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Take the Lead

Your accountabilities in leadership roles

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New practice documents

Two practice documents are now available on the website:

- ***Working with Unregulated Care Providers***
- ***RN and RPN Practice: The Client, the Nurse and the Environment***

Download them at www.cno.org/docs.

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Find out more on page 8.

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COVER

Taking the Lead

When leadership responsibilities expand, accountabilities can, too. In our cover story on page 15, read about two nurses who handle evolving accountabilities in their practice.

Photo: Swavek

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Watch for the spring issue of *The Standard* in mid-March.

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Leadership in times of change

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To stay relevant, a profession must constantly evolve to meet changing environments and the needs of clients.

In the 14 years since I began practising, I have seen nurses embrace many changes. We have seen increasingly complex client needs, the integration of technology into care and the introduction of new roles like Nurse Practitioners (NPs). All the while, the pace of our work never slows. If our profession hadn't been on the forefront of recognizing and adapting to these changes, where would we and our clients be today?

Fortunately, nursing is one profession that continually adapts. Time and again, the profession has kept pace with society's needs and initiated meaningful change.

Over the years, the College has supported the safe evolution of nursing practice for Registered Nurses (RNs), Registered Practical Nurses (RPNs) and NPs. We have consistently shown leadership in ensuring that the roles of RNs, RPNs and NPs grow and develop to keep pace with the changing needs of clients.

One recent example of this is the evolving role of the NP. While RNs and RPNs have been regulated by the College for almost 50 years, it was only 13 years ago, in 1998, that Ontario became the first Canadian province or territory to regulate NPs. This milestone was a reflection of the public's confidence in the nursing profession and in the College's ability to regulate this new role.

Because NP regulation is relatively new, it has been evolving quickly. Just two years ago, we saw the addition of Acute Care NPs to the regulated NP role. And even more recently, the government approved changes in our controlled acts regulation related to NP practice.

The Council has an important role in ensuring that changes in practice meet client needs for safe and ethical care. This year, Council approved the revised NP practice standards. The standards will guide the safe practice of the new controlled acts for NPs. Council's approval of the documents ensures NPs are guided by the College to support safe and ethical care within the expanded scope.

As with most major changes, none of this was quick or simple. It took changes in regulation and in nursing education. It took the support of RNs and RPNs, of employers and of professional colleagues. Just as importantly, it took trust from the communities where we practise.

As the profession evolves, Council and the College are here, providing guidance and leadership to ensure the nursing profession is ready and able to provide the safe and ethical care the Ontario public expects and deserves.

Kris Voycey, RN
President

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NEWS

Renewal deadline is approaching

If you haven't yet renewed your 2012 membership with the College, don't wait until the last week of December! The deadline to renew is Saturday, Dec. 31, 2011. Renew online by visiting the Maintain Your Membership area of the website at **www.cno.org/mym**.

The College experiences an increase in the number of callers looking for assistance in the days before the Dec. 31 deadline. If you think you may require help completing the online renewal form, call early. Otherwise, expect to wait for customer service support during this time.

Customer Service Representatives are available to assist you with renewal from Monday to Friday, 0830 hrs to 1900 hrs, and on Saturday, Dec. 31 from 0830 hrs to 1700 hrs, at:

- Email: renewal@cnomail.org
- Phone: 1 866 573-5405 (toll-free in North America), or 416 849-6135 (outside North America).

Members who do not renew by Wednesday, Feb. 15, 2012 will be suspended. Once suspended, an individual is prohibited from practising nursing in Ontario.

The annual fee for 2012 has increased to $175.15 ($155 + 13% HST). Payments received after the Dec. 31 deadline are subject to an additional $113 late fee ($100 + 13% HST). Find out more about the increase at: **www.cno.org/2012-fee-increase-faqs**.

For more information, see *Getting Started with Renewal 2012* at **www.cno.org**. You will also find renewal information in the fall 2011 issue of *The Standard*. S

New year for QA

Looking for a New Year's resolution? How about trying the online Quality Assurance (QA) Program? Nurses who used it in 2011 found it to be "convenient" and an "easy way to save all my learning goals and Learning Plan in one place."

You can use the online QA Program to complete the Self-Assessment component, including Practice Reflection. You can also use it to create, edit, save and review your learning goals and Learning Plan, which you can save for seven years. The College does not have access to your Learning Plan unless you are selected to participate in Practice Assessment.

In 2012, the QA Program will focus on the *Documentation, Revised 2008* and *Therapeutic Nurse-Client Relationship, Revised 2006* practice documents. You can start developing your learning goals, and planning your activities to support these goals, based on these documents. Nurse Practitioners (NPs) are also required to create a learning goal for the newly revised *Nurse Practitioner* practice document.

The College selected *Therapeutic Nurse-Client Relationship* because "it is a foundational document for nursing practice," says Janet Anderson, RN, Director of Practice and Regulatory Policy.

"Nurses regularly contact the Practice Support Line and Outreach Consultants with enquiries about the therapeutic relationship. Plus, because the nurse-client relationship is fundamental to nursing practice, almost all professional conduct issues that the College deals with have a component related to the therapeutic nurse-client relationship."

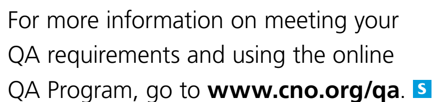
This is the second year that *Documentation* is part of the QA Program. "It is still relevant," explains Anderson. "With the continuing change of documentation systems from paper to electronic, it is important that nurses maintain a focus on the key principles outlined in this practice document."

Focusing on a practice document for two consecutive QA Program years also gives you a longer timeframe to implement and achieve your learning goals.

In March, the College will contact nurses who have been randomly selected for the Practice Assessment component of the QA Program. This component is completed using the online program; the deadline for completion, once selected, is April 30, 2012.

Starting in 2012, NPs from the three specialties—Adult, Paediatric and Primary Health Care (PHC)—will be randomly selected to complete the Practice Assessment component. (Previously, only NP-PHCs were selected.) Selected NPs are required to complete the multiple-choice objective test online. In addition, a subset of NP-PHCs will be selected to complete additional assessments, including a Chart Review and Interview and/or Practice Simulation.

For more information on meeting your QA requirements and using the online QA Program, go to **www.cno.org/qa**.



Stop illegal practitioners

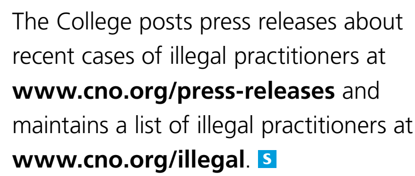
Since July, the Ontario criminal courts have prosecuted three illegal practitioners. Illegal practitioners are people who have gained nursing employment without qualifications or College registration. Those who use deceit and fraud to obtain nursing employment put the public's safety at risk.

Employers play a vital role in stopping illegal practitioners. Information on all nurses registered in Ontario is found on Find a Nurse, a searchable database at **www.cno.org**. Or, you can call the Customer Service Centre at 416 928-0900 (toll-free at 1 800 387-5526). Employers should contact the College if they cannot find the name of a person claiming to be a nurse on Find a Nurse.

This summer, Steven Roppel was convicted of 50 counts of impersonating a nurse. In the fall, Eva Donna Akinyi Okello and Jacqueline Leslie-Johnston were charged with practising nursing without the proper qualifications.

"Confirming the registration of anyone calling themselves a nurse is the first line of defence against illegal practitioners," says Karen McGovern, RN, Director of Professional Conduct.

The College posts press releases about recent cases of illegal practitioners at **www.cno.org/press-releases** and maintains a list of illegal practitioners at **www.cno.org/illegal**.



Changes to Registration Regulation

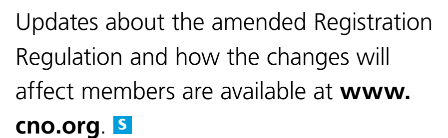
The College has submitted an amended Registration Regulation to the Ministry of Health and Long-Term Care and will be working with the Health Ministry on passing significant changes.

Council approved the amendments in late 2010 after reviewing member and stakeholder feedback. When the Ministry approves the amended regulation, the College will ensure that members and applicants are informed of the changes as they are brought in, and how the changes will affect them.

The amended regulation sets out the requirements for entry to practice, ongoing membership and reinstatement for all College members. While most of the changes will affect applicants and former members who wish to return to nursing practice, there are several important changes that will affect current members, including:

- new requirements for mandatory professional liability protection (PLP)
- revised evidence of practice requirements
- the creation of a new Non-Practising Class to replace the Retired Class
- new provisions that permit the College to place members in administrative suspension and deem them resigned if they fail to produce evidence of PLP or other requested information, in addition to nonpayment of fees.

Updates about the amended Registration Regulation and how the changes will affect members are available at **www.cno.org**.



The Right Role

Two new practice documents explain how to decide when a UCP, RPN or RN should provide care.

In most health care settings, nurses and unregulated care providers (UCPs) work closely together—but there are important differences in knowledge, skill, authority and accountabilities. Furthermore, Registered Nurses (RNs) and Registered Practical Nurses (RPNs) have different foundational knowledge related to length of study, which affects the level of autonomy.

Because of these differences, it is important for nurses and employers to use a thorough decision-making process when deciding which care provider should care for clients.

Two new practice documents

To guide nurses in making these decisions, the College has developed two new practice documents:

- *Working With Unregulated Care Providers*
- *RN and RPN Practice: The Client, the Nurse and the Environment*

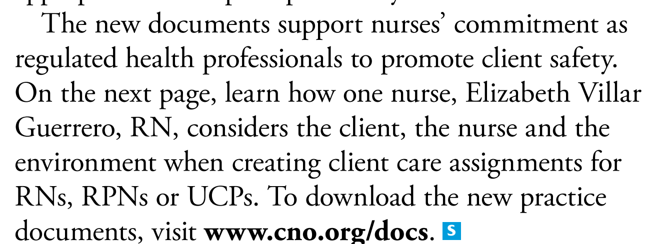
The documents contain new and updated information from previous documents—*Working With Unregulated Care Providers*, *Utilization of Unregulated Care Providers* and *Utilization of RNs and RPNs*.

"Nurses and stakeholders wanted documents that were more concise and easier to apply," says Lori Adler, RN, Manager of Practice Standards. "In response, the College updated the content, resulting in two streamlined documents."

The new *Working With Unregulated Care Providers* practice document clarifies nurses' roles and responsibilities when working with UCPs and outlines when it is appropriate to teach, delegate to, assign or supervise UCPs. It examines the factors nurses are expected to consider before taking on these responsibilities, including the UCP's competence, the client's condition, the activity and its associated risks, and the environmental supports available.

The theme of *RN and RPN Practice: The Client, the Nurse and the Environment* is the "three-factor framework." This framework looks at how the client needs, the nurse and the environment should affect decisions, such as which nursing category (RN or RPN) to match with client needs. Stakeholders who provided the College with feedback about the practice documents identified this framework as being particularly useful to nurses making these kinds of decisions.

"These three factors are equally important," emphasizes Adler. "They should not be looked at in isolation when making decisions about assigning client care to nurses, or when nurses are making decisions about if or when it is appropriate to accept responsibility for client care."



The new documents support nurses' commitment as regulated health professionals to promote client safety. On the next page, learn how one nurse, Elizabeth Villar Guerrero, RN, considers the client, the nurse and the environment when creating client care assignments for RNs, RPNs or UCPs. To download the new practice documents, visit **www.cno.org/docs**. S

We Asked: Elizabeth Villar Guerrero, RN

Photo: Melanie Gordon

As the clinical manager of in-patient rehabilitation service at Baycrest hospital in Toronto, Elizabeth Villar Guerrero works with nurses and unregulated care providers (UCPs) to provide the best possible care to aging clients. Guerrero has been a nurse for 18 years; assigning RNs and RPNs for client care is a common part of her practice.

We asked Guerrero to share some of her experiences.

What are the expectations for nurses who work with UCPs?

When assigning aspects of care to a UCP, a nurse should use critical-thinking skills and judgment to determine whether the UCP is able to perform the assigned activity or task. The nurse should also assess the learning needs of the UCP. Overall, when assigning, teaching or delegating care to a UCP, the nurse must confirm that the UCP is able to carry out the assigned activity or task in a safe manner.

What are the most common misunderstandings about UCPs with regards to accountability and delegation?

A common assumption is that because a UCP has worked with the client before, she is familiar with the plan of care. When this happens, the nurse may ask the UCP to perform procedures she is not familiar with.

Also, nurses who do not understand what the controlled acts are, may not realize when a UCP requires delegation to perform a procedure. For example, administering a subcutaneous injection is a controlled act procedure, which a UCP can perform only when it is considered a routine activity of living, or if it is delegated to the UCP by a nurse who has the authority to order or perform the procedure.

How do you use the three-factor framework—nurse, client and environment—in decision-making about RN or RPN utilization?

The three factors are a central part of our efforts to achieve and promote an environment of client safety.

To optimize client safety, it is crucial to match the category of nurse to client care needs, considering the three-factor framework. This can be done partly by discussing unit activities with nursing staff to determine the types of admissions, discharges and referrals the unit receives daily.

When applying client factors to decision-making, nursing staff must understand the level of complexity, predictability and risks of negative outcomes for each client. I discuss with staff all aspects of client care requirements, which help determine when we need to consult or change assignments from RPN to RN or vice versa. These ongoing discussions help the nursing staff understand the basis of assigning clients to the most appropriate care provider.

For instance, clients newly admitted to my unit are assessed by an RN to determine the complexity,

continued on page 12

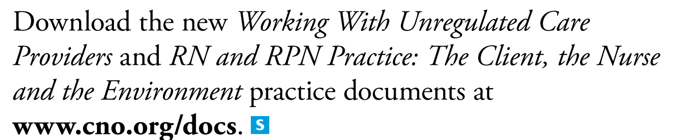
predictability and risks of negative outcomes. After the assessment, the RN considers whether an RN or RPN is appropriate for client care.

We determine the level of stability of the unit based on practice supports, resource needs and availability of those resources. As a manager, I anticipate changes within the environment, which may be dependent on various factors. I might not have full control of these factors; however, by helping staff know what supports are available, we build the foundation for client safety and a quality practice setting.

The new *RN and RPN Practice: The Client, the Nurse and the Environment* document discusses the need to consult with other members of the health care team. In your view, when should a nurse consult?
My general advice for a nurse who wonders if she should consult is: when in doubt about how to manage a client's situation, stop what you are doing and ask for a consultation on how to proceed.

Good knowledge of the client's situation or care needs will help a nurse know when there is a need to consult. As a client's situation becomes more complex, there may be an increased need for consultation. For instance, if there is a decline or change in the client's condition or status, or if the procedure is not within the nurse's scope of practice or within the organization's policies and procedural guidelines.

It is essential to consult and collaborate to ensure client safety. I am now looking into implementing a process called "SBAR" (Situation, Background, Assessment, Recommendation) when consulting with other nurses and/or members of the health care team. [*SBAR is a tool used among members of a health care team to communicate about a client's condition.*]



Download the new *Working With Unregulated Care Providers* and *RN and RPN Practice: The Client, the Nurse and the Environment* practice documents at **www.cno.org/docs**. S

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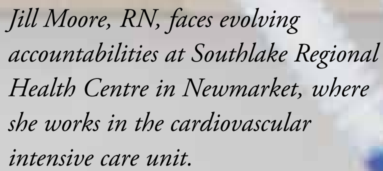


Jill Moore, RN, faces evolving accountabilities at Southlake Regional Health Centre in Newmarket, where she works in the cardiovascular intensive care unit.

Photo: Swavek

Taking the Lead

All nurses demonstrate leadership. Here's how two nurses handle expanding accountabilities when their leadership roles increase.

The ancient Romans had a tradition when they completed an arch. As they hoisted the capstone into place, the engineer in charge of construction showed accountability in a profound way: he stood underneath.

In some practice settings, staff nurses are asked to fill leadership roles during a shift. What does it mean for them to "stand under the arch?"

"Sometimes, you should probably wear a hard hat," jokes Jill Moore, Registered Nurse (RN), a staff nurse in the cardiovascular intensive care unit at Southlake Regional Health Centre in Newmarket. She knows that her responsibilities evolve when, a few times each month, she takes the helm of the nursing team as charge nurse. "You're accountable to the unit as a whole to ensure that it's running as best it can."

Nurses must always possess the abilities to assess a situation, think critically and provide the appropriate response. That foundation doesn't change. But as a leader on a shift (such as a team leader, patient care coordinator or charge nurse), nurses have to build on that by constructing something as solid as an archway—in which they can be a staff resource, role model and collaborator.

Leadership is an expectation

Vici Del-Mei, RN, who works at Kingston General Hospital in internal medicine, calls the role of the leader "overarching." While bedside nurses are accountable to their clients, Del-Mei says the leader is accountable in a larger sense for helping other nursing staff meet care needs. For example, she might not know every time a client needs blood work, but she does know which clients have more issues or which nurses need help.

"Leadership skills are ingrained in all nurses, and they're exercising them all the time."

As staff resources who offer leadership and expertise to the nursing team, Moore and Del-Mei understand they're ultimately helping colleagues provide quality care to their clients.

Every nurse on the unit is accountable for their own actions and decisions. Nurses in leadership positions can only be accountable for situations they can reasonably be expected to know about. For instance, a nurse leader who is responsible for receiving client reports from a bedside nurse must use critical thinking to determine whether to rely on a nurse's assessment of a client.

In formal leadership roles, including temporary ones on a shift, nurses draw on the leadership qualities they exhibit daily, from providing direction to developing innovative solutions.

"Leadership skills are ingrained in all nurses, and they're exercising them all the time," says Anthony Derro, RN, Practice Consultant. "In nursing, being a leader isn't a position; it's an expectation."

The College's *Professional Standards, Revised 2002* practice document specifically focuses on leadership, but Derro notes the other practice documents apply, too. For instance, *Ethics* includes sections on maintaining commitments to nursing colleagues and to the nursing profession, which are important elements to any discussion about leadership.

Getting the big picture

As a team leader, start with the need to grasp the overall perspective on the shift. "You're the 'go-to,' the 'point person,'" Moore explains. "I would get a report at shift change, then do rounds from bed to bed, to get a sense of each client from each nurse based on their assessment. You need to be abreast of what's going on because you're the one person in the unit who knows a little bit about everybody and everything."

All nurses are accountable for sharing knowledge; however, Moore says team leaders can be the primary contact for other nurses on everything from practices to organizational policies. "If I don't have the answers, I know how to get them," she says.

Del-Mei works with her team to create appropriate assignments, and says that part of her accountability is being proactive. As a team leader, she's aware of acuity levels, for instance, from the start of a shift. She also holds a team huddle halfway through the shift to review how nurses and their clients are faring.

"It gives me the opportunity to talk to them and get a sense of the issues," says Del-Mei. "But everyone can also step up and offer suggestions. That allows each nurse to demonstrate leadership."

Supporting growth

Any encounter with a nursing colleague is a chance to learn and develop. Leaders can foster a congenial atmosphere where problems are solved together. It's about working with colleagues to think through a process and take different approaches to resolving issues.

While the leader may be seen as an authority, the leader shouldn't be authoritarian, says Moore. She embraces the fact that leaders are accountable for helping colleagues grow. That often happens best, she says, when colleagues feel accountable for such things as their personal development or helping peers become engaged in issues that affect them. As co-chair of Southlake's nursing council, Moore encourages nurses to be involved in making their practice area a healthy work environment.

One time, Moore was mentoring an RN who was taking a critical care course. This nurse was unsure of how to handle a concern about a client's hemoglobin, and asked Moore for assistance. Moore responded by asking the nurse what she wanted to do.

The nurse appeared surprised, recalls Moore. She had grown accustomed to colleagues simply telling her how to proceed. Moore's question prompted her to articulate the possibilities.

Del-Mei remembers when she discovered that a nurse had left her shift without resolving a problem. Rather than adopting an accusatory tone the next time she saw her, Del-Mei deftly turned the situation around.

First, she said that she was aware of the problem. She asked what had prevented the nurse from mentioning it, and wondered if she, Del-Mei, had seemed busy or unapproachable. That strategy helped the nurse avoid being defensive. "When you talk to people without judgment," says Del-Mei, "you help them to 'take ownership' of an issue."

Photo: Swavek

Vici Del-Mei, RN, at Kingston General Hospital, where she acts as a staff resource offering leadership and expertise to the nursing team.

Modelling behaviour

While filling a leadership role, nurses are accountable not only to clients and nurses, but also to the profession. In *Professional Standards*, nurses demonstrate leadership by, in part, "role-modeling professional values, beliefs and attributes."

To Moore, that means being extra conscientious about how she behaves when she speaks to colleagues or during times of stress. "I am always conscious that I am a nurse and that I have a responsibility to present myself in a certain way," she explains. "But to be a leader, you must have the ability to influence. How do you influence if you don't maintain a certain level of professionalism?"

Another way of showing leadership described in the *Professional Standards* is by "taking action to resolve conflict." Del-Mei describes one instance when she walked into the middle of an encounter between two nurses who had differing viewpoints about methods. Del-Mei felt that the best action was letting her fellow professionals arrive at the best resolution themselves.

"I said it was interesting to hear both points of view, and I tried to be a mediator," says Del-Mei. "This wasn't about telling them what to do. This was about de-escalating the confrontation, so they could have a conversation."

> "In nursing, being a leader isn't a position; it's an expectation."

"Every day, nurses demonstrate accountability by providing, facilitating and promoting the best possible care to the public," Derro explains.

In lending experience, facilitating solutions, serving as role models and more, leaders show how they're accountable to the College's standards, and they help to create an environment in which nursing colleagues can do—and be—their best. S

Have a comment about this article?
Send an email to editor@cnomail.org.

Overtime… or Over-Tired?

Nurses must consider client needs before accepting overtime and additional shift work.

Nurses are accountable for the care they provide at all times. When receiving care, clients trust that nurses are able to practise safely and are not impaired. Obviously, alcohol or drug consumption compromises the ability to practise safely. However, in nursing, where shift work is common, exhaustion can also affect nurses' ability to exercise their knowledge, skill and judgment.

Nurse Practitioner Tara Leach, who works shifts for two employers, identifies "lack of sleep" as one of the biggest challenges she faces. "You develop an altered sleep schedule due to constantly changing shifts," she explains. "But, I always make sure that my family and personal needs are taken care of first. This supports my ability to take on overtime. I don't want to overextend myself or put my clients at risk."

Nurses are expected to meet the practice standards regardless of whether they are working in the daytime, at night, or during an overtime shift. In addition, while it can be tempting to accept extra shifts for the pay or to help busy colleagues, the priority must be providing clients with safe and competent care.

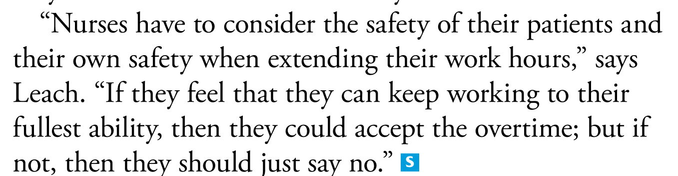
Before accepting overtime, ask yourself if you will be able to stay alert during the shift. If you feel too tired to provide quality care, then you should choose not to work. Fatigue can lead to falling asleep on the job, making errors while assessing clients or administering medication, needing longer breaks or feeling irritable, all of which make it difficult to manage the therapeutic nurse-client relationship.

Employer support

Employers also play a role in managing the amount of shift work and overtime nursing staff take on. In her role as the director of care and chief nursing executive at St. Joseph's Villa in Dundas, Jennifer Banks, RN, creates the work schedules for the facility's nursing staff.

"Our focus is establishing consistent staff assignments, and we try to be creative in our scheduling to accommodate staff," Banks says. "We do this in the hopes of retaining them for our organization. We don't require nurses to work a lot of overtime shifts, but when they do, we offer extra rest breaks, or require a break prior to the nurse starting the second shift. We might offer a free meal, and will ensure that there is support from fellow co-workers and that responsibilities are divided up."

While employers should help their staff achieve a healthy work/life balance, nurses must speak up when they feel that fatigue is affecting the care they provide, or if they are asked to take on too many overtime shifts.



"Nurses have to consider the safety of their patients and their own safety when extending their work hours," says Leach. "If they feel that they can keep working to their fullest ability, then they could accept the overtime; but if not, then they should just say no."

Saying 'no'

Sometimes, nurses fear they may be seen as abandoning clients when they refuse a request to work overtime. However, refusing to work overtime is not abandonment.

Abandonment occurs when nurses accept a client assignment, and then stop providing care without managing appropriate alternatives for the client's care.

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Working with PAs

What are my accountabilities when working with a physician assistant?

For years, the PA (physician assistant) has delivered health care services to members of the Canadian Forces and their families. Now, the role is entering Ontario's broader health care system. What does this mean for nurses?

Here is a Q&A on the PA role, and your accountabilities when working with PAs.

Where do PAs work?

PAs work in a range of health care settings, under the direction of a physician. The role depends on the PA's competencies, the supervising physician's area of practice and the duties the supervising physician assigns. Examples include conducting client interviews and taking medical histories, performing physical exams, performing certain controlled acts as delegated by a physician and providing counselling on preventive health care.

Are PAs regulated?

PAs are unregulated care providers (UCPs), so they are not accountable to a regulatory body. The College's guidelines about working with UCPs can be used when working with PAs.

Can nurses accept orders from a PA to perform a controlled act?

No. Under the *Nursing Act, 1991* nurses can only accept orders for controlled acts from the following regulated health care professionals: physicians, chiropodists, dentists, midwives and nurse practitioners.

Can nurses accept orders from a PA to perform a procedure that is not a controlled act?

If the procedure is not a controlled act, then whether a nurse may implement the order depends on the legislation that is relevant to the setting. For instance, under provincial legislation, PAs cannot authorize orders in hospitals or long-term care homes. Nurses in other practice settings should check their organization's policy about who can order a procedure that is not a controlled act. As always, nurses should use their judgment and ensure their practice is consistent with College standards.

If a PA implements a medical directive involving a nurse, is the nurse accepting an order from a PA?

No, in this situation, the nurse is not accepting an order from a PA. It is the medical directive (the physician's order) that authorizes the nurse to perform the procedure. In such cases, nurses should follow the same steps they would follow if the PA were not involved, such as ensuring that specific client conditions have been met.

Some care settings might have medical directives in place that are authorized by a physician but are initially implemented by a PA.

In some circumstances, a PA can transcribe an order in a client's chart based on a medical directive. If this order includes something a nurse will be doing (for instance, performing venipuncture or administering medication), then the nurse is considered to be "co-implementing" a medical directive with the PA.

Before implementing medical directives, nurses should be aware of and involved in the directives' development and approval—if not directly, then through an appropriate nursing representative. Nurses who implement directives must understand how they will be applied in their practice setting.

When is delegation required when implementing a medical directive with a PA?

A medical directive to perform a controlled act that is not authorized to nursing under the *Nursing Act, 1991* requires delegation. The delegation must come from a regulated health care professional who is authorized by legislation to perform the controlled act (for example, a physician).

A physician can delegate a controlled act to a PA, giving the PA the authority to perform the controlled act. The PA, however, cannot delegate the controlled act to a nurse.

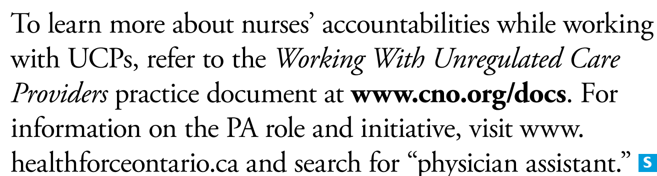
Can nurses accept verbal orders communicated through a PA?

No. The only time a nurse can accept verbal orders is when the prescriber (in this case, a physician) is physically present but unable to document the order. However, if organizational policy supports it, a PA can transcribe a telephone order from a physician into the client's chart. If nurses have questions about the order, then they should verify it with the prescriber.

What else should nurses who work with PAs do to ensure quality care?

Nurses should collaborate with PAs and other members of the health care team to create a quality practice setting that best meets the needs of clients. Nurses should advocate for organizational policies that are consistent with College standards, and that can support all care providers in their practice.

Where can I learn more?



To learn more about nurses' accountabilities while working with UCPs, refer to the *Working With Unregulated Care Providers* practice document at **www.cno.org/docs**. For information on the PA role and initiative, visit www.healthforceontario.ca and search for "physician assistant." S

The practice documents selected for the 2012 QA Program

- *Documentation, Revised 2008*
- *Therapeutic Nurse-Client Relationship, Revised 2006*
- *Nurse Practitioner*

Create your learning goals using the online QA Program at **www.cno.org/qa**.

Resources for the 2012 program year will be available online at the end of December.

College of Nurses of Ontario
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THE STANDARD OF CARE.

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

To promote client safety and timely access to care, nurses have broad authority to delegate and accept delegation to perform controlled act procedures.

Take the Quiz: Delegation

1 Justin, six years old, has recently been diagnosed with diabetes and will soon be discharged from the hospital. Larry, an RN, is caring for Justin and is preparing to teach his mother, Ann, how to administer her son's insulin by injection. Because administering a substance by injection is a controlled act, Larry wonders if he needs to delegate insulin injections to Ann.

Does a family member require delegation to perform a controlled act?

- ☐ **Yes** Delegation is mandatory for those who are not regulated health professionals.
- ☐ **No** Delegation is not needed because Ann is the client's mother.

2 Geoff is an RN who practises in the emergency department of a community hospital. The physicians have delegated the authority to perform diagnostic ultrasounds—a controlled act—to Hua, a physician assistant. Yesterday, the ER manager called Geoff into his office to inform him that Hua will be delegating the authority to perform diagnostic ultrasounds to certain nurses, including Geoff.

Can Geoff accept delegation from a physician assistant?

- ☐ **Yes** Geoff can accept delegation if he has the knowledge, skill and judgment to perform the controlled act.
- ☐ **No** A nurse can only accept delegation for a controlled act from a regulated health professional who has the legislated authority to perform the act.

3 Margaret, an RPN, works for a home care agency. One of her clients requires routine changes of the packing dressing for a surgical wound that is slow to heal. Margaret's supervisor asks her to delegate the dressing changes to Rosalia, an unregulated care provider who works for a different agency. After teaching Rosalia this controlled act procedure, Margaret will have no contact with her because they care for the client at different times. When Margaret points out to her supervisor that she will not be able to evaluate Rosalia's ongoing competence, the supervisor accepts responsibility for this part of the delegation process.

Can Margaret delegate a controlled act if she cannot evaluate ongoing competence?

- ☐ **Yes** Margaret can delegate the act if there is a mechanism to determine continuing competence.
- ☐ **No** Margaret cannot delegate the act unless she can monitor ongoing competence.

4 Josephine is an RN who has just joined the emergency department of a rural hospital. Dr. Bruno, the attending physician, asks Josephine to cast a simple arm fracture. Casting a fracture is a controlled act that is not authorized to nursing. In her previous position, though, Josephine practised in a fracture clinic, and believes she is competent to cast a simple fracture. She tells Dr. Bruno she will need an order to cast the arm, and he writes a direct order without delegation for the casting of the fracture.

Does an order give Josephine the authority to cast a fracture?

- ☐ **Yes** Since Josephine has the knowledge, skill and judgment to perform the procedure, she only requires an order.
- ☐ **No** In addition to an order, a nurse needs to accept delegation to perform this controlled act.

Answers on page 27

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Council meetings

The draft minutes of the December Council meeting will be posted on the website at **www.cno.org/agendas** in late December.

Council meetings are open to the public.

Upcoming meetings:
March 7, 2012
June 7, 2012
September 12, 2012
December 5, 2012

Council meetings begin at 0900 hrs in the College's Council Chambers at 101 Davenport Rd. in Toronto. 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.

Exploring Social Media

What are the personal and professional implications of using social media? What are the regulatory opportunities and challenges?

To explore the answers to these—and other—questions, members of Council and College staff participated in an educational session on social media at the College in September.

Two external experts, Joe Thornley, strategic planner, and Jesse Hirsh, CBC technology columnist, discussed many aspects of social media. Staff members shared research findings and the College's work supporting nurses' use of social media.

Photo: CNO

Photo: CNO

Council President Kris Voycey, RN (middle), with social media experts Joe Thornley (left) and Jesse Hirsh (right).

GET Involved

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario

THE STANDARD OF CARE.

Be part of Council

- Shape the future of nursing practice
- Support nurses in providing quality care to clients
- Participate in decision-making about College policies and programs to facilitate quality nursing care for the public

This is Your Chance to put yourself in nursing regulation

Submit your name to stand for election or nominate a colleague.

Nomination packages for the election of Council members were included with the last issue of *The Standard* and are available at www.cno.org/elections.

Nominations are due by Jan. 16, 2012.

RNs and RPNs from the
Central Western
Southwestern
electoral districts

RPNs from the
Central/Toronto
electoral district

Have a question or want to learn more about our elections?
Visit: www.cno.org/elections
E-mail: jhofbauer@cnomail.org
Contact: Jenna Hofbauer, Council Affairs Coordinator
Tel.: 416 928-0900, ext. 7566
Toll-free in Ontario: 1 800 387-5526, ext. 7566

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Quiz answers

from page 22

1 No An individual who is not a member of a regulated health profession can perform certain controlled acts through exceptions set out in the *Regulated Health Professions Act, 1991*. One exception is that any person can perform a controlled act procedure when treating a member of his or her household if the procedure falls within specified controlled acts. Administering a substance by injection or inhalation is one of the specified controlled acts. Consequently, Larry does not need to delegate the procedure to Ann.

Larry does need to ensure he can meet the conditions for teaching a procedure. For example, Larry needs to have the knowledge, skill and judgment to perform and teach the procedure competently. He also needs to assess the appropriateness of teaching the procedure to Ann. If Larry decides to teach Ann how to administer insulin, then he is accountable for his decision.

2 No As a nurse, Geoff can only accept delegation for a controlled act from a regulated health professional who, through legislation, has the authority to perform the act. For example, a physician would be able to delegate the authority to perform diagnostic ultrasounds to Geoff. He cannot accept delegation from unregulated care providers, such as physician assistants.

As a physician assistant, Hua has acquired the authority to perform diagnostic ultrasounds through delegation from a physician, but not through legislation.

Delegation of a controlled act by an individual who has acquired the authority to perform the act through delegation is not in keeping with the College's standards of practice.

3 Yes Margaret can delegate the controlled act if she reasonably believes there is a mechanism in place to determine Rosalia's continuing competence. Here, the supervisor has assumed this responsibility.

Ultimately, a nurse is accountable for her or his decision to delegate a controlled act. Before delegating the controlled act, Margaret should determine that Rosalia has the competence to perform the procedure. Once Margaret has taught Rosalia the procedure, the supervisor will be responsible for ensuring Rosalia's continuing competence.

However, if Margaret believes that delegating this procedure is not in the client's best interest, then she must refrain from delegating it and discuss the situation with the supervisor.

4 No Since the controlled act of casting a fracture is not authorized to RNs and RPNs (it is authorized to NPs), Josephine needs to accept delegation and receive an order before she can cast the fractured arm.

Delegation and orders are two distinct authorizing mechanisms. Delegation provides the legal authority to perform a controlled act, whereas an order outlines what to perform.

Delegation may or may not include an order, and an order may or may not indicate a delegation.

Josephine should consult with her manager and review relevant organizational policies to develop a delegation process with Dr. Bruno. Delegation will give Josephine the authority to perform this controlled act when she receives an order.

For more information, refer to the *Authorizing Mechanisms* practice document at **www.cno.org/docs**.

Online
Illegal Practitioners
Listing

A list of illegal practitioners is posted at **www.cno.org/illegal.** These individuals, if employed as nurses, pose a threat to the public's right to safe, ethical and competent nursing care. Review this listing regularly to protect your clients, co-workers and yourself.

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario
THE STANDARD OF CARE.

You Asked Us

Teaching a UCP to administer oral narcotics

Meeting QA requirements

Administering OTC medications

Special Assignment Class

Q I'm the manager of a retirement home and I want to ask an RPN to teach an unregulated care provider (UCP) how to administer oral narcotics. Can an RPN teach a UCP this procedure?

A Yes, an RPN in this setting can teach a UCP how to administer oral narcotics if the nurse has the knowledge, skill and judgment to perform the procedure competently, knows how to teach it and meets certain conditions, such as ensuring there will be follow up for the UCP.

The nurse is responsible for determining if the procedure is appropriate to teach to a specific UCP and for deciding to teach it. Before offering instruction, the nurse must have firsthand knowledge of the UCP's competence. The nurse could obtain this by working with or observing the UCP directly, or by asking the UCP if they have administered the medication before and asking about those situations. It's up to the nurse to determine if the UCP has the knowledge, skill and judgment to administer the medication, including knowing when and who to ask for assistance.

In the situation you describe, the nurse would typically teach the UCP how to administer an oral narcotic to a specific client. There may be times, though, when a nurse will teach a UCP how to administer an oral narcotic to more than one client (for example, if there is more than one client who receives the medication).

The nurse or another health care professional remains responsible for assessing the health care needs of the client and developing an ongoing plan of care. The nurse should not expect the UCP to take on these responsibilities.

The UCP's continuing competence must be evaluated on an ongoing basis. The nurse who is accountable for teaching the UCP should ensure that adequate arrangements have been made for this evaluation to occur.

Q In the mail this morning, I received a notification package saying I've been randomly selected for a Quality Assurance (QA) Program Practice Assessment. I'm on parental leave from work. Do I have to complete the Practice Assessment now?

A By participating in the QA Program, nurses demonstrate their commitment to continuing competence in their nursing practice. If you are registered in the General, Transitional or Extended class, it is your legislated responsibility to participate in the Self-Assessment portion of the QA Program. In the Practice Assessment component, the College reviews your Learning Plan, and you take multiple-choice tests online. Parental or maternity leave does not automatically guarantee you a deferral from the Practice Assessment component of the QA Program.

When determining whether to defer a member's participation in Practice Assessment, the College will consider the member's individual circumstances. For example, the College may grant a deferral if the baby requires hospitalization, the member is recovering from complications related to childbirth or the member is adopting a baby from another country at the time of the assessment. Other examples

of when the College will consider a deferral are when the member is ill or when there has been a death in the member's family.

If you decide to request a deferral, you must notify the College within three weeks of receiving notification of being selected for Practice Assessment. To support your request, you will need to mail, fax or email the appropriate documentation such as a physician's note or adoption certificate.

For more information about the QA Program, visit **www.cno.org/qa**.

Q As an occupational health nurse in a car manufacturing plant, I'm often asked for an over-the-counter (OTC) headache remedy, such as ibuprofen or acetaminophen. We stock these medications, but do I need an order to administer them?

A Since OTC medications, including herbal therapies, do not require a prescription, they are not part of the controlled act of prescribing. Regardless, some practice settings—including hospitals, which are governed by the *Public Hospitals Act, 1990*—require an order for a nurse to administer any treatment, including OTC medications.

When a nurse independently recommends or administers an OTC medication or herbal therapy, the nurse is solely accountable to the client for any outcomes. Before recommending or administering any OTC medication or herbal preparation, a nurse must have knowledge of the client's situation, condition and medication profile to determine if it's an appropriate intervention for the client. The nurse must also have current knowledge of the use and action of the medication or herbal therapy, including its potential benefits and risks. By communicating this information to clients, nurses allow them to make informed choices.

For more information, refer to the *Medication, Revised 2008* and *Complimentary Therapies* practice documents.

Q I teach a post-RN course at a community college. We're offering the course to internationally educated nurses and it includes a clinical placement. Each post-RN student is registered in their home country, but not with the College. Can these students practise in Ontario as part of the course?

A To practise in a post-RN clinical placement, nurses who are not College members must first register in the College's Special Assignment Class. This is a non-renewable registration. It provides an opportunity for nurses from outside Canada (and others with special circumstances) to fulfil an appointment or assignment as an RN or RPN at an approved facility for a limited time. The registration allows students to practise in the clinical placement within the scope of their appointment and under defined terms, conditions and limitations.

Registration in this class is for a limited term only. It expires on the earliest of the following three dates: the date on the Certificate of Registration, the last date of the appointment or one year after the College notified the applicant that they qualified for registration in the class.

To qualify for registration in the Special Assignment Class, the applicant needs to meet several criteria, including:

- having successfully completed a nursing program that was approved or recognized in their jurisdiction
- not having been refused nursing registration in another jurisdiction
- having practised safely as a nurse within the five years of the date of application
- being able to speak and write in English or French with reasonable fluency.

All applicants must sign an undertaking agreeing to follow any specified terms, conditions or limitations. The employer is responsible for ensuring that these terms are met.

As the nurse educator, you need to provide students with proof of their special assignment as an RN or RPN at a recognized facility in Ontario. The students will need this to register with the College.

For more information, refer to the *Special Assignment Class* fact sheet or call the Customer Service Centre at 416 928-0900 or 1 800 387-5526. S

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

Have a question about applying the College's practice standards?
Contact the Practice Support Line:

- email ppd@cnomail.org
- call 416 928-0900, ext. 6397 or toll-free in Ontario 1 800 387-5526, ext. 6397.

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The College responds to concerns received from the public, employers and other sources through its complaints and reports processes. The goal is to enhance the quality of nursing care and ensure public protection by reinforcing the College's standards of practice, and by providing nurses with opportunities to reflect on and improve their practice.

This column is intended to help nurses understand and reflect on commonly raised concerns, as well as the College's overall approach to resolving those concerns.

The scenarios are examples based on actual complaints or reports. All names, locations and identifying characteristics have been changed to protect confidentiality.

Listening to family members

The complaint

The College received a complaint from Darren, whose mother, Joan, had been admitted to hospital after suffering a heart attack at the long-term care facility where she lived. Darren wrote:

My mother was confused and physically weak for several days following her admission. I was concerned particularly with the care she was receiving at night because the nurses did not appear to monitor her sufficiently. One night, the staff forgot to activate her bed alarm. Mom was found lying on the floor in the morning. She had broken her hip and was in a lot of pain.

Following hip surgery, the physiotherapist instructed that two people help my mother whenever she had to move from her bed to use the washroom or sit in her chair. One day, I called for the nurse because Mom had become uncomfortable sitting in her chair for over an hour. When the nurse, Sherry, came in the room, I asked if she could get someone to help put Mom back in bed right away. Sherry said she was covering for my mother's regular nurse who was on break, and that she could do it herself. I explained that Mom was supposed to have two people help her, but Sherry simply grabbed Mom under her armpits and lifted her from the chair. Mom was screaming, so the nurse quickly tossed her onto the bed.

The College responds

After assessing the complaint, the College proposed a resolution that could address Joan's son's concerns and protect the public. Both Darren and Sherry agreed to participate in the College's resolution process: Darren hoped that Sherry might benefit from the experience and improve her practice, and Sherry was interested in engaging in the College's process to address the issues Darren raised.

In the proposed resolution, Sherry agreed to review the letter of complaint, meet with the Manager of

Questions to consider

1. What indicators or statements in the *Therapeutic Nurse-Client Relationship, Revised 2006* practice standard could provide guidance to Sherry about the expectations for nurses in this scenario?
2. What specific strategies might Sherry use in the future if she is faced with the same situation?

Complaints, complete a review of the *Therapeutic Nurse-Client Relationship, Revised 2006* online learning module and document her reflections on the standard on a participation form before the meeting.

The member responds

The purpose of Sherry's meeting with the Manager of Complaints was to facilitate her reflection on the issues Darren raised and on the applicable standards. During the meeting, Sherry said that she had been upset to learn she was the subject of a complaint, and hoped it would not be considered representative of her lengthy nursing career. She felt very sorry for the distress she had caused the client and her family.

When reflecting on what had taken place, Sherry said that when she initiated the transfer, she did not have sufficient information from her colleague—the client's primary nurse—about the client's condition or abilities. She also admitted that she should not have disregarded the transfer instructions. Sherry explained that she felt rushed to do the transfer. This was because the client was in discomfort, her son had voiced concerns about his mother's care and he seemed anxious to have her returned to the bed. However, as soon as she began the transfer, Sherry realized she could not get Joan into bed by herself without causing her pain. At that point, Sherry decided to continue transferring Joan because she knew she could not easily return Joan to the chair.

The College helped Sherry reflect on the family's request that she find assistance before attempting to transfer Joan. Sherry acknowledged that she had not taken the time to become more familiar with the client's care plan or listen to the family's concerns, which would have helped her provide the best possible care to the client.

Reflecting on the complaint

Nurses are expected to develop collaborative, therapeutic relationships with clients and their families, regardless of the context and length of their interactions. Client-centred care involves understanding the clients' abilities, limitations and needs related to their health conditions. This also includes listening to the family's concerns and acting on these concerns as appropriate, since family members are often very knowledgeable about client care needs. Since Sherry was providing care in place of the primary nurse, Sherry was accountable for obtaining the best possible outcome for Joan, with no unnecessary exposure to risk of harm.

In her meeting with the Manager of Complaints, Sherry outlined several strategies for addressing a similar situation in the future:

1) She would ensure that she had clear and complete instructions about the client's health condition, needs, abilities and limitations before accepting the care of a client on behalf of a colleague.
2) She would not attempt a one-person transfer in these kinds of circumstances, regardless of how urgent the request appeared to be.
3) She would offer the client pain medication if needed, before initiating a transfer.
4) She would assure the client and family that she would return, within a defined time, with another person to transfer the client to her bed after pain medication had taken effect. She would also seek the client's consent to this plan of care.

By the end of the resolution process, Sherry said that she appreciated the chance to reflect on the concerns, and to work with the College and Joan's son to address the issue in a constructive way that could help her improve her practice.

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 constitutes 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 1 800 387-5526, ext. 7590 (toll-free in Ontario) or 416 928-0900, ext. 7590.

JENNIFER BILLESBERGER 0310748

Allegations and Plea

The College alleged that the Member inappropriately and without consent accessed the personal health information of four people who were not her clients and disclosed the health information of one person.

The Member admitted 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's common-law spouse (E) has an 11-year-old daughter (D) from a previous marriage, who is the subject of custody proceedings between E and his ex-wife (A).

In September 2008, A told the privacy office at the Member's employer hospital that she suspected that the Member had accessed D's health information. An audit revealed several occasions between May 2007 and May 2008 when the Member had accessed the personal health information of A and D, and the information of A's parents (B and C).

The Member had never provided nursing care to any of these individuals, and did not have permission to access their medical records.

The Member said she accessed D's health records out of concern for her well-being, and shared the personal health information with her common-law spouse, E, who is D's father. The Member had no explanation for accessing the health information of A, B or C.

Finding

The Panel found that the facts supported a finding of professional misconduct as alleged. The Panel found the Member's behaviour to be dishonourable because it involved dishonesty and deceit, and unprofessional because it showed a persistent disregard for professional standards.

Submissions on Order

The College and the Member sought an oral reprimand and a one-month suspension. The Member would be required to complete specified remediation activities in preparation for a meeting with a regulatory expert. 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, and only practise 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 submission 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. She expressed remorse and had no prior history with the College.

The public and the profession expect members to protect client confidentiality. Failure to do so is a serious matter that will not be tolerated.

YVONNE FARQUHARSON JA05304

Allegations and Plea

The College alleged that the Member practised nursing, performed controlled acts and used the title "nurse" while her membership was suspended for nonpayment of fees, and provided false or misleading information to the College by declaring that she had not presented herself as a nurse and by failing to disclose that she had worked at two agencies since her graduation.

The Member was neither present nor represented by counsel at the hearing. The hearing proceeded on the basis that the Member denied the allegations.

Evidence

College staff identified documentation and correspondence that indicated the Member's Certificate of Registration had been suspended for nonpayment of fees on April 10, 2008.

The human resources coordinator at Agency A identified a work schedule and documentation that indicated the Member provided nursing care to a client between April and July 2008, and the director of clinical operations at Agency B testified that the Member provided nursing services to several clients between April and July 2008, which clearly revealed that the Member had practised while her certificate was suspended. Agency A advised the Member that she was placed on hold until she produced the original copy of her certificate, which she did not do.

College staff identified documentation that indicated the Member signed her name on a reinstatement form, clearly indicating that she had not used the title Registered Practical Nurse, or represented herself as a nurse since her certificate was suspended. Her reinstatement form also listed only two employers, and did not include either Agency A or Agency B.

Finding

The Panel found the witnesses' testimony to be clear, precise, credible and consistent with the documentation provided. The Panel also found that the facts supported findings of professional misconduct as alleged, and that the Member's conduct would be considered unprofessional and dishonourable.

Submissions on Order

The College sought an oral reprimand and a two-month suspension. The Member would be required to complete specified remediation activities in preparation for a meeting with the Director of Professional Conduct. 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, and only practise 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. Aggravating factors included the falsification of forms and that the Member had been given adequate notice of suspension if she did not pay her fees. Mitigating factors included that no clients were harmed and that the Member had no discipline history with the College.

The penalty emphasizes the importance of participating effectively in self-regulation of the profession and increases the Member's accountability to her employer and to the College.

EULALEE LOWE 0108043 AND IH06209

Allegations and Plea

The College alleged that the Member failed to comply with terms, limits and conditions imposed pursuant to previous orders from the Fitness to Practise (FTP) and Discipline Committees, failed to disclose the orders and information about them to a new employer, and accepted employment for a nursing position she could not fulfil as a result of her terms, limits and conditions.

The Member admitted 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

In December 2006, the Member was found by the FTP Committee to be incapacitated. By December 2008, the Member was able to return to work with specified terms, limitations and conditions. She was required to inform the College immediately when she obtained nursing employment; inform the employer of her terms, limits and conditions; and file with the College a letter from her employer confirming receipt of a copy of the FTP order.

In February 2008, the Member was again referred to the Discipline Committee, and the Panel made findings of professional misconduct. She received an oral reprimand and a three-month suspension, and terms, conditions and limitations were imposed on her certificate. As part of the order, the Member was required to provide current and prospective employers with certain documents from the Discipline Committee hearing.

In April 2009, the Member applied for a nursing position at the facility and was interviewed by the director of emergency services (DES). In a series of conversations with the DES and a human resources representative, the Member made no mention of her terms, conditions and limitations. In May 2009, she indicated on her application that there were restrictions on her certificate. The Member would say that it was her intention to disclose the restrictions to the DES on a number of occasions, but the opportunity did not present itself until her first day of orientation, which was in June 2009. The Member provided the DES with the FTP order at that time. The Member was terminated a week later. The Member's first contact with the College about her employment at the facility was when she advised the Monitoring Coordinator of her termination.

Finding

The Panel found that the facts supported a finding of professional misconduct as alleged. The Panel found the Member's behaviour to be unprofessional.

Submissions on Order

The College and the Member sought an oral reprimand and a six-month suspension.

Mitigating factors included the Member's remorse and cooperation, and that she did not completely disregard the previous orders. Aggravating factors included the repetitive nature of the misconduct and that the conduct demonstrated a degree of ungovernability.

Panel Order

The Panel accepted the joint submission 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 penalty sends a clear message that failure to comply with orders of a Discipline or FTP Panel will not be tolerated. This penalty, along with the terms, conditions and limitations already imposed, provides for remediation, rehabilitation and monitoring.

LEO LUPP
IF07375

Allegations and Plea

The College alleged that the Member physically and emotionally abused a client, lied about the incident and falsified his nursing note about the incident.

The Member admitted 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 at a mental health centre on a unit for older clients with severe behavioural issues related to dementia. Staff were concerned that Client A had been engaging in inappropriate sexual behaviour with female clients, including Client B.

The Member observed Client A in Client B's room. It appeared that Client A had partially undressed Client B. The Member intervened and called a code white.

In his nursing notes, the Member charted that he confronted Client A about being in Client B's room. Client A lunged at him, and the Member secured Client A against the wall and called for assistance. As part of the facility's investigation into the matter, the Member said that Client A had his arm up as he came toward the Member.

Video footage revealed that the Member walked by Client B's room with a jug of water in his right hand, did a double take and returned to the room. As the Member arrived in the hallway outside the room, Client A left the room with his hands clasped behind his back. The Member raised his left arm to place his left hand against Client A's right shoulder and pushed him back into the room and against a wall. The Member kicked Client A in the upper thigh/groin area and punched him in the face, continuing to hold the jug of water throughout. Client A turned away, and the Member pushed him into a corner. The Member used his shoulder to pin Client A, face-first, against the wall. The Member set down the water jug. Staff arrived shortly thereafter to tend to Client A and wipe blood from the walls and floor.

As a result of the Member's intervention, Client A was injured. An initial examination revealed a four-cm laceration above the bridge of his nose. A second physical examination revealed a bruise on the medial aspect of his left thigh, about six by three inches.

At a second meeting, the Member confirmed the accuracy of his initial

response, adding that Client A had sworn at him and had come at him "with his arm up and his foot up." The Member's employment was terminated.

Finding

The Panel found that the facts supported a finding of professional misconduct as alleged. The Panel found the Member's behaviour to be 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 complete specified remediation activities in preparation for a series of meetings with a nursing expert. For 12 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 only practise 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 submission 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.

Mitigating factors included that the Member had no prior history and had cooperated with the College. Aggravating factors included the abusive behaviour and falsification of records.

MICHELE MATHEWSON
JE01320

Allegations and Plea

The College alleged that the Member falsified a police clearance certificate (PCC).

The Member admitted 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

In 1999, the Member was convicted of fraud under $5,000 in relation to a bounced cheque. She obtained her registration with the College following a decision of the Registration Committee exempting her from the requirement that an applicant must not have been found guilty of a criminal offence.

The Member began employment at the facility in September 2008 and was advised of the need to provide a PCC within 30 days. She failed to do so and was given an additional two weeks to comply. She provided a very poorly photocopied PCC from 2005, which the facility found unacceptable. She was given one more week to provide an original PCC from 2008, which she did. It was immediately apparent to the facility that the document had been altered.

At a meeting, the Member denied having altered the document and said that she had no criminal record. She then said a family member must have altered the document and she revealed the fraud conviction. She resigned in lieu of termination for breach of trust.

Finding

The Panel found that the facts supported a finding of professional misconduct as alleged. The Panel found the Member's behaviour to be dishonourable and unprofessional as it compromised the integrity of the nursing profession and was relevant to the practice of nursing.

Submissions on Order

The College and the Member sought an oral reprimand and a one-month suspension. The Member would be required to complete specified remediation activities in preparation for a meeting with a nursing expert. 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, and only practise for an employer who agreed to advise the College if the Member breached the standards of practice of the profession.

Mitigating factors included the Member's admission, her cooperation with the College during the investigation, and the absence of a prior disciplinary history. Aggravating factors include the seriousness of the criminal offence and the Member's act of dishonesty.

Panel Order

The Panel accepted the joint submission 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. She expressed remorse and had no prior history with the College.

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.

Major contributor to recovery

Sharon MacKnight, RN, was our home care nurse for the better part of 10 months. Throughout this time, Sharon was helpful in so many ways. She helped us get information, answered endless questions and generally helped facilitate my husband on his road to recovery. Sharon was always available by phone and often took our calls well into the evenings.

We especially appreciated her efforts to answer our children's questions (they are 4, 6 and 8 years old). With our permission, Sharon answered their questions about what she was doing in a gentle and age-appropriate way. As you can imagine, the events of their father's illness had made them apprehensive and afraid; Sharon did an excellent job of easing their fears. She did not ignore them or pretend they weren't there; she made them feel as if they were part of the healing process.

The service that Sharon provided my husband was executed both professionally and efficiently, and I believe it is one of the major contributing factors that aided in his recovery. I know that she will be missed; however, it means that she has done her job well and is now helping someone else.

Respectfully,
Catherine Sohl

Our "Dream Team"

I recently gave birth to our first child at Ottawa General Hospital. On behalf of myself, my spouse and our families, we would like to express a great deal of gratitude and respect to two of our labour and delivery nurses, Jennifer Hoar, RN, and Yvonne McLeod, RN — or as we like to call them, the "Dream Team." Both nurses exemplified the qualities that great nurses possess, and both demonstrated the standards of practice to a "T."

As a nurse myself, I understand the demands and challenges in our practice, and I am thankful for two professionals who went above and beyond for us. They provided support and encouragement to not only myself and our baby, but to my spouse and family as well. Jennifer and Yvonne advocated for me and helped me make the best informed decisions for me and my baby. They were respectful to us and our doula, and made me smile when I didn't think I could. Often, people are eager to complain about the negative experiences they have with health care staff or services, which is why we feel it is so important to let you know about the excellent care we received during our stay.

Sincerely,
Anneke Kooistra, RN, Eric Rochon and families

Wonderful professional care

I want to express my gratitude for the terrific care we receive from Lisa Babcock, NP, in Wallaceburg.

Lisa has given us wonderful, professional health care since we first met her and we feel fortunate to have her looking after us. I am a heart patient and I always feel satisfied that my health is being addressed in the proper way when I visit Lisa. We are quite happy with having a professional, caring person care for us. Thank you so much.

Sincerely,

Rod Nixon and Yvonne Clarke

Grateful during a difficult time

My spouse was an in-patient twice (and is now an outpatient) at Princess Margaret Hospital, where he received amazing, professional care by a group of dedicated (and very smart) nurses. The nurses responded quickly to emergency situations, while providing supportive bedside nursing care.

It's hard to choose specific names as they all provided excellent care. I would single out Ruby Magalque, RN, on 14A who has now retired (and will be greatly missed), Kiing Eng Chan, RN, in the blood clinic and Paul Tascione, RN, on 14A who was kind and supportive. What a team! I am so glad I saw nursing alive and well at Princess Margaret Hospital, and I'm grateful they helped my spouse get through a difficult time.

Sincerely,

Karen Kelly

Very fortunate for dedicated nurses

Shortly after being discharged after surgery at Brantford General Hospital, I had to be re-admitted due to complications. As a result of this, I had the opportunity to encounter nurses on a number of different units.

I was very impressed with the professionalism and caring every nurse demonstrated — not only to me, but also to the worried members of my family. Regardless of how busy the unit was, each nurse I encountered took the time to listen to my concerns and answer my questions. Our community is very fortunate to have access to such dedicated nurses and I am tremendously grateful for their compassion and caring.

Sincerely,

Tammy Coates-St Laurent, RN

Unending gratitude

I would like to express my unending gratitude to the nurses at Chapleau General Hospital. Almost one year ago, I lost someone very special to me to cancer. The wonderful nurses supported my friend, her family and myself through every step of the journey. They did all they could to make sure my friend was comfortable day and night. This could not have been an easy task, as my friend was also an employee of the hospital. They were looking after one of their own.

When my good friend unfortunately lost her battle, the loss was felt throughout the hospital, but the support for us during our grieving was always put before their own feelings. It took those few short months last winter for me to realize just how much dedication the nurses of Chapleau General Hospital have, not only to the care of their patients, but to all who walk through the hospital doors. From the bottom of my heart, thank you.

Sincerely,

Natasha Orton

Genuine, compassionate care

I would like to compliment the fifth floor nursing staff at St. Mary's Hospital of St. Joseph's Health Care in London for the outstanding care delivered to my client. As her power of attorney, I was impressed with the attention paid to her over the course of her stay.

No matter when I visited, it was evident that there was genuine, compassionate care provided. All of my contacts with the staff either in person or by telephone were received in a kind, professional manner. My client did not have any local family, but I was so very grateful that the staff replicated such attention. May they continue in the delivery of a very high standard of practice with pride.

Sincerely,

Barbara Haggarty-Hebert

Send your letters to:

InPraiseOfNurses@cnomail.org or

College of Nurses of Ontario

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THE STANDARD OF CARE.

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"A nurse demonstrates the standard by advocating for clients, the workplace and the profession."
– from *Professional Standards*

THE STANDARD OF CARE.

Photo: Melanie Gordon

IT DOESN'T HAPPEN EVERY DAY, but Anne Marie Batten, RN, admits she has ridden the train home in tears more than once. Thankfully, they're not always tears of sadness.

"The days that are awful are when someone comes in suicidal, or something sad like that," says Batten, a nurse with the Street Health clinic in downtown Toronto.

But then she remembers days like the one when she and her team helped an elderly woman regain her independence by directing her to an agency that provides scooters. "There are days like that you're also welling up with tears, but it's a good thing. For all the negativity, there are positives that balance it out."

Batten began nursing in an emergency department, and early in her career she often spoke out on behalf of clients unable to advocate for themselves. Her passion for advocacy led to positions with a domestic abuse team and as a crisis nurse before arriving at Street Health.

On any given day, she and her nursing colleagues provide care at a clinic in a church, visit elderly clients and mobility-impaired people in their homes, or hit the streets with medical supplies for the city's homeless people and safe-injection kits for those suffering from addictions.

Because of her frontline experiences, Batten is often invited by media outlets, schools and government officials to discuss public health issues. During last summer's heat wave, she appeared in newspapers and on radio programs speaking about the importance of public health measures in protecting our more vulnerable citizens.

Batten has also taken her advocacy efforts online, using Twitter and Facebook to connect with other health care professionals across Ontario, the U.S. and overseas. While sharing best practices and news items about public health issues, her message is clear: every client, regardless of background, deserves quality health care.

"The people we see can't get their voices out there, but I can," she says. "And I feel as a nurse we ought to do that more. I can't imagine doing anything else." S

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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