



COLLEGE OF NURSES
OF ONTARIO
ORDRE DES INFIRMIERES
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THE STANDARD OF CARE.

THE STANDARD

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Technology and You

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COVER

Technology and you

Providing quality care means staying abreast of the latest developments in technology. On page 12, three nurses (including Ade Oyemade, RN, below) share their experiences integrating new technologies into the workplace. Get acquainted with the College's online services today.



Photo: Swavek

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Watch for the fall issue of *The Standard* at the end of September.

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Strategic planning at the College



OUR MISSION is to protect the public's right to quality nursing services by providing leadership to the nursing profession in self-regulation.

OUR VISION is excellence in nursing practice everywhere in Ontario.

As a practising nurse in Ontario, I have always been proud and acutely aware of my responsibilities as a member of a self-regulating profession. The social contract between the people of Ontario and regulated professionals is undergoing significant change. Changes in legislation and high expectations for transparency and accountability are changing the landscape of self-regulation.

To remain a leader in regulation and to continue to be effective, the College needs to reflect on how it has evolved as a leader in self-regulation. By looking at our past successes and asking critical questions about where we need to go in the future, the College will develop a 10-year strategic plan that will meet the challenges of fulfilling our social contract with the people of Ontario.

Nurses are often involved in developing strategic plans in their workplaces and know that asking relevant questions is critical to finding the right strategy. To this end, in March, Council and the College began the work of writing a new Strategic Plan that will guide us for the next 10 years.

An essential part of this planning process includes taking a close look at what is happening in the world today and asking: What role does the regulator have in this changing environment? What do the public and the government expect from a regulator? How does the profession need to evolve to continue to provide the care needed?

We see that the public—whether as media scrutiny or consumer expectations—wants increased accountability from regulators and we have to ask ourselves: Do the public and the College see safe, effective and ethical care in the same way? What do transparency and accountability mean to the public? What is our role in delivering these to the public?

We also have to factor in the substantial increase in the legislative requirements that regulators must implement and support, the demand of interprofessional collaboration, the increase in specialization that is requiring new classes of registration, and national and international labour mobility demands that require regulators to collaborate in new ways to ensure that practitioners are safe and competent.

What do these changes in the social contract mean for you and me, nurses practising in Ontario? As we provide nursing care to our clients, we can see how the public's expectations are changing and that we have a direct effect on the public's confidence in the nursing profession and in self-regulation.

When completed later this year, the new strategy will guide the choices and actions of Council and the College for the next 10 years. By being thoughtful and thorough in our planning and research, we will have a strategy that will allow the College to continue to be an able leader on the forefront of self-regulation.

You can read more about the new Strategic Plan in upcoming issues of *The Standard*.

A handwritten signature in black ink, appearing to read 'George Fieber', written in a cursive style.

George Fieber, RN
President

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NEWS

National standards on the way

CNO and the College of Registered Nurses of Manitoba are leading a project to develop national professional regulatory standards for all nurses in Canada.

Nursing standards are authoritative statements that set out the legal and professional bases of nursing practice. They describe the behaviour required of every nurse and are used to evaluate individual performance.

Commissioned by the executive directors of nursing regulatory bodies across Canada, the project will set the stage for further collaboration between provincial nursing regulators.

"While each province has its own legislative requirements and approach to nursing regulation, the basic issues we deal with in the nursing profession are comparable," says Heather Campbell, RN, Director of Practice and Regulatory Policy. "National standards will create similar expectations for the knowledge,



Photo: CNO

Members of the National Standards Working Group met at the College in February to develop regulatory expectations for all nurses in Canada.

skill and competencies nurses should have, regardless of the jurisdiction in which they practise. This will, in turn, facilitate safe labour mobility."


The project's guiding principles require the national standards to be open and transparent, consistent, current, informed by evidence, impartial and respectful of jurisdictional differences.

Last year, representatives from nursing regulatory jurisdictions across Canada, except Quebec, as well as the Canadian Nursing Association, formed the National Standards Working Group.

Each provincial regulatory body, including CNO, is consulting

with its members and stakeholders through a variety of means such as teleconferences, advisory groups and the web. The working group will then incorporate the feedback it receives into the national standards.

"The final result will be shared professional regulatory nursing standards," says Campbell. "This is in the public's interest as it will help Canadians to be confident that no matter where they choose to reside, their nurses will meet the same high standards of professional practice."

Look for updates on the national standards in future issues of *The Standard* and at www.cno.org. 

NP competency framework updated

The core competency framework for Nurse Practitioners (NPs) has been revised to ensure that it reflects the current health care needs of the population and the realities of the Canadian health care system.

The *Canadian Nurse Practitioner Core Competency Framework* describes the knowledge, skill, judgment and professional attributes that NPs need to practise safely and ethically, regardless

of practice sector, clinical focus or client population.

A national committee made up of NPs and representatives of the regulatory bodies oversaw the revision, which was initiated by the executive directors of the provincial regulatory bodies for nurses last year. The national committee included a representative from the College and an NP from Ontario.

To guide the revision, the committee oversaw surveys, focus groups and analysis of the results.

"To be meaningful, the core competencies must evolve to reflect population health care needs, which are constantly changing," says Heather Campbell, RN, Director of Practice and Regulatory Policy. "Regular reviews and updates also ensure that graduates of NP education programs continue to demonstrate the current competencies necessary for safe and ethical NP practice in an evolving health care system."

In March 2005, the College adopted the *Canadian Nurse Practitioner Core*

Competency Framework as the entry-to-practice competencies for NPs in Ontario.

The College uses these core competencies to support regulatory activities that protect the public, such as approving programs and exams, and developing practice standards and quality assurance tools.

Nurse educators at Ontario universities also use the competencies to develop the NP curriculum. Before a university implements an NP education program, College Council must approve it.

Check www.cno.org for the updated *Canadian Nurse Practitioner Core Competency Framework*. **S**

Revised Registration Regulation coming

Recent changes in federal and provincial legislation has led the College to revise its *Registration Regulation*, which outlines the requirements for registration as a nurse

in Ontario and how a member remains in good standing after becoming registered.

"These are the rules by which the College decides who becomes a member, and once they are, how and when they can move from one class to another—for instance, from Temporary to General Class," says Cheri Vigar, RN, Manager of Regulatory Policy.

"The *Registration Regulation* mainly affects College applicants, but current members should also be aware of it because it has a very real impact on their ongoing practice and the options available to them as they progress in their careers."

One recent legislative change that will affect nurses requires health regulatory colleges, like the College of Nurses of Ontario, to support the principle of labour mobility by registering, with few exceptions, those who are registered in another Canadian province or territory. Another change makes it

a legal requirement for all practising regulated health professionals to be personally insured or to have personal protection against professional liability.

Revising its *Registration Regulation* gives the College a unique opportunity to streamline the regulations and make them more accessible and transparent to members—a key step in ensuring that all nurses are accountable to the public.

If Council approves the proposed revisions to the *Registration Regulation* for circulation to members, then they will be included with the fall 2010 issue of *The Standard*. That issue will also include a summary of how the revisions will affect both new applicants and College members.

Once you receive the proposed revisions, you will have 60 days to provide the College with feedback. Council will consider this feedback when it debates approving the new regulations at its December meeting. **S**

Visit the College's new online

Ask Practice
section at www.cno.org/AskPractice.

Ask Practice offers nurses up-to-date and accurate information to help them practise in their settings.

The Q&As are based on actual questions from nurses, and new ones are frequently added, so check the section regularly.

Have a practice-related question? Call the Practice Support Line at 416 928-0900, ext. 6397, or toll-free in Ontario at 1 800 387-5526, ext. 6397 (0830 to 1700 hrs, Monday to Friday). Or, e-mail your question to ppd@cnomail.org.



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New learning module

The College has added the Quality Assurance (QA) Program: Self-Assessment learning module to its online Learning Centre at www.cno.org/learning.

The module contains information about the Self-Assessment component of the QA Program, in which all nurses in the General, Transitional and Extended Classes must participate.

“The module offers an overview of the program, with a focus on reflecting on your nursing practice, obtaining peer input, and developing and maintaining a Learning Plan,” explains Shandelle Johnson, RN, Practice Consultant.

The module has three chapters:

- Chapter 1: An Overview
- Chapter 2: Practice Reflection
- Chapter 3: Learning Goals and Learning Plans

“This module will help nurses

understand how to incorporate the College’s practice documents into their learning goals,” says Johnson. “It also clarifies the elements required in their Learning Plans.”

The QA Program module is the latest in a number of learning modules that are designed to further a nurse’s understanding of the College’s practice documents and programs. Participation is self-directed and anonymous. The College does not record a nurse’s participation in the Learning Centre. **S**

HST on College fees

The Provincial Sales Tax (PST) is being combined with the Goods and Services Tax (GST) to create a federally administered harmonized sales tax (HST) that takes effect July 1, 2010.

The HST will apply to all goods and services that are currently subject

to GST. As a result, fees for all products and services that the College charges applicants and members will include 13% HST instead of the previous 5% GST.

This includes all College fees, such as the annual renewal fee and all fees related to application and registration (including examination fees, which were previously exempt from PST).

Applicants who register with the College after July 1 will be required to pay the 13% HST on their annual membership fee for 2010. Beginning in the fall, all College members will be required to pay the HST on their annual membership renewal for 2011.

To learn more about the HST and what will and will not be subject to it, visit the Ministry of Revenue’s special HST section at www.rev.gov.on.ca/en/taxchange. **S**

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*(Left to right:) Patti Tracey, RN, Peggy White, RN,
and Ade Oyemade, RN, at The Scarborough Hospital
in Toronto.*



Technology and

New technologies aren't going away
—here is how to integrate them into your
workplace and your practice



Photo: Swavek

YOU

TODAY, CHANGES IN TECHNOLOGY AFFECT OUR lives continuously. This seems to be especially true in the health care sector. When working as a health care provider, staying on top of new technology is crucial to maintaining competence.

“Health care technology supports safer, more efficient, timely and accessible client-centred care,” says Peggy White, RN. “Nurses need innovative technology at the point of care. It allows them to apply best practices and create more favourable outcomes for clients.”

White’s insights come from her work as program manager for Health Outcomes for Better Information and Care (HOBIC), a province-wide program conducted by the Ministry of Health and Long-Term Care. HOBIC is introducing the electronic collection of standardized clinical outcomes to acute care, long-term care, complex continuing care and home care organizations across Ontario. One aspect of the program examines how technology fits into daily nursing practice. This has given White an understanding about how technology is best introduced to nurses in the workplace.

“Providing quality care means staying abreast of current best practices and minimizing adverse events,” says White’s colleague Patti Tracey, RN, who coordinates HOBIC from Ajax across several Local Health Integration Network regions. “Technology can help us do this. For example, caring for clients is information-intensive. Much of the care we provide is based on the information we have about clients. So, information technologies can help by making information more readily available and useable.”

“In addition, nurses today are providing care to clients who are very knowledgeable about their health, and who no longer hesitate to ask questions,” continues White, who is based in Toronto. “Being able to explain how a piece of technology works, what it does and how it benefits the client, is reassuring. It builds the client’s confidence in the nurse’s knowledge and judgment.”

Building buy-in

Nurses’ attitudes toward new technology, and whether they will accept or resist its introduction into the workplace, depend on a number of factors.

“If a nurse is working in an unsupportive environment—one in which they are constantly on the go during their shift and leave exhausted—then they will likely resist any changes,” explains Tracey. “If a unit is constantly plagued by daily challenges like staffing issues or lack of resources or time, the introduction of new technology is unlikely to be well-received. Such challenges need to be addressed first.”

Open communication is also necessary when introducing a new

technology or policy, adds Ade Oyemade, RN, who is the manager of interprofessional education, and a professional practice leader in nursing at The Scarborough Hospital in Toronto. “Creating an environment in which discussions are open builds trust and respect, and gives nurses the opportunity to identify barriers such as lack of time, resources or support,” she says. “Open discussion can also decrease fears about a new technology. For example, nurses may worry that a new technology will actually increase their workload.”

Nurse involvement in the introduction and appraisal of any new technology is critical to successful implementation. “This is especially true if the change is something that everyone is required to adopt,” says Tracey.

“Nurses also need time and resources when adopting and incorporating new technologies into their daily practice,” adds White.

A new technology may have greater longevity in the workplace when nurses are involved in its implementation. “Supporting nurse participation in the development of implementation strategies means the technology will be disseminated in a more meaningful and useful way within the organization,” Oyemade says.

Education and support

Practical hands-on training allows nurses to learn and have their questions answered. “Issues about lack of experience, incorrect assumptions about how complicated a technology is to use, or fear of making a mistake while using a technology, can be addressed through education,” says Tracey.

“If we want nurses to embrace technology, we need to show them how it supports them in providing better client care. We can also provide them with up-to-date evidence that helps them develop care plans that integrate the technology,” says White. “Nurses need to evaluate the impact the technology is having on their practice.”

“Listening to nurses’ experiences on how a technology is affecting their nursing practice brings the feedback full circle,” says Oyemade. “Receiving feedback from staff helps educators and nurse managers adopt policies around technology that promote best practices. It ensures a new technology is integrated effectively into nurses’ workflow.”

For example, nurses working with a new technology may want to track its impact on performing procedures. Or, if they find that a newly introduced piece of technology isn’t compatible with previously existing technologies, then they should let their managers know this.

As well, support from educators and peers is essential to encouraging nurses to embrace new technology. For


instance, Tracey suggests that nurses find coworkers who are comfortable using technology and ask them for assistance. Or, they could request that their organization conduct staff education days so they could all learn as a group.

Staying informed

The College’s Quality Assurance (QA) Program requires nurses to stay up-to-date with technology and take opportunities to enhance their skills in this area. There are many readily accessible resources available to help nurses meet this requirement.

“The mainstream media is an easy way to stay current with the latest consumer tools and gadgetry,” suggests Tracey. “Conferences are good places for learning about clinically specific technologies. Many vendors also provide online discussion and support forums for their devices or computer software; these can be invaluable tools for more advanced technology users. Resources are available through the professional associations and, through the College, there is the QA Program. The ‘advances in technology’ element in the Self-Assessment component supports nurses in developing Learning Plans around technology. Information and resources are everywhere.”

In addition, the College’s practice documents can also help nurses make decisions about the appropriate use of technology. For instance, *Documentation, Revised 2008* includes a section about electronic documentation resources. You can download all of the College’s practice documents at no cost at www.cno.org. (See the sidebar on page 15 for more online resources.)

“Most nurses recognize the benefits of technology, but not all do,” says White. “However, all nurses need to understand that technology is going to play an increasingly important role in health care. It is not going away.” 

New website coming soon!

This fall, the College launches a revamped website at www.cno.org that will provide easier navigation, allowing you to quickly find the information you need. In the future, more resources to help you fulfil your QA Program requirements will be available, including applications to help you create Learning Plans online.

Tech-savvy at the College

The College's website has become an increasingly popular way to relay information and offer support to members and stakeholders. Here are some of the resources at www.cno.org that nurses, researchers and employers, as well as members of the public, government and media, find useful.

Annual membership renewal

One nurse called it, "One of the best things the College has ever done," and many members agree! Since 2006, the College has seen a steady increase in members' use of online renewal. In October, when renewal for 2011 opens, all members will be required to go online. See page 16 for more about this change.

Update your information

Launched in 2007, the Members' Area allows nurses to create an online profile that helps them keep their personal and business information up-to-date. As members of a self-regulated profession, nurses are required by legislation to provide the College with a current business address and phone number; the Members' Area makes this easy to do. All members will be required to create a Members' Area profile before renewing their membership for 2011.

Register of Ontario's nurses

The online register of members, Find a Nurse, went live in June 2009. Between June and December 2009, visitors to the website conducted more than 1.6 million searches on Find a Nurse. The Customer Service Centre reported an 86% drop in the number of requests it receives for register-related information.

Learning opportunities

The College's online Learning Centre currently includes 11 learning modules that nurses can use to test their knowledge of practice standards and guidelines. This innovative use of technology has proven very popular; so much so that other nursing regulatory bodies have adapted the College's learning modules for their own members. Plus, the College offers teleconferences on the standards and its programs on a regular basis. Visit the Learning Centre on the website to see what teleconferences are being offered and sign up.

Latest demographics

A valuable resource for researchers, the media and the government, our online data query tool allows individuals to tailor-make statistical data requests quickly and easily. Find it at www.cno.org/dqt.

Volunteer opportunities

The College often requires input from nurses during the development or testing of services, programs and documents. Nurses are also needed to sit on the College's statutory committees. By visiting the website, nurses can find information about such opportunities. In addition, applications for volunteer positions can be completed and submitted online.

Electronic newsletter

The College's e-newsletter, *Quality Practice* (QP), provides information geared toward nurse employers and nurses working in administrative roles. Since QP went online in March 2008, its subscriptions have risen from about 2,100 to over 6,000! For back issues, or to sign up to receive QP by e-mail, visit www.cno.org/qp.

Make the Shift

This fall,
get ready
to go online!

Starting Oct. 20, 2010, you, along with all your nursing colleagues, will be required to renew your College membership for 2011 online. The College will no longer distribute a paper renewal form.

“This year, the College changes to online renewal exclusively for a number of reasons,” explains Suzanne Vogler, Manager of Customer Service. “For example, the Ministry of Health and Long-Term Care now requires the College to ask members additional questions about their practice history, education and hours of work. Adding these questions to the paper form would have increased it by several pages. Completing such a complex form would not have provided members with a positive renewal experience. It would have resulted in more forms being completed incorrectly and returned to members.”

In addition, the College has been researching nurses’ use of new technologies. In its 2009 membership survey, the College learned that over 91 per cent of you have access to the Internet, and use it to conduct research, read online nursing journals and network with colleagues. Staying up-to-date with technology is an important part of maintaining competence in nursing. (See the cover story on page 12 for more information about integrating new technology into your practice.)

The College has also seen a continuous increase in your use of its online resources, from the learning modules to the *Compendium of Standards of Practice for Nurses in Ontario* and online renewal. In its first year, almost 40 per cent of Ontario nurses accessed online renewal. The following year, in 2008, this number climbed to just over 50 per cent. Last year, there was a big jump to almost 64 per cent who used online renewal.

Feedback from nurses who have renewed their

memberships online has been overwhelmingly positive. Since launching in 2007, the College has received feedback regularly that online renewal is “one of the best things that the College has ever done.”

New questions

This year, you will be asked more questions on the renewal form. These questions will focus on aspects of your education and practice, including:

- languages in which you can provide nursing care;
- education in nursing and non-nursing you have obtained;
- your practice history (for example, other countries in which you’ve practised, as well as a summary of past and current employers);
- the year in which you first started practising nursing in Canada;
- other jurisdictions in which you are registered to practise nursing; and
- hours of practice (for instance, estimating how many hours per week you work in nursing, and how these practice hours are divided among a range of nursing-related activities such as direct care, clinical teaching and administration).

The Health Ministry, which has mandated the College to ask its members these questions, will use this additional information for health human resource planning. The College will also be using some of this information to support its own activities.

Some of these questions will require you to provide start and end dates for employers, or the month and year in which you completed education programs. If you’ve


had multiple employers over the years or have taken many nursing education courses, determine these dates in advance so you can recall them while renewing.

Safe and secure

To ensure that online renewal will be a positive experience for you, the College has engaged nurses in the development and testing of the service. “The feedback received from nurses during focus groups and individual testing greatly enhanced the functionality of the program,” says Vogler. “We looked at how nurses responded to the wording of the questions and how they clicked their way through the screens, then made adjustments to ensure that navigation is as intuitive and straightforward as possible.”

Online renewal has measures in place that ensure all the information you provide on the site is secure. The service uses industry-standard encryption technology to make certain all personal information, including credit card or bank information you supply if paying your membership fee online, is safe.

In the coming months, the College will provide you with more information about online renewal, and how to

prepare for it, via the website and *The Standard*. On the next page, read how British Columbia’s regulatory college adopted online renewal. You can also see a list of Frequently Asked Questions at www.cno.org/renewal. 

No more Annual Payment Cards

Starting with 2011 renewal, the College will no longer be issuing Annual Payment Cards (APCs) to its members.

Discontinuing the APC will reduce incidents of forged, lost or stolen cards. Instead, there will be a record of payment in your Members’ Area profile and of your membership status on the online register, Find a Nurse. The College will also provide you with an electronic receipt that you can save or print for income tax purposes.

To see or set up your profile in the Members’ Area, visit www.cno.org.

The NEW Q&A learning module

The new Quality Assurance Program : **Self-Assessment** learning module is now available online at www.cno.org/learning.

Watch the module to learn more about the Self-Assessment process, including practice reflection and developing your Learning Plan.



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We Asked: Lynn Cairns, RN

The College of Nurses of Ontario isn't the first regulatory college in Canada to shift to online renewal. The College of Registered Nurses of British Columbia (CRNBC), which has just over 41,700 members, first piloted online renewal in 2003.

We asked CRNBC's Registration Advisor, Lynn Cairns, RN, about their registrants' experiences with online renewal.



Why did the CRNBC decide to promote the use of online renewal?

One of our organizational goals is to communicate with registrants electronically. As part of this, our corresponding registration and renewal goal is to move to a paperless system.

Registrants benefit from online renewal because renewal applications are processed much more quickly and registrants are notified instantly when their registration has been approved. Registrants can complete the process at their convenience, anywhere they have computer access and at any time of day.

We were successful at encouraging registrants to renew online because we stopped sending paper forms automatically.

How did the membership react to this change?

Feedback from registrants has been overwhelmingly positive. Online renewal is quick and hassle-free. There are no paper forms to fill out, and it can be done at the registrant's convenience and from any computer.

In 2003, CRNBC piloted online renewal with a group of 1,150 registrants. In the following years, the number of online renewals increased exponentially, with 97 per cent of our registrants renewing their registration online in 2010. We were surprised at how rapidly online renewal was adopted.

Some registrants, mainly those who were not comfortable using a computer, indicated that they prefer to

fill out a paper form. In these cases, registrants who lived in Vancouver were invited to our office so that we could assist them in completing their renewal electronically.

Other registrants were uncomfortable providing payment details over the Internet. These people could complete the renewal process electronically, and then send a cheque or money order by mail. We also offered registrants the option of setting up preauthorized monthly debit payments.

What benefits have you experienced?

Our registration department's workload during renewal has decreased significantly, since most renewals are now done electronically and the need for data entry is virtually eliminated. There is less opportunity for transcription errors by staff since registrants complete the forms themselves, giving them greater "ownership" of their registration and renewal information. This also means that staff members are now free to focus on new applicants.

In addition, on Dec. 16, 2009, we stopped issuing printed registration cards. Registrants are now informed by e-mail once their registration has been issued, and they are able to verify their status online on our website. This ensures that registration status is always accurate, and it eliminates the problem when a registrant's status may change after a card has been printed. The online verification process is also helpful for employers, who can check if their staff members have current registration. And, finally, online renewal and verification offers the best protection for the public. **S**

Annual Renewal Is Changing ...

1. Easy!
2. Fast!
3. Convenient!
4. Secure!

it's getting better

We are making your annual renewal easy, convenient and secure.

Starting on Oct. 20, 2010

- You will renew your membership online at www.cno.org. You will have the option of completing your online renewal in English or French. The paper form will be discontinued.
- You will be asked more questions. Your answers will be used to assess health human resources in Ontario.
- You will have more secure online payment options to choose from. Payment can also be made by cheque.
- You will confirm your renewal with a receipt from the College or the Find a Nurse register. The Annual Payment Card (APC) will be discontinued.
- The suspension date for those who do not renew by the Dec. 31, 2010 deadline will occur in mid-February, 2011.

To learn more about these important changes, read the article on page 16 of this issue and visit www.cno.org/renewal.



COLLEGE OF NURSES
OF ONTARIO
ORDRE DES INFIRMIÈRES
ET INFIRMIERS DE L'ONTARIO

THE STANDARD OF CARE.

Ready. Set. Participate!

Nurses and employers work together on continuing competence

When Lianne Wheeler, RN, learned that her colleagues had concerns about completing the Self-Assessment component of the College's Quality Assurance (QA) Program, she found a solution that resulted in nurses working together to meet their goals for continuing competence.

"During performance appraisals with staff, some of the nurses brought up questions about the College's program," says Wheeler, who is the chief nursing officer at Deep River and District Hospital. "They were concerned about how to apply the selected practice standards to their practice."

As more nurses approached her with QA-related questions, Wheeler recognized that the issue needed to be addressed. She suggested that the hospital's professional development committee create an action plan to help nurses complete the Self-Assessment requirements. The committee eagerly embraced this idea and started to conduct informal discussion forums with nurses.

Creating dialogue

As self-regulated professionals, nurses are expected to maintain and continually improve their competence, through professional development activities as well as the QA Program. This contributes to quality nursing practice and increases the public's confidence in the nursing profession.

The College encourages nurses to have discussions with their peers, supervisors and/or members of their interprofessional health team to get information they need for Self-Assessment. Self-Assessment is one of the three

components of the QA Program. (See the sidebar on page 22 for more information about QA.) Janet Anderson, RN, Manager of Quality Assurance, believes that the common issues nurses face in their practice settings are a great starting point for productive dialogue.

"A discussion forum is an example of a learning activity that can be used on an ongoing basis to support nurses in any practice setting," Anderson says.

Working together

When organizing and facilitating the forums, nurse-clinician Laurie Menard, RN, chose to take an informal approach. "From experience, I know that people don't share openly when a discussion session feels like a formal meeting, so I wanted the sessions to be informal, yet effective," she says.

Menard's strategy worked. Using food as an incentive, news about the session spread by word of mouth. Although the professional development committee originally offered two sessions, nurses requested a third session, which had the largest attendance.

"During each forum, we used the QA section of the College's website as a reference while we reviewed the selected practice standards—*Ethics* and *Infection Prevention and Control*—and discussed how they applied to our practice," explains Menard.

"We discussed general examples and listened to each other's suggestions about how our individual Learning Plans could address advances in technology, changes in the practice environment, entry-to-practice competencies and interprofessional care. We were all able to come up with



Photo: Olivier Thiriet Photography

(Left to right:) Laurie Menard, RN, James Elliot, RN, and Lianne Wheeler, RN, at Deep River and District Hospital, where the nurses organized discussion forums to help each other complete the Self-Assessment component of the College's QA Program.

goals and sort out how we were going to achieve them.”

The discussion forums were an innovative approach to obtaining peer input—a one-stop avenue for discussing ongoing issues and developments in their health unit or in individual nurses' roles, which the nurses personally applied to their QA exercises. These exercises made it easier for each nurse to reflect on their strengths and areas they needed to improve, and then determine their individual learning goals and create Learning Plans.

James Elliot, an RN at the hospital, appreciated the support he received from the sessions. “Being able to discuss with other nurses helped me put together my Learning Plan,” says Elliot. “In the informal setting, we were free to express our opinions and come up with viable solutions for one another.”

Always learning

The College's QA Program is based on the principle that lifelong learning is essential to continuing competence.

“Learning is not a finite activity or concept; it is a lifelong experience,” says Anderson. “Participating in the QA Program is essential not only because it is required by legislation, but also because it helps nurses keep up with changes in the health care environment and promotes quality client care.”

While nurses are expected to make a commitment to

continuing competence, employers, too, have a role to play in supporting the professional development of nurses.

“We try to support our nurses in every possible way to meet their learning needs,” says Wheeler, to whom 75 nurses report directly. “We provide an annual skills day for all nurses so that we can come together to learn from each other, review skills we may not have used very often and incorporate any practice changes. I review progress on goals annually during performance reviews.”

To ensure nurses will receive ongoing support beyond the recent QA discussion forums, Deep River has committed to holding annual forums to help nurses review their progress and receive feedback from their colleagues and supervisors.

“I can even foresee us incorporating the QA Program's Learning Plan into our formal performance appraisal process in the future,” Wheeler adds.

Deep River's example is one of many efforts nurses and employers are making in different practice settings to help one another maintain and improve their competencies. “It is exciting to see that nurses are finding proactive ways to support each other in completing QA requirements,” says Anderson. “This is one of many examples of how employers and nurses can work together to promote continuing competence.” **S**

Have you reviewed your

QA

Learning Plan lately?

Engaging in Quality Assurance activities is an ongoing process.

Remember to update your Learning Plan on a continual basis.

Visit www.cno.org/qa to find sample learning plans, forms and step-by-step instructions for creating your Learning Plan.



COLLEGE OF NURSES OF ONTARIO
ORDRE DES INFIRMIÈRES ET INFIRMIERS DE L'ONTARIO

THE STANDARD OF CARE.

About QA

All regulated health professionals in Ontario, including nurses, are required to participate in their college's quality assurance program.

The College's QA Program measures nurses' knowledge and application of the College's practice documents, including practice standards, guidelines and related competencies.

Each year, the College selects two practice standards and/or guidelines as the focus of the year's QA Program (this year, they are *Ethics* and *Infection Prevention and Control*). In addition, Nurse Practitioners must review the *Nurse Practitioners* practice document.

Three components:

There are three components to the QA Program: Self-Assessment, Practice Assessment and Peer Assessment.

- **Component 1: Self-Assessment** is a self-directed two-part process that results in the creation of a Learning Plan. To launch this component, the College sent a resource package to members in the fall of 2009. The package explains how to meet the requirements of Self-Assessment through practice reflection, which leads to developing and maintaining learning goals and Learning Plans. View the new Quality Assurance Program: Self-Assessment learning module in the online learning centre at www.cno.org/learning.
- **Component 2: Practice Assessment** requires randomly selected nurses to submit their Learning Plans to the College and participate in other specified assessments. The Practice Assessment process started in April.
- **Component 3: During Peer Assessment**, a peer assessor reviews a nurse's Learning Plan and the results of the other specified assessments. Then, the College's QA Committee decides if the nurse has successfully completed the program or if they must participate in remedial activities.

For more information, visit www.cno.org/qa.

Ad removed
for web
publishing

Penny Hunter, NP, at Group Health Centre in Sault Ste. Marie, is one of 11 Nurse Practitioners participating in a pilot project on ePrescribing.



ALL PRESCRIPTIONS MUST BE WRITTEN AND SIGNED BY THE PHYSICIAN.
You must be present to receive your medication. The pharmacist will contact you if there is a change.
You must be present to receive your medication. The pharmacist will contact you if there is a change.

A NOTE TO PATIENTS
Please do not give your medication to anyone else. It is for you only.
If you have any questions, please call your pharmacist.

Please do not give your medication to anyone else. It is for you only.
If you have any questions, please call your pharmacist.



Photo: Northern Lens Photography

eVolving practice

NPs help test new electronic methods of prescribing

Technology has revolutionized almost everything we do. So, it's not surprising that information-sharing and documentation in health care have become more electronics-based, too.

"New technology brings change, and change is inevitable in any nurse's career," says Janet Anderson, RN, Manager of Quality Assurance. "As self-regulated professionals, nurses must be prepared to perform in changing health care environments."

As well, the Ministry of Health and Long-Term Care requires all health care professionals to incorporate

elements of advances in technology into their learning activities when completing their health regulatory college's quality assurance requirements.

Electronic prescribing, or ePrescribing, is an example of a technological advance that could have an impact on all health care providers in Ontario.

eHealth Ontario is working on a strategy that will lead to an electronic health record for all Ontarians by 2015. To test this strategy, it is conducting an ePrescribing Demonstration Project, which started in April 2009 and will run until July 1, 2010.

Two locations that are advanced in the use of electronic medical records were selected for the ePrescribing Demonstration Project: Group Health Centre in Sault Ste. Marie and the Georgian Bay Family Health Team in Collingwood.

A total of 47 physicians and 11 Nurse Practitioners (NPs) from these two health facilities, and 42 pharmacies in their areas, are participating in the project, including Penny Hunter, an NP with the Group Health Centre.

“The expectation is that ePrescribing will eliminate the need for handwritten prescriptions and the particular challenges they present,” explains Hunter.

Paper versus electronic

Traditionally, prescriptions are written by hand, but this can present a number of challenges for prescribers and pharmacies, including slower turnaround times and an increased likelihood of medication errors due to illegible handwriting or the manual nature of the process.

“While ePrescribing improves accuracy and makes it easier and faster to generate prescriptions, it is not without challenges,” says Hunter. “At the outset, an extensive amount of work is required to create a detailed electronic medical record of clients’ health information.”

Also, investing in the technology is very expensive given the costs of developing the system, ensuring security of client information, and training medical and nonmedical staff to use the technology. However, Hunter believes the benefits can be worth the investments of time and money.

“I know from my experience during this pilot project that ePrescribing can reduce wait times for medication as well as reduce medication errors,” she says. “This would promote client safety and reduce unnecessary hospitalizations. Besides, paper storage can be a nightmare for health facilities, especially when searching for archived information. But ePrescribing technology allows for greater efficiency because of detailed electronic records, which are easy to find and require little-to-no storage space.”

Adapting to change

“While new technology such as ePrescribing can bring greater efficiencies to processes, it can also test nurses’ ability to adapt,” says Anderson. “As a result, the need to embrace changes in technology and apply the College’s standards and guidelines to the electronic elements of their practice is becoming a priority for nurses.”

Regardless of whether they use technology or manual processes, what is most important for nurses is to ensure they provide safe, effective and ethical care. Nurses must have the supports in place to deliver nursing care that meets clients’ needs.

“Nurses who do not have adequate resources to help them apply College standards to electronic elements in their practice setting should advocate for policies that are consistent with the College’s standards,” says Lori Adler, RN, Manager of Practice Standards.


In addition, when introducing a new technology, health facilities should ensure that the system’s design and accompanying processes are developed with the College’s standards in mind.

ePrescribing is the process of electronically generating, authorizing (signing) and transmitting prescriptions from physicians and other prescribers, such as NPs, to pharmacists and other dispensers.

Visit www.cno.org/publications to view practice documents that are relevant to prescribing, such as *Nurse Practitioners; Documentation, Revised 2008*; *Medication, Revised 2008* and *Confidentiality and Privacy—Personal Health Information*.

Next steps

eHealth Ontario, together with CNO, the College of Physicians and Surgeons of Ontario and the Ontario College of Pharmacists, are evaluating the ePrescribing project to determine whether new regulations, standards or guidelines are necessary to support ePrescribing and a province-wide drug information system.

For more information about the ePrescribing project and Ontario’s eHealth strategy, visit www.ehealthontario.on.ca. 

College funds at work

Where does your money go?

This year, the \$122.66 annual membership fee that renewing members will pay will account for 78 per cent of College revenue. The College uses membership fees and the revenue it generates from other sources (such as application fees and advertisements in *The Standard*) to fulfil its mission, guide the profession and protect the public. The revenue supports the work that legislation requires the College to perform. This work includes assessing applicants, developing practice documents and administering a Quality Assurance (QA) Program, as well as implementing programs that address concerns about practice and conduct.

A portion of the revenue funds strategic initiatives that advance the College toward its vision of excellence in nursing practice everywhere in Ontario. One such initiative is the Outreach Program, which helps members apply the standards in their practice. The College provides teleconferences that allow nurses and employers to communicate with the College about practice issues. As well, online learning resources based on the standards are available on the website.

In 2010, significant College resources will continue to be allotted to implementing the changes to the *Nursing Act, 1991* brought about by the *Health Systems Improvement Act*, which passed in 2009. To meet the requirements of this new legislation, the College is launching the Practice Assessment and Peer Assessment components of the revised QA Program.

Other projects requiring significant College resources are a redesign of the website and the development of online resources for members, including an expanded online renewal tool.

Because the College is a non-profit organization, its Finance Committee previously determined that the appropriate level of surplus to maintain was a minimum of two months to a maximum of six months of budgeted operating expenses. To maintain this surplus, the College might consider a fee increase to fund operations in 2012. **S**

College expenses for 2010

Executive Office (3%)

Provides strategic leadership to College operations and support to Council and committees.

Council and Committees (5%)

Council sets the strategic direction for the College and governs the regulation of the nursing profession in the public interest. Committees have the legislated authority to carry out specific statutory responsibilities of self-regulation.

Practice and Regulatory Policy (12%)

Develops and articulates standards of practice and entry-to-practice competencies, and provides policy support on regulatory issues. Provides member consultation services. Administers the College's QA Program.

Professional Conduct (17%)

Responds to issues about nurses' practice, conduct or health via a resolution or investigation process, and prosecutes the most serious cases of professional misconduct at public hearings. Supports the disciplinary and incapacity adjudication processes, and monitors compliance with committee orders.

Corporate Services (19%)

Provides customer service to members, applicants and the public. Supports College operations through building maintenance, finance, office services and human resources.

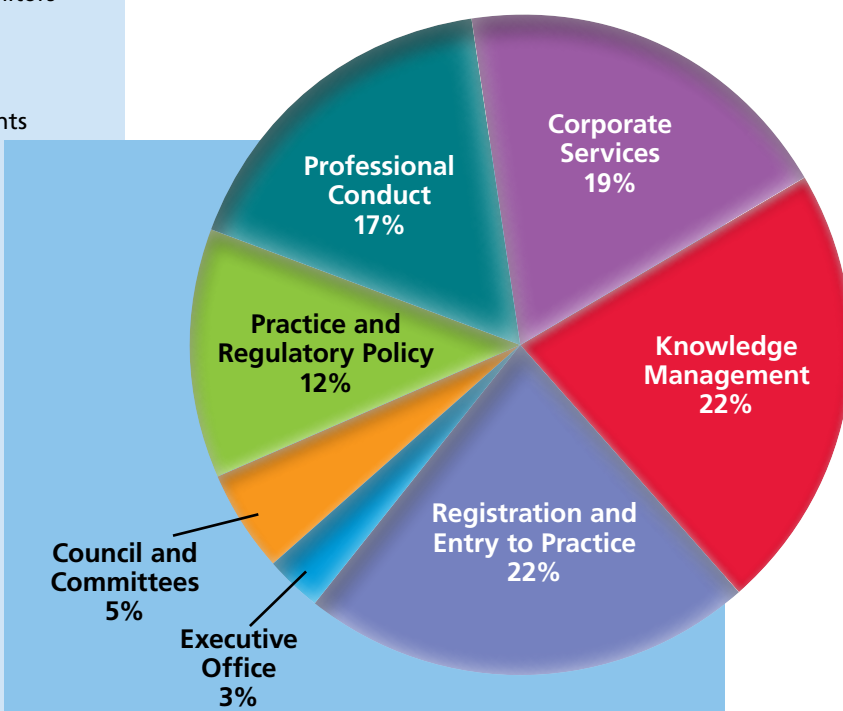
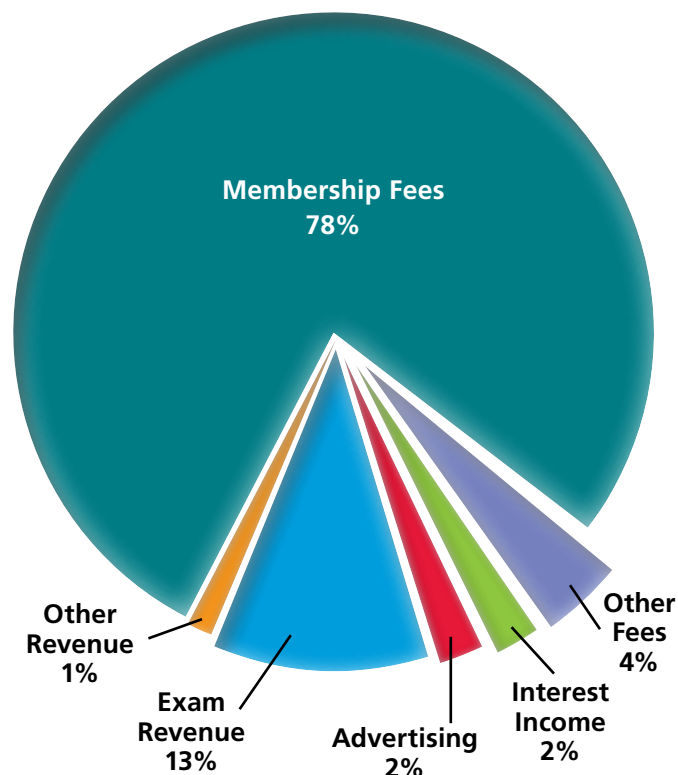
Knowledge Management (22%)

Generates and shares knowledge with members, employers, the public and the media through publications and the website. Maintains the College's records, produces membership statistics and conducts statistical analyses. Implements and maintains the software and technological infrastructure to support College functions.

Registration and Entry to Practice (22%)

Assesses applicants and registers those who qualify. Renews ongoing members, and supports online renewal and the members' section of the website.

2010 revenue budget



Responding to change

A letter from the President
and the Executive Director

For the College, 2009 was a year of change.

On June 4, legislative amendments reflecting the public's expectations for more accountable, transparent and effective self-regulation came into effect. Our focus was on ensuring that we could meet our new legislative obligations in a way that engaged nurses, supported employers in meeting their commitments and enhanced public confidence.

Our user-friendly online register, Find a Nurse, was launched on June 4, and our Inquiries, Complaints and Reports Committee was ready to go. Tools and resources were available to support nurses and employers in meeting their new obligations for reporting concerns. In the fall, we launched the first phase of our innovative Quality

Assurance Program, designed to support individual nurses in enhancing their practice.

Throughout the change process, we benefited from an approach that engaged nurses and stakeholders. Members of the public participated in multi-phased testing and assisted us in ensuring that Find a Nurse was accessible and easy to use.

We had not yet finished our preparations to meet the June 4 legislative requirements when additional changes were introduced. The *Ontario Labour Mobility Act* and the *Regulated Health Professions Law Statute Amendment Act* were introduced in May and received Royal Assent on Dec. 15, 2009. These Acts set high expectations for the mobility of professionals across Canada and introduced a



range of amendments to health regulatory legislation, including changes to controlled acts for nursing.

The College seized the opportunity presented by the introduction of new legislation to shape the future of nursing regulation and practice. Among other things, we supported changes

to the controlled acts for the profession, and made a strong public interest argument for enhancing the ability of Nurse Practitioners to prescribe medication. The resulting legislative changes that removed the requirement for NPs to prescribe from restrictive lists reflect the public's confidence in nursing self-regulation.

As a regulatory body, the College provides nurses with support and acts on behalf of the profession in the public interest. But, it is each nurse, in each client interaction, who takes her or his knowledge and skill, guidance they've received from the College, and compassion and caring, and shapes it into The Standard of Care.

See the full *Annual Report* and the Annual Report webcast at www.cno.org/AnnualReport.

George Fieber, RN
President

Anne Coghlan, RN, MScN
Executive Director and CEO

Auditors' Report

To the Council of the
College of Nurses of Ontario

We have audited the statement of financial position of the **College of Nurses of Ontario** as at December 31, 2009 and the statements of operations, changes in net assets and cash flows for the year then ended. These financial statements are the responsibility of the College's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the College as at December 31, 2009 and the results of its operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Hilborn Ellis Grant LLP

Chartered Accountants
Licensed Public Accountants

Toronto, Ontario
April 6, 2010

Statement of Financial Position

December 31	2009 \$	2008 \$
ASSETS		
Current Assets		
Cash	12,212,348	17,118,628
Investments (note 3)	17,325,501	2,609,726
Sundry receivables	197,617	166,489
Inventory	16,686	78,741
Prepaid expenses	391,465	358,789
	<u>30,143,617</u>	<u>20,332,373</u>
Investments (note 3)	-	11,811,020
Accrued pension asset (note 4)	1,047,960	1,130,604
Capital assets (note 5)	<u>10,005,662</u>	<u>9,817,915</u>
	<u>41,197,239</u>	<u>43,091,912</u>
LIABILITIES		
Current Liabilities		
Accounts payable and accrued liabilities	3,052,410	3,734,229
Deferred membership and examination fees	16,651,231	16,247,125
	<u>19,703,641</u>	<u>19,981,354</u>
NET ASSETS		
Net assets invested in capital assets	10,005,662	9,817,915
Unrestricted net assets	<u>11,487,936</u>	<u>13,292,643</u>
	<u>21,493,598</u>	<u>23,110,558</u>
	<u>41,197,239</u>	<u>43,091,912</u>

Approved on behalf of the Council:

George Fieber, RN
President

Nicole Florent, RN
Vice-President

Terry Holland, RPN
Vice-President

Statement of Operations

Year ended December 31	2009	2008
	\$	\$
		(note 7)
Revenues		
Membership fees	19,197,172	18,826,791
Credential evaluations, endorsements and transcripts	1,072,739	953,912
Examinations	3,123,827	2,780,335
Publications	478,945	639,155
Investment income	648,171	955,958
Other	253,515	260,681
	<u>24,774,369</u>	<u>24,416,832</u>
Expenses		
Practice and regulatory policy	3,149,763	3,087,882
Professional conduct	5,053,009	4,388,718
Council and committees	626,995	647,916
Executive	1,664,009	1,749,115
Knowledge management	5,367,855	4,933,298
Corporate services	10,529,698	9,894,598
	<u>26,391,329</u>	<u>24,701,527</u>
Excess of expenses over revenues for year	<u>(1,616,960)</u>	<u>(284,695)</u>

Statement of Changes in Net Assets

Year ended December 31	Invested in		2009	2008
	Capital	Unrestricted	Total	Total
	Assets		Total	Total
	\$	\$	\$	\$
Balance, beginning of year	9,817,915	13,292,643	23,110,558	23,395,253
Excess of expenses over revenues for year	(1,064,765)	(552,195)	(1,616,960)	(284,695)
Purchase of capital assets	1,252,512	(1,252,512)	-	-
Balance, end of year	<u>10,005,662</u>	<u>11,487,936</u>	<u>21,493,598</u>	<u>23,110,558</u>

Statement of Cash Flows

Year ended December 31	2009	2008
	\$	\$
Cash flows from operating activities		
Excess of expenses over revenues for year	(1,616,960)	(284,695)
Adjustments to determine net cash provided by (used in) operating activities		
Amortization	1,064,765	1,005,700
Interest capitalized on investments	(582,651)	(564,697)
Funding of pension benefits	(642,579)	(580,718)
Pension benefits expense	725,223	627,575
	<u>(1,052,202)</u>	<u>203,165</u>
Changes in non-cash working capital		
Increase in sundry receivables	(31,128)	(12,523)
Decrease in inventory	62,055	17,629
Increase in prepaid expenses	(32,676)	(48,905)
Increase (decrease) in accounts payable and accrued liabilities	(681,819)	284,902
Increase in deferred membership and examination fees	404,106	776,352
	<u>1,331,664</u>	<u>1,220,620</u>
Cash flows from investing activities		
Purchase of investments	(10,346,133)	(8,000,000)
Proceeds from disposal of investments	8,024,029	4,380,044
Purchase of capital assets	(1,252,512)	(837,975)
	<u>(3,574,616)</u>	<u>(4,457,931)</u>
Net decrease in cash during year	<u>(4,906,280)</u>	<u>(3,237,311)</u>
Cash, beginning of year	<u>17,118,628</u>	<u>20,355,939</u>
Cash, end of year	<u>12,212,348</u>	<u>17,118,628</u>

Notes to Financial Statements

December 31, 2009

1. Description of Organization

The College of Nurses of Ontario ("College") was incorporated as a non-share capital corporation and continued as such under the Nursing Act, 1991. As the regulatory body of the nursing profession in Ontario, the College's major function is to administer the Nursing Act, 1991 in the public interest.

The College is a not-for-profit organization, as described in Section 149(1)(l) of the Income Tax Act, and therefore is not subject to either federal or provincial income taxes.

2. Significant Accounting Policies

a) New accounting standards adopted during the year

During the year, the College adopted a new standard recommended in the Canadian Institute of Chartered Accountants (CICA) Handbook on financial statement presentation by not-for-profit organizations, Section 4400.

Section 4400, Financial Statement Presentation by Not-for-Profit Organizations, allows organizations to segregate the amount invested in capital assets either as a component of net assets in the statements of financial position and changes in net assets or to disclose this amount in a note to the financial statements. The revised standard also requires organizations to present revenues and expenses at their gross amounts when the organization acts as a principal and to prepare the statement of cash flows in accordance with Handbook Section 1540 - Cash Flow Statements. The College adopted the standard for the fiscal year ended December 31, 2009. No adjustments were required to the presentation of the financial statements.

b) Investments

Investments consist of fixed income investments whose term to maturity is greater than three months from the date of acquisition. Fixed income investments maturing within twelve months from the year-end date are classified as current.

The investments are classified as held to maturity and are recorded at amortized cost as it is management's primary objective to hold investments to maturity.

The amortized cost of an investment is the amount at which the investment is measured at initial recognition minus principal repayments, plus or minus the cumulative amortization using the effective interest method of any difference between that initial amount and the maturity amount, and minus any reduction for impairment or uncollectability.

Transaction costs associated with the acquisition and disposal of investments are capitalized and included in the acquisition costs or reduce proceeds on disposal. Investment management fees are expensed as incurred.

The purchase and sale of investments are accounted for using trade-date accounting.

c) Capital assets

Capital assets are recorded at cost. Amortization is provided for on a straight-line basis at rates designed to amortize the cost of the capital assets over their estimated useful lives. The annual amortization rates are as follows:

Building	- 2½%
Building improvements	- 6⅔%
Office furniture	- 10%
Office equipment	- 20%
Computer hardware	- 20%
Database application software	- 14%
Other application and operating software	- 20%

d) Revenue recognition**i) Membership fees**

Membership fees are recognized as revenue proportionately over the fiscal year to which they relate. The membership year coincides with that of the fiscal year of the College, being January 1 to December 31. Membership fees received in advance of the membership year to which they relate are recorded as deferred membership fees.

ii) Services

Revenue from credential evaluations, endorsements and transcripts and examinations is recognized when the service is rendered. Examination fees received in advance of the date the examination is held are recorded as deferred examination fees.

iii) Publications

Revenue from publications is net of estimated returns and is recognized at the time of shipment.

iv) Investment income

Investment income comprises interest from cash and fixed income investments. Revenue is recognized on an accrual basis. Interest on fixed income investments is recognized over the terms of these investments using the effective interest method.

e) Pension benefits

The actuarial determination of the accrued pension obligation uses the projected benefit method prorated on service (which incorporates management's best estimate of future salary levels, other cost escalation, retirement ages of employees and other actuarial factors).

For the purpose of calculating the expected return on plan assets, those assets are valued at fair value.

Actuarial gains (losses) arise from the difference between the actual long-term rate of return on plan assets for a period and the expected long-term rate of return on plan assets for that period or from changes in actuarial assumptions used to determine the accrued pension obligation. The excess of the net accumulated actuarial gain (loss) over 10 percent of the greater of the pension obligation and the fair value of plan assets is amortized over the average remaining service period of active employees. The average remaining service period of the active employees covered by the pension plan is 12.1 years (2008 - 12.1 years).

The College adopted the current accounting standard on employee future benefits in 2000 using the prospective application method. The College is amortizing the transitional asset on a straight-line basis over 18 years, which was the average remaining service period of employees expected to receive benefits under the pension plan as of January 1, 2000.

Past service costs arising from plan amendments are deferred and amortized on a straight-line basis over the average remaining service period of employees active at the date of amendment.

f) Financial instruments

In accordance with Section 3855, certain financial instruments are classified into one of the following five categories: held for trading, held to maturity, loans and receivables, available for sale, or other financial liabilities. The classification determines the accounting treatment of the instrument. The classification is determined by the College when the financial instrument is initially recorded, based on the underlying purpose of the instrument.

The financial assets and financial liabilities of the College are classified and measured as follows:

Financial Asset/ Liability	Category	Measurement
Cash	Held for trading	Fair value
Investments	Held to maturity	Amortized cost
Sundry receivables	Loans and receivables	Amortized cost
Accounts payable and accrued liabilities	Other financial liabilities	Amortized cost

Financial instruments measured at amortized cost are initially recognized at fair value and then subsequently at amortized cost with gains and losses recognized in the statement of operations in the period in which the gain or loss occurs.

The fair value of a financial instrument is the estimated amount that the College would receive or pay to settle a financial asset or financial liability as at the reporting date.

The fair values of sundry receivables and accounts payable and accrued liabilities approximate their carrying values due to their nature or capacity for prompt liquidation. It is management's opinion that the College is not exposed to significant interest rate, currency or credit risks arising from these financial instruments.

Disclosure related to other financial instruments is found in note 3, Investments, and note 4, Accrued Pension Asset.

g) Management estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period.

Key areas where management has made complex or subjective judgments (often as a result of matters that are inherently uncertain) include, among others, amortization, pension benefits and accruals related to professional conduct. Actual results could differ from these and other estimates, the impact of which would be recorded in future periods.

3. Investments

	2009	2008
	\$	\$
	17,325,501	14,420,746
Portion maturing within twelve months from the year-end date	(17,325,501)	(2,609,726)
Classified as long-term for financial statement presentation	-	11,811,020

The fixed income investments have effective interest rates ranging from 0.85% to 5% (2008 - 4% to 5%), with maturity dates ranging from March, 2010 to December, 2010 (2008 - July, 2009 to December, 2010). The fair values of the fixed income investments approximate their carrying values.

Interest rate price risk

The College manages the interest rate price risk exposure of its fixed income investments by using a laddered portfolio with varying terms to maturity. The laddered structure of maturities helps to enhance the average portfolio yield while reducing the sensitivity of the portfolio to the impact of interest rate fluctuations.

Credit risk

The College has an investment policy which restricts the types of eligible investments. The policy permits investments in securities issued or guaranteed by the federal government or a provincial government and other investments approved by Council on the advice of the Finance Committee.

4. Accrued Pension Asset

a) Description of plan

The College maintains a registered pension plan for its employees, which comprises defined benefit and defined contribution components. The defined benefit component provides benefits based on years of service and a base pensionable earnings year which is automatically updated each January 1 to the year three years prior to the current year. The College's policy is to fund the registered pension plan in the amount that is required by governing legislation and determined by the plan's actuary.

b) Total cash payments

Total cash payments for pension benefits for 2009, consisting of cash contributed by the College to its funded registered pension plan, were \$642,579 (2008 - \$580,718).

c) Defined benefit plan

The College measures its accrued pension obligation and the fair value of plan assets for accounting purposes as at December 31 of each year. The most recent actuarial valuation of the pension plan for funding and accounting purposes was as of December 31, 2006, and the next valuation (which is in progress) will be as of December 31, 2009.

Elements of defined benefit costs recognized in the year

	2009	2008
	\$	\$
Current service cost, net of employee contributions	67,907	96,214
Interest cost	266,326	241,672
Actual return on plan assets - (gains) losses	(365,461)	604,626
Actuarial (gains) losses	1,076,321	1,218,074
Elements of defined benefit costs before adjustments to recognize the long-term nature of defined benefit costs	<u>1,045,093</u>	<u>2,160,586</u>
Adjustments to recognize the long-term nature of defined benefit costs:		
Difference between expected return and actual return on plan assets for year	138,216	(879,051)
Difference between actuarial (gains) losses recognized for year and actual actuarial (gains) losses on accrued pension obligation for year	(1,016,882)	(1,153,620)
Difference between amortization of past service costs for year and actual plan amendments for year	28,499	28,499
Amortization of the transitional asset	(8,425)	(8,425)
	<u>(858,592)</u>	<u>(2,012,597)</u>
Defined benefit costs recognized	<u>186,501</u>	<u>147,989</u>

Reconciliation of funded status of plan to the amount recorded in the statement of financial position

	2009	2008
	\$	\$
Plan assets at fair value	3,683,269	3,415,385
Accrued pension obligation	<u>4,132,525</u>	<u>3,571,147</u>
Funded status of plan - deficit	(449,256)	(155,762)
Unamortized transitional asset	(67,407)	(75,832)
Unamortized past service costs	257,378	285,877
Unamortized net actuarial loss	<u>1,307,245</u>	<u>1,076,321</u>
Accrued pension asset in statement of financial position	<u>1,047,960</u>	<u>1,130,604</u>

Accrued pension obligation

	2009	2008
	\$	\$
Balance, beginning of year	3,571,147	4,381,841
Current service cost	93,255	120,393
Interest cost	266,326	241,672
Actuarial loss (gain)	428,579	(956,350)
Benefits paid	<u>(226,782)</u>	<u>(216,409)</u>
Balance, end of year	<u>4,132,525</u>	<u>3,571,147</u>

Plan assets

	2009	2008
	\$	\$
Fair value, beginning of year	3,415,385	4,111,108
Actual return on plan assets	365,461	(604,626)
Employer's contributions	103,857	101,133
Employees' contributions	25,348	24,179
Benefits paid	<u>(226,782)</u>	<u>(216,409)</u>
Fair value, end of year	<u>3,683,269</u>	<u>3,415,385</u>
	2009	2008
	%	%
Plan assets consist of:		
Equity securities	62	25
Debt securities	36	14
Guaranteed interest accounts	-	35
Cash	2	26
	<u>100</u>	<u>100</u>

Actuarial assumptions

The significant actuarial assumptions used in measuring the accrued pension obligation and the defined benefit costs are as follows (weighted-average):

	2009	2008
	%	%
Accrued pension obligation as of December 31:		
Discount rate	6.50	7.50
Rate of compensation increase	4.00	4.00
Defined benefit costs for years ended December 31:		
Discount rate	7.50	5.50
Expected long-term rate of return on plan assets	6.75	6.75
Rate of compensation increase	4.00	4.00

d) Defined contribution plan

	2009	2008
	\$	\$
Defined contribution costs recognized, net of forfeitures	<u>538,722</u>	<u>479,585</u>

5. Capital Assets

	Cost \$	Accumulated Amortization \$	2009 Net \$
Land	3,225,009	-	3,225,009
Building	6,502,403	3,944,778	2,557,625
Building improvements	2,959,437	1,094,717	1,864,720
Computer hardware and software	4,758,640	3,189,313	1,569,327
Office furniture and equipment	3,327,623	2,538,642	788,981
	<u>20,773,112</u>	<u>10,767,450</u>	<u>10,005,662</u>

	Cost \$	Accumulated Amortization \$	2008 Net \$
Land	3,225,009	-	3,225,009
Building	6,502,403	3,782,218	2,720,185
Building improvements	2,374,587	916,011	1,458,576
Computer hardware and software	4,615,273	2,790,073	1,825,200
Office furniture and equipment	2,964,737	2,375,792	588,945
	<u>19,682,009</u>	<u>9,864,094</u>	<u>9,817,915</u>

During the year, amortization in the amount of \$1,064,765 was provided for in respect of capital assets (2008 - \$1,005,700).

6. Capital Disclosures

For its own purposes, the College defines capital as the sum of net assets invested in capital assets and unrestricted net assets. The College is not subject to externally imposed requirements on capital.

The College's objectives when managing capital are to hold sufficient unrestricted net assets to provide for normal operating requirements on an ongoing basis and to enable it to withstand negative unexpected financial events, in order to maintain stability in the financial structure. The College holds fixed income investments with varying terms to maturity to ensure sufficient liquidity.

7. Comparative Figures

Certain of the prior year's figures have been reclassified to conform with the current year's presentation. The changes do not affect prior year excess of expenses over revenues.

Entry to Practice

Standards

Quality Assurance

Enforcement

Webcast of Annual Report



Anne Coghlan, RN, the College's Executive Director, narrates the highlights of last year's key accomplishments. Learn more about the four components of self-regulation at www.cno.org/AnnualReport.

Quiz questions are based on queries to the College; real names have not been used.

Nurses have ethical and legal obligations for obtaining consent. Do you know when consent is required, and who can give consent when a client cannot?

Take the Quiz: Consent

1 Faaiza, an RN, has just started to practise at a sexual health clinic. Tina, a 13-year-old, arrives and tells her that she wants to go on the birth control pill. Faaiza isn't sure if Tina is old enough to consent to an oral contraceptive. She wonders if she should ask Tina to bring in a parent or guardian.

Can a person under 16 consent to treatment in Ontario?

- Yes** There is no minimum age for consenting to treatment.
- No** You must be 18 or older to give consent for treatment.

2 Greg is a novice RN who recently started practising on a busy medical unit. Greg's co-worker, Sang-ki, asks him to obtain signed consent for a blood transfusion from her client. Greg informs Sang-ki that he has no experience with blood transfusions and doesn't know much about them. Sang-ki tells Greg that he doesn't need to explain the procedure to the client, he only needs to witness the signature.

Can Greg obtain consent for a procedure he's unfamiliar with?

- Yes** He's only witnessing that the client signed the consent form.
- No** He isn't able to inform the client of the risks and benefits of the procedure.

3 Janica, an RPN, practises in an internal medicine unit at an acute care facility. One of Janica's assigned clients, Latif, is an elderly man who is illiterate. A CT scan with contrast dye has been ordered for Latif, but organizational policy requires that a written consent form be completed before this procedure can be performed. Latif's physician, Dr. Montgomery, has obtained informed consent and asked Janica to witness the consent. Janica wonders if Latif's inability to read affects his ability to give consent.

Is a client who can't read or sign a consent form capable of giving consent?

- Yes** An illiterate client can provide consent.
- No** A client must be able to read the form and sign it to give consent.

4 Jane, an RPN, has just arrived at a flu vaccination clinic to fill in for a nurse who is off sick. She asks the supervisor, Lloyd, where the consent forms are. Lloyd says clinics that only give flu shots don't require consent, so they don't need consent forms. Jane wonders if consent is assumed because the clients have come to the clinic voluntarily.

Does Jane require consent to administer the flu vaccine?

- Yes** Nurses must obtain informed consent prior to any intervention.
- No** Consent can be assumed at a flu vaccination clinic.

5 Thomas has been on a disability leave for an injury he suffered while working at a large manufacturing firm. A staff member in the human resources department asks Molly, an RN who is the firm's occupational health nurse, to send her Thomas' health information so she can set up a back-to-work program allowing him to return to full-time employment. Since Molly is being asked to transfer health information within the firm, she wonders if she needs to ask Thomas for his consent to give confidential health information to the HR staff member.

Do you need client consent to share health information within an organization?

- Yes** Consent is required if the health information is to be shared with someone who isn't directly involved in the client's health care.
- No** Consent is not needed if health information is to be shared within an organization.

Answers on page 41

2010 Council election results

Regions: Central (RNs), Central Eastern (RNs and RPN) and Toronto (RNs)

Central

RNs (two positions)

Marianne Fletcher	599
Dennis Curry	557
Lorenza Barron	552
Shaeralee McCutcheon	449

Central Eastern

RNs (two positions)

Nancy Sears	615
Nicole Florent	568
Mandy Edgerton-Reid	446
Ruth Kitson	361

Toronto

RNs (two positions)

Agnese Bianchi	1052
Joseph Gajasan	844
Carolyn Sibbick	722
Jody Macdonald	508
Julia Rock	367
Alicia Moonesar	340

Central Eastern

RPN (one position acclaimed)

Leslie (April) Cheese

Council meetings

The minutes of the June 2 Council meeting will be posted on the website at www.cno.org/connect in July.

You are invited to attend Council meetings.

Upcoming meetings:

Sept. 15 and 16

Dec. 1 and 2

Council meetings begin at 0900 hrs in the College's Council Chambers. The Council agenda, as well as any changes to dates and times, are posted at www.cno.org/agendas at least two weeks before the meeting.

Space is limited. To attend, contact Jenna Hofbauer, Council Affairs Coordinator, at 416 928-0900, ext. 7566; 1 800 387-5526, ext. 7566 (toll-free in Ontario); or jhofbauer@cnomail.org.

Did you know?

Every year, Council members elect the President and two Vice-Presidents. The President can be an RN or RPN, or a public member. The *Nursing Act, 1991* requires that one Vice-President must be an RN and the other, an RPN.

Visit www.cno.org/council for more information.



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need**

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the College's
e-newsletter,
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employers the
information they
need to meet
their legislative
and professional
obligations.

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Have you moved or changed employers?

If you change your home or business address, you are required to **notify the College within 30 days**. There are three ways to inform the College of an address change:

1 Visit the Members' Area of the College's website at www.cno.org/members and change your address online.

2 Complete the Change of Address Notice form (right) and mail it to:
Customer Service Centre
College of Nurses of Ontario
101 Davenport Rd.
Toronto, ON M5R 3P1

3 Complete the Change of Address Notice form and fax it to 416 928-6507.

Please include your registration number on all communications.

The College posts every member's business address on the Register. If you'd like a different address to appear on the Register, contact the Customer Service Centre.

To change your home address, contact the Customer Service Centre:

Tel.: 416 928-0900

Toll-free in Ontario: 1 800 387-5526

E-mail: cno@cnomail.org

Change of Address Notice

Please print (To process your address change, you must complete all of the information requested.)

Last name

First name and initials

Registration number

Date of birth

School of nursing

Year of graduation

NEW INFORMATION

New address takes effect on

Home address

Apt. no. Street no. Street name

City Province/state Postal/zip code

Country

Home telephone

E-mail address

If you are employed (in nursing, in a job other than nursing or if you are self-employed), you must provide a business address.

Business address (Primary nursing practice location preferred)

Name of employer/agency/institution

Street address

City Province/state Postal/zip code

Country

Business telephone

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Quiz answers from page 34

1 Yes There is no minimum age for consenting to treatment in Ontario. However, Faaiza is accountable for using her professional judgment to determine if her client is capable of understanding and appreciating the information needed to make a decision about using this form of birth control, and can appreciate the possible consequences of her decision. Faaiza needs to provide Tina with the information necessary to make a decision about the treatment, answer her questions and discuss alternatives to oral contraceptives. To determine whether the client is capable of giving consent, Faaiza could ask the client to repeat in her own words what she understands the treatment to be, and consider both her questions and responses. Before deciding whether the client is capable of giving consent, Faaiza also needs to take into account the circumstances and Tina's condition.

Consent must relate to a specific treatment. For example, if Tina returned next month to request an IUD, Faaiza would have to assess her capability to consent to that treatment, and may decide that she is incapable of making the decision about that treatment.

2 No Greg cannot obtain consent from the client. A nurse has a responsibility to ensure that clients are fully informed about a treatment. Greg must be able to inform the client of the nature of the treatment, the expected benefits of the treatment, the material risks and side-effects of the treatment, alternative courses of action and the likely consequences of not having the treatment. He must also be able to answer or find an answer to any questions the client may have about a blood transfusion. Because Greg has concerns about his knowledge and understanding of the proposed treatment, he should not proceed to obtain consent at this time.

3 Yes The ability to read or write does not affect capacity to provide consent, just as literacy is not indicative of a person's ability to understand relevant information and make a decision about a treatment. In fact, consent may be oral, written or implied, depending on the circumstances and context of the situation. A nurse should not obtain consent for, or provide, a treatment if there is any doubt that a capable client understands the information needed to make the decision.

Latif is capable of giving consent for the CT scan if he understands the information, the possible consequences of the treatment as well as the alternatives, and the

consequences of having or not having the treatment. Dr. Montgomery or Janica could read the consent form to Latif, and then give Latif an opportunity to ask questions. After addressing any concerns that Latif has, they could ask him if he consents to the procedure. How Latif provides consent should be documented in the client record.

4 Yes Nurses must obtain informed consent for all interventions they provide, except in certain emergency situations (for instance, when a client is at risk of sustaining serious bodily harm if treatment is not administered promptly). Although consent can be written or oral, nurses must be aware of their organization's policies regarding the use of consent forms. If consent is oral, nurses need to document it in the immunization record and/or the organization's form.

At the clinic, Jane must ensure that her clients have given informed consent before administering the flu vaccination. Jane must ensure the clients are competent to consent to the vaccine and have enough information about the treatment (including its nature; expected benefits, risks and adverse effects; likely consequences of not having the treatment; and alternative courses of action) to make an informed decision. Nurses must use their professional judgment to determine whether clients can understand the information. For example, if a client who shows signs of cognitive impairment does not understand the information, the nurse could inform the client that a substitute decision-maker is needed to decide on their behalf.

Because this flu vaccination clinic does not have a consent policy, Jane must advocate for one. She should start by speaking to her supervisor about the College's standards and the *Health Care Consent Act*. She could also become involved in developing the new policy, which would support nurses' ability to provide ethical care.

5 Yes If client information is to be shared outside of the health care team, then consent is needed. Nurses have ethical and legal responsibilities to maintain the confidentiality and privacy of client health information. In this case, consent is required since the information will not be used for the purpose of providing health care to the individual the information relates to. For more information, refer to the *Confidentiality and Privacy—Personal Health Information and Consent* practice documents at www.cno.org/publications. Visit www.e-laws.gov.on.ca to review the *Health Care Consent Act*.

You Asked Us

Phoning in
prescriptions

Bedside reporting

Reporting abuse

Student
accountability

Q I'm an RN working in a family physician's office. The other day, Dr. Mell asked me to provide a client with a new prescription on her behalf. She instructed me to write the prescription and sign my name followed by, "as per Dr. Mell." Can I do this?

A No, you cannot sign the prescription as the physician requested because RNs do not have the authority to authorize prescriptions. Since the physician was physically present in the office to instruct you, the safest practice would have been for Dr. Mell to write and sign the prescription. Then, you could either have given the prescription to the client or faxed it to the client's pharmacy via a secure fax.

Furthermore, this is a verbal order, which is inappropriate because it is not an emergency situation. (For more information on verbal orders, see the *Medication, Revised 2008* practice document.) Nurses are expected to advocate for systems, processes and environments that support safe and ethical medication practices.

If a prescription is needed and the physician isn't present, you can receive the order from the physician by telephone to facilitate client care. Ensure accuracy of the information by repeating the order back to the physician. Then, document the telephone order in the client's chart and phone the pharmacy with the prescription.

Nurses who phone pharmacies with prescriptions should speak directly to the pharmacist (not leave the telephone order on voice mail). After giving the pharmacist the prescription, ask the pharmacist to repeat the prescription back to you. Then, document the details of the phoned-in prescription in

the client's chart (name of the pharmacy, day and time you phoned in the prescription and name of the pharmacist who transcribed it). Pharmacists may request your name and registration number for their records, as well. For more information, refer to the *Decisions About Procedures and Authority, Revised 2006* practice document.

Q I'm an RN practising in the telemetry unit of an urban hospital. All of the clients are in ward rooms with four clients per room. At change-of-shift, I give an oral report on each client to the incoming nurse at the bedside. Should I be concerned about breaching client confidentiality when giving a bedside report?

A Yes, you should be concerned about breaching client confidentiality. While nurses are obligated to communicate client information to the health care team and involve clients in decisions about treatment, they also have ethical and legal responsibilities to maintain the confidentiality and privacy of client health information.

The *Confidentiality and Privacy—Personal Health Information* practice document states that nurses should not discuss client information with colleagues or the client in public places such as elevators, cafeterias and hallways. A telemetry unit is not a public place, but it is not a private room either. Discussions in shared settings such as ward rooms are likely to be overheard by other clients, family members, visitors or health care facility employees.

If you choose to give an oral report at the bedside, discuss it with

clients beforehand so they know this is how their information will be shared. It will also give them an opportunity to consent to this method of information-sharing. If there is a specific aspect of health information that a client does not want to have discussed, you should abide by this request. If you can move the discussion to a more private area while still including the client as a participant in the discussion, then explore this with the client and the health care team.

There are many benefits to giving oral reports at the bedside. Face-to-face reports at the bedside facilitate information-sharing between the client and health care team. This provides the client with an increased opportunity to be involved in decisions about their care. It also provides nurses with opportunities to clarify information for the client.

Nurses must use professional judgment when considering what information will be shared at the bedside, and to decide if the situation calls for a more private setting that still involves the client.

Q I'm an RN working in a long-term care facility. Recently, a client's daughter told me that another nurse had pushed her mother. I know the other nurse and I can't imagine that she would harm a client. Since I didn't see what happened, am I responsible for reporting it to my supervisor or to the College?

A Nurses must intervene when the safety and well-being of a client is in question. You are responsible for ensuring that the client is not at risk of abuse.

You are responsible for reporting the alleged physical abuse to an appropriate authority, such as the nurse manager. All practice settings should have a clear procedure for reporting abuse. If your workplace doesn't have a process, discuss the need and rationale for having one to support a safe practice environment and your accountabilities as a nurse.

If you had been told that a nurse had sexually abused a client, then you would be required to report the alleged abuser to the College within 30 days or sooner. *The Regulated Health Professions Act, 1991* legislates health professionals' mandatory reporting of sexual abuse to their health regulatory college.

For more information, refer to the *Ethics and Therapeutic Nurse-Client Relationship, Revised 2006* practice documents, as well as *Mandatory Reporting: A process guide for employers, facility operators and nurses*. To learn more about the College's abuse prevention program, One is One Too Many, visit www.cno.org/one.

Q I'm an RPN who is enrolled in the BScN program at a local university. As part of the program, the students are supervised in practicums in a variety of practice settings. When I am in a clinical placement as a student, am I still accountable to the College as an RPN?

A Yes. If you're in a clinical placement as a BScN student, and an unexpected occurrence requires you to act as an RPN to ensure the safety and well-being of a client, you must act as an RPN until another nurse can assume the care of the client.

Before you start a new placement, familiarize yourself with the organization's policies on RN and RPN roles. Then you'll be able to act in accordance with them if you are required to step outside the student role and into the role of an RPN.

As a nurse, you are expected to meet the practice standards of the College. Even when in a learner role (in this case, as a BScN student), you are still accountable to the College.

All learners need to know what knowledge, skill and judgment they have; the limits of their responsibilities; their legislative authority; as well as the organizational policies, procedures and principles that are relevant to them. They also need to identify the need for, and obtain, appropriate supervision. Learners are accountable for the quality of care they provide within the objectives that they have established with the preceptor or educator. The nurse supporting you is accountable both for sharing appropriate nursing knowledge and for maintaining safe, effective and ethical client care in accordance with the standards.

For more information, refer to the *Supporting Learners* and *Working in Different Roles* practice documents. **S**

All College documents can be found at www.cno.org/publications.

Have a question about applying the College's practice standards? E-mail the Practice Support Line at ppd@cnomail.org. Or, call 416 928-0900, ext. 6397; or 1 800 387-5526, ext. 6397 (toll-free in Ontario).

There is something to be learned from every complaint. Each time the College receives a complaint, it provides an opportunity for nurses to learn and reflect on their practice. It can help nurses understand the issues that led to the complaint, find out why misunderstandings may have occurred and identify ways to improve their practice.

The College responds to the public's concerns about nurses' practice and conduct through its complaints process. When nurses take part in the process, they participate in self-regulation and demonstrate accountability as members of the nursing profession.

This column is intended to help nurses understand and reflect on common concerns raised by the public. The following scenario is based on an actual complaint. However, all names, locations and identifying characteristics have been changed to protect confidentiality.

Participating in a resolution

The complaint

The College received a complaint from Eileen, whose husband, Jerry, died in hospital after contracting *C. difficile*. Before his death, Jerry had fallen, been taken to the hospital for hip surgery and then discharged to a long-term care facility.

Eileen wrote to the College about her concerns regarding Lucinda, a nurse at the long-term care facility who admitted and cared for her husband for several days before he was readmitted to the hospital:

My husband, Jerry, was in good health before he fell and broke his hip. After that, the recovery from his surgery was difficult, and he required more care than I could provide at home. We made the difficult decision that Jerry should go to a long-term care facility, with the hope that I would be admitted to the same home one day. Before the surgery, Jerry had been

very independent and had no significant health issues.

*My husband was admitted to the long-term care facility on April 10. When the doctor examined him on the first day, we told him that Jerry had had some diarrhea over the past 24 hours. Nothing was done at that time. The next day, my husband's diarrhea was worse. I reported this to Lucinda, who dismissed my concerns. She said that the doctor would see him in a few days and that the diarrhea was probably due to his medication. On the third day, my husband vomited during breakfast and was extremely tired all day. I reported this to Lucinda, but I don't know whether she did anything about it. On April 14, the doctor sent Jerry to the emergency department, where he died three days later. Afterward, we found out there had been an outbreak of *C. difficile* at the hospital when Jerry had his surgery, and this was likely why he had gotten sick.*

Questions to consider

1. What practice documents apply in this scenario?
2. What factors might have contributed to this complaint?
3. What might Lucinda reflect on and/or include in her Learning Plan for the College's Quality Assurance Program?

The College responds

After assessing the information in Eileen's letter, the College considered the complaint appropriate for its resolution process. This voluntary program provides nurses with an opportunity to work with the College and the complainant to resolve the issues in a manner that does not lay blame or involve a formal investigation. It would provide Lucinda with an opportunity to consider the issues in relation to her practice and the College's standards, and for Eileen to help promote excellence in nursing practice by providing this opportunity.


When a College investigator contacted Eileen, she agreed to participate in a resolution. She wanted Lucinda to understand how their interactions affected her, and to consider that the situation might have been avoided if Lucinda had paid attention to Jerry's overall health status and Eileen's expressions of concern.

The College contacted Lucinda, who was upset by the complaint because she thought she had developed a good relationship with Eileen and Jerry. She agreed to participate in a resolution that would provide an opportunity for her to review the letter of complaint, complete the online learning modules for the *Professional Standards, Revised 2002* and the *Therapeutic Nurse-Client Relationship, Revised 2006* practice documents, and fill out a form outlining her reflections. Lucinda was to complete these activities within 30 days after the Inquiries, Complaints and Reports Committee approved the agreement. The parties agreed that these terms would be a full and final resolution of Eileen's complaint. The terms of the agreement and all communications between the parties and the College would remain confidential.

Reflecting on the complaint

Lucinda could reflect on whether she listened to Eileen's concerns and acted on them appropriately. For example, she could ask herself the following questions: Did I collaborate with Eileen, who had greater experience with Jerry's health? Did I document my assessments and Eileen's concerns? Did I take action in this situation, in which client safety and well-being were potentially compromised? Did I notify the physician over the several days in question, and if not, why not? Did I communicate the outcome of my assessments and interventions to Eileen in an appropriate manner? Was I conscious of my tone and body language?

The Inquiries, Complaints and Reports Committee agreed that this matter was suitable for the resolution process and approved the terms of the agreement. By agreeing to participate in the resolution, Lucinda acknowledged her accountability to respond to public concerns and to continually improve her practice. When she returned her participation form to the College, Lucinda included a letter to the College investigator. In it, she expressed that, as difficult as it was to be on the receiving end of a complaint, the resolution process had been a positive experience for her. It reminded her of why she had become a nurse, and that she needed to be conscious of her actions and communication with clients and their family members.

For more information, refer to the College's *Addressing Complaints* guide at www.cno.org/AddressingComplaints. 

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It's why the College created its **Outreach Program** for nurses in different practice settings: as a way to **connect** with nursing colleagues and **gain knowledge** about practice standards.

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Visit www.cno.org/outreach or phone 416 928-0900, ext. 6397, or 1 800 387-5526 ext. 6397 (toll-free in Ontario).



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Now's the time

Keep infection prevention in mind

As health care professionals, nurses need to be prepared to handle all kinds of emergency situations at any point in their practice. While there have been no new H1N1 developments at the time of writing this article, nurses need to continue to reflect on their H1N1 experiences, infection control practices and pandemic plans.


“Engaging in effective infection prevention is an expectation for safe nursing care,” says Linda Levesque, RN, the College’s Outreach Consultant for the Acute Care–Adult sector. “All nurses should exercise their knowledge, skill and judgment to advocate for and initiate proper infection-control procedures at all times, not just during emergency or pandemic situations.”

To help you stay current on infection prevention, the College offers several resources, including the *Infection Prevention and Control* practice document. Review this document periodically to ensure that your practice reflects the standard. The document contains numerous examples of how to apply infection prevention and control methods in your practice. For example, proper hand washing is the simplest and most effective method of preventing infections.

The practice document also contains information on how nurses can contribute to maintaining a hygienic practice setting. Three informative scenarios based on real-life situations provide nurses with practical approaches to promoting infection control practices. Read or download the practice document at www.cno.org/publications.

Other resources

Learning modules are useful tools for remaining familiar with College standards. Look for the learning module based on *Infection Prevention and Control* in the College’s online Learning Centre at www.cno.org/learning. This module tests your knowledge of preventing and controlling the transmission of infection, and of developing strategies for reducing the risk of transmission. You can access and complete this module (as well as 10 more on other topics), online anytime.

The College will continue to maintain the pandemic planning area of its website, in case a situation similar to the H1N1 pandemic develops in the future. If you have any questions about practising during a pandemic, contact a College Outreach Consultant by visiting www.cno.org/outreach. 

QA Learning Plans

Infection Prevention and Control is one of the two practice documents that this year’s Quality Assurance (QA) Program focuses on. To meet the QA requirements for 2009-2010, all nurses in Ontario are expected to develop a Learning Plan based on this document. Use the resources referred to in this article to help develop your Learning Plan.

Summarized Discipline Decisions

The following decisions and reasons of the Discipline Committee form part of the College's *Annual Report* and are published as a requirement of the *Regulated Health Professions Act, 1991*. By publishing these decisions, the College educates nurses and informs the public about what does and does not constitute professional misconduct and incompetence. These decisions also provide direction to RNs, RPNs and NPs on practice standards and professional behaviour, if they find themselves in similar situations.

The name of the Member who is the subject of the hearing may or may not be included, as required by law. Information revealing the names of witnesses and clients has been removed.

For copies of full decisions, visit the website at www.cno.org/decisions, or contact Bill Clarke at 416 928-0900, ext. 7590 or 1 800 387-5526, ext. 7590 (toll-free in Ontario).

ANDY CODINHA
0384388

Allegations and plea

The College alleged that the Member engaged in conduct that would be considered disgraceful, dishonourable and unprofessional when he failed to report a criminal conviction on his Annual Membership Renewal (AMR) Form.

The Member admitted that the failure to report would be regarded as unprofessional, but denied that it was disgraceful or dishonourable. The Panel proceeded with a hearing with respect to this issue.

Evidence

College staff testified. In 2005, the Member was cautioned by the College's Executive Committee and signed a Letter of Undertaking in connection with failing to report criminal convictions to the College and forging police documents to hide the convictions from a prospective employer. In 2008, the Member was suspended by a Panel of the Discipline Committee for engaging in similar practices and forging a document from another police service to hide recent criminal convictions from a prospective employer. During the process leading up to the 2008 discipline hearing, the Member failed to disclose a 2007 criminal conviction on his 2008 AMR Form.

The Member testified that his failure to check the criminal conviction box on the 2008 AMR Form was not intentional. He was distracted by family issues at

the time. He admitted in cross-examination that he had not been distracted at any other point when filling out the form.

Finding

The Panel found that the evidence supported a finding that the Member committed acts of professional misconduct as alleged. The Member's explanation that he had overlooked filling out the criminal conviction box on the form was not credible.

The conduct involved dishonesty and deceit. In the Panel's view, forgetting to declare a criminal conviction while serving a suspension for the same type of conduct moved the behaviour into the area of the dishonourable.

The fact that this was the Member's third time before the College for very similar issues raised the conduct to disgraceful. A series of repetitions of forgery, misleading employers and failing to disclose convictions to the College would likely be seen as unprofessional, dishonourable and disgraceful.

Submissions on order

The College sought revocation of the Member's Certificate of Registration because the Member has demonstrated that he is ungovernable. This is the third time he has come before the College with respect to issues of dishonesty in his professional practice. The Member's conduct demonstrates a complete disrespect for the College's regulatory functions and for his responsibilities as a member of a regulated health

profession. This disrespect has been persistent and is continuing.

The Member has been given ample opportunity to remediate himself and comply with his professional obligations, but he has demonstrated that he has no intention of doing so.

Panel order

The Panel accepted the College's submissions. Revocation of the Member's certificate best protects the public, as his disregard for honesty could put the public in jeopardy. The repetitive nature of his conduct indicates that rehabilitation would be unlikely. The penalty provides specific and general deterrence, sending a clear message to the Member and the public that violation of the foundation of professional ethics will not be tolerated.

JASON CRAIG
IA11071

Allegations and plea

The College alleged that the Member failed to administer correct doses of insulin to two clients, failed to attend scheduled visits for five clients through two different agencies, billed for visits not made, and failed to assess, provide care to or document care of two clients.

The Member admitted to the allegations, and the College and the Member submitted a written statement to the Panel in which they agreed to the following facts.

Agreed facts

The Member was employed by two different agencies to provide home care services. He administered insulin to Client A in accordance with a cancelled physician's order rather than an updated order. The Member administered Humulin to Client B in

the morning, but failed to administer Novolin in the afternoon, as ordered.

The Member missed scheduled home care visits with five clients, but billed the agencies for the visits. He failed to continue to assess an ulcer on a client's toe, which later had to be amputated. The Member failed to provide care and failed to document the care he provided to another client.

Finding

The Panel found that the evidence supported findings that the Member breached the standards of practice, improperly discontinued professional services, issued a false and misleading statement and engaged in conduct that would be regarded as unprofessional.

Submissions on order

The College and the Member sought an oral reprimand and a two-month suspension. Within 12 months of the order, the Member would be required to complete an approved medication administration course. The Member would be required to review specified College standards and complete Reflective Questionnaires and online learning modules in preparation for meetings with a College Practice Consultant. For 24 months after returning to practice, the Member would be required to advise the College of his employers, provide employers with a copy of the Panel's decision and reasons, and practise only for an employer who agreed to conduct periodic audits of the Member's charts and timesheets, and advise the College if the Member breached the standards of practice of the profession.

Panel order

The Panel accepted the joint submissions as reasonable and in the public interest. The Member

accepted responsibility for his actions and cooperated with the College by agreeing to the facts and admitting to professional misconduct.

ESTHER CRUZ
05101999

Allegations and plea

The College alleged that the Member stole, forged and cashed a home care client's cheques.

The Member admitted to the allegations, and the College and the Member submitted a written statement to the Panel in which they agreed to the following facts.

Agreed facts

The Member provided home care to an elderly client who was immobile and restricted to bed. While providing care, the Member took several blank cheques from the client's personal possessions. The client's power of attorney (POA) was contacted by the bank about suspicious transactions on the client's account and discovered that, over a four-month period, several cheques were processed. The Member admitted to forging and cashing cheques for \$18,536.76. The POA later found that more cheques were missing and the incident was reported to the police. The Member was eventually found guilty of the criminal offences of fraud over \$5,000 and forgery. In the criminal proceedings, the Member admitted to having defrauded the client of \$25,536.76.

Finding

The Panel found that the evidence supported findings that the Member breached the boundaries of the therapeutic nurse-client relationship, misappropriated property and abused the client. She was found guilty of offences relevant to her suitability

to practise, and her conduct would be regarded as disgraceful, dishonourable and unprofessional.

Submissions on order

The College and the Member sought an oral reprimand and a seven-month suspension. The Member would be required to review specified College documents and complete Reflective Questionnaires, online learning modules and the College's abuse prevention program in preparation for a meeting with the Director of Professional Conduct. For 12 months after returning to practice, the Member would not be allowed to have direct control or responsibility over the financial affairs of her employer or clients. For 18 months after returning to practice, the Member would not be allowed to practise independently. For 24 months after returning to practice, the Member would be required to advise the College of her employers, provide employers with a copy of the Panel's decision and reasons, and practise only for an employer who agreed to advise the College if the Member breached the standards of practice of the profession.

Aggravating factors include: the fact that the Member committed the offences shortly after her registration with the College; she took advantage of a vulnerable, elderly and bedridden client; and she stole the cheques over a four-month period. There was no indication that she would have returned the funds if she had not been caught; and there was no effort by the Member to ensure that full restitution had been made.

Among the mitigating factors, defence counsel noted that the Member's need for money was precipitated by a threat against a family member who was overseas. The Member had been in Canada for only a short time and had no credit

history and few friends. She is highly remorseful and cooperative, and her behaviour should be considered a single, out-of-character act.

Panel order

The Panel accepted the joint submissions as reasonable and in the public interest. The Member accepted responsibility for her actions and cooperated with the College by agreeing to the facts and proposed order. The suspension and rehabilitative component serve as general and specific deterrents, and the public is protected by the restrictions and monitoring of the Member's practice.

RICK KLEIN
JA06237

Allegations and plea

The College alleged that the Member sexually abused a client by touching or groping the client's breasts and was found guilty of an offence relevant to his suitability to practise, namely sexual assault of the client.

The Member admitted to the allegations, and the College and the Member submitted a written statement to the Panel in which they agreed to the following facts.

Agreed facts

The Member worked on the dementia unit in a long-term care facility. He attended the client's room to test the client's blood sugar. While awaiting the test results, the Member sat next to the client on the bed, and fondled the client's breasts five or six times. The Member then gave the client the test results and left the room. The Member was identified by the client during a walk through the facility with the Assistant Director of Care. The client also reported that

the Member had taken the client's hand and made the client touch his penis. The Member denied this but indicated that the client's hand could have brushed up against his penis.

The client received a letter one week later, purportedly from a family member of the Member, stating, "Only you [the client] can change your mind and drop the charges." The Member was charged with the offence of sexual assault and found guilty.

Expert evidence

The expert's opinion was that touching or groping the client's breasts and directing or placing the client's hand on the Member's penis constitute sexual abuse. Disclosure of a client's personal information to a third party, without permission, is a breach of client confidentiality. Sexual assault is an offence relevant to suitability to practise. The Member's actions were directed at an extremely vulnerable client.

Finding

The Panel found that the evidence supported findings that the Member committed acts of professional misconduct as alleged. The sexual abuse would be regarded as disgraceful, dishonourable and unprofessional, and the breach of confidentiality would be regarded as unprofessional.

Submissions on order

The College and the Member sought an oral reprimand and immediate revocation of the Member's Certificate of Registration.

Panel order

The Panel accepted the submissions on order as reasonable and in the public interest. The Member accepted responsibility for his actions and

cooperated with the College by agreeing to the facts and proposed penalty. As a general deterrent, the order emphasizes the severity of the misconduct. As a specific deterrent, the order removes the Member from the active nursing community to ensure protection of the public.

MARY MCLEAN
HB12946

Allegations and plea

The College alleged that the Member abandoned an adolescent client who required continuing care and failed to make other arrangements as required.

The Member admitted to the allegations, and the College and the Member submitted a written statement to the Panel in which they agreed to the following facts.

Agreed facts

The Member worked through an agency to provide overnight home care to the client, who is wheelchair-bound, nonverbal and fully dependent on caregivers for her activities of daily living. The client received continuous night feeds through a gastro-jejunal tube and required suctioning to prevent aspiration. One of the client's parents is blind.

At approximately 0400 hours, a massive explosion occurred several blocks away from the client's home. When the client's parent asked what was happening, the Member said she thought all the houses were exploding because of a gas leak, and grabbed her purse and jacket. At the parents' request, she retrieved the client's suctioning equipment. The Member did not help the client or her parents to evacuate the home, did not seek assistance for them from the agency or any emergency services, and did

not report the incident to the agency until three hours later, at the end of her shift.

The parents managed to move the client in her wheelchair down the stairs and out of the house to a nearby apartment building. There, they called 911 and emergency medical services transported the client to a hospital for ongoing care.

Finding

The Panel found that the evidence supported findings that the Member contravened the standards of practice of the profession and discontinued professional services that the client needed. She abandoned her client and did not make arrangements for the client's care. This conduct would be regarded by the profession as dishonourable and unprofessional.

Submissions on order

The College and the Member sought an oral reprimand and a three-month suspension. The Member would be required to review specified College publications and complete Reflective Questionnaires and online learning modules in preparation for meetings with an expert in therapeutic nurse-client relationships. For 12 months after returning to practice, the Member would be required to advise the College of her employers, provide employers with a copy of the Panel's decision and reasons, review any emergency, pandemic or evacuation policies of all employers, and practise only for an employer who agreed to advise the College if the Member breached the standards of practice of the profession.

Panel order

The Panel accepted the joint submissions as reasonable and in the public interest. The Member accepted responsibility for her actions

and cooperated with the College by agreeing to the facts and admitting to professional misconduct. The terms provide for rehabilitation and remediation, as well as specific and general deterrence. The order sends a clear message that abandoning clients is not acceptable, even in a stressful situation. The order protects the public's trust in the profession.

RODERICK MENDOZA
9410655

Allegations and plea

The College alleged that the Member abused Client A by applying inappropriate restraints, and speaking in a loud voice and threatening Client A; and failed to monitor, assess, treat and document the changing condition of Client B. The Member was not present or represented by counsel at the hearing, which proceeded on the basis that the Member denied the allegations.

Evidence

The Program Manager testified that all staff, including the Member, were trained in the facility's restraints policy. The Member admitted to the Program Manager and others that he said in a loud voice to Client A, "I would hate to have to put restraints on you," and applied a restraint to Client A without consent of Client A's substitute decision maker (SDM). RN A testified that when she relieved the Member at shift change, she observed Client A with a waist restraint, curled up in a ball and crying. Client A's SDM testified that when she arrived at the facility, she found a restraint on Client A's bed, even though she and other family members had given staff explicit instructions not to apply restraints. In the event of any

concerns, a family member could be there within 10 minutes, but no family member was contacted.

The Program Manager testified that she observed Client B to be in obvious distress from acute pulmonary edema at the end of the Member's shift. The Member had not informed the Program Manager of Client B's condition, and there were neither documented assessments nor evidence of interventions to alleviate Client B's symptoms.

An expert witness testified that the Member did not meet the standards of practice in connection with the restraint of Client A, or in the assessment and documentation of and response to Client B's changing condition.

Finding

The Panel found that the evidence supported findings that the Member contravened the standards of practice, and verbally, physically and emotionally abused a client. Moreover, the Member's conduct had gone beyond unprofessional and had become disgraceful and dishonourable in that the use of restraints was accompanied by a prior threat.

Submissions on order

The College sought an oral reprimand and a five-month suspension. The Member would be required to develop a learning plan, review specified College publications, and complete the College's abuse prevention package, Reflective Questionnaires and online learning modules in preparation for meetings with a Practice Consultant. Within 12 months of returning to practice, the Member would be required to complete an approved health assessment course, and could not practise independently until this condition was met. For 24 months

after returning to practice, the Member would be required to advise the College of his employers, provide employers with a copy of the Panel's decision and reasons, and practise only for an employer who agreed to advise the College if the Member breached the standards of practice of the profession.

Panel order

The Panel accepted the College's submission. The Panel considered the fact that two clients and two separate incidents were involved, the seriousness of the Member's actions, and his apparent flagrant disregard of facility policies. The order protects the public, provides for specific and general deterrence, and includes both educational and remedial components. Mitigating factors considered by the Panel include the Member's admission to his employer that he applied the restraint and the fact that this was his first appearance before the Discipline Committee.

ANDREW REYES
9413634

Allegations and plea

The College alleged that the Member solicited and received information from nursing students about the Canadian Registered Nurses' Examination (CRNE) that he ought to have known was confidential and copyrighted, and that he later reproduced and distributed the information in materials he used to provide exam preparation courses.

The Member admitted to the allegations, and the College and the Member submitted a written statement to the Panel in which they agreed to the following facts.

Agreed facts

The CRNE is a standardized examination that applicants must write and pass to practise as a Registered Nurse in any Canadian jurisdiction.

In 2001, the Member began offering an exam preparation course for the CRNE. He developed a nursing review manual with over 650 sample multiple-choice questions and over 150 sample short-answer questions, which included a statement that Andrew Reyes held copyright in the information. During the course, the Member asked students to give him feedback after they wrote the CRNE, assess how well his course prepared them for the CRNE, assess the extent to which his practice questions reflected the content and difficulty of the CRNE, and give him types and content of questions they remembered from the CRNE. The Member provided students with a stamped, self-addressed envelope to assist them in providing him with information they remembered about the CRNE.

In 2005, the Member received identical sets of 118 questions on two separate occasions from two students. He did not ask the students where they received the 118 questions from, and he incorporated at least 85 of the questions into his manual. When the Member received other information about the CRNE from students, he reviewed and analyzed the information to determine whether he had previously seen the question or if it was already included in the manual. He refined and revised the questions in the manual to reflect the content of the CRNE based upon information provided by students.

In 2007, students advised the Member that questions in his manual appeared on the CRNE. One student noted that the CRNE included 77

questions from the manual.

After an independent review, it was determined that 153 multiple-choice and 48 short-answer questions from the CRNE were related, similar or identical to questions in the manual. As a result of the compromised questions, the short-answer questions and some of the multiple-choice questions were not included in the marking of the June 2007 writing of the CRNE. The short-answer database was significantly compromised, and the format was removed from the CRNE. Canadian regulatory bodies incurred significant financial and resource repercussions, as did the company that develops the examination.

Finding

The Panel found that the evidence supported a finding that the Member committed acts of professional misconduct as alleged, and that the misconduct would be regarded as disgraceful, dishonourable and unprofessional.

Submissions on order

The College and the Member sought an oral reprimand and a four-month suspension. The Member would be required to review specified College documents and complete Reflective Questionnaires and online learning modules in preparation for a meeting with an approved expert in ethics and education, to be followed by a meeting with the College's Executive Director. For 36 months from the date of the order, the Member would not teach, prepare materials for or participate in any examination prep courses or tutorials. For 12 months after returning to practice, the Member would be required to advise the College of his employers and educational institutions, provide employers and educational institutions

with a copy of the Panel's decision and reasons, and practise or teach only for an employer or educational institution that confirmed receipt of the decision and reasons.

Panel order

The Panel accepted the joint submissions as reasonable and in the public interest. The Member accepted responsibility for his actions and cooperated with the College by agreeing to the facts and admitting professional misconduct. The order provides for specific and general deterrence, rehabilitation and protection of the public. The College takes seriously the importance of maintaining the integrity of the CRNE process.

JULIE TYRRELL
9983859

Allegations and plea

The College alleged that the Member was found guilty of a criminal offence relevant to her suitability to practise, namely assault.

The Member admitted to the allegations, and the College and the Member submitted a written statement to the Panel in which they agreed to the following facts.

Agreed facts

The Member developed a personal relationship and lived with the complainant's ex-spouse. The Member's relationship with the complainant had been tense, and there had been several verbal altercations. After a verbal altercation over the telephone, the Member drove to the complainant's home to speak to her and put an end to what she felt was harassment. The Member screamed and yelled at the complainant in front of

the complainant's home. The complainant drove her vehicle out of the parking garage, and the Member banged on the hood, then physically assaulted the complainant by reaching into the driver's side window, biting the complainant and pulling out her hair weave.

Finding

The Panel found that the evidence supported findings that the Member committed an act of professional misconduct as alleged.

Submissions on order

The College and the Member sought an oral reprimand. The Member would be required to review specified College publications in preparation for a meeting with the Director of Professional Conduct.

Although the criminal offence did not take place during the Member's nursing practice, her conduct demonstrated a lack of judgment and reflects poorly on the nursing profession. As the Member had received a significant jail sentence and lost her employment, the College did not seek a suspension.

Panel order

The Panel accepted the submissions on order as reasonable and in the public interest. The Member accepted responsibility for her actions and cooperated with the College by agreeing to the facts and admitting to professional misconduct. In considering specific deterrence, the Panel took into account the severity of the criminal sentence and the Member's loss of employment. The Panel finds that the remedial component of the order is necessary and appropriate, in keeping with the College's mandate to protect the public.

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Volunteers needed

Jurisprudence Exam development

Nurses from a range of practice settings, environments and roles are needed to help the College develop a Jurisprudence Exam, which tests applicants' knowledge of nursing standards and government legislation.

For more information, visit www.cno.org/Jurisprudence.



In Praise of Nurses

The College welcomes letters commending outstanding nursing care. The College accepts original signed letters from clients or family members, or original signed letters from facilities or agencies with a copy of the author's letter and the author's permission to publish it. Letters may be edited for publication.

Made it feel like home

I am writing on behalf of our family to thank everyone at the McCormick Home in London. The administrator, Terri Guzyk, RN, and all of the staff provided wonderful care to our mother, Marjorie Demare, during her three years at the long-term care home.

I know a great deal about issues affecting seniors, long-term care facilities and seniors' care in general, and I can say that the care you provide is exemplary. My mother was not an easy person to care for; she had many health issues, was in constant pain and could be very demanding. She required a great deal of attention. Staff went beyond the call of duty to ensure that not only were her physical care needs met, but her emotional and spiritual needs were met as well.

Although physically very sick, Mom was mentally competent. Three years ago, she was resistant to the idea of living in long-term care. Over the years, the staff worked hard to make it her home, and it became a place that she did not want to leave. They also became family to my father, who visited her daily.

My mom was very social; she knew

and remembered everyone. She was always advocating for herself and for other residents. Staff in all areas of the facility treated her with respect and love, and listened to her requests and suggestions.

The staff members were not only working with Mom, but they also helped her to see the positive side of situations and count her blessings. This philosophy greatly improved her outlook on life. We can't find the words to express how grateful we are for your expert insight, friendship, hard work and dedication. You are stars in your field.

This facility, in our opinion, is a shining example of the fine health care in the Southwest LHIN and in the province of Ontario. Be very proud of your work!

Sincerely,
*Susan Locke, Paul Locke, Bob Demare,
Edita Demare and Heinz Demare*

A true advocate

I am writing to acknowledge the courteous, kind, supportive and loving care that our mother, Dorothy Smith, received at Beech Villa at Hastings Manor Long Term Care Facility in Belleville. The staff members were always understanding

with our mother and our family during her journey with dementia.

While all staff treated our mother with care and compassion, I would like to praise one nurse in particular: Fran Arbuckle, RPN. Fran was always a true advocate for our mother. There are some people who are excellent at what they do and Fran is one of them. We wish to thank her for being such a wonderful friend along the way.

Thank you to everyone who attended to our mother during her last few days. Everyone was so kind and loving to her: talking to her, tucking her stuffed animal in with her, and showing her dignity and respect at all times. Thank you to all the nurses for giving us such support and tender care, bringing us tea and pie, and making us feel like we were part of one big family at Hastings Manor. We will miss you. Thank you for your dedication.

Sincerely,
Nancy Santon, RPN

Send your letters to
InPraiseOfNurses@cnomail.org or
College of Nurses of Ontario
101 Davenport Rd.
Toronto, ON M5R 3P1

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Pursue a Career at Your College

Are you looking for a workplace that values leadership, integrity and collaboration? Do you want to work for an employer that recognizes the importance of a positive work/life balance? Do you appreciate working with professional and talented colleagues? If so, the College of Nurses of Ontario may have the career you've been looking for.



The College of Nurses of Ontario is a dynamic leader in nursing self-regulation. As the regulator for nursing in Ontario, the College's mission is to protect the public's right to quality nursing services by providing leadership to the nursing profession in self-regulation.

Benefits:

Work with teams of committed nursing colleagues, as well as a wide range of enthusiastic professionals.

Competitive benefit and wage packages.

Opportunities for ongoing professional development.

An active social committee.

Easily accessible downtown Toronto location.

Career opportunities in practice consulting, policy development, investigations and other fields are posted on the College's website as they become available.

Visit www.cno.org/hr for current job opportunities and for more information about growing your career at the College.



COLLEGE OF NURSES
OF ONTARIO
ORDRE DES INFIRMIÈRES
ET INFIRMIERS DE L'ONTARIO

THE STANDARD OF CARE.

“A nurse in an educator role demonstrates the standard by enabling others to develop expertise and confidence in their abilities.”

– from *Professional Standards*

THE STANDARD OF CARE.

Photo: Melanie Gordon

“THERE ARE MANY WAYS TO PRACTISE nursing and all are valuable,” says Mary Bawden, RN. While passionate about clinical practice, Mary always wanted to teach. Eight years ago, she combined her two passions and became a lecturer and clinical nursing instructor at the Arthur Labatt Family School of Nursing at the University of Western Ontario in London.

Mary has been a Registered Nurse for 42 years but points out to her students that she has been “in nursing” for 45 years. She wants them to understand that the years they spend earning a BScN are a significant part of their personal nursing story.

“Even though students do not have the nurse title yet, cultivating a practising nurse’s mindset while in school has a positive effect on their attitude toward learning,” explains Mary. “This attitude makes them realize that the focus of their nursing education should be both academic excellence as well as excellence in nursing practice.”


Mary, who also teaches a leadership course to fourth-year nursing students, believes every nurse has opportunities to be a leader, even if they aren’t in a formal leadership role. A good leader is a good team member who takes initiative and actively participates, she says.

To help her students practise teamwork, learn leadership skills and build professional relationships, Mary

encourages them to participate in professional associations. “This is one of the best opportunities for nursing students to collaborate with, and learn from, practising nurses from various settings, while also contributing to excellence in the nursing profession.”

Mary herself is still learning. “I challenge myself to keep up with technology in the hope that my example will inspire my students to be confident in their ability to adapt to the constant technological changes in their nursing practice.”

She believes that to contribute to advancement in nursing practice, educators have to be willing to complement their teaching with the appropriate use of tools, such as current computing devices, social media, blogs and video sharing. “Educators cannot teach based on the way they learned when they were students,” says Mary.

“A good role model shows others how to learn. I don’t want to merely download information to my students. I want to empower them so they know how to continue learning in a world that’s constantly changing.” 

At the College, the phrase “the standard of care” is more than a tag line for the logo; it’s about setting the bar for safe, effective and ethical nursing care through the practice standards and guidelines. This page features nurses who have raised the bar on the standard of care they provide their clients.

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