INFO NURSING

VOLUME 42 ISSUE 3 WINTER 2011

NANB RECEIVES THE LIEUTENANT GOVERNOR'S DIALOGUE AWARD

Nurses Association OF NEW BRUNSWICK

winter 2011

INSIDE

SNNNAP partnership visits Burkina Faso. See Liette Clément's reflections on page 32.

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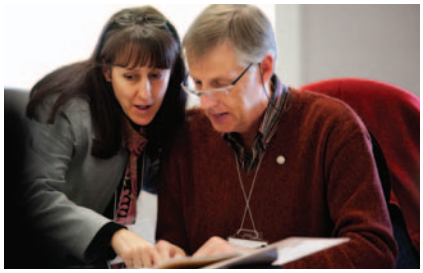
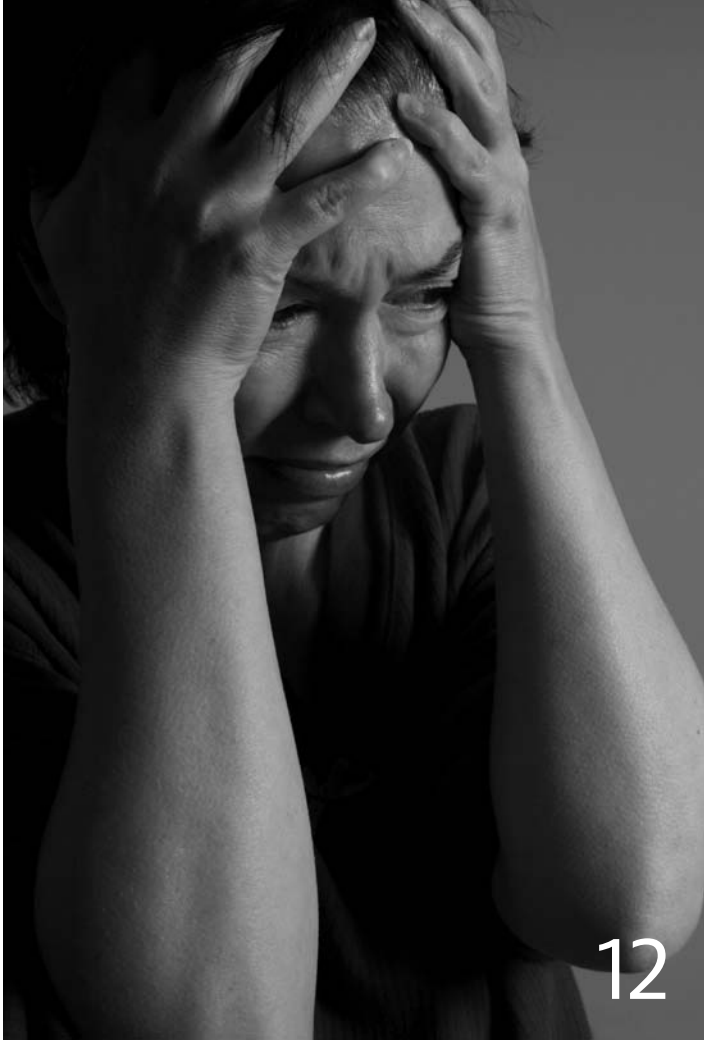
Cover
Photographs compliments of Harry Mullin.
The Honourable Graydon Nicholas hosted the Lieutenant-Governor's Dialogue Award ceremony at Old Government House on September 28th, 2011, recognizing three recipients including the Nurses Association of New Brunswick. To read the acceptance speech, see page 13.





the pulse

The Vision of the
Nurses Association *of* New Brunswick

Nurses shaping nursing for healthy New Brunswickers. In pursuit of this vision, NANB exists so that there will be protection of the public, advancement of excellence in the nursing profession, and influencing healthy public policy all in the interest of the public.

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

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NANB on the Move

The Association has had a busy fall. The 2012 registration renewal is in full swing. By early November, over half of the registered nurses in active practice had completed the registration renewal process. That's great news and indicates we can meet our administrative deadline. Please visit NANB's website at www.nanb.nb.ca and register if you haven't already. We have been able to support you and from our perspective the process and systems are improving from year to year thanks to your input, staff innovation and support from our IT provider *Populus Global Solutions Inc*. NANB's annual Continuing Competence Audit is underway where approximately 177 members were randomly selected to complete the Audit. A full report on the results will be presented to the Board of Directors at the next meeting in February 2012.

Did you notice this issue's cover? This past October, NANB received the Lieutenant-Governor's Dialogue New Brunswick Award in recognition of our efforts to support communication and collaboration between registered nurses from the two linguistic communities in the province. Receiving this award was indeed an honour for NANB as well as for you, the members. For decades, NANB has supported the full participation of members through the translation of all our materials and by providing simultaneous interpretation at all annual meetings and special provincial forums. This value has strengthened our Association as the RN regulator, with the voice of each member heard free of barriers to communication and understanding. It is a value and commitment we hold in high regard and a priority for the present and future.

During the month of November, NANB supported and participated in the launch of the Canadian Nurses Association (CNA) Nurse Practitioner Awareness Campaign *It's about time!* We were privileged to work with CNA over the summer to prepare for this launch and optimized this unique opportunity during the provincial government's focus on Primary Health Care. The Campaign highlights the role, contribution and potential of Nurse Practitioners (NPs) to support and advance the primary healthcare system in New Brunswick and the sustainability of our publicly-funded, not-for-profit health services. The NP Awareness Campaign is moving across Canada over the coming months, appearing in various capital cities of other provinces and territories. Visit the www.npnow.ca website and take action! Speak to your elected representatives, family and friends. The public's understanding of the role and competence of nurse practitioners and how they can be utilized will enhance acceptance of the changes we believe are essential to the future effectiveness and efficiency of our health system. Registered nurses will also play a part in these changes. As we move forward the NANB will be there to support you and your practice along the way.

Additionally, CNA hosted two forums of the *National Expert Commission: the health of our nation, the future of our health system* in Moncton and Saint John this past November. We encourage members to get informed and involved. Go to NANB's homepage www.nanb.nb.ca for a direct link to the Expert Commission's website.

Coming soon, NANB will launch our first e-learning module. We have been able to advance the commitments of our long-range fiscal plan and will launch the first module this January 2012. Congratulations to the NANB team and our partners. With the reality of the fiscal situation for the province, we are committed to enhancing our resources to support your continued competence. Additionally, we are identifying the opportunities to support nursing students with these tools. We believe it is a unique opportunity to support our nurse educator members, enhance our visibility with future members and establish an effective and engaged relationship with NANB throughout their career. Look for additional module announcements in the coming year.

Last but not least, we thought members would be excited to know the full impact and value of the NANB scholarships and awards distributed each year. Through regular investments in our scholarship and thanks to the generosity of our affinity partners, Meloche Monnex and Investors Group, we have been able to build these awards to their current level. Following the closure of the New Brunswick Nurses Foundation in the mid-1990s, available funds were split between the University of New Brunswick, Université de Moncton and the Canadian Nurses Foundation (CNF). Since that time, NANB has continued to make a contribution to our two university programs and CNF scholarships. Our affinity partners have supported nursing

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Making Change Happen: The Five Ws

EXCERPT FROM: *Our Health Our Future: Improving Access and Delivery of Primary Health Care Services in New Brunswick*
Discussion Paper, November 2010

The provincial government has recognized that decisive action is needed because our healthcare system will face extraordinary challenges in the coming decades, and we will need an innovative and effective healthcare system in order to provide sustainable clinical health services.

Chronic diseases are now the most significant cost driver in the healthcare system. The Canadian Community Health Survey (CCHS, cycle 3.1) indicated that 72 per cent of New Brunswickers over the age of 18 self-reported living with a chronic health condition. Of these, 38 per cent reported living with one of the select chronic conditions profiled by the Health Quality Council.

WHAT?—The recent invitational Primary Health Care Summit hosted by the Department of Health focused on Primary Health Care services in our province. Those in attendance all had a vested interest in the topic; whether personal, professional or both. During the day and a half of presentations and breakout sessions, the topic occasionally shifted to "primary care": the first line of care predominately delivered by medical professionals. However, the message by Minister Dubé and Premier Alward, as well as the keynote speakers, was broader and encompassed the principles of Primary Health Care. This is significant, and I believe that it indicates that our leaders are focusing on a much more comprehensive approach to the delivery of health services that ensures timely access, health promotion and disease prevention activities and incorporates the social determinants of health, recognizing that good health is far more than safe, quality health services.

WHY?—The excerpt above should make the 'why' very clear. We are not healthy people here in New Brunswick and our health status is driving health expenditures and may be unsustainable into the future. Additionally, our health status is impacting our province's productivity and our own quality of life. We all need to "face the music" as they say and do our part to make change real, personally for ourselves, our families and communities and as health professionals for the system and the clients we serve.

WHEN?—The simple answer is right away! Change is never simple, but it is constant and a reality of our personal and professional lives. The Primary Health Care Advisory Committee (PHCAC) will make its final recommendations to the Minister of Health early in the New Year, and these will inform the government's health plan for the province during its current mandate. The Committee was established under the former Liberal government and was reconfirmed by Premier Alward. It has been deliberating and focusing on this issue for over six years. For some, that may be discouraging; however, the relationships that have been built and the evidence that has been reviewed, as well as the clarity that the recent Summit provided, should lead to strong, evidence and experience-based recommendations that will define a way forward.

WHERE? & WHO?—I'm combining these two questions because they really can't be separated. Obviously, I'm talking about New Brunswick, but to be more precise, this change has to happen at all levels, from the macro to the micro, the systemic to the personal. If we truly look at health more comprehensively, we must accept that the client and the system will no longer tolerate the lack of coordination and integration that have existed for so long. We now have clear and robust evidence of the inefficiency and ineffectiveness that the current organization of health service delivery creates. We need to do better for our clients and ourselves as health professionals. Imagine our satisfaction and the improved health outcomes when no one falls between the cracks! That means change for each of us. Changing how we work, who we work with and where and when we work. As clients, it means changes in from whom and where care is provided. For all of us, whether provider or client, it means more accountability. As professionals, we hear a lot about making clients responsible for their own health. I agree, with an important proviso: individuals need support to accomplish this, support that is coordinated and responsive to their personal situation. New models of chronic disease management are demonstrating their success here in New Brunswick. The challenge is that they have to become the norm, not the exception. The health system of the future must be driven by performance and real evidence of effectiveness and efficiency. We all deserve nothing less.

—ROXANNE TARJAN, *Executive Director*

THE BOARD OF DIRECTORS MET ON OCTOBER 12 & 13, 2011, AT NANB HEADQUARTERS IN FREDERICTON

The meeting commenced by welcoming a new president-elect, two region directors, two re-appointed region directors and one re-appointed public director effective September 1st, 2011. They are as follows:

- Darline Cogswell, RN
  President-elect
- Terry-Lynne King, RN
  Director—Region 2
- Dawn Torpe, RN
  Director—Region 3
- Noëlline LeBel, RN
  Director—Region 4
- Marius Chiasson, RN
  Director—Region 6
- Roland Losier
  Public Director

Policy Review

The Board reviewed and approved the 2011–12 Board Planning Cycle, as well as policies related to:

- *Governance Process*
- *Executive Limitations*

Organization Performance: Monitoring

The Board approved monitoring reports for the Executive Limitations.

NANB Joins Twitter

With the Board's support, NANB joined the world of social media as an added media monitoring tool, as well as an opportunity to promote to existing and future members the Association's events and the supports and services available. This move will also increase traffic to our existing website.

You can follow us at www.twitter.com/nanb_aiinb. There is also a direct link to the account from our homepage www.nanb.nb.ca.

Healthy Public Policy

Lisa Brazeau, Director of Communications and Josette Roussel, Nurse Advisor with the Canadian Nurses Association (CNA) shared exciting news that New Brunswick would pilot CNA's national NP Awareness Campaign—*Nurse Practitioners...it's about time*. Beginning October 17th, this four week campaign will educate the public on the role of the NP through advertisement campaigns and a website www.npnow.ca.

In an effort to continually enhance services, NANB will launch e-learning modules developed by the Nova Scotia Community College. Scott Conrad, Instructional Designer guided a demonstration of the module on *Problematic Substance Use in Nursing*. This will be the first in a series of e-learning modules available on NANB's website, created to support registered nurse practice.

A project update on CNA's Strengthening Nurses, Nursing Networks and Associations Program (SNNNAP) partnership between NANB and Association Professionnelle des Infirmiers/ères du Burkina (APIIB) was provided by Vicki Campbell, Policy and Development Consultant, CNA.

Board of Directors & Committee Appointments

The Board of Directors approved the following appointments:

- Nominating Committee composed of Martha Vickers, past-president of NANB as Chair; Noëlline LeBel, Director-Region 4; and Marius Chiasson, Director-Region 6 to recruit member nominees to fill vacant region director positions.
- Sharon Hall-Kay, RN, Chief Scrutineer for the NANB 2012 Election and Annual Meeting.
- Discipline and Review Committee: Paul Rousselle, nurse member (North Tetagouche); Charles Flewelling, retired educator (Moncton); and Huguette Frenette, guidance counsellor (Bathurst).

NANB Documents

The Board approved the following documents:

New Document(s):

- *Practice Guideline: Consent*

The practice guideline on *Consent* provides guidance to help registered nurses understand the concept of consent and the RN role in obtaining consent and further interpret the *Standards of Practice* and the *Code of Ethics for Registered Nurses*.

Revised Document(s):

- *Practice Guideline: Working with Unregulated Care Providers*

The Board also approved the retirement of two guidelines and two position statements: *Guidelines for Camp Nursing in New Brunswick*; *Guidelines for the Administration of Medications by Non-Nurses in Non-Health Settings*; *Delegation of Nursing Acts to Family Members*; and *Delegating Nursing Tasks and Procedures*.

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

Staff Recognition

Employment milestones were recognized for the following: Denise LeBlanc-Kwaw, Registrar for 10 years; and Odette Comeau Lavoie and Virgil Guitard for respectively for five years of service to the Association.

Next BoD Meeting

The next Board of Directors meeting will be held at the NANB Headquarters on February 15 and 16, 2012.

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

2011–2012 NANB Board of Directors

- *President*
  France Marquis
- *President-Elect*
  Darline Cogswell
- *Director, Region 1*
  Lucie-Anne Landry
- *Director, Region 2*
  Terry-Lynne King
- *Director, Region 3*
  Dawn Torpe
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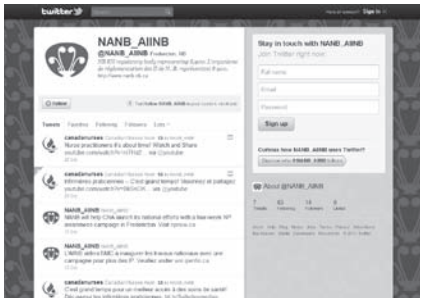
- *Director, Region 7*
  Deborah Walls
- *Public Director*
  Aline Saintonge
- *Public Director*
  Robert Thériault
- *Public Director*
  Roland Losier

Social Committee Update

NANB'S SOCIAL Committee raised approximately $900 this year through Casual Fridays. Proceeds went to: the Fredericton Food Bank, Emergency Shelter, Transition House, and the SPCA. Additional fundraising events included, "Dress Red" for the Heart & Stroke Foundation.

For the last two holiday seasons, a Silent Auction was organized to give a deserving family a Christmas to remember. Last year, NANB was able to raise more than $500 for the second time in a row, prompting the Committee to organize the 3rd Annual Silent Auction for this holiday season.

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



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You can follow NANB at www.twitter.com/nanb_aiinb. There is also a direct link to the account from our website homepage www.nanb.nb.ca.

Notice of Annual Meeting

IN ACCORDANCE with Article XIII of the bylaws, notice is given of an annual meeting to be held May 31st, 2012, 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. A membership certificate will be required for admission. Students of nursing are welcome as observers.

Resolutions for Annual Meeting
Resolutions presented by practising members according to the prescribed deadline, March 11, 2012, will be voted on by the 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

Canadian Nurses Foundation
Fondation des infirmières et infirmiers du Canada

RN Scholarship Recipients

HEATHER MCQUINN, RN, a resident of Fredericton was the recipient of the 2011 NANB-CNA Centennial Scholarship. McQuinn is currently pursuing her Masters at the University of New Brunswick (UNB). Her thesis focuses on the role of spirituality among First Nations individuals who have successfully recovered from alcohol and drug addictions. Since 1990, her passion has been to serve the field of mental health nursing in the clinical, community, and acute healthcare settings, as well as in the voluntary sector. Presently, McQuinn represents the province of New Brunswick on the Board of Directors for the Canadian Association for Nursing Research.

SERENA JONES, RN, based in Fredericton, resident was the recipient of the 2011 NANB Scholarship. After receiving her BN, Jones worked as a registered nurse in Manitoba in the areas of internal medicine, dialysis, and flight nursing before deciding to return to New Brunswick to pursue a Masters of Nursing at the University of New Brunswick (UNB). Jones intends to focus her thesis on the experience of workplace bullying among newcomers to New Brunswick.

Congratulations!

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.

Call for Nominations: Regions 1, 3, 5 and 7

Nominations for the 2012 election are now being accepted.

Nomination forms: page 37

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.

Nominations submitted by individuals must bear the signatures and registration numbers of the nominators.

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

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

Nomination Restrictions

Only nominations submitted on the proper forms and 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 published in the spring 2012 edition of *Info Nursing*. Voting will take place by mail ballot. The names of the elected candidates will be announced at the 2012 Annual Meeting and will be published in the fall edition of *Info Nursing*.

The 2011 NANB Scholarships Recipients

UNB Monnex $1,250.00 ea.	**Recipients** Alison Lynn MacDonald & Natalie Nicole Warren
UdeM Monnex $2,500.00	**Recipient** Amélie Boulay
UNB NANB $1,400.00	**Recipient** Rhonda Sydney Vautour
UdeM NANB $1,500.00	**Recipient** Lorraine Boudreau
NANB/CNA Centennial Masters Level $5,000.00	**Recipient** Serena Jones
NANB Masters Level $5,000.00	**Recipient** Heather McQuinn
Presidents Award UNB—Bathurst $250.00	**Recipient** Vicki Peterson
Presidents Award UNB—Fredericon $250.00	**Recipient** Brittany St. Peter
Presidents Award UNB—Moncton $250.00	**Recipient** Adam Comeau
Presidents Award UNB—Saint John $250.00	**Recipient** Carmen Daamen
Presidents Award UdeM—Moncton $250.00	**Recipient** Cindel Lee Doucet
Presidents Award UdeM—Shippagan $250.00	**Recipient** Tania Nancy Friolet
Presidents Award UdeM—Edmundston $250.00	**Recipient** Véronik Cormier

January 2012: NANB Launches E-Learning Modules

Problematic Substance Use in Nursing is NANB's first in a series of e-learning modules offering members the opportunity to learn more about issues that affect nursing practice and how to apply this knowledge to real-life clinical situations. Even if you participated in last year's forum or received a workplace presentation, this e-learning module will provide more practical information on *Problematic Substance Use in Nursing*, in a user-friendly, interactive and self-directed environment.

Members can access this free e-learning module via NANB's website at your convenience, 24/7 with the ability to leave and return when the time is right for you. Don't miss this professional development opportunity to enhance your knowledge and to apply this towards the Continuing Competence Program.

Planning is already underway for the 2012 e-learning modules based on themes that directly affect the nursing profession. Stay tuned for more information.

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 that you would prefer to receive future issues of *Info Nursing* electronically.

NANB Recognized as a Champion of Linguistic Harmony

EDITOR'S NOTE: On September 28th, 2011, NANB received the prestigious Lieutenant-Governor's Dialogue Award. The following encompasses both the citation provided by Dialogue NB and an abridged version of France Marquis' acceptance speech.

As the largest group of health professionals in the province, with 8,900 members, the Nurses Association of New Brunswick (NANB) champions the principles of harmony and respect between Anglophone and Francophone communities in its daily functions. When the Association speaks, it speaks in the language of both linguistic groups, aligned to the core values espoused by the Lieutenant-Governor's Dialogue Award. Specifically, every official document of the Association is available in both official languages. Every board meeting and annual general meeting is conducted with simultaneous interpretation. NANB's website and journal are offered in both languages. Educational sessions are available for both French-speaking and English-speaking nurses. The Association's commitment to linguistic duality is not required by law. That it nevertheless deems diversity a lynch-pin of its service in New Brunswick makes the NANB a most worthy recipient of the Lieutenant-Governor's Dialogue Award.

NANB was one of three recipients to be awarded the Lieutenant-Governor's Dialogue Award

Photographs compliments of Harry Mullin.

France Marquis, President, NANB accepts the Lieutenant-Governor's Dialogue Award.

"It is indeed an honour and a privilege to accept this award on behalf of the Board of Directors and registered nurses of the Nurses Association of New Brunswick. The mission of Dialogue NB includes the concepts of understanding, respect and appreciation between English and French speaking New Brunswickers with more precise objectives of allowing citizens of both linguistic communities to share their needs, aspirations and concerns through dialogue, that they will meet, interact and collaborate and finally that linguistic equality is valued and appreciated, goals and values shared by the Nurses Association of New Brunswick.

Thank you sincerely for this recognition of our achievements, as an organization and community, to the advancement of these goals. Over 30 years ago, the Board of Directors of the Nurses Association of New Brunswick endorsed a Strategic Communications Plan that has shaped the NANB before you today. The vision and values of the Board are grounded by the values of our profession, a profession of extensive knowledge and expertise but one that happens in the interaction of human beings. Our profession's commitment to effective communication is founded in our commitment to competent, ethical care for the patients, families and communities we serve. As the professional association responsible for the regulation of the practice of registered nurses in the public interest in New Brunswick, the Association, Board of Directors and members have supported the strategic goals, policies and resource expenditures that have supported and nurtured the full participation and contribution of registered nurses, our colleagues , stakeholders and the public of both linguistic communities in New Brunswick to the advancement of our profession, educational programs, code of ethics, standards and guidelines, entrance-to-practice requirements, disciplinary process to highlight some of our activities. This engagement, debate and dialogue, as well as the opportunity for both linguistic communities to contribute without barriers, has strengthened and enriched our Association, our profession and the New Brunswick health system.

I believe this award also calls us to continue to demonstrate our leadership in this area and to model the positive outcomes that full engagement of both linguistic communities has brought as we fulfil our mandate and support and advance registered nurse practice in the province.

Thank you again for this award; we will use it to inspire us every day."

—France Marquis, President ■

Nursing Doctorate Project

Université de Moncton in Collaboration with a Francophone University

By ANIK DUBÉ, SUZANNE HARRISON & DANIELLE CHARRON

At the dawn of the 21st century, the Canadian population needs increasingly complex healthcare services and leading-edge university training programs in nursing, thereby requiring a growing number of doctorally prepared nurses. In fact, nurses who have a Ph.D. promote and conduct research which advances the knowledge and theoretical basis of nursing practice. These nurses fill teaching positions in nursing training programs, play a leadership role within the profession and give direction to nursing and healthcare policies. They are more than essential for the survival of our profession.

It must, however, be recognized that among Canadian provinces competition to recruit health professionals, especially nursing professors with doctorates in nursing, remains a major challenge. The Université de Moncton operates in a Francophone minority setting and has been unsuccessful in filling its vacant teaching positions. These Ph.D. positions require professors who hold a Ph.D. in nursing or who are enrolled in doctoral studies and have already completed the Ph.D. coursework.

In response to this problem, a group of nursing professors at the School of Nursing (ÉSI), of the Université de Moncton, established a committee (DOC-SOS) in January 2010. The purpose of this committee is to explore how these positions might be filled. The committee's goals are as follows:

1. Develop and implement strategies for recruiting professors in nursing (and related fields) with a Ph.D.;
2. Develop tools, such as a survey or other means, for identifying nurses interested in pursuing doctoral studies and teaching at the Université de Moncton's ÉSI;
3. Explore the possibility of offering a doctoral program in nursing at the Université de Moncton, which would likely be headed by the School of Nursing at the University of Ottawa or the Faculté des sciences infirmières at the Université Laval in Québec; and
4. Develop a strategic plan aimed at encouraging nursing BA and Masters of Nursing students to pursue furture graduate studies.

This news release is to inform you of our project and provide you with the opportunity to complete a doctorate in nursing at the Université de Moncton, in collaboration with a Francophone university (University of Ottawa or Université Laval). This doctoral program would be offered via distance learning, and could be done either full- or part-time.

Before we further discuss this ambitious project with our contacts at the University of Ottawa and the Université Laval, we would like to survey you regarding your interest in completing a doctorate in nursing in French at the Université de Moncton.

To this end, we invite you to answer our survey which will be available on-line on the Université de Moncton's École de science infirmière website: www.umoncton.ca/umcm-fssc-scienceinfirmiere.

The results of this survey will be released in 2012. Thank you in advance for your interest in this project.

The Committee Members

For more information, the committee members are:

- Danielle Charron, Ph.D., President, danielle.charron@umoncton.ca or 506-858-4261.
- Suzanne Harrison, Ph.D., Vice-President, 506-858-4342 or suzanne.harrison@umoncton.ca.
- Anik Dubé, Ph.D.(c), Secretary, 858-4256 or anik.dube@umoncton.ca. ■

Igniting Change

Province's Summit on Primary Health Care

By BRONWYN DAVIES

The 200 delegates in attendance at the province's first-ever Primary Health Care Summit agree that change is necessary to provide better, more timely access to quality primary health care services.

The Summit, *Our Health-Our Future: Igniting Change in Primary Health Care*, held on October 20 and 21, was hosted by the Department of Health in partnership with the province's Primary Health Care Steering Committee. The Summit follows an extensive consultation process by the Department in response to the Steering Committee's discussion paper, released by the Minister of Health this past March. The Nurses Association of New Brunswick is represented on the Steering Committee.

Those in attendance included primary health care providers, such as nurses and nurse practitioners, community leaders, policy and decision makers, academics, and representatives from health care-related organizations. Health Minister Madeleine Dubé and Trevor Holder, Minister of Wellness, Culture and Sport, were also in attendance.

The Summit featured three renowned keynote speakers: Dr. Rob Wedel, a family physician from rural Taber, Alberta; Bill Casey, Executive Director of Primary Health Care Services of Peterborough; and John G. Abbott, Chief Executive Officer with the Health Council of Canada.

"At the core of a sustainable health care system is primary health care," said Minister Dubé. "Igniting change in primary health care is the first step to a healthier New Brunswick and a strong, and efficient, health care system."

The following topics were addressed in the breakout sessions, which were structured under the umbrella topics of access, teams and healthy living:

- Access: delivery system design; patient engagement: patients as partners; unattached patients; 24/7 care;
- Teams: integration; performance indicators; team remuneration; governance, accountability and care coordination; and
- Healthy Living: facing health disparities; mobilizing communities around healthy living; citizen centeredness; self-management.

After a full day of discussion, there were a number of common themes that emerged from the breakout sessions. The topics of team-based care, stakeholder collaboration and governance seemed to resonate most with summit delegates.

On the second day, delegates had a chance to provide their feedback on the main themes that emerged the previous day in the breakout sessions. Delegates were given keypad voting devices to vote on a series of questions relating to the main themes of the Summit.

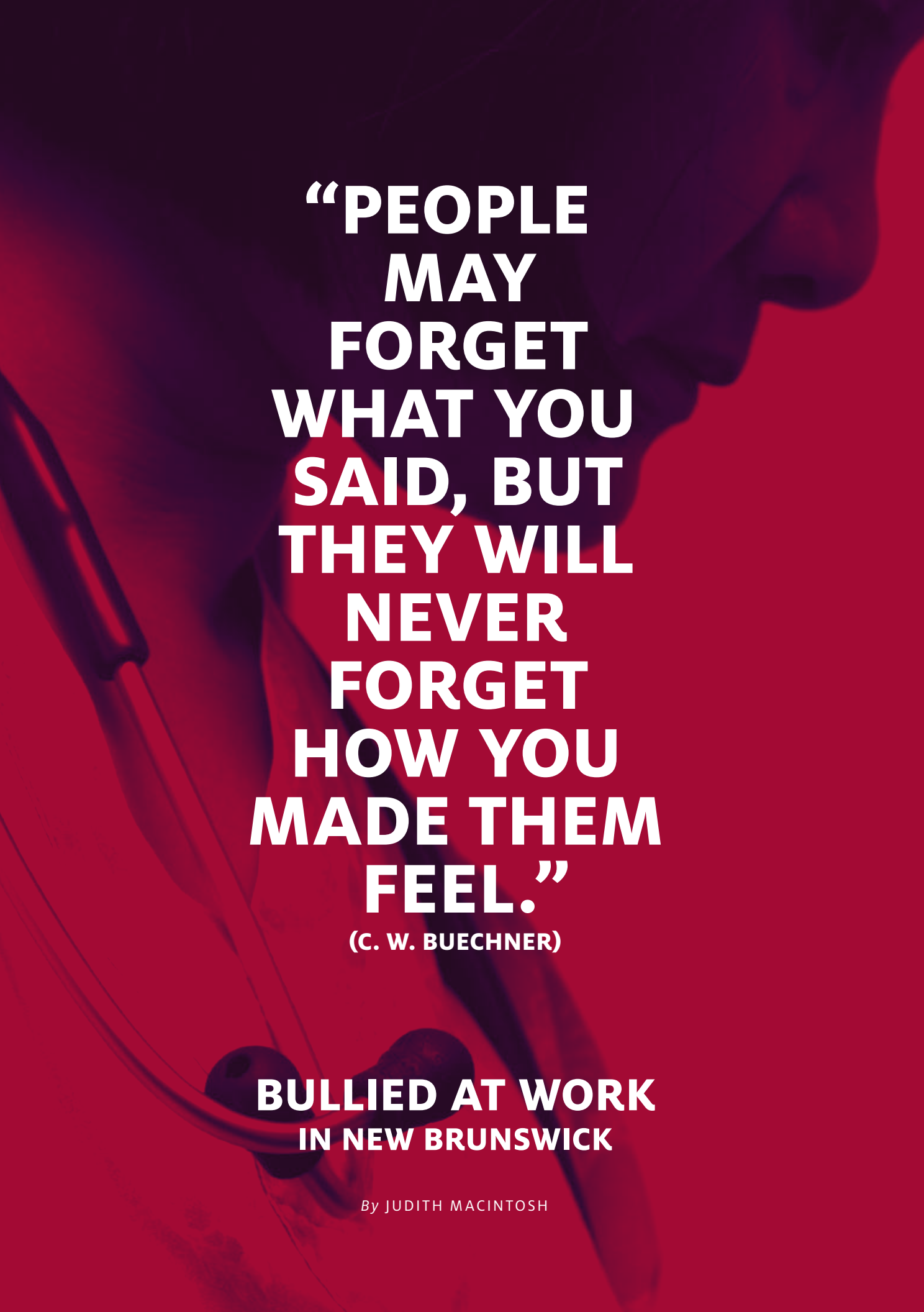
The responses from the delegates were:

- Only 3 per cent of delegates agreed that the current funding models for health professionals encourages a team-based approach to primary health care;
- 99 per cent agreed that community involvement is important in the development of a primary health care model;
- 90 per cent agreed on a team approach as the preferred model to delivering primary health care;
- When asked to vote on what was the next most important criterion for primary health care team development in New Brunswick, over 60 per cent of delegates agreed that defining a governance model was the next step;
- 42 per cent of delegates agreed that the local communities should be responsible for the formation of primary health care teams as opposed to the RHAs (31 per cent), individual providers (16 per cent) and central government (11 per cent);
- Almost 80 per cent of delegates agreed that community engagement is the best way to create a culture of healthy living in New Brunswick;
- Delegates were not unanimous when asked if primary health care providers are equipped to promote healthy living—12 per cent thought that providers were very equipped while most, 81 per cent, felt that providers were only somewhat or slightly equipped;
- 93 per cent of delegates agreed that greater collaboration among government departments and communities is required to improve the overall health of the population;
- 88 per cent of delegates agreed that New Brunswick needs an electronic medical record (EMR) to improve primary health care; and
- When asked if team performance and clinical outcomes should be linked to funding, 68 per cent of delegates agreed.

With the Summit over, the Primary Health Care Steering Committee has been tasked with creating an action plan for government on how to renew primary health care in the province. This action plan will be submitted to government in the New Year.

For more information on the Summit or to learn more about the consultation process, please visit the following web pages.

- Primary Health Care Summit: www.gnb.ca/0053/phc/summit-e.asp
- Primary Health Care Consultation www.gnb.ca/0053/phc/consultation-e.asp



“PEOPLE MAY FORGET WHAT YOU SAID, BUT THEY WILL NEVER FORGET HOW YOU MADE THEM FEEL.”

(C. W. BUECHNER)

BULLIED AT WORK
IN NEW BRUNSWICK

By JUDITH MACINTOSH

The article in the June 2011 Canadian Nurse Journal on workplace bullying, and the many letters to the editor published in the September issue from targets of workplace bullying, highlight the importance of this critical workplace issue.

Over the past decade, I have been doing research into workplace bullying in New Brunswick. My research has included various workplaces but many of my findings reinforce those described in the Canadian Nurse Journal.

I use the label 'workplace bullying' to describe repeated behaviour over time that is known to be, or ought to be known to be, unwanted or unwelcome. The behavior includes any psychological (verbal), physical or sexual abuse, harassment, or hostility against another person that takes place at work or while going to and from work (includes stalking). I use the label 'target' for the person being bullied because many people in my studies do not consider themselves 'victims.'

I see some important issues about workplace bullying:

- Workplace bullying is not easy to identify at first. People do not recognize immediately that the intense misery they feel is caused by workplace bullying. Often, we internalize our experiences, make excuses for the bullying and resolve to work harder to avoid it.
- Bullying makes targets feel alone, that there is something wrong with them and that they are to blame for it.
- The effects of workplace bullying are severe. Targets experience effects in several domains: physical (headaches, fatigue, disruptions to sleeping and eating patterns, digestive problems); emotional (stress, anxiety, dread of going to work, lack of control); social (isolation, withdrawal from family and friends, negativity); and career (damage to reputations, poor references, sickness absences, leaving jobs).
- Experiencing workplace bullying changes targets' views of work and the meaning they take from work. A formerly dedicated employee loses interest in work, takes more sick time, becomes less committed and looks at work as only a job to do.
- Health and social effects persist long after people are out of bullying workplaces, whether they leave their workplaces or whether bullying stops.
- Most targets are dedicated and conscientious employees who love their work and who value doing a good job, but bullying changes all of that for them.
- Targets of workplace bullying want the behaviour to stop and they want to hear someone acknowledge that the behaviour was inappropriate and should not have happened.
- Employers and workers both lose when workplace bullying is not addressed promptly. Bullying escalates over time and becomes harder to address as time goes on.
- Targets say that support from family members, friends and co-workers is very important to helping them recognize and manage bullying.
- Health care professionals who recognize that targets' symptoms may be related to workplace bullying are very helpful; asking "how are things at work?" may begin a new level of understanding.
- There is a myth that the best first approach to addressing bullying is for targets to confront bullies directly. This is often impossible, unwise and unsafe. A target whose self-esteem is diminished is not in a position to confront a powerful person and risks making things worse. This myth emphasizes the expectation that targets should be able to 'fix' it themselves.

To address workplace bullying as a society, we need:

- Strategies to address bullying at personal, group, organizational, public and policy levels because it is complex. Policies and procedures often place responsibility on targets to change or to do something themselves to stop the bullying. This is inappropriate because it 'blames the victim.' Targets need to know that they are not responsible for being bullied.
- Interventions to address bullying that engage whole work groups because everyone in the work environment is affected by bullying.
- Human Resources and unions that are well prepared to support targets of workplace bullying. Currently, few targets find support and help

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1 to 2 women are murdered every week in Canada by an intimate partner.

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VIOLENCE AGAINST WOMEN:
AN IMPORTANT NURSING CONCERN

By MARILYN MERRITT-GRAY & JUDITH WUEST

Intimate partner violence (IPV), also known as woman abuse, is a serious public health problem[1] affecting one in three Canadian women in their lifetimes.[2] Nurses have been leaders in attending to the effects of family violence, particularly on women and children. NANB published a position statement on family violence in 1985 (revised 1996)[3] that was followed by a position statement and clinical guidelines for family violence by CNA in 1992.[4,5] The enclosure of that small red book of clinical guidelines with the Canadian Nurse heightened our consciousness of family violence and nurses' roles in addressing this important issue. More recently, the RNAO developed a best practice on woman abuse (www.rnao.org/Storage/12/655_BPG_Women_Abuse.pdf). The Nursing Network for Violence Against Women, International provided direction in eliminating violence through advancing nursing education, research, practice and policy (www.nnvawi.org). But as much as we have championed the issue of family violence, our response to women and families in our practice has not been as progressive. Although women view nurses and the health care system as an accessible resource, they often feel judged and unsafe when they seek our help. Too often we respond to survivors on the basis of common beliefs or myths, and act as if IPV is an issue better addressed by someone else. Marilyn's clinical concern 20 years ago as a community mental health nurse, about how to help women who were struggling to leave abusive partners was the impetus for our program of research. Our work has contributed to an increasing body of knowledge available to help nurses respond more effectively to abused women.[6]

"Importantly most of these health problems are amenable to interventions well within the nurse's scope of practice."

Why is family violence an important nursing concern?

At least a third of the women for whom we care for will experience family violence in their lifetime. In addition, as a female-dominated profession, we can assume that roughly one in three of our nursing colleagues will experience abuse within a personal relationship in their lifetime. Annually for five years, we assessed the health of a volunteer, community sample of 309 women (NB=110; ON=110; BC=89) who had been separated from an abusive partner for an average of 20 months (see www.women-health.ca/language.htm for key findings). On average, women were 39 years of age, had 13 years of

TABLE 1 *Health Profile of Women 20 Months after Leaving (N =309)*

Health Profile	% of Abused Women (N=309)
Report good to excellent health	62%
Report that physical health problems interfere with work or usual activities	70%
Problems in past month with	
• Feeling Worried or Uptight	• 81%
• Fatigue	• 78%
• Difficulty Sleeping	• 76%
• Back Pain	• 67%
• Headaches	• 65%
• Difficulty Concentrating	• 62%
• Bowel Problems	• 52%
• Swollen and Painful Joints	• 46%
Chronic high-disability pain*	35%
Pre-hypertension	42%
Symptoms consistent with clinical depression*	73%
Symptoms consistent with PTSD*	48%

* as measured using a standardized tool

education, and had experienced 8.5 years of abuse from the partner they left. Their median income was $15,684 and 57% had dependent children.[7] We found that, contrary to popular belief, women had many strengths that helped them counteract abuse and its consequences: 45% were employed; 16% were in educational programs; 16% were looking for work; and 25% owned their own homes. Further, their scores on standardized measures of resilience, mastery, family functioning and social supports were all similar to those of the general population.

What are the health consequences of abuse?

The health effects of violence are a result of physical injury and the chronic, traumatic stress of abuse; these effects last for many years, long after women leave or the abuse stops. In our 5-year study of women's health after leaving (see Table 1 for a health profile), we found that, on average, women reported 12 active health problems, and were taking 3 prescription medications.[8]

The rates of women's health problems were generally high; for example, chronic pain and pre-hypertension rates are about twice that of Canadian women in general. Importantly, most of these health problems are amenable to interventions well within the nurse's scope of practice. In comparison to Canadian women in general, our participants' rates of consultation in the past month with family doctors was 5 times higher, walk-in clinics 8 times higher and emergency departments 24 times higher. However, more than twice as many (73%) had symptoms consistent with clinical depression than reported a diagnosis of depression by a health professional (31%); similarly, 7% reported a diagnosis of posttraumatic stress disorder (PTSD), but 48% had symptoms consistent with mild to severe PTSD. These findings suggest a poor fit between health services and health needs.

Based on analysis of services used by our sample, costs to Canadian health and social systems attributable to violence are $11,370 annually per woman, suggesting an annual national cost of $3.1 billion for women who have left abusive partners in the past 3 years.[9] Many of these costs could be mitigated by timely trauma-informed services that acknowledge and address the cumulative effects of abuse across the lifespan. In our sample, 81% reported child abuse, 40% adult sexual assault by someone other than the partner, 59% more than one abusive partner and 78% abuse-related injury.

What have we learned from abused women about how to help?

Our theory of reclaiming self shows that leaving is a slow and iterative process.[10] Contrary to popular belief, women caught in abusive relationships are not passive victims. Almost from the onset of the abuse, they actively engage in counteracting abuse. For most, the abuse persists and erodes their energy as they take steps to break free, at least emotionally, until they are able to do the work of not going back and, over time, moving on. The process of leaving can be long and tortuous; support that fortified a woman's confidence and sense of capacity was vital. Recreational opportunities, educational upgrading, new employment challenges and volunteer activities were fortifying and transformative for many women. When families and helpers supported fledgling competencies and do not give up on

What Can Nurses Do Now?

- Name ABUSE as abuse when you see it, and help others do the same.
- Assume that most women (colleagues and patients) in their lifetimes are abused by someone who is important to them, perhaps many times.
- Raise and talk about the issue of woman abuse with nursing colleagues.
- Talk about what you can do collectively to create a safer health care environment where women can talk about a current or past trauma, access help and not feel judged.
- Know that the question "Why don't you just leave?' is not helpful and is destructive.
- Focus on the woman's strengths.
- Ask her what you can do to help her stay as physically and emotionally safe as possible now and in the future.
- Remember that leaving is a process for all women and, for many, leaving an abusive situation is currently not their best option.
- Remind trauma survivors that research has shown that physical or emotional abuse can aggravate and, at times, cause health problems. Review common abuse-related health problems (chronic pain, insomnia, depressive symptoms, PTSD-type anxiety, GI & neurological symptoms, increased substance use), and their relationship to abuse-related stress and injury.
- Acknowledge the challenge of mothering during abuse. Remind her that a partner's abusive behaviour toward her DOES negatively affect her children. Reinforce that she is NOT a poor mother because the father batters.
- Become aware of local and provincial resources available to people dealing with a current or past trauma (Page 2 of every phone book lists resources such as Transition Houses, Outreach workers, Crisis Lines).

info LAW
Vol. 19, No. 2, December 2010
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Long-Term Care

www.cnps.ca

Canadian Nurses Protective Society

With the aging population, longer lifespans and the increasing complexity of care, the demand for long-term care (LTC) in Canada will increase and more nurses will be involved with caring for these patients. Nurses should be aware of the more prevalent risks of harm for this segment of our population.

Falls

Injuries sustained as a result of falls are one of the major reasons for admissions to LTC and transfer of patients from LTC to acute care hospitals for treatment of serious injuries. Seventy per cent of major injury-related hospitalizations for patients 65 years of age and older are as a result of unintentional falls.[1] *Safer Healthcare Now!* information indicates that 40% of admissions to LTC facilities are directly related to falls, almost half of elderly residents in LTC facilities fall every year, and serious injuries are sustained by a third of those who fall.[2] One such case involved an elderly LTC patient with dementia who fell from an elevated lift chair when it tipped over. The fall-related injuries contributed to her death.[3]

Over a 15 year period, 16% of incidents reported to the Canadian Nurses Protective Society (CNPS), involving LTC patients, related to falls. It appears that elderly patients can sustain serious injuries or even die as a result of the trauma sustained during a fall. Some falls were blamed on a lack of appropriate supervision, medication errors, and improper use of transfer equipment. In other cases, it was alleged that nurses failed to appropriately assess patients after a fall resulting in delays in diagnosing and treating fractures or other serious injuries. The patients' inability to communicate due to their medical condition or a language barrier may also have played a part.

Medications

A Canadian Institute of Health Information study of drug claims by more than one million seniors gives a clear picture of the multiple medications taken by the elderly: 67% of people over 65 take five or more types of drugs; 21% take 10 or more; and 6% take 15 or more.[4] The use of multiple medications increases the potential for medication errors and adverse reactions because of the interactions of these medications. As well, failure to appropriately monitor medications given to LTC patients can have negative consequences. For example, Haldol was ordered by a psychiatrist to manage the verbally-abusive behaviour of a patient in a nursing home. Because the medication was not effective, the patient's primary physician increased the dosage, without consulting the psychiatrist, and did not monitor the effects of the increased dosage. The patient's condition deteriorated and she developed tardive dyskinesia which rendered her completely spastic.[5]

The provision of inaccurate or incomplete medication information also increases the risk of medication errors when the elderly are admitted, discharged or transferred between healthcare facilities. To prevent near misses and adverse events in this area, Accreditation Canada has included medication reconciliation as a required organizational practice. Preventing adverse drug events through drug reconciliation is also one of the targeted interventions in the *Safer Health-care Now!*[6] program.

Abuse

Investigations by Alberta's Protection for Persons in Care (PPC) office are an indication of the prevalence of emotional, physical and financial abuse suffered by the elderly under the care of

healthcare providers. In one year, the PPC office received 447 reports of alleged abuse. The breakdown of these complaints was emotional harm (49%), failure to provide the necessities of life (27%), bodily harm (17%), unwanted sexual contact (3%), inappropriate medication administration (2%), and financial abuse (2%). Fifty-nine per cent of the victims of alleged abuse were over 65 and the largest age group involved in the abuse reports were between 81 and 90 years of age. Of these complaints, 82.8% of the alleged abusers were healthcare service providers.[7]

A finding of patient abuse against a healthcare provider or healthcare organization can lead to serious legal consequences. Healthcare providers involved in such activities may be disciplined by their employer and their professional licensing body, sued, fined[8] and have criminal charges laid against them. For example, after being found responsible for physical and emotional abuse of residents in a nursing home, a registered nurse was terminated from her employment and had her nursing license revoked by her professional association.[9] A personal support worker was recently sentenced to eight months in jail, after pleading guilty to charges of assaulting four vulnerable residents, all in their eighties and nineties who had Alzheimer's disease or dementia.[10] A civil lawsuit was also initiated against a nursing home because of the failure of the organization and its nursing staff to provide a safe environment for an elderly resident with Alzheimer's disease who wandered into the room of a known combative resident, was thrown to the floor and fractured her hip. The court concluded that the nursing home and its staff failed to make the premises of the nursing home reasonably safe for its residents.[11]

Summary

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Canadian Nurses Protective Society

Professional Liability Protection for Nurses by Nurses

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

"The process of leaving can be long and tortuous; support that fortified a woman's confidence and sense of capacity was vital."

women when the challenges of establishing a life separate from the abuser overwhelmed her, she was more likely to not go back, and eventually move on.

In our later study of family health promotion after leaving abusive partners, we found that fortifying was also important for mother-headed families experiencing the unrelenting intrusion of ongoing abuse, physical and mental health problems, 'costs' (measuring up, surveillance) of seeking help and reduced social and economic circumstances.[11] Despite increasing intrusion after leaving, we found that women strengthen their capacity to limit intrusion through natural processes of safeguarding, cautious connecting, managing basics, managing symptoms, regenerating family and renewing.[12, 13] As families achieved some stability and predictability in day-to-day life, they were able to take the calculated risks to better position themselves for the future.

This framework with our findings about women's health after leaving has lead to the development of the 6-month Intervention for Health Enhancement after Leaving (iHEAL) designed for 1:1 delivery in the community by nurses and domestic violence outreach workers in 12 to 14 meetings.[13] The purpose of this intervention is to improve quality of life and health for women who have left abusive partners by reducing intrusion and increasing their capacity. We have partnered with the Government of New Brunswick's Women's Issues Branch, and Department of Health, as well as with Liberty Lane Inc. to obtain funding from the Canadian Institutes of Health Research and the New Brunswick Health Research Fund to examine the feasibility of the intervention in the NB context. Fifty women have been recruited from Fredericton, Miramichi, Saint John and Sussex to participate in this study, which will be completed in August 2012. These findings will help us to better understand the role that nurses can play to support abused women and improve their health.

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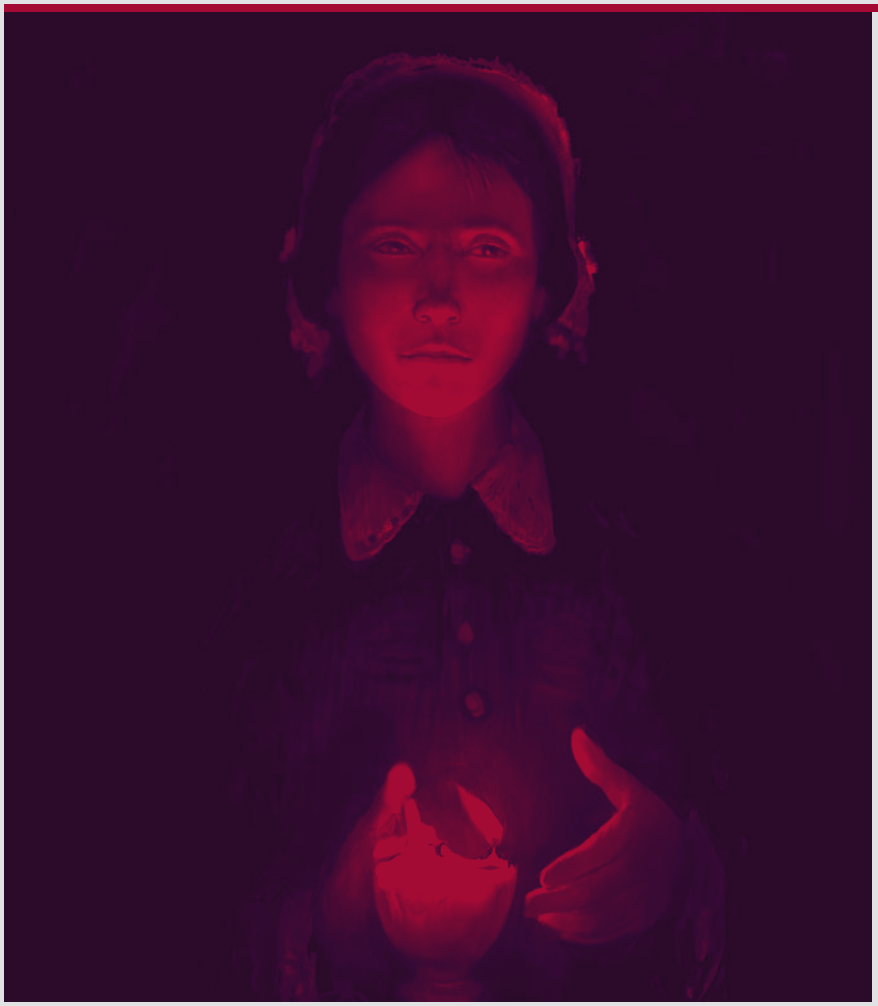

Florence Nightingale's Beliefs and Primary Health Care (PHC)

By ANNE-MARIE ARSENEAULT

EDITOR'S NOTE: The following is a continuation of the article originally published in *Info Nursing*, Spring 2010 (www.nanb.nb.ca/PDF/INFO-Spring2010-ENG-web.pdf) to commemorate the 100th anniversary of Florence Nightingale's death.

ARE FLORENCE NIGHTINGALE'S beliefs on public health still relevant? To answer this question, several paths for reflection are offered in some of Nightingale's assertions found in various sources. The principles of PHC provide a basis for this reflection.

The WHO-UNICEF Declaration of Alma Ata issued in 1978 put forward for PHC an approach to reach health for all by the year 2000. This WHO declaration identifies intersectorial strategies centered on the community in order to improve health and reduce inequalities. PHC is defined as essential health care made universally accessible to the community, by means acceptable to them, through their full participation and at a cost the community and country can afford (Carroll, 2006, p. 10). The values advocated by PHC include health for all, social justice and equality (Smith, in Stamler & Yiu, 2005). The five principles of PHC are: accessibility; public participation; health promotion; appropriate technology; and intersectoral collaboration (CNA, 2000). Each of these principles is presented and supported by Nightingale's ideas or activities.

Accessibility: The five types of care, which are health promotion, disease prevention, curative care, rehabilitation, and support and palliative care, are accessible to all, no matter the geographic location. Accessibility means that individuals and populations receive appropriate care provided by the right professional at the right time.

One of Nightingale's projects was improving the living conditions and the health of individuals in workhouse infirmaries. To improve services, she facilitated the integration of properly trained nurses into this population. She also supported the development of community-based health services in the form of district nursing to bring nurses closer to the population, for example, in rural areas (McDonald, 2004). Thus, home visits by these nurses allowed families to receive practical teaching in order to be able to provide care and maintain health.

Public participation: People and individuals take part in the decision making related to their own health and define their needs. Services are organized in a flexible way to meet the needs of the population.

Nightingale's *Notes on Nursing*, published in 1860, illustrates this principle eloquently. Through her advice to women who were responsible for the health of their families, this book became a self-learning tool that allowed women to better fill their roles as caregivers. Nightingale encouraged people to take charge of their own situation and become independent, instead of relying on charity. In a letter sent to her father in 1850, Florence denounced Christian benefactors who acted for the villagers instead of helping them to act for themselves (McDonald, 2003). She claimed that the role of district nurses was to teach family members the art of caring for the sick (Baly, 1993). Besides the services provided to inpatients, she argued for developing services focused on specific populations such as the poor, pregnant women and workers.

Health promotion: Health education is concerned with lifestyles and disease prevention activities. These activities are aimed at maintaining health through knowledge of health determinants.

Florence Nightingale is recognized for her efforts in this area. The goal of her work in Crimea was to improve the health and survival of soldiers, while reducing environmental factors contributing to high mortality rates. The effectiveness of her interventions aimed at improving factors such as

quality of the environment, diet and psychological support for the sick and the injured led to an important reduction in the mortality rate. Her vision was that any disease not prevented is a societal crime (McDonald, 2004).

In 1893, she demonstrated that the cost of crime prevention through education and rehabilitation of young people were considerably lower then the costs generated by punishing and incarcerating criminals. In the past, she had denounced the negative impact of smoking on young boys' growth (McDonald, 2004, p. 161).

The advice she gave women in her book *Notes on Nursing* demonstrates the importance she attached to the environment in health promotion. For example, she insisted on good air quality and less noise, and having light and cleanliness. She also put efforts into developing health services in the community. She was of the opinion that hospitals could not look after every sick person. She saw hospitals as a useful place for individuals who suffered from a major illness or needed surgery (McDonald, 2004; Baly, 1993).

Her remarks on the degradation of the environment in India caused by deforestation, which leads to monsoon damage, illustrate in a convincing manner her environmental approach (Dossey, 1999).

Appropriate technology: This principle supports care tailored to the community. It calls for the development of skills, innovative models for health care and research.

Nightingale used the various means and tools available in her time to improve the health of target populations. She thought that observation of the context of care was an essential strategy for caregivers. Without this skill, it is preferable to leave nursing, despite having personal qualities such as kindness (McDonald, 2004).

Her research and the inquiry commissions she led on health services in order to identify the causes of disease and mortality were aimed at improving services. For example, she studied mortality rates in British colonies and among students in Canadian schools for natives (McDonald, 2004). Her voluminous correspondence and numerous publications give us a better understanding of the findings of her studies.

Concerning the motion of change in the profession, Nightingale stated that "unless we are making progress every year, every month, every week, take my word for it, we are going back" (Ulrich, 1992, p. 10). Thus, she demonstrated her great capacity to act as a change agent, a quality that is forefront in the profession today. The influence of Nightingale's environmental model is still present in nursing education and research. For example, the Developmental Health conceptual framework of the McGill model is largely based on Nightingale's "laws of nature" to explain the role of the nurse in maintaining and promoting health (Gottlieb & Gottlieb, 2007).

The following anecdote is a great example of the concept of appropriate technology as we understand it today. One day, Florence Nightingale asked a nurse who was caring for a young girl suffering from bed sores if she wanted to put her on a waterbed (McDonald, 2004). Even at that time, such technologies were known.

Intersectorial collaboration: Nightingale acknowledged that health and wellness are related to economic and social policies. Various disciplines collaborate interdependently. This collaboration includes being involved in public policy development, planning, and health care services delivery and assessment.

Nurses have been collaborating with a variety of health care professionals for a long time. However, collaboration with professionals outside the health care field is not as obvious (Rodger & Gallagher, 2000). To improve intersectorial collaboration, CNA has developed tools to facilitate political action amongst members of the profession. Nightingale was already attempting to implant this approach to health services. The many biographies of her life recount her contacts with and the pressure she put on various political bodies such as Queen Victoria, government members, numerous civil servants and print journalists to advance her projects. Also, the work she did in collaboration with social reformers of that area to reduce mortality rates shows how much Nightingale believed in this strategy. Her somewhat liberal education, in major part because of her own efforts, allowed her to develop useful knowledge in history and mathematics, essential to the implementation of her projects.

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

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

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Medication Incidents Involving Digoxin Leading to Harm, Including Death

ISMP Canada has received a total of 414 reports involving digoxin since 2001. In total, 18 of these incidents have been reported to be associated with harm (n = 11) or death (n = 7). This safety bulletin is intended to remind Canadian healthcare professionals about the dangers of errors with digoxin, one of the oldest known cardiac drugs.

Example Incident

A patient received a prescription for digoxin 0.25 mg to be taken once daily. At the pharmacy, both the technician and the pharmacist misread the numeral "2" as "7" and therefore misinterpreted the prescription as "digoxin 0.75 mg po daily". When a drug information reference was consulted to verify appropriateness of the dose, the dosage used in "rapid digitalization" was misinterpreted as an appropriate daily dose for digoxin. Several days later, after taking daily doses of 0.75 mg, the patient experienced nausea and dizziness, and admission to hospital was required.

Overview of Digoxin Incidents Reported to ISMP Canada

When the reports of harm and death were analyzed further, 4 types of errors were identified: incorrect dose (n = 8), omission of a dose (n = 4), incorrect drug (n = 2), and other (n = 4) (see Table 1). Notably, the category with the highest overall number of incidents causing harm or death—incorrect dose—was also the category with the highest number of deaths: 6 of the 7 reported deaths were related to an incorrect dose.

Five of the deaths involved incidents with oral digoxin, and the other 2 involved incidents with intravenous digoxin. Two of the deaths were associated with incidents in the community, and the other 5 with incidents in the hospital setting.

Background Information about Digoxin

Digoxin is a digitalis glycoside used to treat congestive heart failure and to control the heart rate in atrial fibrillation.[1-7] It is available in an injectable formulation, as well as in liquid and tablet formulations for oral administration. Digoxin tablets are available in 0.0625 mg, 0.125 mg, and 0.25 mg strengths.[1]

Digoxin has a narrow therapeutic window (the difference between an effective dose and a toxic dose).[1,8] It is excreted primarily through the kidneys, and elderly patients in particular may be at higher risk of experiencing toxic effects of digoxin secondary to age-related renal impairment.[1,8] A number of medications, herbal products, and other agents can affect serum levels of digoxin.[1,8]

Table 1: Types of Medication Incidents Involving Digoxin Reported as Causing Harm to Patients*

Type of Error	Total No. of Incident Reports	Category of Harm†; No. of Incident Reports with Harm		
		Mild to Moderate (NCC MERP Category E or F)	Severe (NCC MERP Category G or H)	Death (NCC MERP Category I)
Incorrect dose	96	2	0	6
Omission of dose	177	3	0	1
Incorrect drug	32	2	0	0
Other	24	3	1	0
Total	329‡	10	1	7

*These data come from voluntarily shared reports, and it is therefore impossible to infer or project the probability of specific types of incidents.

†Based on NCC MERP (National Coordinating Council for Medication Error Reporting and Prevention) Index for Categorizing Medication Errors (2001). Available from http://www.nccmerp.org/pdf/indexColor2001-06-12.pdf

‡This total includes reports of all incidents involving 1 of the 4 types of errors identified in the 18 reports of harm. Incident reports involving other types of errors are not included in this table.

The common signs and symptoms of digoxin toxicity include bradycardia (heart rate below 60 beats per minute), gastrointestinal problems (e.g., diarrhea, loss of appetite, nausea, and vomiting), headache, and visual disturbances (e.g., flashing lights, halo, and impairment of green–yellow perception). Serious adverse effects include cardiac dysrhythmia, which can lead to death.[1,8]

Recommendations

The following recommendations are intended to minimize the potential for digoxin dosing errors that can lead to toxic effects:

- Computer order entry systems should have built-in alerts to warn practitioners of daily digoxin dosages that are outside normal limits. For patients with renal impairment, the dose should be reduced substantially.[1,4,8,9]
- Order entry systems should also be tested to ensure that appropriate alerts are provided for drug interactions with digoxin.
- Monitoring is crucial in preventing digoxin toxicity. For example, hypokalemia may increase the risk of digoxin toxicity, so initiation of a drug that can cause hypokalemia (e.g., diuretic, corticosteroid, insulin) should trigger closer monitoring of a patient and his or her digoxin dosage.[8]
- Engaging and educating patients (or families) about their digoxin treatment, including dosage, is paramount. Patients who are undergoing treatment in the community should know how to take their pulse rate, because a low heart rate can be an important indicator of problems before harm occurs. In fact, a pulse rate below 60 beats per minute is sometimes the only sign that a patient's digoxin level is abnormal.

Many hospitals already have safeguards in place for the parenteral and/or pediatric administration of digoxin (e.g., independent double checks) to prevent administration of an incorrect dose. A review of reported incidents with oral digoxin has revealed that incorrect dosing may lead to death after only a few incorrect doses. It is hoped that sharing information about reported incidents will remind practitioners about the dangers of errors with digoxin, and lead to additional system enhancements to ensure its safe use.

Please refer to page 3 for references.

Muscle Relaxant Cyclobenzaprine Ordered as "Cycloprine" and Interpreted as Immunosuppressive Agent Cyclosporine

An order for "cycloprine 10 mg po qhs", which was intended to refer to the muscle relaxant cyclobenzaprine, was entered into a pharmacy system as "cyclosporine 10 mg po qhs". Fortunately, the error was caught, and cyclosporine was not dispensed.

Cycloprine is not a generic drug name. The name of the generic drug cyclobenzaprine has been truncated to "cycloprine" in certain brand names (e.g., Riva-Cycloprine).

This term "cycloprine" resembles the drug name cyclosporine. Furthermore, cyclobenzaprine and cyclosporine are both available in a 10 mg dose form.

As noted above, cyclobenzaprine is a muscle relaxant, whereas cyclosporine is an immunosuppressive agent. As such, a mix-up between these 2 drugs could lead to patient harm. Although the incorrect medication did not reach the patient in the case summarized here, the incident became an important impetus for change. ISMP Canada contacted the manufacturers of generic cyclobenzaprine to seek their commitment to change any drug names containing the word "cycloprine". One manufacturer, Laboratoire Riva Inc., was very receptive to the suggestion and is changing the name of its product. Teva Canada has changed the name of its product in the course of product rebranding (i.e., Novo-Cycloprine has been changed to Teva-Cyclobenzaprine). These newly renamed products will be available once existing stocks are depleted.

ISMP Canada reminds practitioners that removing the prefix (e.g., an abbreviated manufacturer's name) from a brand name to identify the official generic medication name may not always work. During the course of this review, other brand names with truncated versions of the generic drug name were noted. ISMP Canada encourages all manufacturers to avoid using truncated versions of generic drug names within product brand names. As the incident described above illustrates, this practice can lead to confusion and unanticipated look-alike, sound-alike drug names.

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Mix-ups Continue between Conventional Amphotericin B and Lipid-Based Amphotericin B

Amphotericin B, a systemic antifungal medication, is not commonly used, and health care practitioners may be unfamiliar with its various formulations and the potential consequences of mix-ups among them. The standard dosing for conventional amphotericin B (brand name Fungizone) is substantially lower than those for the lipid-based formulations (AmBisome, a liposomal formulation, and Abelcet, a lipid complex formulation). **The dosage of conventional amphotericin B** (Fungizone) **should never exceed 1.5 mg/kg daily.** Higher doses can result in potentially fatal cardiac or respiratory arrest.

An article recently published on this topic in *Dynamics*, the Journal of the Canadian Association of Critical Care Nurses (entitled "*ALERT: Mix-ups between conventional and lipid formulations of amphotericin B can be extremely dangerous*") provides an overview of incidents involving amphotericin B that have been reported to ISMP Canada. The article includes a description of a recently reported mix-up between the lipid complex formulation amphotericin B (Abelcet) and the conventional amphotericin B formulation (Fungizone), along with suggested strategies to prevent recurrence. This article is available from http://www.ismp-canada.org/publications.htm

ISMP Canada thanks the Canadian Association of Critical Care Nurses (www.caccn.ca) for granting permission to share this and other medication safety information with the healthcare community through its *Dynamics* journal.

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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

Photograph compliments of Harry Mullin.

RN Receives NB's Highest Honour

By JESSICA RYAN

EDITORS NOTE: The Order of New Brunswick, established in December 2000, is the highest honour in the province. Its objectives to recognize those individuals who have demonstrated excellence and who have made outstanding contributions to the social, cultural or economic well-being of New Brunswick and its residents. Proudly, we pay tribute to one of our members, Jessica Russell Ryan, 2011 Order of New Brunswick recipient.

RYAN'S REFLECTIONS: One afternoon, I received a phone call from a gentleman stating that I had been chosen to receive the award known as 'the Order of New Brunswick'. I was shocked and thrilled. He continued by saying this information was highly confidential until the Premier had the opportunity to make this announcement on New Brunswick Day. In the meantime, I was permitted to tell family. Further information to arrive in the mail.

Thinking about what this award meant and its objectives, I humbly reflect on my proudest achievement, a career which spans fifty-four years and sixteen non –practicing as a registered nurse.

Throughout the early years, I studied and travelled in Quebec City, Vancouver and California. I later returned home, to the Hôtel Dieu Hospital in Bathurst and was asked to join the teaching staff at the Hôtel-Dieu School of Nursing. I taught Nursing Arts and Surgical Nursing for ten years. When I returned to nursing, it was as Head Nurse of the Pediatric Department at the new Chaleur Regional Hospital. For a time, I was President of the Association for Care of Children in Hospital and was very involved with the IWK Children's Hospital. During this time, I also sat on the Bathurst City Council and became President of the Bathurst Heritage Trust Commission. I was elected President of the Bathurst Chapter of the NANB and consequently sat on the Board of Directors. I became a member of the Council of the Status of Women and had a lot to say about our children and those living in poor housing. The NANB created a Committee for the Social and Economic Welfare of our nurses and I became active on the committee which eventually led to the development of Unions for Nurses in New Brunswick. The election of a candidate for the Board of the Canadian Nurses Association became a relevant topic at chapter meetings and my peers decided I should seek the candidacy. My friends worked very hard and I was elected for two consecutive terms to the CNA Board.

I was also part of the committee to develop a Definition of Nursing Practice and Standards for Nursing Practice (July 1979 to June 1980) with many outstand-

ing women, especially Dr. Evelyn Adam, author of *To Be a Nurse*. The Standards were adopted and accepted throughout Canada and some of those amazing women have remained my dear friends.

I continued as Head Nurse in Pediatrics, always attempting to make the service to the children and their families the best it could possibly be. One of the most important changes was the creation of play rooms and the hiring of a permanent Child –Life worker. This made all the difference in the department and in the life of the children and the staff. I was also involved as a member of the New Brunswick Council on the Status of Women.

One morning, I received a call from the Department of Health to join the team who were creating an innovative program called 'The Extra-Mural Hospital'. They had already opened one office in Woodstock and were reaching out to the Miramichi and Bathurst, and would very much like to have me as the first Director/Manager in the Bathurst area. I accepted the challenge and resigned from the Chaleur Hospital, agreeing to open the EMH in January of 1985. This meant setting up a complete hospital outside the walls of a traditional hospital. We had patients instantly, as people were anxious to be cared for in their own homes. It was such an experience and required that as Manager, you trusted the nurses to do and say the right thing. One of the nurses was hired to be a liaison nurse with the ability to scan patients care and help the doctors decide if home care was the best option for the patient. Workshops and special courses about such things as home dialysis, as well as intense courses in management, were delivered and we earned our Health Service Certificate from the University of Ottawa. As the system grew, I was called on to set up similar hospitals in Dalhousie and Campbellton.

I retired from the EMH and from nursing about ten years later, while continuing to work on a Federal anti-smoking project for the next two years. Although I was no longer nursing, the people skills and the managerial courses and skills I had been taught came in very handy when we opened a large Community Museum, the first in the City of Bathurst.

Last year, the Museum was fortunate to tell the *History of 100 years of Nursing in New Brunswick* through the collections of the NANB and the New Brunswick Museum and the collections of the Sisters of the Nursing Schools and hospitals in the Chaleur Region and the Acadian Peninsula. Our display gave a full perspective about the Extra-Mural Hospital, the availability of palliative care in the home and the pastoral support which is being offered to the community.

Today, any spare time is spent with family. I also love knitting, playing cards, gardening and painting with water colors. I have published a few of my favorite articles and keep a close eye on my four nieces and great-grand-nephew. I currently sing in the senior's choir and am faithful to my church, my book club and many charitable organizations.

I also write a weekly article, 'Looking Back', for the local paper.

Bullied

continued from page 17

through these avenues because those resources are often poorly equipped or lack knowledge about intervening. Targets feel their complaints are ignored or that people have 'gone through the motions,' leaving targets feeling further abused.

- More public awareness about what workplace bullying is and that it is unacceptable.
- Workplace policies aimed at the kinds of behavior that occur within the workplace.
- Frequent staff education about policies and appropriate enforcement of these policies.
- People who bully to take responsibility for their actions by providing targets with effective and sincere apologies.
- Managers who act promptly and appropriately when they become aware of bullying by targets' co-workers. When targets are bullied by managers, it is unlikely that targets can report bullying to managers and we need alternate routes for stopping that bullying.

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NURSING KNOWS NO BOU

Liette Clément Reflects on a Career Opportunity of a Lifetime

The Strengthening Nurses, Nursing Networks and Associations Program (SNNNAP) exists to build the capacity of national nursing associations and regional nursing networks around the world while increasing the understanding of global health issues amongst Canadian nurses. SNNNAP is now in seven countries and one region, in order to: enhance the contribution of the nursing profession strengthening health systems and health policy, improve nursing practice and care through regulation of the profession and build the leadership capacity of nurses and deepen the public recognition of the important contribution the nursing profession has on the health system and health status of the population.

As part of the recent mission to Ouagadougou, Burkina Faso, a three-day workshop on *Influencing Public Policy & Leadership* was provided. It focused on providing the Association professionnelle des infirmières et infirmiers de Burkina (APIIB) with information and tools to assist in strengthening capacity to organize themselves and to become a strong voice for nurses in Burkina Faso. Participants were positive, engaged and focused, not to mention respectful of opinions and wonderfully humorous.

Representing NANB and the Canadian Nurses Association (CNA) on this mission was without a doubt the proudest moment of my nursing career—an opportunity I never thought would come my way. Not only did the delivery of the workshop content require me to draw from a lifetime of nursing knowledge and experience, it also caused me to reach deep into my soul and my humanity. One cannot remain untouched by the resiliency, adaptability and generosity of these nurses and colleagues. Even though an ocean and a world of resources separate us, we have developed a strong and hopefully long-lasting professional

N D A R I E S

bond which will forever impact the way I see my role and my world.

Thank you APPIB, CNA and NANB.

Mission Itinerary:

DAY 1—Upon arrival in Ouagadougou, there was very little time to unpack and get settled before we headed to the APPIB office. Not a moment was wasted, our group got right to work with APIIB's project coordinator and Board of Directors to finalize program details and to discuss future partnership funding.

DAY 2—The next morning, we visited an urban medical center in Pissy and a rural health clinic in Bazoulé, then met with the coordinator for Uniterra Burkina Faso.

DAY 3—By day three, we had a meeting with the Ordre des infirmiers et infirmières du Burkina Faso and APIIB to discuss joint interest and potential partnership in adopting a code of ethics and developing standards for nurses. The day ended with a meeting with the Canadian Embassy representative and APIIB.

DAY 4—Most of the day was spent organizing and setting up a mobile bibliothèque before travelling to Koudougou by bus.

DAY 5—Day 1 of the workshop: The group spent most of the day updating APIIB's 2009-2012 Strategic Plan, ensuring they were on track to achieve the goals and objectives of the overall plan.

DAY 6—Day 2 of the workshop: A guided workshop on Influencing Public Policy (What is Policy, the Policy Cycle & Being Strategic) was delivered to the group.

DAY 7—Day 3 of the workshop: The majority of the day was educating the group on ways to engage people, lead change and manage that change through participative role playing and group discussions.

DAY 8—On the last day, the group met at the APPIB office to debrief and say our goodbyes.

Ask a
PRACTICE ADVISOR

By VIRGIL GUITARD

YOU'VE ASKED

I read that RNs should obtain consent for the nursing care they provide. Am I to obtain consent for all nursing care provided?

THE SHORT ANSWER TO THIS question is YES. Obtaining consent for nursing care protects clients' rights to manage their own health care through a process of meaningful decision-making. Furthermore, clients have a legal right to information about their care and treatment, and a right to consent to, or refuse nursing care.

If the client's consent is to be obtained for nursing care, should a consent form be signed?

Not necessarily. The consent form is merely a tool sometimes used to obtain consent, such as for nursing research and in situations normally determined by employer policy. A written consent is not required for "repetitive and routine aspects of nursing care". To obtain consent for repetitive and routine aspects of nursing care, the client should be given the opportunity to participate in the development of the nursing plan of care and consent to it. RNs must, however, remember that even if consent was obtained, they are still responsible to provide information to the client when providing care.

If a consent form is not required, how will the nursing team know that consent has been obtained for the overall plan of care?

By documenting. Documentation is an important step of the consent process. Documentation does not mean having the client sign a consent form (which is a tool), but means having the RN make and keep records of her practice, thus meeting professional standards. Documenting the participation of the client in the development of the plan of care will demonstrate that the patient was informed regarding the plan and has consented to it.

What about obtaining consent for care or treatment provided by other health care providers?

When involved in care or treatment that is provided by another health care provider (e.g., surgeon, anaesthetist), RNs must ensure the client has given consent, has sufficient information and understands the proposed care or treatment. If necessary, she must advocate for and support the client in getting more information.

Registered nurses, however, may have to witness the signing of a consent form. According to the Canadian Nurses Protective Society, a nurse or other designated person may witness the signing of the consent form even when the physician has explained the procedure elsewhere. Witnessing a signature is not a declaration that the RN provided information about risks and alternatives (CNPS, 1994). Institutional policies should be followed regarding witnessing consent and the duration of a previously signed consent form.

For more information:

- Practice Guideline: Consent (2011)
- Or contact NANB's Practice Department at 1-800-442-4417 or by e-mail at www.nanb.nb.ca. ■

STAFF PROFILE

Take a walk in her shoes...

Meet Shelly Rickard, Manager of Corporate Services

Describe for members the role of the Manager of Corporate Services at NANB.

Primarily, this position is responsible for day to day accounting, annual budgeting and forecasting, as well as supporting long-range fiscal planning. I also manage the NANB premises and tenant relationships, information technology requirements, affinity relationships and capital improvement projects. Last but not least, I am responsible for managing human resource functions including personnel policies, health benefits and payroll. All things considered, this job keeps me on my toes!

The Association's fiscal planning requires accountability, transparency and responsibility to members. How do you plan financial stability in uncertain economic times?

Regular long-range fiscal planning is carried out with an ad hoc committee appointed from the NANB Board of Directors, including the Executive Director and Manager of Corporate Services. Using historical data, current financial trends, current NANB members and operating projections, we forecast for over a four-year period to ensure that we are able to meet our mandate, the Board's goals and member requirements and provide financial stability to the NANB.

How has your position evolved since you joined NANB over six years ago?

Since I joined the NANB, the role of Corporate Services has evolved to encompass both Human Resource and IT Management, functions that were previously managed in other departments. My previous position provided me with the experience that allowed these other responsibilities to easily transition into the Corporate Services Department.

What are the most challenging and rewarding aspects of your current position?

I would have to say human resource management is both challenging and rewarding. Hiring someone new into a mix of senior staff that brings fresh ideas and enthusiasm adds an element of creativity to day-to-day processes and can sometimes change the way we do things for the benefit of the public and members. On the other hand, recruitment and determining those specific skills in individuals is always a challenge!

What significant projects or innovative ideas would you like to implement in the near future?

The NANB would like to become a fully and easily accessible building for our members and stakeholders. As a result, we have started to build a fund for Capital Improvements that would include the installation of an elevator.

Being part of a small team of employees, what traits/skills do you look for when recruiting for the Association?

We look for professional individuals who are interested in being part of a busy organization, who work well in teams, and who are passionate about the profession itself and its reputation in the public.

What influential mentors and life lessons best prepared you for this position?

My previous career was in the e-learning industry in a very similar role. In my first "career" position, the President of our organization and later the Chief Financial Officer was extremely influential in guiding and mentoring me into a management role that

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JAN. 13, 19 & 23, 2012

NANB Student Forums: *Professionalism in Nursing*

- Edmundston, Fredericton & Bathurst, NB
- » www.nanb.nb.ca/index.php/news/post/nanb_student_forums

JAN. 18–19, 2012

Atlantic Ballet Theatre of Canada: *Ghosts of Violence*

- Fredericton, NB
- » http://atlanticballet.ca/en/repertoire/ghosts-of-violence

JAN. 25–28, 2012

2012 National Conference of the Canadian Nursing Students' Association: *"Overcoming Challenges, Harmonizing Our Voices"*

- Saskatoon, Sask.
- » www.cnsa.ca/english/conferences/national

FEB. 2–4, 2012

The Early Years Conference 2012: *The Development of Children's Mental Health: How Do We Become Who We Are?*

- Vancouver, BC
- » www.interprofessional.ubc.ca/EarlyYears

FEB. 12–14, 2012

4th National CANN Conference: *Neonatal Nursing: Today, Tomorrow, Together*

- Toronto, ON
- » www.neonatalcann.ca/SitePages/EventDetails.aspx?itmID=6

FEB. 15 & 16, 2012

NANB Board of Directors Meeting

- Fredericton, NB
- » www.nanb.nb.ca/index.php/about/board

MAR. 14 & 15, 2012

Atlantic Ballet Theatre of Canada: *Ghosts of Violence*

- Saint John, NB
- » http://atlanticballet.ca/en/repertoire/ghosts-of-violence

APR. 26–28, 2012

Canadian Respiratory Conference: *A Breath of Fresh Air*

- Vancouver, BC
- » http://lung.ca/crc/_pdf/CRC2012Announce_ENG.pdf

JUN. 18–20, 2012

CNA Annual Meeting and Biennial Convention: *Nurses: Movers and Shapers*

- Vancouver, BC
- » www.cna-aiic.ca/CNA/news/events/convention/default_e.aspx

Hours & Dates

NANB Office Hours:

Monday to Friday 08:30 to 16:30

We Will be Closed:

- December 23, 26, 27, 31
  Christmas Holidays
- January 2
  New Year's Day

Dates to Remember:

- December 30
  Registration Renewal Deadline
- January 30
  Deadline for NANB Election Nominations
- February 15, 16
  NANB Board of Director's Meeting

NANB on the Move

Continued from page 5

education for over a decade. Meloche Monnex provides two scholarships for RNs studying in the Nurse Practitioner programs at UNB and UdeM and Investors Group provides an award to a student every two years, alternating between the two universities. In total, this represents an investment of $36,750 and $19,650 value to students and NANB members this year. Now that's something to celebrate!

In closing, on behalf of the Board of Directors, I would like to extend Season's Greeting and best wishes to you and your families for a healthy 2012!

—FRANCE MARQUIS, *President*

Meet ShellyRickard...

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eventually became an executive position. I believe that this, combined with my life experiences, has enabled me to take on this role and offer my experience and expertise back to the staff and members of the NANB.

In addition to managing the finances, human resources and building maintenance of the Association, you are a wife, mother of two and lifelong tap-dancer. How do you balance both worlds?

I would have to say the dance class is what helps balance it for me. It's the time of the week that is exclusively for me, away from my family/work/volunteer commitments, a time to re-energize with great friends and have some fun and then tackle another week!

Nomination Form

ELECTIONS 2012

(To be returned by chapter member)

The following nomination is hereby submitted for the 2012 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, 2012**. Return to:

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

Acceptance of Nomination

ELECTIONS 2012

(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, 2012**, to:

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

REGISTRATION SUSPENDED

On July 14, 2011, the NANB Complaints Committee suspended the registration of registrant number 026118 pending the outcome of a hearing before the Discipline Committee.

REGISTRATION SUSPENDED

On August 9, 2011, the NANB Complaints Committee suspended the registration of registrant number 017955 pending the outcome of a hearing before the Discipline Committee.

REGISTRATION SUSPENDED

On September 6, 2011, the NANB Complaints Committee suspended the registration of registrant number 027306 pending the outcome of a hearing before the Review Committee.

CONDITIONS IMPOSED

On September 21, 2011, the Discipline Committee ordered a conditional registration be imposed on registrant number 019895.

SUSPENSION CONTINUED

On September 28, 2011, the Review Committee found that Joseph André Beaudet, registration number 019799, demonstrated incompetence and professional misconduct. The member's acts and omissions demonstrated shortcomings with respect to his nursing practice such as medication errors, documentation, communication, a lack of judgement and a disregard for the welfare and safety of patients. The Review committee ordered that the suspension imposed on the member's registration by the Complaints Committee be continued for a minimum of one year and until conditions are met. At that time, the member will be eligible to apply for a conditional registration. The Committee also ordered that he pay costs to NANB in the amount of $5000 within 12 months of returning to the active practice of nursing. ■

Photographs compliments of Harry Mullin.

NANB Receives **Lieutenant-Governor's Dialogue Award**

ESTABLISHED IN 2003, THE LIEUTENANT-Governor's Dialogue Award is awarded to those role models who champion the principles of harmony and respect between the province's Anglophone and Francophone communities.

The only honour of its kind in Canada, the Lieutenant-Governor's Dialogue Award is sponsored by Dialogue New Brunswick, an organization whose mission is to foster mutual understanding and respect between English-speaking and French-speaking New Brunswickers.

Insurance program recommended by

Nurses Association of New Brunswick

See how good your quote can be.

At TD Insurance Meloche Monnex, we know how important it is to save wherever you can. As a member of the **Nurses Association of New Brunswick**, you can enjoy preferred group rates and other exclusive privileges, thanks to our partnership with your association. You'll also benefit from great coverage and outstanding service. At TD Insurance, we believe in making insurance easy to understand so you can choose your coverage with confidence.

Get an online quote at

www.melochemonnex.com/nanb
or call 1-866-269-1371

Monday to Friday, 8 a.m. to 8 p.m.
Saturday, 9 a.m. to 4 p.m.

TD Insurance Meloche Monnex is the trade name of SECURITY NATIONAL INSURANCE COMPANY which underwrites the home and auto insurance program. The program is distributed by Meloche Monnex Insurance and Financial Services Inc. in Quebec and by Meloche Monnex Financial Services Inc. in the rest of Canada.

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

*No purchase required. Contest ends on January 13, 2012. Each winner may choose the prize, a 2011 MINI Cooper Classic (including applicable taxes, preparation and transportation fees) for a total value of $28,500, or a cash amount of $30,000 Canadian. Odds of winning depend on the number of eligible entries received. Skill-testing question required. Contest organized jointly with Primmum Insurance Company and open to members, employees and other eligible persons belonging to all employer and professional and alumni groups who have an agreement with and are entitled to group rates from the organizers. Complete contest rules and eligibility criteria available at www.melochemonnex.com. Actual prize may differ from picture shown. MINI Cooper is a trade-mark, used under license, of BMW AG, which is not a participant in or a sponsor of this promotion.

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