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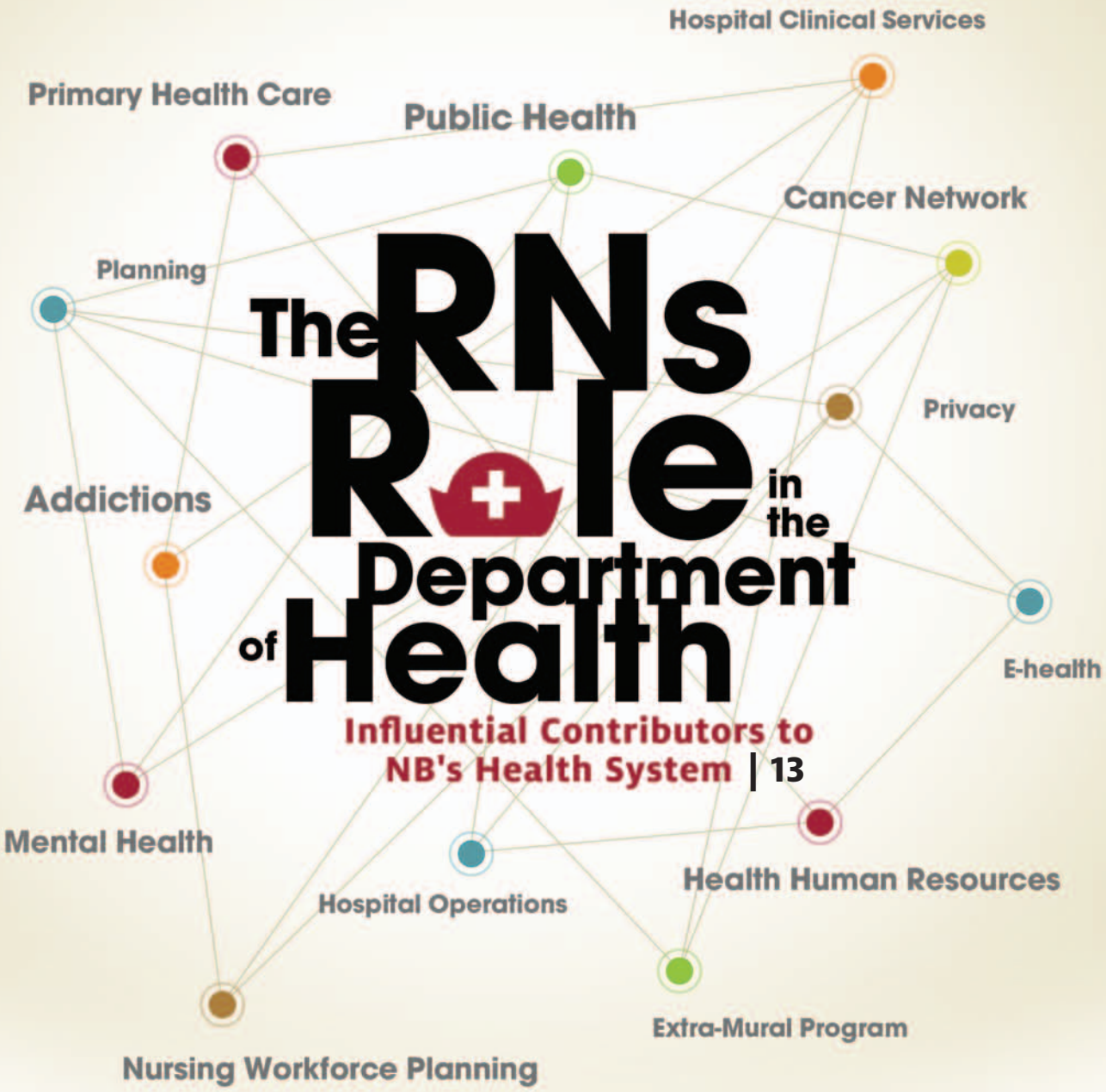


The RNs Role in the Department of Health

Influential Contributors to NB's Health System

| 13

Nurses Association OF NEW BRUNSWICK

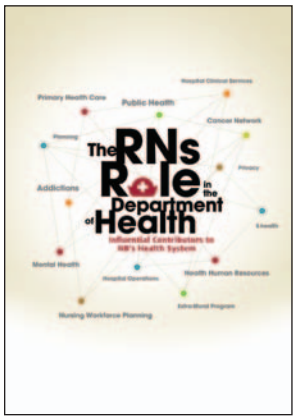
winter 2012

INSIDE

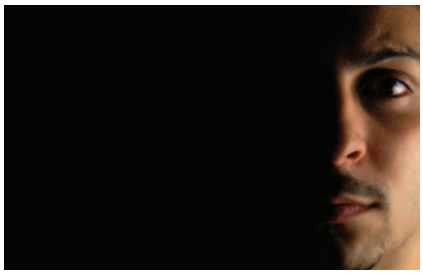
Celebrate Excellence: NANB Awards 2013

Nominate a colleague, friend or health care advocate who strives to improve health care delivery and promote health public awareness every day. See page 47 for details.

47



Cover
Nursing professionals are contributing to the policy deliberations in our province on a daily basis, providing research and support as public policy is developed and reviewed. See page 13 for the series introduction.



the pulse

Nurses Association *of* New Brunswick

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

The NANB Board of Directors

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Director, Region 6

Rhonda Shaddick
Director, Region 7

Aline Saintonge
*Public Director **

Roland Losier
Public Director

Robert Thériault
*Public Director **

* Awaiting replacement appointment by the Lieutenant-Governor in Council.

Info Nursing is published three times a year by the Nurses Association of New Brunswick, 165 Regent St., Fredericton, NB, E3B 7B4. Views expressed in articles are those of the authors and do not necessarily reflect policies and opinions held by the Association.

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

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

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Reflecting on a Year Full of Accomplishments

The past twelve months have been very productive for your Association. While 2012 has not been without its challenges, supporting quality nursing practice in the public interest is readily evident in all aspects of our work.

To start, 2012 represents the first year of NANB's current Long-Range Fiscal Plan (2012–2015). The increased revenues have supported the development of a variety of new tools to support and enhance nursing practice in New Brunswick. The current Fiscal Plan focused on the Board's strategic objectives and goals to enhance the resources available to support nursing practice and public safety. NANB's virtual presence has grown significantly over the past 12 months. Thus, making information and materials to support practice available virtually allows you, the NANB member, to access these tools at your convenience and adds to the efficiency and effectiveness of NANB investments. The Virtual Forums and E-learning Modules, available through NANB's website www.nanb.nb.ca, can be used individually, in groups or by nurse managers and administrators to support professional development. Our provincial nursing education programs are also able to access these materials to support and enhance curricula delivery, providing NANB with a unique opportunity to support student acquisition of essential nursing competencies and standards as expected by our nursing legislation and professional standards. These tools also support members in their continuing competence requirements. The NANB also recently launched webinars, an additional resource delivered through a series of live presentations and archived for future reference on NANB's website www.nanb.nb.ca. Members were invited through November's e-bulletin, the *Virtual Flame*, as well as a notice posted on the website. This new communications initiative will offer information to support practice in an interactive format as well as by means of recordings for static posting. Sessions will be in a shorter format to meet the demand for condensed materials and "just-in-time" delivery. We hope you make full use of these resources. We also welcome your suggestions for the development of future materials. Together, we will ensure the effectiveness of resources and optimize our capacity to support and advance nursing practice for all.

The year 2012 also included the NANB Board of Directors' decision to transition to a computer adaptive (CAT) entry-to-practice exam, effective January 2015. This new exam format and delivery have been adopted by all Canadian registered nurse regulators, with the exception of the Ordre des infirmières et infirmiers du Québec. The NANB will continue to utilize the current Canadian Registered Nurse Exam (CRNE) purchased from the Canadian Nurses Association (CNA) through to the 2015 transition. We thank the CNA for this partnership over a significant number of years. We also thank their staff at Assessment Strategies Inc., the CNA company that developed and maintained the CRNE. Finally, and most importantly, we thank all those New Brunswick nurses who have brought their content and practice expertise to the same task. Without you, there would have been no CRNE. As we transition to the new CAT exam we will be counting on your continued engagement with the new exam provider, the National Council of State Boards of Nursing. Opportunities for volunteering for item development, item review and test pool review are now open. Visit NANB's website www.nanb.nb.ca for further information. The NANB Board of Directors is confident in this decision and the advantages it will provide in meeting our regulatory mandate and enhancing access, flexibility and security in exam delivery. A comprehensive transition and change management plan is being implemented to ensure all involved nurses, stakeholders and students are informed and supported as required for a successful transition. Work will be ongoing in this effort over the next two years and beyond.

Before closing, I would like to take this opportunity to encourage all members interested in a leadership role or those of you who may know of a colleague that exemplifies leadership skills to submit their nomination for the position of President-elect and or Director for Regions 2 (Saint John), 4 (Edmundston), and 6 (Bathurst and the Acadian Peninsula) with the Association. This experience of becoming part of the most progressive Association of health professionals in New Brunswick will also present the opportunity to influence health care policies; network with leaders; and make things happen in the nursing profession. The Call for Nominations closes January 23, 2013. Please visit NANB's website www.nanb.nb.ca for details.

Finally, as President and on behalf of the NANB Board of Directors, I want to extend our sincere thank you for your continued commitment over the past year to quality nursing care in New Brunswick and wish each of you, and your families, a healthy and happy holiday season. ■

France L. Marquis

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RN's Contributing to Safe, Quality Nursing Care in Our Province

You may recall that volume 40, issue 3, winter 2009 edition of *Info Nursing* included a theme focusing on our provincial nursing education programs that provided a unique opportunity to highlight the contribution of the education sector to the quality and safety of nursing care in our province. Educators responded beyond our expectations. The sharing of advancements, innovation and challenges in nursing education was of benefit to all.

Following in that tradition, we approached our Chief Nursing Officer, Mary O'Keefe-Robak, and the team of registered nurses working within the Department of Health to highlight the experience and contribution of registered nurses in the policy arena. Without hesitation and surpassing our expectations, they too jumped at the opportunity. Given space limitations, we will be carrying some articles over to the spring edition of *Info Nursing*.

Nursing professionals are contributing to the policy deliberations in our province on a daily basis, providing research and support as public policy is developed and reviewed. Their contributions are developed through their nursing lens. Nursing has consistently noted four domains of practice; direct care, administration, education and research. Policy is increasingly recognized as a fifth domain of nursing practice. As registered nurses, I believe we bring valuable experience and expertise with a specific lens to these deliberations. Our understanding must be part of health policy development. Additionally, our knowledge is essential to sound public policy that considers and supports the determinants of health and well-being.

On behalf of our Board of Directors and members, I want to sincerely thank each of our contributors and the teams of unnamed individuals that supported this work as well. Thank you for this effort. In our already full days, taking on a challenge like this reflects your professionalism and pride in the work you do. Thank you for sharing. Providing this insight will inform and enlighten and may well move others to consider this career path. Congratulations!

In that light, I want to challenge and encourage you, the nursing community, to consider proposing a focus and your contribution to upcoming editions of our journal. This is a wonderful opportunity to inform your peers and stakeholders who receive and read our journal of the good work you are doing and the contribution you are making to quality nursing care and patient safety in our province. If you are interested or have more questions, please contact our editor, Jennifer Whitehead at jwhitehead@nanb.nb.ca or 506-459-2852.

Finally, I wish to extend best wishes for the coming holiday season to all NANB members and your families. I wish you peace, joy and good health in the coming year. Thank you for your contribution to our Association over the past year and your commitment to safe, quality nursing care in our province. ■

ROXANNE TARJAN
Executive Director

PRIOR TO THE MEETING, an orientation session was held welcoming two new regional directors effective September 1, 2012, through to August 31, 2014. The following are newly appointed and re-appointed directors:

- Chantal Saumure, RN, *Director, Region 1*
- Dawn Torpe, RN, *Director, Region 3**
- Linda LePage-LeClair, RN, *Director, Region 5**
- Rhonda Shaddick, RN, *Director, Region 7*

**re-appointed directors*

Policy Review

The Board reviewed policies related to:

- *Ends*
- *Governance Process*
- *Executive Limitations*

New and Amended Policies

The Board of Directors approved amendments relating to: E-4, Healthy Public Policy; GP-12, Board Linkage with Other Organizations; GP-7, Board and Committee Expenses; EL-3, Financial Planning; and EL-13, Information Management; as well as a new policy EL-17, Entry to Practice Examinations.

Organization Performance: Monitoring

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

Board of Director's & Committee Appointments

The Board approved the appointment of the Nominating Committee for the NANB 2013 election consisting of NANB's immediate past-president and two registered nurse directors. The members are:

- Martha Vickers, RN, *Past-president*
- Chantal Saumure, RN, *Director, Region 1*
- Dawn Torpe, RN, *Director, Region 3*

The Board approved an ad hoc Queen Elizabeth II Diamond Jubilee Medals Committee to review nominees and select two for submission to CNA. The Committee consists of:

- Terry-Lynne King, RN, *Director, Region 2*
- Marius Chiasson, RN, *Director, Region 6*
- Roland Losier, *Public Director*

Sharon Hall-Kay, RN, York-Sunbury Chapter, was appointed Chief Scrutineer for the NANB 2013 Election and Annual Meeting by the Board.

Dr. Kathy Woods' appointment to the Nurse Practitioner Therapeutics Committee was approved by the Board.

NANB Documents

The Board approved the following documents:

- *Ethical & Responsible use of Social Media Technologies—Guideline* (new)
- *Standards of Practice for Registered Nurses* (revised)

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

Presentation(s)

Bronwyn Davies, Director of the Primary Health Care Unit, and Jean Bustard, Director of the Extra Mural Program, from the Department of Health gave a presentation on the Primary Health Care Framework which was released in August and which will serve as a long-term strategic plan for improving primary health care in New Brunswick.

NANB staff provided an orientation session to the Board as they transition to paperless meetings. This change supports NANB's objective of being an environmentally responsible organization while also being a more economical means of preparing and distributing materials. This method provides Directors with the required documentation securely wherever Internet access is available.

Next Board

The next Board of Directors meeting will be held at the NANB Headquarters on February 20-21, 2013.

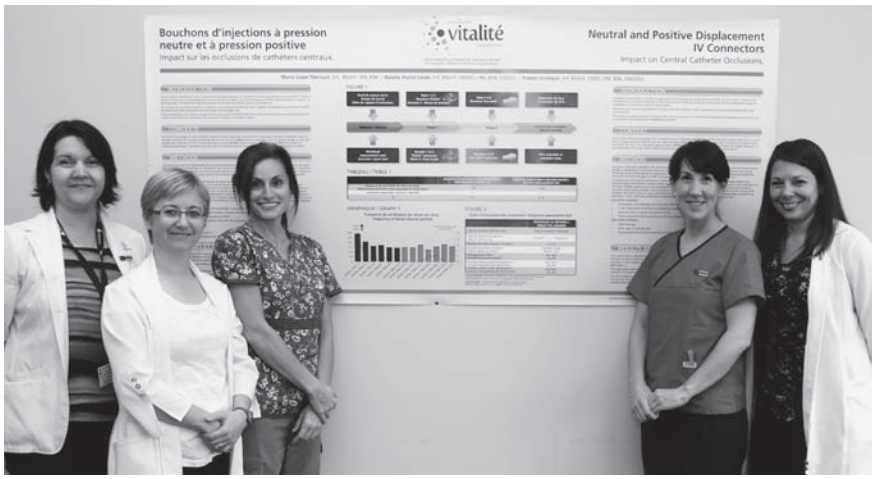
Observers are welcome at all Board of Directors meetings. Please contact Paulette Poirier, Executive Assistant/Corporate Secretary, at ppoirier@nanb.nb.ca or call 506-459-2858 / 1-800-442-4417.

2012–2013 NANB Board of Directors

- President, *France Marquis*
- President-Elect, *Darline Cogswell*
- Director, Region 1, *Chantal Saumure*
- Director, Region 2, *Terry-Lynne King*
- Director, Region 3, *Dawn Torpe*
- Director, Region 4, *Noëlline LeBel*
- Director, Region 5, *Linda LePage-LeClair*
- Director, Region 6, *Marius Chiasson*
- Director, Region 7, *Rhonda Shaddick*
- *Public Director, *Aline Saintonge*
- *Public Director, *Robert Thériault*
- Public Director, *Roland Losier*

**Awaiting replacement appointment by the Lieutenant-Governor in Council.*

THE BOARD OF DIRECTORS MET ON OCTOBER 10 AND 11, 2012 AT NANB HEADQUARTERS IN FREDERICTON.



Three NB RNs Win National Recognition

By CHANTAL SAUMURE

Congratulations to Marie-Josée Thériault (Nursing Consultant,IV therapy), France Levesque (Nursing Consultant, Surgical Intensive Care) and Nathalie Haché-Losier (Nursing Consultant, Dr-Léon-Richard Oncology Centre) for the poster they presented at the CVAA (Canadian Vascular Access Association) National Conference. The poster, Neutral and Positive I.V. Connectors Impact on Central Catheter Occlusion, was awarded first prize at the conference, which took place in Montreal from May 9 to 11, 2012.

I also want to thank the nurses of the Dr-Léon-Richard Oncology Centre who were closely involved in carrying out this clinical nursing project, aimed at improving patient care. Ultimately, it's the patients who will benefit the most from these efforts!

It was a concerted team effort that showed very clearly how engaged and rigorous the nursing profession is towards the continous improvement of processes. Furthermore, it fits directly with the theme of National Nursing Week *Nursing: the health of our nation*. Once again, congratulations to the whole team. ■

Medication Administration: The 30-Minute Rule

After conducting an extensive survey of approximately 18,000 nurses in 2010, the United States (US) branch of the Institute for Safe Medication Practices (ISMP) developed *Acute Care Guidelines for the Timely Administration of Scheduled Medications*. Though the *Guidelines* were developed in the US, they are applicable to Canadian health care settings. The *Guidelines* highlight that delays in administrating certain time-sensitive medications can result in harm **BUT** a one-size-fits-all, inflexible requirement to administer **ALL** scheduled medications within 30 minutes is an unwarranted mandate, given that relatively few medications truly require exact timing of doses. To review the full article, please visit www.ismp.org/tools/guidelines/acutecare/tasm.pdf. ■

NANB Documents: Supporting Safe Practice

The staff at NANB have documents to inform you on many topics. These documents may be accessed at www.nanb.nb.ca.

- *Advanced Nursing Practice: A National Framework*
- *Assigning, Delegating and Teaching Nursing Activities to Unregulated Care Providers*
- *Code of Ethics for Registered Nurses*
- *Conflict of Interest*
- *Consent*
- *Continuing Competence Program*
- *Decision-Making: Examining Requests for New Nursing Procedures*
- *Documentation: Practice Standard*
- *Ethical and Responsible Use of Social Media Technologies: Practice Guideline*
- *Framework for Managing Professional Practice Problems*
- *Graduate Nurse Scope of Practice*
- *Infection Prevention and Control*
- *Managing Registered Nurses with Significant Practice Problems*
- *Medication: Practice Standard*
- *Minding Your Business: A Guide for Establishing an Independent Nursing Practice*
- *NANB Complaints and Discipline Process*
- *NANB Supports Practice: Education Series*
- *Nurse Practitioner Core Competencies*
- *Nurse Practitioner Schedules for Ordering*
- *Principles to Guide Health Care Transformation in Canada*
- *Professional Accountability During a Job Action*
- *Professional Boundaries and the Nurse-Client Relationship*
- *Recognition and Management of Problematic Substance Use in the Nursing Profession*
- *Staff Mix Decision-Making Framework for Quality Nursing Care*
- *Standards of Practice for Primary Health Care Nurse Practitioners*
- *Standards of Practice for Registered Nurses*
- *Supporting Learners in the Workplace*
- *The Therapeutic Nurse-Client Relationship: Practice Standard*
- *Working Together: A Framework for the Registered Nurse and the Licensed Practical Nurse*
- *Working Understaffed: Professional and Legal Considerations (NANB & NBNU)*
- *FAQs for RNs and NPs*

■

NANB LAUNCHES WEBINARS FOR MEMBERS

The Nurses Association of New Brunswick proudly enters the world of webinars in an effort to provide members another opportunity to inform, educate and exchange virtually with minimal disruption to your busy schedules. LIVE presentations will be presented by a CONTENT EXPERT and last approximately 45 minutes, offering members a question and answer period at the end of the session.

ONLINE NOW!

Leadership: Every Nurse's Responsibility

French Presentation:
December 4, 2012

English Presentation:
December 5, 2012

This webinar explored the concept of leadership in nursing incorporating NB RNs' opinions of this topic as it applies to their practice.

Visit our website (www.nanb.nb.ca) to view the recorded session. Stay tuned for future presentations.

NANB Welcomes Mali Delegation

On November 5, 2012, NANB received the visit of a three-person delegation from Mali. Mali is working towards legislated regulation for nursing in their country. This was Mali's fourth visit to New Brunswick as part of a partnership developed with the *Dr. Georges-L.-Dumont University Hospital Centre* and IPAC with funding from the Government of Canada. NANB was invited to support this project by sharing information around registration requirements and NANB's database, professional conduct review, Standards of Education and review/approval of education programs and Standards for Nursing Practice.

Pictured, left to right—first row: Liette Clément; Roxanne Tarjan; Odette Comeau Lavoie; Monique Cormier-Daigle; Lise Guerrette-Daigle. Second row (Mali Delegation): Lanseni Gagyogo; Ousmane Sadou Maiga; Boukarra Diabaté and Laurent Tyers, from the Institut d'administration publique du Canada (IAPC).

New NANB Staff: Louise Smith

Louise Smith, RN, Oromocto, NB, accepted a one-year term appointment as Regulatory Consultant effective September 4, 2012. Ms. Smith brings over 37 years of nursing experience in a variety of roles and settings, including Extra-Mural, Public Health, VON, and hospital practice (ICU, Med-Surg, CNC and ER) as a staff nurse and manager. She has practised in New Brunswick, Nova Scotia, Ontario, Quebec and Nunavut. In this position, her primary responsibilities will be with registration and other related regulatory duties.

Notice of Annual Meeting

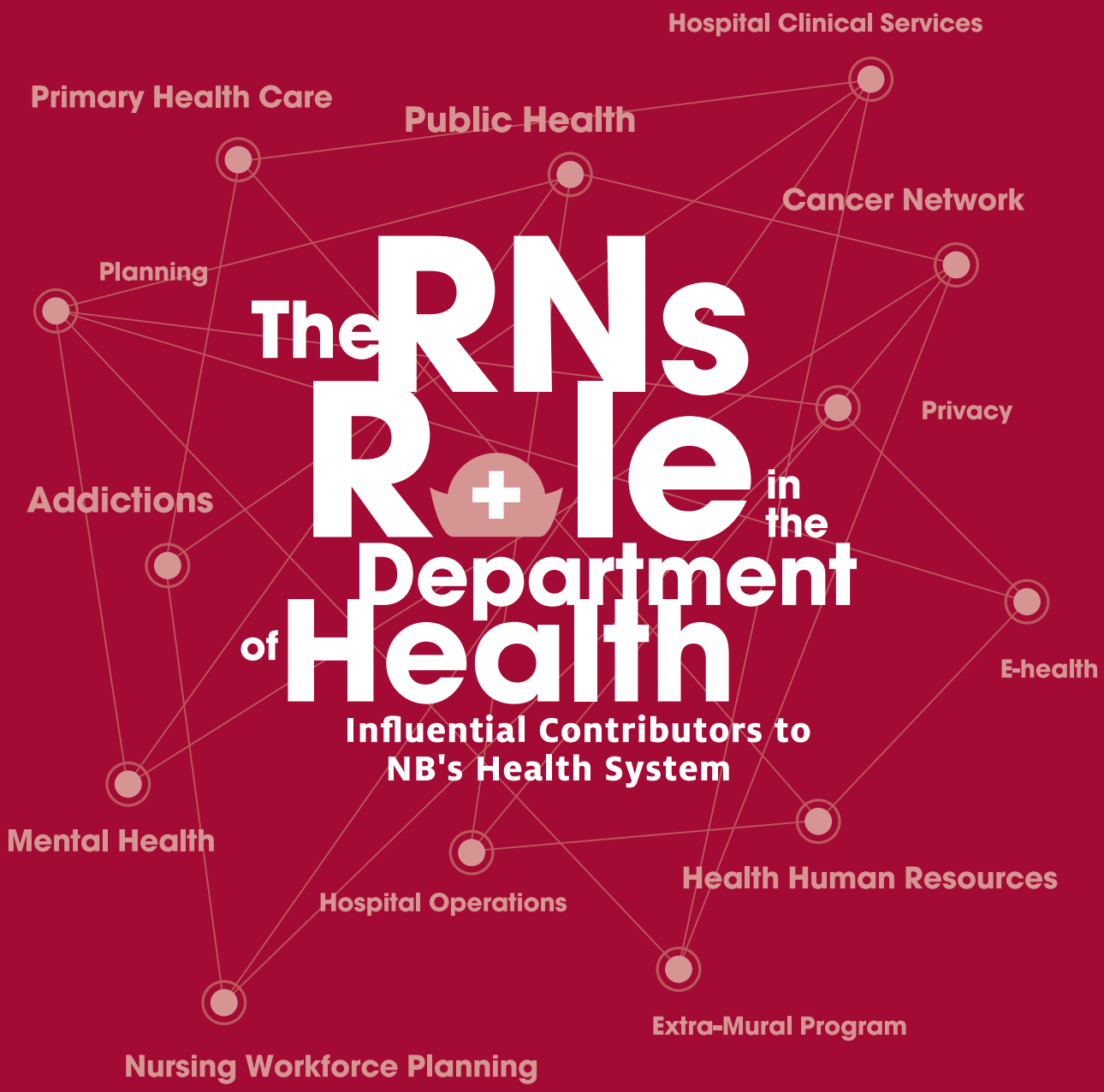
In accordance with Article XIII of the bylaws, notice is given of an annual meeting to be held May 29, 2013, at the Delta Fredericton, Fredericton, NB. The purpose of the meeting is to conduct the affairs of the Nurses Association of New Brunswick (NANB).

Practising and non-practising members of NANB are eligible to attend the annual meeting. Only practising members may vote. Students of nursing are welcome as observers.

Resolutions for annual meeting
Resolutions presented by practising members according to the prescribed deadline, March 4, 2013, will be voted on by the voting members. During the business session, however, members may submit resolutions pertaining only to annual meeting business.

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

Roxanne Tarjan,
Executive Director, NANB



The RNs Role in the Department of Health

Influential Contributors to NB's Health System

By MARY O'KEEFE-ROBAK

Registered Nurses who work as public servants in central government in New Brunswick have a unique opportunity to contribute to the development of public policy, programs and services in the field of health.

I am a registered nurse working at the Department of Health. As Chief Nursing Officer and Nursing Resources Advisor, I advise senior management and the Minister of Health on a variety of nursing related issues, such as planning for future nursing resource needs and better integration of nurse practitioners into our healthcare system.

One of my friends recently asked me if I ever miss being a nurse. Although I was surprised by her question, I expect she is not alone in her view that nurses work only in hospitals, community health centres, clinics and nursing homes.

Some of us have followed less traditional paths and work in areas where the need for nursing skills and knowledge may not be as evident to the general public. I began my nursing career in a hospital setting where I worked for several years before joining the Canadian National Institute for the Blind, a national not-for-profit agency for blind and visually impaired people. It was there that I became more attuned to the importance of advocacy in helping improve the lives of those that such an organization serves. The experience and knowledge I gained eventually led me to a position as a consultant for seniors programs with the former Department of Health and Community Services. Over time, I have taken on a variety of roles and increasing responsibilities with the Department of Health related to nursing and health policy.

When I joined the public service, I quickly realized that government decisions with respect to the development of policy, programs and services require careful consideration of many factors and the points of view of many stakeholders. I had to learn that governments strive to balance all the requests, expectations and needs of the community and develop policies that are reasonable, evidence-based and sustainable. This is a complex and daunting challenge.

In New Brunswick, about thirty nurses are currently employed in the Central Office of the Department of Health. Registered nurses who work as public servants in central government in New Brunswick have a unique opportunity to contribute to the development of public policy, programs and services in the field of health. We provide support and expert nursing advice to government in general, and to the Department of Health in particular, in carrying out its functions of planning for the future of health care, and funding and monitoring specific programs or services.

Registered nurses in Central Office work in a variety of areas including: primary health care; public health; mental health and addiction services; institutional services; cancer network; eHealth; accountability and health information management and health human resources. In our respective jobs, we use our nursing knowledge and expertise every day to make sound recommendations on health policy and programs to benefit all New Brunswickers. In turn, we are part of a larger team that includes other professionals whose backgrounds in health, finance, business, law, project management and informatics help run the machinery of government.

Approximately thirty statutes fall under the jurisdiction of the Minister of Health and are administered by the Department of Health (http://laws.gnb.ca/en/deplinks?subjectnumber=28). Within this framework, strategies and initiatives such as the Provincial Health Plan, the Primary Health Care Framework and the Mental Health Action Plan are developed to provide direction and structure to our health care system. Depending on their nature, the lead up to the release of government strategies and initiatives can involve weeks, months and sometimes years of background work.

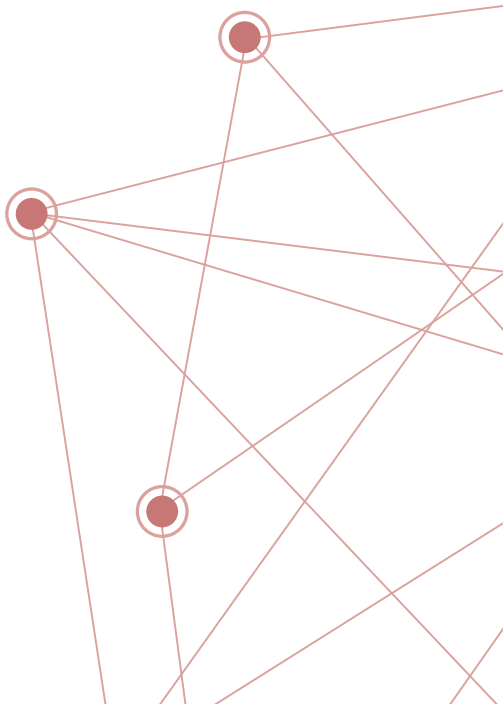
Department of Health RNs investigate and research trends, analyze relevant issues and present options for senior management to consider. This is done through a variety of approaches that includes committee work with stakeholders, such as Regional Health Authorities, professional organizations, interest groups, not-for-profit organizations, community groups, and members of the general public. We collaborate with partners from other provincial government departments such as Social Development, Post Secondary Education, Training and Labour, Public Safety and Healthy and Inclusive Communities.

At the national level, we have the opportunity to work together with colleagues from ministries of other provinces, as well as from Health Canada and other federal agencies. We provide briefings and make recommendations to senior management and the Minister of Health and other officials based on results of research, analysis, expert advice and recommendations of stakeholders in the development of legislation, policy, programs and services.

In order to carry out our roles, we require a broad understanding of both government structure and processes and the intricacies of our health care system. We are involved with diverse issues across the health spectrum from population health and prevention of illness, development of program policies for home care, safety in hospitals, review of requests for new programs, to predicting health human resource requirements.

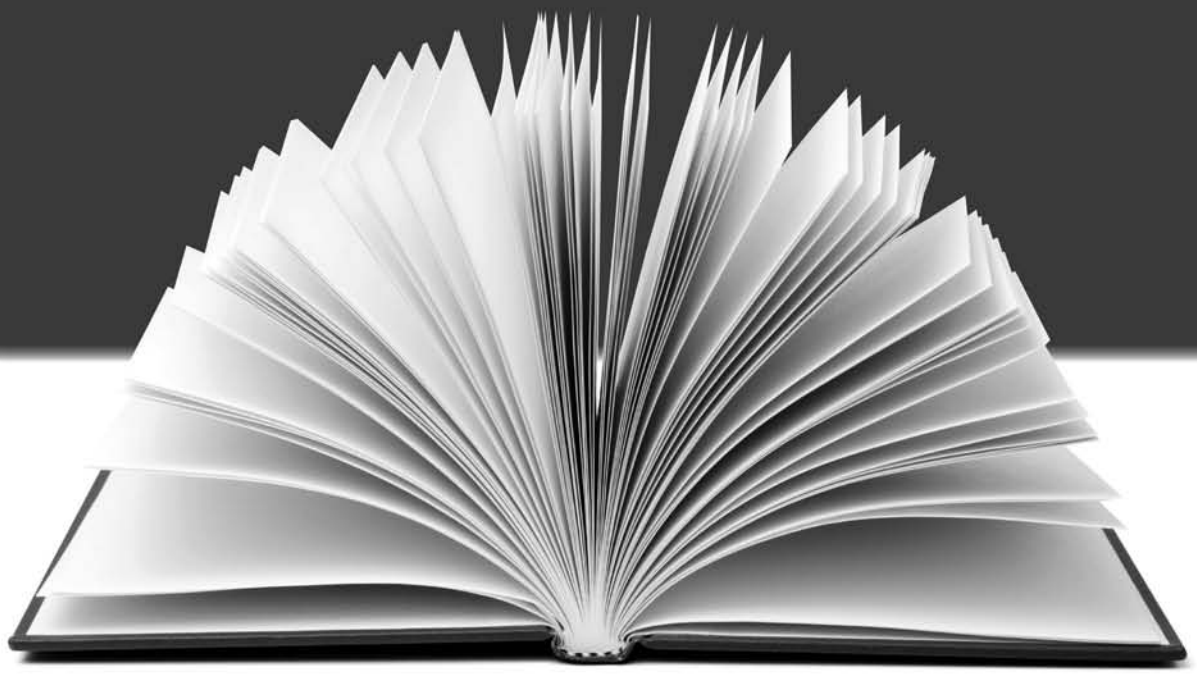
In the pages that follow, nurses at the Department of Health describe in greater detail the roles they play in helping to improve the lives of all New Brunswickers. While not all-inclusive, these will give you a flavor of the kinds of things we do on a daily basis.

On behalf of my nurse colleagues and myself, I would like to thank the Nurses Association of New Brunswick for providing us with the opportunity to explain our roles as consultants and policy advisors. I am proud and thankful for the collaboration that has developed between the Department of Health and NANB.



PROFESSIONAL PRESENCE

JUDGING THE BOOK *AND* THE COVER



Share Your Opinions **Dec 12, 2012–Jan 11, 2013** **www.nanb.nb.ca**

For the first time, NANB is asking you to judge the book and the cover. Members and the public are being asked to share their opinions of RN's professional presence with expert Dr. Catherine Aquino-Russell, Bachelor of Nursing Program Director and Researcher at the University of New Brunswick. Visit www.nanb.nb.ca and share your opinions anonymously.

Nurses Association
OF NEW BRUNSWICK


PROFESSIONAL PRESENCE
An Internal Compass to Guide You in Nursing Practice
BY SUSANNE PRIEST
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In October 2012, the revised *Standards of Practice for Registered Nurses* was approved by the Nurses Association of New Brunswick's (NANB) Board of Directors. Standard 4, Public Trust, addresses professional presence. Section 4.1 reads: "The registered nurse demonstrates a professional presence and models professional behavior," (NANB, 2012). Public trust in a healthcare profession is created when what a client expects is in sync with the health care they receive. Hence, a gap between what a client expects from the healthcare team and actual care received, could result in decreased trust and decreased satisfaction in healthcare providers (Scottish Government, 2012).

In early fall 2012, the Practice Department at NANB sent out an informal survey to members and to student nurses regarding professional presence in nursing. In total, 1,001 surveys (980 RNs and 21 student nurses) were completed and the results from this survey will be discussed with supporting information found in current literature.

Professional Presence

Professional presence is more than a to-do list, but it does include how you look and the impression you give upon entering a room. It reaches beyond the uniform to include self-confidence and a way of being, knowing and doing. Lachman (as cited in Muzio, 2007) lists the following characteristics of an RN with a professional presence: competent; collaborative; able to cope with uncertainty; reflective in practice; open to change; optimistic; passionate; empathetic; full of integrity; adheres to professional standards, guidelines and codes; able to articulate one's role; maintains a professional image; and implements proper use of name and title.

McMahon and Christopher (2011) describe nursing presence as physically "being there" and psychologically "being with" the client (*presence = being there + being with*). For example, an RN using a personal communication device at the bedside is an RN who is physically there, but potentially not with the client psychologically. An RN committed to holistic care is more likely to relationally engage with the client while performing clinical hands-on care, including care involving technological devices. To be professional and to be present means professional presence needs to be embedded into who you are as a person.

When asked on the NANB survey if technology and skill related tasks were interfering with the humanistic aspects of nursing, 63% of the respondents agreed, but many wrote that it was the perceived lack of adequate numbers of RNs and not the technology that was the interference. One RN wrote: "Skill related tasks and technology are an important part of the world around us and nursing must adapt to integrate this with the humanistic aspects of our profession." Healthcare should not be process-driven and bureaucratic but rather, client-centered. The client is not an interruption to an RN's work – but the purpose of it. Standard 3 is entitled Client-Centered Practice and section 3.1 states that the RN "practises using a client-centered approach," (NANB, 2012). RNs should focus on working with clients; a "doing with" approach to care versus a "doing to" approach.

Professional Image

Professional image is an integral component of professional presence and it is created when there are positive interpersonal skills, polite behavior, professional attire, and confidence in one's knowledge and abilities. It is influenced by active listening and effective communication (both written and verbal), personal attitudes and appearances (Davidhizar, 2005).

Appearance is ongoing in most nurse-client relationships; therefore it is not only the first impression that counts, but every encounter with the RN. A consistent exposure to professional presence will most likely foster a therapeutic relationship between the RN and the client. A first impression communicates how the RN feels and respects the self. If the client thinks the RN takes care of and respects his or her self, then they will be inclined to trust the RN to take care of them as well (LaSala & Nelson, 2005). RNs have the ability to increase public and collegial respect for the profession of Nursing through professional presence.

Professional Presence and Trust

Changes in society's expectations and advancements in both science and technology have increased health care consumers' knowledge and expectations. There is a demand for transparency and accountability. Society is quick to congratulate and quick to condemn, therefore the first impression through to the last impression are pertinent. Professional presence needs to be a constant in the workplace and one's social life (including social media).

Professional presence, communicated through words, actions and physical appearance can either cause a lack of trust, or be the commencement of a trusting nurse-client relationship (Davidhizar, 2005; Mahon, 2011; Spitzer, 2012). When asked in the NANB survey, 58% of the RNs responded that it appeared clients were satisfied with nursing care in their workplace and 39% replied that clients were somewhat satisfied with the nursing care. This was personal perception of clients' reactions, but it was an overwhelming positive response.

Standard 2 is entitled Knowledge-Based Practice and section 2.5 states: "An RN initiates, maintains and concludes the therapeutic nurse-client relationship," (NANB, 2012). Professional presence is foundational in the therapeutic nurse-client relationship and has the ability to transcend all interactions between the RN and the client. Tone of voice, appropriate touch, body language conveying genuine concern and self-confidence in one's professional abilities, are all characteristics of an RN being present with clients. An RN being truly present with the client should foster a meaningful and trusting exchange (Zyblock, 2010).

A visible nametag and an introduction, including name and the designation RN, should also foster a sense of trust that someone is in charge of client care and capable of providing safe, competent and ethical care (Davidhizar, 2005). Speaking with confidence and compassion is often a reassurance of the RN's capability and ability to meet the demands of the job and the needs of the clients.

Work Environment and Leadership

A supportive environment which fosters learning and models professionalism, will encourage RNs with varying years of experience to strive to grow in

knowledge, confidence, and the ability to provide quality health service to clients. Role-modeling is important in developing awareness of professional behaviour or a lack of it. When asked if professional presence and behaviour should be recognized and reinforced in day-to-day practice, 99% of respondents to the NANB survey replied YES, but only 61% felt strong and effective leadership, including positive rolemodeling was actually present in their workplace. One respondent shared: "I think we all have our own professional role models in the workplace. I have a few who have been like that for me since the beginning. I think some of the RNs that tend to have an overall bad attitude towards their work are less likely to have role models than those who have support."

Leadership is about finding your strengths and helping others to do so, too. It is about RNs working together to provide quality care despite the circumstances, while being open to new ways of "doing" nursing but also not "chucking" the strengths of the profession out the proverbial window. It is about "knowing what we know" and not being afraid to stand firm on that knowledge base. When asked: "Do you consider yourself a leader," 80% of the respondents to the NANB survey replied YES. One RN wrote: "I believe we are all leaders. Every RN has something to share, to offer and we can learn a lot from one another. Being a leader is believing in what you do and wanting to improve our profession, and the care we offer." Another RN expressed the impact of an aging workforce on leadership in nursing: "As many of the nurses near retirement, they often seek positions in areas where there is less shift work. This means that many of the experienced nurses have left the unit, leaving it staffed with inexperienced nurses. The mentors are gone, making it more difficult for new nurses to make that transition from graduates to RNs."

During confidential interviews, RNs from three hospitals in Ontario revealed why they thought nursing morale and patient satisfaction were so low in their workplaces. Client care was diminished by the low morale of the staff who perceived that they were not valued as professionals (Ferguson-Paré, 2012). RNs revealed the desire to be respected as professionals, with opportunities to learn. They wanted the tools to do their work in a supportive environment which allowed them to work to their best potential. They expressed the need to be heard and included in the interprofessional team.

The findings from the NANB survey were not much different from Ontario. One New Brunswick RN wrote: "I think part of the reason for the good morale is the autonomy that RNs have, as this is a department outside of the hospital where RNs have a lot of autonomy and do not have the hierarchical structure…" Another wrote: "Our efforts are rarely appreciated and we receive a great deal of negative feedback. When I speak to my co-workers, they all see/hear/feel the decline in morale." Most respondents working in areas in which their role has less hierarchy and more autonomy stated that their workplace has good morale.

From an organizational perspective or an employer perspective, boundaries and principles need to be clearly laid out, the values of the employer need to be shared with and modeled by staff, and expectations need to be be clearly defined. This includes communicating professional values and professional expectations (Scottish Government, 2012). Many RNs from the NANB survey shared that the teamwork amongst RNs at the unit level is good, but there is a perceived disconnect from management and upper management, including nurse leaders. When asked if they thought there was good collaboration amongst healthcare professionals in their workplace, 56% of respondents to the NANB survey replied YES and 36% replied SOMETIMES.

Retention of staff and quality of care go hand-in-hand. Retention of staff is probable if RNs feel they are valued for their knowledge and contribution to the health care team. Reciprocal respect from nurse to nurse and nurse to other healthcare provider is a characteristic which impacts clients and staff alike. Regarding staff morale in their workplace, 32% of respondents in the NANB survey replied that staff morale was not good and 46% replied that it was only satisfactory.

Professional presence is also impacted by context. Context includes support from the employer and the expectations from others, including clients. Nursing is not for the faint at heart—RNs are required to react professionally in varying circumstances or to have "situational judgment". The term "situational judgment" refers to the ability to judge circumstances and then react in the most appropriate way (Scottish Government, 2012). In other words, one may have knowledge and skill but not react appropriately in a situation and come across as unprofessional. Self reflection as a practitioner is considered professional behaviour, including how one's practice adheres to employer policy, regulatory standards, the code of ethics, and legislation. This may be described as *professional self-awareness*. Professionals who self-reflect are more apt to respond positively to feedback and are more willing to adapt to change behaviour and practices as required (Scottish Government, 2012).

Conclusion

The concept of presence is widely accepted as a core relational skill within the profession of nursing. Scope of nursing practice continues to expand and RNs are challenged to prioritize the humanistic aspects of nursing care as they integrate increasing numbers of technical and scientific expectations (McMahon & Christopher, 2011). Standard 1 entitled Responsibility and Accountability states that the RN is "responsible for practising safely, competently and ethically and is accountable to the client, employer, profession and the public," (NANB, 2012). Registered nurses need to value the profession of nursing and what RNs contribute to the healthcare team and to the public.

Valuing the nursing profession is projected in our appearance, body language, and both verbal and non-verbal communications including characteristics of professional presence. Professionalism must speak to multi-generational RNs that reflect today's realities in the healthcare workplace, to become a spark that motivates staff to work with passion. Professional presence can become the driving force for safe, competent and ethical care – an internal compass that guides RNs in their nursing practice (Scottish Government, 2012).

NANB invites you to take part in a virtual forum, happening from December 12, 2012, until January 11, 2013,

on professional presence in nursing. The facilitator of the forum will be Dr. Catherine Aquino-Russell from the UNB Moncton Faculty of Nursing.

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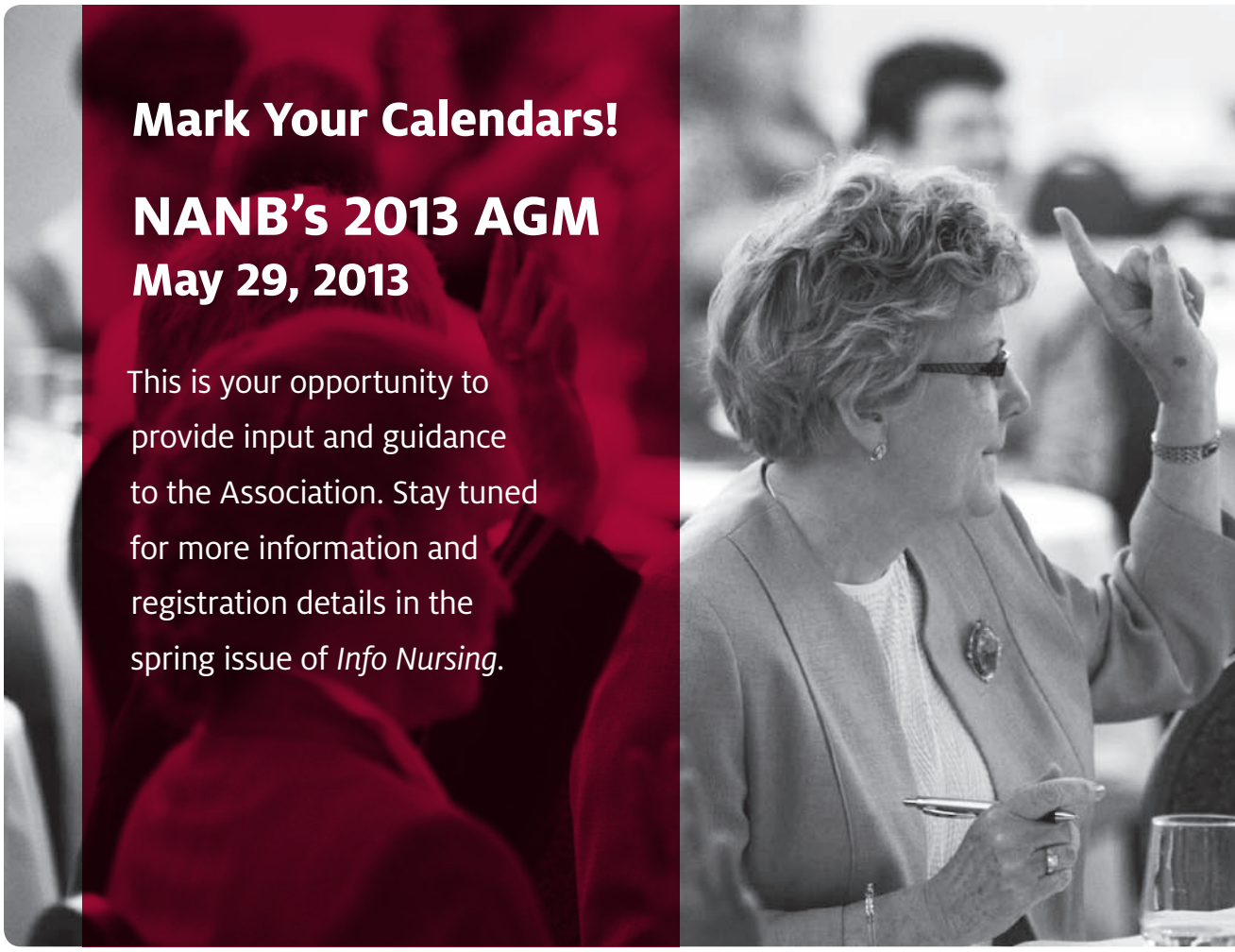
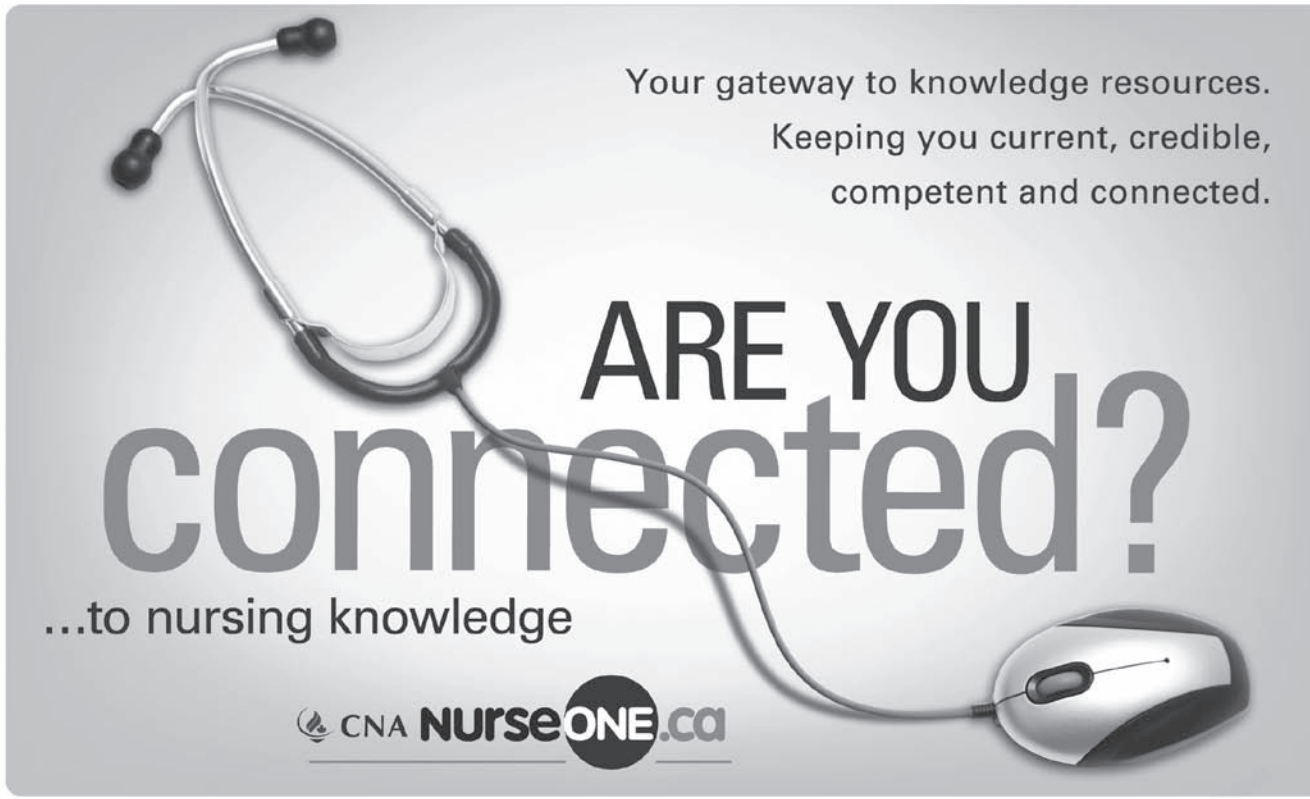
Remembrance Day Ceremony

Remembrance Day Ceremony in Edmundston, NB, on Sunday, November 11 (from left to right): France Chassé, professor, Nursing Department, Université de Moncton, Edmundston Campus; Hélène Rossignol, Corporal, Bagotville Canadian Forces Base, Quebec; France L. Marquis, NANB President, director of the Nursing Department and professor, Nursing Department, Université de Moncton, Edmundston Campus; Pierre-Luc Rossignol, Corporal, Gagetown (N.B.) (Corporal Rossignol carried out a 7-month mission in Afghanistan in 2009 and a 3-month mission in Haiti in 2010).


Mark Your Calendars!
NANB's 2013 AGM
May 29, 2013
This is your opportunity to provide input and guidance to the Association. Stay tuned for more information and registration details in the spring issue of *Info Nursing*.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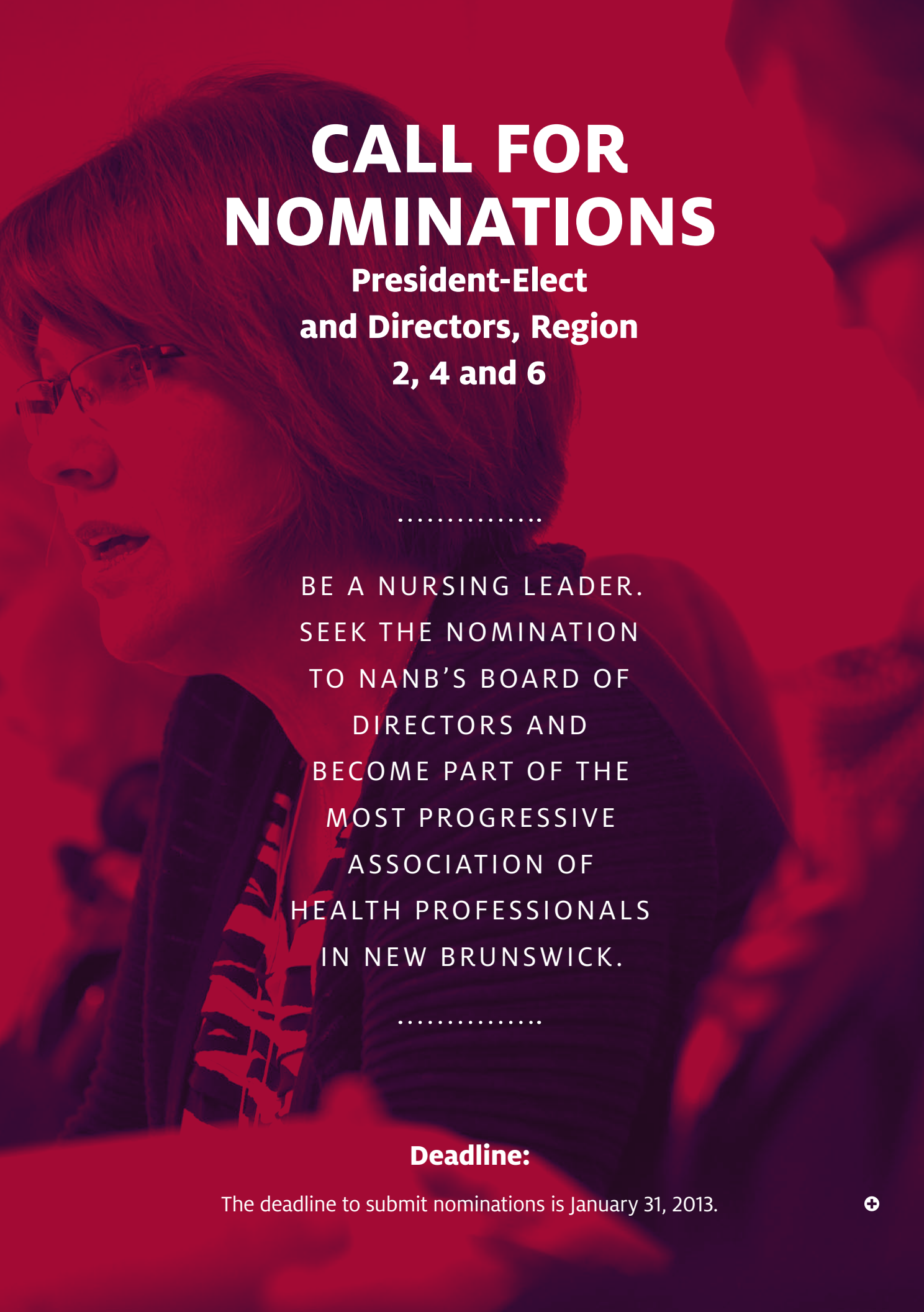

CALL FOR NOMINATIONS

President-Elect and Directors, Region 2, 4 and 6

BE A NURSING LEADER. SEEK THE NOMINATION TO NANB'S BOARD OF DIRECTORS AND BECOME PART OF THE MOST PROGRESSIVE ASSOCIATION OF HEALTH PROFESSIONALS IN NEW BRUNSWICK.

Deadline:

The deadline to submit nominations is January 31, 2013.

See the Nomination Form on page 37 or visit NANB's website www.nanb.nb.ca

NANB ELECTIONS 2013

Call for Nominations

Role

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

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.

How can I become a candidate?

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

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

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

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

POSITION	CHAPTER(S)	TERM
President-Elect	—	2013–15
Director: Region 2	Saint John, Charlotte County, Sussex	2013–15
Director: Region 4	Edmundston	2013–15
Director: Region 6	Bathurst, Acadian Peninsula	2013–15

Qualifications

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

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

Nomination Restrictions

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

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

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

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

Information and Results of Elections

Information on candidates will be published in the March 2013 edition of *Info Nursing*. Voting will take place by mail ballot. The names of the elected candidates will be announced at the 2013 Annual Meeting and will be published in the September edition of *Info Nursing*.

For further information, please contact a local Chapter President or NANB headquarters at 1-800-442-4417, 458-8731 (local) or email: nanb@nanb.nb.ca.

With Pride and Gratitude...

By STEPHANIE SMITH

JUST SOME OF the emotions I experienced as the 2012 Remembrance Day Nursing Sentry. As a graduate of the Bachelor of Nursing Program at the University of New Brunswick, I am honoured that NANB has provided me with a forum to share this once in a lifetime opportunity.

On a cold November 11 in the nation's capital surrounded by the country's most influential and high-ranking officials, I stood at attention at the National War Memorial, overwhelmed with gratitude for being selected to such an honourable position. I know many nursing officers who have fulfilled this role in the past and I have always admired them. I feel fortunate and appreciative for this experience and am humbled by the many nursing sisters that have paid the ultimate sacrifice serving their country in wars gone by. I am proud to be a nurse and even more proud that I represent the country as a Canadian Forces (CF) Nursing Officer.

Throughout my 11-year tenure in the CF, I have been afforded many opportunities including deployments to Afghanistan in 2007 and 2009. I have competed on behalf of the CF in running and triathlon at World Championships in Belgium, Estonia, Switzerland and Tunisia, as well as the Military World Games in Brazil. Although these experiences have brought great excitement and challenges, representing the Nursing Sentry was certainly the opportunity that touched me deeply and will hold a special place in my heart forever.

While in Afghanistan, I volunteered at the local Afghan National Army Hospital mentoring nurses, which solidified my love for teaching. Fortunately, for the past three years, I have been employed at the Canadian Forces Health Services Training Center in Borden, Ontario instructing all members of the health care team, as well as completing an MA in Disaster and Emergency Management through Royal Roads University. I respect all health care professionals and feel fortunate that a nurse is specifically selected to represent the health services.

They say that every second counts, so I made sure that it did! Not even numb fingers and toes could alter my joy at that moment. Memories of both grandfathers who served in the Second World War; my parents who served their country as well as my patriotic friends who served with me in Afghanistan; and every man and woman who suffered through cold and dangerous days made numb fingers and toes seem pretty insignificant. There were no feelings of sadness but admiration for all the soldiers that fought for our country so selflessly. I continue to wear my army uniform with pride, thankful for the many opportunities I have had to help others in need through my employment with the CF.

A TIME OF CHANGE

MOVING TO A RECOVERY ORIENTED APPROACH

By CLAUDETTE LANDRY

Without doubt, mental health problems and substance use issues are costly to the Canadian health care systems. However, of equal importance is the cost to the individuals, their families and significant others, as well as friends, their communities and society as a whole.

In the report, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, the Standing Senate Committee called for sweeping changes in the delivery of addiction and mental health services across the country. Distressing is the following statement found in the initial paragraphs of the report that speaks to the experiences of persons seeking services and their encounters with the system at the time. "The Committee heard about the enormous challenges that they face and the tremendous barriers that hinder their efforts to recover: their confusion and frustration over how and where to find help; ignorance, lack of compassion, and poor treatment from health care professionals; long wait times for service; and the stigma and discrimination that make so many affected individuals hide their problems and often even avoid seeking help in dealing with them".

Despite tough economic times, the clarion call to action was heard in New Brunswick and change is happening. In place is a strong foundation that results from significant public and stakeholder engagement. Tasked with the development of strategic priorities for renewing the mental health system in the province, Judge Michael McKee and his team gathered information from multiple sources and received responses from approximately 2,000 people including representatives from government departments, as well as from numerous professional and community groups and organizations. The NANB is among the organizations listed as having taken part in the exercise. Recommendations made to government subsequent to this extensive consultation are presented in *Together into the Future: A Transformed Mental Health System for New Brunswick*.

The development of an action plan soon followed. Launched in May 2011, The Action Plan for Mental Health in New Brunswick 2011-18 provides the blueprint for an extensive overhaul of the addiction and mental health system in the province. Ninety-four action items are attached to seven major goals that address 1) transforming service delivery through collaboration, 2) realizing potential through an individualized approach, 3) responding to diversity, 4) collaborating and belonging: family, workplace and community, 5) enhancing knowledge, 6) reducing stigma by enhancing awareness, and 7) improving the mental health of the population. It involves an all of government approach that is crucial to its future success and points toward the health, social, cultural, legal, and educational complexities experienced by individuals who live with addiction and mental health issues.

Over a seven-year period, primary, secondary and tertiary levels will undergo organizational and cultural change to reflect the desired future vision; one that offers hope, respect, and opportunity; and supports a recovery approach. Emerging as a central focus of reform, the recovery approach is fundamental to national strategies in several countries including Australia, New Zealand, the United Kingdom, the Netherlands, Spain, the United States, and more recently in Canada .

The New Brunswick Action Plan for Mental Health supports The Collaborative Model of Response (Figure 1). It is an integrated system that provides a full scope of services for individuals at various times in their recovery journey. In keeping with the premise that addiction and mental health is everyone's responsibility, the multi-level model depicts an approach that involves individuals, caregivers, community, providers and government. Furthermore, the model integrates partnerships, sector collaboration, community mobilization strategies, service specialization and promotion of mental health at each level.

As the transformation moves forward, health care providers are called upon to participate in the process and champion change. Nurses are present at all levels of care and are key members of interdisciplinary teams. Their voices are heard on planning committees and will be there as the recovery approach is operationalized. Last but not least, nurses are fortunate to benefit from the public trust and have a professional responsibility to foster attitudes and activities that promote positive mental health.

$51 Billion

The estimated cost of mental illness to the Canadian economy in terms of health care and lost productivity (based on the 2003 Canadian Community Health Survey).

1 in 10

1 in 10 Canadians 15 and over report symptoms consistent with alcohol or illicit drug dependence (Canadian Community Health Survey, 2003).

1 in 5

1 in 5 Canadians will experience a mental illness during their lifetime (Public Health Agency of Canada).

$1,267

The Costs of Substance Abuse in Canada 2002 was released in April, 2006. The study estimated the total cost to be $39.8 billion, or $1,267 for every Canadian (Canadian Centre on Substance Abuse).

TRUE OR FALSE?

1. The role of nurses working in Mental Health is to give injections and provide medication information.
2. Psychologists in Community Mental Health Centre prescribe medication.
3. NB has the only provincial FASD centre of excellence in the Maritimes.
4. The Action Plan for Mental Health calls for a recovery approach for addiction and mental services.
5. A new psychiatric facility is in construction in Campbellton.
6. It is estimated that 20% of Canadians will personally experience a mental illness during their lifetime.
7. The onset of most mental illnesses occurs after 40.
8. Mental illness is the result of a weak character.
9. The Youth Engagement Initiative provides a sentencing alternative for youth in trouble due to problematic substance use.
10. The Child and Adolescent Psychiatric Unit (CAPU) is an inpatient facility that serves children and adolescents.
11. A new addiction services centre is slated for Edmundston.
12. Community Mental Health Centres are located across the province.
13. Primary health care practitioners are an important element in supporting mental health and addiction services.
14. Gambling addiction is defined as engaging in any form of gambling on a weekly basis.

ANSWERS

1. FALSE: Although Community Mental Health Centre nurses do give injections and provide drug related information to clients, their role is much broader and includes, but is not limited to, providing individual therapy sessions and leading educational groups.
2. FALSE: Only physicians and nurse practitioners prescribe medication; psychologists provide therapy to individuals with mental health issues.
3. TRUE: The FASD Centre of Excellence opened in February 2012 and is located in Moncton. It serves children from across the province and carries out co-ordination and service delivery related to fetal alcohol spectrum disorder prevention, diagnosis and intervention. The Centre results from a partnership between the Department of Health, Regional Health Authorities, and Family Services Moncton, a not-for-profit organization. Public Health Agency of Canada (PHAC) has estimated that nine in 1,000 are born with FASD.
4. TRUE: The Action Plan for Mental Health in New Brunswick: 2011-2018 calls for sweeping changes in addiction and mental health services. A significant change is the implementation of a recovery oriented approach that fosters respect, hope, and opportunity and believes in the potential of all individuals (www.gnb.ca/0055/pdf/2011/7379%20english.pdf).
5. TRUE: The Restigouche Hospital Centre is currently under construction; the design of the new facility favours recovery oriented care.
6. TRUE: In 2002, the Public Health Agency of Canada (PHAC) published in A Report on Mental Illnesses in Canada that 20% of Canadians would personally experience a mental illness and the remaining 80% will be affected by an illness in family members, friends or colleagues.
7. FALSE: The onset of most mental illnesses occurs during adolescence and young adulthood (PHAC, 2002).
8. FALSE: Mental illness is not the result of a weak character. Several factors contribute to mental illness, including genetic factors

page 44

How many patients are admitted with COPD and what is the readmission rate for them? What is the cost to the health care system to support their care?

How many staff are required to staff a 30-bed medical unit?

Why do I need to collect all this data?

By MARGIE EASTWOOD, CARLA MACLEAN & DEBBIE PETERS

How far are patients travelling, on average, for a particular health service?

How often are post-op blood pressure checks being done on patients who have returned from the recovery room to the surgical unit?

What percent of procedures currently being done on an inpatient basis could be performed through a day surgery program?

Just some examples of the types of questions that are answered through the work of the Accountability and Health Information Management (AHIM) Unit at the Department of Health (DoH). The AHIM unit employs twelve staff, three of these whom are (25%) registered nurses. The staff backgrounds vary considerably, and include: health information management, database management, and research. The role of the unit is to collect, analyze and report objective information to inform decisions and to enable monitoring and reporting on the

health care system's performance, including:

- decision support—the analysis and reporting of information held in a variety of databases (e.g., Annual Report of Hospital Services);
- database management—the receipt, storage, verification, clean-up, retrieval and transmission of raw data which is held in large repositories;
- data quality management—improving or maintaining the quality of the raw data submitted to the DoH;
- new systems support—providing expertise to support the development, implementation and operation of new tools and systems for collecting, storing, analyzing and disseminating health information (e.g., Workload Measurement System, Utilization Management reporting, Client Registry, Surgical Access Management project, Breast Feeding Monitoring project);
- program evaluation—designing and managing projects aimed at reviewing health care programs or services (e.g., staffing and/or service level reviews); and
- research—responding to requests for data for research purposes.

The data maintained and managed through the AHIM unit comes from a variety of sources and covers many facets of the health care system including:

- information on inpatients and day surgeries (e.g., patient demographics; admission and discharge data; diagnosis and interventions data);
- statistical and financial information on the inflow and outflow of patients (e.g., occupancy rates, ER visits by triage level, cost per ER visit, cost per patient day, workload per patient day);
- workload measurement for various clinical services;
- information on patients receiving services through the Extra-Mural Program, Addiction Services, Mental Health and Public Health; and
- a variety of externally collected and managed data sets (e.g., Statistics Canada's *Canadian Community Health Survey*; and the Canadian Institute for Health Information (CIHI) Portal, which provides pan-Canadian clinical and administrative data from which various indicators can be derived, such as mortality rates, re-admission rates by diagnosis, the number of Alternate Level of Care days).

A significant responsibility that comes with holding and managing these data sets is ensuring that the privacy and confidentiality of the information is protected; the AHIM unit staff work closely with the staff in the Department of Health's Corporate Privacy Office to ensure compliance with *New Brunswick's Personal Health Information Privacy and Access Act*.

Where does all of this information come from? Most of it starts with clinicians, many of them nurses, accurately and diligently collecting information at the patient's bedside through such tools as workload measurement. Other tools and processes, such as financial systems and admission/discharge abstracting, also collect information at the patient level. Increasingly, patient-oriented data is required to estimate demand for healthcare services, evaluate outcomes of care, and assess the sustainability of the healthcare system. The data collected at the individual patient level is critical to the work performed by the AHIM unit staff.

Also critical to the work performed by the Unit is the multitude of collaborative relationships established to support the data collection, analysis and reporting. These relationships are evident through the numerous liaison processes and work groups and committees functioning at both the provincial and national level.

A wide array of stakeholders use the information, for a variety of purposes, for example:

- managers at all levels within the province's two health networks use the data to inform their decisions (e.g., regarding programming, allocation of resources, development of business plans);
- policy makers within the DoH, and other government departments, use the data in a variety of ways (e.g., to understand service utilization patterns across the province, to plan new facilities or renovations to existing facilities, to revise program or service delivery plans);
- communities and community organizations use the information when conducting community needs assessments;
- the New Brunswick Health Council uses the data on a regular basis to prepare reports on various subjects (e.g., health system performance, population health);
- CIHI uses the data in its reporting on health systems across the provinces;
- other national and international agencies (e.g., OECD) use the data for reporting on specific indicators, such as reports on national expenditures, health human resources;
- independent researchers request data to use in their research; and
- independent consultants retained either by government or by other organizations request and use data to conduct analysis on specific topic areas (e.g., tobacco litigation project).

Registered nurses are involved at the patient level in data collection and are involved, through the AHIM unit, in the analysis and interpretation of the data. The years of experience in clinical practice that the AHIM RNs bring to their health information management work provides invaluable insight into what the numbers represent and what they are actually telling us.

The CIHI has identified New Brunswick as a Canadian leader in providing accurate, timely, comparable, and relevant health information. This is only possible through the daily commitment of staff to collect the data at the patient level. With this support, AHIM's role of providing world class information is possible. It is very rewarding to see that this information is being used by various individuals and organizations answering all kinds of questions about NB's health care system.

Canadian Nurses Protective Society

infoLAW®

Social Media

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Social media websites such as Facebook, Twitter, Google+, MySpace, YouTube and blogs allow us to communicate in real-time with "friends" or the public. Nurses use these sites as research and educational tools, for information sharing and as a way to network. Understanding the risks involved in using social media may prevent potential adverse personal and professional consequences.

Confidentiality and Other Professional Obligations

Nurses, like other health care professionals, are held to a high standard of confidentiality with respect to all patient information.[1] Professional practice standards regarding confidentiality, therapeutic boundaries and professional image are engaged when nurses use social media in connection with their professional activities. Nurses are required to conduct themselves with a professional manner towards patients and colleagues. Failure to abide by these standards can lead to serious legal consequences. For example, a nurse was found guilty of unprofessional conduct by her professional licensing body because she posted a patient's first name and the patient's personal health information on a co-worker's Facebook page.[2] Another example is the termination of employment of a personal care giver because of the postings on her blog. She posted personally-identifying information about residents without their consent and made derogatory comments about residents, colleagues and management.[3] If this person had been a regulated health professional, such as an RN, LPN or RPN she could have also faced disciplinary action by her professional licensing body.

The breach of professional standards could also result in a prosecution against the nurse for breach of privacy legislation.[4] Additionally, if defamatory comments are made by a nurse about another person or institution on a social media site, a civil action alleging defamation could be commenced against the nurse. A nurse who is found liable by the court could be required to pay damages.[5]

Social Media Risks

Scope of distribution

Because information in electronic form is easily distributed, archived and downloaded, the person posting the information may have very little control over who sees it and its use.

Permanence of information

Postings to social media sites are generally permanent records that cannot easily be deleted. Copies of deleted information may still exist on search engines or in friends' (or others') electronic files. During sentencing of a young man who had posted explicit photos of his teenage ex-girlfriend on Facebook, the judge stated: "What you chose to do is unfortunately something that cannot be undone.... There's no delete button on the internet. Those things float forever on the internet."[6]

Misapprehension of the extent of privacy controls

Although these sites have privacy controls, be aware that the default for many of them allows others to see some of the posted information. Even information on a social media website that is not normally publicly available may have to be disclosed in court if relevant to the issues in a proceeding.

"Twitter is a great place to tell the world what you're thinking before you've had a chance to think about it."
- Chris Pirillo

More than liability protection

Pseudonyms

Posting anonymously or under a pseudonym does not protect against the possible consequences of a breach of confidentiality or defamation.[7]

Reputation damage

Postings may come back to haunt you on a personal or professional level. Many employers check social networking profiles of current and prospective employees looking for misconduct or inappropriate behaviour.

Risk Management

To decrease your professional and personal risks, consider adopting the following best practices:

- avoid posting/sharing confidential information: an unnamed patient or person may be identifiable from posted information;
- avoid using social media to vent or discuss work-related events or to comment on similar postings by others;
- avoid posting negative comments about your colleagues, supervisors and other health care professionals; disclosing information obtained at work could be considered unprofessional and, if erroneous, could lead to a defamation claim;
- respect and enforce professional boundaries: becoming a patient's electronic "friend" or communicating with them through social media sites may extend the scope of professional responsibility;
- be aware that it is difficult to ascertain whether individuals providing or seeking information through a social media account are who they say they are;
- avoid offering health-related advice in response to comments or questions posted on social media sites; if relied upon, such advice could lead to professional liability;
- make your personal profile private and accessible only by people you know and trust;
- create strong passwords, change them frequently and keep them private; and
- present yourself in a professional manner in photos, videos and postings.

Before communicating on a social media website, always consider what is said, who might read it and the impact it may have, if viewed by an employer, a patient or licensing body. Please contact CNPS at **1-800-267-3390** if you have further questions regarding the professional implications of using social media and visit our website at **www.cnps.ca.**

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1. *infoLAW*©, Confidentiality of Health Information (Vol. 1, No. 2, October 2008, Revision of September 1993).
2. *Alberta RN* 64, 6 (July 2008): 25.
3. *Chatham-Kent (Municipality) v National Automobile, Aerospace, Transportation and General Workers Union of Canada (CAW-Canada), Local 127 (Clarke Grievance)* (2007), 159 LAC (4th) 321, [2007] OLAA no 135 (QL).
4. Most provinces have enacted legislation to protect the confidentiality of personal health information.
5. *infoLAW*©, Defamation (Vol. 12, No. 3, September 2003). See also *Hunter Dickinson Inc v Butler*, 2010 BCSC 939, [2010] BCJ no 1332 (QL) and 2011 BCSC 1504, [2011] BCJ no 2099 (QL). In this case, the defendant was ordered to pay $425,000 in general, aggravated and punitive damages for defamatory postings on a website.
6. James Turner, "Facebook revenge plot nets 6-month sentence," CBC News, August 22, 2010, 12:40 pm CST, online: http://www.cbc.ca/canada/manitoba/story/2010/08/22/man-facebook-revenge-child-porn.html.
7. Individuals anonymously posted alleged defamatory comments on a newspaper's website. A judge ordered the newspaper to disclose information to assist in identifying those individuals. The Court did not condone the conduct of anonymous internet users who made defamatory comments and found they had to be accountable for their actions like other people. *Mosher v Coast Publishing Ltd*, 2010 NSSC 153, [2010] NSJ no 211 (QL).

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

SOCIAL MEDIA

THE PROMISES, THE PERILS & THE "PATIENT 2.0"

By LORELEI NEWTON

Do not underestimate the impact social media will have on your personal and professional life. Social media, described as "a group of internet based applications and technologies that allow users…to interact and collaborate with each other online in the creation and sharing of information, ideas and opinions," is firmly embedded in the fabric of our day-to-day lives (CNA, 2012, p. 1). The promises and perils of social media provoke much discussion regarding registered nurses' use, especially in a professional capacity. Within the context of registered nursing, such technologies are most often referred to as a group of constantly evolving "digital tools" that can be used in various ways (Fraser, 2011). As Canadians become more familiar and comfortable with these new technological 'tools,' it is inevitable that patients and their families will begin to demand access to healthcare through such mediums (just like the telephone, email and websites). Thus, while considerations of how we might strategically and ethically use social media in our registered nursing practice are important, what is equally important is to think about how incorporating these tools into our practice will not just change how we deliver healthcare but how we view our patients, our practice and the very notion of healthcare.

The promises of social media are plenty. For example, social media is said to offer the potential to enhance communication and keep healthcare practitioners current and more efficient (e.g., Change Foundation, 2011). It provides readily accessible and inexpensive platforms for both professional and patient education. In the near future, I predict that the trend in Canadian healthcare will be the use of social media as a "quality improvement tool" and this will be done through the lens of "patient engagement." In spite of the many promises, the perils of inappropriate use of social media by registered nurses receive considerable attention. Social media poses risks to be managed, such as breaches of patient confidentiality and privacy as well as the inadvertent co-creation of exclusionary practices that may have the unintended consequence of limiting access to those without the ability or desire to inhabit the virtual world. It is also important to consider that at the

foundation of social media's success is creating and sustaining trusting relationships. While building such relationships is one of the strengths of registered nursing practice, we know that the time and energy necessary to establish good relationships is often undervalued. In addition, all this participation in, and co-creation of, greater connectivity ultimately leads to systems with increased potential for surveillance (Rheingold, 2008). In healthcare, this can mean greater surveillance of both healthcare practitioners and patients. For example, imagine that your patient can report (through a social media platform) such things as: Did they feel listened to? How many times did the nurse wash his or her hands? Was all your paperwork filled out correctly? It is interesting to consider how regulatory bodies and healthcare organizations will respond to this type of feedback. In the business literature, such reporting by "consumers" is often referred to as "Accountability 2.0."

Looking to the business literature also provides clues to how healthcare delivery may change. Successful companies in this millennium realize that in the emerging digital culture, they are required to act more like party planners, content providers and aggregators rather than relying on traditional marketing methods (Qualman, 2009; Weber, 2009). In addition, it is interesting to note that while 78% of consumers trusted peer recommendations for products and services, only 14% trusted direct advertisements from a company (Weber). This is creating a subtle shift in how we see ourselves as consumers and as citizens. The business of the "news" is a good example. We now see that 24 of the top 25 newspapers are in the midst of record declines in circulation. This is because "we no longer search for the news—it finds us" (Qualman, p.12). In this same way, we are searching less and less for products and services and starting to expect that they will find us via social media (Qualman). Such reorganization of expectations can be extended to health and healthcare—soon Canadians may not necessarily come to us for healthcare, they will expect us to go to them.

This shift in how we think about our health and our selves may be part of a global phenomenon Luciano Floridi (2010) calls "re-ontologizing." Floridi theorizes that the human race is undergoing a dramatic shift in how we view our reality largely due to the blurring of the distinction between what we consider "on-line" and "off-line." In healthcare, this new view seems integral to the conceptualization of the "patient 2.0." While there is little consensus on what constitutes the "patient 2.0," this patient appears in the juncture of what is considered "health 2.0" (sometimes called participatory healthcare) and the "e-patient." This "patient 2.0" is empowered through access to an unprecedented volume of health knowledge (often denied to previous generations) and is said to result in new forms of collaboration and self-management practices. Within the healthcare literature, this "patient 2.0" is mostly constructed as "a consumer." Interesting, this patient is described as being engaged and savvy while at the same time, passive and troublesome. This literature also seems to be very physician focused (e.g., Van Dam, 2010). In addition, the impression one has while perusing the literature regarding the "patient 2.0" is that healthcare professionals are in constant contact with this patient. Looking more closely, however, it appears that while we are having lots of conversation *about* these patients, we do not seem to be talking *with* them.

Social media supports connections among millions of patients and families from all over the globe. It appears that these patients are only linked through a similar diagnosis. Despite this seemingly superficial point of connection, they share their experiences, symptoms, fears, questions, concerns, interactions with the healthcare system and with providers in a very much uncensored way (Davies, 2011). One very good study, by NM Incite (www.nmincite.com/?p=5469), illustrates through an infographic who is talking to whom through social media in healthcare. In these vast networks of connections, healthcare providers only have minimal interactions with these groups of patients. Communication through informal social media connections seems to be where the "patient 2.0" is getting the vast majority of their health advice, not from healthcare professionals. In another recent study, at least one third of the survey adults said social media was their normal environment for discussions about their healthcare (PwC, 2012). What these two studies point to is how vital it is for registered nurses to recognize that these important conversations regarding health happen whether we are there or not (and mostly, it seems, we are not).

In order to be responsive to this 21st century patient, we need to find ways to get out into those virtual communities and build relationships. We also need to recognize that we will not have total control of all healthcare related information, including patients' electronic medical records. We need to expand our understanding of the body, as boundaries between the physical and virtual aspects of the 'body' will be fluid and open to much interpretation. In this regard, registered nurses have a huge advantage. Nurse theorists, such as Martha Rogers (1990), have already theorized about this for decades. Although Martha Rogers can be considered a woman ahead of her time, I also wish to emphasize that in this moment in history, nothing is "settled." We have an opportunity to choose how we proceed as a profession and how we will influence this emerging "healthcare 2.0." If we do not, it will be imposed upon us with little consultation through legislation and policy.

It is likely that social media and electronic health records will eventually merge and the resulting hybrid will be under the control of the patient. In a way, patients are already in control of their information to a limited extent: they can delete/omit/highlight what they determine is relevant when they tell us their story (that we request of them over and over). Yet what is different about people born today is that their electronic chart may contain every bit of their personal information from ultrasounds of them as a fetus to their heart surgery eighty years later. And it needs to be the patient who decides which healthcare practitioner will have access to what information. To many, this sounds radical; however, it is already happening. *Patients Know Best* (created by Dr. M. Al-Ubaydli) is the world's first patient-controlled medical records system. This digital tool has been shown to be so effective it is now being integrated into the UK's National Health System (www.patientsknowbest.

com/about-us.html). Each patient has a "profile page," similar to a Facebook page, where patients can organize their information, lab work, and update their files. In addition, the patient decides, through invitations similar to "friending," who is part of their healthcare team (and who is not). The patient then organizes online consultations and team meetings through their profile page. The patients are responsible for summarizing various practitioner visits in order that other healthcare practitioners can be updated quickly to address the patient's current concern with the necessary information. Patients can report their outcomes of various interdisciplinary interventions and have access to tools that help them track their individual progress. Through this medium, the changing network of patients' family and friends can also be accommodated. It is easy for me to imagine skyping family from across the globe into a meeting in Fredericton regarding decisions and direction of individual patient care.

This convergence of social media and electronic patient records in combination with more sophisticated knowledge use and expectations results in individualized care requiring that we listen carefully to the patient and their family. Through this, how we think about and develop "best practice guidelines" may be substantially changed. As Shirky (2008) points out, a "revolution doesn't happen when the society adopts new technologies—it happens when society adopts new behaviours" (p. 160). While social media may be considered merely "technological tools," they are also integral to the creation of cultural conditions that allow for a new form of communication, collaboration and human connection. I think that in the future, crowdsourcing will be a new patient behaviour that will allow them to have input into best practice guidelines and policy. Crowdsourcing, a term first coined by Jeff Howe in 2006, is a simple principle: An undefined, large group of people share knowledge in a way traditionally done by a designated authority in order to find a solution to a problem (Howe, 2009). Sometimes crowdsourcing is called the 'wisdom of the crowd' (e.g., Surowiecki, 2005). Some argue that "in general, "transparency breeds self-correcting behavior' among all types of actors" (Meier, 2012). Furthermore, since crowdsourcing is, as Meier suggests, "in its very essence based on universal participation," it supports the empowerment of patients and the democratization of healthcare.

Here is a straightforward example: In the Netherlands, a group of healthcare workers wished to create an application for cellular phones that identifies the location of AEDs (automatic external defibrillators) in order that one could be quickly accessed during a cardiac emergency (Engelen, 2011). By asking citizens to report the locations of AEDs, and collating the tremendous responses, this goal was quickly realized. Now when you travel in the Netherlands, you can find an AED as easily as a restaurant. This grassroots project has since become international and you can participate by identifying the location of an AED while you are on vacation anywhere in the world (www.aed4.us). While this might seem like a simple project, looking more closely reveals the effects of crowdsourcing.

When sifting through various social

media sites, especially comments and discussions, we can see traces of the tremendous potential crowdsourcing represents for both registered nursing practice and healthcare. For example, in reviewing information and news stories about parents of children with Trisomy 13/18, I came across an entry by one mother in the comment section (for Susan Budd's full story, see http://buddzoo.blogspot.ca/2012/07/our-trisomy-community-has-voice.html). In summary, her child with trisomy 13/18 was having distressing episodes of apnea. Her requests for surgery were denied because it was counter to current practice guidelines and policy. Current scientific belief was that these children had apneic periods due to problems with the respiratory centre of the brain and surgery would be pointless. Based on her own "evidence," this mother believed her child was experiencing obstructive apnea. Through the use of social media, and the support from the community created by social media platforms, the mother was successful in advocating for her child's surgery. Much to the amazement of the healthcare team involved, the mother was correct and the child's surgery successfully treated the obstructive apnea. Yet such a story illustrates how this mother was doing more than advocating for her own child. She was challenging established authority and the best practices guidelines at the foundation of their healthcare practices. In this way, and with such intense connection, she was not just advocating for one child but for every family linked by this diagnosis. It seems she is pulling together "the wisdom of the crowd" to work cooperatively and change policy for all children with trisomy 13/18. I can see crowdsourcing being used to address the one main concern I have regarding best practice guidelines: A lack of input by patients.

In the end, I do believe that social media will profoundly change how we view ourselves as humans and, by extension, how we view our registered nursing practice and healthcare. Yet I also believe that there is too much hype around social media, too much focus on the technology that can cause us to lose sight of what is really important. Essentially, it all comes down to building connections and relationships at the individual and community level to provide optimum care and address issues of social justice. We already know the power of listening to patients and their families. While the ever-changing technology is important (and challenging), we already have well-established professional values through our regulatory bodies and a solid code of ethics as a foundation that remain relevant, applicable and constant. So let us work together to de-mystify these new "digital tools" for patients and their families and work with them to expand our ideas of the body and health to ensure equitable care. Finally, in the spirit of social media, I invite you to consider that you are not just reading this article, you are instead a co-creator of how nursing will take up and use social media to ensure safe, compassionate, competent and ethical care for all Canadians (CNA 2008).

Acknowledgements:

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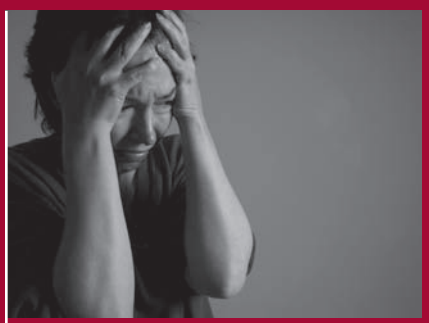

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Electronic Health Record
A Nurse's Perspective

By JOCELYN BURNS-MCCUE

My name is Jocelyn Burns-McCue and I am a clinical business analyst with the Health Business and Technology Solutions Branch at the Department of Health.

Why are you leaving the hospital? So, you are not going to be a nurse anymore? What do computers have to do with nursing? These were a few common questions posed in my role as a critical care nurse and clinical instructor to my current position as a clinical business analyst with the Department of Health.

My nursing career began in Bathurst at the Chaleur Regional Hospital. I then moved to Connecticut, where I worked as a critical care nurse and clinical instructor. During my last two years in Connecticut, I became a user of their new electronic physician order entry system, Sunrise Clinical Manager, and the new electronic medical application record (eMAR).

When I began my nursing career, I never imagined myself working at a desk in a health business and systems world. One of the many amazing aspects of our nursing profession is that it is multifaceted. There are many avenues we can pursue, leading us to endless opportunities. Advances in information technology in our healthcare setting have resulted in challenging new roles for nurses. Furthermore, these advances facilitate improvements in patient care—an important aspect of our nursing profession.

My role at the department encompasses a large variety of responsibilities such as business analyst issues, policy development and clinical decision making. My nursing experience, clinical judgment, and critical thinking skills are utilized to help make clinical decisions. Having practiced as a front line nurse who was a user of a new electronic system has been very helpful in my role today. This experience helps me understand what the user may need in a system and how it will benefit the workflow of their everyday practice.

A large part of my responsibilities relate to the development and implementation of the Electronic Health Record (EHR) which is a bilingual, province-wide tool that the New Brunswick Department of Health has developed in partnership with the regional health authorities (RHAs) and FacilicorpNB. It includes one health record for each individual within the province's health care system. In addition, I am part of a team that developed and implemented a provincial data quality program to continually monitor information coming to the EHR from the RHAs. This required a tremendous amount of collaboration and work with the RHAs.

The EHR allows for the seamless sharing of information across systems for authorized health care providers. It also permits nurses and other health care providers to access health information with greater speed and efficiency. This, in turn, allows for more timely decision making, a potential reduction of tests, as well as improved communication on the delivery of care.

The use of the EHR introduces nurses

page 38

RNs Working in the Primary Health Care Branch

EDITOR's NOTE: The following interview is conducted with two RN employees of the Primary Health Care Branch within the Department of Health.

By BEV GREENE & LYNN KELLY DE GROOT

Bev Greene, RN, MN, brings with her a strong management background with a particular focus on program design and implementation along with varied clinical nursing experience.

Lynn Kelly De Groot, NP, BA, MBC (candidate), brings wide-ranging clinical and management experience, Lynn has also played a leadership role in staff training and development, primary health care and new program implementation.

What is the Primary Health Care Branch (PHCB)?

Bev: The Primary Health Care Branch, of the Addictions, Mental Health, Primary Health Care and Extra Mural Services (Division) at the Department of Health, had its genesis as a unit with the funding received in early 2000 from the Primary Health Care Transition Fund. It gradually developed into a permanent branch within the Department of Health, with the establishment of the community health centres.

What skills are important for a nurse working in PHCB?

Bev: An intimate knowledge of the working environment across clinical health settings and a strong network of built relationships within the provincial community of practice are key to our work.

Lynn: Effective interpersonal skills, strong writing and verbal communication and expertise in project planning and management are also essential to the on-going work of the nurses in the Primary Health Care Branch.

What responsibilities fall within the PHCB?

Bev: The work of the Primary Health Care Branch has focused on redesign and reinvestment in primary health care delivery systems to improve the accessibility, availability, appropriateness and affordability of our health care system.

How does the PHCB achieve its objectives?

Lynn: In order to achieve our objectives, efforts are concentrated into four major streams—primary health care redesign; chronic disease prevention and

management; patient and stakeholder engagement; leadership and change management for system transformation.

What are the PHCB's major accomplishments?

Bev: A major accomplishment has been introducing community health centers and collaborative practices and aligning existing health service centers. With this has come interdisciplinary practices, expanded scope of practice for nurses in primary care as well as in community development and health promotion.

Lynn: Another major accomplishment is the release of *The Primary Health Care Framework for New Brunswick*, released in August 2012, which is a 10-year vision to transform primary health care in this province.

How will government meet the objectives of this framework?

Lynn: The vision "better health and better care with engaged individuals and communities" will be achieved through a better integration of primary health care services and the creation of patient-centered primary health care teams working collaboratively together with the Regional Health Authorities to meet the identified health needs of communities.

The PCHB was also instrumental in the *Chronic Disease Prevention and Management Framework*. Why is this framework important?

Bev: Chronic disease has long been acknowledged as a major cost driver in the health care system. It is also recognized that the complications of diabetes are significant, and as an example, almost one third of hospital days are used by persons who have diabetes. Today in New Brunswick, about one in ten persons has diabetes. In response, the government endorsed the *Chronic Disease Prevention and Management Framework* as a coordinated approach to optimize the management of chronic disease within New Brunswick in May 2010. One year later, in June 2011, the province released the *Comprehensive Diabetes Strategy*, outlining a four-year road map to reorganize care delivery across the continuum of health care services.

How did nurses play a role in these important initiatives?

Lynn: Bev and I have been intimately involved in the development and rollout of these initiatives. Understanding and navigating the health care system, as well as leveraging and building relationships among stakeholders, have been a core requirement.

Bev: There's no question that our nursing background and varied experience is a natural backdrop to the development of collaborative frameworks that integrate the abilities and skills among health care providers, community agencies, industry and government. ■

Electronic Health Record

continued from page 36

to a new era of work efficiencies (e.g., less faxing or calling for patient results). Today, many patients across New Brunswick travel outside their health zone to receive healthcare services. The systems within each health zone currently do not speak to one another; in other words the data is not easily accessible and transferable. Take, for example, a patient in Bathurst who is referred to Moncton for healthcare services. Having access to the EHR means clinicians who are providing care to that patient can look up his/her health information in a timely manner, eliminating multiple faxes and phone calls for results. Furthermore, when this patient returns to Bathurst, his healthcare providers can view what tests were done in Moncton to better assist with follow-up care. Another scenario where the EHR can be beneficial is in the emergency department. Clinicians working in the ER will sometimes encounter patients that are unconscious, patients from other health zones, or patients who are unable to provide staff with their medical background. As long as you have an identifier of some type, such as name, Medicare number or patient chart number, you can look up that individual's medical history through the EHR.

Various nurses, nurse practitioners, physicians, and pharmacists from across the province currently have access to the EHR. Authorized users are granted access upon completion of the online privacy course, the access request form and EHR training. Request for access to the EHR can be completed by emailing ehradministrator@gnb.ca and stating your interest. Authorized users will then be directed through the appropriate steps.

As nurses, we know that information is critical to the work we do every day. We need information to assess our patients, for documentation, to communicate to other healthcare professionals as well as family members, and also in various administrative roles, including staffing, scheduling and budgeting. As technology continues to advance and have a greater presence in our healthcare setting, it is essential for nurses to be informed about new advancements in information technology in order to maximize its use and utilize the tools that can benefit their nursing practice. Having access to the EHR in New Brunswick allows nurses to have access to up-to-date health information. The EHR supports improved communication on the delivery of care and effective decision making, thus potentially leading to improved patient outcomes.

If you are interested in learning more about the EHR please contact OPOR@gnb.ca. ■

Nomination Form

ELECTIONS 2013

(To be returned by chapter member)

The following nomination is hereby submitted for the 2013 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 31, 2013**. Return to:

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

Acceptance of Nomination

ELECTIONS 2013

(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 31, 2013**, to:

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

NANB Documents

Supporting Good Practice

In 2012, the NANB Board of Directors approved the following additions/revisions to five NANB documents.

NEW

Graduate Nurse Scope of Practice: Guideline

This guideline document was created in response to practice queries mainly from employers. It serves to increase understanding and provide guidance for graduate nurses, registered nurses and employers regarding the scope of practice of graduate nurses and to the restrictions that apply.

www.nanb.nb.ca/downloads/Practice%20Guidline%20Graduate%20Nurse%20Scope%20of%20Practice-E(1).pdf

Managing Registered Nurses with Significant Practice Problems: Guideline

This guideline document was created in response to practice queries regarding the role of nurse managers in assisting nurses experiencing significant practice challenges. A five-step framework is suggested to guide and support nurse managers working with RNs experiencing significant practice problems. Managing these problematic issues will ultimately have a positive impact on the safety of the nursing care provided to clients.

www.nanb.nb.ca/downloads/Practice%20GuidelineManaging%20RNs%20with%20Significant%20Practice%20Problems_E.pdf

Ethical and Responsible Use of Social Media: Guideline

The purpose of this guideline document is to help registered nurses protect client privacy and confidentiality of personal and health information, and to reiterate the importance of maintaining the boundaries established within the therapeutic nurse-client relationship when using social media tools in their practice. This guideline further interprets NANB's standards and the Code of Ethics (CNA) and provides recommendations to registered nurses, employers and nursing education programs.

Advanced Nursing Practice: Position Statement

This position statement: *Advanced Nursing Practice (ANP)* has been developed to recognize the importance of advanced nursing practice roles. In New Brunswick, there are two such roles, the nurse practitioner (NP) in primary health care and the clinical nurse specialist (CNS).

www.nanb.nb.ca/downloads/Advanced%20Nursing%20Practice_E.pdf

REVISED

Standards of Practice for Registered Nurses

The primary purpose of these Standards are to identify the level of performance expected of registered nurses in their practice, against which actual performance can be measured. Standards are intended to be dynamic enough to define competent practice across all practice settings and domains. They serve as a framework for professional development and continuous quality improvement.

www.nanb.nb.ca/downloads/NANB Standards of Practice 2012_E.pdf

Publications are available on NANB's website www.nanb.nb.ca under Publications and Resources.

We Asked, *You Answered*

New Revised NANB Standards of Practice for Registered Nurses

ONE WOULD THINK an invitation to review standards of practice would not be answered with much enthusiasm considering that standards can appear somewhat dry and distant from your practice—but answer you did! NANB would like to thank the more than 168 RNs who took the time to read, compare and critique the document which will sustain nursing practice for the next five years.

Standards are actually dynamic statements describing who registered nurses are as professionals. Standards tell our colleagues, our clients, and the public what we do. They not only describe our fundamental legal responsibilities, but also identify our leadership roles and ethical and societal obligations.

Standards Tell Part of Our Story

To help create the full story, it is important to understand how various

standards fit into the plot. The NANB *Standards of Practice for Registered Nurses* form the basis for the entire storyline. These Standards describe the expectations for all RNs in all domains and settings. Although too many to list, story characters include: accountability, scope of practice, continuing competency, advocacy, and leadership. As you know, every story needs a setting. Many groups have developed or adopted standards to describe their unique area of practice in areas such as community health, critical care, emergency, and gerontology. Furthermore, there are some NANB standards that are part of the setting in almost all stories, such as medication administration and documentation. Stories also need a script. Agency standards or best practices, often articulated as employer policies, along with unit level standards or procedures, form the script. They articulate how you perform or carry out a responsibility. Finally, the story needs a climax—the pivotal point of the story. In standards language, this would be the care plan or client specific expectations, the assessments, interventions, and evaluations carried out at the point of care.

To ensure that standards stand the test of time, they are updated approximately every five years. A working group consisting of counterparts from other Canadian nursing jurisdictions helped in drafting the story and you, the registered nurses of New Brunswick, have added life to the final version of the Standards. Thank you.

You can access the revised *Standards of Practice for Registered Nurses* at NANB's website (www.nanb.nb.ca/downloads/NANB Standards of Practice 2012_E.pdf).

Ask a
PRACTICE
CONSULTANT

By VIRGIL GUITARD

YOU'VE ASKED

what are the implications for Registered Nurses (RN) in relation to the use of Social Media tools?

The Canadian Nurses Association (CNA) defines the term social media as "a group of Internet-based applications and technologies that allow users to have the same kind of real-time conversation that they might have with friends or neighbours with virtual friends from around the globe. Social media technologies allow users to interact and collaborate with each other online in the creation and sharing of information, ideas and opinion" (CNA, 2012). The Nurses Association of New Brunswick (NANB) does not regulate the use of social media; it does however regulate the practice of registered nurses (RNs) within an environment where social media is ever present.

The following information has been compiled in response to inquiries from registered nurses.

Why is the use of social media an issue?

RNs are legally, professionally and ethically required to maintain a high level of confidentiality, which makes maintaining the separation of one's personal and professional life essential.

Social media has brought about the possibility of blurring our professional and personal worlds giving rise to potential risks to privacy, confidentiality, reputation, intellectual property and public trust of and confidence in of the nursing profession. When we combine the use of technology with social connections, the line between what we think of as "private" and "public" becomes blurred. Being mindful about your use of social media and understanding the division between your personal freedoms and your professional obligations is a great place to start. You should also check with your employer to make yourself aware of their policies regarding social media use. It is important to remember that your conversations on social networking sites are not actually private—despite privacy settings—and are easily accessible to others. This means that the utmost caution must be taken with your online conversations/posts to ensure that you do not violate your professional boundaries. A breach of patient privacy and confidentiality could have implications with your employer and the NANB. RNs are held to a high standard of confidentiality with respect to client information. To understand the limits of appropriate use of social media, it is important for RNs to understand the concepts of confidentiality and privacy in the health care context and use NANB's standards and the Code of Ethics as a guiding framework when making decisions about their use of social media.

What constitutes inappropriate use?

To manage/decrease your professional and personal risks, NANB recommends RNs adhere to the following when using social media tools:

- always follow/ abide by employer policies concerning personal and professional social media tools;
- always protect personal identity;
- always maintain privacy and confidentiality of clients and co-worker's information and immediately report any breach to your employer;
- build personal social media competence; know the technology and have the skills and judgment to use it appropriately and ethically;
- always maintain professional nurse-client professional boundaries and avoid engaging in personal social media relationships with clients;
- refrain from posting any client information or image(s) unless it is related to employer expectation for client care;
- never post unprofessional or negative comments about clients, co-workers or employers;
- do not use social media sites to vent or discuss work and refrain from commenting on posts of this nature made by others;
- always maintain a professional manner in postings, photos and/or videos;
- never speak on behalf of a health care organization unless authorized to do so;
- promptly report any identified breach of confidentiality or privacy;
- always keep work-related social media activities separate from personal social media activities;
- create strong passwords and change

them frequently. Do not share passwords with others; and

- avoid offering health-related advice in response to posted comments or questions; if relied upon, such advice could trigger professional liability (CNPS, 2010) and/or a complaint to the NANB.

Could disparaging and negative comments made concerning colleagues on social media sites be considered bullying?

Most definitely. Individuals who make negative comments about a colleague on social media sites may feel there is no harm being done, especially if they think the person in question is not actually able to view the information. Once content is posted online it is easily shared with others and even content that has been deleted is still accessible. Negative comments can be detrimental to the creation of a cohesive health care delivery team and this could result in risks to patient safety.

It is possible that negative online comments may be considered intimidating and bullying, a form of lateral violence. This is often referred to as "cyber bullying". This type of behavior is cause for concern for both employers and nursing regulators and may result in sanctions against the RN.

I'm sometimes invited to be 'friends' with previous patients—and even their family members—when they're no longer in my care. I don't want to offend anybody by denying their request, but I also don't want to do anything that would be considered 'inappropriate'. Can you clarify what I should do?

It is not uncommon for RNs to be invited to join a former or existing client on a social media site.

The Canadian Nurses Protective Society (CNPS) cautions registered nurses to respect and enforce professional boundaries and not to communicate with clients through social networking sites as it may extend the scope of professional responsibility (www.cnps.ca/index.php?page=147).

It is understandable that you may be sensitive about offending someone by denying their *friending* request on social media sites such as Facebook and if you feel as though declining the request could be hurtful to your client, and damaging to the therapeutic relationship, you should have a discussion with the client to indicate why this relationship could be considered inappropriate.

Refraining from engaging with past and present clients on social media is one step towards ensuring that you do not blur personal and professional lines. The Canadian Nurses Association developed in February 2012 an Ethics in Practice document that also offers information to RNs in relation to "friending" clients using social media tools and your professional association—NANB—has recently published guidelines for the ethical and responsible use of social media available on NANB's website at www.nanb.nb.ca/index.php/publications/practice.

For more information on the use of social media in relation to nursing practice, contact NANB to speak with a Practice Consultant at 1-800-442-4417 or by email at nanb@nanb.nb.ca.

NANB offers a pamphlet on the dos and dont's of the use of social media technologies to further support nursing practice. Please download your copy on NANB's website www.nanb.nb.ca.

REFERENCE

Canadian Nurses Association (2012). Ethics in Practice. *When Private Becomes Public: The Ethical Challenges and Opportunities of Social Media*. Ottawa: Author. www2.cna-aiic.ca/CNA/documents/pdf/publications/Ethics_in_Practice_Feb_2012_e.pdf

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Acknowledgements

The Nurses Association of New Brunswick gratefully acknowledges permission granted by the College of Registered Nurses of Nova Scotia to quote and adapt, in whole, or in part, from the publications cited.

JANUARY 23–26, 2013

CNSA-National Conference—*Cultivating Passion, Motivating Action*

- Halifax, NS
- » www.cnsa.ca/english/conferences/national

JAN.31–FEB.2, 2013

The Lung Association: Better Breathing Conference

- Toronto, ON
- » www.on.lung.ca/page.aspx?pid=757

FEBRUARY 10–12, 2013

5th National CANN Conference—*Nursing is our Passion, Knowledge is our Power - Let's Share It!*

- Montreal, QC
- » www.neonatalcann.ca/SitePages/EventDetails.aspx?itmID=16

FEBRUARY 20–21, 2013

NANB BoD Meeting

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

FEBRUARY 21–23, 2013

WNRCASN 2013 Conference—*Education for Leadership: Imagining the Possibilities*

- Edmonton, AB
- » www.nursing.ualberta.ca/WNRCASN2013

JUNE 28–30, 2013

Stanton Hospital Reunion

- Yellowknife, NT
- » www.stantonyk25.com

Addiction & Mental Health Quiz

Continued from page 26

and environmental stressors such as experiences of severe child abuse, war, torture, poverty, loss, isolation, neglect or abandonment. It can occur in combination with substance abuse (www.ontario.cmha.ca/fact_sheets.asp?cID=2795).

9. FALSE: Created by the Department of Health, the goal of the youth engagement initiative is to promote positive mental health in all youth and reduce risk factors associated with problematic substance use, bullying, crime and violence.

10. TRUE: Patients are referred from the Community Mental Health Centres when all regional resources have been exhausted in addressing psychiatric diagnoses and treatment recommendations (www.gnb.ca/0055/capu-e.asp).

11. TRUE: A parcel of land has been selected and architectural planning and design are underway for the new Addiction Services Centre in Edmundston. The centre will provide prevention services; residential withdrawal management (detoxification); and counselling services for individuals and families struggling with substance abuse and gambling issues (News Release 2012-09-24).

12. TRUE: There are 14 Community Mental Health Centres located in New Brunswick.

13. TRUE: Primary health care refers to an approach to health and an array of services that go beyond traditional health care to include all services that play a part in health such as: income, housing, education, and environment. Primary care is part of primary health care and focuses on health care services like health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury (Health Canada) www.hc-sc.gc.ca/hcs-sss/prim/index-eng.php.

14. FALSE: Problem gambling relates to the loss of control over one's behaviour; it is not defined by the number of times a person gambles (www.gnb.ca/0378/addiction-e.asp). ■

fáilte a chur roimh добро пожаловать dialu-alukan vitajte welcome akeyi bienvenu välkommen bem-vindo में आपका स्वागत है

Supporting International Applicants

Meet NANB's Regulatory Consultant, Jocelyne Lessard

Part of NANB's regulatory role is to ensure internationally educated nurses (IENs) are supported in their application for registration with NANB. As a Regulatory Consultant, what are your responsibilities?

In my position as a Regulatory Consultant, my primary responsibility is the assessment of applications for registration from internationally educated nurses (IENs). Once received, I review the application to ensure all the required documents are included before continuing the registration process. I respond to all inquiries in a timely manner and am available by phone, email or in person in order to facilitate the process.

From your experience, what attracts IENs to New Brunswick?

Established family and friends are typically the best recruiters to New Brunswick. IENs learn from a trusted source the lifestyle and opportunities available to them and their families. The Government of New Brunswick's Population Growth Secretariat has also been actively recruiting professionals to our province through the New Brunswick Provincial Nominee Program facilitating immigration for qualified applicants who meet specific economic and labour market needs in New Brunswick. As the only officially bilingual province in Canada, New Brunswick's language diversity provides opportunities for IENs to work in their preferred language.

What process does the IEN go through to become registered with NANB?

IENs must first submit an application for registration with proof of language proficiency and provide all the necessary documents to support that they have completed an approved nursing education program in another country. Once the application is complete, an assessment is made to determine if the applicant's nursing education is equivalent to that of a New Brunswick entry-level registered nurse. In some instances, the IEN may be required to undergo a competence assessment to identify any gaps in their nursing education. If gaps in knowledge and competencies are identified the IEN will be required to complete a bridging program to fill the identified gaps before being eligible to write the registration examination.

On average, what would be a typical time-frame for an IEN to become registered in New Brunswick?

Time-frames vary. If all the documents are received and meet the necessary requirements for registration then processing an application can be completed in just a few days. Lengthier application processes can be attributed to retrieving the necessary information from other countries, immigration related issues, and completing required assessment and bridging courses.

How has NANB evolved to more efficiently process IENs application requests?

Through funding received from Health Canada, NANB has partnered with the Registered Professional Development Centre (RNPDC) in Halifax, Nova Scotia to deliver a Competence Assessment and Bridging Program in both official languages. Being able to complete a competency based assessment provides access to bridging courses which means that the IEN has access to a comprehensive menu of services to support them in achieving registration and authorization to practice as a registered nurse in New Brunswick.

The Health Canada funding has also enabled NANB to enhance and develop pre-arrival information and web-based tools on our website to assist the IEN through the registration process.

What advice would you give IENs interested in becoming registered in New Brunswick?

To avoid unnecessary frustrations, IENs should go to the NANB website prior to arrival in Canada to access the information that is available to them. Also ensuring that they have a good understanding of the immigration requirements in Canada will alleviate potential frustration.

SUSPENSION CONTINUED

On September 6, 2012, the NANB Review Committee found Luc Pitre, registration number 027306, to be suffering from an ailment or condition rendering him unfit and unsafe to practise nursing when the ailment or condition is not adequately treated and controlled, and that the member demonstrated professional misconduct and a lack of judgement and professional ethics. The Committee also found that the member demonstrated a disregard for the welfare of and safety of patients by continuing to practise while incapacitated by his ailment or condition.

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

REINSTATEMENT OF REGISTRATION

In a decision dated September 21, 2012, the NANB Review Committee granted reinstatement of the registration of Marie Jocelyne Gisèle Richard LeBlanc (former name Richard), registration number 019026. The Review Committee further ordered that conditions be imposed on the member's registration.

REGISTRATION SUSPENDED

On October 25, 2012, the NANB Complaints Committee suspended the registration of registrant number 027907 pending the outcome of a hearing before the Discipline Committee.

CONDITIONS LIFTED

The conditions imposed on the registration of registrant number 021584, have been fulfilled and are hereby lifted effective October 31, 2012. ■

Hours & Dates

NANB Office Hours:
Monday to Friday 08:30 to 16:30

We Will be Closed:

- December 24, 25 & 26
  Christmas Holidays
- January 1
  New Year's Day

Dates to Remember:

- December 31
  Registration Renewal Deadline
- January 31
  Deadline for NANB Election Nominations
- January 31
  Deadline for NANB Awards Nominations
- February 20–21
  NANB Board of Director's Meeting

Celebrate Excellence

NANB AWARDS 2013

Nominate a colleague, friend or health care advocate who strives to improve health care delivery and promote health public awareness every day. The Nurses Association of New Brunswick (NANB) proudly acknowledges the contributions made by current and former members of the profession and will honour these individuals at this year's Annual General Meeting and Awards Banquet hosted on May 29th, 2013.

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

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

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

AWARDS OF MERIT—the awards of merit recognize nurses from each of the four key areas of nursing who have made a unique contribution to the nursing profession and who demonstrate excellence in nursing practice. Awards of Merit: *Nursing Practice*, *Administration*, *Education* and *Research*.

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

HEALTHY PUBLIC POLICY AWARD—NANB's healthy public policy award recognizes individuals or groups who foster a greater public understanding of the New Brunswick health care system. The objective of this award is to promote the advocacy role of individuals and groups in our health care system.

The deadline for submission of nominations for all NANB awards is January 31, 2013.

For more information about eligibility, criteria, guidelines for submission and procedure for selection, or for a nomination form, visit Awards at www.nanb.nb.ca.

165 Regent Street, Fredericton, NB E3B 7B4
phone: 506-458-8731, toll-free: 1-800-442-4417
fax: 506-459-2838, email: nanb@nanb.nb.ca
or through your local Chapter President

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Saturday, 9 a.m. to 4 p.m.

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