In this issue: Free Professional Education Forum (p. 16) and Refocusing the Depth of RN Practice (p. 8)
In this issue ...

President’s Message ......................................................1
Executive Director’s Message .......................................2
College News ................................................................3
Council Highlights ........................................................6
Members’ Corner ..........................................................8
Ask a Practice Consultant ...........................................10
Cultivating Compassion in Nursing Practice ..............14
Professinal Development Opportunity .......................16
iN Practice ..................................................................19
In Memoriams .............................................................21
Professional Conduct Decisions ..................................22
Calendar of Events ......................................................24

Nursing in Focus is a publication of the College of Registered Nurses of Nova Scotia, published Spring and Fall. The Editor welcomes comments and suggestions from readers. Letters to the Editor are also welcome.

Members’ articles will be printed according to availability of space, and may be edited for length or content. Articles submitted should not exceed 1500 words, and electronic copies are required. Signed articles represent the views of their authors and do not necessarily reflect the College’s position or policies on a specific topic. Submission deadlines: February 15, August 15.

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Hooked on Our Future

At this time last year, I wrote in my message that during my two-year term as president I would like to see great strides made in registered nurses’ understanding of the significance of self-regulation and the relevance of the College. And just last week I heard comments from two registered nurses that made me think we have started to put one foot steadfastly in front of the other.

In the first situation, a registered nurse asked a group of other RNs what could be done to help make their standards of practice come alive — so that all nurses could see how critical they are in their day-to-day delivery of safe, quality care. Then another registered nurse remarked on the great work being done at the College and that more RNs should know about it.

For me, the most exciting aspect of these comments is that they reflect what we heard as we travelled around the province earlier this year and met with the more than 300 RNs who took part in the Real eNgagement initiative. Although this number represents only 3% of our total membership, everyone involved was 100% committed to talking honestly and constructively about what we, individually and collectively, need to do to shape the future of nursing in Nova Scotia. Among the many incredible messages from RNs, two stood out most powerfully for me: one from an RN who said she had been disengaged from the profession, but after attending a Real eNgagement session felt she needed to step up and show up in a manner that supports nursing in Nova Scotia; and another from an RN who said she never spoke up about changes affecting nurses in her community, but now felt empowered to speak up and participate in a manner that would bring nursing back to the forefront in Nova Scotia.

I am so pleased with the success of the Real eNgagement initiative … and very proud to report that two other nursing regulatory bodies in Canada are now looking into the possibility of doing similar projects in their provinces. Never one to rest on laurels though, my wish for the coming year is to at least double the number of RNs engaged in the next phase, Real Action. This is when the College, with the help of the Advisory Committee, will develop an action plan and begin to introduce specific strategies to re-ignite pride within the profession, help RNs lead with a solution-focused approach, and be decision makers in the healthcare system.

When I looked up the definition of ‘engagement’ I knew it could only be good to have more RNs engaged in this work. Just think what we could achieve as a profession if more RNs were “hooked, committed, interested and involved” in the work of the College, in self-regulation and in shaping the future of nursing in Nova Scotia. To learn about Real eNgagement, which had its beginnings in motions submitted by members at two of our annual general meetings, check out the latest report entitled Real eNgagement for Real Action (available at www.crnns.ca) — and stay tuned for other opportunities to be involved in 2014.

Engagement is also something that the College’s Council wants to work on, however, in this case the focus will be on what is referred to in governance policy as “ownership linkages”. Given that nursing is a self-regulating profession, our owners are the public, with a sub-set being the RNs and NPs in Nova Scotia.

After extensive and exciting discussions, Council established an ad hoc committee this past September to look at ways in which we could find out what the public and members need, want and expect from us — and how we could effectively relay to them the connection between quality nursing practice and self-regulation. These ownership linkages will be front and centre as we head into our strategic planning sessions in April 2014 — planning for the next three-year cycle, from 2015-2018.

At the CNA Board table, I have also been involved in discussions about member relationships at the national level. As a not-for-profit organization, CNA is governed by the Canada Not-for-profit Corporations Act (NFP Act) and must now comply with some new rules that have been introduced by the federal government for all not-for-profit organizations. As a result, the Association’s by-laws have undergone extensive review in the past year and changes are being proposed to its governance model, including the composition of its board of directors and membership classes. We will be doing further work on the model at our January Board meeting, in preparation for a vote at CNA’s annual general meeting in June 2014. Stay tuned for updates on CNA’s website and via College communications.

I know that there is still so much to do to get to our preferred future as a profession, however, as 2013 comes to an end, and I head into my last six months as President of the College, I feel very good about what has been accomplished and hope that more of you will be ‘hooked’ by the direction in which we are heading.

On behalf of everyone on Council, have a great holiday … and best wishes for a healthy and happy New Year!

Peter MacDougall, BScN, RN
President
The landscape of nursing regulation in Canada is changing in significant and exciting ways, and I am proud to say that Nova Scotia is always ‘at the table’ and involved in discussions and decisions focused on quality health care and regulatory excellence.

However, after reading an article in a recent issue of Grey Areas (No. 108, October 2013), a newsletter on legal issues affecting professional regulation, I found myself stepping back and looking at the state of nursing regulation from yet another perspective. In this synopsis of a presentation by Steven Lewis, a respected health policy consultant, the author recounts a number of challenges to the traditional approaches to professional regulation and five trends that Lewis believes are inevitable:

1. Entry-to-practice credentials will matter less and career-long competency will matter more.
2. Emphasis on core standards for practitioners, and even quality assurance, will have to give way to continuous quality improvements.
3. Regulators will be expected to anticipate more and react less.
4. Siloed and distinct regulation of individual professions will transition into integrated regulatory activities.
5. Culture of professional autonomy will almost certainly be replaced with a culture of collaborative and joint accountability.

Although these trends warrant discussion at all levels, thinking that they could someday be considered a benchmark of success I was curious to see if there was any alignment between them and the direction of the College and Canadian Council of RN Regulators (CCNR) – the national forum for RN regulators. My humble conclusion: We are ‘spot on’ and moving in a very positive and strategic direction.

Besides acknowledging that continuous quality improvement is at the core of everything we do, here are some examples of how I think these trends are already being reflected in the work of the College and CCNR.

In addition to announcing new entry-level competencies earlier this year, the College has done preparatory work to improve our Continuing Competence Program (CCP) - and Council recently approved several recommended changes to the program. Leading up to the launch of a new CCP in 2015, College staff will meet with both NSNU and NSGEU to talk about new components of the program and begin an extensive consultation process with members early next year. Competence throughout one’s nursing career, beyond entry-level, has also been identified as one of CCNR’s future priorities.

In terms of regulators being ‘expected to anticipate more and react less’, the College decided some time ago to strengthen the criteria for registration in Nova Scotia by moving to a computer-adaptive RN entry exam (NCLEX®) in 2015 and introducing jurisprudence exams this past September.

Among the resources to make a smooth transition to the NCLEX, the College hosted a workshop in October with the National Council of State Boards of Nursing to help nurse educators learn more about the development and use of the exam (e.g., item writing and exam administration). A total of 39 educators joined in-person or via a webinar from the schools of nursing at St. F.X., CBU, and Dalhousie (Halifax and Yarmouth).

Collectively, as members of CCNR, nursing regulators across the country are also anticipating what needs to be done to advance nursing regulation, and have set the following priorities for 2013-2014:

- transition to NCLEX
- analysis of NP practice across the country
- development of new NP examinations
- establishment of NP working group to address changes to the federal Controlled Drugs and Substances Act (CDSA).

The College is lead on two of these priorities - the NP practice analysis and NP exams. It is anticipated that the practice analysis, which will help develop consistent requirements for NP licensure across the country and form the basis for one or more entry-level exams for NPs, will be completed by March 2015 – with funding recently announced by the federal government. Until such time, the regulators are exploring alternatives to the current adult and pediatric NP exams.

The College has also made substantial contributions to the CDSA working group, including the development of a regulatory framework that has been, in many ways, leading the thinking at the national level about NPs’ practice in the prescribing of controlled drugs and substances.

As an aside, Nova Scotia is also ahead of the trend in terms of collaborative regulation. The Regulated Health Professions Network Act received Royal Assent earlier this year, and as Chair of the Network I am pleased to inform you that Bruce Holmes, a former public representative on the College’s Council, has been selected as the Network’s first executive director.

While we have much to be proud of as a profession in Nova Scotia, I know there is still work to be done to help RNs see the connection between excellence in nursing regulation, excellence in nursing practice and the challenges that many of you face in your quest to provide quality health care. Having hundreds of RNs taking part in College workshops over the past couple of years, and hundreds more involved in the Real eNgagement project, has made a huge difference. We are also now focusing attention on an exciting new trend - right-touch or relational regulation. You will hear more about this trend in the New Year, but in a nutshell it is about managing risk with the most reasonable level of regulation and finding ways other than regulation to promote good practice and high quality healthcare.

All in all, 2013 was a busy yet incredibly exciting year and as it comes to a close, on behalf of the College staff, I wish you all a happy and healthy holiday season … and best wishes for 2014!

Donna Denney, MN, RN
The College has recently revised the Entry-Level Competencies for RNs. Wondering why this is important to you? Here is what you need to know.

Entry-level competencies primarily serve the purpose of approving nursing education programs by describing the competencies entry-level registered nurses require to provide safe, competent, compassionate, and ethical nursing care. The competencies also inform the public and employers about what to expect from the practice of entry-level RNs in addition to helping guide curriculum development for nursing programs.

While entry-level competencies reflect the knowledge, skill and judgment required of entry-level RNs, every RN in Nova Scotia is held accountable to these competencies.

So now that you know why the entry-level competencies are essential to your practice as an RN, check out crnns.ca for more information.

Another Successful Renewal Season

Tasha Smith of Yarmouth, Nova Scotia is this year’s early bird winner of $565.80, the amount equivalent to the College’s 2014 licensure fee. Tasha renewed her licence by October 1st and was one of 4,492 applicants who took advantage of the College’s early registration.

Congratulations, Tashah!

To qualify for next year’s draw all you have to do is submit your application for licensure by October 1, 2014.
Stay connected with the College for the latest documents created to enhance your nursing practice.

New and Revised College Documents

- College By-Laws
- Entry-Level Competencies for Registered Nurses in Nova Scotia
- Guidelines to Assist Registered Nurses and Nurse Practitioners with the Personal Directives Act
- Personal Health Information Act: Questions & Answers for Registered Nurses
- Prescribing Methadone and Benzodiazepines on In-patient Withdrawal Management Units in Nova Scotia
- Profile of a Newly Graduated Registered Nurse
- Recommended and/or Publicly Funded Vaccines for Immunizations of Staff and Volunteers in Nova Scotia Health Agencies/Facilities
- The Role of Registered Nurses in Cosmetic Procedures: BOTOX and Dermal Fillers

Please stay tuned to crnns.ca for publications that matter to you.

The fourth annual Excellence in Preceptor Recognition and Appreciation luncheon was held this past spring in Dartmouth. The event, sponsored by the Registered Nurses Professional Development Centre, honored the outstanding contributions that preceptors provide to the health care system. The award recognizes outstanding staff nurses who demonstrate exceptional abilities as a preceptor to new nurses and who create a positive, encouraging and respectful learning environment. Preceptors are the first and best introduction to the team.

The preceptor role includes welcoming, introducing, and including new hires into the work team, and sometimes it means standing up for the preceptee and being a little protective.

We know that one preceptor acting in a welcoming way has the power to change the experience from negative to positive for a newly hired nurse. An entry-level nurse who is welcomed and supported will respond to others in the same way.

Congratulations to the 2013 award recipients!

Front row (L-R): Alana Woods (Yarmouth Regional Hospital), Linda Boudreau (Digby General Hospital), Janet MacCuspic (Victoria County Memorial Hospital), Lesley Austin-Smith (Valley Regional Hospital), Mary-Lou Chaulk (Valley Regional Hospital), Linda MacNeil (Aberdeen Hospital), Susan Hughes (Aberdeen Hospital)

Back row (L-R): Melissa Demone (South Shore Regional Hospital), Debbie Cotton (Gaysborough Antigonish Strait Health Authority), Joyce Dobbin (St. Martha’s Regional Hospital), Sheri Turnbull (Halifax Infirmary Hospital Site), Maureen MacEachern (Victoria General Hospital Site), Shelley Stewart (St. Martha’s Regional Hospital), Brittany Hadley (Victoria General Hospital Site)

Missing: Sonya Hudgins (IWK Health Centre), Charlotte Guyomard (IWK Health Centre), Alanna Ferguson (IWK Health Centre)

SUBMITTED BY PAT BELLEFONTAINE

The fourth annual Excellence in Preceptorship Award 4th Annual Excellence in Preceptorship Award
Council Election 2014

Nominate now ... and vote in 2014!
Deadline date: January 31, 2014

Would you like to help shape the future of nursing in Nova Scotia? Registered nurses throughout the province will soon have an opportunity to elect new members to the College’s governing Council.

In March 2014, every active-practising registered nurse in Nova Scotia who entered an email address on their 2014 licence application will receive one or more electronic ballots to vote for new (RN) Council members.

Before elections can take place, the Nominations Committee needs you to submit nominations* for the following Council positions:

- President-Elect (1)
- Councillor-at-Large (1)
- Annapolis District Councillor (1)
- Atlantic District Councillors (2)
- Western District Councillor (1)

*Please note that: a) candidates for Council positions must be nominated by at least two active-practising members of the College or by the Nominations Committee, and b) the electoral district in which a member is eligible to run as a candidate is determined by the mailing address entered on the member’s licence renewal form.

Visit crnns.ca to learn how you can nominate someone by January 31, 2014.

Remember ...

JANUARY 31, 2014
deadline for Council nominations

MARCH 2014
election ballots will be distributed

APRIL 11, 2014
voting will close for election of new Council members

MAY 13, 2014
election results will be announced at the AGM.

Election Scrutineers

Two scrutineers will be needed on Friday, April 11, 2014, to do the final tally of the electronic ballots. If you are interested, please contact the Executive Office at 491.9744, ext. 223 (1.800.565.9744) or sf@crnns.ca.

Deadline for election scrutineers is March 1, 2014.

You do not have to be a registered nurse to be a scrutineer. However, if you are, please note that you will not be able to be a candidate for office or for the Nominations Committee, and if otherwise eligible, not able to vote in an election for which you are appointed as a scrutineer.

2014 Council Meetings

February 11-12
April 8-9
May 13 (Annual General Meeting)
September 23-24
December 2-3
Ownership Linkage Plan
Council approved the creation an ad hoc Ownership Linkage Committee, with the goal to determine how best to connect with Council’s owners (i.e., public, members) - to better understand their values, perspectives, wants and needs. This committee was tasked with developing an action plan and submitting it for review during a special teleconference meeting at the end of October. The members of this ad hoc committee are Ed Cayer, public representative and Chair; David Samson, public representative; Tim Guest, RN, and Marian Mac Lellan, RN.

Audit Committee
Council approved the membership of an audit committee tasked with the development of a tender, to be issued in October 2013, for a new four-year contract for auditing services. This committee will also be responsible for presenting Council with a recommendation on the selection of an auditing firm at the December 2013 meeting. The contract with the current auditors expires in December. In addition to the annual audit, the tender is to include relevant financial training for Council members in February 2014. Council appointed the following members to the committee: Tim Guest, Ruth Whelan and Ed Cayer.

Appointment of Cobequid District Councillor
Council ratified the appointment of Kathy LeBlanc as Cobequid District Councillor for the 2013-2015 term, effective July 1, 2013. This position was not filled in the last election, however, Kathy LeBlanc put her name forward at the 2013 Annual General meeting.

2014 Nursing Exam fees
Council set the 2014 fees for the following exams:

- Canadian Registered Nurse Examination (CRNE): $598.45 ($395.39 CNA exam fee + $125.00 CRNNS administrative fee + $78.06 HST)
- Canadian Nurse Practitioner Exam (CNPE): Family/All Ages: $1535.71 ($1210.40 base fee + $125.00 CRNNS administrative fee + $200.31 HST)
- American Nurses Credentialing Center (ANCC) Adult or Pediatric NP Examinations: $1535.71 ($1210.40 base fee + $125.00 CRNNS administrative fee + $200.31 HST)

For information on how to apply for one of the above exams, visit www.crnns.ca or email registration@crnns.ca.

New Entry-Level Competencies
Based on a five-year cycle approved by Canada’s nursing regulators, the entry-level competencies for registered nurses were revised by a national working group (working under the auspices of the Jurisdictional Collaborative Process) in 2012. Following approval of these national competencies by the Canadian Council of RN Regulators, member organizations were to seek approval within their respective jurisdictions.

Earlier this year, College staff used the national competencies framework to revise the entry-level competencies for registered nurses in Nova Scotia. These revisions, which were validated by a number of Nova Scotia stakeholders in areas such as practice, education, research, administration and government, were approved by the College’s Council at its September meeting.

Changes that you will see in the 2013 Entry-Level Competencies for Registered Nurses in Nova Scotia include:

- a reduction in the total number competencies, to 104 (a decrease from 127 in 2009)
- rewording of several competencies to address some that were at either too high or too low a level for entry-level practice
- the addition of a new competency: Demonstrates honesty, integrity, and respect in all professional interactions.
- updated examples, to reflect current health concerns and issues (e.g., palliative and end-of-life care; obesity; rehabilitation; infection control; use of social media)
- the addition of new definitions; for terms such as compassionate, family, health disparities, health inequities, humanities, individual competence, interprofessional collaboration, palliative care, and population health.
- updated references.

The 2013 Entry-Level Competencies for Registered Nurses in Nova Scotia will be officially printed and distributed to appropriate audiences in the near future. They will also be accessible at www.crnns.ca.

College By-laws
Council was presented with a report from an ad hoc committee established in February 2013 to identify gaps between the legislation (i.e., RN Act and Regulations) and College By-Laws. This committee brought forward a series of proposed revisions, which Council approved, to clarify language and processes noted in the By-Laws and eliminate redundancies. Examples of these revisions include:
Policy Governance Workshop
September 25, 2013

Council members took part in a full-day education session with their governance coach, Jannice Moore. Topics for the day ranged from the purpose of standing and ad hoc committees of Council, to what Council can and cannot delegate to the Executive Director, and Council’s role in monitoring its own performance and that of the Executive Director. In addition to identifying education on financial statements as a priority, Council also had great dialogue on its linkage with owners and put the idea forward to create an ad hoc Ownership Linkage Committee. This motion was added to the Council’s meeting agenda for September 26th.

• Proof of current licensure has been eliminated as a requisite for registering as a voting delegate at AGMs as paper licences are no longer issued and licensure can be verified by College staff for members registering the day of the AGM.
• The exams currently approved by Council have been itemized, as below, to provide greater clarity on which exams require approval and when:
  – Canadian Registered Nurse Examination (CRNE), until December 2014
  – National Council Licensure Examination (NCLEX)®, beginning January 2015
  – Provincial Jurisprudence Exam, beginning September 2013
  – Canadian Nurse Practitioner Examination (CNPE) – Family/All Ages
  – American Nurses Credentialing Center – Adult NP Exam
  – American Nurses Credentialing Center – Pediatric NP Exam
  – Ordre des infirmières et infirmiers du Québec (OIIIP) - Neonatal NP Exam
• A clause referencing Council’s need to approve the College’s budget, submit audited financial statements at the AGM, and appoint the College’s executive director, auditor and solicitor, has been deleted as these responsibilities are already covered in the RN Act.
• The authority to remove Council members (by a two-thirds majority vote at any Council meeting) before the end one’s term of office was expanded to include not only the President or President-Elect but also any registered nurse, public representative or student member.
• The President has been designated as the official spokesperson for the Council rather than the College as this more accurately reflects current practice. The Executive Director speaks to operational matters, while the President speaks on matters related to the governance role of the Council.
• Voting at Council meetings has been changed to exclude the President, except in the cast of a tie vote. This more accurately reflects current practice. A new clause has also been added to allow electronic voting as this reflects current practice.
• The timeframe for the Nominations Committee to call for candidate nominations has been changed from five to three months prior to an election date set by Council.
• It has been clarified that to be eligible to run in a Council election, candidates must be residents of Nova Scotia.
• To manage costs associated with an election, paper ballots will no longer be issued unless requested.
• The submission of resolutions to regularly scheduled Council meetings, outside of AGMs, has been deleted as no such resolutions have ever been received.
• Liability protection, through the Canadian Nurses Protective Society, has been included as a requirement for all individuals holding a licence to practise in Nova Scotia. In the past, this has been an understood requirement, however, never stated in the By-Laws.
How deep is your focus on your practice? In reflecting on the intent of this publication, *Nursing in Focus*, I began to ask myself a series of questions. How focused are we on practising to our optimal scope? Are we focused on improving client care, transforming practice, strengthening inter-professional relationship, and/or boosting our professional identity? What lenses are we choosing to examine the structures and processes that influence our ability to practise? Are these lenses crystal clear or have they become so blurred by the grime of the past and our current reality that they obscure our vision for our future?

Many nurses will tell you that they hardly have time to focus on anything other than daily care delivery. However, the time has come for us to ramp up our clarity of thought, communication, and our actions that demonstrate what working to optimal scope really looks like. I believe that in many sectors it has taken too long to clear the path for RNs to practice to optimal scope and we’ve failed to create tools in support of RN practice. Or we’ve neglected to have the conversations with nurses about accountability in their practice. Are we being heard or taken seriously by those who make decisions about service provision? Being able to work to our optimal scope is a legal requirement of RN practice. Yet this is easier said than done for reasons that remain unclear. In some situations we are not heard. Additionally, the RN Act is not taken as a key driver of practice, or some practitioners feel that this ‘legal mumbo jumbo’ doesn’t apply to them. We have long discussed the benefits of RN practice. We have engaged in research that provides evidence and have repeatedly sought out workshops to help us ‘find our voice’. Yet the ability for nurses to work to optimal scope remains spotty at best.

If what we’re doing to shine the spotlight on RN professional practice is not working, something has to change. We do not have the power to change the behaviour of others; we only have power to change our own. If we continue to wait for others to change, give us more funding, reorganize structures, or suddenly see the light, I am afraid we will wait forever. All RNs have the responsibility to grab their professional reins (no matter what their practice setting), initiate new conversations to influence systems, and demonstrate the practices required to work to their optimal scope.

Many of us are already working on our 15-second elevator identity speech. The next step is to develop a laser-focused approach to altering our traditional rhetoric and others’ perceptions about our practice. We can begin right now! We do not need to wait for...
Each nurse has the ability, methodology, and tools to launch their professional campaign. Everything is clearly spelled out in our ‘Operator’s Manual of Professional Nursing Practice’ otherwise known as the RN Act, ‘Standards of Practice for Registered Nurses’, and ‘Code of Ethics for Registered Nurses’.

Changing the language we use for professional practice is a powerful tool to shift our nursing culture. For example, when speaking with a colleague about my role in care delivery I could say, “According to the legislation and my professional standards of practice, I am required to conduct a nursing assessment of our client, identify a nursing diagnosis, develop a nursing plan of care in conjunction with the team’s plan, evaluate the effectiveness of our nursing interventions, and make necessary revisions.” The delivery of these messages needs to be respectful, authoritative, and without deference or apology.

Our practice must change to reflect meeting the requirements of the legislation and the standards of practice. The following two, uncontestable statements can help RNs embed their professional identity, showcase their accountability and responsibility to help them get our message out there, clarify practice, and educate others:

1. RN practice is governed by law.
2. Registered nurses are accountable and responsible for practising according to their professional standards of practice and code of ethics.

**RN practice is governed by law**
This means that according to legislation (Registered Nurses Act, 2006), RN practice must demonstrate or give evidence of (paraphrased):

i. assessment of health status
ii. identify a nursing diagnosis based on the assessment
iii. develop and implement the nursing component of the plan of care
iv. coordinate client care in collaboration with others
v. monitor and adjust the plan of care
vi. evaluate client outcomes
vii. perform other roles, functions and accountabilities within their scope of practice

These requirements are ground zero for all RNs. If they are not met then, “Houston, we have a problem”. And this problem could pertain to those individual nurses who may choose not to do what they should be doing; organizations that fail to support nurses’ legislated practice; governments that do not legislate employment conditions that support professional practice; and the public who are probably unaware that legislation exists for their protection.

2. **Registered nurses are accountable and responsible for practising according to their professional standards of practice and code of ethics.**

Here’s the rub! Standards are neither a U-pick option nor negotiable. What is most disturbing is that too often the most basic tenets of professional nursing practice are missing-in-action. When the RN presence is viewed exclusively as task-focused care, it raises the value-added question in the minds of decision-makers. When RN practice lacks a visible theoretical framework, it lessens nurses’ credibility as knowledge workers. When evidence of the nursing process is invisible, nurses appear like players in a ‘whack-a-mole’ game - frenetic and haphazard. If care plans are developed and not followed clients may well ask, “Does anyone here really know what’s going on?” When a nursing diagnosis is not offered then what is the point of nursing care? When the therapeutic relationship is regarded as a time-consuming task, some nurses have entirely missed the boat on the foundation of nursing practice. As self-regulated professionals, nurses place themselves at a regulatory risk when their practice fails to demonstrate these most basic aspects of care.

Whether or not others agree with these statements, this is our reality. Focus on them. Start educating others. Model behaviours and actions outlined in the legislation and the standards documents. And, finally, keep advocating for system changes that allow you to practise in the way that you are supposed to practise.

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**Support for members is the click of a button away**

Contact the College today with your questions about issues that impact your nursing practice.

Email us at practice@crnns.ca or call us at 902.491.9744 (1.800.565.9744) for support from one of the College’s registered nurses.

Call extensions
250 for Trent MacIsaac and 256 for Jennifer Best.

[www.crnns.ca](http://www.crnns.ca)

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College of Registered Nurses of Nova Scotia
During the holiday season the census on my unit is usually low and management requires that we float to other nursing units. What can I do to ensure clients receive safe care? Can I refuse to float?

Floating to other units to support the delivery of services is a common practice, which can lead to anxiety for you as a registered nurse (RN). Typically, RNs are hired by an organization and not a specific unit. This means that the RN has a contractual obligation to provide care to clients within the organization, which is not limited to the unit where the RN works.

Employers do have the right to re-assign you to another unit. In fact, they have an obligation to assign you if inadequate staffing on a particular unit puts clients at risk. In accordance with the “Code of Ethics for Registered Nurses”, you are bound to accept the assignment and collaborate with the nursing staff to enable priority adjustment to minimize harm (CNA, 2008).

The refusal of an assignment in an unfamiliar practice setting is only justified when the risk of harm to a client is greater by accepting the assignment than by refusing it (CRNBC, 2013). If you choose to refuse an assignment for any reason, you must inform your employer of the reason for refusal, document the decision-making process, and provide the employer with enough time to find a suitable replacement.

Accepting the assignment to float does not mean you are obligated to practice beyond your level of competence. Rather than refusing an assignment related to perceived lack of competence, you should negotiate the work assignment with your manager. This should be based on your individual scope of practice and competencies as a registered nurse. You should reflect on how you can meet your “Standards of Practice for Registered Nurses” while in this new practice setting, with consideration of the patient population, and communicate your needs and limitations related to this request (CRNBC, 2009). Every RN has many entry-level competencies (e.g., carrying out client assessments, taking vital signs, assisting clients in activities of daily living) that are to be applied in any practice setting.

If you are asked to float to a clinical area that is unfamiliar to you, the College recommends that you follow these steps:

- Ask the charge nurse or an experienced nurse for an orientation to the unit.
- Meet with the charge nurse to discuss your assignment. Inform the charge nurse of the care that you are competent to perform and care that you do not have the knowledge or skill to perform. You should then collaboratively develop a plan for client care for that shift.
- Request an experienced nurse to be buddied with you for the shift.
- Establish a plan for regular communication with the charge nurse/buddy to apprise them of any changes in clients care needs during the shift.

We know that floating to unfamiliar nursing units can cause some apprehension. These steps should help you feel more comfortable with this practice. If you still have questions or concerns and are looking for support you can always speaking confidentially with one of the College’s Practice Consultants. Please call Trent MacIsaac or Jennifer Best at 1-800-565-9744 or email askapracticeconsultant@crnns.ca.

I have been approached by a local family physician to assist her to provide Flu Immunization Clinics in her office. What do I need to consider to ensure that I am meeting my standards of practice as a registered nurse? Am I able to provide vaccines to the office staff as well as the clients?

This sounds like an exciting opportunity to work in a collaborative way to provide care to your community. Before you start there are several things to consider.

Do you have the required competencies specific to immunization?
You first must determine if you have the necessary knowledge, skills and judgment to safely administer immunizations to the patient population you will be serving. These competencies include:

- safe administration of the vaccine,
- knowledge of the scientific basis of immunizations,
- essential immunization practices and contextual issues relevant to immunization.

For further information related to the competencies required to administer vaccinations please see page 5 of the College’s “Immunization Guidelines for Registered Nurses”.

What will your employment status be? Will you be an employee of the physician or will you be considered an external contracted service? Regardless of whether you are an employee of the physician or are considered an external contracted service you must think about having an employment contract. The College advises you to contact The Canadian Nurses Protective Society for advice concerning the preferred type of employment status for your individual circumstance.
How will you get the order for the immunization?
Registered nurses can only administer immunizations when there is a direct order or care directive written by an authorized prescriber, which, in your case, is the physician. Without a care directive, you would not have liability coverage for the administration of immunizations. You will need to determine if the physician will see each patient and write an order or if a care directive can be developed in collaboration with the physician to enable you to use your knowledge, skills, and judgment to safely assess a client and administer the flu vaccine. For further information of Care Directives, please see the College’s publication, “Care Directives: Guidelines for Registered Nurses”.

Once you have determined you have the required competencies and an order (either for each individual or through a care directive) you may administer the flu vaccine to staff and/or volunteers within the office. If the physician’s office currently has a care directive, you can follow this. However, if the office you are working in does not have a care directive in place, you should follow the Nova Scotia Immunization Schedule as a care directive (endorsed by the Chief Medical Officer of Health).

For further information please see the College joint position statement on “Recommended and/or Publicly Funded Vaccines for Immunizations of Staff and Volunteers in Nova Scotia Health Agencies/Facilities”.

I work in the Emergency Department and we want to create a protocol for patients who present with migraines. We’d like the protocol to include the initiation of an IV and the administration of medications after the RN assesses the client, but prior to the physician assessment.

Would this protocol be a ‘care directive’ or a ‘delegated function’? Also, what do I need to do to create the protocol?

This protocol would be considered a ‘care directive’, formally known as a ‘medical directive’.

A care directive (CD) is an order written by an authorized prescriber (a physician or nurse practitioner in your situation) for an intervention, or series of interventions, to be implemented by a registered nurse (RN) for a range of clients with identified health conditions, only when specific circumstances exist. The interventions outlined must be within the scope of practice of the RN who will be implementing the care directive. CDs can be implemented only when an authorized prescriber is available. Availability is to be determined by agency policy. The authorized prescriber holds ultimate responsibility in terms of ordering the intervention.

It is within the RN scope of practice to complete the required assessment for a patient presenting with a migraine, determine the appropriateness of the care directive, and initiate the care directive protocol by initiating the IV and administering the medication. As well, in an emergency department (ED) a physician would be readily available (either on-site or by telephone). In this situation a care directive would be the correct approach to provide the patient with timely treatment for their migraine and would provide an opportunity for RNs to optimize their scope of practice as well.

Care Directive Development
Once it has been identified that a specific client need could be better met through the implementation of a care directive, the first step is to determine whether the required interventions are within the RN scope of practice and that the authorized prescriber sees a benefit in the development of the care. It is then time to start developing the CD by considering and answering the following:
- the interventions that will be ordered by means of a CD;
- whether an authorized prescriber is available;
- the competencies required for the RN to perform the CD;
- specific educational requirements
- identification of the practice environment (specific units or services) in which the CD can be implemented;
- identification of the authorized prescriber for whom a Care Directive applies. Some prescribers might not approve of a CD for their clients and, therefore, the nurse cannot use the CD with their clients;
- documentation requirements for the RN performing the CD; and
- development of a review and revision mechanism for the CD.

Once you have made these decisions you will need to document these decisions in a policy format which should include:
- name and description of the intervention(s) being ordered;
- specific client clinical conditions and situational circumstances that must be met before the intervention can be implemented;
- identification of the healthcare professionals who can perform the CD;
- a relevant assessment process to be used by registered nurses in making the decision as to whether to implement the directive;
- specific monitoring parameters, and reference to appropriate emergency care measures;
- identification of the contraindications to implementing the care directive;
- name, date and signature of the authorized prescriber or the signature of an authorized prescriber who represents a group (e.g. department head could sign for a CD that applied to patients of all physicians under his/her service);
- identification of any educational requirement(s);
- date and confirmation of policy approval by appropriate approval body.

Once the CD has been developed it must be approved for use in your ED. Your employer must ensure that there is an appropriate approval body and processes to approve a care directive such as a Medical Advisory Committee (MAC) or an equivalent body. An equivalent body should consist of a representative authorized prescriber providing the CD, a representative RN involved in implementing the CD and other content experts – including representatives of risk management - as appropriate.

Additional Support
The College has developed a document titled, “Care Directives: Guidelines for Registered Nurses”, to better support RNs to optimize their scope of practice and contribute to providing safe, timely, effective and efficient client care. See this document for further information or call one of the College Practice consultants at 1-800-365-9744 ext. 250 or 256 with any questions you may have.

Related Documents
Care Directives: Guidelines for Registered Nurses
Delegated Functions: Guidelines for Registered Nurses
Increasing numbers of nurses are using smartphones and other mobile devices to communicate with colleagues and patients by telephone, text message or email and even to photograph wounds or skin conditions. Understanding the risks involved in using mobile devices may prevent potential adverse personal and professional consequences.

Risk Management Considerations

Privacy Breaches

Unauthorized disclosure of a patient’s personal health information (PHI) is a risk because mobile devices, such as smartphones, generally store and retain data on the device itself. Also, mobile devices are vulnerable to loss and theft because of their small size and portability.

Nurses have a professional and legal obligation to protect the privacy of patients’ PHI. This is commonly accomplished through the use of strong passwords and encryption to safeguard electronic PHI being communicated through mobile devices. Employers generally have policies that require the use of such safeguards. Without encryption, any emails, voicemails, pictures or text messages containing a patient’s PHI could be inappropriately accessed or disclosed if the mobile device is lost, stolen or inadvertently viewed by a friend or family member. Unauthorized disclosure can also occur during the wireless transmission of personal data.

There have been several reported privacy breaches in Canada involving mobile technology in the healthcare sector. Recently, a nurse lost an unencrypted USB key that contained the personal health information of approximately 83,500 patients who had been immunized for H1N1. The memory stick was not encrypted. This incident resulted in an investigation by the privacy oversight office and a class action lawsuit. In another case, a nurse working for a large teaching hospital had her laptop stolen from her car. The laptop contained records of approximately 20,000 patients. It was determined that the laptop was not encrypted, despite the hospital’s stated policy. These cases highlight that encryption is now the expected safeguard for data protection on mobile devices.

Workplace Integration

Some employers have prohibited the use of personal mobile devices during work hours or in certain areas of the workplace, while others provide nurses with employer-owned mobile devices for clinical use. More commonly, healthcare employers are implementing bring-your-own-device (BYOD) programs in which employees are permitted or even encouraged to use their own mobile devices in the workplace. Employers with BYOD programs will generally implement corresponding policies, protocols and systems that enable healthcare practitioners to use wireless devices to securely interact with other healthcare practitioners and to access patient records. However, the use of personal mobile devices without secure workplace integration, support (including the implementation of adequate encryption modalities) or knowledge can create an increased risk of a privacy breach and other adverse consequences.
Managing Expectations
In some cases, nurses, including nurse practitioners, are using their mobile devices to communicate directly with patients, both during and after hours. In addition to managing the privacy and security concerns associated with these communications, nurses are reminded to manage patient expectations about permitted purposes of these communications, how quickly they will respond to enquiries and what to do if the nurse is unavailable. Reasonable limits and response times can then be clearly communicated to patients.

Infection Control
Studies have found high bacterial contamination, (including MRSA), on mobile devices, which are likely to have originated from the hands of the healthcare workers. Since mobile devices are frequently handled and carried into multiple patient rooms, nurses are reminded to disinfect them often.

Consider Implementing the Following Precautions for the Security of Mobile Devices
- Use employer-issued mobile devices, where available, instead of your own device.
- Limit the use of your device for recording, transmitting or storing patients’ PHI, unless there are clear organizational policies permitting this practice.
- Work with your employer’s information technology department, if using your own device, to ensure your device has features and software that comply with your employer’s BYOD policies.
- Follow employer policies and only use employer-issued mobile devices for taking photographs or videos of patients for clinical purposes.
- Have and use strong password and encryption capabilities.
- Limit the amount of PHI stored on your device or, de-identify the PHI it contains.
- Turn off or do not enable WiFi and Bluetooth on any device containing or having access to patients’ PHI without confirming the connection is secure and protected.
- Transfer patient health care information recorded on your mobile device to the patient’s record as soon as practical, then use wiping software to permanently erase the information from your device.
- Use the time-cut feature on your device, such that it automatically locks when not in use.
- Store your mobile device in a secure location; avoid leaving it unattended or allowing others to have access to it.
- Confirm whether your device has the capability to remotely erase data stored on the device, in the event that it is stolen.

Please contact CNPS at 1-800-267-3390 if you have questions regarding the professional implications of the use of mobile devices in the workplace and visit our website at www.cnps.ca.

3. Order HO-007 and Order HO-008, Office of the Information and Privacy Commissioner of Ontario, online: www.ipc.on.ca.

This publication is for information purposes only. Nothing in this publication should be construed as legal advice from any lawyer, contributor or the CNP®. Readers should consult legal counsel for specific advice.
Although compassion is hard to define, it generally involves an emotional response to the perceived suffering of others and an authentic desire to act in a humane and caring way. A recent survey conducted by the College of Registered Nurses of Nova Scotia (CRNNS) indicates that members of the public as well as registered nurses in Nova Scotia consider compassion to be a vital component of patient care. While it is encouraging to note that 89% of the public surveyed agreed that nurses were compassionate or very compassionate, almost half of the nurse respondents believed that the overall level of compassionate care has decreased over time, citing reasons such as limited time, fatigue, and overall stress levels. Many nurses experience significant distress when there is a gap between the professional expectations of compassionate care delivery and the reality of ‘missing the mark’ in everyday nursing practice. This can result in compassion fatigue, which reduces the capacity of nurses to recognize and respond to the suffering of others.
The Challenge

Several interrelated factors act to impede nurses’ recognition of the need for a compassionate response as well as their ability to act with compassion. For example, the core training and socialization of nursing students is increasingly based on technical aspects of care with lesser value being placed on the humane aspects of care. Another consideration is the emotional labour inherent in nursing work, whereby nurses are required to sustain relationships in situations that are often difficult and demanding. The environment of care also influences the provision of compassionate care, especially when the need to meet performance targets within shrinking budgets can result in a privileging of measurable activities over intimate nurse–patient interactions that constitute a compassionate response. In addition, organizations themselves can be fraught with pain and suffering, as people often carry the pain from their personal lives into the workplace. Finally, there is some evidence that nurses and other caregivers may inadvertently dismiss empathic clues from patients, especially when they come from diverse ethnic groupings, socioeconomic classes, or geographic area. So, although all nurses must follow professional practice standards and ethical codes, each nurse has a unique personal history, professional training and experience that can influence her or his ability.

The Way Forward

Given the complexity and interrelatedness of the factors influencing compassionate care, where do the opportunities exist for nurses, educators and nursing leaders to make a change for the better? On the organizational level, positive organizational and individual outcomes are increasingly being associated with the creation compassionate work environments. These environments are fostered through everyday high quality connections in the workplace that include nurses feeling known and understood and having a sense that coworkers and administrators are responsive and available to one another. This kind of attunement - or noticing what others are going through - mirrors the compassionate response expected of nurses in their everyday nurse-patient interactions. Nursing leaders can help to build these kinds of environments by recognizing individuals’ contributions, directly addressing problems when they arise, enabling collaborative decision-making where possible, and acknowledging important milestones in the lives of nurses. A second feature of enhancing compassion capability within organizations involves recognizing the permeability between the professional and personal roles and identities of nurses. In other words, even when nurses are ‘at work’, there may be times when a nurse’s capacity to respond to the suffering of another may be constrained by events in her or his own life. If a climate can be created in which nurses feel safe in revealing personal and situational difficulties, the silence and shame that can compromise care delivery and nurses’ well-being can be averted and avenues opened up to provide necessary support. Similar opportunities for enhancing compassion exist within nursing education programs. When students are treated in a supportive and compassionate manner, they are more likely to show compassion towards their patients as well as to themselves. Modeling compassionate care to students, which includes placing emphasis on the importance of the faculty-student relationship as well as the relationship with the patient, is also a critical element of health professionals’ education and clearly indicates to students the importance of this aspect of care.

While organizational and educational initiatives are important, there is a growing consensus that in order to enhance the capacity of nurses to provide compassionate care, we must begin with cultivating compassion towards ourselves. Self-compassion is strongly associated with the development of coping strategies and can help to limit the use of avoidance strategies, which lead to ethical disengagement, compassion fatigue and detached, impersonal care. A key component of self compassion includes the cultivation of mindful awareness, which enables nurses to be present ‘in the moment’ and to remain open, non-judgmental and accepting of their own thoughts and feelings as they go about their daily care activities and interact with patients, families and colleagues.

Nurses, members of the public, health care institutions and regulatory bodies are all invested in the promotion of compassionate care delivery. Although this is a shared responsibility, opportunities exist to work individually and collectively to enhance compassion within our organizations and within ourselves in order to meet expectations for safe, competent and compassionate care.

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We’re asking you to ‘save the date’ for a special day of professional development and celebrations on Tuesday, May 13th, 2014.

Here’s what you can expect:
• Free Education Forum
• Annual General Meeting
• Nursing Awards Banquet

Meeting times will be determined soon so stay tuned in early 2014.

The theme of our free education forum is “Optimized Scope: RNs and NPs Leading the Way” and we have an exciting line-up of presenters and topics as selected by you. The day will include a Key Note Speaker and concurrent sessions covering a variety of nursing topics you will want to hear. Clear your calendars now and prepare to spend the day with us.

Stay tuned for more information.

The College has plans to support your professional development goals - in pursuit of the delivery of quality nursing care in the public interest - by offering all members a free educational opportunity in the spring of 2014.

We asked you to tell us what you felt would be more beneficial to your learning goals and this is what you ranked as most important to you.
• Leadership in nursing practice
• Optimizing the scope of RN and NP practice
• Compassionate Care

And we’re listening! We have found some of the most knowledgeable and engaging speakers in each topic area and are in the process of planning sessions you won’t want to miss. Stay tuned to our website and mark your calendars now.

Education Forum, Annual General Meeting and Awards Banquet

Tuesday, May 13, 2014
Holiday Inn Harbourview, Dartmouth

Voting Body Registration — Opens February 3 2014

Voting at the AGM is limited to only those active-practising RNs who register as voting body members prior to the meeting. Pre-registration will begin on Monday, February 3, 2013, and close on May 6, 2013.

To register in advance, to be a member of the voting body, simply type ‘events.crnns.ca’ in your browser OR go to www.crnns.ca, on or after February 3, 2014. While voting body registration will also take place at the door on the day of the AGM, pre-registration is recommended.

Voting Body Subsidies

Subsidies will be available, on a first-come, first-served basis, to cover out-of-pocket expenses for pre-registered voting body members. Voting body members must attend the AGM to receive a subsidy.
Awards Banquet

The College’s Annual Awards Banquet is a celebration of the contributions of just some of the many incredible registered nurses within Nova Scotia. The evening is an opportunity to come together to recognize the hard work and dedication of RNs and NPs and to celebrate the nursing profession.

CALL FOR RESOLUTIONS
Deadline: February 12, 2014

College members are encouraged to submit resolutions to be voted upon at the AGM. While resolutions could relate to a number of issues (e.g., the practice of nursing, role of the College, role of RNs within the healthcare system), it is important to remember that the intent of all resolutions MUST fall within the parameters of the College’s regulatory mandate.

Resolutions received by February 12, 2014, will be published in the spring 2014 issue of Nursing in Focus and posted on the College’s website. Although resolutions will be accepted at the AGM (given that they meet specific criteria), having them published in advance will allow others to think about them prior to the meeting. Resolutions passed at an AGM are non-binding; to be considered by the College’s governing Council at a subsequent meeting.

Deadlines/Dates to Remember

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>JANUARY 31</td>
<td>Submit nominations for Council election</td>
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<tr>
<td>FEBRUARY 3</td>
<td>Submit nominations for College Awards</td>
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<tr>
<td>FEBRUARY 3</td>
<td>Pre-register as a voting body member (ends May 6)</td>
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<tr>
<td>FEBRUARY 3</td>
<td>Book a seat for the awards banquet (ends May 8).</td>
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<tr>
<td>FEBRUARY 12</td>
<td>Submit resolutions for AGM</td>
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<tr>
<td>MARCH 1</td>
<td>Submit name to be a scrutineer for Council election</td>
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<tr>
<td>MARCH 1</td>
<td>Submit name to be a scrutineer at the AGM</td>
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<tr>
<td>MARCH 8</td>
<td>Council Election voting commences</td>
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<tr>
<td>APRIL 11</td>
<td>Election Day (polls close)</td>
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<tr>
<td>APRIL 29</td>
<td>Deadline to book a guest room at the Holiday Inn Harbourview</td>
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Scrubineers, required to count votes at the AGM, will have their expenses covered as per the Voting Body Subsidy. If you are interested, please submit your name to the Executive Office by March 1, 2014 (see contact information below).

Accommodations will be available at the Holiday Inn Harbourview at a conference rate of $127.00/night for single or double occupancy by calling the toll free reservation line at 1-888-434-0440 or hotel direct 902-463-1100 or email reservations@hiharbourview.ca and request a reservation for the College. All reservations must be guaranteed at the time of booking, by either a credit card or deposit of the first night room and tax.

The deadline for reservations is April 29, 2014. (After that date you must contact the hotel directly, and the group rate will be based on room availability.)

Parking at the Holiday Inn Harbourview is FREE.

Stay tuned to our website and upcoming newsletters for more information or contact Shelley Farouse with your questions. Shelley’s email is sf@crnns.ca or you may call her at 491.9744 (1.800.565.9744) ext. 223.
The CNA Annual Meeting: Call for Scrutineers and Voting Delegates

The 2014 annual meeting of the Canadian Nurses Association (CNA) will be held during the Biennial Convention in Winnipeg, Manitoba in June, (June 16-18, 2014).

If you will be in Winnipeg in June 2014, and would like to be considered as a scrutineer or voting delegate, please contact the College’s Executive Office, Shelley Farouse, at sf@crnns.ca or 491.9744 (1.800.565.9744 in NS), ext. 223, before May 1, 2014.

The College’s Holiday Office Hours

The College’s office will be closed from noon on December 24, 2013 to January 2, 2014.

College staff will be monitoring voice messages and e-mails remotely as follows:

- December 24th (8:30 a.m. – noon)
- December 27th (8:30 a.m. – 4:30 p.m.)
- December 30th (8:30 a.m. – 4:30 p.m.)
- December 31st (8:30 a.m. – noon)

E-leaRNing brings life to the College documents essential to your successful nursing practice.

Check out the most recent e-leaRNing programs on:

- Documentation Guidelines for RNs
- Standards of Practice for RNs
- Effective Utilization of RNs and LPNs in a Collaborative Practice Environment
- Professional Boundaries in Nurse-Client Relationships
- Assignment & Delegation Guidelines for RNs & LPNs
- Social Media NEW

To access all the E-leaRNing programs visit the College website.

www.crnns.ca

The College’s Holiday Office Hours

Learn at your own pace... anytime... anywhere...

LeaRNing Online
The College has been working on the implementation of the expanded prescriptive authority for nurse practitioners (NPs) under the New Classes of Prescriber Regulations (NCPR) under the Controlled Drugs and Substances Act (CDSA) since September 2012. We are pleased to provide the following update:

- The CDS Advisory Committee, chaired by Donna Denney, Executive Director of the College of Registered Nurses of Nova Scotia (the College), has met regularly over the past year. This group of stakeholders represents government, practicing NPs, employers, the Nova Scotia Prescription Monitoring Program, the College of Physicians and Surgeons of Nova Scotia, the Nova Scotia College of Pharmacists, and College staff. To date, the Advisory Committee has validated the nurse practitioner Standards of Practice for CDS Prescribing, the College's direction for education and continuing competence, and policy development.

- The work of the NP CDS Practice and Education Working Group has been instrumental in the development of standards and policies to guide implementation of the NCPR in Nova Scotia. This group has also utilized reviews of existing Canadian CDS education programs and continuing competency frameworks to provide the College with practical advice in the development of policy. The Working Group members include practicing NPs from all streams of practice, an educator, a pharmacist and a physician representing the Atlantic Mentorship Network (formerly the Nova Scotia Chronic Pain Collaborative Care Network).

- On a national level, College staff have actively participated on the Canadian Council of Registered Nurse Regulators (CCRNR) CDS Working Group by participating in:
  - regular meetings of the national CDS working group
  - a sub-group looking at Competencies for NP-CDS prescribing
  - a sub-group to evaluate available Canadian CDS education programs
  - a sub-group to develop draft national Standards of Practice for NP CDS prescribing.

The Working Group has forwarded recommendations to CCRNR on these items and once decisions are made, the College will send updates to NPs in Nova Scotia.

### Next Steps

1. **NP Standards of Practice for CDS Prescribing**
   The Standards have been circulated to all NPs and other stakeholders for feedback. The feedback received has been incorporated into the final draft revisions of the NP Standards of Practice document. The revised 2014 Nurse Practitioner Standards of Practice were approved at the December meeting of Council and will come into effect once NPs officially begin prescribing controlled drugs and substances, anticipated for the fall of 2014.

2. **Telehealth**
   In January 2014, the College will be providing a Telehealth session to update NPs and other stakeholders on the proposed implementation plans and education requirements for initiating NP CDS prescribing.

3. **CDS Education Programs**
   It is anticipated that CDS education programs will be available in early 2014. Education will consist of an online course as well as a one-day workshop, which will be brought to NPs at various sites throughout the province.

4. **Nova Scotia Prescription Monitoring Program (NSPMP)**
   The College is preparing the required applications documents for the College to be added as a licensing authority to the Nova Scotia Prescription Monitoring Board. Membership is a requirement of all regulators who have providers prescribing and dispensing controlled drugs and substances. Once this application is approved by the NSPMP Board, regulations will be developed by government for approval by cabinet. This is the crucial last step in enabling NP CDS prescribing in Nova Scotia.

If you have any questions about any of the information you see here please contact Lynn Miller, DNP, NP. Lynn is a Policy Consultant with the College and can be reached by email at lmiller@crnns.ca or phone at 1.902.491.9744. (Calling long distance? Reach Lynn at 1.800.565.9744)
Leading Education: CNE Telehealth

Continuing Nursing Education (CNE) Telehealth has been a longstanding program established by the College with the support of the Department of Health and Wellness. It brings continuing nursing education to RN’s across the province through the use of technology. Clare Brown who is a registered nurse that was just recently hired as a Practice Consultant with the College now leads the telehealth program and is interested in what you have to say.

CNE sessions are organized 2-3 months ahead of their delivery date. As a result of staff changes and a gap in time filling the position, the number of CNE Telehealth sessions was reduced this fall. It is hoped these sessions will be back on target (8 per month) by April or May, 2014. If you have any topic ideas, are a content expert who would like to share, or know of a dynamic speaker on a great nursing topic, we would love to hear from you. Please forward your ideas to cbrown@crnns.ca anytime.

Do you enjoy lifelong learning? We’re talking to you.

Would you like to influence what education sessions are offered to nurses across Nova Scotia? Here is an opportunity for you to do just that! We would like to work with R.N.’s from a variety of practice settings (acute care, community, pediatrics, maternal child, LTC, research, palliative care etc.) from rural and urban areas. This group of nurses would form a committee to help select Continuing Nursing Education (CNE) Telehealth session topics.

Your commitment would be to attend two meetings per year (can be done by teleconferencing) to share session topic and/or presenter ideas.

If you are interested in this opportunity or have any questions, please contact Clare Brown at cbrown@crnns.ca. Feel free to contact Clare any time you have CNE session ideas.
Sincere sympathy is extended to the family and friends of:

Dr. Mona Jane Horrocks  
Vancouver General Hospital, 1954  
March 18, 2013

June Gertrude (Zinck) Mitchell  
Halifax Infirmary, 1946  
March 22, 2013

Edith Pauline (Potter) Thompson  
Yarmouth Hospital  
March 26, 2013

Cecilia Margaret (Thompson) Bruno  
Halifax Infirmary, 1945  
March 30, 2013

Jean Evelyn Mavis (Smith) Barnes  
Children’s Hospital, 1957  
April 1, 2013

Susan Elizabeth ‘Sue’ Hedley  
Halifax Infirmary, 1974  
April 3, 2013

Theresa Margaret (MacLean) Rostiek  
St. Rita Hospital, 1958  
April 4, 2013

Marjorie Elizabeth (Rhodenizer) Hebb  
Yarmouth Hospital, 1951  
April 4, 2013

Mary Ellen (Hodgson) Swetnam  
Children’s Hospital, 1966  
April 8, 2013

Barbara Jean (Salter) Whyte  
Children’s Hospital, 1953  
April 19, 2013

Ella M. (Mitchell) Macdonald  
Sydney City Hospital, 1944  
April 21, 2013

Mary Patricia (West) Brown  
Halifax Infirmary, 1940  
April 24, 2013

Frederick Walter Kelly  
Victoria General Hospital, 1995  
April 24, 2013

Margaret Doreen (Smeltzer) Higgins  
Victoria General Hospital, 1969  
April 26, 2013

Chester Roy Smith  
Nova Scotia Hospital, 1937  
April 28, 2013

Shirley Noreen Manthorne  
St. Francis Xavier University, 2005  
April 29, 2013

Helen Dorothy (Moore) Rennie  
Children’s Hospital, 1954  
April 30, 2013

Ella Maude (Smith) Richards  
Victoria General Hospital, 1952  
April 30, 2013

Natalie Elizabeth (Hegan) Snell  
Victoria General Hospital, 1957  
May 4, 2013

Georgina Margaret (MacNeil) McNeil  
Halifax Infirmary, 1958  
May 7, 2013

Jean M (Livingstone) Coleman  
Victoria General Hospital, 1937  
May 7, 2013

Hazel Elizabeth (McLean) Gordon-Morrison  
Victoria General Hospital, 1951  
May 9, 2013

Marion Sophia ‘Mackie’ (MacIntosh) Moore  
Yarmouth Hospital, 1952  
May 13, 2013

Isabel (MacLean) Bowen  
St. Joseph’s Hospital, Hamilton, ON, 1942  
May 18, 2013

Anna Sarah (MacRury) Burrell  
Glace Bay General Hospital, 1951  
May 19, 2013

Patricia Louise (Langille) Newcombe  
Victoria General Hospital, 1960  
May 22, 2013

Greta Claire (Hunter) Harvey  
Victoria General Hospital, 1947  
May 30, 2013

Mary Jane (Harvey) Clarke  
Grace Hospital, Windsor, ON, 1944  
May 31, 2013

Ruby Ileen (Stone) MacDonald  
Aberdeen Hospital, 1977  
June 9, 2013

Ruth Eleanor (Bantfield) Hill  
Sydney City Hospital, 1964  
June 27, 1973

Mary Colleen (Craig) Kiberd  
Halifax Infirmary, 1977  
July 3, 2013

Eleanor ‘Joyce’ (Campbell) Keith  
Aberdeen Hospital, 1948  
July 12, 2013

Sheila McCabe (Darrow)  
St. Joseph’s Hospital, Glace Bay, 1954  
July 24, 2013

Ethel Mae (Laing) Crook  
Royal Jubilee Hospital, England, 1970  
August 30, 2013

Betty Jean (Martin) Simpson  
Peterborough Civic Hospital, 1964  
August 2, 2013

Grace Edna (Wright) (Curtis) Bethel  
Victoria General Hospital, 1938  
August 29, 2013

Bertie Marie (Mailman) Cook  
Hotel Dieu Hospital, Bathurst, NB, 1948  
August 21, 2013

Raylene Gerhart Mackley  
St. Rita Hospital, 1963  
August 26, 2013

Maxine Elizabeth (Hunter) Al-Molky  
Children’s Hospital, 1968  
August 26, 2013

Ruby Barter  
Hammersmith Hospital, London, England, 1970  
August 30, 2013

Margaret Catherine (McCarthy) Dean  
St. John General Hospital, 1941  
August 30, 2013

Mary Evelyn (Cochrane) Jackson  
Victoria General Hospital, 1949  
September 5, 2013

Colonel (Ret’d) Joan Fitzgerald  
Halifax Infirmary, 1941  
September 7, 2013

Eunice Gwendolyn ‘Gwen’ (Abriel) McKenney  
Victoria General Hospital, 1952  
September 8, 2013

Carol Lee (Patterson) Lutz  
Yarmouth Regional Hospital, 1974  
September 9, 2013

Florence E. ‘Flo’ (Larramore) MacGillvray  
Herbert Reddy Memorial Hospital, Montreal, 1951  
September 9, 2013

Evelyn Harriet (Rice) Bickerton  
Jeffrey Hale Hospital, Quebec City, 1947  
September 15, 2013

Margaret Ross  
St. Mary’s Hospital, Montreal, 1964  
October 2, 2013

Doris Ruth (Albright) Morgan  
Carleton Memorial Hospital, Woodstock, NB  
October 2, 2013

Elizabeth Adelaide ‘Betty’ (Gillis) Flemming  
Halifax Infirmary, 1946  
October 9, 2013

Gertrude Jean (MacPherson) Drover  
Glace Bay General Hospital, 1952  
October 12, 2013

Doris May (Margeson) Benson  
Victoria General Hospital, 1946  
October 13, 2013

Heather Ena (MacKay) Devlin  
Dalhousie University School of Nursing, 1974  
October 17, 2013

Dorothy Jean Gogan  
Highland View Hospital, 1950  
October 21, 2013

Stephen Wolsey ‘Steve’ Callender  
Derby Royal Infirmary, Derby, England, 1967  
October 22, 2013

Dorothy May (Davidson) Dicair  
Glace Bay General Hospital, 1943  
October 23, 2013

Florence Lorraine Dunlop  
Victoria General Hospital, 1956  
October 24, 2013

Audrey Bernice (Saunders) Joudrey  
Victoria Public Hospital, Fredericton, 1958  
October 26, 2013

Robert Mae (Mackenzie) Chitick  
Aberdeen Hospital, 1956  
October 27, 2013

Mary Glen (Keirstead)  
Royal Jubilee Hospital, Stirling  
Yarmouth Hospital, 1950  
October 27, 2013

Viola Mae ‘Vi’ (O’Connell) Lombard  
Yarmouth Regional Hospital, 1973  
October 31, 2013

Shirley Ann (MacDonald) MacDonald  
Sydney City Hospital, 1957  
November 5, 2013

Doris Pauline (Brown) Bacon  
Memorial Hospital, St. Thomas, ON, 1946  
November 9, 2013

Anna Mae (Lowe) Sheffield  
Nova Scotia Hospital, 1935  
November 10, 2013

Opal Holland ‘Holly’ (Salsman) Robins  
Aberdeen Hospital, 1951  
November 10, 2013

Elizabeth Harrison (Lewis) Dingwall  
Hospital for Sick Children, Toronto, ON, 1952  
November 12, 2013

Elizabeth ‘Betty’ Mae (MacLennan) Kearney  
New Waterford General Hospital, 1955  
November 12, 2013

Lyghle (Iseon) Janet Louise  
Children’s Hospital, 1961  
November 15, 2013

White, Geraldine Eleanor  
Halifax Infirmary, 1964  
November 15, 2013

Mary ‘Bernice’ (Stewart) Sullivan  
Royal Victoria Hospital, Montreal, 1943  
November 15, 2013

Alice Marion (Walker) Howe  
Montreal General Hospital, 1948  
November 21, 2013

Christine Barbara Kreutz  
Yarmouth Hospital  
November 26, 2013

Angela Marie (Vassallo) Blake  
Victoria General Hospital, 1993  
December 4, 2013

Mamie Lavinia (Williams) MacKenzie  
St. Joseph’s Hospital, Glace Bay, 1942  
December 7, 2013
**Consent Reprimand**

**Consent to Conditions and Restrictions**

Capstick-Fricker, Kathleen Rose
Dartmouth, Nova Scotia
CRNNS Registration No. 17425

On August 6, 2013, the Complaints Committee of the College of Registered Nurses of Nova Scotia (the College) ordered that pursuant to s. 58(3)(d) of the *Registered Nurses Regulations*, and with Kathleen Capstick-Fricker’s consent, Ms. Capstick-Fricker receive a reprimand for failing to:

- Adequately assess, intervene and/or monitor a patient in her care with respect to post-operative pain, nausea and urine retention; and
- Appropriately and/or adequately document her assessments and nursing care provided.

The Committee also decided pursuant to s. 58(3)(e), and with Ms. Capstick-Fricker’s consent, to impose the following condition on Ms. Capstick-Fricker’s licence:

*Ms. Capstick-Fricker will successfully complete, at her own expense, College-approved courses in pain assessment and pain management prior to renewing her licence to practise nursing.*

*Ms. Capstick-Fricker will successfully complete, at her own expense, a College-approved documentation course, prior to renewing her licence to practise nursing.*

*Ms. Capstick-Fricker will provide the College with a physician’s report, in a form satisfactory to the College, stating that she is medically cleared to return to nursing practice, prior to renewing her licence to practise nursing.*

On the night shift beginning October 27, 2011, Ms. Capstick-Fricker failed to adequately medicate a ‘day one’ post-operative patient for over six hours, despite the patient’s repeated complaints of pain and nausea. During this same period, Ms. Capstick-Fricker failed to adequately address the patient’s complaints of urine retention when she failed to perform a catheterization. Ms. Capstick-Fricker also failed to document her nursing care until the end of her shift at 0700 hours, and did not document or completely document, her nursing assessments of the patient.

It was the Committee’s opinion that Ms. Capstick-Fricker’s actions and behaviours constituted professional misconduct as defined in the *Registered Nurses Act*. However, as there have not been any previous complaints to the College throughout Ms. Capstick-Fricker’s 38 years of nursing practice, and as she has agreed to undertake the above-noted conditions and restrictions to improve her nursing practice, the Committee believed the issuance of a reprimand and the conditions and restrictions were the appropriate outcome in this case.

Because Ms. Capstick-Fricker also provided the Committee with information that demonstrated she is currently suffering from health issues, that prevent her from returning to nursing practice, the Committee also believed that the issuance of a condition that requires her to provide a physician’s report prior to her renewing her licence to practice nursing is the appropriate outcome in this case.

On October 2, 2013, Ms. Capstick-Fricker consented to the reprimand and conditions and restrictions on her licence.

---

**Consent Reprimand**

**Consent Condition on Licence**

Gordon, Wilfred Douglas
Dartmouth, NS
College Registration No: 30233

On October 2, 2013 pursuant to Section 58 (3)(d) of the *Registered Nurses Regulations*, the Complaints Committee orders that with Mr. Gordon’s consent, he receive a reprimand for the breach of professional boundaries both with a patient and with female staff, medical residents, medical and nursing students.

The Complaints Committee also decided that pursuant to Section 58 (3)(e) of the *Registered Nurses Regulations* and with Mr. Gordon’s consent, that the following condition be imposed on Mr. Gordon’s licence:

*Successfully complete at his own expense the boundaries course, “Respecting Professional Boundaries in Nursing Practice” and provide proof of successful completion to the College by January 6, 2014.*

In the event Mr. Gordon does not complete the mandated course within the required time frame, the Complaints Committee will reconvene to further consider this matter. The Committee believes Mr. Gordon breached professional boundaries with a patient when he engaged in behaviours...
which included exchanging phone numbers prior to her
discharge from the hospital, repeatedly texting her after
her discharge, coming in on two of his days off to be with
the patient when she had to return for follow-up treatment
several weeks after discharge, and communicating with her
in a personal manner.

The Committee also believes Mr. Gordon breached
professional boundaries with staff, nursing colleagues,
medical students and medical residents when he interacted
with them in a very personal manner.

It was the Committee’s opinion that Mr. Gordon’s actions
and behaviours breached the ‘Standards of Practice for
Registered Nurses’ and the ‘Code of Ethics for Registered
Nurses’. The Committee also believes that Mr. Gordon
failed to meet competency #92 from the ‘Entry-Level
Competencies for Registered Nurses in Nova Scotia’ (2009),
which deals with establishing and maintaining professional
boundaries. The Committee believes the issuance of a
reprimand and the imposition of a condition related to the
provision of education on professional boundaries is the
appropriate disposition in this case.

In accordance with Section 84 (1)(f) of the Regulations,
the Committee directs that if Mr. Gordon changes his
employment within two years of the date of this decision, a
copy of this decision will be provided to his new employer.
Mr. Gordon will provide notification of such change
in employment to the College’s Professional Conduct
Consultant, who will then forward the decision to the
appropriate person.

On November 7, 2013, Mr. Gordon consented to the
reprimand and condition on his licence to practise nursing.

**Consent Revocation**

Wiseman, Jesse Gilbert
Terence Bay, NS
CRNNS Registration No. 33010

The following allegations of incompetence and/or
professional misconduct arose from a complaint against Mr.
Wiseman that was investigated by the College:

**Allegation I**
Between October 19, 2010 and October 30, 2011,
Mr. Wiseman failed to use appropriate and effective
communication with and/or around patients and their
family members.

**Allegation II**
Between October 19, 2010 and October 30, 2011, Mr.
Wiseman failed to ensure safe administration of medication.

**Allegation III**
Between October 19, 2010 and October 30, 2011, Mr.
Wiseman failed to practise nursing with appropriate
knowledge, skill, and judgment.

**Allegation IV**
Between October 19, 2010 and Oct 30, 2011, Mr. Wiseman
failed to appropriately document care and medication use.

**Allegation V**
Between August 2009 and October 30, 2011, Mr. Wiseman
practised outside of his scope of practice.

Mr. Wiseman did not contest the allegations and agreed
to the revocation of his licence, with the condition that
he be permitted to apply for reinstatement of his licence
following a period of at least two years from the date of the
Professional Conduct Committee’s decision.

The Professional Conduct Committee accepted Mr.
Wiseman’s request and revoked his licence to practise
nursing for a period of not less than two years. The
Committee unanimously agreed that the revocation serves
and protects the public interest and preserves the integrity
of the nursing profession while giving the member the
opportunity to re-enter the nursing profession in appropriate
circumstances, which will be seriously considered by any
re-instatement process to which the member will be subject.

Before reinstatement will be granted Mr. Wiseman will
be required to go through the process set out in Section
52 of the Registered Nurses Act and the Regulations made
thereunder and the burden will rest with him to establish
that reinstatement of his licence is in the public interest. If
his application is accepted, the Reinstatement Committee
may impose conditions or restrictions on his licence to
practise nursing.
### Calendar of Events

#### JANUARY

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Details</th>
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<tbody>
<tr>
<td>10 Call for Abstracts - The 45th Annual Meeting and Scientific Sessions of the Canadian Association of Neuroscience Nurses</td>
<td>&quot;Scaling New Heights in Neuroscience Nursing – practice, education, research, leadership, patient safety, and quality improvement&quot;. Banff, AB. Conference dates: June 3-6, 2014. Contact: Canadian Association of Neuroscience Nurses <a href="mailto:info@cann.ca">info@cann.ca</a> <a href="http://cann.ca">http://cann.ca</a></td>
</tr>
<tr>
<td>22-25 2014 Canadian Nursing Students’ Association (CNSA) National Conference</td>
<td>“Envision. Create. Innovate.” Vancouver, BC. Contact: CNSA Tel 613.235.3150 <a href="mailto:conference@cnsa.ca">conference@cnsa.ca</a> <a href="http://www.cnsa.ca/english/">http://www.cnsa.ca/english/</a></td>
</tr>
<tr>
<td>24-25 6th Annual Ottawa Conference: State of the Art Clinical Approaches to Smoking Cessation. Ottawa, ON. Visit the University of Ottawa Heart Institute website <a href="http://www.ottawamodel.ca">www.ottawamodel.ca</a> for details.</td>
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#### FEBRUARY

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#### MARCH

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<tr>
<td>1 Call for Abstracts - 4th International Conference on Violence in the Health Sector.</td>
<td>Miami, USA. Conference dates: October 22-24 2014. Contact: Oud Consultancy &amp; Conference Management, Amsterdam, the Netherlands. Tel: ++ 31 (0)20 409 0368 Fax: ++ 31 (0)20 409 0550 <a href="mailto:conference.management@freeler.nl">conference.management@freeler.nl</a> <a href="http://www.oudconsultancy.nl">www.oudconsultancy.nl</a></td>
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#### APRIL

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<tr>
<td>25-27 The International Emergency and Catastrophe Management Conference &amp; Exhibition. Dubai</td>
<td>Contact: INDEX Conferences &amp; Exhibitions Organisation Est. Tel: +971 4 362 4717 <a href="mailto:exhibit@emergency.ae">exhibit@emergency.ae</a> <a href="http://www.emergency.ae">www.emergency.ae</a></td>
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#### MAY

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<tr>
<td>4-7 The Canadian Orthopaedic Nurses Association 37th National CONA Conference</td>
<td>“Trailblazing in Orthopaedics.” Calgary, AB. Contact: Canadian Orthopaedic Nurses Association <a href="http://www.conanurse.org">http://www.conanurse.org</a></td>
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<tr>
<td>13 CRNNS Education Forum, Annual General Meeting and Celebration Banquet.</td>
<td>Holiday Inn Harourview, Dartmouth, NS <a href="mailto:sf@crnns.ca">sf@crnns.ca</a> <a href="http://www.crnns.ca">www.crnns.ca</a></td>
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#### JUNE

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<tr>
<td>2-4 Community Health Nurses of Canada (CHNC) 9th National Community Health Nurses Conference.</td>
<td>Ottawa, ON. Contact the Conference Registrar: <a href="mailto:chnc@absolutevents.com">chnc@absolutevents.com</a> or Tel. 416.595.1414. <a href="http://www.chcn.ca">www.chcn.ca</a></td>
</tr>
<tr>
<td>4-7 Canadian Ophthalmological Society Annual Meeting &amp; Exhibition.</td>
<td>Halifax, NS. Contact: Canadian Ophthalmological Society <a href="mailto:cos@cos-sco.ca">cos@cos-sco.ca</a> <a href="http://www.csorn.ca">http://www.csorn.ca</a></td>
</tr>
<tr>
<td>7 Canadian Council of Cardiovascular Nurses (CCCN) Spring Nursing Conference</td>
<td>“Update Your Cardiovascular Nursing Toolkit”. Calgary, AB. Contact: Canadian Council of Cardiovascular Nurses. Tel 613.599.9210 <a href="mailto:info@cccn.ca">info@cccn.ca</a> <a href="http://www.cccn.ca">http://www.cccn.ca</a></td>
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- Free Education Forum
- Annual General Meeting
- Nursing Awards Banquet

Meeting times will be determined soon so stay tuned in early 2014.

The theme of our free education forum is “Optimized Scope: RNs and NPs Leading the Way” and we have an exciting line-up of presenters and topics as selected by you. The day will include a Key Note Speaker and concurrent sessions covering a variety of nursing topics you will want to hear. Clear your calendars now and prepare to spend the day with us.

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