BREAST CANCER: NURSES AS PARTNERS IN CARE
Carolyn Tayler, Chris Emery and Allison Palmer of the Fraser Valley Cancer Clinic

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RNABC BOARD OF DIRECTORS NOMINATIONS

You Can Make a Difference

RNABC’s Nominations Committee is seeking nominations for registered nurses to serve on the Association’s 1996-98 Board of Directors. Elections will take place throughout May and June of next year.

The Director-at-Large and District Director* positions are two-year terms. The President-Elect serves for one term and then-assumes a two-year term as President. Terms of office begin Sept. 1, 1996.

The Board of Directors is RNABC’s policy making and governing body. It receives its authority from the Nurses (Registered) Act. It manages, on behalf of 35,000 nurses, the business and professional affairs of the Association. Through their election, Board members ensure that RNABC meets its legislative and constitutional objects, which are to serve and protect the public and enhance the practice of nursing.

To carry out the Association’s public interest mandate, the Board makes rules respecting standards of education, registration of persons wishing to become nurses, the renewal and reinstatement process, continuing education, licensed graduate nurses and student nurses. It is comprised of elected RNABC members and public representatives appointed by government.

Board meetings are held six times a year in Vancouver. Members of the Executive Committee also meet between Board meetings. As well, directors attend the annual leaders conference and the Association’s annual meeting. Directors also serve on various Association committees, make visits to chapters and may attend public appearances on RNABC’s behalf.

Eligibility

To be eligible for an elected position, a nurse must be a registered nurse member of RNABC and hold a current practicing or non-practicing membership. Electoral District Directors must reside in the districts they represent or be a member of a chapter in that district.

Nominations are requested for the following Executive Committee positions:

President-Elect — Serves on the Board for one year and then automatically becomes President for a two-year term. Serves on the Executive Committee and the board of the RNABC Captive Insurance Corporation, and performs functions delegated by the President or Board. Elected by all members every second year.

Director-At-Large — Serves on the Executive Committee and the board of the RNABC Captive Insurance Corporation, and may chair an RNABC standing committee. Elected by all members of the Association.

Nominations are requested for the following Electoral District Director positions (one to be elected in each district):

A Mainland-Coastal District* 
B Fraser Valley District 
C North Vancouver Island District 
D Northwest District 
E Okanagan District 
F Northeast District

Nominations for all elected Board positions can be made by chapters or any five members of RNABC. Deadline for submitting nominations is January 16, 1996.

Further information and nomination forms are available from RNABC Chapters, Professional Practice Groups, Workplace Representatives or RNABC Member Development.

* Director for District A term begins immediately after the 1996 election results and ends August 31, 1997.

REGISTERED NURSES ASSOCIATION OF BRITISH COLUMBIA
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From the first moment the patient hears the word "cancer" through to surgery, treatment, supportive care and follow-up, nurses can be partners and advocates for women with breast cancer. (Andrew Klarer photo)

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RNABC Mission Statement
The goal of the Registered Nurses Association of British Columbia is safe and appropriate nursing practice regulated by nurses in the public interest and achieved by promoting good practice, preventing poor practice, and intervening when practice is unacceptable.

Publications Mail Registration 6866
Date of issue December 1995
Back to Basic Values

By Arlen Bruce, RN, RNABC President

Is the nursing profession shooting itself in the foot? Why is there so little regard for consensus among nurses? Do we attempt to understand each other, who we are, where we are at, and where we want to go? Do we value each other regardless of where we are in our careers or in nursing. Is there a family or community of nursing? Do we lose our credibility because of the profession’s fragmentation?

Do we communicate and collaborate well with other health care professionals? Must we publicly criticize other health care providers? Do we really believe multidisciplinary community health centres are the most appropriate health delivery mode for the future?

These are not rhetorical questions, but ones that demand answers if our profession is to present credible counsel in these changing health care times. These are questions that each of us must explore within ourselves and with our colleagues if we are to develop true professional awareness.

Exploring Basic Values

Over the next couple of years, I plan on exploring the basic values of our profession to seek answers to these questions. Concepts such as professionalism, self-regulation, a college of nursing, member participation, scope of nursing practice, and multidisciplinary health care are based on our professional values — values that sometimes seem to be misunderstood or negated by nurses themselves.

This is the time for making commitments, for unity and for taking a stand internally among nurses and externally within the health care community.

I sometimes wonder why those who dislike nursing or managing nurses don’t consider leaving the profession. Self-assessment and self-awareness is what legitimizes us.

As a member of the RNABC Board over the past four years, I have had the privilege of being part of a review of our professional organization, including the role of your Board of Directors. This has traditionally been a usual and thorough process for the Association. However, recent politics and trends have caused greater scrutiny, and the Board is now satisfied with its role of setting policy for RNABC staff to carry out (you can read more about this in this issue of Nursing BC). With each decision your Board makes, the mission of RNABC remains foremost in our minds:

The goal of the Registered Nurses Association of British Columbia is safe and appropriate nursing practice, regulated by nurses in the public interest, and achieved by promoting good practice, preventing poor practice, and intervening when practice is unacceptable.

Choices For All

There are always choices. We can pull together, learn about nursing issues and our professional organization or choose fragmentation. We can choose self-regulation and fight for it or we can give our regulatory power away to others who do not know the patient as we do.

I chose to make a difference by using the democratic process to get elected to the RNABC Board. As your President I will speak out for self-regulation and an unrestricted Nurses (Registered) Act. I will also advocate for competencies as well as credentialing as means of licensing nurses to practice safely and competently.

The Board cannot work on your behalf without your support, and not just the support of a few nursing leaders. We need to build a sense of community among nurses. A major challenge for us, if we remain fragmented, is helping others to understand our scope of practice — what we have to offer society.

Is the nursing profession shooting itself in the foot? Sometimes I think it is. And the damage it may be inflicting upon itself could be unrepairable. To quote Albert Einstein, “the significant problems that we face cannot be solved at the same level of thinking we were at when we created them.”

We can’t adjust the wind, but we can set the sail. Remember your roots and value them.
DUTY COMES FIRST

I wish to add my voice to the debate about male circumcision that has been ongoing in your publication for well over a year. With respect to the nursing role concerning informed consent, it is my belief that we help our clients understand the risks and benefits of procedures so that they can decide for themselves and for their infant children how to proceed.

This can, and indeed must be achieved without treading on religious and cultural practices that are legal in many countries of the world, including our own.

In a multicultural society such as Canada, it is imperative that nurses be aware of their own values and beliefs, but acknowledge and respect cultural differences held by others. Nurses are not going to agree with everything that is done to or for a patient. That does not, however, preclude us from performing our duty as nurses to the highest professional standards.

Miriam Cohen, RN
Vancouver, B.C.

PERSONAL STANDARDS LACKING

Recently I had occasion to visit two friends in hospital. As a retired nurse and supervisor, and member of the RNABC, I was astounded by the diversity of uniforms worn by hospital personnel, making it virtually impossible to differentiate among nurses, administration staff and janitorial staff.

I am of the opinion that nurses should be clearly identifiable as such. I see nothing wrong with a clearly defined uniform for the nurses, which may have two or three variations to provide a choice for individual preferences. I think this would be preferable to the complete mish-mash I saw on my visits.

The following are some of the points I feel should be addressed and improved upon:

Hair grooming. If nurses wish to have long hair, that is their choice, but when they come on duty it should be arranged in such a way that it does not fall down over their faces when attending to patients.

Ratty white sweaters worn on duty when attending patients. Name tags should be compulsory. Top supervision appears to be lacking. Lack of personal pride in appearance and deportment. Lack of professional attitudes.

Nurses have always had professional standards, and from what I see, the standards have either been lowered or they are not being adhered to.

Marion Lewis
Vancouver, B.C.

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BRITISH COLUMBIA INSTITUTE OF TECHNOLOGY
On December 1, 1995, the RNABC Board of Directors reversed the decision of the Professional Conduct Committee regarding Nancy Barr and cancelled the disciplinary action (see page 31). To ensure fairness, the Association made every effort to prevent the Board from receiving information prior to the appeal about members' criticisms of the publication of the disciplinary summary. Following its decision, the Board received and discussed members' comments and made plans to further review its publication practices and rules.

NURSES SOUND OFF ON PROFESSIONAL CONDUCT REPORTING

Having read the last issues of Nursing BC's detailed Professional Conduct Committee decisions (September 1995), I must register my personal disgust and horror.

I understand and agree with the duty of professional organizations to police their members and ensure public safety through ensuring competency and standards of practice.

I fail to understand, however, why every nitty gritty detail of the cases must be reported. When our patients/clients suffer an illness such as chemical dependency or a psychiatric problem, the details of their illness are kept confidential. When one of our peers is the client, it seems confidentiality and privacy are no longer an individual's right.

I believe the detailed reports are an invasion of privacy, despite the rationalizations I have heard about the need to protect and inform the public.

Surely it is sufficient to report the individual's name and the standards violated. Those who desire the details can read the standards document.

This reporting method illustrates yet again a punitive, versus a rehabilitative, approach to our peers which continues in nursing. While I do not agree with the lack of disciplinary action against its members displayed at times by the College of Physicians and Surgeons, I do have to admire the peer support displayed.

I have no illusion that my protest will change the method of reporting, but simply had to register my personal dis-taste for this "National Enquirer" method.

Ivery Warner, RN
Kamloops, B.C.

Where is the compassion in nursing? Nurses who are disciplined and lose their license to practice now have all the sordid details printed in their professional journal.

Our ex-colleagues are going through enough without the added humiliation. No one denies the fact that any nurse found guilty of unethical conduct.

Letter to Nancy Barr

The following is printed in Nursing BC at the request of Nancy Barr:

I am writing on behalf of the RNABC Board of Directors to extend the Association's very sincere apologies regarding the publication of certain personal information about you in the August issue of Nursing BC.

We appreciate that the Association did not protect your identity as a victim of sexual abuse and we are very sorry for this, as well as for any embarrassment or other distress you may have experienced as a result of our actions.

As you are no doubt aware, RNABC is required by its rules to publish a summary of decisions and reasons when disciplinary action is taken, for purposes of notification and education. We have carefully reviewed the published report and have concluded that the decision could have been effectively summarized in a different manner without disclosing details of such an intensely private and personally distressing nature.

We also want to acknowledge that we have reviewed the September 21, 1995 letter written by Catherine Wedge on your behalf. In it she raises certain issues about protecting the identity of the physician whom you consulted in a private capacity as the individual who abused you. We would like you to know that there was no specific decision made to protect his identity from readers. The lack of identification reflects RNABC's current practice of naming no persons other than the nurse herself. The practice was established for a variety of reasons, but primarily because so many of the references to other persons would involve patients.

Ms. Barr, RNABC will be issuing a public apology to you in the next issue of Nursing BC. The same issue will carry a notice of the Board's decision on your appeal. This notice will state that the Board reversed the decision of the Professional Conduct Committee and found that the committee erred when it concluded that you were under an obligation in the circumstances in question to report that patients might be at risk. It will state also that your registration was restored in good standing immediately.

In addition, the Board would like you to know that we are taking steps to revise our rules and policies so as to avoid incidents of a similar nature occurring in the future. This includes, in particular, further limitations on the nature and extent of information that ought to be published about any disciplinary decision prior to appeal or expiry of the appeal period. If publication is to be made prior to any appeal, it will be noted that an appeal is or may be pending.

Again, we regret the publication of the information about you in August and want you to know that we are indeed very sorry that this occurred.

— Pat Cusshall
Executive Director
on behalf of the RNABC Board of Directors
should not be allowed to practice in the profession of nursing. But to expect a little compassion from our regulatory body is surely not a lot to ask.

Any prospective employer of nurses in B.C. need only contact RNABC to ascertain whether or not nurses who present themselves for employment are in good standing.

While you continue this abhorrent practice of publishing names of offenders, Nursing BC is not welcome in my home.

Katie Di Iorio, RN Sardis, B.C.

We are writing to express our continuing dismay with the printing of reports of the results of disciplinary actions against nurses in Nursing BC. In particular, we are offended by such reports when the process is not yet exhausted and when the nurse subjected to discipline is more victimized than victim.

These reports of late have been of a character more suited to the tabloid press than to a professional journal. They have quoted events in a nurse’s life that are not the business of anyone but the nurse, and in such a way as to appear very one-sided. They seem to justify the need for discipline without allowing for any mitigating circumstances. In addition, some reports have cited events that have nothing to do with the nurse’s professional practice.

We believe that all that is necessary to meet the mandate of RNABC to protect the public would be to publish the nurse’s registration number along with the final result of the disciplinary process. Names can easily be changed, but the registration number is the only information pertinent to whether or not a nurse is currently registered. The public should be educated to check the registration of any nurse of whose services they may wish to avail themselves. They should also be made aware that they should not hire anyone who is not registered or licensed to practice nursing in B.C.

We would urge the delegates to the RNABC annual meeting to veto in favor of any resolution directed towards revision of the discipline process that protects the privacy and reputation of the nurse at the same time as the safety of the public. In addition, we request a moratorium on the printing of any further disciplinary action results until the discipline process has been revised.

A. Ellen Phillips, RN Westbank, B.C.
(and 38 other names)

Empathy, a word that was heard frequently to describe nurses during training. Empathetic was a word used to tell how a nurse should feel toward her patients.

I’ve seen examples of nurses being empathetic toward injured drunk drivers and their families on our workplace bulletin board.

Yet, nurse to nurse, there is little empathy shown. An excellent example of this was written in the August-September issue of Nursing BC.

I ask you, if empathy cannot be shown to your members, how can you expect your nurses to show empathy to their patients?

Myrna Allison, RN Okanagan Falls, B.C.
(and 17 other names)
Reading nursing journals and talking to management about issues affecting nursing are the two methods most popular with nurses in maintaining their competence to practice. Conversely, these activities are seen to be the least effective in helping nurses maintain their competence. These are two findings of a recent survey of a cross-section of RNABC members.

A total of 80% of the nurses surveyed said they read nursing journals at least one to three times a month. Almost half (48.5%) reported that they discuss nursing organizational issues with management monthly or more often. Activities with the lowest involvement included participating in nursing research and taking a health or nursing related course offered by a post-secondary education institution.

In-service nursing education programs, attending health or nursing related education events outside of their workplace, and courses on health or nursing offered by post-secondary institutions were rated as “effective” or “very effective” by at least half of all respondents.

Overall, respondents were positive about the extent that employers enabled them to participate in programs that help them maintain their competence. For example, more than half reported that their employers did “a lot” or “everything” to make it possible for them to attend in-service nursing education programs and discuss nursing care organizational issues with management.

Some other findings of the survey:
- Most respondents have experienced organizational changes in their workplace during the past five years, mainly in program management and patient-focussed care. The majority thought these changes had a negative (42.1%) rather than a positive effect (23.4%) on the quality of patient care.
- Approximately one third (37%) of the respondents said they had participated in the development of a formal clinical protocol to guide nursing practice. Overall, respondents believed that a combination of research, expert opinion and anecdotal evidence was the basis for this protocol development.
- Six out of 10 respondents said that while their employers had a computerized health information system, almost half of those surveyed were not using it and 51.1% said they were not at all knowledgeable of the system.
- Over half of the respondents believed that the scope of nursing should be expanded to include practices presently reserved for other health care professionals, while only 40.6% thought that some practices traditionally reserved for nursing should be delegated to others.
- Nurses continue to strongly support the government’s New Directions initiatives with the number thinking that reforms are moving too fast (28%), about the same as those who thought they are going too slowly (29%). Compared with a similar survey done last year, the percentage of those who had a negative view of the health care reforms nearly doubled from 13% in 1994 to 25% in 1995.
- Slightly more respondents (38.2%) said they were familiar with the Standards for Nursing Practice in B.C. than those who reported being unfamiliar with them (34.6%). Although not all respondents were familiar with the stan
standards, almost six in 10 said they did not have any difficulty applying them. Too few staff or too little time were the main problems cited, similar to what was reported in previous surveys.

- The survey indicated that employers were active in promoting the use of the standards. Over half of the respondents reported that employers had incorporated standards into mission statements, nursing job descriptions, continuous quality improvement programs, and performance appraisals.
- While more than half of the respondents (57.8%) said they were at least somewhat aware of the fact that RNABC had to give priority to the public interest over the professional interests of nurses, sizeable numbers also believed that the Association should help nurses achieve good working conditions (67.2%) and fair payment for their services (50.3%) — activities which are not part of RNABC’s mandate.
- Respondents gave high ratings to the appropriateness of three of the Association’s key mandated roles: ensuring that nurses entering the profession are qualified to practice (96.2%); setting and promoting standards for nursing practice (94.2%); and assisting nurses to find answers to professional practice problems (90.3%).
- Although 80.7% of the respondents believed it was appropriate for RNABC to influence health policies, many were uncertain about the Association’s effectiveness. A total of 48.2% said RNABC was neither effective nor ineffective in this role.

The telephone survey was conducted in late June and early July by Market Reach Research Inc. A total of 507 nurses participated. They were randomly selected to represent the population of practicing RNABC members. Results have a margin of error of +/- 4.5% at a confidence level of 95%. While member surveys were also conducted in 1993 and 1994, changes in methodology made it impossible to compare responses with most questions in the 1995 survey.

The survey is being used to evaluate and plan the Association’s programs.

Copies are available for loan from the RNABC Helen Randal Library.
We have all heard the frightening statistics — a woman in Canada has a lifetime chance of one in nine of developing breast cancer. By the time she presents herself at a cancer treatment facility, she will have likely undergone a mammogram, a biopsy, surgery and many other tests in order to stage or determine the extent of the cancer.

From the moment the patient hears the word “cancer” through to surgery, treatment, supportive care and follow-up, nurses can be partners and advocates for women with breast cancer. For a woman diagnosed with breast cancer, obtaining care, seeking advice and dealing with treatment can be like running a marathon — often down what feels like a dark and treacherous road. A nurse can run along beside the patient, offering a light to shine in the dark and a caring hand when footsteps falter.

Nurses provide support, teaching and treatment from a variety of work settings, such as a community wellness project teaching breast self-examination (BSE), a surgical in- or out-patient unit, a chemotherapy and radiotherapy clinic, or a palliative care unit.

Nurses at the Fraser Valley Cancer Centre in Surrey see women who come for consultation as new patients, and then who may go on to receive radiotherapy, chemotherapy and follow-up care. As nurses, and as women, we need to educate ourselves, our families and the community to approach breast cancer in a positive and proactive way.

Let’s follow a patient we will call Mary through a “typical” course of treatment at our centre. Although many young women diagnosed with breast cancer will identify with Mary’s story, we must always remember that each “real” patient will respond in a unique way.

Mary was diagnosed at the age of 39 with infiltrating ductal carcinoma, the most common type of breast cancer. It is an invasive cancer, meaning that the cancer cells have grown beyond the walls of the milk ducts into the fatty tissue of the breast. Mary’s cancer was described as medium in size (between 2 and 5 cm).

The primary treatment for Mary’s breast cancer was a partial mastectomy or lumpectomy. This removes the cancerous lump and some normal breast tissue around it to ensure that any microscopic cancer cells that have grown away from the outer edge of the tumor are removed.

An axillary node dissection was also carried out and 10 axillary lymph nodes were examined by a pathologist to determine the spread of the cancer. With seven of Mary’s lymph nodes positive and tumor size of over 2 cm, Mary was considered to be in a high risk category for the recurrence of her cancer.

After Mary recovered from her surgery, she attended a new patient visit at the Fraser Valley Cancer Centre. Because this is a time of great anxiety for patients, they are encouraged to bring a family member or close friend. Having another person hear the “news” is often very helpful.

A primary nurse met Mary and her husband and was able to offer support in a number of ways. Mary was assessed by her primary nurse using a nursing assessment based on Virginia Henderson’s 14 functional categories. She was given appropriate educational handouts on lymphedema and post-
surgical exercises. At the new patient clinic, Mary met with a medical oncologist to discuss treatment options. Like many women with breast cancer, Mary was given choices about the nature of the treatment she would receive. The nurse in a teaching role makes sure patients have enough information to make decisions and know where to access further resources such as the Canadian Cancer Society, the British Columbia Cancer Agency library and community support groups.

The treatment option Mary and her oncologist chose involved about 12 weeks of chemotherapy followed by five weeks of radiotherapy. Adjuvant chemotherapy, which involves drugs given orally or intravenously, prevents systematic spread of disease while adjuvant radiotherapy prevents recurrence of the breast cancer in the same breast. This “adjuvant” or preventive treatment is called “combined modality treatment” because both chemotherapy and radiotherapy are given to prevent recurrence.

The primary nurse was able to clarify information about the responses to treatment program and answer Mary’s “pressing” questions, such as “Will I be sick?” or “Will I lose my hair?” Mary called her primary nurse a number of times before coming for her first chemotherapy treatment, as many questions surfaced after she went home from the centre.

Since all of Mary’s treatment was to be given as an outpatient, Mary returned to the centre to meet with her primary nurse for a formal teaching session about the side-effects of chemotherapy and how to manage these at home. Mary expressed many concerns during that session (most patients have heard horror stories about the effects of chemotherapy) which her nurse was able to address to help allay feelings of anxiety and fear. The nurse also referred Mary to the Patient and Family Counselling Department for relaxation classes and assistance in dealing with the questions and worries of her teenage children.

During ongoing visits, Mary continued to be assessed by the nurse. Did her antiemetic regimen need adjusting? How was she managing at home? How was she dealing with the loss of her hair — a very visible and outward sign of being a cancer patient.

At this midpoint in our treatment marathon, patients have usually made the adjustment to treatment. They begin to exhibit a level of trust in the nurse who they are encouraged to call between treatments if they have any concerns.

As her chemotherapy treatments ended, Mary began to ask questions about radiotherapy treatments. We tried to prepare Mary for the preparation time that would be needed by the radiation therapy department to plan her treatment, which is based on her individual body size and shape as well as location and extent of the tumor. Radiation treatments, in the curative or adjuvant setting, are given over a period of 4-6 weeks. Mary’s skin was marked with a permanent “tattoo” so that we can assure that she is in the exact same position for each treatment.

Mary finished her radiotherapy treatment and returned to a follow-up clinic six weeks later. Now she had to learn to live for the “rest of her life.” The marathon of diagnosis and treatment was over, but since we have no absolute way of measuring the absence of disease, patients like Mary are encouraged to approach the future in a positive way. Maintaining hope, however, the patient and their family define it, will assist the patient to adjust to what will always seem like an uncertain future. Mary’s nurse helped her to normalize the feelings that are often associated with a breast cancer diagnosis before and after treatment.

As nurses, when we now see Mary returning for her follow-up clinic visit, feeling well and returning to her work and community activities, we feel a real sense of partnership and achievement in being part of her life and supporting her to “go the distance” against breast cancer.

(Carolyn Tayler is the president of the RNABC Nurses in Oncology Professional Practice Group and manager, ambulatory clinics for Fraser Valley Cancer Centre. Chris Emery is a staff nurse in the ambulatory clinic of the Fraser Valley Cancer Centre.)
Nurses as Partners in Care

Teaching women self-defence

By Allison Palmer, RN

When we reflect on our careers as health care professionals, we can always remember a patient who influenced our lives, both personally and professionally. One patient I will never forget, I first met at the British Columbia Cancer Agency. She came, accompanied by her husband, to her first appointment in the ambulatory care clinic.

Her name was Brenda. She was a vivacious 39-year-old woman who was in the prime of her life. She was a mother of two boys and married to a very loving man. She sat numb in the waiting room, holding her husband's hands. Both she and her husband looked bewildered. Before taking the couple into the examining room, I briefly read over her medical history. I realized that their lives had literally changed overnight.

Brenda had been in seemingly excellent health. Her lifestyle reflected nothing short of "pure" — a lifestyle that included organically grown foods, natural herbal remedies and antioxidants. She had breastfed both her sons past the ages of one year, and there was no indication of cancer on either side of her family. Brenda was a woman you would least expect to develop any health problems.

As I took Brenda and her husband into the examining room I could feel their anxiety and apprehension. Being a young, health conscious mother, I found myself connecting with them immediately. Through a tearful and

Brenda did not believe she was at risk of developing breast cancer and therefore did not question the implications of her symptoms.

Allison Palmer, RN — Because some breast tumors have the potential to double in size within several months, it is imperative to do monthly BSEs to detect changes as early as possible.
emotionally exhausting 30-minute interview, they revealed their nightmare story to me.

During the months that Brenda breastfed, she noticed that her left breast was larger and firmer than her right. This continued even long after she finished breastfeeding. Then she had 18 months of clear discharge that drained from the left nipple, which was not investigated further by Brenda’s family physician.

Brenda did not believe she was at risk of developing breast cancer and therefore did not question the implications of her symptoms. Finally, the concrete evidence appeared. Brenda “accidentally” felt a lump in her left breast while she was reading a book. This was to be the beginning of several tormenting months filled with tests, biopsies and examinations, only to be followed by a visit to the cancer clinic.

The oncologist concluded that Brenda had inflammatory carcinoma of the breast — a cancer that was particularly aggressive and rapidly spreading in nature. Brenda was given two options for treatment — a standard chemotherapy and radiation treatment protocol, or an investigational treatment protocol that could give her more hope for cure. Being a young mother, Brenda felt she had no choice but to accept the very aggressive investigational protocol. The regime includes mastectomy, axillary lymph node removal, chemotherapy and radiation, which has the potential for serious, even life-threatening side effects such as neutropenia, systemic infection and kidney failure.

Brenda proceeded with the treatment, but unfortunately she was physically and mentally unable to tolerate the full 21 weeks of grueling therapy. Because she had very advanced cancer at the time of diagnosis, and did not complete the course of treatments, her prognosis was guarded.

As I analyzed Brenda’s tragic situation, it became clear to me that no single woman is immune to this dreaded disease. Suddenly, I felt vulnerable as I realized that I had been neglecting my own health. I could not recall the last time that I had performed breast self-examination. Subsequently, my worrisome suspicions were confirmed when I discovered that the women in my immediate community were not doing regular BSEs either. In fact, the majority of them were relying on their family physician to examine their breasts during their annual physical. Because some breast tumors have the potential to double in size within several months, it is imperative to do monthly BSEs to detect changes as early as possible.

Because of my professional association with Brenda, and the fact that I am a woman, I felt compelled to get involved in a research study through the B.C. Cancer Agency. The division of epidemiology at the Vancouver Cancer Centre was looking for a nurse examiner. The job description included performing breast examination and doing a thorough history on a group of women selected from the breast screening clinics. I accepted the position with great enthusiasm because it would give me the opportunity to educate women about signs and symptoms of breast cancer and show them how to do proper BSE.

As a health professional, I firmly believe that women should become more accountable for their own health and wellbeing. Although the use of mammography is 80% accurate in diagnosing breast cancer in its early stages, it should not be considered an insurance policy (there continues to be controversy around mammography screening).

Routine mammograms, combined with monthly BSE are the most effective screening techniques to date for women over 40 years of age. However, for premenopausal women, monthly BSE plays a very important role in early detection. For Brenda, prognosis would likely have been better with earlier detection and treatment.

As nurse practitioners, how many of us would be able to do a complete breast examination and recognize the signs and symptoms of breast cancer? With education and the correct use of BSE, women, young and old, can arm themselves with the artillery to fight the battle against breast cancer.

(Allison Palmer is a staff nurse at both the Vancouver and Fraser Valley Cancer Centres.)

**BREAST CANCER FACTS**

- Breast cancer is the most common type of cancer among Canadian women. An estimated 17,700 Canadian women will be diagnosed with breast cancer in 1995.
- One woman in nine will get breast cancer — but only if she lives to be 90. A woman has a risk of 1 in 1,000 by age 25; 1 in 63 by age 50; and 1 in 15 by age 75.
- The major known risks of breast cancer are: female sex, advancing age, and family or previous personal history of breast cancer.
- There is no single factor that causes breast cancer, but rather a combination of things. Some more important than others.
- Effective early detection includes a three-pronged approach. A woman must take responsibility, for learning and performing regular breast self-examination, for having an annual physical examination by a trained health professional, and for having mammography done annually if she is in the appropriate age category. No single approach can detect all cancers, and each assesses the breast in a different way.
- Male breast cancer makes up approximately 1% of all breast cancers.

(Source: Breast Cancer: All You Need to Know to Take on Active Part in Your Treatment, by Dr. T. O’Lovett, Dr. U. K. Rass, and Dr. Karen Gelmon.)

**BREAST CANCER INFORMATION PROJECT**

The B.C. and Yukon Breast Cancer Information Project (BCIP) was initiated by the B.C. Cancer Agency and the B.C. and Yukon Division of the Canadian Cancer Society. It is one of five such projects across Canada, all funded by Health Canada.

Its purpose is to provide personalized, timely and accurate breast cancer information to people in B.C. and the Yukon. It also publishes a quarterly newsletter, Breast in the Nineties, with current information on breast cancer, research and support groups.

If you have any questions about breast cancer, call the BCIP cancer information line (604) 873-2323 or 1-800-663-4242.

NURSING BC NOVEMBER/DECEMBER 1995 13
Throughout the life of the Comox Valley Nursing Centre Demonstration Project, the most frequently asked questions from other nurses have been: What nursing work do you do at the Centre? Is it different from what other nurses do? If so, how is it different?

Staff at the nursing centre and other nurses who have been involved with the project through the Comox Valley Nursing Practice Council or other volunteer roles have had many interesting discussions about what we are, or should be, doing. Through these explorations, we have become increasingly aware of the complexities of nursing work and the challenges encountered when we try to articulate nursing’s unique role. These discussions have, in turn, reflected on the work we are doing.

Many themes related to the provision of care have emerged over the life of the project. Some of these themes are common threads in all nursing practice, although they may have achieved greater prominence in our work. Examples of these common themes are the importance of flexibility, client centeredness, advocacy and clear communication.

The prominence that these themes has gained in our practice may be the result of our relatively unstructured work environment, which offers us the freedom to evolve a practice model from “scratch” in collaboration with the community and the clients we serve. It may also be because we work in many different capacities with individuals, groups and the community.

Empowering Strategies

There are, however, two key themes found in our practice at the nursing centre. The first is empowerment, the foundation of our work. The following quote from the RNABC document, Determinants of Health: Empowering Strategies for Nursing Practice (1992), describes how we understand this concept:

“Empowerment is neither something that occurs purely from within (‘only I can empower myself’); nor is it something that can be done for others (‘we need to empower this or that group to be healthier’). Rather, empowerment describes our intentional efforts to create more equitable (fair) relationships with one another, relationships in which there is greater equality in resources, status and authority. This requires those with more resources, status and authority to ‘give up’ some of their power, so that others might ‘take’ it.”

The set of empowering strategies, described in the document — personal empowerment, small group development, community organization, coalition advocacy and political action — is the framework on which we base our work at the centre.

Human Relationships

The second key theme is relationship building. Human-to-human relationships enable us to break down the barriers inherent in the traditional client/health professional relationship. For many of us, this concept may seem to be in complete opposition to the traditional warning to “not get involved with our patients.” Through our experiences at the nursing centre, we have come to realize that nurses’ understanding of what a therapeutic relationship is and how it is developed needs to be rethought.
All nurses are aware that respect for the individuality, autonomy, values and beliefs of the person are the basis of every relationship. Nurses working at the nursing centre are beginning to understand that relationships also depend on how we relate on a human-to-human level, and that this type of interaction does not lead to unprofessional relationships. By altering our practice to bring more of ourselves to the relationship, while at the same time keeping the focus of our interactions on the client's concerns, we have found that an atmosphere of genuineness, warmth and trust is created.

We strongly believe that the creation of such a positive atmosphere allows clients to enter into a supportive therapeutic relationship with us. Once this occurs, clients are more able to focus their energies on constructively addressing their health concerns.

Anyone of any age and with any health concern is welcome to drop in to the centre see a nurse. There are neither “criteria” for admission, nor a requirement that clients make an appointment to come to the centre. Clients coming to the nursing centre for the first time will often declare “I don’t know why I came here, but I think I have some problems.”

This statement is the beginning of a partnership in exploration. Using a health promotion perspective as a framework, clients are invited to tell their stories, and in so doing lead the process. Nurses use their knowledge and skills to guide the process to facilitate an understanding of the issues by both parties. Clients become more aware of the dimensions of their concerns, and of how these concerns fit within their whole life experience. As these concerns are discussed with them, clients also become more aware of their wholeness and of their potential to address their own concerns. The following simulated scenario exemplifies a typical case situation.

**One Person's Story**

An elderly man visited the centre. He was in apparent emotional distress as a result of the impact of a variety of long-term, unresolved physical complaints. After he had told his story, and he and the nurse had explored his various concerns, several issues were identified: his feeling that a variety of his physical complaints resulted from the many medications he was taking; his feeling of "not being heard" when discussing the issues with his physician; and his concerns about being perceived as a whiner or hypochondriac by others.

Working with the nurse, the client put his concerns in priority and identified that his most pressing need was to alleviate his physical complaints. Several strategies to address this issue were considered, beginning with a discussion regarding the types of medications he was taking, their purpose, side-effects, and relation to his complaints. Ways to ask his physician questions about his medications and to assist his concerns about his symptoms were explored.

The complexity of the situation, and the long history of multiple physical complaints, prompted the client and nurse to conclude that resolution of the most pressing concerns would likely be most readily accomplished through a joint discussion involving the client, nurse and physician. Prior to the joint consultation with the physician, the client's role in leading the process and the nurse's role in supporting the client and bringing another perspective to the situation were clarified. This process reflects an intentional effort of the nurse to create an equitable relationship and empower the client so he may address his own concerns.

The joint visit resulted in an appreciable decrease in the medications prescribed for the client and the client's increased confidence in the strengths that he brings to the relationship with his physician. Further medical investigations aimed at assessing his physical complaints were planned once the influence of the readjustment of his medical regime was evaluated. The client feels hopeful that his health problems will be resolved and he no longer feels that he is "whining" when he discusses his health concerns with health care providers.

**The Holistic Perspective**

As this story illustrates, a crucial element to successful outcomes in our relationships with clients is allowing the time to develop the relationship and explore the multiple aspects of each situation from a holistic perspective. Clients have reinforced our belief in the importance of taking the time to work with them to understand all the issues. Many have stated that they have, often for the first time, felt listened to and been given the opportunity to discuss all their issues and ask questions (enhancing their understanding of their situation). As a result of their increased understanding of their problems and the relationships between their health concerns and other aspects of their lives, they feel more in control of their health.

Our work with groups at the centre is almost always initiated by our recognition of an unmet need, as evidenced by several individual clients coming to the centre with a similar health concern or unmet care need. For example, during our first week of operation, an individual with chronic pain came to the centre. This prompted an exploration by the nurse and client of some of the issues confronting people with chronic pain.

Over the next few weeks, several more clients with chronic pain issues began coming to the centre for support, discussions regarding coping strategies and information. Recognizing that people with chronic pain have many similar needs, nursing centre staff acted as facilitators to bring these individuals together to share their feelings and experiences and address their common concerns. Using self-help and mutual aid strategies, these people intentionally worked to create relationships to empower all members to take greater control over their own health concerns.

As the group evolved, another focus was identified and a sub-group calling themselves the Chronic Pain Action Group emerged. The focus of this subgroup was to promote awareness of the issues encountered by individuals with chronic pain. Empowered members recognized the need to educate others, including health care professionals, about chronic pain. The group also realized that there was a real need to explore the gaps in services and to work toward developing resources to meet their needs. Such activities indi-
cated the group's movement towards empowerment through community organization.

The group, with assistance from the nursing centre staff, spearheaded an education session to help the community to understand issues associated with chronic pain. A specialist in the field of chronic pain was brought in and 150 people attended. Thirty-five health care professionals attended a seminar given by the same specialist in the morning at hospital rounds.

Other issues, such as the impact of chronic pain on individuals' and families' economic situation and quality of life, are now beginning to emerge as concerns within the group, indicating a further movement toward the coalition advocacy and political action end of the empowering strategies continuum.

Other groups such as the Anorexia and Bulimia Recoverer Groups, Sandwich Generation Group and a project involving a lower income housing development are emanating from the centre. They too have had their beginnings with individuals coming to the centre and are now functioning at various points along the empowerment continuum. The role of the nurses in the centre has been to facilitate the development and movement of these groups, withdrawing or enhancing their support as directed by each group's vision.

An extremely important component in the development of the approach used by the nursing centre has been the partnership between the Community Advisory Committee, the Nursing Practice Council and the staff. These groups have been instrumental in the evolution of the centre. For example, the very existence of an advisory committee made up of "ordinary" people has provided a unique opportunity for the staff at the centre to develop a partnership with community members. From its inception, the centre has turned to the community for advice and direction. The result has been the development of a viable and valued service.

Continued collaboration with this group has been essential to the continued development of services that meet the community's needs and truly reflect the values, beliefs and vision people expect in a community based service. Together, we have learned a great deal about the true meaning of empowerment and the importance of equitable relationships between health providers and community members.

Efforts to describe our work at the nursing centre are in their infancy. Nevertheless, preliminary evaluations seem to indicate that when nurses are empowered to work as independent and valued professionals, and when they are allowed the time to enter into equitable and meaningful relationships with people, the outcomes for clients are positive.

Nursing care is a key component of the health care system. This project has presented an opportunity to highlight the strengths and uniqueness of nurses' work and the important role nurses can play.

(Yinda Ritchie is coordinator of the Comox Valley Nursing Centre. Brenda Bouell, Cathy Buchanan, Pat Foster and Maggie St. Aubrey are nurses at the nursing centre.)
A mazed and elated. That's how Sylvia MacKay remembers feeling when she and her coworkers got the word, "We couldn't believe it," she exclaimed. The note in her hand was clear: "The hospital board has unanimously voted to provide funds for you to attend the Operating Room Nurses' Association of Canada (ORNAC) Conference in Vancouver."

It was a well deserved break for the four nurses reading the note. They had all been at Kitimat General Hospital for more than 15 years. For two of them, it had been that long since they had been out of town for professional development. The other two had never had the opportunity.

In the past, the nurses kept up-to-date mainly by taking correspondence courses, reading their journals and attending hospital inservice programs. Learning about new equipment usually meant taking home a video. A couple of nurses had been to workshops in Terrace or Prince Rupert over the years, but sometimes even getting to a noon hour presentation in the hospital was difficult enough with the heavy O.R. schedule.

"We see 130 cases a month," MacKay explained. "The four of us work full-time, and on top of that we're on-call 17 days a month. There's a lot of overtime involved."

In fact, overtime had become an issue for the hospital. For several years, staff had been hearing that there was too much of it. With an orthopedic surgeon, a general surgeon, visiting specialists and staff doctors all competing for time in the O.R., costs were spiralling out of control.

Last December, the hospital hired Anne Ardiel as director of patient services. With her background in surgical nursing, it was hoped Ardiel would be able to make the operating room more efficient.

Although the O.R. was closed over the Christmas period, there was still a cost overrun. It seemed costs had stayed up because surgery was still being done and nurses were being called in at expensive times. There was talk of a similar shutdown over spring break, but Ardiel questioned whether it would make a difference.

When a brochure arrived announcing the ORNAC convention in May, it gave her an idea. She thought, "If the nurses were out of town, that would guarantee an O.R. closure. And what a great learning opportunity at the same time."

Ardiel knew it was tough for the nurses to get away while the operating room was open. She was also concerned that they had little chance for updating their skills. The Standards for Nursing Practice in B.C. underline the importance of this kind of professional growth. Standard 5: Self-Regulation states that every nurse "assumes primary responsibility for maintaining competence, fitness to practice, and acquiring new knowledge and skills." Granted, the nurses had been making an effort to learn with what was available, but a national conference is another level of opportunity entirely.

The nurses were thrilled with the idea and immediately started brainstorming about fundraising.

Ardiel approached the surgeons. They were quick to offer support. One of them even endorsed the proposal with an unsolicited letter.

A discussion with medical staff about the extent of the closure concluded with a decision to do only emergency C-sections for the week. All other surgery would go to Terrace or Vancouver. With the O.R. nurses out of town, new staff would have to be orientated to cover any C-sections. The unit manager would arrange for training of casual staff...
should they be needed.

Meanwhile, Ardiel was also meeting with hospital administration. With that approval and endorsement for the closure, the board was approached for approval and support. She advised them that the service to the community would be temporarily discontinued. Board members were comfortable with the closure because it was only to be for one week.

By this time, MacKay and three other nurses, Mary Ellen Byrne, Virginia Chapdelaine and unit manager Pat Reilly had a couple of fundraising ideas in the works. They had received permission to turn their second annual "Cafe O.R." into a fundraising luncheon. With help from a retired colleague, a housekeeping staff member, and the wife of their anesthetist, one of the operating rooms and a recovery room became the setting for an elaborate buffet, complete with delectable desserts. Despite emergency surgery that morning that lasted until 0400 (some staff never made it to bed), the event was carried out in grand style serving 60 people and raising $560 for the conference fund.

A Superbowl football pool added over $100 more, but it was becoming clear that fundraising alone wouldn't get the nurses to the conference in Vancouver. Not that it would have stopped them. They were already deciding which sessions they would attend. Trauma in rural hospitals? Spinal cord injury? Open heart surgery? For opportunities like this, they were prepared to pay their own way.

Ardiel saw it a little differently. She went back to the board to talk about funding. She explained that the nurses had been working very hard under a great deal of pressure for a number of years. During that time, there had been almost no funding for educational purposes. This would have a positive impact on their operating room and be a great way for the facility to officially recognize the nurses and their service. The board agreed. Funding would be provided for airfare, accommodation and registration.

"Although we were very keen to attend the conference, the transportation costs alone would have been a major obstacle," said MacKay, "but it meant a lot to us to know we had such support from Anne, the physicians, the administration and the board. It was a great feeling to have as we left for Vancouver."

The conference itself was more than they could have hoped for. It was described as "uplifting, reinforcing, confirming, enlightening and motivational." Their days were full and their feet were tired - quite an admission for O.R. nurses - but they were determined to take full advantage of every moment. Lectures were split between the four of them and notes were exchanged in the evenings on everything from general anesthesia to transplantation.

"Awesome" was the word used to describe the opportunity to meet other O.R. nurses from across the country. Often, new and useful information was gathered through informal conversation and breaks. From one group they learned a better way of using their new steam sterilizer.

Another highlight was the exhibit fair; finally an opportunity to talk directly with sales reps about the equipment nurses use. One such discussion became a trouble shooting session for their gastroscope. The fair also provided a chance to learn about new equipment.

Enlightened in spirit, but weighted down with handouts, souvenirs and free samples, the nurses boarded the plane for Kitimat noting the week had been "harder than O.R. work, but more fun."

They were waiting for Ardiel the next morning at 0730 with MacKay modeling an ORNAC t-shirt and all of them bubbling over with enthusiasm. For the four nurses, the week had been an obvious success.

Things had gone well for the hospital too. The O.R. managed to stay closed with one exception - the C-section delivery of a healthy 12 lb. 14 oz. baby. With the physicians away because of the O.R. closure, there had been no temptation to book surgery. That meant significant savings.

More than a month after the conference, MacKay is still charged up. She says all nurses should make the effort at some point in their career to get to a national conference. "Don't let a budget squeeze discourage you," she advises. "We met nurses from a large hospital in Montreal who raised $5,000 over a year just by keeping a full coffee pot outside the O.R."

But that kind of fundraising is more difficult in a smaller hospital. And Ardiel points out that it's rare to have the opportunity to attend a conference of such magnitude so close to home.

To be fit for practice, nurses have to stay current. It's in the standards for nursing. But, Ardiel says, "we must look to the wealth of expertise we have in our own facilities and regions for this." Currently she is looking at ways to strengthen ties within her region to facilitate this kind of exchange.

In the meantime, the O.R. nurses are putting a presentation together to share their new knowledge with their colleagues. They want to show their appreciation to Ardiel, the board, the administration, and the physicians at Kitimat General Hospital for helping them get to the conference and meet their needs for new knowledge and skills.

(Patricia L. Howard is a registered nurse and freelance writer in Vancouver.)
Using Research TO IMPROVE THE QUALITY OF NURSING CARE

Nurses are using research to guide and develop their practice - improving both its quality and cost-effectiveness - and adding to their professional satisfaction.

By Heather F. Clarke, RN, PhD

More and more, nurses in all areas of practice see using research as an increasingly important strategy for promoting “best practice” and being accountable for outcomes of their practice.

Standard 1 for nursing practice in B.C. requires all nurses to base their practice on nursing science (knowledge of nursing derived from systematic observation, study and research) and on related content from other sciences and humanities. Using research findings throughout the nursing process supports Standard 2, which requires all nurses in all areas of practice to diagnose actual or potential problems and strengths, plan and perform interventions, and evaluate outcomes.

The primary goal of using research in nursing is to improve the quality of nursing care and health outcomes. Through research utilization, nurses can:

- Create relevant and innovative interventions.
- Improve the effectiveness and efficiency of their practice.
- Use health care resources more efficiently.
- Validate their decisions.
- Influence the development of policy.
- Develop supportive work environments.

PRINCIPLES OF RESEARCH UTILIZATION

Using research to guide practice doesn't just happen. Successful research utilization requires planning, using such guiding principles as:

1. Have a nursing and/or corporate philosophy that emphasizes evidence-based nursing as “best practice”.

2. Use a research utilization framework to assist nurses to move through the process in a systematic and satisfying way.

3. Develop agency supports, such as a committee or group, library and research resources, and paid time for project work.

4. Plan for change and allow time for all those affected to adopt the new or modified innovation.

5. Identify individual, group and agency responsibilities, and resources required for each phase of the research utilization process.

RNABC RESEARCH UTILIZATION FRAMEWORK

Using research in practice involves four interacting phases:

1. Defining the problem identified in practice.

2. Critically reviewing the literature.

3. Comparing research findings to the current practice and setting.

4. Applying relevant findings to practice, followed by evaluation or monitoring.

The phases are not always sequential. You may go back and forth between and among them to: clarify the question or issue as more knowledge is uncovered; search for more literature or experiences as more is learned about the problem; and understand different aspects of your practice and setting.

It is also possible that you will not have the same people involved in all phases. Different competencies are required in each phase. For example, it is most important that those closest to the issue are involved in Phases 1 and 3, but perhaps other expertise is required in Phases 2 and 4. The framework illustrated on the next pages can be used as a basis for reaching evidence-based “best” nursing practice. Keep it handy and feel free to modify the RNABC research utilization framework as required to fit your practice setting.
Phase 1

PROBLEM DEFINITION

A. Define the Issue
State your issue or problem as questions. This helps to clearly define the problem and identify important gaps in your knowledge. Consult with others who are closest to the problem and most affected by it.

B. Locate Literature
Find literature related to your problem. Reviewing this literature helps to identify various factors associated with the issue. Then you can be more precise about your questions. Although anecdotal, theoretical or opinion articles may be useful, it is important to focus your search on research articles. RNABC's Helen Randal Library is a good place to start your search. Use the Cumulative Index of Nursing and Allied Health Literature (CINAHL), or the computerized database of the library's book and file holdings, or have a librarian do a broader search for a fee. Other resources included university, college and public libraries, the Ministry of Health Library in Victoria, and perhaps your agency library.

Phase 2

LITERATURE REVIEW

A. Scientific Merit

- Analyze the study to identify and understand component parts and procedures used by the researcher.
- Appraise the strengths and weaknesses of those areas identified in the analysis.
- Judge the merit or worth of the study.

Once you have completed these activities for one study, you will need to do the same with the other studies and compare results. Similar results lend strength to the findings. On the other hand, conflicting results may be difficult to interpret and not be ready to use in practice. To evaluate the overall impact of findings from multiple studies about a single issue, meta-analysis can be used to integrate the findings. An experienced nurse researcher or statistician can help with this.

B. Significance

- Statistical significance refers to whether the result(s) could have just happened by chance, or were due to the study.
- Clinical significance relates to the importance or potential importance of a finding when the "whole picture" is taken into account. It may be clinically important that an intervention caused some change towards normal, even though the small change was not statistically significant.

Phase 3

Comparisons

A. Feasibility
- What are the risks of changing or not changing from current practice?
- What are the costs and benefits of the change?

B. Fit of Setting
- How similar are characteristics of those studied to those of your setting?
- What are the differences or similarities of the research to your setting?
- Are the resources (human and material) you'll use similar to those of the research?

C. Current Practice
- How effective is your current practice?
- Is your nursing practice based on a nursing model or philosophy similar to that of the research, if there was one? How will this affect using the findings in your setting?
- How will differences affect application of findings?
- Is the type of organization or management of nursing practice critical to the implementation of the findings?

Phase 4

Application

A. Determine the contributions of the research findings to the nursing practice problem identified in Phase 1.

The decision about using the research findings may be to:
- Not use because of risks or costs involved or lack of consistent, strong findings.
- Consider for future use, but not now, because research findings and/or comparisons are tentative only.
- Use to inform colleagues that current practice is evidence-based.
- Use to plan for change or to provide new options in practice.

B. If the practice is to be changed, you may now have to involve others in the process such as senior management, a quality improvement program, and/or a research committee. You may wish to conduct a pilot project before bringing about an agency-wide change.

C. Applying research findings requires attention to three key processes:
- change and adopting innovations
- evaluation
- dissemination
Using research findings to change practice is like adopting an innovation - a new idea, way of behaving or thinking - and does not come about automatically. A number of factors need to be considered in planning for successful implementation.

Evaluating the changed nursing practice is essential in determining if you have indeed dealt successfully with the questions posed in Phase 1 and reached your goal of evidence-based practice. If you have been successful, and the practice is to continue, then monitoring the change will be the responsibility of the quality improvement program. If not successful, they you will want to revisit Phase 1.

Communicating your experiences and findings is essential if nursing is to expand and use its body of knowledge to effect the quality of care. Research utilization is an ongoing process - one that can be rewarding professionally and personally.

For more information, contact
Heather F. Clarke, RN, PhD
RNABC Nursing Research Consultant
(604) 736-7331 (local 318)
or 1-800-565-6505

B.C. Examples of Research Utilization

Clinicians
• Public health nurses at the Boundary Health Unit used research findings to develop a protocol for Neonatal Abstinence Syndrome care.
• In the Capital Regional District, Home Care Nurses used research findings for developing their guidelines on skin care.
• Nurses at B.C. Women’s Hospital introduced hydrotherapy in the labor and delivery unit after reviewing the literature on its safety for laboring women with and without ruptured membranes.

Policy Makers
• Thirteen hospital nurses from 11 agencies used the results from their research on Nurses’ Perceptions of Patient Controlled Analgesia (PCA) to change the policy in their agencies for introducing a PCA approach, implementing it, and educating others about the approach.

Administrators/Managers
• Palliative care managers used research results from a joint project of the Capital Regional District Home Nursing Care and the University of Victoria School of Nursing to improve use of human and material resources.

Educators
• Professors at the University of British Columbia School of Nursing are using survey results on Primary Health Care content in Canadian University Schools of Nursing curricula to guide UBC’s curriculum and program development.

Researchers
• In the Okanagan, a team of university college professors and community members is carrying out action research - a process that includes using their research to concurrently develop and evaluate an aboriginal community-directed prevention program on diabetes.

REFERENCES


8:30 - 9:00 Registration (participants receive extensive outline and current bibliography).

- **Aging Brain, Aging Mind:** physical changes, gila, and vascular system. Genetically programmed aging of the brain (e.g., Progerial/ental influences. Mental changes: the distinction between crystallized and fluid intelligence.

- **Stress-Related Aging of the Brain:** a new discipline chronic stress can endanger neurons, impair short-term memory, and accelerate aging. 

- **Alzheimer's Disease:** initial symptoms and co-diagnosis, which genes are responsible for the highest risk, and environmental factors (e.g., smoking, head injury, zinc, and aluminum); update on treatment: prevention/anti-inflammatory drugs and mortality.

- **Disease of Oxygen Radical Production:** how damages the brain; efficacy of antioxidants, Parkinson's disease; treatment with nerve growth transplants and a new understanding of the risk of depression and dementia.

11:30 - 12:00 (in your own).

- **Stroke:** clinical picture of vascular disease; infarct dementia; advances in prevention and treatment of stroke-related disorders.

- **Diseases of Frontal Cortical Damage and Prone Old Age:** frontal lobe syndromes and behavioral problems; special vulnerability of frontal cortex: advice for caregivers.

- **Sleep:** sleep-wake rhythms in aging: disordering and maintaining sleep, including sleep apnea: diagnosis and treatment via pharmacological therapies (e.g., melatonin).

- **Depression:** major and minor (dysthmic) vs. menopausal depression; mental changes in depression; antidepressants and non-drug therapies of sleep and appetite.

- **Hormones, Diet, and Brain:** how ERT affects you and risk of Alzheimer's disease; effectiveness of DHEA, growth hormone, and noradrenaline and other alternative therapies; efficacy of antioxidant nutrients; moderate caloric restriction utility.

- **Physical and Mental Stimulation:** how physical exercise in the brain that can enhance learning and memory; mental exercises improve word finding and memory for faces and places; how enriching experiences, e.g., stimulation, enhance the mind as we age: aging with creativity, compassion, and humor.

4:00 Adjournment (certificates of attendance are issued to participants who attend the entire program let a program evaluation form).

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Rates may vary due to exchange rate fluctuations.

To register by credit card on-line (24 hours): (800) 777-7768
or FAX registration form with information to: (415) 949-2818
The Aging of the Brain
The Aging of the Mind

A new 4-day seminar for health professionals

About the Instructor

Bruce Quinn, M.D., Ph.D., is an Assistant Professor, Division of Neuropathology at New York University and is affiliated with the Alzheimer Disease Center. Dr. Quinn is an expert in the study of degenerative disorders affecting the aging brain. His outstanding research has examined degenerative processes in Alzheimer's, Parkinson's and related disorders and novel approaches to treat these conditions. An articulate, enthusiastic, and interesting speaker, Dr. Quinn provides a wealth of fascinating case histories, clinical insights and practical information.

Learning Objectives

Participants completing this seminar should be able to:

1. List several factors that can accelerate aging of the brain.
2. Describe one or more advance in understanding or preventing Alzheimer's disease.
3. Describe pharmacologic advances in treating Parkinson's disease.
4. List one or more method of preventing stroke.
5. Name an effective pharmacologic or non-drug therapy for treating age-related disorders of sleep, memory, or mood.

Accreditation

This course has been approved for six hours of continuing education credit for:

NURSES: This six-hour seminar for Nurses is designed to meet the Standards for Nursing Practices in British Columbia for maintenance of professional knowledge and skills. This program is approved for Nurses licensed in the U.S. via cosponsorship with ICRED. ICRED is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation.

PSYCHOLOGISTS: This survey course provides 6 hours of credit. This program is cosponsored by CorText and Mind Matters Seminars. CorText is approved by the American Psychological Association to offer continuing education for Psychologists. CorText is responsible for this program.

Other professions: This course is designed to enhance the professional knowledge and skills of Social Workers, Marriage and Family Therapists, Occupational Therapists and allied health professionals.

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Register Early: Dr. Quinn is a wonderful speaker and it is anticipated that some courses will be sold out. Please register early for important seminars to ensure space.

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A Chapter with a View

By Jan Walker, RN

These are changing times. With respect to nurses, what they do is not changing — caring, teaching, supporting. But how they do their work is — using computers, closer to home strategies.

The same is true for activities of the professional association. The need for a full and active nursing voice is not changing. How that voice is effectively gathered and heard may be undergoing some significant pressures to change.

The experience of RNABC's North Shore Chapter suggests that members need new and different ways to dialogue with each other and with RNABC.

THE ISSUE

The North Shore Chapter — the sixth largest chapter in RNABC with more than 2,000 members — has had an active history. However, over the past number of years, member activity and attendance at chapter meetings have fallen such that the continuation of the chapter is in doubt.

As the executive for the chapter, we made some changes that were intended to increase attendance at chapter meetings. The result was a modest increase, but it was not enough to achieve what should be a vibrant and professionally active group of nurses.

So we asked our members for their thoughts. At a cost of more than $1,000, we mailed a survey to each of the 2,107 nurses who live within the boundaries of the North Shore Chapter. An accompanying letter explained the situation and set out the importance of the nursing voice, particularly during this time of health care change. The survey itself asked two questions:

- "Do you support the continuation of the chapter in some form?"
- "If yes, how will you become involved?"

Members were further encouraged to offer their comments, ideas and suggestions.

MEMBERS RESPOND

One hundred and twenty members or approximately 5% of the total membership of the North Shore Chapter responded. There was overwhelming support for the continuation of the chapter in some form. Of the 116 respondents, 64 indicated they would attend meetings and 12 indicated they would participate in some way in the various planning responsibilities.

A total of 26 comments were received. They indicated that members were too busy to attend meetings or that chapter meetings were not a high priority in their busy lives. Only one person made a suggestion and that was to have the meetings held during the noon hour. Some people requested an advance calendar of meetings.

Members wrote movingly about their busy lives. They told us of their challenges with immediate family and eldercare responsibilities. They described work environments in which nurse participation was becoming greater. Others shared their activities in professional practice groups or commitments in educational pursuits.

These results raised two issues for the executive of the chapter. One was the use of the chapter as a vehicle for nurses to connect and speak. Clearly, members supported the value of RNABC, but they found the chapter format either difficult or irrelevant in their pressured lives.

Thus, the question of change comes up. How do we change our process of communication and connection so that nurses can and will add their voices to others in the professional association?

The other issue related to the status of the chapter. Could the chapter remain active when the attendance was so low and we were unable to fill some executive positions? While support for continuation was generally present, the number of respondents who were willing to commit in a significant way was less than convincing.

The executive reported the results of the survey to members at the chapter's annual general meeting last June. A special meeting focusing on the fate of the chapter was publicized at that time. Unfortunately, the meeting saw only three new people attend. It was decided to request the RNABC Board of Directors to grant a change in chapter status from active to modified.

MODIFIED STATUS

One call to RNABC Member Development brought helpful and friendly guidance. Staff provided us with the chapter policies in which statuses are defined and explained. Briefly, there are two statuses — active and modified active. Active status is the normal chapter functioning as we know it. Modified active status carries with it certain procedures including:

- modified status must be requested and granted by the Board of Directors.
- The purpose of modified status is
to allow a period of creative problem solving.
- There is a one-year time limit unless further discussions take place with the Board.
- The outcome of modified status is either a return to active status or the dissolution of the chapter.

A written request for modified active status was made and in September, the Board of Directors granted modified status to the North Shore Chapter for one year.

NOW WHAT?
The clock has started ticking on our year of problem solving. The chapter executive understands that the fate of the chapter and the problem solving that it will take to preserve the collective voice of nurses living within the North Shore boundaries rests with every nurse, not just with the few volunteers who are willing to act as executive members. Thus, we have generated a calendar of North Shore chapter meetings for 1995-96 (printed elsewhere in this issue). The first meeting in November will focus on new ideas.

There are 35,000 members of RNABC. The professional knowledge and opinion of every nurse must be available and included if nurses are going to ensure the safety of patient care and the best of advice to government. Our chapter members told us that they value the purpose of chapters in gathering and carrying the voice of nurses. But the realities of today's life raise the challenge of finding newer and easier ways of speaking with each other and with the professional association.

WHAT IF?
- What if the RNABC was newly created and had no way of connecting its members or sharing member information and advice with others? What would be the meaningful and effective ways of doing this?
- What if every nursing workplace had a computer that provided a direct link to RNABC? Perhaps nurses could conveniently and effectively communicate with each other and RNABC via electronic mail. Meetings and discussions could take place in a fast and "real time" way.

What if the workplace representatives were the connecting points for all nurses? With computers at hand and a personal connection of a workplace rep, one could envision increased movement of information and more nurses who participate in RNABC activities and discussions without adding to the burden of busy lives.

What if only three meetings of RNABC members took place each year in different locations throughout the province instead of each chapter holding its own meetings? Rather than issuing chapter grant money, RNABC could fund these few mass meetings where all nurses could network and speak as one group. Anyone who has attended the RNABC annual meeting knows how exciting it is to be in one room with nurses from all over B.C.

What if nurses organized themselves according to the new health regions? Would the nurses of one region have more relevant things to say to each other and more relevant information to share with RNABC?

What if RNABC members applied the principles of evidenced-based practice to the operation of the association? The focus would be on demonstrable outcomes, keenly relevant to members. How would that affect communication, funding, decision-making and activities? These what if's are just ideas and require further exploration. But they illustrate that change is indeed happening and that we all need to be responsive in some way or another.

Constant change is challenging all of us to rethink the way we work and communicate in organizations. Working and communicating within our professional organization is no exception. The experience of the North Shore chapter may be unique, but it can help to raise the issues of how nurses connect within chapters, with RNABC and whether future connections and activities should be different.

Members of the North Shore chapter have the opportunity to add ideas so that their nursing voice will remain alive and included with the entire chorus of B.C. nurses.

(Jan Walker is president of the RNABC North Shore Chapter.)
Dispensing Revisited

I work in the emergency department of a small rural hospital. On occasion, the emergency physician will ask the nurses to provide a supply of prescription drugs to clients who won't be able to immediately access their community pharmacy. When we previously consulted with RNABC, we were told that it is illegal in B.C. for nurses to dispense. Now we are being told that nurses can dispense medications in situations like this. Has the law changed? Are nurses now allowed to dispense medications?

By Jo-Ellen Zakoor, RN

In the past, nurses have been told that it was not within the scope of nursing practice to dispense. While that is still true, a process has recently been introduced that allows nurses in certain situations to dispense medications as a delegated medical function.

Who Can Dispense

The dispensing of medication in B.C. continues to be regulated under the B.C. Pharmacists Act. Dispensing is defined in the act as “the preparation and release of a drug prescribed in a prescription and the taking of steps to ensure the pharmaceutical and therapeutic suitability of a drug for its intended use.”

The act permits licensed pharmacists to dispense medications to the public, and physicians to dispense medications to their own clients. The existing legislation does not provide for registered nurses to dispense medications.

However, situations often arise where there is no pharmacist or physician immediately available to dispense urgently required medication. An RN may be the only qualified health care professional available.

Through the collaborative efforts of RNABC, the College of Pharmacists of B.C., and the College of Physicians and Surgeons of B.C., guidelines were recently developed to allow nurses in certain situations to dispense medications as a transfer of function. (These guidelines are in the RNABC document, Dispensing of Medications by Registered Nurses, available from RNABC's Professional Services Division.)

The following criteria should exist before the dispensing of medications is delegated from a physician to a registered nurse:

- there is no in-hospital pharmacist available; and
- there will be no physician immediately available; and
- there is no immediate access to a community pharmacy; or
- there is an urgency to the dispensing of the medication because of unique need, such as anticipated non-compliance, threat of communicable disease, excessive hardship on the client or family, etc.

Delegating Medical Functions

Once a decision is made to delegate the dispensing of medication to a registered nurse, the process outlined in RNABC's 1992 Guidelines for Specialized Nursing Skills and Delegated Medical Functions should be followed. This process includes agreement between medicine and nursing for the delegation to occur and for establishing policies, procedures and plans for education and reassessment of nurses who will perform the delegated function.

When dispensing is delegated, a physician or pharmacist with relevant expertise must ensure that the required knowledge and skill are appropriately taught. Guidelines from the College of Pharmacists of B.C. have been included inDispensing of Medications by Registered Nurses. These guidelines must also be followed. Key points from these guidelines include:

Drug Information

Nurses who have been delegated the responsibility of dispensing medications should have appropriate medication reference material. The physician should be notified of the client's medication allergies, current medications and any other relevant medication information. Prior to supplying any medication, the registered nurse must identify:

- appropriateness of therapy
- medication allergies
- major drug interactions
- correct dosage, route and frequency of administration and dosage form.

Other nursing responsibilities include reporting all identified medication problems to the physician and relaying to the client any specific instructions from the physician regarding medication use.

List of Medications

The pharmacy and therapeutics committee or equivalent in the agency will provide a list of medications that may be supplied by registered nurses who have been delegated the medical function of dispensing. The list of medications will be limited to medications required when outpatient treatment cannot be delayed, such as antibiotics or NSAID pain relievers. The amount of medica-

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tion dispensed should be the minimum required for the period that community pharmacy services are unavailable.

It is preferable that emergency departments provide prelabelled starter packages that leave blank spaces for dates and the names of the client and physician.

Some medications may not be dispensed by the nurse. These include narcotics and other medications that require triplicate prescription. Inhalers, eye drops or injectable medications would not normally be supplied. Furthermore, patients requesting routine filling or refilling of prescriptions should be referred to the community pharmacy.

Additional guidelines on medication preparation, including containers and prescription labels are included in the document, Dispensing of Medications by Registered Nurses.

Accountability and Quality Assurance

The nurse is responsible for recording the following:

• the name, strength, dosage form and quantity of medication provided
• the name of the delegating physician
• the name of the nurse who prepares and provides the medication.

The agency's pharmacy and therapeutics committee will regularly review the medications and the quantities dispensed from the emergency department by registered nurses.

RNABC is pleased that the three organizations have worked together to develop a process that enables registered nurses to provide clients with urgently required medication when there is no pharmacist or pharmacist available. The option of delegating dispensing responsibilities to nurses helps in addressing this issue, which has been troubling to registered nurses, physicians, pharmacists and health care agencies throughout B.C. Moreover, it helps nurses who work in rural and other unique health care settings to meet their client needs more efficiently.

(Jo-Ellen Zakoor is a nursing practice advisor in RNABC's Professional Services Division.)
**RESEARCH UPDATE**

- The West Kootenay Nursing Research Group has been awarded a $30,837 grant by the B.C. Medical Services Foundation (BCMSF) to study patients' perceptions of self-care abilities following discharge from hospital. It is anticipated that the study will enhance the effectiveness of patient teaching during discharge planning. The group consists of Kathi Anderson (home care), Vivian Baumgartner (home care), Irene Bridge (acute care), JenniferCraig (education consultant), Sue Hackett (acute and home care), Maureen Little (nursing education), Margaret Nickel (nursing education), Teresa Petrick (nursing education), Sharon Pompu (acute care) and Elaine Sloan (acute care). The 12-month study will be conducted in the West Kootenay region. The grant will be administered by Selkirk College in Castlegar.

- Funding has also been made available through a grant from BCMSF for a preliminary study to pretest interventions, which were designed specifically for postpartum women who stopped smoking cigarettes during pregnancy, to provide them with the necessary support and skills to remain abstinent from smoking. The nurse investigators are J. Bottorf, J. Johnson, W. Hall and P. Ratner.

**CORONER’S RECOMMENDATIONS**

RNABC frequently receives reports from the chief coroner following an inquest or inquiry into a death. Follow-up by RNABC can take many forms, depending on the nature of the problem. For example, RNABC nursing practice consultants may visit the specific agency involved and assist with revising systems to support nurses to meet the Standards for Nursing Practice in B.C. In other cases, the Association may choose to follow up by publishing the recommendations in Nursing BC for the benefit of all members.

Here are findings of a recent coroner’s report that has significance for RNABC members.

**Deflation of gastrostomy tube balloon**

Following the death of a 54-year-old woman, an autopsy revealed that the gastrostomy tube had become misplaced and feedings were administered into the peritoneal cavity causing peritonitis and death. The gastrostomy tube had been inserted under radiological guidance two days before her death. Correct placement of the gastrostomy tube within the stomach was confirmed by radiography. Over the course of the next two days, continuous tube feedings were administered along with regular four hourly gastrostomy tube flushes with 50 cc's of water.

The patient’s condition deteriorated. In spite of treatment, her condition failed to improve and she died the following day.

At autopsy, the feeding tube tip was located outside the stomach within the abdominal wall and the bulb was inflated. The spring loading device of the gastrostomy tube was found within the stomach lumen, supporting the radiological impression of improper positioning of the tube.

The gastrostomy tube used for this patient was clearly labelled with a red warning sign on the balloon port in order to avoid tube feeding or irrigation attempts at this port. It appears that one of the health care professionals caring for her may have inadvertently attempted to administer a tube feeding or conduct an irrigation of the feeding tube through the wrong port, causing the balloon to be deflated and the tube to become dislodged outside the stomach wall. Upon discovery of such an error, the balloon may have then been re-inflated. However, by then the gastrostomy tube tip was most likely positioned incorrectly. Studies have shown that there is a high degree of traction on the stomach wall in percutaneous gastrostomies. This traction could account for easy displacement of the tube even upon inadvertent deflation of the balloon with immediate re-inflation.

The coroner recommended that:

- The Radiation and Medical Devices Bureau of Health and Welfare Canada examine the safety of this gastrostomy tube and that the balloon bulb port site be designed with a cap to deter inadvertent attempts to feed or flush through this port causing deflation of the bulb.
- All members of RNABC know the importance of immediately reporting any incidents where a gastrostomy tube balloon may have been inadvertently deflated.
- Nurses should also refer to guidelines or policies in their agencies in relation to continuous tube feedings and intermittent flushes with water. It is customary to aspirate stomach contents prior to completing the flushes. It is likely that with the tube outside the stomach wall, nothing would be withdrawn into the syringe. This would alert nurses to discontinue any further flushes or feedings until placement of the tube could be checked.

**TWO-TIER HEALTH NOT WARRANTED**

The threat of a two-tier health system as a result of listing which health services should receive public funding and which should not has prompted RNABC to broaden its position on core health care services.

With federal funding cutbacks for health care, downsizing by health care agencies due to financial constraints, and regionalization, RNABC is concerned, as are many others, about the growing interest in creating a two-tier health care system for essential services.

While the Association has often stated its position in a variety of documents that there is no need for a two-tier health system in Canada, the Board of Directors felt that a new position statement summarizing RNABC’s relevant positions should be developed.

As a complement to the Association’s existing Creating the New Health Care Position Statement (pub. no. 77), the new position statement on core services will address the following:

- All essential health care should be publicly funded and forms of the two-tier health care system that currently exist should be eliminated. (RNABC’s existing views on restructuring strategies will be incorporated in the statement.)
- Restructuring of health care services should reduce substantially the need to ration services and thus reduce the pressure for two-tier health care.
- Rationing decisions will still have to be made and should be a dynamic process involving community and providers.
- Cutbacks in transfer payments should be phased in more slowly than now planned to allow for restructuring to occur.
- In making rationing decisions the five components of essential health care (health promotion, disease and injury prevention, curative care, supportive care, rehabilitative care), consideration should be given to the potential of each to contribute to the
health of as many people as possible.
- A list of core services can provide a framework for guiding communities about equitable access to health care in the province, but it is not a viable approach to de-insuring existing services.
- Private health care should be limited to non-essential health care, recognizing that the public system may incorporate innovative services whose effectiveness is demonstrated in the private system.

Three important assumptions underlying this position:
1. Overall, there is enough money being spent on health care services in Canada.
2. The public system is the most effective approach to health care financing. Although a predominantly public financed system limits some individual choices, these are minimal given the universal access it provides.
3. There will always be some degree of rationing in health care delivery.

NO RESERVED ACTS FOR NURSING, RNABC TELLS HEALTH PROFESSIONS COUNCIL

On July 5, RNABC presented its submission to the Health Professions Council panel reviewing scopes of practice and titles of registered nurses. The following are some of the highlights of RNABC's report titled, The Scope of Nursing Practice.
- The scope of nursing practice for RNs should be maintained in its current form in the rules pursuant to the Nurses (Registered) Act.
- Creating reserved acts for nurses is neither a necessary nor feasible approach to the regulation of nursing.
- Exempting RNs from the exclusive scopes of practice or reserved acts in legislation regulating other professionals would be one of the most effective ways the Health Professions Council could achieve its mandate to "maximize consumer choice and limit the cost of health care services."
- The "professional practice model," which is the regulatory framework used by RNABC, has proved to be effective in protecting the public from unsafe practice.
- The public interest will be best served by strengthening the approaches used to regulate all RNs.
- Creating a list of tasks requiring supervision by RNs is not feasible.
- The restricted title provisions currently in the Nurses (Registered) Act should remain unchanged.

The Health Professions Council is expected to take almost a year to complete its final reports of scopes of practice reviews.

RESTRICTING CHAPTERS MAY GIVE NURSES A STRONGER COMMUNITY VOICE

Restricting chapters as nursing councils may be one way nurses can have a strong voice in local health planning and nursing practice. That was one of the ideas stemming from a recent Board discussion on member involvement.

While some nurses want more opportunities to be involved in RNABC activities, others want to be more actively involved in their local community health councils and regional health boards.

The idea is somewhat appealing because it builds on something that is already developing in some areas of the province where nurses want to be involved in activities relevant to their professional lives.

In September, the Board passed a motion to encourage chapter exploration of methods of involving nurses in nursing standards support, including promotion of good practice, through participation in local health planning and governance activities.

RNS HAVE LEGAL AND ETHICAL DUTY TO CARE

In September, the Board of Directors approved several statements on nurses' duty to provide care. This will allow the Association to speak out on a variety of issues and concerns expressed by members, and to give clear advice to nurses who have concerns about participating in certain practices or difficulty in interpreting the direction provided in the Code of Ethics regarding duty to care.

The Board concluded that registered nurses have a legal and ethical obligation to provide competent care to clients. Generally, when the rights of the nurse are in conflict with the rights of the client, the rights of the client take precedence. There are situations, however, when it is acceptable for registered nurses to withdraw from or refuse to provide care. Such decisions must be guided by legal and professional as well as contractual obligations.

The statements identify potential situations in which nurses — after careful consideration of the situation and discussion with relevant parties, including their employer — may decide to withdraw from or refuse to provide care. Situations include nurses being asked to provide care outside their scope of practice or beyond their level of competence, nurses facing personal danger as a result of providing care, nurses being verbally or physically abused by clients, and nurses being asked to provide care which conflicts with their moral or religious beliefs.

In situations where unreasonable expectations, lack of resources or excessive workload compromise nurses' ability to provide competent care, nurses must continue to do their best to provide care while taking steps to make their concerns known.

Also acknowledged are nurses' rights to participate in job action as provided for in legislation, the requirement to provide essential care as determined by the Labour Relations Board, and nurses' obligations to continue to advocate for clients during job action.

The obligations of employers to support nurses to provide competent care are also addressed.

Plans are underway for communicating and interpreting this new position to members. The Board has also withdrawn its position statement on therapeutic abortion.

MORE FEEDBACK SOUGHT ON MERGER WITH RPNABC

Discussions are continuing between the Registered Psychiatric Nurses Association of B.C. and RNABC on increased collaboration and the possible organizational merger of the two associations.

The two organizations have been collaborating, along with the B.C. Council of Licensed Practical Nurses, on an education program addressing the needs of nurses in rural communities. Some sharing of member services between RNABC and RPNABC is scheduled to
begin on a trial basis before the end of the year.

Feedback from a discussion paper circulated during the summer, and an article by Pat Cutshall in the August-September issue of Nursing BC has been analyzed and a number of issues identified. One of these is a desire expressed by many RPNs to ensure that their professional identity is preserved.

"The feedback from our members is that they want to be referred to as psychiatric nurses, because it identifies the kind of work they do and the kind of patients they provide care for," says Keith Best, executive director of RNABC. "It's a critical part of our ongoing discussions with RNABC."

Plans are being developed to hold talks with groups of members of the two organizations.

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**RNABC: INFLUENCING HEALTH POLICY**

- In a letter to Health Minister Paul Ramsey prior to the provincial health ministers meeting in September, RNABC expressed support for an increase in alternative payment mechanisms such as capitation. RNABC also called for the government to implement the Seaton Commission's recommendations concerning alternative health service delivery organizations. Alternative health care facilities, such as community health centres, would provide an integrated approach to primary health care as well as an alternative point of entry into the health care system.

- RNABC has been collaborating with the B.C. Health Association, the Ministry of Health and the B.C. Health Care Research Foundation to develop regional workshops on evidence-based practice. One workshop was held in September and three others are scheduled.

- After reviewing a draft of the regulations for licensed practical nurses, which are being brought under the Health Professions Act, RNABC responded to the Health Professions Council that the draft is not consistent with submissions of nursing organizations to the council. The Association emphasized that LPNs are accountable for their practice and, as a regulated profession, should practice within the limits of their competence. RNABC also stated that they should not be required by legislation to work under the direction of a "medical practitioner" or supervision of a registered nurse.

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**RNABC IN BRIEF**

- The North Shore Chapter has been granted modified active status for one year. This will allow the chapter to find ways to encourage greater member participation in chapter activities.

- To promote public awareness of RNABC's public service responsibilities, every telephone Yellow Pages directory in B.C. now carries an RNABC advertisement under "Nurses and Nurses' Registries."

- Staff and visitors to the RNABC office in Vancouver are asked to refrain from wearing perfume products so as to eliminate discomfort to others who may have allergies to such scents.

- The Canadian Nurses Association sends its thanks to the 1513 B.C. nurses who donated more than $14,000 towards the 1997 ICN Congress in Vancouver.

- RNABC has written to the Canadian Nurses Association requesting that it lobby the federal government to provide additional funding for breast cancer research. The B.C. Minister of Health has also been asked to provide a stable and adequate level of funding for the B.C. Health Research Foundation so that it can respond to meritorious requests for breast cancer research.

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**NEW MEMBERS TO REQUIRE CRIMINAL CHECKS**

Starting January 1, 1998, all new applicants for RNABC registration will require criminal record checks prior to obtaining registration. Under the Criminal Records Review Act (Bill 26), which was passed in late June, new applicants will not be able to obtain registration until a criminal record check is completed.

Current members will not require criminal record checks until April 1, 1997.

The act makes a criminal records check mandatory for anyone working with children or who may have unsupervised access to children in the ordinary course of their employment. All nurses are deemed to fall within this description.

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**CNA BIENNIAL DELEGATES**

If you are interested in becoming a B.C. voting delegate to the CNA Biennial, June 16-19, 1996 in Halifax, contact Jill Blake Coltrin, RNABC Executive Office, before Jan. 1, 1995. Telephone (604) 736-7331 (local 321) or toll-free in B.C. 1-800-565-6505.

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**CALLING ALL MIDWIVES**

The College of Midwives of B.C. would like to hear from midwives interested in applying for initial registration in early 1996. Following recent legislation, only persons who are registered with the College of Midwives will be allowed to practice midwifery in B.C.

Contact the College of Midwives of B.C., Room F502, 4500 Oak St., Vancouver, B.C. V6H 3N1. Telephone (604) 875-3580. Fax (604) 875-3581.
On December 1, 1995, the Board of Directors heard an appeal by Nancy E. Barr (Crick, Smith) of Kelowna, B.C. (B.C. registration no. 569402) of the Professional Conduct Committee decision that she was guilty of conduct contrary to the ethical standards of the profession of nursing. The Board reversed the decision and cancelled the disciplinary action. The Board found the Professional Conduct Committee erred when it concluded that the member was obligated to report that patients may be at risk as a result of misconduct by a physician. The Board determined that the information available to her, by and of itself, was insufficient to create an obligation to report the physician as posing a risk to patients. Nancy Barr’s registration was restored in good standing immediately.

On May 14-15, 1995, the Professional Conduct Committee of RNABC considered allegations that Teresa Ann Wright of Vancouver, B.C. (B.C. registration no. 542021) abused her position of trust and failed to act with honesty and integrity while providing nursing care to patients.

Teresa Wright began working for the B.C. Registered Nurses Directory on November 30, 1992. This directory provides nurses with assignments to care for private clients. From December 11, 1992 to January 2, 1993, she cared for Mrs. X, a client referred to her through the directory. When the assignment ended, she made arrangement with Mrs. X’s family to provide ongoing support to Mrs. X and her husband Mr. X. They had no family in the area to look in on them.

She was hired, in part, because of her nursing background. She was to perform a number of non-nursing, personal tasks for Mr. X who was 87 years old and frail. She was also to keep Mrs. X’s daughter informed about her parents’ well being. After March 1993, she failed to keep the daughter so informed.

She advised the directory that she could not work between May and July 1993, and between October 1993 and February 1994 due to health problems. From January until November 1993, she received $42,512.36 from Mr. X. Of this amount, she received $22,800 as loans, which were never repaid. She received $18,520.94 for nursing and personal services, but the evidence revealed she did not spend more than four hours per week with Mr. and Mrs. X. She obtained $1,191.42 as payment for clothes for Mrs. X, but these items were never seen by the family. Further, she had asked the daughter to purchase a VCR for her and took delivery of this, but did not reimburse the daughter.

A representative of the directory and the daughter confronted her seeking a return of the clothing and payment for the VCR. She was unable to account for her failure to visit Mr. and Mrs. X and did not pay for the VCR or return the clothing.

The committee concluded that the former member breached Values I, VI, and XI of the Code of Ethics and Standards 4 and 6 of the Standards for Nursing Practice in British Columbia.

On August 28, 1995, the committee terminated Teresa Wright’s membership in RNABC. It concluded that her conduct could not be tolerated. She did not attend the hearing and the committee had no evidence to suggest another remedy that would ensure that she will not engage in similar conduct in the future if she were permitted to continue to practice.

As a nurse, she posed a serious risk of harm to the public in that she had fostered a relationship of trust and dependence with an elderly client and then used that relationship for her own gain, ultimately abandoning her client. The committee found that such conduct is reprehensible and harms the integrity and good standing of the profession.

On July 12, 1995, the chair of the Professional Conduct Committee accepted an undertaking from Helen Frances Fawcett (Gilbert) of Victoria, B.C. (B.C. registration no. 809858) to not apply for reinstatement of her membership without first obtaining approval of the Board of Directors. In considering such an application, the Board may exercise the same discretion as if her membership had been terminated as a result of disciplinary action under section 27 of the Nurses (Registered) Act.

On July 24, 1995, the chair of the Professional Conduct Committee accepted an undertaking from Marilyn Elizabeth Gibson (Ward) of Port Alberni, B.C. (B.C. registration no. 228617) to not apply for reinstatement of membership without first obtaining approval of the Board of Directors. In considering such an application, the Board may exercise the same discretion as if her membership had been terminated as a result of disciplinary action under section 27 of the Nurses (Registered) Act.
The following books and videos can be borrowed from the RNABC Helen Randal Library (604) 736-7331 (ext. 456) or 1-800-565-6505.

**BREAST CANCER**


*Breast imaging services: mammography guidelines.* (1986). Ottawa: Minister of Supply and Services. (PAM: Breasts)


Describes B.C.'s Mammography Screening Program and its importance to screening and treating breast cancer in women.

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**BOOK REVIEW**


Reviewed by Jennifer Bradbury, RN

This informative, locally-written book provides women living with breast cancer with information they need to become actively involved in their treatment decisions. The book is filled with current information about breast cancer that is appropriate not only for these women and their families, but also for nurses and other members of the health care team.

The book is well written, providing up-to-date and comprehensive information. Topics are logically organized, beginning with a description of the anatomy of the breast and progressing through explanations of early detection, methods of diagnosis, the latest treatments for breast cancer and follow-up beyond the initial phase of treatment.

Medical information is supplemented by information about life style issues, including coping methods, diet and relaxation. Special topics such as non-traditional methods of treatment and clinical research are covered. A list of recommended reading and audiotapes is also provided.

This is a user-friendly book that can be used as a teaching tool. Chapters are short and succinct. Headings in each chapter make information quick and easy to find. Explanations are written in technically-correct terms at a level that non-health professionals will find easy to understand. A glossary provides definitions of words readers may not be familiar with, and many explanations are supplemented by tables, diagrams or photographs.

The book's principle authors are physicians affiliated with the B.C. Cancer Agency. Two are oncologists and one is a surgeon. All are actively involved in breast cancer research and have clinical faculty appointments at the University of British Columbia. Contributing authors include a clinical nurse specialist, a dietitian-nutritionist, a physiotherapist, a clinical-hypnotherapist and a plastic surgeon.

The final word is contributed by a breast cancer survivor and advocate.

Nurses can confidently recommend this book to women with breast cancer. I would also encourage health care professionals caring for women living with breast cancer to have a copy on hand to use as a reference for themselves and a teaching tool for their clients.

(Jennifer Bradbury, BSN is coordinator of the B.C. and Yukon Breast Cancer Information Project.)
To Reach RNABC
Tel: (604) 736-7331
Toll-Free 1-800-565-6505
Fax: (604) 732-2272
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Jan 30 Nursing Inpatient Services: Further Management Applications of Departmental Information — Vancouver, BC. Contact: Marilyn Harbottle. Tel: (613) 241-7860. Fax: (613) 241-8120.

Jan 31 MIS Guidelines for Ambulatory Care Services, Advanced Level — Vancouver, BC. Fee: $155 +GST - Early Bird, $180 +GST - Regular. Contact: Canadian Institute for Health Information, Education Program, 377 Dalhousie Street, Suite 200, Ottawa, ON K1N 9N8. Tel: (613) 241-8760. Fax: (613) 241-8120.

Mar 2-9 International CME Programme — Cancun, Mexico. Contact: Society of Obstetricians and Gynaecologists of Canada (SOGC) - Education Division. Tel: (603) 730-4192. Fax: (603) 730-7314. Internet: sogc@fox.nsn.ca.

Mar 7-9 12th International Seating Symposium — Vancouver, BC. Contact: 12th International Seating Symposium, Continuing Education in the Health Sciences, Room 105, 2194 Health Sciences Mall, UBC, Vancouver, BC V6T 1Z3. Tel: (604) 822-4965. Fax: (604) 822-4835.

Mar 14-16 The British Columbia Operating Nurses Group 15 Biennial Conference: Ride the Wave — Victoria, BC. Contact: Carmen Moore, Registration, 10633 Madrona Drive, Sidney, BC V8L 5L8. Tel: (604) 655-5770. Fax: (604) 655-3640.

Mar 21-24 1996 West/Central CME Programme — Banff, AB. Contact: Society of Obstetricians and Gynaecologists of Canada (SOGC) - Education Division. Tel: (603) 730-4192. Fax: (603) 730-7314. Internet: sogc@fox.nsn.ca.

June 13-15 Teaching to Promote Women’s Health Conference — Toronto, ON. Fee: $400 before Dec 31, $450 after Jan 1, $275 for students, $125 daily. Contact: c/o Coordination Plus, Suite 3504 Aetna Tower, TD Centre, PO Box 68, Toronto, ON. Tel: (416) 862-9067 ext 231. Fax: (416) 862-2238. Email: health@web.apc.org.

Sept 3 Nursing in the New Millennium — Winnipeg, MB. Contact: Tracey Fallak, Chair, MARN Global Conference Planning Committee, Manitoba Association of Registered Nurses, 647 Broadway, Winnipeg, MB R3C 0X2. Tel: (204) 774-3477. Fax: (204) 775-6052.

Conferences, workshops and seminars will be listed free in the Calendar as space permits. Items for the Calendar should be submitted in writing six weeks prior to publication Jan. 15, Mar. 15, June 1, Aug. 15, and Nov. 1. Send Calendar items to: Education Coordinator, RNABC, 2855 Arbutus St., Vancouver, B.C. V6J 3Y8. RNABC cannot assume responsibility for cancellations or changes to events.

REGISTERED NURSES ASSOCIATION OF BRITISH COLUMBIA

NORTH SHORE CHAPTER

Hello Chapter Members! We welcome you to attend your Chapter meetings.

WHERE: Auditorium – Lions Gate Hospital

SCHEDULE OF EVENTS

Nov. 15 General Meeting at 7:30 p.m.
Feb. Heart Month – B.P. Clinic – TBA
March 6 Preparation for RNABC Annual General Meeting – Resolutions
April RNABC Convention & Annual Meeting – No Chapter Meeting
June Chapter Annual General Meeting – Annual Dinner – Lonsdale Quay Hotel. Ticket info TBA

YOUR EXECUTIVE

President Jan Walker 926-3506
Vice-President Marie Cameron 980-1274
Treasurer Marion Cameron 985-0718
Recording Secretary Janice Robinson 921-9341
Education Bev Brewer 987-4532

NURSING BC NOVEMBER/DECEMBER 1995 33
RNABC is looking for a nurse with significant experience in education for the position of education coordinator. You will have at least five years' experience as a nurse educator. You will also have a strong background in adult education theory. You will be able to identify education needs of nurses, develop goals, plan, carry out and evaluate projects relevant to continuing education. Responsibilities include:

- designing and developing education programs on maintaining and improving standards of nursing practice;
- developing education materials that can be disseminated to nurses in a variety of ways.

Resumes and letters of application will be accepted until January 15, 1996.

Send to:

Human Resources Coordinator

REGISTERED NURSES ASSOCIATION OF BRITISH COLUMBIA
1515 Homer St., Vancouver, B.C. V6G 1P9

NURSE MANAGER

Acute Care Services

We are seeking a motivated, experienced professional to play a key role within our Nursing Management team to ensure the provision of quality acute care services, and maintaining direct clinical liaison with extended care services.

The hospital has 126 beds providing acute care and extended care services. Because the hospital serves a large retirement population in Oliver and Osoyoos, geriatric services form a major portion of the care provided. The hospital has taken a leadership role regarding integration and coordination of health services in the community.

The hospital is located in Oliver, British Columbia, an all-season resort area in the Okanagan Valley. The area provides unlimited recreational opportunities, attractive housing costs, a good education system and numerous other advantages.

The successful candidate will be recognized as an exceptional and energetic leader with an established record of achievement and success in management and acute nursing. The incumbent will possess a sound knowledge of current clinical and theory nursing practice. Management experience, continued educational growth and excellent communication skills will complement the candidate's leadership and interpersonal style of team-oriented management.

Interested and qualified persons are invited to submit their application in confidence by 31 December 1995, to Anne Ardiezel, AED, Patient Care, South Okanagan General Hospital, Box 760, Oliver, B.C., V0H 1T0. Telephone (604) 498-3474.
**REGISTRATION OFFICER**

This job has been designed especially for RNABC members who are looking for unique professional development opportunities. We guarantee you a special kind of work experience.

During your 18 month appointment, you will:
- provide information and assistance to nurses who wish to register, enroll or renew membership in RNABC;
- assist other registration staff to assess professional credentials and interpret registration and examination policies;
- be the first contact with RNABC members.

If you are a registered nurse with experience in nursing, preferably in more than one province or country, and have good communication and public relations skills, enjoy talking to people by telephone and in person, and like working as part of a team, this may be a carer opportunity for you.

**Resumes and letters of application should be sent by January 15, 1996 to:**

Human Resources Coordinator

**REGISTERED NURSES ASSOCIATION OF BRITISH COLUMBIA**

2855 Arbutus Street, Vancouver, B.C. V6J 3Y8

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**HEAD NURSE**

**Pediatric Rehabilitation**

Sunny Hill Health Centre for Children is a major resource for the provision of habilitation and rehabilitation services to the children of BC, providing leadership and excellence in clinical services, community care, research and education. Utilizing a program management model, Sunny Hill Health Centre provides tertiary services for children up to 19 years of age who require interdisciplinary developmental assessment, treatment and ongoing follow up.

As the Head Nurse, you will take a strong leadership role in the provision of quality patient care on the 25 bed inpatient unit. You will be responsible for managing the budget, quality assurance activities and act as a liaison between nursing staff, the interdisciplinary team and the community.

Qualifications: A BSN degree (MSN preferred), current RNABC registration, five years experience in pediatric nursing, and at least one year of nursing management experience. Acute care pediatric experience is essential.

The position commences immediately and the salary and benefits are as provided in the BCNU contract, Level DC3. Applicants are invited to reply in writing by December 29, 1995 to:

**HUMAN RESOURCES**

Sunny Hill Health Centre for Children
3644 Slocan St. Vancouver, BC V5M 3E8
THE NURSING RECRUITMENT GROUP
Est. since 1988
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Work permit for your spouse in approximately 6 weeks.
We require nurses with experience in the following areas:
- ICU/CCU
- OB/L&D
- Telemetry
- OR
- Recovery
Only if you have experience in the above, call toll free:
1-800-828-0161
FAX: 305-489-0793
All others write to us for an application:
2455 NE 51st Street
Suite E316
Ft. Lauderdale, FL 33308

NURSING PRACTICE CONSULTANT
RNABC is seeking an outstanding and creative individual as a nursing practice consultant. The position will interest those who would like to:
- Consult with nurses in all settings and at all levels on nursing practice issues.
- Assist nurses to meet nursing practice standards and resolve their difficult practice issues.
- Explore current topics in health care and professional nursing issues with nurses in their practice settings.
- Develop resources for RNABC members to address professional nursing practice issues and to apply practice standards.

To be eligible for this position, you must:
- Possess extensive competencies gained through education and at least 10 years of experience in a variety of settings and positions.
- Be experienced in managing projects and working with others to achieve satisfactory outcomes.
- Have excellent writing, interpersonal and presentation skills
- Be available for up to 30% travel throughout B.C.

Letters of application and resume should be sent by January 15, 1996 to:
Human Resources Coordinator

REGISTERED NURSES ASSOCIATION OF BRITISH COLUMBIA
2653 Arbutus Street, Vancouver, B.C. V6J 3Y8

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Ph. 416-977-6941 0r 1-800-387-4616 Fax: 416-977-6128

Continuing Health Care Administration
2-year Distance Learning Diploma Program
Malaspina University-College is now accepting applications for this program which is designed for persons presently employed in the Continuing Health Care field. This introductory course starts in March 1996. Applications are accepted any time as courses may be taken on a full or part-time basis.

For full details, contact Ann Avery, Program Coordinator, or Cella Sharp, Administrative Assistant.

Tel: (604) 741-2211 Fax: (604) 741-2152

Malaspina University-College
Nanaimo Campus
900 Fifth Street
Nanaimo, BC V9R 5S5

NURSING BC NOVEMBER/DECEMBER 1996 37
You’re Not Alone

By Pat Cutshall, RNABC Executive Director

So what do you do when you feel like you’re in over your head? Or are the nurses you used to turn to for answers aren’t there? Or you are sort of new on the job, but everyone’s too busy to help?

Or maybe you’ve been around a while, but right now it seems as though things are just falling apart.

RNABC receives calls from nurses like you all the time. You’re not as alone as you might think. That’s part of what our practice consultation service is there for — to assist you with issues that arise in your professional nursing practice. Here’s how it might work for you.

Identifying the problem

You call a nursing practice consultant on our toll-free line. The consultant will work with you to identify and describe your issues and concerns. You might be asked to collect more information. You will certainly be helped to identify how your particular problem relates to one or more of the standards for nursing practice.

Resolving the problem

Using the “Guidelines for Resolving Professional Practice Problems” in appendix 1 of the Standards for Nursing Practice in British Columbia, the consultant may help you through a three-step process to:

- describe the problem and determine which standards are not being met as a result;
- document and communicate the problem to the appropriate people as needed; and
- participate in resolving the problem.

If it appears you might have to use this process in a more formal manner, the consultant can assist you to communicate with senior people in your agency.

As an additional benefit, you will learn how your written and oral communications — even about problems — can be developed in ways that are professional, that reflect well on you and that are likely to get results. It’s not always easy, but it works.

Increasing your knowledge

This process of reflecting with an “outsider,” who is also a nurse, can sometimes lead you to make plans to increase your own knowledge and skills through continuing education, or simpler yet, by using RNABC’s Helen Randal Library to get current information about nursing practice issues. Again, toll-free access, friendly search services and books or articles mailed to you free of charge could make a major difference to your professional life.

Occasionally, you will discover that your personal learning needs are similar to the learning needs of others in your agency or community. Co-sponsored education programs developed by RNABC and available to you and your colleagues at your agency are also an option. If your agency has RNABC workplace representatives, ask them to check it out for you or call us direct.

Some people say RNABC “just isn’t there for the grassroots nurse.” Before you say you don’t think it gives us a try. So that they can get to know you better, RNABC’s team of practice consultation nurses have been assigned to geographic areas throughout the province.

About 51% of all nurses who call RNABC are staff level nurses. We’d like to see that increased. Because nurse-to-nurse problem-solving is part of what RNABC is all about, there is lots of room for the Association to work with working nurses. Jane Ellis, our new director of Professional Services, and her division staff are ready and willing. Let us hear from you.

WHO TO CALL

(604) 736-7331 1-800-565-6505

- Morrie Steele (ext. 308)
- District F (Northeast)
- District H (Kootenays)
- District E (Upper Fraser Valley)
- Royal Columbian Hospital
- St. Mary’s Hospital
- Eagle Ridge Hospital
- Burnaby Hospital
- All legal calls regarding enquiries and other court proceedings

- Mary Adlersberg (ext. 305)
- District A (Mainland-Coastal area)
- St. Paul’s Hospital
- G.E. Strong Rehab Centre
- B.C. Rehab Centre
- Riverview Hospital
- All legal calls related to personal health issues from or about nurses

- Pam Otten (ext. 306)
- District G (Northwest)
- District C (Vancouver Island)
- District D (Greater Victoria/Gulf Islands)
- B.C. Cancer Agency
- Vancouver Hospital (both sites)
- Vancouver Long Term Care Agencies

- Heather Mass (ext. 307)
- District J (Okanagan)
- District I (Thompson-Columbia)
- District E (Lower Fraser Valley)
- B.C.’s Children’s Hospital
- B.C. Women’s Hospital
- Vancouver Health Department
- Burnaby Health Department
- St. Vincent’s and Mount St. Joseph’s Hospitals (Chara Health Care Society)
- Comox Valley Nursing Centre

- Jane Ellis (ext. 301)
- Director Professional Services Division
- Jo-Ellen Zakoor (ext. 303)
- Practice Advisor
HAS YOUR ADDRESS CHANGED?

Last year more than 3,000 RNABC member registration renewal forms were returned as "address unknown." If you've moved and changed your address since the last time you returned your registration renewal form, we would like to know what your new address is so that your 1996 renewal form can be sent to you at your home. Please fill out the change of address form below and return it to RNABC by mail, fax or telephone. If leaving a message, please speak slowly and clearly and provide all of the information below.

To ensure your registration package arrives on time, RNABC provides a 24 hour change-of-address line: 1-800-565-6505 Local 620. In Vancouver: 736-7331 Local 620

PLEASE PRINT CLEARLY

NAME

NEW MAILING ADDRESS

CITY          POSTAL CODE          TELEPHONE

YOUR SECURITY WORD          YOUR REGISTRATION NUMBER

REGISTERED NURSES ASSOCIATION OF BRITISH COLUMBIA

2835 Alberni St., Vancouver, B.C. V6J 3Y8
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- 20 Opening the Door posters.

Cost:
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To order, contact:
Publications Clerk, RNA8C Helen Randal Library
Tel (604) 736-7331 (local 118) or toll-free in B.C. 1-800-565-6505
Fax (604) 736-2272 VISA and MASTERCARD accepted