ACCESS
Association of Registered Nurses of Newfoundland and Labrador

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“Be the change” – Advocating for a better system.

As nurses, we understand that patients’ and nurses’ welfare are closely aligned. Firstly, RNs are essential to the smooth functioning of the health care system. We also know a shortage of nurses will impact the system’s ability to provide quality services. If it goes unchecked, services will have to be reduced and the public’s wait time for health care services will increase. Secondly, there is research demonstrating the obvious, when RNs are required to work excessive overtime, the likelihood of errors increases. Thus the shortage, if left unchecked, will not only impact the quality of care but jeopardize the safety of nursing care.

Every day, as I work as both a nurse and as President of the ARNNL, I look around and try to think of what to say to inspire people as we work during these trying times. I feel my best advice to you all is to continue acting as advocates for you patients and for the profession. Nursing has long been associated with advocacy. In Canada the nurse acts as both a patient advocate, working to ensure patients receive the highest quality of care, and a system advocate, working to ensure our health care system is protected and maintained as a universal, publicly funded system. Our desire to deliver the best care possible drives our advocacy and is at the basis of our practice, our professionalism and our many calls for improvement in the health care system.

Now, as we face these challenging times, acting as our own best advocates is more important than ever. We must, all of us, act as leaders in our areas and speak out as patient and system advocates if we are to effect change.

As nurses, we are highly educated professionals who are dedicated to the provision of quality care. Our profession is rewarding and respected. It is easy to see the high regard in which nursing is held on a local, provincial, national and international level. I have seen this in our own environmental scans of the public, in the interaction we have at the national level through the CNA and from the recognition sent to the CNA from other nursing associations, such as the Ethiopia Nursing Association, for the work done by the CNA in the promotion and support of the development of nursing within their country.

It is in our position as respected professionals that we can truly bring forward the voice of change in our healthcare system. I know time is in very short supply and that it might seem easier to retreat rather than to work on our issues, but I believe that the vast majority of nurses are dedicated to patient care and improving the quality of health care for the people we serve. We are here to make things better for the people who need us and, while it may be a difficult, I believe that if we work together, we can and we will make the changes needed and in the end the system will be the better for it. As Registered Nurses, we have an important role to play in bringing issues related to, and affecting the delivery of, quality health care to the attention of our employers, our public and our political representatives. It is important that we act as advocates so our voices can be heard at all of these levels so we can improve health care delivery. The CNA’s Vision for Change challenges us to move forward with these ideas. I believe is our time to be the change.

On a closing note, in November I had the privilege of attending the CNA Centennial Award Presentation to 100 nurses from across Canada. The Centennial Awards are a one-time award created to celebrate 100 exceptional registered nurses whose personal and professional contributions have made an outstanding and significant impact on the nursing profession, it was an opportunity to hear their stories and share our pride in the profession. I would like to take a final moment to congratulate these wonderful nurses and offer them, and their work, as a source of inspiration for each and every one of us as we face the challenges within our profession.

Until next time….

James W. Feltham
Practicing nursing during a shortage is not easy. Members in all roles - direct care givers, educators and managers - report they are experiencing increased workloads, and having to cope with difficult scheduling issues, including working excessive overtime. The breakdown in contract negotiations, NLNU’s job action and pending strike vote all add to uncertainty and stress in members’ current work environments. ARNNL is concerned that these workplace issues are jeopardizing the smooth functioning of the health care system and ultimately will impact the delivery of patient, resident and client care. We know adequate RN staff is essential for producing good patient outcomes. We know high quality workplaces are a key strategy in addressing the shortage. So what is ARNNL doing about the situation?

ARNNL is working with the Department of Health and Community Services and other stakeholders on the completion of a nursing human resource plan and the development of a comprehensive, integrated workforce action plan for all health professionals. These plans are essential and will provide the vision and direction needed to address the shortage of nurses and other health professionals over the long term in an evolving health care system. The nursing human resource plan advocates strategies such as, targeted retention initiatives for experienced nurses, continued increases in nursing education seats, innovative recruitment approaches for ‘home grown’ and internationally educated nurses, etc.

In October, ARNNL and the College of Licensed Practical Nurses (CLPNNL) met with the Minister of Health and Community Services, Honorable Ross Wiseman, and Chief Nursing Officer, Anita Ludlow, to position our Quality Professional Practice Environment (QppE) program as a powerful strategy to help improve nurses working conditions in the province. We know the QPPE Program improves both the quality of nurses’ work life and the quality of client care and, therefore, will help to attract and retain nurses. ARNNL cannot meet the demand for the QPPE program and is, therefore, seeking financial support to be able to increase the number of participating workplaces/units at all four regional health authorities.

ARNNL is in touch with NLNU President, Debbie Forward, and is on record as supporting the need for a competitive compensation and benefits package which we believe is essential to attract nurses to our province, to repatriate Newfoundland and Labrador educated nurses and to retain our current nursing workforce. While increases in government and employer bursaries and bonuses are having the desired effect in the retention of our newly graduated nurses, it is equally important to have a salary and benefits package that ensures this positive trend is maintained over time. ARNNL is working with the NLNU on the development of guidelines to assist nurses to meet professional and legal obligations when working understaffed. Chronic understaffing and continued overtime are two issues that have professional, labour and regulatory implications and, in which, nurses often experience ethical dilemmas. The guidelines will help nurses meet their professional and legal responsibilities to provide care in such situations.

ARNNL also met with Minister Wiseman in December to discuss the future of health care in our province. We discussed the nursing shortage and our concern that it is just beginning and without resolve will jeopardize the public’s timely access to health care. We acknowledged government’s promising recruitment strategies while pointing to the evidence supporting serious problems in nurses’ working conditions (for example, high rates of absenteeism, increased violence in the workplace). We also reiterated our belief in the benefit and success of our Quality Professional Practice Environment program (QPPPE). In our QPPE program, ARNNL has articulated the ideals of a good work place and professional practice environment. We believe nurses, health care organizations and the public will all benefit from moving in this direction.

At ARNNL, we recognize that most members are experiencing the realities of practicing with a shortage of nurses and other health team members on a regular basis. You know your professional values. You know what is needed to provide safe and quality care in your workplace. While these times are challenging, it is important that all of us participate in finding the right solutions to workplace issues. The shortage of nurses is not going away soon. It requires a continued, coordinated approach from multiple levels - the individual, employer, union, association and government - in order to improve the quality of work life in our health care system and ultimately, the quality of patient, resident and client care.
JUGGLING OVERTIME AND FATIGUE
SHARED PROFESSIONAL RESPONSIBILITIES

BY LYNN POWER RN, MN, ARNNL NURSING
CONSULTANT-PRACTICE

Research indicates that nurses are required to work overtime (OT) on a regular basis. In fact, in 2005, the amount of OT Canadian RNs worked equated to approximately 10,000 full time positions (CFNU, 2008). Data and experience also show that excess OT can lead to fatigue and other undesired client, nurse and system outcomes (NSWHN, 2006). The following information is provided to assist RNs as they make personal and professional decisions on how to juggle their ethical and professional duty to care and provide the best care that circumstances permit (Code of Ethics - CNA, 2008), while maintaining a standard of personal health and safety such that the ability to practice is not compromised (Standard 1.6 - ARNNL, 2007).

Am I Covered?
There are no professional restrictions on the number of consecutive hours a nurse may work. Contrary to a common myth you are still “covered” (have liability protection) on your 4th shift or 15th hour. Liability protection is not linked to a schedule; it is available 24/7. There are, however, contractual obligations related to rest periods between shifts and clauses whereby shifts can be altered or extended that you may want to consider (NL, Labor Relations Act, 1990: NLNU Contract, 2002-2004).

Am I Accountable?
Accountability cannot be reneged or assigned to another person. Whether you work overtime by choice, or because you are required to, does not change your professional responsibilities. Proclaiming that the “agency is responsible if anything happens” is not plausible. At all times, an RN is accountable and responsible for his/her own actions (Standard 1.5). However, it is important to note that the ‘agency’ is held to the same standard and higher. Nurses in administration are required to promote and initiate measures to create practice environments that support professional accountability and personal health and safety (Standard 1.16-1.18). Accountability is thus automatically shared.

Am I Safe?
As a professional you are expected to evaluate your level of personal fatigue, assess the situation reflecting upon client safety and determine your own limitations. Evidence has shown that fatigue can impair judgment and reaction time, which can jeopardize client care. Rogers et. al. (2004) found that nurses who regularly work overtime self-report a 30% error rate. They concluded the likelihood of making an error was significantly linked to longer working hours. At times though, you and your manager may determine that a “tired” nurse is better then no nurse. In this situation, be sure to work within your defined limits, prioritize what must be done versus what is usually done, delegate and assign tasks and roles accordingly and communicate with management on a regular basis.

Can I Refuse?
This answer requires a careful analysis of whether a duty of care has been established. If you are already at work and refuse to work overtime thus leaving your clients unattended, you can be called to account for your actions. This practice is commonly referred to as abandonment. The concept of abandonment is not applicable if there is no established duty of care i.e. you are on your “day off”. Refusing to come back to work because of physical, mental or emotional fatigue is then a professional option.

If you are mandated to work overtime and honestly feel that you are not “fit” to practice, you need to take measures to prevent putting you or your clients in danger. Discuss your concerns with your manager and determine the maximum period of time you can work (e.g. till midnight). In the interim, work to the best of your ability, as required update your manager on your “fitness” status and leave only when appropriate action has been taken to replace you (CRNBC, 2008). If this becomes common practice, communicate your concerns in writing in accordance with the Professional Duty to Address Unsafe and Unethical Situations (ARNNL, 2007).

Employer Roles
Employers have an obligation to assist nurses to meet their standards of practice. These administrative responsibilities include: assessing and monitoring each situation, seeking alternative options, adjusting assignments to reflect priority client needs and/or reducing workload e.g. limiting admissions (AARN, 2001). When overtime is unavoidable, employers should consider relevant strategies to mitigate the risks of fatigue. This may include juggling overtime through split shifts, providing access to nutritious food and showers, allowing extra break time or “nap” periods and/or maximizing the use of support staff (CRNM, 2004).

References supplied upon request
RN RESPONSIBILITIES DURING JOB ACTION

BY LYNN POWER, RN, MN, ARNNL NURSING CONSULTANT-PRACTICE

Job action by nurses is ultimately for the purpose of securing conditions of employment that enable safe and ethical care of current and future clients. Unfortunately, such action could hinder the quality of care in the short term, therefore, nurses need to be cognizant of and participate in workplace discussions and planning to address client safety, both before and during job action (CNA, 2008, p 50).

To help facilitate understanding of these dual accountabilities, I have highlighted the relevant responsibility statements outlined in the Code of Ethics for Registered Nurses (CNA, 2008) and the Standards for Nursing Practice (ARNNL, 2007). It is worthy to note that nursing ethics and standards apply to all nurses, and therefore apply to RNs in administrative/policy roles. Although individuals and groups of nurses participating in, or affected by, job action, share the same commitment to assure the safety of persons in their care, their particular responsibilities may lead them to express this commitment in different but equally appropriate ways. ARNNL encourages RNs and employers to explore the implications of job action on the safety and quality of client care together.

Responsibility Statements

- Each nurse is accountable for their own actions and decisions at all times in all circumstances, including during a legal or an illegal strike (ARNNL Standard 1.5).
- Each nurse is expected to maintain a professional image that enhances public confidence and reflects positively on the profession (ARNNL Standard 1.7).
- Each nurse is expected to keep persons in their care, families and employers informed about potential and actual changes to the delivery of care (CNA Code A 6).
- Each nurse is expected to provide the best services circumstances permit, setting priorities and communicating decisions with clients and relevant others (ARNNL Standard 4.7).
- Each nurse is expected, when resources are not available to provide ideal care, to collaborate with others to adjust priorities and minimize harm (CNA Code A 6).
- Each nurse must support persons whose safety requires ongoing or emergency nursing care to have those needs satisfied throughout any job action (CNA Code appendix D).
- Each nurse is expected to act as an advocate to protect clients from harm due to unsafe situations and or incompetent or unethical care (Standard 4.11).
- Each nurse is expected to report concerns about their ability to maintain practice and ethical standards or their ability to ensure the safety of persons in their care, they are responsible for communicating this concern in accordance with identified lines of accountability so that corrective action can be taken as quickly as possible (CNA Code appendix D).

The decision to take job action is never made lightly and the resulting implications are never easy. The Standards and Code can help guide and balance these dual responsibilities in a professional and ethical manner. If you would like further information both documents are available on www.arnnl.ca
ISSUES IN RN REGULATION AND LICENSURE: INTERNATIONALY EDUCATED NURSES (IENS)

BY MICHELLE OSMOND, RN, MS, ARNNL DIRECTOR OF REGULATORY SERVICES

Many nations worldwide are experiencing a shortage of health professionals, including nurses (ICN, 2006). Canada is no exception. The current nursing shortage in Canada is well documented and expected to intensify over the next 10–20 years (CNA, 2002). This reality has increased government and employer interest in recruitment of internationally educated nurses (IENS) as a possible option to address the nursing shortage.

Historically, IENS have comprised only a small percentage of Newfoundland and Labrador’s provincial workforce. In the 2007/2008 licensure year approximately 1.6% (or 97) of practicing members were internationally educated. This is below the national average of 7.4% as reported in the Canadian Institute for Health Information 2005 Workforce Trend Report (CIHI, 2005). The low percentage in the province is consistent with the national distribution of IENS as reported by CIHI in the 2005 workforce report.

Although the number of practicing IENS in NL is small, IENS continue to express interest in practicing in the province. ARNNL staff receives regular requests for registration information from RNs who trained abroad. On average, ARNNL forwards 95 information packages annually to IENS who express an interest in obtaining registration in Newfoundland and Labrador. In 2007/2008, ARNNL received 41 new IEN applications. In comparison, the College and Association of Registered Nurses of Alberta currently reports receiving 200 IEN applications per month (CARNA, 2008). Other jurisdictions such as British Columbia, Ontario and Saskatchewan are also reporting significant increases in IEN applications.

The increase in IEN applications to nursing regulatory bodies in larger Canadian jurisdictions can be attributed to various factors. Globally, the nursing workforce has become more mobile (CNA 2005) and more IENS are seeking registration and employment opportunities in Canada. In addition, IENS traditionally have selected large communities as preferred destinations when seeking to enter the Canadian nursing workforce (CIHI, 2005). Relocation to large centers provides the IEN greater opportunity to access social networks with similar cultural and ethnic backgrounds. More recently, active recruitment of IENS by employers, and government related initiatives to address the nursing shortage, has also contributed to a direct increase in IEN applications in larger jurisdictions.

The increased volume of IEN applications presents various challenges to nursing regulatory bodies such as providing internal staff resources, timely review of applications and ensuring the process of assessment to determine eligibility for licensure is fair, transparent and accessible. Jurisdictional counterparts are also experiencing increased external pressure to streamline the process of determining eligibility of IENS for RN licensure so that IENS are available to the workplace sooner. However, nursing regulatory bodies’ primary mandate is public protection in the provision of nursing services through licensure of qualified competent practitioners. With this in mind, nursing regulators are working collaboratively with employers and government to facilitate IENS licensure while upholding their responsibilities to public safety. Governments in BC, AB and SK have committed funding to assist processes to address administrative and other issues related to IENS (i.e., expansion of education/bridging and remedial programs for IENS, fast-track assessment service, extended orientation, etc.); employers in these jurisdictions are also developing processes that will support IENS’ success in the workplace such as mentoring and transitional programs (BC Ministry of Health, 2007; Hamilton, 2008, Alberta Government, 2007; Lindberg, 2008).

Although ARNNL is not experiencing a large volume of IEN applications at this time, there has been an increase in the number of requests for information related to IENS. Several employers have contacted the Association to obtain information to help them as they consider IEN recruitment as a possible strategy to address the nursing shortage.

The increased focus on IENS nationally is providing ARNNL an opportunity to be informed on key issues. ARNNL is proactively preparing should recruitment efforts of IENS to Newfoundland and Labrador expand. ARNNL staff has already participated in initiatives that are informing current and future decisions related to IENS. Some of these initiatives include:

1) Completion of a background paper to inform ARNNL Council on emerging issues related to IENS.
2) Submission of a letter to support a proposal to establish a National Assessment Center for IENS.
3) Consultation with key stakeholders to discuss potential partnerships in the development of an IEN regional assessment service.
4) Participation in a national working group to develop recommendations related to IEN language fluency requirements.
5) Examination of best practices in IEN registration to inform ARNNL future policies.
6) Confirmation of ARNNL’s participation in a working group of the Department of Health and Community Services (DHCS) that will address recruitment of IENS.

ARNNL is committed to its mandate of public protection and will continue to actively participate in efforts to develop and support best practices related to registration and licensure of IENS. The Association will continue to monitor emerging developments related to IENS so that we can provide consultation to employers and governments, as well as prepare to respond if increased numbers of IENS seek registration in the province.

References available on request
Healthcare reforms in the late 90’s resulted in the loss of more than 380 management positions; almost half of these were nurse managers. While we have seen some increases in recent years, the number of nurse managers has yet to return to the level of the late 90’s. This loss of management positions, combined with position changes as a result of recent system restructuring, means increased responsibility, workload and stress for those who remain in the system. It also means that managers are experiencing many of the same worklife issues as staff nurses. The ARNNL (2008) Survey of Nurses in Management Positions provides nurse managers with an opportunity to give us feedback on the roles and responsibilities of management positions. From this we can gain insight into the quality of worklife of nurses in management positions.

Workload for nurses in management positions can be determined by their span of control, amount of overtime and requirements for travel. One measure of span of control is the number of employees who report directly to you. In the ARNNL Management Survey, greater than 80 percent of managers reported that they have staff reporting directly to them. The total number of direct reports ranged from 1 to 215. These staff members can include RNs, LPNs, Allied Health and other types of employees as well as employees in another building or location. Fewer than 30 direct reports is considered to be reasonable. More than half of nurse managers reported that they have greater than 30 staff reporting to them. The fact that so many managers have large spans of control implies that they are experiencing leadership and workload challenges. For example, management duties such as dealing with shortage/staffing issues, employee performance evaluation, mentoring and providing guidance become extremely challenging when you have a large span of control. The situation is further complicated by responsibility for employees that are in other locations.

The majority of managers also reported that they are required to travel for their position. More than half travel at least once every two weeks and most travel 100 kilometers or more per month; about one-third travel 500 or more kilometers per month. The extent of travel most likely contributes to workload and stress levels. As one manager put it, “…managing a unit in two communities 90kms apart is not reasonable. How can the poor person do justice to that? They are in a car 2 hours a day!”. The time associated with travel also takes away from work hours and personal time.

An obvious indicator of workload is overtime. Very few managers (less than 10 percent) reported that they do not work overtime; most work an average of 5 or more overtime hours per week. This equates to at least one hour of unpaid overtime every workday. Approximately one-in-five managers work more than 10 hours of overtime per week. Working two or more hours of overtime every day on an ongoing basis has serious implications for work life balance. This could be viewed by unionized staff as a barrier to moving into a management position, particularly if they have family responsibilities.

The results of our survey suggest that nurse managers are being asked to deal with excessive workload demands. You may be wondering why we are focusing on management workload in this article when staff nurses are experiencing challenges that directly impact their ability to provide quality patient care. Nurse managers, while not directly involved in patient care, contribute to that care by influencing the work environment, supporting professional development, mentoring staff and ensuring staff nurses have the resources, including human resources, necessary for quality patient care. Research has shown that workplace environments and availability of resources influence patient outcomes and are important factors in job satisfaction, turnover and retention of staff nurses. Good nursing leadership is one of the indicators of a quality workplace – one in which staff nurses will want to work. The bottom line is we need adequate numbers of nurse managers in order to ensure delivery of quality health care.

Although it is not discussed much in the mainstream media, our nursing shortage applies to nurses in management positions as well. The reported RN vacancies in the province include a small number of nurse manager positions. Although the number is small, remember that it does not account for the positions that were eliminated during restructuring. And with impending retirements, we are likely to see the number of management
vacancies grow. Compared to the provincial nursing workforce, nurse managers are older than the general nursing population. This makes sense as nurses moving into management positions tend to be older, more experienced nurses. However, it also means that this group is facing significant staffing reductions due to impending retirements. Approximately 4 percent of managers responding to our survey indicated that they plan to retire in less than 1 year and a little more than one-third reported that they plan to retire in 1-4 years. This means that almost 40 percent of nurses currently working in management positions will retire in less than 5 years. More than half of those who plan to retire in the next 5 years have been in management for 15 or more years. This will be a significant loss of experienced leaders within a short period of time.

Perhaps of even greater concern than the number expected to retire, is that less than 20 percent of managers reported that their organization would have no difficulty replacing them with a qualified individual. They identified stress levels, workload, compensation level, lack of supports and lack of preparation and willingness on the part of direct care nurses to move into management positions as recruitment barriers.

Also of concern is that 60 percent of managers report that their organization’s efforts to provide leadership development for future nurse leaders is ineffective. Survey results indicate that new managers would benefit from training in conflict management, HR issues, evidence based practice, scope of practice and budgeting. Practical skills such as report writing and program planning, skills to manage workload, time and stress, as well as interpersonal skills such as complaints management are areas in which new managers need preparation in order to be able to cope with the expectations and responsibilities of management positions. Several managers stressed the need for a comprehensive orientation program for new managers and continued support through mentorship from experienced managers.

In spite of significant challenges, most managers remain positive about their position. They have opportunities to be innovative, and gain satisfaction from their ability to guide and enact changes that improve patient care, enhance the role of nurses, create quality work environments and shape the delivery of care in our province. In order to ensure a quality health care system, steps must be taken to avoid ‘burning out’ our current nurse managers so that they are willing and able to continue working. Quality of worklife issues must be addressed in order to improve the lot of managers in the system and make management positions attractive to staff nurses. Serious consideration should be given to re-examining management roles with large spans of control and workload demands that require excessive amounts of overtime and travel in order to meet the responsibilities of the position. It is also clear that we are facing a shortage of nurse managers and in order to stem the tide of management retirements, we are going to need staff nurses who are willing and prepared to move into management positions. Our results suggest that succession planning combined with orientation and mentorship for new managers are vital to future management recruitment and retention efforts.

For more information on the ARNNL (2008) Survey of Nurses in Management Positions, please see our website.
ARNNL CONTINUING COMPETENCE PROGRAM UPDATE
BY COLLEEN KELLY, RN, MN, ARNNL NURSING CONSULTANT-EDUCATION

The ARNNL Staff Advisory Committee on Continuing Competence is well underway and working towards its mandate of developing a mandatory continuing competence program (CCP) for RNs and NPs. Committee members and their representation follow:

Joanne Baird (NL Nurses’ Union/acute care)
Dorothy Bragg (nurse practitioner, rural/remote)
Cathy Burke (NL Health Boards Association)
Maureen Doody (staff education and development)
Marcy (Greene) Feder (nurse practitioner/educator)
Sharon Fitzgerald (continuing nursing education)
Patricia Grainger (nursing research)
Fatima Hewitt (nursing management)
Lisa Hoddinott (quality initiatives)
Heather Hunt-Smith (long-term care/advanced practice)
Rhonda McDonald (community nursing)
Anne Rowsell (staff education and development)
Colleen Kelly/Beverly McIsaac ARNNL Staff Support

The target date for implementation of the ARNNL CCP is the 2010-2011 licensure year. At present, the Committee is developing a CCP framework for presentation to Council during its February 2009 meeting. Member consultation feedback has been very helpful in the development of the CCP framework. A summary of the consultation results follow.

CONSULTATION RESULTS: AN OVERVIEW OF THE FINDINGS
BY JANET MURPHY GOODRIDGE, RN, MN, IBCLC, ARNNL CCP PROJECT CONSULTANT

A consultation process was initiated in January 2008 with the release of the document, Continuing Competence Programs for RNs and NPs: Consultation Paper. From January 2008 to May 2008, open consultation sessions were held throughout the province. The purpose of the sessions was to seek input into the development of a meaningful CCP. Specifically, members were asked about the approaches that would most effectively assist RNs and NPs in providing safe, competent and ethical care, and meet their professional commitment to lifelong learning. An overview of the consultation findings is presented here followed by recommendations for proceeding with a CCP.

A total of 592 nurses (10.1% of the ARNNL practicing membership) participated in the consultation process. The majority of respondents (75%) indicated that it was “very important” for ARNNL to develop a CCP. Respondents revealed a variety of reasons for why a CCP is important. There was widespread acknowledgement that the health care system is changing and becoming increasingly complex. Therefore, nurses must be prepared with up-to-date, relevant knowledge and skills to provide safe, quality care. Respondents noted that the public expect ARNNL, as the regulatory body for the profession, to develop a CCP.

RNs and NPs in this province currently engage in a wide and varied array of activities to maintain competence. Many respondents noted that they are committed to lifelong learning and professional development, and they are investing in this already. Attendance at in-service education/workshops/conferences was the most common approach mentioned, followed by reading nursing journals, searching the Internet (e.g., NurseONE) and completing certification in specialty areas. When asked about the preferred approaches to continuing competence, the majority (66%) of respondents in all positions chose mandatory continuing education (MCE). Greater than 50% chose self-assessment, performance appraisal and certification/recertification. NPs overwhelmingly support MCE hours (83%). Self-assessment, peer feedback, professional portfolios and practice reviews were all equally mentioned. Respondents identified limitations with all of the preferred approaches. A combination of formal, structured education programs and informal, self-directed approaches were recommended. There was considerable support for recognition of specialty nursing certification within a CCP. Mandatory testing was the most frequently mentioned approach that members would like to see excluded. Participants reported barriers within the current work environment that create significant challenges for nurses in accessing continuing education and professional development opportunities. Most importantly, the practice environment needs to be more positive and encouraging of ongoing learning.

In summary, nurses want a model of continuing competence that ensures flexibility, choice of approaches, and application to a variety of practice settings. Nurses want a program that is effective in enhancing their competence and improving client outcomes. The program must be meaningful to nurses in all practice settings. Communication and collaboration with stakeholders is needed every step of the way.

A detailed report of the consultation results is found at: www.arnnl.ca

1 Bold print identifies nurses in direct nursing care positions
By Linda Norman-Robbins, RN, MSC(A), Chair of the Consortium’s Administrative Council, on behalf of the Provinces Three School’s of Nursing and their Joint Program Evaluation Committee (Colleen Anderson, RN, MN; Andrea Brennan-Hunter, RN, MN; and Velma Jacobs, RN, MN, with Joanne Smith-Young, RN, BN, Research Coordinator)

By now the news, about the ARNNL granting seven-year approval to the BN (Collaborative) Program and the Canadian Association of Schools of Nursing awarding seven-year accreditation to the BN (Collaborative) Program and its partner schools/academic units: Memorial University School of Nursing, the Centre for Nursing Studies, and Western Regional School of Nursing, may seem like old news. However, we at the School’s of Nursing are all very proud of having achieved these awards – the highest levels achievable provincially and nationally. This is the second time these awards have been granted: first in 2001 and now again in 2008. Our success would not be possible without the support of the hundreds of nurses across the province that share in our efforts to graduate some of the country’s best practitioners! On behalf of our students, staff, faculty and patients I wish to extend a sincere thank you to all of you.

You may be interested to learn that evaluation of the BN (Collaborative) Program occurs much more frequently than required by the regulating and accrediting bodies. In fact all graduates are surveyed one year following graduation and all employers are asked to evaluate our graduates every three years. The latest two surveys, The Graduate Survey of the Graduates of 2006 and The Employer Survey of the Graduates for 2004, 2005, and 2006 were completed during the summer of 2007.

Forty-eight employers completed and returned a questionnaire. Of these, forty were from agencies located in NL. The majority of employers expected, and felt, that graduates were able to carry full responsibility in their nursing assignments in six months or less. In comparison to previous surveys, expectations related to length of graduate transition time have increased and more closely match the time graduates report that they need to “feel comfortable” in their transition to the workplace. Employers, in this survey, report that more time was allotted for graduate workplace orientation than was noted in the 2001 and 2004 surveys.

The majority of employers were satisfied with our graduates. Although employer and graduate perspectives differ on graduate abilities, there was agreement on areas of strength and areas where graduates were less well prepared.

Eighty of 198 graduates completed the survey: 69 from the regular stream and 11 from the fast track option. Key findings were as follows:

70% of the respondents were employed in NL usually in acute care units. Most (76.2%) were employed in permanent positions.

41.7% held positions requiring that they float to two or more units (50% employed in NL; 21.7% employed outside NL).

Most reported feeling comfortable in their positions in six months or less.

All reported receiving some unit specific orientation; one third of the group reported orientations of two weeks or less. Fifty-six (70%) reported having a preceptor, mentor or co-signed nurse as part of their orientation, most commonly for 3-5 weeks.

Graduates listed workplace and educational program factors that most helped or hindered role transition.

By far, clinical experiences, in particular preceptorship and the total number of clinical hours in the program were listed as the most helpful factors.

“Not enough clinical” was reported by 27 (34%) of the graduates as hindering their adjustment to practice after graduation. The period of time between acute care experience as a student and graduation was also reported to be a hindering factor.

In relation to workplace factors that had an impact on graduates’ transition to their role as a RN, supportive staff, a through orientation, and assignment to a preceptor, mentor or co-signed nurse during the initial period of employment, were strongly reported to be helpful. Conversely, unit atmosphere, non-supportive staff, insufficient orientation and high workload pace were reported to hinder graduates’ adjustments.

Graduates’ ratings in relation to 29 program preparation items revealed that the items with the highest mean scores were: preparation to practice within ethical, legal and professional standards, practice nursing from a caring perspective and effectively document client care.

Comments about the program and graduates’ transition in the first year after graduation documented some of the challenges and complexities of the world of nursing today and reiterated the call for a clinically rich curriculum with solid theory courses that provide clinically applicable skills, effective orientation programs and work environments supportive of the graduates integration into their units and their roles.
Patti Glover

Patti graduated from the Grace General Hospital in 1991. While many of her friends and colleagues left the province to pursue their nursing career, Patti chose to return to her hometown of Labrador City where she has worked since in a combination of casual, full time and part time positions. She quickly became a skilled obstetrical nurse and has been invaluable in her positions at the Captain William Jackman Memorial Hospital in both practice and as a mentor and role model for many of her peers. Her leadership skills at both the clinical and team levels stand out in any discussions about Patti.

Her leadership skills were most evident in her contributions to the QPPE program. Patti, and the members of the working group (named the MINERS Team: Measures Improving Nursing Environments, Respect & Safety) knew right from the onset that they wanted to make a difference. With Patti’s quietly enthusiastic and positive approach, they focused on issues of respect, team work, quality patient care, professional development and coping with change. She consistently challenged and supported group members to “be creative, to think outside the box” and always led by example.

Speaking to ARNNL from Labrador, Patti says she was motivated to take on this role by her strong belief that the QPPE program could be a way to make some positive changes on her unit. The unit was going through a period of low morale at that time and she felt this was a way to improve matters.

She also elaborates on how QPPE has made a difference in her work place, particularly in how staff relates to and supports each other. According to Patti, one of the MINERS biggest accomplishments was the introduction of a modified total patient care model of care delivery. Patti was a major supporter of this move, saying ‘the new model is so much better and has greatly improved the coordination and quality of patient care and increased staff satisfaction in their professional roles.’

Commenting on how QPPE has impacted her professional growth, Patti says that, as a result of these experiences, she feels better prepared and more confident in her ability to step up to the plate and take on leadership responsibilities. She admits that despite always wanting to be a leader, she has hesitated and often lacked confidence to do so in the past. She now feels her Team Leader role has contributed to her personal and professional growth and development. She calls herself a change agent and works each and every day to motivate others to maintain a positive attitude towards change.

Patti also speaks enthusiastically of the role of nurse mentors in today’s nursing world. In her opinion nurses develop a level of comfort and confidence through the mentorship experience. She says: “it’s our responsibility and part of our job as professionals to mentor new nurses.”

When asked what she would say to her nurse peers who are thinking of taking on leadership roles, Patti says she would strongly encourage them to “just do it!” And while she acknowledges that change takes time and is hard work, she readily believes it is well worth the effort when you hang in there. “The system is not perfect,” she says. “It’s always changing and is a work in progress – but, as I learned from the QPPE program, simple changes make a big difference.”

While Patti might dispute that she had done anything out of the ordinary, she is a shining example of how a nurse can positively influence her work place and nurse peers by getting involved and being a leader. Patti is indeed, a worthy “Nurse of Note” in our province.

If you would like to nominate an RN you know for our Nurse of Note, please contact Janice Lockyer via e-mail at jlockyer@arnnl.ca
PAYMENT

Payroll Deduction
Members who have been paying into your employers’ payroll deduction program are required to submit the renewal form to your employer. Your employer will set a deadline to receive your completed form and any fees owed. If you have not had the total fee (367.00) deducted from your pay, you must pay the balance to the employer, not ARNNL. Each employer sets a deadline for RNs to submit their applications. Members who do not submit your application to the employer by this deadline may experience difficulty in getting your licence issued on time.

As soon as you receive your form, check it, sign it, and pass it to the designated person at the agency. DO NOT SEND TO ARNNL.

Visa/MasterCard/ Cheque
You can pay your renewal fee by Mastercard / Visa or cheque. This service is available when renewing in person or by mail. Remember your licence will not be issued until the date of the cheque or the date you wish the transaction posted to your credit card.

Interac® Direct Payment (Debit CARD)
This service is available only for those members who renew in-person at ARNNL House. Cash payment is also accepted.

ARNNL Drop Box
You may drop off your completed renewal form with the payment at ARNNL office. Use the locked drop box by the front door any time up to 1630 on March 31, 2009.

MAIL
If you are mailing the renewal form, ARNNL must receive it by March 31. It is not acceptable that you have mailed it by March 31, 2009. Ensure you give the mail system plenty of time for the form to reach ARNNL House.

* No FAX Service *
ARNNL will not be accepting membership renewal applications by fax. The reason for this is that the quality of the form received is often poor and illegible requiring ARNNL staff to make contact with the member for clarification of information. Given the volume of renewal activity in February and March this is not possible.

Faxing your application will result in a delay of your registration and you may incur late and penalty fees as a result.

2009 registration Fees
Practicing membership 367.00
Non-practicing membership 24.60

Outstanding Fees owing to ARNNL
Members who have outstanding fees owing to ARNNL will not be able to renew their 2009/2010 membership until outstanding fees are paid.
BN (COLLABORATIVE)
OCTOBER 2008 GRADUATES

FAST TRACK

Sarah ALLEN
Newcumberland, NS
La Scie, NL
Gander, NL
Corner Brook, NL
London, ON
Charlottetown, PEI
Melrose, NL
St. John's, NL
Winnipeg, MB
Halifax, NS
Labrador City, NL

Chad LUNDRIGAN
Chapel Arm, NL
Red Bay, NL
St. John's, NL
Lerar
Halifax, NS
Kept Creeks, NS

Stephanie MOORES
Sonja MULLER-SIMPSON
Usha NANDURI
Rebecca NICHOLSON
Christopher NOLAN
Jeremy PEDEL
Joanne RIDEOUT
Amanda ROLFE

Terra BATH
Sarah COLE
Sacha CRAIG
Nicole DONOVAN
Elizabeth GRAHAM
Kimberley HILLIER
Catherine HOWATT
Erin LAIDLEY

Nicole CHRISTOPHER
Newcumberland, NS
La Scie, NL
Gander, NL
Corner Brook, NL
London, ON
Charlottetown, PEI
Melrose, NL
St. John's, NL
Winnipeg, MB
Halifax, NS
Labrador City, NL

BN (COLLABORATIVE)
Black Duck Cove, NL
York Harbour, NL
Lethbridge, AB
Lamaline, NL
Benoit's Cove, NL
Bay de Verde, NL

Retired Nurses Tea

THE ARNNL WAS PLEASED TO ONCE AGAIN HOST THE RETIRED NURSES TEA ON WEDNESDAY, DECEMBER 3RD, 2008. SOME EIGHTY-SIX RETIRED NURSES ATTENDED THE TEA HELD AT ARNNL HOUSE.
**WEB TIP**

Want to know more about sexual health? We recommend you visit: [www.sexualityandu.ca](http://www.sexualityandu.ca)

The Provincial Woman’s Wellness Committee

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**Children and Cough Syrup**

Health Canada warns that there is limited data on the effectiveness of over-the-counter cough and cold medicines in children under the age of 12. Further there are reports of misuse, overdose and very rare adverse events related to their use in this age group. The US FDA and US based manufacturers of cough and cold medicines have voluntarily relabelled all products to indicate they should not be used in children under 4. Consequently Health Canada is evaluating the situation. For more information see [www.hc-sc.gc.ca/ahc-asc/media/advisories-avis/_2007/2007_147-eng.php](http://www.hc-sc.gc.ca/ahc-asc/media/advisories-avis/_2007/2007_147-eng.php)

Health Canada, November 2008

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**SAFETY TIP: Energy Drinks**

Excessive drinking of “energy drinks” or mixing them with alcohol can have serious health effects. These drinks contain caffeine, taurine (an amino acid, one of the building blocks of protein) and glucuronolactone, a carbohydrate. Reported adverse symptoms included:

- Electrolyte disturbances
- Nausea and vomiting
- Heart irregularities

Currently, only Red Bull Energy drink is authorized for sale as a natural health product and bears a natural health product number. The safety of other “energy drinks” has not been evaluated under the Natural Health Product Regulations.

Health Canada Alert submitted by Sheila Domeniaux, RN, Nurse Manager, VON St. John’s

---

**Bunny Boots**

The Prevalon™ Heel Protector Boots from Sage is a great way to minimize pressure, friction and shear on the feet, heels and ankles of patients in bed. This device delivers total, continuous heel pressure relief by elevating the foot and separating the heel from the mattress. It can also help reduce the risk of foot drop. There is no hard plastic to interfere with comfort yet the outer surface is made of a covering that repels liquids and makes it easy to wipe down. There is even a foam wedge that can be ordered to prevent lateral rotation of the foot and leg. For more information go to [www.sageproducts.com](http://www.sageproducts.com)

Pat Rodgers RN, B.Voc Ed CNCC(c), Clinical Educator, General Hospital - Eastern Health

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**Be Careful What You Sign**

Co-signing refers to a second or confirming signature on a witnessed event or activity. Nurses are accountable for their own actions and do not routinely need someone to check their work. However, there are some examples where co-signing is prudent practice such as recording a critical incident witnessed by a second care provider, verbal consent or telephone orders, verification of a medication dosage or discard, and/or accurate client identification for a blood transfusion. Co-signing implies shared accountability. It is imperative that the person co-signing actually witness the event, and not simply rely on someone else’s word that the event took place.

The ARNNL Documentation Strategy Committee
Central Health has committed to providing human as well as financial resources to support the changes required to move PHC forward. Under the leadership of a regional VP for Community Health/PHC, there are two PHC Consultants whose role is to both support and guide the processes of PHC within existing areas, as well as work with new sites. Each health service area is under the leadership of a Director of Health Services whose role is to ensure that the principles of PHC are adhered to. In order to support work that is required at the local level, PHC facilitators have been developed to support health care professionals working within the system, as well as work with communities. The development of these critical masses at the regional and local levels will help ensure future sustainability of this model.

Community involvement and participation is integral to the successful implementation of a PHC Model for service delivery. One mechanism used by Central Health to ensure meaningful community involvement is the establishment and support of a Community Advisory Committee (CAC) in each PHC site. Each CAC is comprised of a maximum of 15 members who come from diverse backgrounds and who are broadly informed and involved in their community.

The involvement of CACs ensures the voice of the community is brought into the decision-making processes, thus ensuring that programs and services are based on the needs of the community served. CACs act as both conduits and sounding boards for community input, participating in community consultations, forums, health fairs, etc. This provides them with an opportunity to not only hear from community members, but to also provide information about PHC to the public.

A highlight for CACs took place in October 2008, when Central Health hosted its first regional CAC Day where CAC members from all four CACs, PHC Providers, the Board of Trustees and senior staff all came together to learn, network and to showcase some of the work that is being done through the CACs. Central Health reinforced its commitment to CACs by sharing their overall vision for “healthy people and healthy communities”. The guest speaker, Bev Kirby, Community Education Network Associate, talked to the group about ways to ensure ongoing broad community engagement in the process. Without a doubt, at the end of the day, everyone agreed that this should be an annual event.

As Central Health continues to move forward with its commitment to CACs it will be important to build in a strong evaluation processes that will help us learn as we go. This will allow us to further understand how CACs make a difference to the work that we do and the people we serve and how we can continue to improve the process. In the meantime, community involvement is alive and well in Central and communities are growing together.
Nurses are expected to not only be an advocate for their patient’s physical needs but also to support their spiritual, emotional, and cultural well being as well. In this regard, nurses need to recognize, and promote, the patient’s rights to be informed about the source of a given product, should it conflict with their beliefs. If a patient unknowingly takes a product, such as an animal or porcine derived medicine, it may cause undue spiritual burden or guilt. In many cases, once informed, individuals may choose to have a medication despite its source and their convictions if it is deemed necessary in relation to the severity of an illness (Mynors, Ghalamakari, Beaumont, Powell & McGee, 2004).

To properly address this issue in our multicultural patient environment, nurses must educate themselves on their patient’s religious and cultural needs, as well as the sources of a huge number of medications that are prescribed. For example, the nurse should be aware that Muslim, Jewish and the Christian Seventh-day Adventist groups are especially vulnerable as the ingestion of pig derived products is forbidden by religious law. This issue may also be problematic for the largely vegetarian groups of Buddhism, Hinduism and Sikhism, or for people who are vegetarians by choice who do not have a religious aspect dictating their abstinence to animal products. Nurses need to understand their patient’s convictions, educate them regarding their prescribed medications, advocate for them regarding informed choices or for alternative medications should they exist and respect their choices. The importance of this is paramount as full patient partnership in treatment is known to lead to better health outcomes (Mynors et al., 2004).

Many drugs from animal sources now have synthetic alternatives that can be offered, but to do this the nurse must educate him or herself on the options available. A few examples of porcine derived drugs follow:

- **Insulin:** Though originally all insulin was of animal origin, there is now only a very small proportion of insulin in use that is of pure porcine or bovine origin. The great majority of insulins are now referred to as ‘human insulins’. These can be made in one of two ways. Recombinant DNA technology can ‘program’ yeast or bacteria with the human insulin gene to produce human identical insulin. These insulins are identified by the suffixes ‘ge’, ‘crb’, ‘prb’, ‘pyr’ and are usually acceptable. Another method of concern to those opposed to porcine origin drugs uses enzymatically modified porcine insulin which once modified is classified as ‘human insulin’. This process takes porcine insulin and transforms it to resemble human insulin. These modified porcine insulins are referred to as semi-synthetic insulin and carry the suffix ‘emp’. This distinction should be made clear to the diabetic patient facing these issues, as it is of porcine origin (Mynors et al., 2004).

- **Heparin and low molecular weight heparins such as Lovenox:** Heparin is derived from bovine lung and porcine intestinal mucosal lining, low molecular weight heparins are derived solely from porcine intestinal mucosal lining (Mynors et al., 2004). There is a new synthetic anticoagulant, antithrombotic that is available in Canada, and is indicated for the prevention and treatment of DVT and PE after orthopedic surgery. It is called fondaparinux, or Arixtra. It contains no porcine products and so should be acceptable. Fondaparinux has been proven more effective than enoxaparin in the prevention of venous thromboembolism complications after orthopaedic surgery by numerous studies, one study finding that it decreased the risk of VTE-effects by at least 55% over that of enoxaparin (Bjorvatn, 2005).

- **Pancreatin:** This drug or by any of its numerous trade names is another drug of solely porcine origin. It has no non-porcine alternative, so caring, compassionate education is called for. A patient may require time, if possible, to consult with religious leaders.

A nurse’s duty of care to the patient is far larger than simply the physical sphere. We must be aware of the religious/cultural implications in health care and support our patients to meet all their needs.

References available on request
Goings on...Goings on...

NURSES FOR MEDICARE
The Canadian Nurses Association (CAN) and the Canadian Federation of Nurses Unions have launched Nurses for Medicare, a grassroots initiative to engage nurses in advocating for the sustainability of the Canadian health system. Their goal is to promote publically funded, not-for-profit health care in Canada. For more information please visit www.nursesformedicare.ca

CONGRATULATIONS
Congratulations to Marilyn Butcher and Roberta Heale on having their article ‘Beyond Nursing’ in the November/December edition of Best Health magazine. ‘Beyond Nursing’ discusses the first NP-led Clinic to open in Canada in Sudbury, Ontario. Butcher and Heale are both from Newfoundland and Labrador. The Best Health magazine is part of the Reader's Digest family and has a national distribution. For more information visit: www.besthealthmag.ca

SCHOLARSHIPS
The TD Bank Financial Group and the Canadian Nurses Foundation (CNF) recently announced a new $100,000 fund for Aboriginal students studying nursing. The TD Aboriginal Nursing Fund will support Aboriginal nurses at the Bachelor, Master's, PhD and Nurse Practitioner levels. The fund will also provide research awards for Aboriginal students and research teams who are conducting studies with the goal of improving health outcomes for Aboriginal Canadians.

More details about the fund will be available in January 2009 on the CNF website: www.cnf-flic.ca or you can call 1.800.361.8404 ext. 242.

ARE YOU A MENTAL HEALTH NURSE?
ARE YOU INTERESTED IN PROFESSIONAL DEVELOPMENT?
WOULD YOU LIKE TO TALK TO OTHER MENTAL HEALTH NURSES?
PSIGNAL wants you as a member.
To find out how to get involved contact:
Karen Whitehorne Karen.Whitehorne@easternhealth.ca

SERVICE CANADA CELEBRATES
National Nursing Week 2008

From front to back, left to right: Front row: Jennifer Mugford, Carolyn Hynes, Madeline Wilson, Colleen Kieley, Rhonda Bridger 2nd row: Tammy Pennell, Denise Feaver, Sarah Cahill, Kim Spurrell, Kyla Connors 3rd Row: Susan Harris, Joy Bishop, Elaine Beckton, Mary Johnson, Doris Robinson Back row: Susan Manning, Jackie Bishop, Carolyn Coady, Michelle Pieroway Missing from photo: Cheryl Belbin, Cindy Butler, Connie Davis, Marie Griffin, Mona Patford, Nancy Summers, and Laura Stanford-Martin

NATIONAL NURSING WEEK May 11-17, 2009
It's time to start planning!
If you have a great idea for NNW, or an event that you would like us to know about, e-mail the details to jlockyer@arnnl.ca

CONFERENCES AND WORKSHOPS

The 15th National Conference on Gerontological Nursing is Alberta bound! The theme for the conference is ‘Making Moments Matter’. It will be held May 27 – 30, 2009 at the Banff Centre in Banff, Alberta.

The Healing Touch Association of Canada will hold its 2009 National Conference & Canadian Instructors Meeting from April 24-26, at The Fairmont Newfoundland Hotel, St. John’s, NL. For more information email Maxine Gladney at ht.conference2009@hotmail.com or phone 1-709-364-6919

The 2009 CNA Nursing Leadership Conference “Leaders in Action: Mobilizing Nursing Leadership” will be held from Feb 8-10 2009 at the Sheraton Centre Hotel in Toronto. To register, and get up to date information, visit www.cna-aiic.ca
MARGE LOVELL AWARD WINNER

ARNNL is pleased to congratulate Joan Bursey, divisional manager of the Vascular Surgery Program in Newfoundland & Labrador, on receiving the 2007 Marge Lovell Award from the Canadian Chapter Society for Vascular Nursing (CCSVN).

CONGRATULATIONS

Congratulations are extended to Marilyn Beaton and Jeanette Walsh who have been awarded a Hannah Development Grant of $7700 grant from Associated Medical Services, Inc. (AMS) to complete data analysis of their most recent research project about the history of nursing of Newfoundland and Labrador titled ‘Overseas recruitment: Experiences of nurses immigrating to Newfoundland and Labrador’.

Associated Medical Services Inc. (AMS) was established in 1936 by Dr. Jason Hannah as a pioneer prepaid non-for-profit health care organization in Ontario. With the advent of Medicare AMS became a charitable organization supporting innovations in academic medicine and health services, specifically the history of medicine and health care, as well as innovations in health professional education and bioethics.

CONGRATULATIONS

We congratulate Kathy Stevens and Lori Robbins whose poster was acknowledged by esteemed nurse theorist Patricia Benner in her keynote speech at the ‘Creating Jazz: Transforming Exchanges in Education and Practice’ Conference held in Kansas City in October 2008. Out of over 75 posters at the conference, Kathy and Lori’s was the only poster she referred. In her address, Benner said how impressed she was with the work Kathy and Lori had done and that all nurse educators should be inspired by such work.

REUNION

The General Hospital School of Nursing Class of 1989 will be holding their 20th Reunion Celebration at the Mayan Riviera in Mexico. For more information contact Kim Pinsent pinki489@yahoo.ca, Carolyn Hynes carolyn.hynes@servicecanada.gc.ca, Paula Gidge pigidge@nl.rogers.com, Lisa Freake lisadaely11@yahoo.com

THE POTTLER AWARD

This award was established in memory of the late Dr. Clarence Pottle, a psychiatrist in Newfoundland and Labrador and former director of mental health services. Ms. Sharron Barnes, a long serving CMHA board member and volunteer with CMHA at the national and provincial levels is this year’s recipient of the Pottle Award in recognition of her outstanding contribution to CMHA-NL and mental health in general.

Left to Right: Sharon Barnes (Department of Health and Community Services) receives the Pottle Award for Mental Health Volunteer Service from Nadia Power (CMHA-NL Board of Directors)

A COLLECTION OF ORAL HISTORIES FROM NEWFOUNDLAND NURSES PRACTICING DURING THE 1920S & 1930S.

“Sometimes the doctor would come, but other times the doctor would ring and say, ‘If the baby is coming, you go ahead and let me know.’ I was never taught how to do deliveries. I just watched what they were doing and learned on the job.”

Alma Moores

“Telling their tales”

Jeanette Walsh ~ Marilyn Marsh

Marilyn Beaton

“Sometimes the doctor would come, but other times the doctor would ring and say, ‘If the baby is coming, you go ahead and let me know.’ I was never taught how to do deliveries. I just watched what they were doing and learned on the job.”

– Alma Moores

“A collection of oral histories from Newfoundland nurses practicing during the 1920s & 1930s.”

– Marcella French

July 6680 · 800 563 3333

www.breakwaterbooks.com

Available through the publisher and at all fine bookstores.
RE-DESIGNED ARNNL WEBSITE TO LAUNCH IN JANUARY 2009

Keep your eyes open for the new ARNNL website, due to launch this month. The site has been redesigned to be more user friendly, providing you with the information you need, when you need it. We will also be using the new web address www.arnnl.ca from this point on, so be sure to adjust your bookmarks. There will be opportunities to offer feedback and win some prizes in the process.

So be sure to visit often and let us know what you think of our new site!

WELCOME

ARNNL is pleased to welcome BEVERLEY MCISAAC RN, NP, MN (ANP) in the position of NURSING CONSULTANT, REGULATORY SERVICES.

Beverly graduated with her RN diploma from Western Memorial Regional Hospital School of Nursing in 1979 and subsequently completed her NP-PHC program at the Centre for Nursing Studies (1998), a BScN from St Francis Xavier University (2002), and a MN - Advanced Nursing Practice from Athabasca University (2005).

Beverly has worked as a staff nurse in various roles and locations throughout the province and has, for the past 10 years, worked in advanced nursing practice as a primary health care nurse practitioner and educator. Most recently, Beverly served as an NP Educator with the BN Nurse Practitioner Primary Health Care Program at Memorial University.

Beverly brings a vast array of knowledge and experience to the ARNNL and we welcome her insight and understanding of the nursing profession.

ARNNL E-MAILS TO CHANGE FROM @ARNNL.NF.CA TO @ARNNL.CA

We’re changing our email address! From now on, you’ll be able to reach us at personname@arnnl.ca. Not to worry though, if you forget and send it to the old address, it will get through for the next 6 months. So, please keep in mind to change any ARNNL staff address you have in your contacts to arnnl.ca within the next 6 months.

FAREWELL

ARNNL wishes to announce that Elizabeth (Betty) Lundrigan, RN, MN has moved on from her role as Nursing Consultant Advanced Practice and Administration. Betty accomplished much in her 10 years with the ARNNL including, but certainly not limited to, the development and implementation of the Nurse Practitioner Competency Assessment Program, the development of the statement of competencies for Nurse Practitioners – Specialists and authored the joint ARNNL/NLNU report on Enhancing the Role of the Registered Nurse in Long Term Care.

We at the ARNNL would like to thank Betty for her immeasurable contribution to both the ARNNL and the nursing profession. Thank-you!

ARNNL AWARDS FOR EXCELLENCE IN NURSING

Nominate a RN for an Award for Excellence in Nursing.

Every year ARNNL presents awards for excellence to Registered Nurses who demonstrate excellence in nursing practice, administration, education, and/or research. We know there are many RNs who demonstrate professional excellence on a daily basis and are very deserving of an ARNNL Award for Excellence in Nursing. However, in order for ‘excellent’ nurses to be considered for this accolade they must be nominated. That’s where you come in…Take this opportunity to nominate a colleague for an award for excellence in:

• Nursing Practice
• Nursing Education
• Nursing Administration
• Nursing Research
• Elizabeth Summers Novice Nurse Award…or
• Nominate a Colleague in each category!

Visit our web site to learn more about the criteria and nomination process. We want to be inundated with nominations by the February 28th deadline!

Award for Excellence in Nursing nomination forms are attached and are available on www.arnnl.ca. (Awards for Excellence) or contact Jeanette Gosse at ARNNL House (753 6060; 1 800 563 3200).

ARNNL HONORARY MEMBERSHIP

Call for Nominations

Members are encouraged to nominate a Retired Nurse who has contributed to the advancement of nursing and/or the profession as a whole for honorary membership.

Criteria and nomination forms are available on www.arnnl.ca. Honorary membership deadline for receipt of nominations is Feb 28th, 2009.
IMPORTANT NOTICE TO REGISTERED NURSES WHO WORK IN NP-TYPE ROLES AND EMPLOYERS Regarding the ARNNL Nurse Practitioner Competency Assessment Program

The ARNNL Nurse Practitioner Competency Assessment Program (NPCAP) will be discontinued. With effect from July 1, 2009 the ARNNL will no longer be issuing initial NP registration and licensure to registered nurses based on the successful completion of the NPCAP. As of July 1, 2009 only RNs who have successfully completed a course of study approved by Council will be considered for initial registration as an NP.

Note: This will not affect the ongoing licensure status of any NPs who were assessed as eligible for registration and licensure using the NPCAP up to and including June 30, 2009.

Anyone who requires more information about the NPCAP or this notice should contact bmcisaac@arnnl.ca

CONTINUING COMPETENCY CHAMPIONS WANTED!

Continuing Competency Champions are nurses who are passionate about lifelong learning, improving nursing practice and patient care.

Champions influence colleagues, groups and committees.

If you would like to join ARNNLs Continuing Competency Champions, send me an email:

Bev McIsaac, Nursing Consultant bmcisaac@arnnl.ca
**PRONOUNCEMENT OF DEATH & CERTIFICATES OF DEATH**  
**A NURSE PRACTITIONER’S ROLE**  
BY SUEANN KEAN, BN, NP-PHC, MSc (c)

Nurse practitioners across the province may have different levels of understanding with respect to the pronouncement of death and the completion of death certificates. This article intends to clarify the role that nurse practitioners can play as stipulated in the provincial legislation.

There are three pieces of legislation in this province pertinent to the circumstances surrounding death: The Human Tissue Act, the Fatalities Investigation Act and the Vital Statistics Act. The following table explains the differences between the legislation and the legal role that nurse practitioners can play.

<table>
<thead>
<tr>
<th></th>
<th>HUMAN TISSUE ACT</th>
<th>FATALITIES INVESTIGATION ACT</th>
<th>VITAL STATISTIC ACT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Explanation</strong></td>
<td>This Act is the only piece of legislation that speaks to the pronunciation of death. The legislation limitedly speaks to deaths in which there will be an after death transplant. When the deceased will provide an after death transplant, the fact of death must be determined by at least 2 physicians. If there is no after death transplant, there are no legal restrictions on who can pronounce death.</td>
<td>This Act describes which deaths that require investigation. Such investigation is carried out by a medical examiner or an investigator appointed by the medical examiner. Examples of deaths that require an investigation are explained below.</td>
<td>All deaths in this province, whether or not they require investigation, have to be registered with vital statistics under this Act. This information needs to be given to the Registrar of Vital Statistics within 48 hours.</td>
</tr>
<tr>
<td><strong>Role of NP</strong></td>
<td>Nurse Practitioners can determine and pronounced death <strong>except</strong> when an after death transplant will take place.</td>
<td>Nurse Practitioners should be able to recognize which deaths require investigation and ensure that the medical examiner is promptly notified promptly.</td>
<td>If the nurse practitioner was the primary medical attendant when the person was pronounced dead the nurse practitioner is responsible for notifying the Registrar. The nurse practitioner can only sign the death certificate if the death is expected for example palliative care.</td>
</tr>
<tr>
<td><strong>Other important facts</strong></td>
<td>The pronouncing physician cannot participate in the transplant procedure. Regional Health Authorities can set their own policies regarding which health care professionals can pronounce death.</td>
<td>Deaths that occur in a healthcare facility are not defined in the Act. In this case, the person in charge of the facility is responsible for notifying the medical examiner or investigator.</td>
<td>If the medical attendant is not able to notify the Registrar, an undertaker or lastly the next of kin should notify the Registrar. If the death requires an investigation, the person doing the investigation is responsible for notifying the Registrar.</td>
</tr>
</tbody>
</table>
Deaths that Require an Investigation

- violence, accident or suicide
- unexpectedly when the person was in good health
- where the person was not under the care of a physician
- where the cause of death is undetermined
- as a result of improper or suspected negligent treatment

A death that occurs in a health care facility or other place where a person is receiving care or treatment should be reported by the person in charge of the facility if the cause of the death is:

- a result of violence, attempted suicide or accident
- a result of suspected misadventure, negligence or accident on the part of the staff
- undetermined
- during or following a pregnancy in circumstances that might reasonably be related to the pregnancy
- a stillbirth or neonatal death has occurred and is possibly related to maternal injury (includes prior to admission or during delivery)
- within 10 days of an operative procedure

The person in charge of the facility should also notify the medical examiner or designated investigator if a person is declared dead on arrival to the emergency department or dies in the emergency room as a result of the above circumstances.

Deaths that occur while a person is in:

- a jail or penitentiary, guard room, remand center, detention center, youth facility, lock-up and any other place that a person may be held in custody
- a treatment facility designated under the Mental Health Act
- custody under the Director of Child, Youth, and Family Services
- custody of a peace officer

— must be reported by the person in charge of the institution or the person who has custody.

If the cause of death is related to a person’s employment, occupation or former occupation, the person attending shall immediately notify a medical examiner or an investigator. This person may be a nurse practitioner.

In all of the above cases, death certificates should be completed by the medical examiner. The medical examiner may consent for a physician or nurse practitioner to complete the death certificate.

References available upon request
“With so many technical skills for nurses to attain and maintain, more complex patient care and faster patient turnover rates, nurses need access to the right information – quickly and easily. Almost everything they need to know is available through NurseONE.”

Rodolfo (Rody) Pike, RN RN
Clinical Educator, Cardiac/Critical Care, Eastern Health
St. John’s, Newfoundland

Be sure to visit the NurseONE booth at the 4th International Conference, Education for the Future of Nursing: Building Capacity through Innovation in Markham, Ontario, from October 29-30, 2008.

CALL FOR RESOLUTIONS TO THE ARNNL ANNUAL MEETING

Resolutions are an important way to raise issues for discussion by colleagues at the Annual Meeting and to call for action by elected ARNNL Council representatives.

Resolutions, which are consistent with ARNNL’s vision and jurisdiction, may be submitted by chapters, special interest groups, or individual ARNNL members.

The deadline for submission of resolutions to ARNNL House is March 22, 2009. Resolutions may be submitted by mail, fax or email.

FOR GUIDELINES ON SUBMISSION OF RESOLUTIONS, VISIT WWW.ARNNL.CA ‘EVENT SCHEDULE’ ANNUAL MEETING, OR CALL COLLEEN JONES AT ARNNL HOUSE 753-6041.

DEADLINE: MARCH 22, 2009

ADVANCED NOTICE: ARNNL AGM

JUNE 22-24, 2009
ANNUAL MEETING
ARTS & CULTURE CENTRE, CORNER BROOK

THEME
NURSING ADVOCACY: RNS MAKING THE DIFFERENCE

Keynote Speaker: Joy Richards RN PhD
Vice-president Collaborative Practice and Chief Nursing Executive, Baycrest Geriatric Health Care System

HEALTHCARE JOURNALS, DRUG HANDBOOKS, NURSING E-BOOKS, INTERACTIVE TRAINING MODULES, GUIDANCE WITH PROFESSIONAL DEVELOPMENT