. In Great Britain, as of 2016, e-cigarettes with nicotine will be regulated as medication. Private organizations also took a position. The International Air Transport Association (IATA), which is comprised of about 250 airline companies, is recommending that operators "not permit the use of any item which could insinuate that smoking is permitted on board aircraft".

THE E-CIGARETTE HEATS A MIXTURE OF PROPYLENE GLYCOL AND/OR FLAVOURED GLYCERINE, TO WHICH NICOTINE CAN BE ADDED. THE MIST PRODUCED IS INHALED BY THE USER.

Canada is lagging

In Canada, the federal *Food and Drugs Act* only regulates e-cigarettes with nicotine, and mostly in terms of manufacturing and labelling of the device – advertising and sales to minors are not regulated. Basically, the law allows the marketing of e-cigarettes approved by Health Canada. However, the law is not really enforced: although Health Canada has not approved any e-cigarettes with nicotine, these are sold in every major Canadian city. According to the National Post, the federal Department investigated about 200 of these merchants but, at the beginning of the year, none had been formally charged.

In Québec, most health groups, including the Canadian Cancer Society and the Conseil québécois sur le tabac et la santé (CQTS), are demanding that e-cigarettes, with or without nicotine,



be regulated under Québec's tobacco law. This would prohibit:

- the use of e-cigarettes where tobacco products are prohibited;
- the sale of e-cigarettes to minors.

The law would also regulate the advertising of the device. According to documents obtained by the Financial Times, the World Health Organization (WHO) is also considering this type of legislation. It wants to subject e-cigarettes to the WHO Framework Convention on Tobacco Control. Over 130 researchers and physicians have publicly supported this option. However, over 50 experts, including three from Québec, have expressed their disagreement. They are not objecting to regulating e-cigarettes per say, but they emphasize that it is important to set them apart from other tobacco products. In their public opinion letter, they write that "If regulators treat low-risk nicotine products as traditional tobacco products, … they are improperly defining them as part of the problem [of tobacco addiction]".

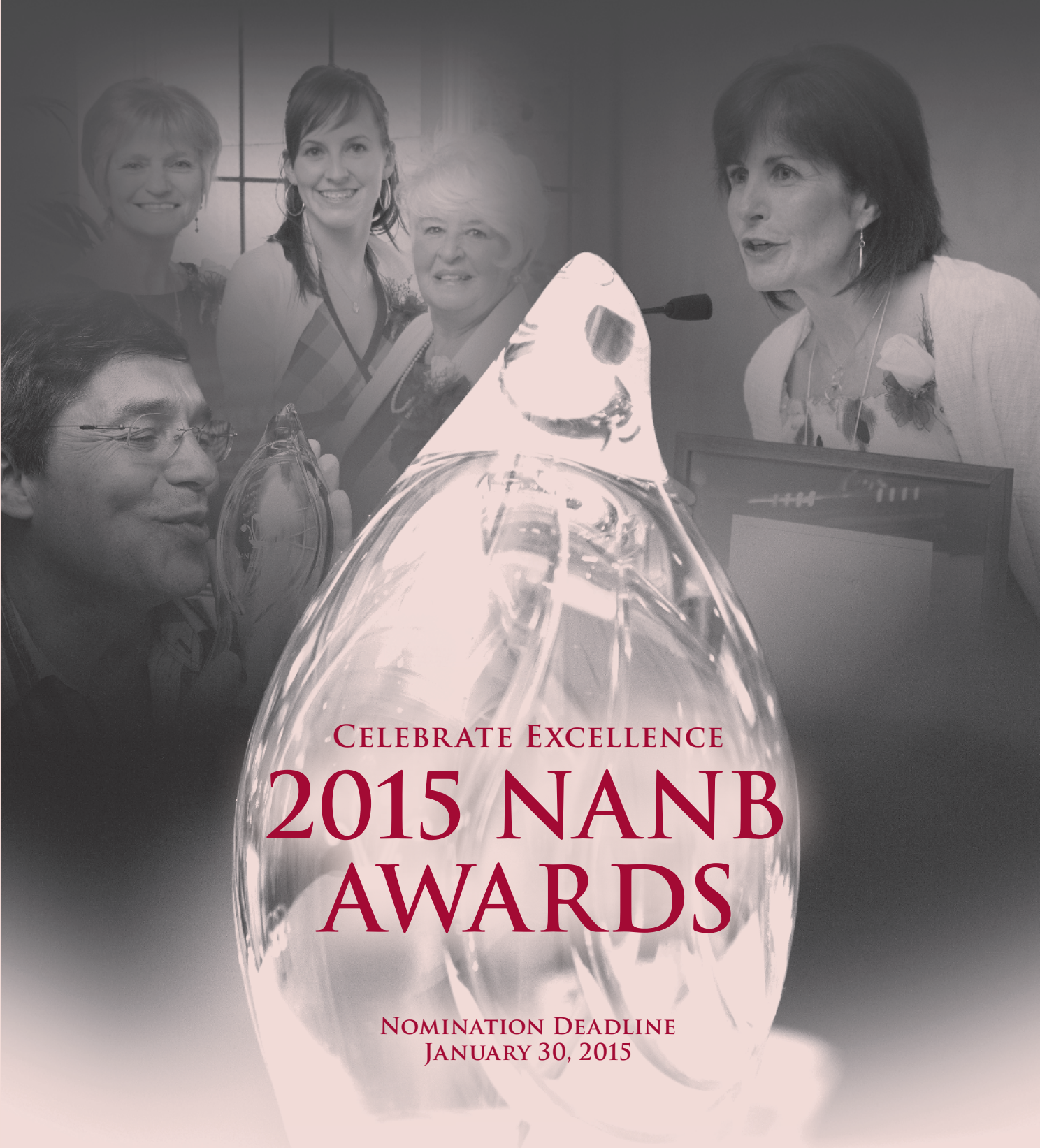
Even if Québec's *Loi sur le tabac* did regulate e-cigarettes, it would not solve all problems, warns Mario Bujold, CQTS executive director. "We must also ensure that the exact ingredients of e-cigarettes be disclosed and that e-cigarettes are safe and have health warnings," said Mr. Bujold. For Flory Doucas, codirector of the Coalition québécoise pour le contrôle du tabac, the European legislation is incomplete. "For one thing, it doesn't cover the lifestyle promotion nor e-cigarettes without nicotine, which means that the industry can co-brand—in other words, promote e-cigarettes with nicotine that have a similar appearance to other tobacco products," stated Mrs. Doucas.

Damned flavours!

The addition of candy, alcohol or sweet flavors to e-liquids is another unresolved issue. Since flavors added to tobacco products have contributed to tobacco use, including among young people, they will also probably encourage the use of e-cigarettes, according to Mario Bujold. He thinks their impact should be monitored in order to decide if adding flavors to e-cigarettes should be prohibited. For Flory Doucas, it is possible to allow flavors while preventing industry from using flavors as a marketing tool. The Non-Smokers' Rights Association (NSRA) is asking that only flavors attractive to children be prohibited. For François Damphousse, NSRA's executive director, flavors are one of the appeals of e-cigarettes. "If we prohibit flavors entirely, we could be discouraging some smokers from switching to e-cigarettes." As we can see, it is more than time to regulate! ■

IN CANADA, RED DEER, ALBERTA, AND HANTSPORT, NOVA SCOTIA HAVE PROHIBITED THE USE OF E-CIGARETTES WHERE TOBACCO PRODUCTS ARE PROHIBITED.

In fulfillment of its role to promote healthy public policy, NANB is developing a position statement on e-cigarettes.



Celebrate Excellence

2015 NANB AWARDS

Nomination Deadline
January 30, 2015

Nominate a colleague, friend or health care advocate who strives to improve health care delivery and promote public health awareness every day.

The Nurses Association of New Brunswick (NANB) proudly acknowledges the contributions made by current and former members of the profession and will honour these individuals

at this year's Annual General Meeting and Awards Banquet on June 3, 2015. The NANB Awards are:

Life Membership

A select number of nurses are recognized for long or outstanding services to the nursing profession either by serving in elected office or by participating in committee work at the national or provincial level.

Honorary Membership

This membership recognizes distinguished service or valuable assistance to the nursing profession by a member of the public. Nominees may be persons who have played a leadership role within an allied health care group or a member of the public who has performed meritorious services on behalf of nurses and nursing.

Awards of Merit

The awards of merit recognize nurses from each of the four key areas of nursing who have made a unique contribution to the nursing profession and who demonstrate excellence in nursing practice.

- Award of Merit: Nursing Practice
- Award of Merit: Administration
- Award of Merit: Education
- Award of Merit: Research

Excellence in Clinical Practice Award

NANB believes that the clinical practice role is fundamental to nursing and that all other roles within the profession exist to maintain and support nursing practice. NANB established a biennial award to honor a staff nurse providing direct care to clients in any nursing setting and who has made a significant contribution to nursing. The intent of this award is to foster excellence in clinical practice and to recognize nursing peers.

Entry-Level Nurse Achievement Award

NANB believes in recognizing entry-level nurses for their early contribution in the nursing profession. This award is specifically for registered nurses who have entered the nursing profession by graduating from their nursing education program not more than two years prior to being nominated.

Deadline for Submissions

The deadline for submission of nominations for all NANB awards is January 30, 2015.

For more information about eligibility, criteria, guidelines for submission and procedure for selection, or for a nomination form, please visit the 'Awards' section of www.nanb.nb.ca, call 506-458-8731, 1-800-442-4417 (toll-free), email to nanb@nanb.nb.ca, or contact your local Chapter President.

Send mail to 165 Regent St., Fredericton, NB, E3B 7B4, or fax to 506-459-2838.

CALL FOR NOMINATIONS

Be a Nursing Leader

Nominations for the 2015 elections are now being accepted for the position of President-Elect and Directors of Regions 2, 4 and 6.

Seek the nomination to NANB's Board of Directors and become part of the most progressive association of health professionals in New Brunswick.

Why should I run for office?

This is your opportunity to:

- Influence health care policies;
- Broaden your horizons;
- Network with leaders;
- Expand your leadership skills; and
- Make things happen in the nursing profession.

The deadline to submit nominations is January 30, 2015.

Role

The Board of Directors is the Association's governing and policy-making body. On behalf of registered nurses in New Brunswick, the Board ensures that the Association achieves the results defined in the Ends policies in the best interest of the public.

How can I become a candidate?

Any practising member of the Association may nominate or be nominated for positions on the board of directors of the Association.

Nominees for president-elect must be willing to assume the presidency.

Nominations submitted by individuals must bear the signatures and registration numbers of two practising members. Nominations submitted by chapters must bear the signatures and registration numbers of two members of the chapter executive who hold practising membership.

Nominators must obtain the consent of the candidate(s) prior to submitting their names.

Qualifications

The successful candidates are visionaries who want to play a leadership role in creating a preferred future. Interested persons must:

- be registered with NANB;
- have the ability to examine, debate and decide on values that form the basis for policy;
- understand pertinent nursing and health related issues; and
- have a willingness to embrace a leadership and decision-making role.

Nomination Restrictions

Only nominations submitted on the proper forms signed by current practising members will be valid.

No director may hold the same elected office for more than four consecutive years (two terms).

A director is eligible for re-election after a lapse of two years.

If there is only one person nominated, the nominee is elected by acclamation and no vote will be required.

Information and Results of Elections

Information on candidates will be posted on the NANB website in March 2015. Voting will take place either online or by telephone.

The names of the elected candidates will be announced at the 2015 Annual Meeting and will be published in the September edition of *Info Nursing*.

For further information, please contact a local Chapter President or NANB headquarters at 1-800-442-4417, 506-458-8731 or nanb@nanb.nb.ca. Nomination Forms are on page 36.

Canadian Nurses Protective Society

infoLAW®

Mobile Healthcare Apps

Vol. 21, No. 2, December 2013

Nursing Apps: Reliable or Risky?

The term "app" became a catchphrase several years ago when Apple popularized the term through the company's iTunes store. The term generally refers to small programs, called applications, developed specifically for mobile devices such as smartphones and tablets.

Potential Uses and Benefits of Mobile Healthcare Apps

Mobile healthcare apps have been developed to provide healthcare professionals with point-of-care access to searchable information, including drug monographs and diagnostic tools. Many professional organizations and educational institutions have designed apps that offer useful links to databases, sources of clinical evidence and best practice guidelines designed for use on a variety of mobile devices. Nurses can use apps to identify pills, to calculate medication dosage, for clinical decision support and to record notes relevant to patient care. Apps can also be used to allow healthcare professionals to communicate with patients by translating questions with yes or no answers into other languages such as Cantonese, Mandarin, Spanish and Russian.[1] However, the use of mobile healthcare apps is not without concern.

Concerns and Risks of Mobile Healthcare Apps

Reliability

Apps, such as those created by reputable organizations that simply offer links to databases or best practice guidelines, generally carry minimal or no risk as long as the information is current. However, others can pose significant risks to patients if they are unreliable. For example, an app that affects the programming of a drug infusion pump could lead to a drug overdose if it is inaccurate. An app that incorrectly measures blood oxygen levels in a patient with chronic lung disease could delay lifesaving diagnosis and treatment. Mobile healthcare apps can pose the same risks of failure as medical devices, including faulty design, poor manufacturing quality and user error. Despite the potential concerns associated with their use, the current regulatory requirements for these programs are complex.[2] Not all healthcare apps are approved for use by Health Canada, and there is no requirement to clearly identify apps that have received such approval.

App software may be written by a developer without healthcare training. There is no requirement for an app to be reviewed by a physician, nurse or any healthcare organization.[3] The rapid growth of the healthcare app market has increased the risk of using an app that is not reliable or evidence-based. Nurses are reminded to consider the source of the app they are using and the variation in quality with commercially-available downloadable apps.

Healthcare Apps:

Know the Privacy Risks.

In addition, apps are often adopted almost as quickly as they can be developed. This means errors may only be discovered once the app is on the market. While "recalled" apps can be removed from an online app store, this only prevents new downloads. As a result, there is a risk that recalled or outdated apps could continue to be used by nurses.

Disclaimers

Many apps, including those developed by reputable organizations, carry disclaimers warning that app developers make no representations about their completeness, accuracy or reliability and may provide a statement that the app is for general information purposes only. While the inclusion of such a statement may not be sufficient to absolve developers and distributors from liability, nurses should be wary of using apps with a strongly worded disclaimer.

Proper Use of Apps

Even reliable apps can pose significant risks to patients if they are incorrectly or improperly used. Nurses should consider whether they are using health apps that have been reviewed and approved by their employers. In addition, nurses should consider whether they have sufficient training to use the app accurately and appropriately. Using apps that have not been sanctioned by employers (or contrary to employer policy) can increase the risk of personal liability for any harm that occurs to patients.

Improper Use of Apps

Apps should not be used as a substitute for clinical judgment. As with any other tool, the healthcare professional remains ultimately responsible. While apps can be used to support or assist with clinical decisions, the decision making should be carried out by the nurse, not by the healthcare app. Also, nurses may consider whether the use of the mobile device is distracting them from providing appropriate and professional clinical care.

Breach of Privacy

A significant concern related to the use of mobile healthcare apps is the potential for a privacy breach. Some apps can function as an electronic health record system and with increased mobility comes an increased risk that a patient's personal health information (PHI) will be inadvertently or carelessly disclosed. Nurses should review the privacy settings on both their mobile devices and the app and be aware that default settings may allow sharing of information with others. Nurses using apps that store PHI on the mobile device itself should take appropriate steps to protect and secure the information.[4]

Current Best Practices for Mobile Healthcare Apps

- Consider the source and any other information available about the app's reliability before downloading it.
- Use mobile healthcare apps that have been reviewed and approved by your employer.
- Consider whether you have sufficient training and knowledge to use the app accurately and appropriately in your clinical area.
- Frequently update any apps used to ensure all data is current.
- Avoid relying on the app to complete a task you could not otherwise complete on your own.

- Evaluate apps recommended to patients to ensure they are reliable and appropriate.
- Take appropriate steps to maintain the privacy of patient PHI collected through the use of the app.
- Review and set appropriate privacy settings on the app and your mobile device.
- Know what permissions you are giving the app and don't install it if you don't feel comfortable giving the app the access it is requesting.
- Review the app's privacy policy to determine whether third parties have access to information obtained and, if so, whether users have the ability to opt out.[5]

Legal and professional issues surrounding the use of mobile healthcare apps are emerging as more nurses adopt these tools in everyday practice. CNPS will continue to update nurses on the legal and regulatory developments in this area.

Please contact CNPS at **1-800-267-3390** if you have questions regarding the professional implications of using mobile healthcare apps and visit our website at **www.cnps.ca**.

1. Laura Eggerston, "Info in your pocket", *Canadian Nurse* 108, 12 (January 2012).
2. Scott D. Danzis and Christopher Pruitt, "Rethinking the FDA's Regulation of Mobile Medical Apps", *SciTech Lawyer* 9, 3, (Winter/Spring 2013) and Health Canada, *Notice 10-25797-779: Software regulated as a Class I or Class II Medical Device*, 2010.
3. Orrin I. Franko, "How Helpful are Mobile Healthcare Apps? Without clinician input and validation, healthcare apps could be a liability", *AAOS Now,* (March 2013).
4. *infoLAW®*, Mobile Devices in the Workplace, Vol. 21, No. 1, November 2013.
5. American Health Information Management Association, "Best Practices for Mobile Health? There's an APP Guide for That: AHIMA Develops a Best Practice Primer for Consumers," 2013, available at http://www.myphr.com/HealthLiteracy/MX7644_myPHRbrochure.final7-3-13.pdf (accessed on December 4, 2013).

"THERE ARE NEVER ANY BARRIERS WHEN IT COMES TO HUMAN KINDNESS"

Nancy Duguay is the Cardiac Rehabilitation Coordinator at the Campbellton Regional Hospital. Nancy was honored at the 2014 Proudly UNB Awards with the Alumni Award of Distinction for her volunteer work in Honduras.

EDITOR'S NOTE: Nancy would like to dedicate the following profile to her mother, Winnifred Florence Brown, who was her greatest inspiration in pursuing a career in nursing.

Can you describe your role as Cardiac Rehab Coordinator?

As a cardiac rehab nurse, I receive referrals for patients who have been diagnosed with some form of heart and/or vascular disease. I meet these patients one-on-one for a history and physical exam. I provide education in regards to their risk factors and to the roles that lifestyle behaviors and medication have in halting the progression of their disease and counsel them on recommended physical activity to improve their overall fitness levels. Motivational interviewing for behavior change is used for smoking cessation and other goal setting for chronic disease management. From this visit, individuals are placed into different programs depending on their needs and availability. Along with other health care professionals, we teach our 12-week education sessions and supervise physical exercise. For those unable to attend, I offer case management sessions where I continue to monitor individual goals and progress with one-on-one visits. Many clients will be referred to other services depending on their needs, i.e., diabetes educators, smoking cessation clinics, blood pressure clinics, nutritional counselling.

How does your daily practice positively influence the health outcomes of your patients?

Many programs have proven over the years that outcomes and compliance improve with education. Knowledge is great, but actionable knowledge is very empowering. Most clients suffer a heart attack unexpectedly. It can be a total blur from the emergency department, to the cath lab and back to their beds at home. Many suffer from anxiety, depression, and insomnia, similar to post traumatic stress disorder. Taking the time to see these clients, one-on-one, in an office setting to educate and meet the patient's needs has a positive impact. Giving the patient the tools to take control over their health status empowers them to make healthy choices and understand they have the opportunity for improved health. Having this resource available for further concerns can avoid an unnecessary ER visit or admission to hospital.

What led to your decision to volunteer in Honduras?

In 2010, my son was at Mount Allison University obtaining his Science degree and he and his friends partnered with an organization from Honduras to bring medical, dental, public health, architecture, water, and microfinance support to their country. Upon his return, I learnt about the medical clinics and the need

for a nurse, I promised I would return with him the following year. In 2011, my husband and I joined our son in Honduras. They worked on a public health brigade while I worked as the triage nurse in our makeshift clinics. Caring for students who fell ill or were injured was also my role. I was hesitant about the quality of the care we would deliver, due to language barriers, but I soon realized that there are never any barriers when it comes to human kindness. I returned to Honduras again in 2013, when a faculty member contacted me, as the nurse who was scheduled to go had to cancel at the last minute. My son joined me on this trip as well to work on a water brigade. During this visit, I was able to visit with two young girls that my family sponsored in an orphanage. I, their "Canadian Godmother", was greeted with warm, loving hugs. The organization called Friends of Honduran Children (www.honduranchildren.com) maintains the orphanage and assures

"KNOWLEDGE IS GREAT, BUT ACTIONABLE KNOWLEDGE IS VERY EMPOWERING."

the children are safe, educated and healthy.

In March 2014, I returned to Honduras again, with students from MTA, but my family was unable to join me. If anyone would have asked me 20 years ago if my nursing career would have evolved to delivering health care to impoverished Honduran people I would have given a definite "no". The experience of caring that is a huge part of nursing is widely received and appreciated by the Honduran people. The workers from Honduras as so grateful for the professional expertise, health care, education, and supplies provided. Teaching about hygiene, diabetes, hypertension, and birth control is a big part of my role, as well as providing mentorship for the students working in the clinics with me.

What significant changes have occurred in the profession since you first started your nursing career?

I think specialization has changed nursing, with roles such as nurse practitioners, resource nurses, diabetic educators, cardiac rehab nurses, and nurse associates, to name a few. Areas like women's wellness, healthy aging, etc., offer nursing roles with great challenges for ongoing education. Evidence-based practice guidelines have changed the way we nurse. The evolution resulting from the collaboration with so many resources for the best holistic care for our patients' gives us reassurance that all of our patients needs are being met.

What could nurses in New Brunswick, either as a group or individuals, be doing to maintain the quality of care and support health care?

I don't believe every patient is presently having the access to the right professional at the right time. Nurses can have a very strong role in educating the public about where to access care and about who to access the care from. Nurses can take the opportunity to educate patients at their bedsides or during discharge from an emergency or clinic visit. A message that a patient may repeatedly hear through the media may have a different meaning and impact coming from a nurse. You never know who you may influence.

What is your vision for the future of Nursing in New Brunswick's Health Care System?

I believe we are fortunate to live in a country with Medicare. Regardless of the challenges our patients face with low socio-economic status or low literacy levels, they have access to affordable health care. Nurses can be leaders, role models, educators, supporters—the opportunities are endless. We are fortunate and privileged that we have patients who trust us with their health and confidential information. There are not many professions who have the honor that nurses have, to be allowed to care for patients in their most vulnerable times; I never ever take this for granted. Every questionnaire I go through with a patient, I remember how important it is that they trust me enough to divulge all of this information and I treat that trust very preciously. ■

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 10, Number 9 **ISMP Canada Safety Bulletin** December 10, 2010

Medication Incidents Occurring in Long-Term Care

This bulletin shares information about medication incidents occurring in the long-term care environment that have been voluntarily reported to ISMP Canada. The bulletin includes an overview of the medication incidents that had an outcome of harm or death and highlights the major themes identified through an aggregate analysis. Specific examples of the reported incidents are summarized to provide insights into opportunities for system-based improvement.

Background and Overview of Findings

To gain a deeper understanding of medication incidents occurring in the long-term care environment, data were extracted from voluntary reports submitted to ISMP Canada's medication incident database. The data reviewed for this analysis spanned a period of almost 9 years (August 1, 2000, to February 28, 2009). The analysis (which encompassed both quantitative and qualitative aspects) focused on medication incidents in which the outcome was harm or death.

The database search identified a total of 4740 medication incidents in the long-term care environment. Of these, 131 (2.8%) had an outcome of harm or death. Further quantitative analysis revealed that 116 (88.5%) of the 131 incidents were associated with an outcome of harm and 11 (11.5%) with an outcome of death. Administration of an incorrect dose was the single most common type of incident, followed by dose omission, administration of the incorrect drug, and administration of a medication to the incorrect patient (Figure 1).

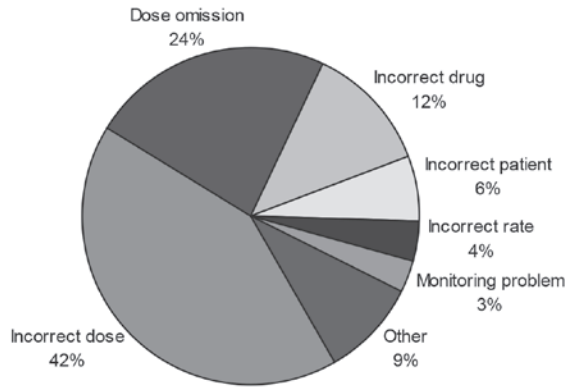


Figure 1: Types of incidents in long-term care facilities that resulted in harm or death (n = 131), identified in an analysis of aggregate data from the ISMP Canada medication incident database for the period August 1, 2000, to February 28, 2009. Incorrect dose, dose omission, incorrect drug, and administration of one or more medications to the wrong patient accounted for almost 85% of the harmful incidents reported.

Qualitative Analysis

The qualitative analysis of the 131 incidents that were associated with harm or death generated 3 main themes:

- incidents involving high-alert medications
- incidents involving anxiolytic–sedative and/or antipsychotic medications, including incidents leading to falls
- incidents involving patient transfers

The sections below present more detail about the medication incidents within these 3 main themes, and selected examples from the analysis.

Main Theme: Incidents Involving High-alert Medications

The majority of the harmful incidents reported involved 1 of 3 classes of medications that are considered high-alert medications: anticoagulants, insulin, and opioids (narcotics).

Anticoagulants

The majority of anticoagulant incidents involved errors in monitoring warfarin therapy. A number of anticoagulants, including warfarin, require monitoring via blood tests to ensure that the drug is maintained within a therapeutically effective range. The processes of ordering, transcribing, dispensing, and administering warfarin are tightly coupled with the concurrent processes associated with monitoring the international normalized ratio (INR) in the serum: ordering blood tests, drawing blood, ensuring timely availability of test results, checking the results, and updating orders for warfarin. Missing or weak links in any of these processes may result in warfarin-related medication incidents.

Example

- Warfarin was initiated for a nursing home resident, but the patient's INR was not ordered at the time of initiation. More than a month later, the patient's condition was deteriorating, and it was identified that no INR results had been recorded in the chart. A sample of blood was

obtained and sent to the laboratory, but the measured value was above the test limits, and a numeric value could not be reported. The patient was admitted to hospital and died shortly thereafter.

Insulin

Insulin has a narrow therapeutic index. Administration of an excessive dose of insulin can rapidly lead to hypoglycemia, which can progress to seizure, coma, and death if left untreated. Missed doses can also cause harm, because the patient's hyperglycemia may worsen, leading to other problems, such as ketoacidosis. The amount of insulin required for a particular patient varies according to a number of patient-specific factors, including serum glucose level and dietary intake.

Examples

- A patient was given a short-acting formulation of insulin, Humulin-R, instead of the intended longer-acting Humulin-N. Treatment with glucagon was required.
- A patient did not receive the prescribed morning dose of long-acting insulin because of absence from the patient care area. Upon returning to the floor, the patient was given 8 units of short-acting insulin, on the basis of an insulin scale for elevated blood glucose between scheduled insulin doses. At the time of the patient's scheduled evening insulin dose, the blood glucose level was well over 30 mmol/L. Omission of the morning dose of long-acting insulin was then identified.

Opioids (Narcotics)

Analysis of the opioid-related medication incidents revealed 4 subgroups: incorrect dose, medication mix-up, dose omissions, and incidents involving fentanyl patches.

Examples:

- A resident was to receive morphine 10 mg orally for pain but was instead given 10 mL (50 mg) of morphine suspension.
- An order for hydromorphone ".5 mg" (i.e., 0.5 mg) was interpreted as "5 mg"; and the larger dose was administered to the patient.
- A prescription for morphine 7.5 mg subcutaneously was interpreted as hydromorphone 7.5 mg subcutaneously, and the incorrect drug was administered to the patient.
- An order for hydromorphone was not transcribed. The patient missed several hours of therapy and experienced a significant escalation of pain.
- A patient was found unresponsive with abnormal vital signs. The patient had a prescription for fentanyl patch 12 mcg/hour, but a 75 mcg/hour fentanyl patch had been applied. The patch was removed, naloxone was administered, and continuous monitoring was initiated.
- A patient was found unresponsive in a long-term care facility and was transferred to the emergency department of a local hospital, where staff found multiple fentanyl patches in situ. The staff interpreted this to mean that existing patches were not removed when each new patch was applied. The patient was given naloxone, to which there was a response. However, pneumonia was also diagnosed, and the patient was admitted. The patient died about a week later because of the pneumonia.
- A patient with a prescription for fentanyl by patch was experiencing increasing pain. It was determined that a dose of fentanyl had been missed. Administration of a short-acting opioid was required to bring the pain under control.

Main Theme: Incidents Involving Anxiolytic–Sedative and/or Antipsychotic Medications

The majority of reported incidents involving anxiolytic–sedative and/or antipsychotic medications led to falls.

Examples

- An elderly resident of a long-term care facility was given extra doses of zopiclone, which might have led to an injury when the resident attempted to walk without assistance.
- A resident had a prescription for lorazepam 1 mg as needed for escalation of aggressive, agitated behaviour. About 30 minutes after administration of a dose of the lorazepam, the resident was started on clonazepam. The combination of drugs led to disorientation and difficulty walking, which resulted in a fall. The resident was admitted to a nearby emergency department, where staff concluded that the combination of the 2 benzodiazepines likely contributed to the disorientation.
- A resident of a long-term care facility was admitted to hospital with behavioural challenges. The patient's condition was stabilized on olanzapine, among other medications. After discharge from the hospital, the resident required readmission a short time later because of oversedation and falls. At the time of the second admission, the resident's pills were counted, and it was determined that the resident had received 4 times the prescribed dose of olanzapine.

Main Theme: Incidents Involving Patient Transfers

Transfers between facilities and care areas within a facility represent high-risk situations in which medication incidents may occur.

Example

- A patient was transferred from acute care to a long-term care facility. Information about the patient was sent from the hospital to the long-term care facility by fax. The fax consisted of multiple documents, including the patient's MAR and a copy of the "orders and progress notes" which listed the most recent updates to the morning and evening doses of

insulin that the patient was to receive. The nurse at the long-term care facility copied the medication orders from the MAR, which did not specify the insulin dosage, using the insulin concentration of 100 units/mL as the "dosage". Staff in the long-term care facility called the physician to request admission orders. Because the physician had known the resident previously and had followed the resident during the hospital stay, the physician instructed the long-term care staff to "continue the same orders". A pharmacist processed the insulin order as 100 units in the morning and 100 units in the evening. The resident experienced a severe hypoglycemic reaction, at which point the physician recognized the incorrect dose. The resident was transferred to acute care but died shortly thereafter.

Conclusion

Reporting medication incidents is important both for identifying opportunities for enhancing medication safety and for monitoring the effects of system changes. The findings from this analysis can be used to support local quality improvement initiatives. ISMP Canada incorporates learning from incidents such as those described above into its self-assessment programs, to facilitate enhancement of medication-use systems. (Refer to sidebar for additional information about the Medication Safety Self-assessment for Long Term Care.)

Acknowledgements

Sincere appreciation is expressed to the many healthcare professionals who have demonstrated support for a culture of safety, exemplified by their willingness to share information about medication incidents.

Risk Assessment Program for Medication System Safety in the Long-Term Care Setting

The long-term care environment presents unique challenges for the development and implementation of safe medication systems.

ISMP Canada developed the Medication Safety Self-Assessment® (MSSA) for Long Term Care to assist and guide individual long-term care facilities in identifying opportunities to improve their medication-use systems. The program, which complements other efforts to decrease the risk of harm to residents, can be used by facilities of any size, organizational structure, and geographic location. The program's self-assessment criteria are related to potential system improvements that have been identified through analysis of medication incidents. Completion of this Medication Safety Self-Assessment helps facilities to prepare for accreditation, and it can also be an important element of a facility's quality improvement program.

The program's web-based interface allows individual long-term care facilities to compare their own results over time, thereby tracking the impact of any changes made, as well as to compare their results with the aggregate results of other participants in the program, both regionally and nationally. Several Canadian provinces have supported the use of this program as a component of quality improvement. The program is also available at a reasonable cost to individual facilities that are not covered by a regional or provincial agreement.

For more information about the MSSA program for long-term care facilities, please contact ISMP Canada by email (mssa@ismp-canada.org) or by telephone (1-866-544-7672).

ISMP Canada is a national voluntary medication incident and 'near miss' reporting program founded for the purpose of sharing the learning experiences from medication errors. Implementation of preventative strategies and system safeguards to decrease the risk for error-induced injury and thereby promote medication safety in healthcare is our collaborative goal.

Medication Incidents (including near misses) can be reported to ISMP Canada:
(i) through the website: http://www.ismp-canada.org/err_report.htm or (ii) by phone: 416-733-3131 or toll free: 1-866-544-7672.

ISMP Canada can also be contacted by e-mail: cmirps@ismp-canada.org. ISMP Canada guarantees confidentiality and security of information received, and respects the wishes of the reporter as to the level of detail to be included in publications.

A Key Partner in the Canadian Medication Incident Reporting and Prevention System

Nomination Form

ELECTIONS 2015

(To be returned by chapter member)

The following nomination is hereby submitted for the 2015 election to the NANB Board of Directors. The nominee has granted permission to submit her or his name and has consented to serve if elected. All of the required documents accompany this form.

Position

Candidate's Name

Registration Number

Address

Telephone Home Work

Chapter

Signature

Registration No. Chapter Position

Signature

Registration No. Chapter Position

Nomination forms must be postmarked no later than **January 30, 2015**. Return to:

Nominating Committee
Nurses Association of New Brunswick
165 Regent Street
Fredericton NB E3B 7B4

Acceptance of Nomination

ELECTIONS 2015

(The following information must be returned by nominee)

Declaration of Acceptance

I, _____
a nurse in good standing with the Nurses Association of New Brunswick, hereby accept nomination for election to the position of

_____
If elected, I consent to serve in the foregoing capacity until my term is completed.

Signature

Registration No.

Biographical sketch of nominee
Please attach separate sheets when providing the following information:

- basic nursing education, including institution and year of graduation;
- additional education;
- employment history, including position, employer and year;
- professional activities; and
- other activities.

Reason for accepting nomination
Please include a brief statement of no more than 75 words explaining why you accepted the nomination.

Photo
For publication use, please forward an electronic self-image to jwhitehead@nanb.nb.ca. Return all of the above information, postmarked no later than **January 30, 2015**, to:

Nurses Association of New Brunswick
165 Regent Street
Fredericton NB E3B 7B4

POINT-OF-CARE INR TESTING

This article originally appeared in the July 2014 edition of Hospital News—Canada's health care newspaper since 1987.

Submitted By STEPHANIE SMITH

When a group of drugs called the "new oral anticoagulants" or "NOACs" recently became available in Canada, many felt that it would be the end of an era for warfarin. Warfarin had been used for over 60 years to prevent blood clots and stroke in patients at increased risk, and it is safe and effective. But dietary restrictions and the need for regular blood monitoring can make warfarin therapy challenging—challenges that don't exist with the NOACs. However, the NOACs cost significantly more than warfarin even when the cost of blood monitoring is factored in. And clinician and patient experience with the newer drugs is limited.

To help physicians and patients make informed decisions about medications for blood clot and stroke prevention, a review of the medical evidence was needed. And, after all of the medical evidence on warfarin and the NOACs was reviewed by CADTH—an independent, evidence-based health technology agency, a panel of experts recommended that warfarin remain the first choice for the prevention of blood clots and stroke in patients with atrial fibrillation. The NOACs were recommended as a second-line option for some patients.

But the experts also recommended that to maximize the benefits of warfarin, a structured treatment plan should be followed, including regularly scheduled blood tests to monitor therapy, the use of dosing tools, patient education, and the involvement of caregivers and health care professionals.

CADTH has just completed another research project looking more closely at the issue of regular blood tests to monitor warfarin therapy. When taking warfarin, patients must be monitored to ensure that they are getting the right amount of the medication and are not at risk for bleeding or blood clots. The standard method for monitoring the drug therapy is testing of blood drawn from a patient at a lab to measure the INR (which stands for "international normalized ratio" and is a measure of the time it takes a patient's blood to form clots). However, point-of-care INR testing—testing the blood not at a lab but instead where the patient is already located—is another way of monitoring warfarin therapy.

Point-of-care INR testing is similar to the way patients with diabetes test their blood sugar. A small sample of blood is obtained by pricking the fingertip. The blood is placed on a test strip and inserted into a device called a coagulometer, which analyses the blood and displays the INR result. Point-of-care INR testing provides quicker results than lab testing and can be more convenient for patients and their caregivers by removing the need to travel to a lab. This can be particularly helpful for patients in rural or remote areas who live long distances from lab facilities.

Point-of-care INR testing can allow patients to manage their own warfarin dose adjustments using the testing results. This is called "patient self-management." For patients unable to manage dose adjustments, they could use point-of-care INR testing to get their INR results and then call a health care professional who will then adjust their warfarin therapy as needed. This is referred to as "patient self-testing." Alternatively, point-of-care INR testing could be used by health care professionals with their patients in a clinical setting such as family doctor's office or anticoagulation clinic.

After reviewing all of the medical evidence on point-of-care INR testing for patients taking warfarin, an expert panel agreed that point-of-care INR testing is accurate. The experts recommended that patients should be offered, if they are willing and able, the option to test their own INRs and make dose adjustments to their medication. The panel recognized that these patients will require ongoing education and support to ensure the success of their self-management of warfarin and that quality assurance of point-of-care INR testing is important.

The expert panel also recommended that if patients are not willing or able to manage their own warfarin dose

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Leaders: Nursing Voices for Change

By SHARI GRAYDON

It was 1984, and I'd been lying on a gurney, crippled by the pain of an undiagnosed ruptured ovarian cyst, for two hours by the time my mother arrived at the emergency ward of the Vancouver General. She hadn't nursed for a decade, but you wouldn't have known it to watch her. She swept into action with such urgency and authority that my hovering boyfriend overheard someone ask in awe, "Is she the chief of staff?"

I tell you this just so you know: I'm deeply familiar with the force that nurses channel every shift, when patients are suffering or lives are at stake. And I'm urging you all to channel that energy outside of the clinics and hospitals in which you work.

Here's why: Even though it's 2014, women's voices remain chronically under-represented in Canada's public discourse. In both the halls of power, and in the newspapers, broadcast talk shows and blogosphere that help to determine what's on the political

agenda, whose priorities count, and where spending is allocated, male perspectives outnumber women's by more than 4 to 1.

That's a concern – not just for women, but for all of us. And in the context of our precarious health care system, it's particularly problematic.

Nurses – still overwhelmingly female – represent the face of health care to patients, and earn higher trust ratings than virtually every other profession. Given the depth and breadth of knowledge and experience you have about patient care and safety, it's clear that communities would benefit from hearing your informed opinions more often. Yet even though you outnumber doctors by a factor of 2 to 1, they take up much more space in our public conversations, and wield correspondingly much more influence on decision-makers.

I understand some of the circumstances that keep you quiet. Cultural stereotypes still encourage women to work hard, avoid confrontation and hope they'll be rewarded for good behavior. And health care issues have become highly politicized as one jurisdiction accuses the other of offloading costs and jeopardizing care.

But that's all the more reason that it's important for the public and politicians to hear from professionals who are both intimately familiar with health care delivery in Canada, and dedicated to ensuring it remains sustainable.

When you are individually advocating for a sick child or a dying patient, you make sure the critical information you have to share gets heard. What if all nurses channeled that kind of forceful energy into focused conversations, sharing concrete suggestions and positioning yourselves as integral partners in crafting and implementing solutions? The opportunities are numerous, and range from informal social interactions to more deliberate political interventions and engagement with both traditional and social media.

In advance of the recent New Brunswick election, NANB staff developed a package of well-researched resources to support members in not just becoming familiar with the issues, but in articulating their concerns – when canvassed at their front doors, attending all-candidates' meetings, or chatting with neighbours across the fence.

Although political parties released their own platforms during the campaign, reporters covering elections invariably ask candidates about issues being raised by voters. And a number of you responded to my online post in the Members' Corner, identifying matters worthy of more attention, and explicitly calling on colleagues to speak up.

Several commented on the crisis of identity they feel threatens nurses, as other professionals are incorporating technology into their practices through mobile devices, or being educated to perform duties that have traditionally been nursing responsibilities.

Others pointed to the imbalance between the northern and southern parts of the province, and the need for more priority to be placed on long-term care, arguing that,

> The needs of the elderly are the same regardless of location… and keeping elderly patients in their own homes is much less costly than institutionalized care… Nurses can lend their voices to eliminating imbalances and lobbying for proper allocation of resources."

A colleague added,

> The future for RNs is… providing health care and leadership to a multitude of community projects including clinics, home care, and answering the call for the 'neighborhood nurse.' To those RNs who feel that they are being displaced… think of how much your community needs your knowledge, skills, professionalism, leadership and… critical thinking skills. You have the capacity to be part of a growing ground floor movement that could ultimately change the way we do health care in Canada.

Another commentator urged nurses to play a greater role in advocating prevention:

> My concern as a nursing educator now is "how come we have not been able to get a buy in from the public regarding their own sense of responsibility for keeping themselves and their families well? What have we missed? It is our job as Health Care Professionals not only to help those recovering from illness; but also to engage folks in the discussion about how to stay well, prevent chronic illnesses, prevent needless runs to the ER, and to take action from a more sustainable and cost effective process."

Still another acknowledged the impact that individual nurses can have in shaping the future of both the practice of your profession, and health care delivery in New Brunswick, writing:

> I have always been selective in disclosing that I am an RN and have never actively sought out opportunities to share my opinion in a public forum. This is, in part, because I've never viewed myself as a "political" person. However, I think I need to change the way I think about this. My voice can be heard and if it is joined with the voices of my colleagues, it can influence change.

Nurses have always been patient advocates. If those who responded to the online forum are representative, many of you embrace the notion of expanding that role to encompass the health care system more broadly. Indeed, the very existence of nurses' associations reflects this. Your collective power is far greater than the influence you can each wield alone. By the same token, the impact of the NANB is enhanced by your willingness to share your professional insights, putting your individual faces to the concerns you share.

In her book *Ascent of Women*, multi-award-winning journalist and activist Sally Armstrong noted, "If you can't talk about it, you can't change it." Nurses are the only ones likely to draw attention to health care issues from the unique perspective you have. If you're not articulating the solutions you believe in, no one will. ■

Ask a
PRACTICE
CONSULTANT

By VIRGIL GUITARD

YOU'VE ASKED

As a registered nurse (RN), do I have the authority to suggest or administer "over the counter" medications without a prescription?

THE ANSWER IS YES. BASED ON THE employer policy, the registered nurse's judgement and competence, and in specific situations, such as at a children's camp, a registered nurse may suggest or administer OTC medications, provided they are in their original container. Because of the complexity of client care and of the involvement of many health care providers, most settings (i.e., hospitals, nursing homes, community nursing, extra-mural program) have policies in place requiring RNs to have a prescription from an authorized prescriber before administering or recommending OTC medications.

Over-the-counter (OTC) medications refer to medications that can be obtained without a prescription from an authorized prescriber. Over-the-counter medications (OTC) can be purchased, without a prescription, in local pharmacies and other retail outlets.

To determine if a certain medication is an OTC medication (medications that are listed within schedule II, III or in the unscheduled section of NAPRA), consult the following link: www.napra.ca/pages/Schedules/Search.aspx.

Whether the medication is prescribed or an OTC medication, the administration is only one component of a continuous process that goes beyond the task of giving a medication to a client. The Nurses Association of New Brunswick's *Medication Administration: Practice Standard* document indicates that the RNs must apply their knowledge about the client and the medication when assessing, planning, implementing, and evaluating the medication administration process, which includes the recommendation or administration of OTC medications. When recommending or administering OTC medications, RNs must:

- have an employer policy supporting the suggestion or administration of OTC medications;
- review the client's lifestyle/routine to identify and eliminate (if possible) any potential barriers or challenges that may exist for adherence to the medication regimen;
- assess the client's condition before recommending or administering the medication;
- be knowledgeable about the actions of the specified medication, and possible interactions with a client's current medications and diet;
- have the necessary skills and judgment required to administer the OTC medication competently, safely and ethically;
- prepare and administer OTC medications according to evidence-based rationale and practice setting policies;
- verify: the right client, the right drug, the right dosage, the right time, the right route, and the right documentation;
- explain the therapeutic effects and potential risks and side effects of the medication to the client;
- document actions or advice given and client outcomes according to documentation standards and practice setting policies;
- recognize client outcomes following medication administration including effectiveness, side effects, and signs of drug interactions;
- refer clients to the appropriate care provider for further assessment and follow-up when necessary (for example, when the underlying problem persists and the medication has no effect).

For more information on medication administration, please review NANB's document: *Medication Administration: Practice Standard* at www.nanb.nb.ca/downloads/Med Standard Revised October 2013.pdf or contact NANB's Practice Department at 1-800-442-4417 or by email at nanb@nanb.nb.ca.

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Does your car have the winter blahs?

Salt and gravel are all used to help make wintery roads and sidewalks safer," says Richard Russell, member of the Automobile Journalists Association of Canada. "But salt encourages corrosion. Gravel, small stones, and jagged ice can cause chips in the paint, which exposes the steel underneath to oxidation and rust. That's why spring cleaning is an important part of car maintenance that will help retain the value of your vehicle."

Mr. Russell recommends a spring-cleaning routine that covers three areas of your car: exterior, interior, and under the hood.

Taking care of the exterior

"As you clean the exterior, get close to spot any rust or damage to the paint job," Mr. Russell says. Tips for washing the exterior:

- Make good use of water. "After a winter of driving, you need a lot of fresh, clean water to clear your vehicle of salt, dirt, and debris," he says. "Salty areas require a lot of water to wash clean. This applies to the underside of your vehicle too."
- Start at the top and work your way down. That way, you're less likely to unknowingly transport grit or small stones up from the doors and wheel well that may scratch the paint.
- Think low. The lower parts of your car will be dirtier, so clean lower than you normally would. And don't ignore around the tires, fenders, headlights, and taillights.
- Check the windshield and wipers. "Clean and inspect your wipers and replace them if necessary," says Mr. Russell. "Clean your windshield, windows, and mirrors and check them for small cracks."
- Dry it off. Use a chamois or an absorbent cloth to dry the car thoroughly.
- Wax protection. Ensure that the wax you use is right for your vehicle and follow the directions carefully.
- Consider a car wash. "Spring cleaning is probably the only time I would advise that drivers consider taking their cars to a carwash that uses fresh water, and get an underbody spray," says our expert. "Of course, you still want to check it thoroughly for damage once it's clean."

What's inside counts too

"Moisture can cause damage to your car's interior," says Mr. Russell. "While we try not to drag snow in when getting into our vehicles, it's also important to set the air control switch on the dashboard to fresh air. That way, you avoid condensation and you're not breathing in stale, recycled air." Tips for interior care:

- De-clutter. Along with the usual garbage roundup, clear any mess that may have piled up since winter started. Put skates, hockey sticks, extra boots, and that one stray glove in their proper place.
- Remove the mats. "Take the mats out and give them a good washing," says Mr. Russell. "Let them dry before putting them back in. Also make sure they're a good fit and cover the entire floor area. If not, get ones that do."
- Make sure everything is dry. Moisture underneath the mats and in hard-to-reach places (like under the seats) can cause damage. Take the time to let things dry before putting anything back inside the vehicle.
- Clean under the rugs. With the mats out, give the car floor a good vacuuming while you check for any damage.
- Clean the upholstery. Vacuum, spot clean, or use the right upholstery cleaner. Clean between and under the seats, and in and around your child's car seat (if you have one).
- Get the salt out. "Pour hot water on a salty area and let it soak," Mr. Russell advises. "Then use a dry/wet vacuum to soak it up. This works better than using rags because you avoid rubbing the salt in deeper."
- Get inside the trunk. Use the same cleaning techniques and check for damage there too.

What's under the hood

If your car's engine is in fine form, all you'll need to do is a few minor adjustments to get ready for spring. If it's not looking great, or you have questions, take it to a professional for a proper tune-up. Tips for mechanical care:

- Change the oil. Make sure you're using the proper grade for your vehicle.
- Check the cooling/heating system. "Look for frayed hoses and belts and get them replaced," advises Mr. Russell. "Also check the air filter and replace it if necessary."
- Do a fluid check. Top up the windshield wiper fluid and check the power steering and brake fluid as well.

Doing it right

"If you have the time and skill to do it yourself, then follow the instructions in your owner's manual," says Richard Russell. "But if you're unsure or uncomfortable, or simply don't have the time, then take your car in to a professional cleaning or detailing service." ■

JANUARY 15, 2015

CNPS Webinar: *The Law at the End of Life*

» www.cnps.ca

JANUARY 23–24, 2015

7th Annual Ottawa Conference: *State of the Art Clinical Approaches to Smoking*

- Ottawa, ON

» www.ottawamodel.ca

JANUARY 28–31, 2015

Canadian Nursing Students' Association National Conference: *Inspire Excellence; Promoting Empowerment to Achieve Superior Quality of Care*

- Regina, SK

» www.aeic.ca/english/conferences/national

FEBRUARY 11, 2015

CNPS Webinar: *New Technology and Social Media*

» www.cnps.ca

FEBRUARY 17–18, 2015

NANB BoD Meeting

- NANB Headquarters, Fredericton, NB

» www.nanb.nb.ca

FEBRUARY 28, 2015

Canadian Association of Hepatology Nurses Education Day and AGM

- Banff, AB

» www.livernurses.org/cahn-education-day-and-agm

MARCH 20, 2015

Anxiety: *Practical Intervention Strategies*

- Saint John, NB

» www.ctrinstitute.com/node/919

MAY 3–7, 2015

Operating Room Nurses of Canada 24th National Conference

- Edmonton, AB

» http://ornac.devicemedia.ca/

MAY 21–24, 2015

Canadian Association for Enterostomal Therapy Annual Conference

- Halifax, NS

» www.caet.ca/caet-english/index.htm

MAY 24–27, 2015

Canadian Orthopaedic Nurses Association Annual Conference

- Fredericton, NB

» www.cona-nurse.org/conf-annual-info.html

MAY 27–30, 2015

Canadian Gerontological Nursing Association Biennial Conference: *Crossing Bridges: Fostering Potential in Gerontological Nursing*

- Charlottetown, PE

» www.cgna.net/Biennial_Meeting.html

JUNE 1 & 2, 2015

NANB BoD Meeting

- NANB Headquarters, Fredericton, NB

» www.nanb.nb.ca

JUNE 3 & 4, 2015

NANB's 99th AGM & Forum

- Delta Hotel Fredericton

» www.nanb.nb.ca

JUNE 14–17, 2015

Infection and Prevention Control Canada: *Surfing Waves of Change*

- Victoria, BC

» www.ipac-canada.org/conf_registration.php

JUNE 15–16, 2015

2015 National Health Leadership Conference: *Driving a culture of engagement, innovation and improvement*

- Charlottetown, PE

» www.nhlc-cnls.ca/default1.asp?active_page_id=1

JUNE 23–26, 2015

Canadian Association of Nephrology Nurses and Technologists 46th Annual General Meeting & Scientific Sessions

- St. John's , NL

» www.cannt.ca/en/index.html

Remembrance Day Ceremonies

President Darline Cogswell placing a wreath to honour all nursing veterans at Remembrance Day Ceremonies, November 11, 2014, in Rusagonis, NB.

Boardroom Notes

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include electrical, flooring, and plumbing updates.

Staff Recognition

Employment milestones were recognized for Marie-Claude Geddry-Rautio, Bookkeeper for 15 years and Angela Bourque, Administrative Assistant for five years of service.

Next Meeting

The next Board of Directors meeting will be held at the NANB Headquarters on February 17 and 18, 2015.

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 or 1-800-442-4417.

2014–15 NANB Board of Directors

- President: Darline Cogswell
- President-Elect: Brenda Kinney
- Director, Region 1: Joanne LeBlanc-Chiasson
- Director, Region 2: Jillian Ring
- Director, Region 3: Amy McLeod
- Director, Region 4: Josée Soucy
- Director, Region 5: Thérèse Thompson
- Director, Region 6: Annie Boudreau
- Director, Region 7: Lisa Keirstead Johnson
- Public Director: Fernande Chouinard
- Public Director: Wayne Trail
- Public Director: Edward Dubé

REGISTRATION SUSPENDED

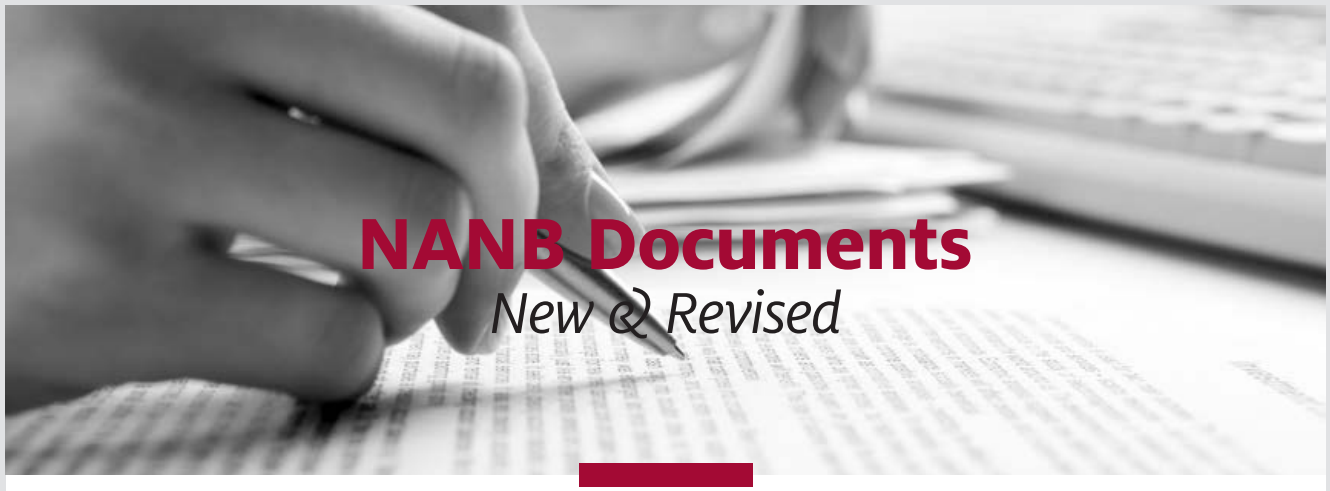
On September 30, 2014, the NANB Complaints Committee suspended the registration of registrant number 027400 pending the outcome of a hearing before the Review Committee.

SUSPENSION LIFTED

In a decision dated October 10, 2014, the NANB Discipline Committee ordered that the suspension imposed on the registration of registrant number 028629 be lifted immediately. The Discipline Committee further ordered that the complaint be dismissed.

REGISTRATION SUSPENDED

On October 21, 2014, the NANB Complaints Committee suspended the registration of registrant number 023625 pending the outcome of a hearing before the Discipline Committee.



NANB Documents
New & Revised

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

Revised Documents

Professional Accountability During a Job Action

The Practice Guideline titled: *Professional Accountability During a Job Action* (2010) has been reviewed and found to be still relevant and useful. The revision offers new language which reflects the 2012 *Standards of Practice for Registered Nurses*, new NANB nomenclature and updated references. The document has been changed to a Frequently Asked Question format titled: *How do I maintain patient safety during a job action?*

Practice Guideline: Infection Prevention and Control

The content was updated and revised to reflect current evidence. A significant change is the renaming of the document as a set of standards. The standards outlined in this document define the expectations and responsibilities of RNs in relation to infection prevention and control (IP&C).

Complaints and Discipline Process

Available soon on NANB's website. This document was reviewed and revised to reflect current processes with regard to formal complaints lodged under the *Nurses Act*. This revision includes recent additions to the By-Laws in this area. The document has been renamed *Professional Conduct Review: Complaints and Discipline Process.*

New Document

Cosmetic Medical Procedures: Position Statement

This new position statement was developed to help guide nursing practice in the emerging field of medical cosmetics. NANB has seen an increasing interest in this area of practice and felt it was time to clarify its' position on this topic. The statement was informed by a literature search, an internal review, a jurisdictional review, consultation with the Registrar of the College of Physicians & Surgeons of New Brunswick and RN and NP members of NANB.

Behind the Scenes: From Start to Finish

Meet Angela Bourque, Adminstrative Assistant: Regulatory Services

What previous work experience/ education led you to the Association?

With a combined interest in the health care industry and office administration, I obtained a diploma in Medical Administration from Oulton Business College in 2004. After working five years as Administrative Assistant in medical offices, I joined the Nurses Association in 2009. The Association has provides an opportunity to continue to work, learn and make a difference in the health care industry by supporting the nurses of New Brunswick.

In October, you were recognized for having reached a five year milestone as an employee of NANB. How has your role evolved during those five years?

Initially hired as an Administrative Assistant: Reception/Registration focused on reception responsibilities, including small tasks for the registration team, I was promoted to the role of Administrative Assistant: Regulatory Services, tasked with supporting the Complaints and Discipline Process. While I had a basic understanding of the Complaints and Discipline process, I was unaware of the level of preparation and administrative requirements involved in supporting both staff and Committee members. With time and a level of comfort, I have accepted more responsibilities providing a broader scope of cross-training to ensure I become an even more valuable member of the NANB team.

What is your current position and what are your main responsibilities?

The Administrative Assistant: Regulatory Services provides administrative support to the Regulatory Consultant: Professional Conduct Review, which includes preparation of documentation, correspondence and planning meetings for the Complaints, Review and Discipline Committees. I deal with confidential material daily and follow protocols set in place to ensure that members' information stays secure. This position also involves providing support to the members of the Regulatory Services Department in matters involving nursing education and the Nursing Education Advisory Committee, Continuing Competence Audit, and registration services.

What part of the Complaints and Discipline Process do you manage? Are you involved from the beginning to the end of the process?

I am involved from start to finish with the Complaints and Discipline Process

from drafting letters acknowledging the Complaint to drafting letters informing members that they have fulfilled the conditions imposed on their registration. I prepare and index the complaint documentation received for those involved, coordinate the meetings, transcribe decisions and notices for the Regulatory Consultant, and maintain the confidential files and database. I am the behind the scenes person: from start to finish for the Committee meetings, ensuring everything runs as smoothly as possible, and that everyone's needs are met.

Cross-training is essential in a relatively small Association like NANB. What other areas have you been trained in to assist other team members?

Since starting my career at NANB in the reception/registration position, I have an understanding of how the NANB team contributes to the organization. Gradually, gaining knowledge and experience in the other departments, including hands-on with Communications and the Executive office, providing the knowledge and skills required to step-in and cover during holidays or absences. Registration season, Annual General Meetings, Board, etc. are all very busy times for NANB, it is imperative that all team members, from various departments collaborate to accomplish the work that needs to be done.

What do you find most rewarding about your job at NANB?

Undoubtedly, it is working with a great group of professionals both at NANB and committee members, including RNs and members of the public. Everyone is committed to making a difference in the nursing and health communities. Being a part of the NANB team has truly been a rewarding and educational experience. ■

Point-of-Care INR Testing

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adjustments, self-testing of INR with dose adjustments by a health professional may be an option, but only if there are significant barriers to patients having their INR regularly tested in a lab. These barriers might include living in rural or remote areas far from a lab, or mobility issues that make travel to a lab difficult.

The evidence also showed that using point-of-care INR testing in a clinic setting can be more costly than lab testing. This doesn't rule out the use of point-of-care INR testing in doctor's offices or anticoagulation clinics but does mean that careful consideration of a clinic's context and costs are important when considering implementing point-of-care INR testing.

If you are a clinician, patient, caregiver, or health care decision-maker and would like more information on this project or other health technology assessments, you can find it all free of charge on our website at www.cadth.ca or please contact Stephanie Smith, CADTH Liaison Officer for New Brunswick, at 506-457-4948. Our information on warfarin, the NOACs, point-of-care INR testing, and other related topics can also be found at: www.cadth.ca/clots.

Created by the federal, provincial, and territorial governments, CADTH is an independent organization responsible for helping decision-makers across the country make the right decisions about how best to use drugs and other health technologies in our health care system. ■

Notice of Annual Meeting

In accordance with Article XIII of the bylaws, notice is given of an annual meeting to be held June 3, 2015, at the Delta Fredericton, Fredericton, NB. The purpose of the meeting is to conduct the affairs of the Nurses Association of New Brunswick (NANB).

Practising and non-practising members of NANB are eligible to attend the annual meeting. Only practising members may vote. Confirmation of membership will be required for admission. Students of nursing are welcome as observers.

Resolutions for Annual Meeting

Resolutions presented by practising members by the prescribed deadline, February 13, 2015, will be voted on by the voting members. During the business session, however, members may submit resolutions pertaining only to annual meeting business.

Voting

Pursuant to Article XII, each practising nurse member may vote on resolutions and motions at the annual meeting either in person or by proxy.

Roxanne Tarjan
Executive Director, NANB

NANB Winter Webinar Series

NANB is proud to offer another series of webinars to provide members with the opportunity to be informed and educated from the comfort of their home or workplace. Presentations by NANB's content experts are approximately 45 minutes long.

Stay tuned to NANB's Website and E-Bulletin, *The Virtual Flame*, for more information on topics and dates.

All previously recorded webinars are available 24/7 on NANB's website at www.nanb.nb.ca:

- Problematic Substance Use In Nursing—Still an Important Issue
- Frequently Asked Questions from RNs Working in Nursing Homes
- When Meeting Standards Becomes a Challenge-Working with Limited Resources and Resolving Professional Practice Problems
- Collaboration: Shared Goals, Different Roles
- MISSION POSSIBLE: Strategies for Embracing Civility
- Safety First! Managing Registered Nurses with Significant Practice Problems
- Documentation: Why all this paper work?
- Leadership: Every Registered Nurse's Responsibility

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Due to provincial legislation, our auto insurance program is not offered in British Columbia, Manitoba or Saskatchewan.

*No purchase is required. There is one (1) prize to be won. The winner may choose between an amount of $60,000 CAD to build a dream kitchen of his/her choosing or $60,000 CAD cash. The winner will be responsible for choosing a supplier and for coordinating all of the required work. The contest is organized by Security National Insurance Company and Primmum Insurance Company and is open to members, employees and other eligible persons who reside in Canada and belong to an employer, professional or alumni group which has entered into an agreement with the organizers and is entitled to receive group rates from the organizers. The contest ends on October 31, 2014. The draw will be held on November 21, 2014. A skill-testing question is required. Odds of winning depend on the number of eligible entries received. The complete contest rules are available at melochemonnex.com/contest.