Judith Shamian Elected New President of ICN; Marlene Smadu Reappointed Director

Judith Shamian has been elected the 27th president of the International Council of Nurses (ICN). The election took place in the context of ICN's governing body meeting, the Council of National Representatives (CNR), during the 25th ICN Quadrennial Congress in Melbourne, Australia. More than 4,000 nurses from 134 countries gathered at the Congress to share knowledge and discuss global healthcare priorities.

Judith Shamian's nursing achievements span all domains of nursing practice: academia, administration, policy and clinical settings. She is recognized as an outspoken advocate on health and nursing issues both in Canada and internationally. She has brought nursing expertise to the World Health Organization through collaboration with WHO's chief nursing scientists, served on the global advisory committee of nursing, which was formed to advise the WHO director general, and established and headed a WHO collaborating centre.

In Canada, Dr. Shamian has held many leading national positions, including president of the Canadian Nurses Association, executive director of Health Canada, president of the Registered Nurses Association of Ontario and vice-president of nursing at Mount Sinai Hospital. She has spearheaded a number of initiatives aimed at improving quality of and access to health services, including a strong focus on the social determinants of health, earning her several honours and awards. Her academic work in public policy models and knowledge transfer has proven highly effective in translating nursing research and advocacy efforts into concrete policy action.

Another Canadian, Marlene Smadu, who is vice-president of quality and transformation at Saskatchewan's Regina Qu'Appelle Health Region, also serves on ICN's board and was reappointed for a second term.

ICN Expands Global Membership

The International Council of Nurses (ICN) has announced the inclusion of two new members in its federation of national nursing associations. The Chinese Nursing Association officially became a member of ICN in April 2013, and the Palestinian Nursing and Midwifery Association was admitted by unanimous vote of the assembled delegates at the meeting of ICN's Council of National Representatives (CNR) in Melbourne, Australia on May 16.

Bringing the total membership to 135 national nurses' associations, the new members were pleased to attend the CNR meeting, followed by ICN's 25th Quadrennial Congress, May 18–23.

ICN Launches Global Nursing Leadership Institute* Colloquium

The International Council of Nurses (ICN) has launched the Global Nursing Leadership Institute (GNLI) Colloquium at ICN's 25th Quadrennial Congress.

Established in 2009, the GNLI offers an advanced leadership program for nurses and midwives at senior-level and executive positions in developed and developing countries across the world. The program, drawing on the expertise of international faculty, allows participants to review and enhance their national and global leadership knowledge and skills within a collaborative and stimulating learning culture. The GNLI is facilitated by Dr. Stephanie Ferguson, associate professor and director of the Community Nursing Organization at Virginia Commonwealth University and director of ICN's Leadership for Change program.

ICN has been a pioneer in leadership, management and negotiation skill development for nurses for more than 20 years through the highly successful Leadership for Change and Leadership in Negotiation programs. The GNLI represents the third component of ICN's leadership development strategy.

Further information about the GNLI is available at www.icn.ch/pillarsprograms/global-nursing-leadership-institute/.

* Support for the Global Nursing Leadership Institute is provided by Pfizer, the founding sponsor.

CNA Launches Nurse Practitioner Awareness Program

The Canadian Nurses Association campaign to raise awareness about nurse practitioners (NPs), and how NPs improve access to high-quality healthcare and reduce wait times, was launched in Prince Edward Island in late April 2013. More

than four million Canadians are without access to a primary healthcare provider, while those that have one often have difficulty accessing care. The result is an unsustainable, heavily burdened and overcrowded healthcare system. As the national professional voice of registered nurses, CNA strongly believes that adding more NPs will improve access, lead to a greater number of healthcare options and enhance care for the whole patient.

NPs are part of healthcare teams in a variety of settings, including community clinics, doctors' offices, nursing homes and hospitals. In British Columbia, Alberta and Ontario, NPs have authority to admit and discharge patients in hospitals and other facilities. In December 2012, PEI Health Minister Doug Currie announced a new pilot project that will see NPs take on an independent caseload of patients while still collaborating with a family doctor for issues outside their scope of practice. Minister Currie says these changes should increase access to healthcare for all Islanders and are an opportunity for NPs to work to their full capacity.

There are more than 3,000 NPs in Canada, and every provincial and territorial government has NP legislation in place. Prince Edward Island currently has five NPs in primary healthcare and is planning to hire an additional four in the near future. There is also one NP at the University of PEI's school of nursing.

The campaign "Nurse Practitioners: It's About Time!" is led by CNA in conjunction with the Association of Registered Nurses of Prince Edward Island. First launched in October 2011, the CNA campaign targets Canada's various jurisdictions to create a regional focus on the value of NPs. For more information about CNA's NP campaign and to access interactive tools, such as video and letters to government, please visit www.npnow.ca.

Electronic Medical Records Deliver Efficiencies, Patient Safety, Improved Communication

With a twofold increase in adoption since 2006, use of electronic medical records (EMRs) in community-based practices in Canada has yielded efficiency and patient care benefits valued at $1.3 billion, a new independent study reveals.

The PwC study drew on more than 250 research publications from around the world and includes up-to-date Canadian results from recent studies and surveys. It was commissioned by Canada Health Infoway and uncovers the benefits achieved over a six-year period (2006–2012):

- $800 million in administrative efficiencies as staff time is redeployed in community-based practices
- $584 million in health system–level benefits, such as reduced duplicate tests and adverse drug events
- Improved interactions and communications among care team members and between providers and patients and
- Better quality of care and health outcomes through preventative care and chronic disease management with advanced EMR use

These results are tied to national progress in EMR adoption over the same period, which saw EMR adoption by primary care physicians more than double in Canada, from 23% in 2006 to 56% in 2012. Use of EMRs by community-based specialists has also increased. (www.infoway-inforoute.ca/index.php/news-media/2012-news-releases/use-of-electronic-medical-records-doubled-over-six-years)

The study demonstrates the potential of EMRs to improve communication among members of the care team, as well as communication between providers and their patients. For example, 93% of physicians in Alberta's EMR program report that access to a summarized patient history means patients spend less time repeating the same information to care providers.

While the study illustrates how the benefits of EMR use are accruing today, it also shows the even greater potential that lies in the use of such advanced features as tools and alerts prompting follow-up that will help clinicians with illness prevention and management of chronic disease. For instance, a recent study found that primary care practices with EMRs conducted reviews of patient records (e.g., for medication recalls) approximately 30 times more quickly than paper-based clinics.

Healthcare Improvement Projects Chosen for High Impact Potential

Ten high-calibre inter-professional healthcare teams from across the country have been selected for the Canadian Foundation for Healthcare Improvement's elite training program known as EXTRA (EXecutive TRAining for Healthcare Improvement). The EXTRA teams will acquire the skills and knowledge over 14 months to launch, implement and sustain major quality improvement initiatives of strategic importance to their organizations and regions. Working with prestigious academic mentors and change management coaches, the EXTRA teams' projects further CFHI's goals to enhance patient outcomes, quality of care and cost-effectiveness.

This 10th cohort aims to become change agents in a host of healthcare areas, including the reduction of antipsychotic medication use among patients with dementia in long-term care; safe transitioning from pediatric intensive care to the ward; and effective strategies for the flow and efficiency in the use of regional emergency departments. One example of a strong and innovative partnership team includes staff from Bruyare Continuing Care, Toronto's University Health Network and the University of Ottawa, which will develop a first-ever framework for case costing in long-term care in Ontario. Case costing is a way to improve resource allocation by providing accurate information on resource utilization and educating leaders to use the results to make sound financial decisions. The project has high impact potential in Ontario and in other jurisdictions across Canada, as Ontario's Standardized Case Costing system (in rehabilitation and acute and complex continuing care, among other areas) is regarded as an international leader.

Another team – Centre hospitalier de l'Université de Montréal – is striving for a safer and more efficient transfer of patients among multiple healthcare facilities, to reduce cost and the incidence of adverse events. Yet another team, from the Toronto-based Centre for Addiction and Mental Health, is developing, implementing and evaluating an integrated care pathway (ICP) for schizophrenia, which affects some 350,000 Canadians and costs over $7 billion annually. The team hopes the ICP will benefit patients with other mental health and addiction diagnoses and serve as a catalyst for the transformation of mental health systems across Canada.

Dr. Alain Beaudet Reappointed as President of CIHR

The Honourable Leona Aglukkaq, minister of health, has announced the reappointment of Dr. Alain Beaudet as president of the Canadian Institutes of Health Research (CIHR) for a five-year term. Dr. Beaudet has served as CIHR president since July 1, 2008. Prior to his appointment, he was president and chief executive officer of the Fonds de la recherche en santé du Québec from 2004 to 2008. He holds many honours and distinctions. In 2007, France bestowed upon him the Order of Academic Palms Distinguished Officer Award, and he was made doctor honoris causa of Université Pierre et Marie Curie. In 2011, Dr. Beaudet became a Knight of the National Order of Quebec, the highest honour awarded by that province's government. Most recently in 2012, he was awarded the Australian Society for Medical Research Medal and toured seven Australian cities as a keynote speaker to highlight the importance of patient-oriented research and illustrate how R&D can be used to face the health needs of aging populations and indigenous people. In November 2012, Dr. Beaudet was inducted as a Fellow of the Royal Society of Canada.

New Appointment to the Governing Council of CIHR

Dr. Paul E. Garfinkel has been appointed to the Governing Council of the Canadian Institutes of Health Research (CIHR) for a three-year term. Dr. Garfinkel is an accomplished healthcare administrator, renowned psychiatrist and researcher who has made landmark achievements in understanding the causes of anorexia nervosa. He is currently a professor in the Department of Psychiatry at the University of Toronto and a staff psychiatrist at the Centre for Addiction and Mental Health in Toronto, where he served as president and CEO from 1997 to 2009. Among his many honours, Dr. Garfinkel has received the Lifetime Achievement Award from the Academy of Eating Disorders, the Pacesetter Award from the Schizophrenia Society of Canada and a Public Service Award from the Canadian Mental Health Association. He became an Officer of the Order of Canada in 2009.

End-of-Life Hospital Care for Cancer Patients

The number of cancer patients who die in acute care hospitals varies across Canada. About two in three cancer patients in Manitoba (69%) and New Brunswick (66%) die in hospital, compared with two in five in Ontario (40%) and British Columbia (39%), according to a new study released by the Canadian Institute for Health Information (CIHI). CIHI's study, End-of-Life Hospital Care for Cancer Patients, examines the use of hospital services by cancer patients who died in acute care hospitals across Canada (excluding Quebec). More than 25,000 people died in hospital from cancer in 2011–2012, representing 45% of all estimated cancer deaths that year. Differences in the availability of palliative care beds in some provinces, and the location of such beds in others, may be contributing to the variations in in-hospital deaths.

The study found that about one in five (22%) patients was admitted to hospital with a sole diagnosis of palliative care. It is possible that some of these patients could have benefited from receiving their end-of-life care somewhere other than a hospital. For example, more than one-

third (34%) of patients with a most responsible diagnosis of palliative care had stays longer than two weeks. This could have been enough time to arrange for care in an alternative setting, if this was the preference of these patients and if such care were available.

The majority (84%) of the patients in CIHI's study died in a hospital with an intensive care unit (ICU). However, only 11% were admitted to the ICU in their final two weeks of life, and only 8% died there. Additionally, very few (3%) patients received inpatient chemotherapy treatment within their final 14 days. CIHI also found that more than four in five (82%) patients had a documented palliative care diagnosis during their last admission. Palliative care was the main reason for hospitalization for more than half (53%) of all patients in the study. However, it is not known what specific palliative care services were received or how many people may have had access to alternative palliative settings, such as hospice or home care.

Cancer patients from rural areas were more likely to have multiple hospital admissions in their last four weeks of life than their urban counterparts. Almost one in three (30%) rural patients had two or more admissions, compared with one in five (20%) urban patients. CIHI found that, across the provinces, the proportion of patients admitted to hospital multiple times in the last 28 days of life was highest in Saskatchewan (31%) and Newfoundland and Labrador (28%) and lowest in Nova Scotia (21%), Prince Edward Island (21%) and Manitoba (19%).

Adverse Drug Reaction-Related Hospitalizations among Seniors, 2006–2011

One in 200 seniors was hospitalized because of an adverse drug reaction (ADR) in 2010–2011, compared with one in 1,000 of all other Canadians. This translates to approximately 27,000 people age 65 and older, according to the Canadian Institute for Health Information. Blood thinners, often used to prevent heart attack and stroke, were the drug class most commonly associated with ADR-related hospitalizations among seniors (12.6%). This was followed by chemotherapy drugs (12.1%) and opioids, a class of strong pain killers (7.4%). The most likely reasons for hospitalization varied based on the drug class. They included bleeding from blood thinners, low white blood cell count from chemotherapy drugs and constipation from opioids. In some cases, these reactions were related to challenges with determining and maintaining the proper dosage. Following an ADR-related hospitalization, a change in dosage was common for both blood thinners (for which there tends to be a small difference between an effective and a harmful dose) and opioids (which tend to require dose adjustments to balance pain relief and unwanted effects). The factors most often associated with hospitalization for adverse drug reactions are the number of drugs, age and being hospitalized in the previous year.

Medication review and management can help reduce the number of ADRs and other adverse events such as drug interactions, which are associated with using a higher number of drugs. Implementation of drug information systems, a key component of the electronic health record, will help with medication reviews by providing a more complete picture of patients' medications.

Newfoundland Offers New Master's Program to Prepare Nurse Practitioners for Advanced Nursing Roles

A new nurse practitioner master's program is being offered through Memorial University School of Nursing in collaboration with the Centre for Nursing Studies. The Master of Nursing, Nurse Practitioner Option, which began in January 2013, will see the enrolment of 12 to 16 women and men annually. It is the result of a provincial government investment of approximately $3.6 million in core funding over the next five years. The first class of students will graduate from this program in October 2014. The new master's program will prepare nurses to work in expanded roles in acute care areas such as emergency rooms, mental health and cardiac care, as well as long-term care and outpatient clinics. This program is unique in that it is offered through distance education, which allows nurses to advance their education while continuing to work in their field.

Currently, there are 123 nurse practitioners registered to practise in Newfoundland. In 2011, the province had 21 nurse practitioners per 100,000 people, the second highest number in Canada. This number has since increased to 24. The master's program will not only deliver a higher level of education and training to nurse practitioners in the province, but will advance patient-centred care and healthcare services overall now and in the future.

New CIHR-GSK Chair in Pediatric Vaccinology

Dr. Joanne Langley was the recent recipient of the new CIHR-GSK Chair in Pediatric Vaccinology. Dr. Langley is a professor at Dalhousie University, a pediatric infectious disease specialist at IWK Health Centre and director of the Clinical

Evaluation Group at the Canadian Center for Vaccinology in Halifax. The chair will provide funding to support Dr. Langley's work in the development and improvement of vaccines for children, including the way vaccines are administered. Her research will also look at immunization strategies for preventing influenza and other respiratory problems in children.

The new chair is supported by a $700,000 investment from the federal government through the Canadian Institutes of Health Research (CIHR) and GlaxoSmithKline (GSK). The funding is part of Canada's Strategy for Patient-Oriented Research, a national initiative to ensure better translation of research findings into clinical practice.

The centre is a collaboration among Dalhousie University, the IWK Health Centre and Capital Health. It was established to develop, implement and evaluate vaccine technologies and vaccines for infectious diseases that have a significant impact on Canadian and global health.

Manitoba Government Investing in Safer Workplaces for Nurses, Other Healthcare Workers

The Manitoba government is investing $2 million to protect nurses, doctors, technologists, healthcare aides and other healthcare staff from workplace violence as well as rolling out a new provincial violence-prevention policy for all health facilities. Health Minister Theresa Oswald announced a new provincial violence-prevention policy that requires all health facilities to take steps to prevent violence, including:

- identifying risks of violence and taking appropriate steps to eliminate or minimize those risks;
- training healthcare workers to prevent and respond to violence-related incidents;
- developing an alert system so that staff can quickly identify potential sources of violence and take action to prevent or respond appropriately;
- ensuring staff can quickly summon security assistance should a violent incident occur or appear imminent, which could include the use of panic buttons or other personal communications devices, and a "code white" procedure to summon internal security personnel or nearby law enforcement officers; and
- requiring mandatory reporting and investigation of incidents to identify any changes that could improve workplace safety, and ensuring staff are offered debriefing and assistance such as counselling.

The minister noted that the new policy is required under new robust regulations focused on violence prevention in health facilities and was developed by the Minister's Advisory Group on Violence Prevention for Healthcare Workers, co-chaired by Prairie Mountain Health chief executive officer Penny Gilson and Sandi Mowat, president of the Manitoba Nurses Union and representative of the Manitoba Council of Health Care Unions.

Oswald said the $2 million will be used to implement the policy, including educating staff on identifying, preventing and responding to workplace violence, and possibly assisting health facilities with acquiring security equipment. The new policy and $2-million fund for health facility security build on other steps to improve workplace safety for health professionals. These include creating the Nursing Safety and Security Fund to invest in measures that improve safety and security for nurses in the workplace, avoiding injuries by installing more patient lifts and offering training on safe patient transfers.

Legislation Would Allow Nurse Practitioners, Midwives to Admit Patients to Hospitals

Manitoba has introduced legislation that would expand the role of nurse practitioners and midwives in the delivery of healthcare to Manitobans by allowing them to admit patients to hospitals.

Nurse practitioners are registered nurses with a master's-level education and clinical experience that allows them to diagnose illnesses, treat conditions, prescribe medications and order diagnostic tests. More than 100 nurse practitioners work in various healthcare facilities across the province including hospitals, QuickCare Clinics, primary care clinics and personal care homes.

Midwives are primary care providers who can order tests, prescribe medications for maternal/newborn care, diagnose and treat minor problems and attend births as the primary attendant. In Manitoba, midwives care for women and newborns in a variety of settings including hospitals, clinics, community health centres, patients' homes and the Birth Centre in Winnipeg. Currently, only doctors, and in some cases dentists, can admit patients to hospitals in Manitoba. More information on primary care in Manitoba is available at: www.gov.mb.ca/health/primarycare/index.html.

Technology Supports Heart Patients at Home

A group of Albertans living with heart failure will

have their condition monitored right from their homes as part of an innovative pilot project. The pilot is a collaboration among the Alberta government, Alberta Health Services and GE Canada.

The pilot, to be delivered through the Sherwood Park–Strathcona County Primary Care Network, will target about 250 patients over the age of 50 who are living with heart failure. Patients who are enrolled in the pilot will receive in-home technology developed by Intel-GE Care Innovations that will collect vital information, engage patients in their own care and enable a team of healthcare practitioners to manage patient care remotely.

The pilot project will accept applications for the program later this month, and after necessary approvals have been obtained. For more information on this program and patient eligibility, please visit www.myhomehealthcanada.com.

Licensed Practical Nurses Now Part of New Bargaining Structure

The government of British Columbia has enacted legislation allowing licensed practical nurses to be in the same bargaining structure as registered nurses. The Health Authorities Amendment Act was introduced on March 4 and received royal assent on March 14. Consultations with a variety of stakeholders, including health employers and union groups, were held following royal assent. Licensed practical nurses are professional nurses in the full sense of the term, as they have a defined and expanding scope of practice and their own college to oversee the administration and evolution of the profession. While the legislation is in force immediately, there will be a period for parties to work out the details of moving licensed practical nurses under the same collective agreement as registered nurses, with a deadline for this to occur by April 2014. This means that existing terms and conditions of licensed practical nurses' employment will continue until the amendments are negotiated, resulting in no immediate cost of bringing licensed practical nurses into the Nurses Bargaining Association.

New Associate Chief, Nursing Practice at SickKids

Mary McAllister has been appointed to the role of associate chief, nursing practice at Toronto's SickKids Hospital. McAllister comes to the position from Bridgepoint Health where she was director of professional practice, nursing. She has also held the position director of patient services and professional practice at North York Branson Hospital, and earlier in her career worked as a staff nurse in Neonatal Intensive Care at SickKids, as well as a clinical nurse specialist in the hospital's pediatric intensive care unit. McAllister has taught at the University of Toronto, Ryerson University and at the School of Nursing, Edith Cowan University in Perth, Australia. In her career, she has been active in several nursing professional organizations and has contributed to many advances in nursing practice, developed innovative programs and championed evidence-informed practice in a variety of health and academic settings provincially, nationally and internationally.