

**CANADIAN NURSES ASSOCIATION**

# **2011 Annual Report**



**CANADIAN  
NURSES  
ASSOCIATION**

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*May 2012  
ISBN 978-1-55119-385-4*

*Photos: Thinkstock; Greg Teckles Photography Inc.; Macdonell Photography*

*This annual report has been prepared by CNA to provide information on activities undertaken by the association in the pursuit of its mission, vision and goals.*

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# President's Message

## *Registered Nurses: Charting the course*

In 2011, Canada experienced election fever, with a round of provincial and territorial elections and a crucial federal election in the spring. This election was particularly important because the winning party would probably be the one to lead important negotiations for the future health funding arrangements between the federal government and the provincial and territorial governments.

There was no doubt that Canada's health-care system had reached a critical juncture in 2011, and Canada's leaders were at a crossroads. With the current 10-year health accord expiring in 2014, discussions were being ramped up regarding the urgent need to transform the health-care system into one that meets the changing health needs of Canadians. CNA swiftly recognized that the renewal of the health accord provided a good opportunity for Canada's registered nurses (RNs) to set out a road map outlining nursing's priorities for the future of our publicly funded health-care system.

Given the significance of the federal election and the looming expiry of the health accord, CNA took every opportunity to rally Canadians and RNs to weigh in on the many health-care debates and discussions taking place across the country. Together with the Canadian Medical Association, we developed a set of principles to guide Canada's premiers and health ministers as they considered how to tackle transforming the system. We also launched an independent National Expert Commission to consult with Canadians about how to shape the health-care system into one that meets the needs of Canada's population and then to generate policy solutions. Up until December 21, when Minister of Finance Jim Flaherty announced



the details of future federal transfers for health care, CNA was calling on the federal government to invest in health outcome targets under the next funding negotiations.

Throughout 2011, we continued our efforts to drive the nursing profession forward — promoting nursing excellence, presenting nursing as a vibrant profession and advancing the practice of nursing. We created many opportunities for nursing knowledge and expertise to be shared, through think-tank sessions, national task groups and summits, to name a few. We put forward ideas, promising practices and credible research on topics related to nursing practice, health and the health-care system. From a position statement on interprofessional collaboration to a major report on nursing-based solutions for reducing wait times, CNA armed RNs with evidence-based tools for practice. These thought-provoking resources also demonstrated to the public the exceptional expertise of our country's RNs.

Judith Shamian, RN, PhD, LLD (hon), D.Sci. (hon), FAAN  
President

*“Nurses are central to the health care of Canadians, who benefit from the knowledge, experience and expertise of nurses from cradle to grave.”*

*CNA president Judith Shamian*



# Reflecting on the Journey

## *New and Noteworthy in 2011*

### **Cross-country tour: Meeting nurses in their communities**

With its 18-month Cross-Country Tour, CNA launched a major outreach and engagement initiative to give our president and chief executive officer (CEO) opportunities for meaningful face-to-face conversations with RNs from all domains of nursing, students, government officials and decision-makers. By visiting RNs in their own communities, touring health-care facilities and speaking with students and faculty at nursing schools, CNA's team was able to get a good read on nurses' hot-button topics. These visits also gave RNs a chance to personally connect with their national nursing association.

The tour kicked off in the spring with trips to New Brunswick, northern British Columbia and the Yukon. In the fall, the tour made stops in Manitoba, Prince Edward Island, Nova Scotia and southern British Columbia. Member assemblies were a popular feature of the Cross-Country Tour; these were open forums for RNs to share their opinions and perspectives on the nursing profession and the health-care system.

Although unique issues were raised by RNs in each province and territory, common themes emerged. The need for more health promotion and disease prevention, better access to care, investment of resources outside the acute care system, more interprofessional teams and the need to reduce barriers so providers can practice to their full scope were all health system issues that CNA heard about at every stop. RNs and students also eagerly discussed successes or concerns about



changes in nursing care delivery models and sought support for nursing education.

On the tour, CNA's president and CEO brought these views to meetings with premiers, health ministers and other decision-makers to motivate them to take action on nursing issues. The lessons learned were also brought back to the CNA boardroom to help shape future work.

*"It's in all of our best interests to ensure a public debate about our health care, and it's up to all of us to participate."*

*National Expert Commission co-chair Maureen McTeer*

## **National Expert Commission**

CNA established its first-ever National Expert Commission in 2011, *The Health of Our Nation — The Future of Our Health System*, to generate policy solutions to transform the health system. The Commission is composed of a diverse group of Canadian experts and is co-chaired by two exceptionally capable and renowned leaders: Marlene Smadu and Maureen McTeer.

## **National Expert Commission**

**Better Health. Better Care. Better Value. Best Nursing.**



To meet its mandate, the Commission set out on a demanding year of consulting nurses and other health professionals, employers and unions, economists and business and government leaders on what must be done to shape the health-care system into one that is better equipped to meet the changing needs of Canadians. The Commission also teamed up with YMCA Canada to host round-table discussions with the public across Canada. Complementing these consultations were three commissioned research syntheses, a series of public polls, online surveys and a national call for written submissions.

Toward the end of 2011 the commissioners began to assess their findings, synthesize existing research results and develop recommendations for the final report, which will be released at CNA's biennial convention in June 2012.

## **NP awareness campaign: It's about time!**

Nurse practitioners (NPs) — RNs who have additional education and experience — provide quality care to many Canadians, help reduce wait times and increase people's access to services across the continuum of care. However, the value of the NP's role is not always well understood in our country.

CNA launched a creative public awareness campaign in the fall of 2011 to raise the profile of NPs. The campaign was piloted in Fredericton, N.B. and Ottawa, Ont. Its slogan, Nurse Practitioners: It's About Time!, contained three key messages: it's about time Canadians had more health-care options; it's also about the time that an NP spends with patients; and it's about the time that Canadians have to wait to see a health-care provider. The campaign's materials and [nknow.ca](http://nknow.ca) website urged Canadians to ask their governments to provide more NPs in their community. People answered CNA's call by viewing and sharing the NP video and sending letters to their elected representatives. Throughout the year, CNA took many opportunities to urge politicians to reduce the legislative barriers that prevent NPs from practising to their full scope. Given how well the pilot was received, the green light was given to take the campaign into other jurisdictions over the next two years.

One of the highlights of CNA's annual meeting was a cake celebrating the certification program's 20th anniversary.



## **CNA certification: Celebrating 20 years of excellence**

The CNA Certification Program began in 1981 with a single nursing specialty. Twenty years later, the program has become internationally recognized, boasting 19 specialties/ areas of nursing practice, and certification is a source of pride for thousands of RNs. The certification program celebrated its 20th anniversary this year, ringing in the occasion with a special acknowledgment at CNA's annual meeting in Ottawa.

CNA certification is a recognized credential that RNs can achieve by meeting specific nursing practice criteria, fulfilling continuous learning and successfully completing a rigorous exam. In 2011, more than 3,600 RNs earned or renewed their certification, joining a growing network of specialized nurses in areas of nursing practice ranging from critical care pediatrics to rehabilitation. As of Dec. 31, more than 16,800 RNs hold a current CNA certification credential.

*“Things are moving so fast in the world of nursing: new treatments, novel technologies and innovations in care mean that nurses have to put a serious effort and a great deal of study into staying current.”*

*CNA president Judith Shamian*



# Routes to a Better Health System

*CNA takes a stand on pressing health issues and advocates for healthy public policy*

## **Journey toward health system transformation**

From their vantage point at the heart of health-care delivery and the health system itself, RNs know well that the health-care system needs considerable improvements. Problems like nursing shortages, hospital bottlenecks, lengthy wait times and the high prevalence of chronic diseases are felt nationwide.

Despite these problems, the ongoing discussions around health-care system transformation provide opportunities for nurses to help lead the health-care system down the right path. Understanding that the 2004 accord was set to expire in 2014, CNA continually called for the nursing community, politicians and the public to focus on how best to transform the system. Throughout the year, we spoke out about what is needed as a start: a national pharmacare program, an electronic health record for every Canadian, a national strategy on aging and health and a greater focus on community-based care services. Further, we emphasized the need for a pan-Canadian approach to health care transformation that meets the real needs of Canadians.

## **Election: Engaging in healthy debate**

The spring federal election proved to be a prime opportunity to push health care to the forefront. This was an especially important election for health care: the winner of the election would probably negotiate the next health-care funding agreements with the provinces and territories.



*“CNA’s priority is to make Canadians healthier, and we need federal government leadership to secure success.”*

*CNA president Judith Shamian*

Leading up to voting day, CNA ensured the public understood the election’s significance and rallied RNs to get actively involved in health care issues. CNA developed election resources and tools to arm RNs with key questions to ask of their political candidates. Our Elections 2011 website became a one-stop hub for RNs to become equipped to engage in the election process. The site included interactive tools for writing letters to candidates or local newspaper editors and featured CNA’s position on health care matters, including pharmacare, affordable housing, air and water quality, climate change, home care and mental health, among others.

After the election, CNA urged members of Parliament to keep the election promises they had made on health care and continued to push politicians to develop a national health care vision.

### **Principles: Guiding health care transformation**

A message Canadians heard loud and clear in 2011 from many health-care sectors was that Canada’s health system needs to evolve for the better. Many health-care sectors were left wondering how to go about producing the necessary changes. For Canada’s RNs and physicians, the answer was straightforward: this evolution needs to be guided by a common framework.

To that end, CNA and the Canadian Medical Association (CMA) jointly developed a set of guiding principles for the transformation of the country’s health system. Both associations strongly believe that by adopting these principles Canadian leaders will ensure a publicly funded, not-for-profit system that is sustainable and adequately resourced with universal access to quality care. Shortly after the release of *Principles to Guide Health Care Transformation in Canada*, momentum started to build, and more than 60 groups from the health-care sector lined up to endorse the principles.



*“We’re advocating for the government to make the health of Canadians a priority and focus efforts on bringing care options as close to home for Canadians as possible.”*

*CNA president-elect*

*Barbara Mildon*

As federal, provincial and territorial governments set out to consider health care renewal, CNA and CMA consistently offered these principles to guide their discussions. In advance of the premiers’ Council of the Federation meetings in 2011 and early 2012, we called on the leaders to take a serious look at the evidence and best practices outlined in our guiding principles.

### **Speaking up on important health issues**

CNA focused much of its efforts in 2011 on presenting nursing’s views on health matters with the goal of encouraging politicians to take action on making Canada the healthiest nation it can be. We argued that Canada’s aging population, the rise in prevalence of chronic disease and the ever-present shortage of health-care professionals require a national plan that protects medicare and meets Canadians’ health needs.

In the fall, CNA’s leadership made presentations to three parliamentary committees, sharing RNs’ message that a greater emphasis on community care is needed in the health-care system. We presented evidence that Canadians will benefit if the system moves beyond a hospital-focused, acute care approach to health. According to the Public Health Agency of Canada, costs associated with chronic diseases represent 67 per cent of all direct health care costs. As CNA’s leaders pointed

out in these presentations, community-based services and care provided by interprofessional teams can help Canadians better understand their health and manage their chronic diseases — ultimately leading to lower health care costs.

CNA also took opportunities to press the federal government for accountable, efficient, quality care. As part of the pre-budget consultation process with the House of Commons Standing Committee on Finance, CNA president-elect Barbara Mildon presented some of the nursing profession's solutions for optimizing the health system. CNA's brief contained recommendations to make the system more accountable to the public, maximize the capacity of the health-care workforce and boost access to preventive and primary care services.

### **Insite: RNs support harm reduction**

In 2011 CNA joined the Registered Nurses' Association of Ontario (RNAO) and the Association of Registered Nurses of British Columbia (ARNBC) to present a case before the Supreme Court in support of Insite, a supervised safe injection facility in Vancouver.

Leading up to this case, the federal government had appealed B.C. court rulings that gave Insite constitutional protection to operate. Without this protection, RNs

could be exposed to criminal penalties for carrying out their ethical and professional obligations to care for their patients — a situation that CNA, RNAO and ARNBC strongly opposed. Together, the three nursing associations applied for and were granted intervener status by the Supreme Court. On the same day that the three associations presented their arguments to the Supreme Court, CNA also released a discussion paper, *Harm Reduction and Currently Illegal Drugs: Implications for Nursing Policy, Practice, Education and Research*. Following the Supreme Court's unanimous ruling in September to keep Insite open, CNA, RNAO and ARNBC celebrated the decision as a victory for harm reduction and noted its significance for nursing practice.

# PROFILE

## KAREN OLDFORD

### **This nurse practitioner found a natural connection between local politics and nursing**

Karen Oldford's "day job" is as a full-time primary health care NP in Labrador City (population about 9,000). She has also been the deputy mayor since her election to municipal council in 2009.

Two years before that, Oldford had taken a run at a Liberal seat in the provincial election. Despite the support she received as a candidate, she was unsuccessful — although many local residents told her afterward that they were reluctant to vote for her because they didn't want to lose their NP.

Oldford got her first taste of political action when she joined the Newfoundland and Labrador Nurses' Union (NLNU) back in 1988. She was part of the negotiation team that battled Brian Tobin's government for better wages for nurses, efforts that led to a nine-day strike in 1999. Although legislated back to work, the nurses forced the government to make classification system changes that raised wages to meet the nurses' demands. Not long after the strike, Oldford was elected the union's provincial secretary-treasurer. She gained a thorough education in politics and leadership; the union was constantly lobbying the federal and provincial governments to improve health care.

Oldford describes her foray into municipal government as "a natural extension" of her nursing work. "In my practice, when I'm dealing with population health, I'm dealing with all the determinants of

— This profile is condensed from “Nurse to Know: On double duty in Labrador City,” by T. Tosh Kennedy, *Canadian Nurse*, April 2011.



health that are affected by politics and policy, such as safe drinking water, community policing and recreation.”

Being an NP gives Oldford an opportunity to use the full scope of her nursing skills. In the last few years, she has run women’s wellness clinics, assessed palliative care patients, been consulted by the public health nurse on baby and mother issues, talked to teens about sexual health, and given presentations on smoking cessation, menopause and other health issues.

Following her studies to become an NP, she faced an uphill struggle lobbying for an NP position to be created in her community. After a part-time position was approved in 2005, it was the local residents who persuaded the region’s health authority that they needed someone full time.

In the fall, Oldford took another try at provincial politics but did not win a seat. “Politics allows me to use my nursing knowledge and skills to help meet the needs of my community by advocating on their behalf for healthy public policy. The ability to advocate, highlight and discuss those needs in an open public forum is what makes the political election race rewarding, regardless of the final outcome!”



# Facing Speed Bumps and Detours

*CNA is committed to the revitalization of our association and primed to handle challenges that come our way*

## **New relationship forms as CRNBC leaves**

CNA experienced changes to its membership in 2011. The College of Registered Nurses of British Columbia (CRNBC) ended its long-standing jurisdictional relationship with our association. And we were pleased to collaborate with the Association of Registered Nurses of British Columbia (ARNBC) to bring the voice of B.C. nurses to the CNA board table.

CNA and the recently formed ARNBC are working in partnership to ensure the professional voice of B.C. nurses is heard. This partnership announcement followed CRNBC's decision to assign its jurisdictional rights back to CNA effective Aug. 31, 2011. As part of this new partnership, CNA and ARNBC entered into a 12-month memorandum of understanding to engage with individual nurses and nursing stakeholder groups in B.C. Both associations felt it important that B.C.'s RNs be represented at the national level on professional nursing issues and social and health matters. As a first step, a joint forum was held in September to get B.C. RNs' input and advice on the current and future governance and structure of ARNBC and the needs of B.C. nurses. In addition, in November, one of ARNBC's co-chairs began representing B.C. on the CNA board. In turn, a CNA representative began to participate in meetings of the ARNBC board.

CNA was disappointed by the decision of the CRNBC board in April 2010 to gradually withdraw from CNA. CRNBC believed this withdrawal was necessary in light of concerns about the incompatibility between CRNBC's and CNA's respective mandates and functions. Specifically, under the B.C. *Health Professions Act*, CRNBC's mandate consists purely of nursing regulation; the college no longer functions as both a regulatory body and a professional association. Although CNA strongly believes that regulation and advocacy in the public interest are mutually compatible for nursing regulators, CRNBC disagreed.

CNA had hoped to find a solution but agreed to respect the decision of the CRNBC board. Thus, many discussions were held to find a measured way for CRNBC to end its jurisdictional membership in CNA. CRNBC and CNA announced a joint agreement, effective Aug. 31, that provided for CRNBC to assign its jurisdictional membership in CNA to CNA in order to maintain the voice of B.C. RNs and NPs at the national level. The agreement means CRNBC registrants will continue to be represented on the CNA board by a B.C. RN and at the CNA annual meeting through B.C. voting delegate(s). CRNBC will also continue collecting CNA fees from registrants at initial registration and registration renewal and will transfer these fees to CNA.

*“ARNBC has worked for the past year on developing its relationship with CNA...and laying the groundwork for a new association that will continue the strong tradition of B.C. nurses working in association with one another.”*

*ARNBC, in an update to members on its website*

## New entry-to-practice exam

On the 2nd of December, 10 of the RN regulatory bodies in Canada announced that the National Council of State Boards of Nursing (NCSBN) had been selected to develop a new state-of-the-art, computer-based entry-to-practice exam for future RN candidates. The new exam would replace the current entry exam, the Canadian Registered Nurse Examination (CRNE), by January 2015. Currently, those RN regulatory bodies purchase the CRNE exam from CNA for use in their jurisdictions.

CNA, through its wholly owned subsidiary testing company, Assessment Strategies Inc. (ASI), has successfully and competently developed and maintained the CRNE for the past 40 years. The presidents and chief executive officers (CEOs) /executive directors (EDs), representing the 10 RN regulatory bodies, had been discussing a move toward a computer-based exam as far back as 2000.

In February 2011 the CEOs/EDs informed CNA of their intent to issue a global Request for Proposals (RFP) for the development of a state-of-the-art computer-based exam. ASI led a consortium that responded to the RFP; however, after a review of the proposals submitted, the CEOs/EDs selected the NCSBN as the successful vendor. Following the notification of the successful vendor, the National Council of State Boards of Nursing announced that the

NCLEX-RN® would be coming to Canada as early as 2015 for the purpose of licensing new RNs. This announcement sparked questions and concerns among Canadian nurses and nursing organizations.

On December 9, CNA president Judith Shamian launched a campaign in favour of a made- and owned-in-Canada exam. The goal of the campaign was to inform, build awareness and allow RNs and the public to share their opinions or contribute to the dialogue. Components of the campaign included video messages and media interviews. CNA also encouraged RNs, nursing students and members of the public to share their opinions or concerns by sending form letters to their provincial/territorial ministers of health and regulatory bodies.

As 2011 was coming to an end, CNA began developing a declaration of principles essential to any negotiations undertaken for the development of the new exam. The declaration, launched during a news conference in January 2012, included seven principles supporting a made- and owned-in-Canada exam.

Toward the end of the year, the RN regulatory bodies and CNA began exploring ways to move forward to maintain a strong relationship and support each others' respective roles in advocacy and regulation.

*“The decision regarding the... RN entry-to-practice exam directly affects the future of quality health care that will be provided to Canadians by effectively changing the testing to entry-to-practice competencies.”*

*Canadian Nursing Students' Association president and CNA Board member Evan Jolicœur*

### **Strengthening nursing globally**

Through the Strengthening Nurses, Nursing Networks and Associations Program (SNNNAP), CNA continued its long-standing tradition of providing direct funding to nursing association partners in seven countries across the globe and one network of 15 national nursing associations in the southern African region. The program was funded by the Canadian International Development Agency (CIDA). With mentoring and technical assistance from Canadian nurses, SNNNAP helped the associations strengthen their ability

to contribute to their country's health systems. CNA and Canadian mentors from our nursing jurisdictions carried out numerous missions to SNNNAP partner nations. For instance, a workshop for nurses in Burkina Faso focused on how to influence the health and nursing priorities of their country's national health plan. Workshops in South Africa and Zambia for members of the Southern African Network of Nurses and Midwives focused on developing exemplary leadership practices. Here in Canada, SNNNAP and the College and Association of Registered Nurses of Alberta co-hosted Globalization: Its Impact on Nurses and Health Systems, a workshop for Alberta RNs, nurse educators, nurse leaders and students. These are just three of the many workshops carried out in 2011.

Just days before the end of the year, CNA learned that CIDA had rejected SNNNAP's proposal for CIDA funding of the program for 2012-17. The news that SNNNAP would not exist after March 2012 was disconcerting to CNA, to its national nursing association partners and colleagues in developing countries and to the mentors who have worked with the program. CNA quickly mobilized to work with our global colleagues to support them as they develop plans to address the loss of funding and support.

# PROFILE

## ROSE LOPETRONE

### **This RN has a new lease on life after narrowly escaping a cardiac crisis**

It snuck up so gradually, she hardly noticed it, but by September 2009, Rose Lopetrone could no longer ignore that she was dead tired. Hardly surprising, she thought, for a 40-something nurse who had, in recent years, earned a master's degree while working full time and raising a teenage son.

High time she got back in shape, she decided. Then one day she became breathless while running on a treadmill, and the machine pegged her heart rate at around 170. She thought it was broken — then a sharp pain shot down her left arm.

"But I didn't do anything. I did the equivalent of pulling a blanket over my head, because coronary artery disease was my worst nightmare."

Lopetrone graduated from the nursing program at Victoria's Camosun College in 1989, later working part time in the cardiac ward at Royal Jubilee Hospital. Over the next few years, she completed a BSc in nursing from the University of Victoria.

But her time in cardiac care was a constant reminder of her family's struggles with heart disease. In 1993, her 60-year-old mother died during open-heart surgery. Six years later, Lopetrone's 40-year-old brother underwent a successful procedure to relieve a coronary artery blockage.

—This profile is condensed from “Nurse to Know: Rose Lopetrone: The changing face of heart disease,” *Canadian Nurse*, October 2011.



In 2001, Lopetrone left cardiac care for a day job at a geriatric assessment clinic. Since then, she has held a number of positions in home and community care and earned an M.A. in leadership from Royal Roads University in 2006.

For a month, the metaphorical blanket remained pulled snugly over Rose Lopetrone’s head. Her physical symptoms worsened.

Eventually, she saw her family physician, marking the beginning of three months of specialist visits and tests. At each turn, the verdict came back the same: there was nothing wrong with her heart.

Finally she saw an internal medicine specialist. Almost as an afterthought, he put her on a treadmill, where he spotted some ischemia on her ECG. She later underwent

a nuclear medicine test, which indicated her left ventricle was getting a dangerously insufficient amount of blood. “It was my worst nightmare — coronary artery disease — confirmed,” she says. Then an angiogram revealed a 95 per cent blockage in one coronary artery.

“I was so relieved that I didn’t have to have open-heart surgery... and that I was still here.”

She set about making a few simple lifestyle changes. That spring she took part in a 10K event. “Around the 9K mark, I got a little teary. I thought, ‘Wow, two months ago I would have died on this route.’”



# Paths to Professional Progress

*CNA provides evidence for practice and promotes nursing excellence*

## **Nursing solutions to bring down wait times**

*Registered Nurses: On the Front Lines of Wait Times — Moving Forward* explores the complex challenges associated with wait times and features examples of nurse-driven solutions that are making a positive difference.

CNA released this report, a follow-up to a widely acclaimed document it published in 2009, at a national wait times conference in March. The report shows how RNs are stepping forward with cost-effective and proactive solutions to reduce and manage wait times, including the following:

- In Toronto, mobile emergency nurses are reducing wait times at emergency departments by making house calls to long-term care residents; their visits cost 21 per cent less than assessments completed in an emergency department.
- NPs opened a clinic in Sudbury, Ont., the first of its kind in Canada. NPs are providing comprehensive primary care, which includes performing physical assessments, treating illnesses and injuries, ordering laboratory tests, prescribing medication and monitoring patients with chronic illness, to several thousand patients who would otherwise go to an emergency department or walk-in clinic.

CNA continues to encourage health leaders, nurses and governments to use and evaluate initiatives like these to improve access to care and the efficiency of the system.

### Mapping the outcomes

CNA's years of involvement in the Canadian Health Outcomes for Better Information and Care (C-HOBIC) project resulted in the development of a joint publication with the International Council of Nurses (ICN) on nursing outcome indicators.

C-HOBIC uses the methodology developed in Ontario through the HOBIC program to collect standardized patient outcome data in regions of Saskatchewan and Manitoba. The focus was on supporting nurses to electronically collect information on patient outcomes that have proven to be responsive to nursing care and to learn to use that data to evaluate and plan care. The project, sponsored by CNA, included mapping C-HOBIC concepts onto the International Classification of Nursing Practice or ICNP®, an international standard nursing terminology for use in electronic health records. Although the

*“Use of international standards, such as ICNP® and C-HOBIC, will support efforts to share best practices on achieving patient outcomes across all settings where nurses practice.”*

*International Council of Nurses CEO David Benton*

original C-HOBIC project finished in 2010, CNA collaborated with ICN to create a publication in 2011 of that cross-mapping: *International Classification for Nursing Practice: Nursing Outcome Indicators Catalogue*. Canadian nurses are doing a great job of sharing these data standards with other countries to support the capture of nursing-sensitive patient data so we can better evaluate and improve the quality of nursing care.

## Looking toward a nursing report card

Nursing leaders understand the value of collecting data to measure nursing's contribution to quality care and assess patient outcomes. In a major think-tank session held in advance of the 2011 Nursing Leadership Conference, nurse leaders and thought leaders debated what a nursing report card for Canada should measure and how it should be implemented.

The think-tank session, co-hosted by CNA and the Academy of Canadian Executive Nurses (ACEN), was called Toward a National Report Card for Nursing. The goal was to work toward developing a report card that would contain structure, process and outcome indicators that could be used by all health-care sectors to measure nursing care.

Following this work, CNA and ACEN submitted funding proposals to the Canada Health Infoway and Health Canada to support several projects in 2012 related to piloting a national nursing report card. The proposals included letters of support from more than two dozen organizations.

*“We have set ourselves on the path of higher quality health information in Canada — and better health information leads to sounder evidence-informed decisions.”*

*CNA president-elect Barbara Mildon, in an address to the Nursing Leadership Network of Ontario*

## Working together on nursing care delivery models

Designing nursing care delivery models and making decisions about staff mix are complex tasks. In recent years, nurse leaders, administrators and policy-makers have been seeking evidence on how delivery models and staffing decisions affect client, staff, organization and system outcomes. CNA continued the valuable work it began in this area in 2010.

Firstly, the *Invitational Round Table Nursing Care Delivery Models and Staff Mix: Using Evidence in Decision-Making* report was published in 2011. It highlights research evidence presented at the 2010 round table, gives examples of how nurse leaders are making changes and makes recommendations for optimizing the staff mix of RNs, licensed or registered practical nurses (LPNs) and registered psychiatric nurses (RPNs).

Secondly, the Staff Mix: Regulated Nurses and Unregulated Care Providers Working Group, created in 2010, continued its focus on reviewing and updating a staff mix framework, developing guiding principles for nursing care delivery models and publishing a focused literature review and

policy documents. These activities culminated in the publication of a major consensus document, *Staff Mix Decision-making Framework for Quality Nursing Care*, which was approved by CNA's board of directors in late 2011. The report presents a systematic approach to staff mix decision-making that can be used in clinical practice settings in all sectors across the continuum of care. The framework as well as the literature review and the principles for nursing care delivery models were scheduled for publication in early 2012.

# PROFILE

## DIANE DORAN

### **This leading researcher recognizes the power of nursing research**

Diane Doran is part of an intellectual lineage stretching back to Florence Nightingale and the beginnings of modern, scientific nursing.

Nightingale insisted that the only way to assess the efficacy of caregiving was to gather, tabulate, interpret and present pertinent data on patient outcomes. The evidence obtained from the crunching of numbers, she felt, could then be used as a tool to improve both practice and policy.

A century and a half later, Doran continues the Nightingale tradition at the University of Toronto. She instructs doctoral students in research methods and serves as scientific director at the Toronto site of the Nursing Health Services Research Unit (NHSRU), where she supervises staff and consults with a broad range of nurse leaders, educators, professional associations and policy-makers.

“We’re building science, testing theories and contributing to the development of a body of literature that will inform future research concerning nursing health services,” says Doran of NHSRU.

Her primary focus is on research intended to improve the capacity of nurses to deliver high-quality patient care. Her past projects have included studies of the nursing workforce, investigations of nurse-sensitive outcomes and explorations of how the latest portable electronic devices can be used to support evidence-based practice.

—This profile is condensed from “Nurse to Know: Diane Doran: Research wins out,” by D. McDonald, *Canadian Nurse*, May 2011.



As an expert on nursing outcomes measurement, she is much in demand, teaching and giving workshops internationally. She has also found time to edit a second edition of her landmark volume *Nursing-Sensitive Outcomes: State of the Science*.

But Diane Doran is no ivory-tower academic. In fact, she spent many years on nursing's front lines, the fulfilment of a childhood dream. She eventually realized she wanted to lead efforts to advance nursing knowledge through research. So she enrolled in the master's in health sciences program at McMaster University, graduating in 1985.

Then, in 1989, she started a doctoral program in health administration at the University of Toronto. Her thesis examined ways to improve quality in the delivery of health care services. As she finished her studies, she

wasn't sure whether to pursue a research career or a senior leadership role in a health care organization. “Research won out,” she says.

“What drives me is the opportunity to improve the way care is delivered, to improve the experience for patients,” she says. “You may not see it immediately — sometimes it takes a while for it to bubble to the surface. But what motivates me is the belief that my research can have an impact, that there's a real opportunity to influence change.”

Spoken like a true descendent of Florence Nightingale.



## Roads that Connect

*CNA reaches out and interacts with RNs through special events and connects RNs with tools to advance their practice*

### **NurseONE: Keeping RNs current, credible, competent and connected**

Through this web-based health information service, RNs across the country can connect with each other — and to credible, up-to-date electronic resources that support patient care and tools for lifelong learning. Access to NurseONE is a significant benefit of CNA membership.

NurseONE's collection was enhanced this year through the regular posting of new webliographies on chronic disease management, the stigma of mental health, knowledge dissemination, health literacy, obesity, aging, moral distress and ethical dilemmas. There were also four knowledge features: chronic disease management, health literacy, evidence-informed decision-making and dietary sodium. Over 4,000 nurses accessed the online modules, entitled Bringing the Code of Ethics to Life.

In 2011, NurseONE welcomed the addition of Longwoods.com to its e-library. Longwoods publishes Canadian research, opinion pieces and news related to health sciences and health care. This arrangement provides nurses with access to the full texts of leading journals, including *Healthcare Quarterly*, *Healthcare Papers*, *Nursing Leadership*, *Healthcare Policy*, *Electronic Healthcare*, *World Health & Population* and *Law & Governance*. NurseONE also introduced a new feature allowing students to register directly, and a new logo and slogan — Are you connected? — was created to encourage more nursing students and RNs to subscribe to its services.

# ARE YOU connected?



*“We heard from a number of veteran nurses who got ‘hooked’ on NurseONE after a student showed them what a powerful resource it is.”*

*CNA CEO Rachel Bard, in an address to nursing students at the Canadian Nursing Students’ Association conference*

## **Canadian Nurse: Leading nursing magazine**

Since 1905, *Canadian Nurse* has presented promising ideas, expert opinions, research and news to inform and inspire RNs across the country. The magazine’s content, in its print and online versions, represents the diverse nature of nursing, professionally and demographically.

*Canadian Nurse* implemented recommendations from its readership survey, including publishing features that expand the magazine’s scope and engage a broader range of readers. Two new columns were introduced: Ask the Expert, which answers readers’ questions about their professional practice, and The Research File, which provides fresh perspectives on the latest research and innovations in nursing. The September 2011 issue also saw the launch of a redesign of the magazine, one that freshened its look and brought consistency to its design elements.



# Put progress into your practice



## Progress in Practice: CNA webinar series

CNA's Progress in Practice webinars are online learning tools, and they provide a way for RNs to use technology to connect with others on practice issues in their specialty area of nursing. The popular webinar series connected more than 1,000 RNs with practical, evidence-based tools and resources to support them in their practice settings. CNA hosted eight webinars on interesting topics: new medication practices, helping during international emergencies, understanding and managing intra-professional aggression, ethics mentoring, becoming CNA certified, navigating NurseONE, using an elder-friendly approach to reduce and prevent constipation, and the role of CNA's independent National Expert Commission in health system transformation. Webinars were offered in both English and French, and audience numbers grew for webinars in both languages over the course of 2011.

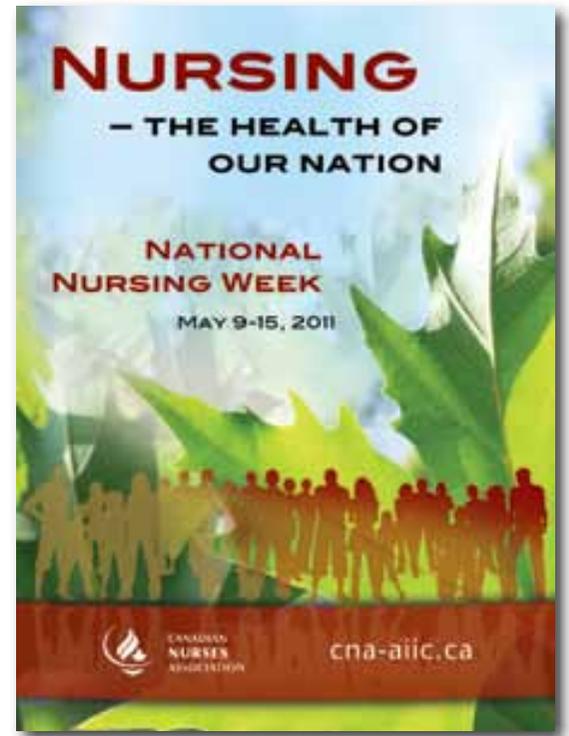
## Nursing Leadership Conference: Following the leaders

The Nursing Leadership Conference brought together nearly 400 nurses from across the country to grapple with the challenging question of Nursing Leadership: So What? Now What? Held in Montreal in February, the conference addressed many aspects of leadership, including understanding how new graduates perceive leadership and the challenges RNs face in implementing modest changes within their workplaces.

Unlike discussions at previous nursing leadership conferences, those at the 2011 event focused less on the profession's internal leadership structures than on the ways RNs are spearheading initiatives that improve system outcomes and patient care. These stories were inspiring for participants because they showed the strong resolve of RNs to effect change.

## National Nursing Week

Through this special event, held every year the week of May 12 — Florence Nightingale’s birthday — CNA raises awareness of the role RNs play in the health and well-being of Canadians. This year’s theme, Nursing — The Health of Our Nation, prompted the public to recognize the cumulative impact of individual nursing gestures in building a healthy society. It specifically drew attention to RNs’ advocacy roles, innovations in research and clinical care, and efforts to defend medicare.



# PROFILLE

## LINDA MOSHER

### **This RN teaches medical students the value of truly communicating with patients**

When she examines patients in the emergency department at the Cobequid Community Health Centre in Lower Sackville, N.S., she checks them over with the care and expertise that come from 40 years of nursing. But Linda Mosher also listens closely for the makings of a compelling story.

Since 2002, she's been one of four educators at the simulated patient program at Dalhousie University's faculty of medicine in Halifax, serving as playwright, stage manager and director. She develops character descriptions of patients, trains the people who portray them and designs the scenarios for them to perform with second-year medical students. The program's purpose is to teach future physicians how best to communicate with real patients in clinical situations.

A few days each month, Mosher pulls out the scripts and starts prepping the simulated patients. She and her colleagues teach them how to give hints about their illnesses through their movements — describing and demonstrating how someone with a broken bone would move and sit, for example. During this practice, the simulated patients join her in critiquing each other's performances.

—This profile is condensed from “Nurse to Know: Keeping it real: Putting ‘patients’ and medical students through their paces,” by K. Kelly, *Canadian Nurse*, February 2011.



Makeup is an essential ingredient of a convincing patient simulation. “If the patient is supposed to be pale, we use white makeup with some gray around the eyes,” explains Mosher. The makeup kit also includes temporary tattoos for depicting melanomas and psoriasis.

Mosher must ensure that the simulated patients know their characters and medical conditions inside out, so that they can offer feedback and any necessary corrections to students when the simulation is over. “The students have to know that this isn’t a game of make-believe, that this is what they’re going to see,” she says. “In a scenario in which they confront someone with alcoholism, for example, they may initially handle the situation very offensively.”

In this educational setting, the students are given a chance to try again, which can be particularly helpful in circumstances that require them to deliver bad news.

As a patient herself, Mosher has seen the need for these types of practice sessions. “Sometimes when I go to a doctor, I’m thinking, ‘You didn’t go through the communication program — your skills are not good,’” she says with a laugh.



# Milestone Publications

## *Reports*

- *Canadian Nurse Practitioner Examination: Family/All Ages Prep Guide, Second Edition*
- *Collaborative Integration Plan for the Role of Nurse Practitioners in Canada*
- *Harm Reduction and Currently Illegal Drugs: Implications for Nursing Policy, Practice, Education and Research*
- *Invitational Round Table Nursing Care Delivery Models and Staff Mix: Using Evidence in Decision-Making*
- *Principles to Guide Health Care Transformation in Canada* (co-authored with CMA)
- *Registered Nurses: On the Front Lines of Wait Times — Moving Forward*
- *Which Doors Lead to Where? How to Enhance Access to Mental Health Service: Barriers, Facilitators and Opportunities for Canadians' Mental Health* (a report of the Mental Health Table)

## *Presentations and briefs*

- *Canada's Health Accountability Plan*. Pre-budget Brief to the House of Commons Standing Committee on Finance
- *Chronic Disease Related to Aging*. Brief to the House of Commons Standing Committee on Health

- *Elder Abuse*. Brief to the House of Commons Standing Committee on the Status of Women
- *Review of the 10-year Plan to Strengthen Health Care*. Brief to the Senate of Canada Standing Committee on Social Affairs, Science and Technology
- *Promoting Physical Activity*. Brief to the House of Commons Standing Committee on Health

## Letters

- to members, in recognition of World AIDS Day, acknowledging RNs' contribution around the world to address HIV/AIDS
- to CRNBC, to thank the college for its years of commitment, following the end of CRNBC's membership in CNA
- to the family of Jack Layton and the New Democratic Party on the passing of the NDP leader
- to members on CNA's continued monitoring of the trials of a group of Bahraini nurses and doctors
- to the minister of foreign affairs on the 23 doctors and 24 nurses in Bahrain, who were arrested and charged with undertaking anti-state activities for providing care to injured protestors
- to the prime minister on the need to demonstrate leadership on health care reform
- to members and the public on celebrating National Nursing Week by acknowledging nurses' contributions to society
- to members, encouraging them to engage people on the health care issues of the federal election
- to members, encouraging them to learn more about the political parties' health care platforms before the federal election
- to the prime minister on a pan-Canadian health human resources strategy
- to members on CNA's commitment to maternal health globally, in recognition of International Women's Day
- to members on recognizing International Day of Zero Tolerance to Female Genital Mutilation

### *Position statements and fact sheets*

- Global Health Partnerships
- Interprofessional Collaboration
- Physical Activity (co-authored with College of Family Physicians of Canada)
- Privacy of Personal Health Information fact sheet
- Registered Nurses, Health and Human Rights
- The Role of Health Professionals in Tobacco Cessation (co-authored with Canadian Association of Occupational Therapists, Canadian Counselling and Psychotherapy Association, Canadian Dental Hygienists Association, Canadian Medical Association and Canadian Physiotherapy Association)

### *Online tools on NurseONE*

- EBSCO database, Consumer Health Information on diseases, conditions and treatment procedures
- Longwoods collection of health care research, reviews, commentaries and news



**Canada's Health Accountability Plan**

Pre-Budget Brief to the House of Commons Standing Committee on Finance

August 13, 2014



**PRINCIPLES TO GUIDE HEALTH CARE TRANSFORMATION IN CANADA**

**PREAMBLE**

The Canadian Nurses Association (CNA) and the Canadian Nurses' Federation (CNF) are pleased to contribute to the development of the Health Care Transformation in Canada report. The CNA and CNF are committed to providing the highest quality of care to all Canadians and to ensuring that the health care system is efficient, equitable, and sustainable. This report provides a framework for the development of a health care system that is patient-centred, evidence-based, and accountable. It is intended to guide the development of a health care system that is patient-centred, evidence-based, and accountable. It is intended to guide the development of a health care system that is patient-centred, evidence-based, and accountable.

**PRINCIPLES**




**Harm Reduction and Currently Illegal Drugs**

Implications for Nursing Policy, Practice, Education and Research

Discussion Paper



[cna-aiic.ca](http://cna-aiic.ca)

**THE CANADIAN NURSE PRACTITIONER EXAMINATION: FAMILY/ALL AGES PREP GUIDE**

SECOND EDITION



[cna-aiic.ca](http://cna-aiic.ca)

Part of the Canadian Nurse Practitioner Exam Prep Series

**REGISTERED NURSES: ON THE FRONT LINES OF WAIT TIMES – MOVING FORWARD**





**COLLABORATIVE INTEGRATION PLAN FOR THE ROLE OF NURSE PRACTITIONERS IN CANADA**

2011-2015



November 2011





# CNA Associate and Affiliate Members and Emerging Groups

CNA relies on the expertise and support of our associate and affiliate members and emerging (AAE) groups, who represent a broad range of nursing specialties. As active members of CNA, AAEs are consulted on all policy documents, feeding into initiatives at the national level. Conversely, through these members CNA is able to reach out to many communities of practice.

## *Associate members*

Aboriginal Nurses Association of Canada (*ANAC*)  
Academy of Canadian Executive Nurses (*ACEN*)  
Canadian Association of Advanced Practice Nurses (*CAAPN*)  
Canadian Association of Burn Nurses (*CABN*)  
Canadian Association of Critical Care Nurses (*CACCN*)  
Canadian Association for Enterostomal Therapy (*CAET*)  
Canadian Association of Hepatology Nurses (*CAHN*)  
Canadian Association for the History of Nursing (*CAHN*)  
Canadian Association for International Nursing (*CAIN*)  
Canadian Association of Medical and Surgical Nurses (*CAMSN*)  
Canadian Association of Neonatal Nurses (*CANN*)  
Canadian Association of Nephrology Nurses and Technologists (*CANNT*)  
Canadian Association of Neuroscience Nurses (*CANN*)  
Canadian Association of Nurses in AIDS Care (*CANAC*)  
Canadian Association of Nurses in Hemophilia Care (*CANHC*)  
Canadian Association of Nurses in Oncology (*CANO*)  
Canadian Association for Nursing Research (*CANR*)  
Canadian Association for Parish Nursing Ministry (*CAPNM*)

Canadian Association of Perinatal and Women's Health Nurses (*CAPWHN*)  
Canadian Association of Rehabilitation Nurses (*CARN*)  
Canadian Association for Rural and Remote Nursing (*CARRN*)  
Canadian Council of Cardiovascular Nurses (*CCCN*)  
Canadian Family Practice Nurses Association (*CFPNA*)  
Canadian Federation of Mental Health Nurses (*CFMHN*)  
Canadian Gerontological Nursing Association (*CGNA*)  
Canadian Holistic Nurses Association (*CHNA*)  
Canadian Hospice Palliative Care Association — Nurses Interest Group (*CHPCA-NIG*)  
Canadian Nurse Continence Advisors Association (*CNCA*)  
Canadian Nurses for Health and the Environment (*CNHE*)  
Canadian Nursing Informatics Association (*CNIA*)  
Canadian Orthopaedic Nurses Association (*CONA*)  
Canadian Pain Society Special Interest Group — Nursing Issues (*CPS SIG-NI*)  
Canadian Society of Gastroenterology Nurses and Associates (*CSGNA*)  
Community Health Nurses of Canada (*CHNC*)  
Forensic Nurses' Society of Canada (*FNSC*)  
National Association of PeriAnesthesia Nurses of Canada (*NAPAN(c)*)  
National Emergency Nurses Affiliation (*NENA*)  
Operating Room Nurses Association of Canada (*ORNAC*)

### ***Affiliate members***

Canadian Nursing Students' Association (*CNSA*)  
Canadian Occupational Health Nurses Association (*COHNA*)  
Canadian Respiratory Health Professionals (*CRHP*)

### ***Emerging groups***

Legal Nurse Consultants Association of Canada (*LNCAC*)

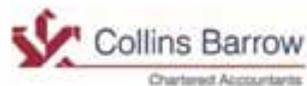
# Financial Information

- Auditor's Report
- Consolidated Financial Statements

**Canadian Nurses Association  
Association des infirmières et  
infirmiers du Canada**



**Consolidated Financial Statements**  
For the year ended December 31, 2011



**Canadian Nurses Association**  
**Association des infirmières et infirmiers du Canada**  
**Consolidated Financial Statements**  
For the year ended December 31, 2011

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## Independent Auditor's Report

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**To the Members of  
Canadian Nurses Association  
Association des infirmières et infirmiers du Canada**

### **Report on Financial Statements**

We have audited the accompanying consolidated financial statements of Canadian Nurses Association / Association des infirmières et infirmiers du Canada and its subsidiary, which comprise the consolidated statement of financial position as at December 31, 2011 and the consolidated statements of operations, changes in net assets and cash flows for the year then ended and a summary of significant accounting policies and other explanatory information.

#### Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with Canadian generally accepted accounting principles, and for such internal control as management determines necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

#### Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the association's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the association's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis of our audit opinion.

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## Independent Auditor's Report (continued)

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### Opinion

In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of Canadian Nurses Association / Association des infirmières et infirmiers du Canada as at December 31, 2011 and its subsidiary, and the results of its operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

### **Report on Other Legal and Regulatory Requirements**

As required by the Canada Corporations Act, we report that, in our opinion, these principles have been applied on a basis consistent with that of the preceding year.

*Collins Barrow Ottawa LLP*

Chartered Accountants, Licensed Public Accountants

March 7, 2012

Ottawa, Ontario

**Canadian Nurses Association  
Association des infirmières et infirmiers du Canada  
Consolidated Statement of Financial Position**

**December 31** **2011** **2010**

**Assets**

**Current**

Cash and cash equivalents (Note 1)	\$ 7,491,351	\$ 5,561,391
Short-term investments (Note 2)	3,850,000	3,850,000
Accounts receivable	2,043,297	1,865,088
Project funding receivable (Note 7)	56,018	80,423
Advances to CNA partners for CIDA projects	108,118	169,563
Unbilled receivables	27,455	-
Receivable from related parties (Note 3)	14,724	14,444
Prepaid expenses	301,462	161,060
Inventory	234,534	139,297
	<b>14,126,959</b>	<b>11,841,266</b>

**Capital assets (Note 4)** 1,795,186 2,129,795

**Accrued pension benefit asset (Note 5)** 477,000 863,000

**\$ 16,399,145** **\$ 14,834,061**

**Liabilities and Net Assets**

**Current**

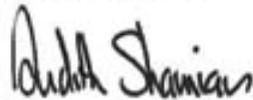
Accounts payable and accrued liabilities	\$ 2,026,830	\$ 1,690,514
Payable to related parties (Note 3)	125,952	115,068
Deferred revenues (Note 6)	3,491,943	3,290,029
Deferred project funding (Note 7)	280,517	273,526
	<b>5,925,242</b>	<b>5,369,137</b>

**Net assets**

Internally restricted net assets		
Net assets designated for capital assets	1,795,186	2,129,795
Net assets designated for future pension obligations	477,000	863,000
Unrestricted net assets	8,201,717	6,472,129
	<b>10,473,903</b>	<b>9,464,924</b>

**\$ 16,399,145** **\$ 14,834,061**

On behalf of the Board:



President



Chief Executive Officer

The accompanying summary of significant accounting policies and notes are an integral part of these consolidated financial statements.

**Canadian Nurses Association  
Association des infirmières et infirmiers du Canada  
Consolidated Statement of Changes in Net Assets**

For the year ended December 31 2011      2010

	Capital Assets	Future Pension Obligations	Unrestricted Net Assets	Total	Total
Balance, beginning of year	\$ 2,129,795	\$ 863,000	\$ 6,472,129	\$ 9,464,924	\$ 8,069,564
Excess (deficiency) of revenue over expenses for the year	(610,319)	(386,000)	2,005,298	1,008,979	1,395,380
Investment in capital assets	275,710	-	(275,710)	-	-
<b>Balance, end of year</b>	<b>\$ 1,795,186</b>	<b>\$ 477,000</b>	<b>\$ 8,201,717</b>	<b>\$ 10,473,903</b>	<b>\$ 9,464,924</b>

The accompanying summary of significant accounting policies and notes are an integral part of these consolidated financial statements.

**Canadian Nurses Association**  
**Association des infirmières et infirmiers du Canada**  
**Consolidated Statement of Operations**

For the year ended December 31	2011		2010
	Budget	Actual	Actual
<b>Revenue</b>			
Membership fees	\$ 7,971,789	\$ 7,952,627	\$ 7,620,842
Examination fees	6,978,512	8,038,566	7,091,192
Advertising	893,000	655,628	837,613
Subscriptions	71,512	99,662	57,005
Publications	609,000	824,511	897,274
Registration fees	329,350	220,576	343,084
Consulting fees	428,908	843,738	628,718
Grants/Affinity/Sponsorship	375,000	309,211	348,462
Investment income	55,000	135,953	71,836
Other income	1,055,878	1,078,930	994,786
Project funding	1,657,085	1,726,164	2,177,747
	<u>20,425,034</u>	<u>21,885,566</u>	<u>21,068,559</u>
<b>Expenses</b>			
Salaries and benefits	10,102,536	9,998,797	9,343,837
Committee meetings	1,110,098	835,299	1,009,366
Travel non-committee	624,905	525,238	426,546
Affiliation fees	469,940	449,459	409,763
Professional fees	1,311,664	1,255,475	1,274,667
Translation and interpretation	243,760	180,484	236,602
Books/Online databases	74,435	49,365	19,532
Printing	897,140	920,247	928,976
Publicity and promotion	515,500	448,327	137,008
General administration	1,100,540	1,069,315	1,156,932
Equipment	333,984	361,289	278,277
Computer services	278,935	163,814	185,243
Building/Space rental	629,654	579,516	621,201
Legal, audit and insurance	268,750	243,275	253,647
Hospitality	132,920	163,263	146,979
Sundry	432,640	598,855	312,462
Contingency/income taxes	101,406	257,468	373,674
Property improvements/Furniture	55,000	54,618	43,597
Project expenses	1,657,085	1,726,164	2,177,747
	<u>20,340,892</u>	<u>19,880,268</u>	<u>19,336,056</u>
<b>Excess of revenue over expenses before amortization and net pension benefit plan gain (loss)</b>	84,142	2,005,298	1,732,503
<b>Less amortization of capital assets</b>	713,469	610,319	578,143
<b>Excess (deficiency) of revenue over expenses before net pension benefit plan gain (loss)</b>	(629,327)	1,394,979	1,154,360
<b>Net pension benefit plan gain (loss)</b>	-	(386,000)	241,000
<b>Excess (deficiency) of revenue over expenses for the year</b>	<u>\$ (629,327)</u>	<u>\$ 1,008,979</u>	<u>\$ 1,395,360</u>

The accompanying summary of significant accounting policies and notes are an integral part of these consolidated financial statements.

**Canadian Nurses Association  
Association des infirmières et infirmiers du Canada  
Consolidated Statement of Cash Flows**

<b>For the year ended December 31</b>	<b>2011</b>	<b>2010</b>
<b>Cash flows from operating activities</b>		
Excess of revenue over expenses for the year	\$ 1,008,979	\$ 1,395,360
Adjustments for		
Amortization of capital assets	610,319	578,143
Net pension benefit plan gain	388,000	(241,000)
	<u>2,005,298</u>	<u>1,732,503</u>
Changes in non-cash working capital items		
Accounts receivable	(178,209)	(473,870)
Project funding receivable	24,405	303,140
Advances to CNA partners for CIDA projects	61,445	87,582
Unbilled receivables	(27,455)	19,709
Receivable from related parties	(280)	48,990
Prepaid expenses	(140,402)	83,600
Inventory	(95,237)	(92,273)
Accounts payable and accrued liabilities	336,316	(469,053)
Payable to related parties	10,884	(1,471)
Deferred revenue	201,914	392,808
Deferred project funding	6,991	(357,276)
	<u>2,205,670</u>	<u>1,274,389</u>
<b>Cash flows from investing activities</b>		
Net purchases of investments	-	(1,350,000)
Purchase of capital assets	(275,710)	(743,523)
	<u>(275,710)</u>	<u>(2,093,523)</u>
<b>Increase (decrease) in cash during the year</b>	<b>1,929,960</b>	<b>(819,134)</b>
<b>Cash and cash equivalents, beginning of year</b>	<b>5,561,391</b>	<b>6,380,525</b>
<b>Cash and cash equivalents, end of year</b>	<b>\$ 7,491,351</b>	<b>\$ 5,561,391</b>

The accompanying summary of significant accounting policies and notes are an integral part of these consolidated financial statements.

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**Canadian Nurses Association**  
**Association des infirmières et infirmiers du Canada**  
**Summary of Significant Accounting Policies**

**December 31, 2011**

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<b>Purpose of the Association</b>	Canadian Nurses Association - Association des infirmières et infirmiers du Canada is a national organization operating programs to advance the quality of nursing in the interests of the general public. The association qualifies as a not-for-profit organization as defined in Section 149(1)(L) of the Income Tax Act and accordingly is exempt from income taxes.
<b>Principles of Consolidation</b>	The consolidated financial statements include the accounts of the wholly owned subsidiary, Assessment Strategies Inc. - Stratégies en évaluation inc. The purchase method has been used to account for the acquisition and the results of operations, cash flows and capital transactions of the subsidiary and are included in these consolidated financial statements from the effective date of its incorporation. All intercompany transactions and balances have been eliminated on consolidation.
<b>Management Responsibility and the Use of Estimates</b>	The financial statements of the association are the representation of management prepared in accordance with Canadian generally accepted accounting principles. The preparation of periodic financial statements necessarily involves the use of estimates and assumptions. The major financial statement areas that require estimates and assumptions are 1) fair value of financial instruments; 2) amortization of capital assets; and 3) employee pension plan. Actual results could differ from management's best estimates and assumptions as additional information becomes available in the future. These estimates and assumptions are reviewed periodically and, as adjustments become necessary, they are reported in the periods in which they become known.
<b>Financial Instruments</b>	<p>The accounting standards for financial instruments require that financial assets and financial liabilities be classified according to their characteristics, management's intentions, or the choice of category in certain circumstances. Financial assets must be classified as either held-for-trading, held-to-maturity, available-for-sale or loans and receivables. Financial liabilities must be classified as held-for-trading or other liabilities. When initially recognized, financial assets and financial liabilities are recorded at fair value. In subsequent periods, financial assets and financial liabilities classified as held-for-trading and financial assets classified as available-for-sale will be measured at fair value. Gains or losses arising from a change in the fair value of financial assets and financial liabilities classified as held-for-trading are recognized in operations as they occur.</p> <p>Changes in the fair value of available-for-sale financial assets are recorded as a direct increase or decrease in net assets until realized or there has been a decline in value that is considered other than temporary in which case the loss will be recognized in operations. Items that are classified in the following categories will be measured at amortized cost using the effective interest method with gains or losses recognized in operations when realized or there has been a decline in value that is other than temporary. These categories are loans and receivables, investments held-to-maturity and other liabilities.</p>

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**Canadian Nurses Association**  
**Association des infirmières et infirmiers du Canada**  
**Summary of Significant Accounting Policies**

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December 31, 2011

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<b>Financial Instruments</b> (continued)	<p>The association's financial instruments consist of cash and cash equivalent, short-term investments, accounts receivable, unbilled receivables, project funding receivable, receivable from or payable to related parties and accounts payable and accrued liabilities. Unless otherwise noted, it is management's opinion that the association is not exposed to significant interest, currency or credit risks arising from these financial instruments.</p> <p>Cash and cash equivalents and short-term investments are classified as held-for-trading and carried at fair value. Accounts receivable, unbilled receivables, project funding receivable and receivable from related parties are classified as loans and receivables. Payable to related parties and accounts payable and accrued liabilities are classified as other liabilities. They are carried at amortized cost which is equivalent to their fair values given their short-term maturities, unless otherwise noted.</p>
<b>Financial Instruments Disclosures</b>	<p>The association has opted to disclose and present financial instruments under the Canadian Institute of Chartered Accountants (CICA) Handbook Section 3861, Financial Instruments - Disclosure and Presentation in these financial statements instead of CICA Handbook Sections 3862 and 3863, which is a permitted option under the transition rules for not-for-profit organizations in these standards. Section 3862 is more onerous placing an increased emphasis on risk disclosures and requiring disclosure of both qualitative and quantitative information about exposures to risks arising from financial instruments, including credit, interest rate, liquidity, currency and other price risks as well as in certain situations sensitivity analyses. The requirements of Section 3863 are consistent with certain applicable parts of Section 3861 and therefore would not impact the association's financial statements.</p>
<b>Financial Management</b>	<p>The association manages its short-term investments according to its cash needs. The association is not involved in any hedging relationships through its operations and does not hold or use any derivative instruments for trading purposes.</p>
<b>Revenue Recognition</b>	<p><u>Membership Fees</u> Membership fees are approved at an Annual General Meeting and are recognized as revenue over the fiscal year.</p> <p><u>Examination Fees, Advertising and Publications</u> Revenue is recognized when the service is rendered or at the time of shipment.</p> <p><u>Subscriptions</u> Subscriptions to the Canadian Nurse magazine and NurseONE are included in membership fees. Subscriptions from non-members are recognized as revenue over the period of the subscriptions. The liability for the portion of subscription revenue received but not yet earned is recorded as deferred revenue.</p>

**Canadian Nurses Association  
Association des infirmières et infirmiers du Canada  
Summary of Significant Accounting Policies**

**December 31, 2011**

**Revenue Recognition  
(continued)**

Registration Fees

Registration fees for attendance at conferences/conventions are recognized as revenue when conferences/conventions are held. The liability for the portion of fees received for conferences/conventions but not yet held is recorded as deferred revenue.

Consulting Fees

Consulting fees revenue is recorded on a percentage of completion basis.

Grants, Sponsorship, Affinity, Investment and Other Income

Revenue is recognized when earned.

Project Funding

The association uses the deferral method of accounting for contributions. Restricted contributions are recognized as revenue in the year in which the related expenses are incurred. Unrestricted contributions are recognized as revenue in the year received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

**Cash and Cash  
Equivalents**

Cash and cash equivalents consist of cash on hand, bank balances, redeemable guaranteed investment certificates and short-term investments with maturity dates of three months or less at the time of acquisition.

**Inventory**

Inventory is valued at the lower of cost and net realizable value with cost being determined on a weighted average cost basis.

**Capital Assets**

Purchased capital assets are recorded at cost. Amortization is based on the estimated useful life of the asset and is provided as follows:

Building	2.5%	straight-line basis
Building improvements	25%	straight-line basis
Computers and software	50%	straight-line basis, and
	30% - 100%	diminishing balance basis
Furniture and equipment	25%	straight-line basis, and
	20%	diminishing balance basis
Leasehold improvements	20%	straight-line basis

Depending on the category or the timing of the acquisition during the year, either one-half of the above rates or the full rate is used in the year of acquisition.

With the exception of the building asset, the amount of assets fully amortized by the end of the previous year are deducted from capital assets cost and accumulated amortization in the current year.

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**Canadian Nurses Association  
Association des infirmières et infirmiers du Canada  
Summary of Significant Accounting Policies**

December 31, 2011

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<b>Employee Pension Plan</b>	<p>The association has a defined benefit pension plan. The association accrues its funded excess net of the pension liability. The association has adopted the following policies:</p> <ul style="list-style-type: none"><li>• The cost of the pension benefits is actuarially determined using the projected unit credit actuarial cost method.</li><li>• For the purpose of calculating the expected return on plan assets, those assets are valued at fair market value.</li></ul>
<b>Internally Restricted Net Assets</b>	<p>A portion of the association's net assets has been restricted in accordance with specific directives as approved by the association's board of directors. The purpose of each is as follows:</p> <p><u>Designated for Capital Assets</u> Designated for capital assets comprises the net book value of capital assets.</p> <p><u>Designated for Future Pension Obligations</u> Designated for future pension obligations comprises the accrued pension benefit asset.</p>
<b>Future Changes in Accounting Standards</b>	<p>The CICA has announced that all Canadian reporting entities, subject to certain exceptions which include not-for-profit organizations, will adopt International Financial Reporting Standards (IFRS) as Canadian generally accepted accounting principles for years beginning on or after January 1, 2011. The association, at its option, may adopt IFRS if it so chooses for the year beginning January 1, 2012.</p> <p>The CICA has also announced that effective January 1, 2012 Canadian private sector not-for-profit organizations (i.e. those not controlled by government entities) will have a new financial reporting framework and that early adoption will be permitted.</p> <p>For organization's that do not adopt IFRS but rather adopt the new not-for-profit standards the existing not-for-profit accounting standards will remain, supplemented by the new private entity standards. The new private entity standards include recognition, measurement and presentation simplification in many areas as well as reduced required disclosures in the financial statements whereas IFRS would require to some extent different and expanded recognition, measurement, presentation and disclosure standards.</p> <p>The association has decided to adopt the new not-for profit standards and is in the process of determining the impact on the association's financial statements.</p>

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**Canadian Nurses Association  
Association des infirmières et infirmiers du Canada  
Notes to Consolidated Financial Statements**

**December 31, 2011**

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**1. Cash and Cash Equivalents**

The association's bank accounts are held at two chartered banks.

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**2. Short-Term Investments**

Short-term investments consist of non-redeemable guaranteed investment certificates totalling \$3,850,000 (2010 - \$3,850,000) with interest rates ranging from 1.10% to 1.60% and maturing by November 2012.

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**3. Related Party Transactions**

Amounts receivable from organizations related by common management are for repayment of expenses incurred by the association on their behalf. Amounts payable to organizations related by common management are for contributions to the employee pension plan. These amounts are comprised of:

	<u>2011</u>	<u>2010</u>
Receivable from related parties:		
Canadian Nurses Foundation	<u>\$ 14,724</u>	<u>\$ 14,444</u>
Payable to related parties:		
Canadian Nurses Association Retirement Plan	<u>\$ 125,952</u>	<u>\$ 115,068</u>

The association rents office space to Canadian Nurses Foundation (CNF). Total rent revenue for 2011 was \$40,330 (2010 - \$35,526). In addition, funding of \$200,000 (2010 - \$200,000) was provided to the Canadian Nurses Foundation as well as a sponsorship of \$15,000 (2010 - nil) to the CNF Nightingale Gala. These transactions are in the normal course of operations and are measured at the exchange amount, which is the amount of consideration established and agreed to by the related parties.

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**Canadian Nurses Association  
Association des infirmières et infirmiers du Canada  
Notes to Consolidated Financial Statements**

December 31, 2011

4. **Capital Assets**

	2011			2010		
	Cost	Accumulated Amortization	Net Book Value	Cost	Accumulated Amortization	Net Book Value
Land	\$ 180,837	\$ -	\$ 180,837	\$ 180,837	\$ -	\$ 180,837
Building and building improvements	2,862,017	2,001,274	860,743	2,964,966	2,019,950	945,016
Furniture and equipment	1,151,484	669,724	481,760	1,204,603	573,878	630,725
Computers and software	1,002,410	870,067	132,343	924,310	721,377	202,933
Leasehold improvements	311,812	172,309	139,503	289,602	119,318	170,284
	<b>\$ 5,508,560</b>	<b>\$ 3,713,374</b>	<b>\$ 1,795,186</b>	<b>\$ 5,564,318</b>	<b>\$ 3,434,523</b>	<b>\$ 2,129,795</b>

Fully amortized assets written off during the current fiscal year amount to \$317,829 (2010 - \$327,115).

5. **Pension Benefits**

*Plan description*

The association has a registered defined benefit pension plan that is mandatory for all employees with greater than one year of continuous service. The plan provides benefits based on length of service and highest three consecutive years' average earnings. For credited service after 1991 and before 2007 there is a defined contribution floor for this benefit. The association's policy is to fund the registered pension plan in the amount that is required by governing legislation and determined by the plan's actuary.

The association measures its accrued benefit obligations and the fair value of plan assets for accounting purposes at December 31 of each year. The most recent actuarial valuation for the pension plan for funding purposes was as of January 1, 2010. The next required actuarial valuation is January 1, 2013.

**Canadian Nurses Association  
Association des infirmières et infirmiers du Canada  
Notes to Consolidated Financial Statements**

**December 31, 2011**

**5. Pension Benefits** (continued)

Information about the association's defined benefit plan is as follows:

	<u>2011</u>	<u>2010</u>
<i>Elements of pension expense recognized in the year:</i>		
Current service cost (employer portion)	\$ 981,000	\$ 644,000
Interest cost	1,240,000	1,067,000
Actual return on plan assets	437,000	(1,360,000)
Actuarial (gain) loss	<u>(392,000)</u>	<u>4,416,000</u>
Costs arising in the period	2,266,000	4,767,000
Differences between costs arising in the period and costs recognized in the period in respect of:		
Return on plan assets	(1,578,000)	346,000
Actuarial (gain) loss	<u>850,000</u>	<u>(4,176,000)</u>
Pension expense recognized	<u>\$ 1,538,000</u>	<u>\$ 937,000</u>

The net periodic pension cost calculated in accordance with CICA Handbook section 3461 for the fiscal year ending December 31, 2011 is a charge of \$1,538,000, as detailed above. The actual employer contributions to the pension fund during the year were \$1,152,000. The difference between these two amounts is the \$386,000 disclosed as net pension benefit plan loss on the consolidated statement of operations. This amount also represents the net loss in the accrued pension benefit asset during the year.

*Reconciliation of funded status to the amount recorded  
in the statements of financial position:*

Plan assets at fair value	\$ 18,903,000	\$ 18,695,000
Accrued benefit obligation	<u>21,973,000</u>	<u>20,651,000</u>
Funded status - deficit	(3,070,000)	(1,956,000)
Unamortized net actuarial loss	<u>3,547,000</u>	<u>2,819,000</u>
Accrued pension benefit asset	<u>\$ 477,000</u>	<u>\$ 863,000</u>

**Canadian Nurses Association**  
**Association des infirmières et infirmiers du Canada**  
**Notes to Consolidated Financial Statements**

December 31, 2011

5. **Pension Benefits** (continued)

	<u>2011</u>	<u>2010</u>
<i>Change in plan assets:</i>		
Fair value, beginning of the year	\$ 18,695,000	\$ 16,468,000
Actual return on plan assets	(437,000)	1,360,000
Employer contributions	1,152,000	1,178,000
Employees' contributions	455,000	434,000
Benefits paid	(962,000)	(745,000)
Fair value, end of year	<u>\$ 18,903,000</u>	<u>\$ 18,695,000</u>
<i>Plan assets consists of:</i>		
Canadian equity securities	31 %	32 %
Foreign equity securities	26 %	26 %
Debt securities	40 %	39 %
Cash and short-term investments	3 %	3 %
	<u>100 %</u>	<u>100 %</u>
<i>Change in accrued benefit obligation:</i>		
Balance, beginning of the year	\$ 20,651,000	\$ 14,835,000
Remeasurement loss	-	486,000
Service cost for the year	981,000	644,000
Interest cost	1,240,000	1,067,000
Employees' contributions	455,000	434,000
Benefits paid	(962,000)	(745,000)
Actuarial (gain) loss	(392,000)	3,930,000
Balance, end of year	<u>\$ 21,973,000</u>	<u>\$ 20,651,000</u>
<i>Actuarial assumptions:</i>		
<i>Weighted-average assumptions for expense:</i>		
Discount rate	5.80 %	6.75 %
Expected long-term rate of return on plan assets	6.00 %	6.00 %
Rate of compensation increase	4.50 %	4.50 %
<i>Weighted-average assumptions for disclosure:</i>		
Discount rate	5.40 %	5.80 %
Rate of compensation increase	4.00 %	4.50 %

**Canadian Nurses Association  
Association des infirmières et infirmiers du Canada  
Notes to Consolidated Financial Statements**

**December 31, 2011**

**6. Deferred Revenue**

Deferred revenue represents restricted funds received in the current period that relates to operations of the subsequent period.

	<b>Balance at Beginning of Year</b>	<b>Additions During the Year</b>	<b>Amounts Recognized as Revenue</b>	<b>Balance at End of Year</b>
Certification exam and renewal fees	\$ 1,296,024	\$ 1,228,444	\$ 1,294,183	<b>\$ 1,230,285</b>
Examination fees	729,398	1,371,332	1,333,190	<b>767,538</b>
CRNE research and development fund	906,622	338,677	-	<b>1,245,299</b>
CNPE research and development fund	17,210	5,075	-	<b>22,285</b>
Conferences/Conventions	138,421	134,139	262,610	<b>9,950</b>
Other	202,356	251,841	237,611	<b>216,586</b>
	<b>\$ 3,290,029</b>	<b>\$ 3,329,508</b>	<b>\$ 3,127,594</b>	<b>\$ 3,401,943</b>

**Canadian Nurses Association  
Association des infirmières et infirmiers du Canada  
Notes to Consolidated Financial Statements**

December 31, 2011

**7. Project Funding**

Restricted project funding received is recognized as revenue when related expenses are incurred. Unspent amounts for expenses to be incurred in subsequent years are recorded as deferred project funding at the end of the year. When expenses incurred are greater than the funding received during the year, the difference is recorded as project funding receivable at the end of the year. A summary of project activities for the year are as follows:

	Balance at Beginning of Year	Contributions Received (Returned)	Restricted Interest Earned	Amounts Recognized as Revenue	Balance at End of Year
Canadian International Development Agency SHINNAP 2007 - 2012	\$ 172,683	\$ 1,060,707	\$ 1,971	\$ 998,661	\$ 246,700
Canada Health InfoWay C-HOBIC	-	-	-	15,021	(15,021)
CHSRF Executive Training for Research Application (EXTRA)	7,383	50,000	-	28,470	28,913
Citizenship and Immigration Canada Regulatory Licensing Exams for Internationally Educated Nurses Outside of Canada Discussion Paper	(17,093)	28,822	-	11,729	-
Health Canada NurseONE	(59,324)	450,618	-	419,237	(27,743)
International Conference Interagency Coalition on AIDS and Development	-	8,850	-	8,850	-
International Youth Internship Program	965	14,000	-	14,965	-
HRSDC Promoting the Awareness of Elder Abuse in Long-Term Care Homes	(4,006)	153,075	-	148,365	704
CRNE and Internationally Educated Nurses	29,023	(6,489)	-	22,534	-
Staff Mix of Regulated Nurses and Assistive Workers	63,472	(17,218)	-	58,508	(13,254)
Public Health Agency of Canada Advancing the Role of RNs and NPs in Self-Management Support for Clients with Chronic Diseases	-	13,004	-	8,824	4,200
	<b>\$ 193,103</b>	<b>\$ 1,755,589</b>	<b>\$ 1,971</b>	<b>\$ 1,720,164</b>	<b>\$ 224,499</b>

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**Canadian Nurses Association  
Association des infirmières et infirmiers du Canada  
Notes to Consolidated Financial Statements**

December 31, 2011

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**7. Project Funding (continued)**

The beginning of year and end of year balances are disclosed in the statement of financial position as follows:

	2011	2010
Deferred project funding	\$ 280,517	\$ 273,526
Project funding receivable	(56,018)	(80,423)
	\$ 224,499	\$ 193,103

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**8. Operating Line of Credit**

The association has access to a bank operating line of credit which is unsecured. The interest rate on the line of credit is at RBC prime and the authorized limit on the line of credit is \$250,000, none of which was utilized at year-end.

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**9. Commitments**

Assessment Strategies Inc. has entered into a long-term lease agreement expiring on April 30, 2013 which calls for minimum lease payments of \$179,521 for the rental of office and storage facilities. Minimum lease payments for the next two years, excluding operating costs and property taxes, are as follows:

2012	\$ 134,641
2013	44,880
	\$ 179,521

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**Canadian Nurses Association  
Association des infirmières et infirmiers du Canada  
Notes to Consolidated Financial Statements**

**December 31, 2011**

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**10. Capital Disclosures**

The association defines capital as its net assets and the association's objectives when managing capital aim to:

- a) Create a budget that provides credible projections of revenues and expenses, separation of capital and operational items, cash flow and disclosure of planning assumptions, based on a three-year forecast;
- b) Ensure there is a provision in place for replacement and preventative maintenance of capital assets, based on long-term administrative planning;
- c) Ensure that expenditures and commitments do not create a deficit of greater than two percent of the revenue; and
- d) Ensure that setting of membership fees and provision of subsidies, take into account necessary revenues, risk management, long-term financial stability, special circumstances of small jurisdictions, and reasonable notice to jurisdictions.

The association manages the capital structure and makes adjustments to it in light of changes in the economic conditions and the risk characteristics of the underlying assets. The board of directors does not establish quantitative return on capital criteria; but rather plans to maintain available for operations, liquid assets in an amount equivalent to two to six months' operating expenses. The association is not subject to any externally imposed capital requirements.

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**11. Comparative Amounts**

In certain instances, 2010 amounts presented for comparative purposes have been restated to conform to the financial statement presentation adopted for the current year.

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# Board of Directors

\*Names of new board members are indicated in italics.

## *CNA Board of Directors*

The contributions and commitment of our volunteer board members are important to the good governance of our association. CNA welcomed seven new members\* to its board in 2011.

Judith Shamian, RN, PhD, LLD (hon), D.Sci. (hon), FAAN  
President

Barbara Mildon, RN, PhD, CHE, CCHN(C)  
President-elect

Rachel Bard, RN, M.A.Ed. (non-voting ex-officio member)  
Chief Executive Officer



*Judith Shamian, RN, PhD, LLD (hon),  
D.Sci. (hon), FAAN*

*Barbara Mildon, RN, PhD,  
CHE, CCHN(C)*



*Rachel Bard, RN, M.A.Ed.*



## Associate member representatives

Claire Betker, RN, MN, CCHN(C)

*Judy Boychuk Duchscher, RN, BScN, MN, PhD*

## Canadian Nursing Students' Association representative

*Evan Jolicoeur* (non-voting ex-officio member)

President



*Claire Betker, RN, MN, CCHN(C)*



*Evan Jolicoeur*

*Judy Boychuk Duchscher,  
RN, BScN, MN, PhD*



## Public representatives

To ensure that board decisions best serve the public interest and represent a broad perspective, the CNA board includes two non-nurse members who are knowledgeable about the health system and possess strong leadership qualities.

Vincent MacLean

Joseph Mapa (not available for photo)

*Vincent MacLean*



## Provincial and territorial representatives

### British Columbia

*Susan Duncan, RN, BScN, MSN, PhD*

Co-chair, Association of Registered Nurses of British Columbia

### Alberta

*Dianne Dyer, RN, BN, MN*

President, College and Association of Registered Nurses of Alberta

### Saskatchewan

*Kandice Hennenfent, RN, BScN, CHA, MA (Leadership)*

President, Saskatchewan Registered Nurses' Association

*Susan Duncan, RN, BScN,  
MSN, PhD*



*Dianne Dyer, RN, BN, MN*



*Kandice Hennenfent, RN, BScN,  
CHA, MA (Leadership)*



*Robin Finney, RN, BN*



## **Manitoba**

Robin Finney, RN, BN

President, College of Registered Nurses of Manitoba

## **Ontario**

David McNeil, RN, BScN, MHA, CHE

President, Registered Nurses' Association of Ontario

*David McNeil, RN,  
BScN, MHA, CHE*



## **New Brunswick**

France Marquis, RN, MScN

President, Nurses Association of New Brunswick

## **Nova Scotia**

Judith Bailey, RN, MN

President, College of Registered Nurses of Nova Scotia

*France Marquis, RN, MScN*



*Judith Bailey, RN, MN*



*Marilyn Barrett, RN, MN*



## **Prince Edward Island**

Marilyn Barrett, RN, MN

President, Association of Registered Nurses of Prince Edward Island

## **Newfoundland and Labrador**

Bev White, RN, MScN, CCHN(C)

President, Association of Registered Nurses of Newfoundland and Labrador

*Bev White, RN, MScN, CCHN(C)*



## **Northwest Territories**

*Angela Luciani, RN, BScN, MN, MPHTM*

President, Registered Nurses Association of the Northwest Territories and Nunavut

## **Yukon**

Peggy Heynen, RN

President, Yukon Registered Nurses Association

*Angela Luciani, RN,  
BScN, MN, MPHTM*



*Peggy Heynen, RN*



# Report from the Board of Directors

*With Canada's health-care system at a critical juncture, a federal election taking place, discussions about future health funding arrangements heating up, and the launch of nursing's first-ever National Expert Commission, 2011 was an exceptionally dynamic year. In fact, 2011 presented prime opportunities for CNA to voice nursing's ideas on transforming health care and to engage RNs in taking action on nursing matters.*

*One of our greatest priorities this past year was accelerating our engagement with RNs from all domains of nursing in all corners of the country. The board enthusiastically endorsed numerous strategies to enhance our outreach. For instance, we affirmed how central our associate and affiliate members and emerging (AAE) groups are to CNA's mission by sanctioning an action plan to engage and support the 41,000 members of the 43 AAE groups. In addition, CNA boosted its social media presence, using it to promote the association's work and to initiate two-way discussions with RNs about current nursing matters. The board also endorsed the CNA Cross-Country Tour, an exciting initiative for meeting face-to-face with nurses in their own communities. As part of the tour, we hosted member assemblies that enabled RNs to share their perspectives about the nursing profession and the health-care system and to hear CNA's stance on the major issues.*

*CNA speaks for and represents RNs on nursing and health issues to governments and other organizations through political action and leadership. A number of national and international nursing issues garnered our attention this year, and, as CNA's president, I wrote open letters to political leaders and frequently commented to the media on these matters. CNA also*

*made evidence-based presentations to parliamentary and Senate committees, putting forth a vision for a transformed health-care system and advocating for a renewed focus on primary, collaborative and community-based care.*

*We continued our efforts to support and promote the role of advanced practice nurses with the launch of a creative nurse practitioner (NP) awareness campaign in several jurisdictions. And, CNA's board members took an active role by bringing messages about the value of NPs to our meetings with members of Parliament and senators during a CNA lobby day on Parliament Hill.*

*One of the year's major milestones was the launch of an independent National Expert Commission on health-care system transformation — the first ever created by the nursing profession. The Commission set out to consult with nurses, health-care professionals, employers, business and government leaders and the public to develop recommendations to help shape the health-care system into one better equipped to meet the changing needs of Canadians. This ambitious work is evidence of the seriousness with which CNA recognizes the need for nurses to be well-informed and well-positioned as leaders at the centre of national discussions on the future of health care.*

*In 2011, the board of directors dealt with several significant changes to CNA's programs and membership. While difficult at times, the board faced these situations with unwavering commitment and dedication. A particular challenge was having to say goodbye to the College of Registered Nurses of British Columbia (CRNBC) from our board. CRNBC decided to give up its jurisdictional membership in CNA over concerns about incompatibility between the two*

***“One of our greatest priorities this past year was accelerating our engagement with RNs from all domains of nursing in all corners of the country. The board enthusiastically endorsed numerous strategies to enhance our outreach.”***

*organizations' respective mandates and functions. However, we moved ahead positively and held thoughtful discussions to find a measured way for CRNBC to end its jurisdictional membership. The board was pleased to come to a joint agreement whereby CRNBC would assign its jurisdictional membership in CNA to CNA so as to maintain the voice of B.C.'s RN and NPs at the national level. The board welcomed the Association of Registered Nurses of British Columbia (ARNBC) to the CNA table and set out to explore how ARNBC would best represent B.C. RNs at the national level on nursing issues and social and health matters.*

*Another change this past year was with the new RN entry-to-practice exam. In December, 10 of the RN regulatory bodies in Canada announced that the National Council of State Boards of Nursing (NCSBN) had been selected to partner in the development of a new, computer-based entry-to-practice exam for future RN candidates. The new exam would replace the current Canadian Registered Nurse Examination (CRNE). CNA, through its wholly owned subsidiary testing company Assessment Strategies Inc. (ASI), has competently developed and maintained the CRNE for the past 40 years. As far back as 2000, CNA and the Chief Executive Officers (CEOs)/Executive Directors (EDs), representing the 10 RN regulatory bodies, had been discussing a move toward a computer-based exam. Following the RN regulators' announcement, CNA initiated a campaign for a made-in-Canada exam. The campaign's goal was to inform, build awareness and allow people to share their opinions or contribute to the dialogue about the exam. As we moved through this process, the RN regulatory bodies and CNA began exploring ways to maintain a strong relationship and to support each others' respective roles in advocacy and regulation. Early in 2012, the RN regulators informed CNA that they were working to ensure that the new exam will be legally defensible and provide an accurate assessment of RN candidates' readiness to practice safely, competently and ethically in Canada.*

*An unwavering commitment to building a healthy tomorrow — this at the heart of what nursing is all about, and it is at the core of CNA's work with Canada's registered nurses. With this commitment, I am pleased to say, we have been mapping out ways of bringing our professional expertise to health system design and transformation. Over the past months, we brought our messages to government decision-makers and encouraged premiers to use our guiding*

*principles — and they listened. Early in 2012, after much advocating, the Council of the Federation invited CNA to play a key role in its health-care innovation working group. This is significant: Canada's RNs are collaborating with the provinces and the territories and playing a direct and integral role in ensuring health systems provide for the needs of Canadians.*

*On behalf of the board of directors, I wish to thank the CNA CEO and staff for their dedication to ensuring we carry out our association's mission with integrity. I extend a heartfelt thank you to the many RNs who have provided their time and expertise to CNA, upholding the nursing profession and advocating for the health and well-being of Canadians.*

A handwritten signature in black ink that reads "Judith Shamian". The signature is written in a cursive, flowing style.

*Judith Shamian, RN, PhD, LLD (hon), D.Sci. (hon), FAAN  
Chair*











CANADIAN  
**NURSES**  
ASSOCIATION