CANNT JOURNAL
JOURNAL ACITN

Volume 25, Issue 1 January–March 2015

IN THIS ISSUE:

JANUARY–MARCH 2015 • VOLUME TWENTY-FIVE • ISSUE ONE

CANNT JOURNAL
JOURNAL ACITN

CANNT ACITN
CANADIAN ASSOCIATION OF NEPHROLOGY NURSES AND TECHNOLOGISTS
L'ASSOCIATION CANADIENNE DES INFIRMIÈRES ET TECHNICIENS DE NÉPHROLOGIE

CONTENTS

IN EACH ISSUE:

The CANNT Journal is printed on recycled paper.

The CANNT Journal is the official publication of the Canadian Association of Nephrology Nurses and Technologists, P.O. Box 10, 59 Millmanor Place, Delaware, ON N0L 1E0, telephone: (519) 652-6767, fax: (519) 652-5015, email: cannt@cannt.ca. Published quarterly, the journal is received by all members of CANNT. Subscriptions are: Canada $80.00 (plus HST), US. $90.00, Outside N. America $115.00. Back issues, when available, are $7.50 (+HST) per issue and are available from the editors. Opinions expressed by writers in the CANNT Journal are not necessarily those held by the editors or CANNT. Contrasting views by our readership and membership are welcome. All letters, comments and articles are to be sent to the CANNT office, P.O. Box 10, 59 Millmanor Place, Delaware, ON N0L 1E0.

1-877-720-2819
Website: www.cannt.ca

Deadlines for submission to the CANNT Journal are:
Jan.–Mar.: Jan. 15, for publication Mar. 15;
Apr.–Jun.: April 15, for publication Jun. 15;
Jul.–Sep.: Jul. 15, for publication Sep. 15;
Oct.–Dec.: Oct. 15, for publication Dec. 15.

The CANNT Journal is indexed in the Cumulative Index to Nursing and Allied Health Literature (CINAHL), the International Nursing Index (INI), MEDLINE, EBSCO, ProQuest and Thomson Gale.

ISSN 2291-644X (Online)
ISSN 1498-5136 (Print)

The CANNT Journal is produced by Pappin Communications, The Victoria Centre, 84 Isabella St., Unit 2, Pembroke, Ontario K8A 5S5

A New Year: A fresh perspective

Janet Baker

Alison Thomas

Happy New Year! 2015 is a year of change for the *CANNT Journal*. As we write this column, we are undergoing preparations to step down from our roles as co-editors. To that end, we wish to introduce our new editors-in-training, Jovina Bachynski and Matt Phillips.

Matt Phillips is Nephrology Quality Leader at the Capital District Health Authority Renal Program in Halifax, NS. He has been in this role since 2011. He graduated from nursing in 2000, and has worked in nephrology since 2005. He worked as staff nurse in the dialysis unit at St. Paul's Hospital in Saskatoon (2005–2007), the Victoria General in Halifax (2007–2010), and as charge nurse at the Victoria General (2010–2011). Matt received his Bachelor of Science in Nursing in 2000 from the University of Saskatchewan, and completed the requirements for the Master's of Health Studies from Athabasca University in December 2014. Matt has been a CANNT member since 2012. Matt has also been an oral presenter at CANNT (2014), Capital Health Quality Summit (2014), and a poster presenter at CANNT (2012 and 2013), and Capital Health Quality Summit (2012, 2013 and 2014). Matt lives in Dartmouth, Nova Scotia.

Jovina Bachynski graduated from the Master of Nursing (Nurse Practitioner) program at the Lawrence S. Bloomberg Faculty of Nursing (University of Toronto) in 2012. She is currently a nurse practitioner in the inpatient nephrology program at University Health Network (Toronto General Hospital). Jovina has worked in clinical nephrology since 1996, sustained by her passion for and commitment to excellence in nephrology nursing—particularly to evidence-based clinical practice. After a brief stint in peritoneal dialysis, she has largely devoted her nephrology nursing career to hemodialysis in leadership roles ranging from resource nurse and transplant liaison to vascular access coordinator. She has been a member of CANNT since 2000 and has previously served on the symposium planning committees for CANNT 2002 (Toronto) and CANNT 2014 (Niagara Falls). It is with this spirit that she looks forward to serving the collective nephrology nursing and technological community as the incoming co-editor of the journal.

We have confidence that we are passing the reins to a keen, experienced and committed pair of nephrology nurses who have the knowledge and skills to work alongside the Board of Directors and Pappin Communications to continue the work of co-editing the *CANNT Journal*. We sincerely thank all of you—our readers, the CANNT Board, the CANNT office management team, and Heather and Sherri at Pappin—for your support of our efforts and initiatives over the past few years.

PLEASE SEND ALL SUBMISSIONS, QUESTIONS OR COMMENTS TO:

Jovina Bachynski and Matt Phillips,
Co-Editors, CANNT Journal, email:
Jovina Bachynski: **CANNT.journal1@gmail.com**
Matt Phillips: **CANNT.journal2@gmail.com**

Une nouvelle année : une nouvelle perspective

Janet Baker

Alison Thomas

Bonne année à tous! 2015 sera une année de changement pour le *Journal de l'ACITN*. En effet, au moment d'écrire ces lignes nous nous préparons à délaisser non fonctions de corédactrices pour les confier à nos successeurs. Alors, sans plus tarder, nous vous présentons les nouveaux corédacteurs de notre journal, Jovina Bachynski et Matt Phillips.

Matt Phillips est chef de la qualité en néphrologie au programme rénal de la Capital District Health Authority, à Halifax, en Nouvelle-Écosse. Il occupe ces fonctions depuis 2011. Matt a obtenu son diplôme en soins infirmiers en 2000 et travaille dans le domaine de la néphrologie depuis 2005. Il a été infirmier soignant à l'unité de dialyse de l'hôpital St. Paul's de Saskatoon (2005-2007) et à l'hôpital Victoria General de Halifax (2007-2010), où il a par la suite assumé le poste d'infirmier responsable (2010-2011). Matt a obtenu son baccalauréat en sciences infirmières en 2000 de l'Université de la Saskatchewan et a terminé avec succès le programme de maîtrise en études sur la santé de l'Université d'Athabasca en décembre 2014. Il est membre de l'ACITN depuis 2012. Il a été présentateur lors de la dernière conférence de l'ACITN (2014) et lors du sommet sur la qualité de la Capital Health (2014) et a fait des présentations sur affiches durant les conférences de l'ACITN (2012 et 2013) et aux sommets sur la qualité de la Capital Health (2012, 2013 et 2014). Matt vit à Dartmouth, en Nouvelle-Écosse.

Jovina Bachynski a obtenu sa maîtrise en soins infirmiers (infirmière praticienne) à la faculté de sciences infirmières Lawrence S. Bloomberg (Université de Toronto) en 2012. Elle occupe actuellement un poste d'infirmière praticienne au sein du programme de néphrologie en milieu hospitalier au University Health Network (General Hospital de Toronto). Jovina travaille dans le domaine de la néphrologie clinique depuis 1996, motivée par sa passion et son engagement pour la prestation de soins infirmiers de qualité en néphrologie et, plus particulièrement, pour la pratique clinique basée sur des preuves. Après un bref interlude dans un service de dialyse péritonéale, elle a poursuivi sa carrière d'infirmière en néphrologie surtout consacrée à l'hémodialyse en assumant divers rôles de leadership : infirmière ressource, infirmière de liaison en transplantation et coordonnatrice du programme d'accès vasculaire. Elle est membre de l'ACITN depuis 2000 et a fait partie du comité de planification des conférences de l'ACITN en 2002 (Toronto) et en 2014 (Niagara Falls). C'est dans cet esprit d'engagement que Jovina entend servir la communauté du secteur de la technologie et des soins infirmiers en néphrologie à titre de nouvelle corédactrice du Journal.

C'est avec confiance que nous remettons les rênes de la revue à un duo passionné, expérimenté et déterminé, qui possède les connaissances et les compétences requises pour travailler en collaboration avec le conseil d'administration et le personnel de Pappin Publishing à la rédaction du *Journal de l'ACITN*. Nous vous remercions tous chaleureusement, nos lecteurs, les membres du conseil d'administration, l'équipe administrative de l'ACITN de même que Heather et Sherri chez Pappin, pour le soutien que vous avez manifesté envers nos efforts et non projets au cours des dernières années.

Le Journal ACITN est la publication officielle de l'Association canadienne des infirmiers/infirmières et technologues en néphrologie, a/s P.O. Box 10, 59 Millmanor Place, Delaware, ON N0L 1E0, téléphone : (519) 652-6767, télécopieur : (519) 652-5015, Courriel : cannt@cannt.ca. Publié quatre fois par année, ce journal est envoyé à tous les membres de l'Association. L'abonnement annuel est: Canada, 80 $ (+TVH), E.-U., 90 $, hors du Canada et E.-U., 115 $. Les publications antérieures, lorsque disponibles, coûtent 7,50 $ (+TVH) chacune. Les opinions émises par les auteurs dans ce journal ne sont pas nécessairement partagées par l'Association ni par le corédactrices en chef. Nous invitons les lecteurs à nous faire part de leurs opinions. Toute correspondance devra être envoyée à l'ACITN, P.O. Box 10, 59 Millmanor Place, Delaware, ON N0L 1E0.

1-877-720-2819; Site web : www.cannt.ca

Voici les échéanciers à rencontrer pour soumettre des articles/nouvelles au journal :

Janv.–mars : le 15 janv., pour publication le 15 mars
Avril–juin : le 15 avril, pour publication le 15 juin
Juil.–sept. : le 15 juil., pour publication le 15 sept.
Oct.–déc. : le 15 oct., pour publication le 15 déc.

Le journal CANNT est maintenant répertorié dans le « Cumulative Index to Nursing and Allied Health Literature (CINAHL) », « International Nursing Index » (INI), « MEDLINE », « EBSCO », « ProQuest » et « Thomson Gale ».

ISSN 2291-644X (En ligne)
ISSN 1498-5136 (Dans la presse)

Le journal CANNT est préparé par
Pappin Communications
The Victoria Centre, 84 rue Isabella, suite 2,
Pembroke, Ontario K8A 5S5.

What are 'your' professional New Year's resolutions?

It is both a great pleasure and a great honour to serve as the 2014–2015 CANNT President. As CANNT President, 'my' professional New Year's resolution is to align my actions with CANNT's vision to provide leadership, and promote the best nephrology care and practice through education, research, and communication. To succeed, my resolution will not be possible without the support and direction from the current Board of Directors, our National Office staff led by Heather Reid, and very importantly, our valuable membership.

My passion for making a difference in the lives of patients with kidney disease has been the driving force in my interest to further my educational pursuits, to run for election on the CANNT Board of Directors, and now to articulate my New Year's resolution. We are expert professionals and humanitarians, committed to working together and with others, to achieve our goals. We are bound only by the limits of our vision and our collective determination. Passion has been linked to career growth and self-fulfillment, so I urge all of you to tap into your passion, and to set professional goals that align with CANNT's longstanding mandate in promoting excellence in nephrology care by either joining or renewing your membership with our specialty organization.

Membership with CANNT, the keystone of excellence in nephrology nursing and technological care in Canada, has many benefits available to support you in achieving 'your' professional goals. Some of these benefits include a complimentary subscription to this peer-reviewed quarterly *CANNT Journal*, connections to the latest information and resources related to nephrology technology or nursing, eligibility to run for election as a Board member, and networking opportunities with colleagues practising in your nephrology specialty on a national level.

Additional benefits to membership include opportunities for collaborative networking and problem solving through participation in a Refined Clinical Practice Group, reduced registration rate at our national conference and, for those of you pursuing education and involved in research activities, eligibility to apply for a CANNT award, bursary or research grant for yourself or to nominate others for these awards. Membership and active participation in CANNT activities is an ideal means to reach your professional goals whether that be in your pursuit to run for election as a Board member, apply for an award, or become involved in a Refined Clinical Practice Group. If you are interested to learn more about how you can become more involved with the association, contact your regional VP, or the CANNT office. Please visit the CANNT website for further information at **www.cannt.ca**.

Never underestimate the power of passion to motivate you to reach your goals. As Nelson Mandela eloquently explains, "There is no passion to be found playing small—in settling for a life that is less than the one you are capable of living." Let CANNT work with you this year to achieve your professional goals. Be passionate, become involved!

Quelles sont « vos » résolutions professionnelles pour la nouvelle année?

Je suis très heureuse et extrêmement honorée d'accéder au poste de présidente de l'ACITN pour 2014-2015. À ce titre, « ma » résolution professionnelle pour la nouvelle année est d'orienter mes actions en fonction de la mission de l'ACITN afin de fournir du leadership et de promouvoir les meilleurs soins et pratiques en néphrologie grâce aux activités de formation, de recherche et de communication. La réussite de ma résolution ne sera pas possible sans le soutien et l'aide du présent conseil d'administration, du personnel du bureau national dirigé par Heather Reid et, évidemment, de nos précieux membres.

Mon profond désir d'améliorer la vie des personnes atteintes de néphropathie a été le moteur de mon intérêt à poursuivre ma formation, à me porter candidate à la présidence de l'ACITN et maintenant à vous part de ma résolution pour la nouvelle année. Nous sommes des professionnels spécialisés et des humanitaires, prêts à travailler ensemble, et avec d'autres, pour atteindre nos objectifs. Nous pouvons aller aussi loin que notre vision et notre détermination collective nous emmènent. C'est la passion qui nous habite qui propulse notre carrière et contribue à notre épanouissement. Je vous encourage donc à puiser dans cette passion et à vous fixer des objectifs professionnels qui concordent avec le mandat historique de l'ACITN, qui consiste à promouvoir l'excellence dans les soins néphrologiques, en vous joignant à notre organisation professionnelle ou en renouvelant votre adhésion.

L'adhésion à l'ACITN, lieu d'excellence des soins infirmiers et de la technologie en néphrologie au Canada, procure de nombreux avantages qui vous aideront à réaliser « vos » objectifs professionnels : abonnement gratuit au *Journal de l'ACITN*, votre revue trimestrielle évaluée par des pairs, liens vers l'information et les ressources les plus récentes en matière de soins infirmiers et de technologie en néphrologie, possibilité d'être élu au conseil d'administration et occasions de réseauter à l'échelle nationale avec des collègues évoluant dans votre spécialité néphrologique.

D'autres avantages sont liés à l'adhésion à notre association, notamment l'occasion de collaborer et de contribuer à la résolution de problèmes grâce à la participation à un groupe de pratique clinique attitré, une réduction des frais de participation à notre conférence nationale et, pour ceux qui poursuivent leur formation ou qui font de la recherche, la possibilité de soumettre une demande de bourse ou de subvention de recherche et de recommander des collègues pour l'obtention de ces bourses ou subventions. L'adhésion et la participation active aux activités de l'ACITN sont le moyen idéal d'atteindre vos objectifs professionnels, qu'il s'agisse de poser votre candidature pour faire partie du conseil d'administration, de présenter une demande de bourse ou de faire partie d'un groupe de pratique clinique attitré. Si vous désirez en savoir plus sur la façon de participer davantage aux activités de l'Association, communiquez avec votre vice-président régional ou avec le bureau national de l'ACITN. Pour obtenir plus d'information, consultez le site de l'ACITN, à **www.ACITN.ca**.

Ne sous-estimez pas la force de la passion comme motivation à atteindre vos objectifs. Comme Nelson Mandela l'a dit de façon si éloquente : « Il n'y a pas de passion dans l'engagement sans envergure, dans l'acceptation d'une vie inférieure à celle que vous êtes capable de mener. » Cette année, laissez l'ACITN vous aider à atteindre vos objectifs professionnels. Soyez passionnés, engagez-vous pleinement!

CANNT REPRESENTATIVES/ CONTACTS; REPRÉSENTANTS/ CONTACTS ACITN

CNA Liaison/Liaison pour AIIC :
Roberta Prettie, RN, CNeph(C)
T: 204-482-9482
email/courriel : rmprettie@mymts.net

Kidney Foundation of Canada, MAC Representative/Fondation du rein—Comité de médical consultatif :
Anne Moulton, RN, BScN, MN, CNeph(C)
T: 905-522-1155 x33916
amoulton@stjosham.on.ca

Bursary Committee/ Comité des Bourses :
Anne Moulton, RN, BScN, MN, CNeph(C)
T: 905-522-1155 x33916
amoulton@stjosham.on.ca

CANNT Administrative Office/ Bureau National de l'ACITN :
PO Box 10, 59 Millmanor Place
Delaware, ON N0L 1E0
New phone: 519-652-6767
Same Toll Free: 877-720-2819
New fax: 519-652-5015
General email: cannt@cannt.ca

Contacts:
Sharon Lapointe,
Manager, Member Services
sharon@cannt.ca

Susan Mason
Manager, Website and Social Media
susan@cannt.ca

Heather Reid
National Administrator/Board
heather@cannt.ca

2015 Symposium: October 22–24, 2015. Vancouver, British Columbia
Heather E. Reid, ARCT, MSc
Principal Planner & Owner
Innovative Conferences & Communications
PO Box 319, 59 Millmanor Place
Delaware, ON N0L 1E0
T: 519-652-0364
F: 519-652-5015
Email: hreid@innovcc.ca
Website: www.innovcc.ca

Journal advertising contact/Personne contact pour la publicité du Journal :
Heather Coughlin
Pappin Communications,
84 Isabella Street, Pembroke, ON K8A 5S5
T: 613-735-0952; F: 613-735-7983
email/courriel : heather@pappin.com
rate card: www.pappin.com

Predatory publishing: What editors need to know

INANE "Predatory Publishing Practices" Collaborative

Editors' Note:

The CANNT Journal Editorial Board stands in support of the International Academy of Nursing Editors in their campaign to raise awareness about predatory publishers and their unethical and unscholarly practices. We encourage our readers—especially those who are authors—to review this editorial reprint and consider its important message. Becoming familiar with the knowledge necessary to distinguish work published by predatory publishers from work published in peer-reviewed, academic, rigorous journals is key to ensuring scholarly publishing standards are maintained.

Reprinted with permission from *Nurse Author and Editor Journal*.

As an unintended outcome of the effort to expand open access to scholarly material, the publishing world now has to contend with new challenges around what academic librarian and blogger Jeffrey Beall (in his blog **Scholarly Open Access**) has termed "predatory publishers." In August 2014, participants at the 33rd Annual Meeting of the International Academy of Nursing Editors (INANE) in Portland, Maine, concerned with the potential for inadvertent submissions to these journals as well as the citation of questionable manuscripts, agreed that it was time to raise awareness and educate our constituent communities about the potential detrimental effects of this emerging phenomenon.

CONDITIONS CREATED BY OPEN ACCESS

Open access publishing is a relatively recent occurrence with the worthy goal of removing restrictions to the online access of peer-reviewed scholarly research.

Although it may have created the conditions under which these new predatory publishing practices are flourishing, open access is not, in itself, the problem. Many highly rigorous, scholarly and professional journals are exclusively open access; other journals offer authors a range of traditional and open access options. These include options for authors or their funders to pay article processing charges for immediate open access and various levels of delayed public access for specific types of articles.

As it has taken hold, the open access movement has significantly altered the conventional financial model of many journals. While journal owners historically relied entirely on journal subscriptions and content licences or advertisements as their revenue base, most open access publishing options are fee-based. Many research granting bodies have strongly advocated for unrestricted access to the findings from studies they fund, and some have willingly funded open access publication costs as a means to make results widely and rapidly available. As a result, publishing has been influenced by for-profit enterprise in ways previously unimagined by scholars. The window of commercial opportunity has been flung wide open, and in many cases thrown completely off its hinges.

Beyond the open access options being adopted by mainstream publishers, the ease of digital publishing and exploitation of this new publishing business model has led to a myriad of new journals, each actively competing for authors and revenue. Some of these new journals, including those introduced by conventional commercial and professional society publishers to augment their journal portfolios, apply the same rigorous peer review practices and standards of scholarly excellence we have come to rely on as consistent with advances in professional disciplines such as nursing.

However, across every academic field, professional discipline, and geographic jurisdiction, we are also seeing the emergence of a new species of publisher whose practices reveal little evidence of editorial and publishing quality. Instead, with profit as the driving force, these "predatory" publishers engage in a range of disturbingly unethical and unscholarly practices.

PREDATORY MOTIVATIONS AND PRACTICES

Typical practices of predatory publishers include promises of rapid review and acceptance for publication, minimal to non-existent review processes, a fabricated editorial board, and mimicry of legitimate journal titles. These publishers often send out flattering individualized email solicitations to potential authors inviting them to submit manuscripts or serve as "guest editors" for their journals. Guest editing typically involves having "editors" invite their own collaborators and colleagues to submit papers for a special issue—for a fee. There are examples of eminent names being listed as an "honorary editor" or members of the "editorial board," where these scholars were unaware of the existence of the journal or the use of their name in that manner.

Conversely, the named "journal editor" may be someone with no qualifications or credibility in the field, and may simultaneously administer a suite of journals in a wide range of fields in an effort to attract as many submissions from author-customers as possible. In the rush to provide rapid review and acceptance for publication, these editors may review submissions single-handedly, or rely on a single employee "peer" to bless the manuscript and deem it publishable. The result is a "review process" unfettered by actual expert critique. This practice is sometimes evident in the eventual published document, with the date of submission, review and acceptance all occurring in close proximity.

Table: Guidelines for Evaluating the Integrity of a Journal		
Question	**What to look for**	**Red flags**
Who is the Editor in charge of journal content?	• A person who has a reputation in the discipline. • Direct contact information for the Editor is provided.	• You cannot find any evidence of the Editor's standing in the discipline. • There is no contact information.
What is the journal's process for assuring quality of content?	• A clear description of the process for review of manuscripts prior to publication is stated. • The names and duties of editorial advisory or review panel members are listed.	• A promise of rapid review and publication (quality reviews take time). • Mystification of those who are involved in the review process.
Does the journal have sound business and publishing practices?	• The journal is a member of **COPE.** • The journal is in the **INANE/NA&E Directory of Nursing Journals.** • Information about author processing charges (APC), if any, is clear and easily accessible. • If the journal shows an impact factor, it is verifiable in the **Journal Citation Reports** (Web of Science).	• The publisher/journal is on Beall's List at **Scholarly OA.** • The journal name or other information is suspiciously like another journal. • The journal/publisher solicits manuscripts using excessively complimentary emails.
Sources: Open Access Scholarly Publishers Association (OASPA) **Code of Conduct** (http://oaspa.org/membership/code-of-conduct/) Committee on Publication Ethics (COPE) **Membership** (http://publicationethics.org/members) International Association of Scientific, Technical & Medical Publishers (STM) **Code of Conduct** (http://www.stm-assoc.org/membership/code-of-conduct/)		

Many predatory publishers also deploy unscrupulous marketing practices to seduce unsuspecting potential authors, such as inventing journal titles that are similar to those of well-known and reputable journals, or using logos deceivingly like those of conventional publishing houses. Operating within the global environment, these journals tend to establish administrative home bases that afford protection from legal repercussions that could arise from such practices as copyright violation. The goal of such creative strategies is always the appearance of authenticity, thereby luring unwary authors to presume credibility.

When the driving motivation of a journal is profit, the focus is fixed on pleasing the author as the primary source of revenue. Predatory publishers therefore target senior scholars to build the journal's credibility and to help attract unsuspecting or naïve authors, who may fall prey to easy flattery. Other targets include those whose academic pressures to publish may blind them to the nefarious nature of what allows a journal to bring a manuscript to print in record time. Unfortunately, aspiring authors caught up in the promise of rapid publication may unwittingly find that (a) their career progress is tainted by the lack of credibility of their selected publishing venues, (b) they are liable for unexpected additional fees once their paper has been published, or (c) their previously published papers suddenly cease to exist, or reside in legal limbo, with the copyright signed away to a non-existent publisher and inaccessible through established search mechanisms, because contractual arrangements for these publications may be unenforceable.

We see a significant collective harm for the body of published scholarly nursing literature because concern about quality inherently reduces the profit margin in this predatory model of doing business. Although we have come to trust the practices and processes of our various scholarly and professional publications for the quality and credibility of the corpus of disciplinary knowledge, the new and unmanaged proliferation of pseudo-scholarly activity could significantly flood the market with journals and articles that discredit the profession. In healthcare, this threat is even more serious, as the pseudo-science and poor scholarship published by predatory journals could conceivably result in harm to patients and the health information seeking public.

THE INANE CALL TO ACTION

The INANE community, representing editors of credible and reputable nursing journals, believes that it is imperative to inform nurses of the harm inherent in this new hazard that has arrived in the publishing scene. We encourage nursing authors to use Beall's list of predatory publishers at **Scholarly Open Access** as a reliable resource. His approaches and methods, including dynamic monitoring of the publishing world for this purpose and a willingness to reconsider and revise any listing found to be in error or misleading, make Beall's site extremely helpful for nurses who now need to ensure the credibility of the journals to which they entrust their manuscripts or become otherwise involved. At the same time, Beall would be the first to acknowledge the impossibility of keeping up with all of the emerging new journals. We therefore also encourage potential authors to consult the **Directory of Nursing Journals**, a collaborative effort between INANE and this publication, *Nurse Author & Editor*, for journals that have been reviewed and vetted within our community, and to be vigilant for the hallmarks of predatory practices. A third useful resource is Thomas Long's blog on **Nursing Writing**, which includes a compilation of recent reports on predatory open-access journals and scholarly conference scams.

Another potentially useful resource may be the **Directory of Open Access Journals**, which is working to strengthen its approvals process based on more strict criteria.

We will maintain information on this topic on **INANE's website** as an ongoing reference for our members. Finally, we offer in the accompanying table a brief compilation of considerations and "red flags" summarized from internationally reputable organizations concerned with publications ethics. These sources too will undoubtedly continue to evolve over time.

In writing this statement, the INANE community hopes to encourage educators, mentors, scholars, and clinical practitioners to join in a campaign to help our colleagues understand emerging hazards on the path to publication. We encourage those who oversee institutional promotion and advancement processes to ensure that (a) their members are well mentored with respect to the publication records they are building, and (b) that their review committees have the knowledge required for fair assessment of work across the spectrum of publication modalities. Above all, we seek to serve the emerging science, knowledge sharing, and authorial careers of our discipline as well as possible by ensuring that nurses are making wise publishing choices.

INANE members are committed to sustaining the high standards we have come to expect in the published body of nursing knowledge, across the full spectrum of theorizing and philosophizing, science and evidence building, clinical applications, education, leadership, social advocacy and policy engagement, even as we embrace the new possibilities for publishing in the digital universe. Open access is both an exciting opportunity and an intriguingly disruptive force in the publishing world. It is unfortunate that it has been exploited in this predatory manner. However, by translating our best nursing health promotion and disease prevention wisdom to the publishing domain, we can help keep our colleagues and their important ideas safe from harm.

Let's spread the word and disarm the threat together.

INANE "Predatory Publishing Practices" Collaborative

INANE "PREDATORY PUBLISHING PRACTICES" COLLABORATIVE

Sally Thorne, Nursing Inquiry
Peggy L. Chinn, Advances in Nursing Science
Leslie H. Nicoll, CIN: Computers, Informatics, Nursing; Nurse Author & Editor
Rita Pickler, Journal of Advanced Nursing
Patricia D'Antonio, Nursing History Review
Cynthia Connolly, Nursing History Review
Cindy Peternelj-Taylor, Journal of Forensic Nursing
Dawn Welliver, Anesthesia eJournal
Joy Don Baker, AORN Journal
Annette Flanagin, JAMA and The JAMA Network
Lucy Bradley-Springer, Journal of the Association of Nurses in AIDS Care

Portland, Maine
August 2014

Your Board in Action

By Roberta Prettie, CANNT Past President

The purpose of this report is to inform the membership of the current and proposed activities of the Board of Directors (BOD). The BOD is composed of nine elected members: president-elect, president, past president, vice-presidents of Western Region, Ontario, Quebec, Atlantic and Technical, and Website/Treasurer. An additional and essential part of the BOD are the journal co-editors and our office administrator. Our fall board meeting was held on October 21–22, 2014.

MEMBERSHIP

We currently have a membership of 483. Our membership base is nurses, technologists and affiliate members. Student memberships are also available at half of full membership cost. This is available to full-time students only. The BOD is committed to maintaining membership by offering many benefits:

- a choice of one-year membership at $75.00 plus tax, or two-year membership at $140.00 plus tax
- access to our peer reviewed on-line journal
- reduced registration fee at our annual symposium
- access to the members only section of the CANNT website
- applications for annual awards, bursaries and grants
- an opportunity to be elected to BOD positions.

FINANCES

The CANNT BOD continually strives to remain fiscally responsible. We have achieved Not For Profit status and must abide by the guidelines set out in the NFP Act. In an effort to curb our spending, we continue to hold regular teleconferences to conduct business. We have one face-to-face meeting per year. This meeting is held in the fall in conjunction with the annual symposium.

STRATEGIC PLANNING

The BOD continues to develop our new strategic plan. We continue to look for growth and development opportunities to assist in maintaining the viability of the association. As we look forward, we hold fast to our mission statement: "to provide leadership and promote the best nephrology care and practice through education, research and communication."

During our meeting in Niagara Falls, the Board participated in a workshop aimed at "Helping Build Successful Service Organizations". We will be using the principles discussed to guide us as we develop our plan. Increasing member benefits is a priority for the BOD. To that end, we are currently partnering with Roche to develop some new educational materials and opportunities for our membership.

JOURNAL

Our peer reviewed quarterly journal is available in a downloadable version in the "members only" section of the CANNT website. It is recognized as a resource for all nephrology health care professionals and is indexed through CINAHL, MEDLINE, and OVID databases. We are pleased to welcome Jovina Bachynski and Matthew Phillips as our new Co-Editors and thank Janet Baker and Alison Thomas as they provide mentorship to Jovina and Matt during this period of transition. We encourage members to submit articles or research papers for publication to the journal. Guidelines for submission can be found under the "CANNT Journal" section of the CANNT website. A Journal Award is presented annually at the AGM for the winning manuscript published in the previous year.

WEBSITE/SOCIAL MEDIA

The CANNT website is easy to navigate, with quick links to available resources. In the members only section you have access to the discussion forum where you can pose questions to your peers across Canada, and the downloadable *CANNT Journal*. Links are also available for our refined clinical practice groups (Home Dialysis Interest Group, Clinical Educators Network, Canadian Hemodialysis Access Coordinators, and the Canadian Nephrology Nurse Practitioners) that will connect you to others within your area of focus in nephrology. Contact information for members of the BOD, Journal Co-Editors and office administration are also available on the website, and membership renewal is made easy by clicking on the "renew now" link. Upcoming events are posted with links to registration as available. CANNT is also active on Facebook and Twitter.

COMMUNICATION

Regular bi-monthly e-mails of the CANNT Connection are sent out to the membership to keep you informed of important deadlines. This is also a forum to keep you connected to activities of the association. On occasion we find it necessary to send out requests for membership participation in surveys. Please be reassured that we will only do this after carefully considering if this will be of benefit to our members.

A CANNT "Booth in a Box" has been created to promote CANNT at the local level. If you are having an educational activity for which you would like to use these materials it can be arranged through the administrative office at **cannt@cannt.ca** or 1-877-720-2819.

ANNUAL CONFERENCE

CANNT 2014 "Pursuing the Power Within" in Niagara Falls, Ontario, was a great success with a total of 538 people in attendance. Planning for CANNT 2015 "Reaching New Heights" at the Hyatt Regency in Vancouver, B.C., on October 22–24, 2015, is well under way. The abstract submission deadline was moved forward this year to February 1. Co-chairs Rick Luscombe and Stan Marchuk and their planning committee have been meeting regularly via teleconference to put together a quality educational experience. We look forward to seeing you there.

STANDARDS OF PRACTICE

The Nursing Standards of Practice have been updated and are posted on the CANNT website. A downloadable version is available in the "members only" section. Copies may also be purchased by contacting the association office. French translation of the Nursing Standards of Practice has been generously funded by Amgen.

AWARDS, BURSARIES AND GRANTS

All information regarding awards, bursaries and grants that are awarded annually during the National Symposium is located on the CANNT website under the "Resources" tab. Awards, bursaries and grants are available to members only. The deadline for applications is May 1st annually.

NOMINATIONS COMMITTEE

The Call for Nominations for positions on the Board of Directors is May 15, 2015. The positions available for the next term are: President-Elect, VP Quebec, VP Atlantic, and Website Co-ordinator/Treasurer.

There will be a motion put forward at the Annual General Meeting in Vancouver in October 2015 proposing a change in the President-Elect position to a dual role of President-Elect/Treasurer, as well as a change to the Website Co-ordinator/Treasurer position to Director of Communications. These motions will be presented, discussed and voted on during the AGM prior to being put in place. Voting for incoming BOD positions will occur online and introduction of the successful candidates will occur during the AGM, at which time they commence their term of office.

CANADIAN NURSES ASSOCIATION (CNA)

CANNT is one of 40 specialty groups that are a member of CNA. Nephrology is one of only 20 specialties that offer certification. As an association we promote certification by providing a certification preparation workshop during our National Symposium, and through the provision of certification/recertification bursaries for successful candidates. Professional certification demonstrates a commitment to the nephrology profession and a desire to maintain a high standard of care to our patients. We congratulate all who have met the qualifications to write the exam and wish you well on April 18, 2015. Remember to apply for the certification/recertification bursaries for financial assistance by the deadline of May 1, 2015.

NEPHROLOGY HEALTHCARE PROFESSIONALS DAY

Each year on the third Wednesday of September we celebrate Nephrology Healthcare Professionals Day in collaboration with our colleagues. We encourage you to take the time to celebrate every member of your team as "Together We Make a Difference". A list of suggested ways to celebrate is located on the CANNT website.

CANNT OFFICE OPERATIONS

The staff of Innovative Conferences and Communications continues to manage our National office. Sharon Lapointe is the main contact person and is available at **cannt@cannt.ca** or through the toll free number: 1-877-720-2819.

New CANNT Board Member

EDITORS' NOTE: In the Fall 2014 issue of the CANNT Journal, the introductory information about the new Vice President, Ontario, was inadvertently omitted. The CANNT Journal regrets this omission and apologizes to the board member for any inconvenience.

BILLIE HILBORN RN, CNEPH(C), BSCN, MHSC

Thank you to the CANNT members who voted for me to join the Board of Directors as the new VP for Ontario. I have been a CANNT member for several years and attended many symposia in varying interesting locations. I presented last year, am a member of a poster presentation this year, and have received two CANNT Awards: the Franca Tantalo Graduate Award (2008), and the Recertification Bursary (2013). I have also been a manuscript reviewer for the *CANNT Journal*.

Since becoming a registered nurse in 1970 my clinical background is broad. My experience as a front-line hemodialysis nurse extended from 1999 until 20I2, when I transitioned into a new role as Educator. I am an active participant in numerous committees within and beyond nephrology at the unit, department, corporate, and national levels.

This is my 11th anniversary with CNeph(C) designation. Certification has provided me with added knowledge, which provides a solid background for involvement in leadership projects at work and beyond, including a 2014 session in Ottawa for the CNA to participate in item review, developing questions for upcoming examinations. It is a pleasure to attend CANNT conferences and receive recognition via the ribbons for 'CNephC' at the CANNT booth and 'Certification' ribbon at the CNA booth to attach to my ID badge, which are on display in my office.

In this new role I am looking forward to learning more about how CANNT works. As a participant at many symposia I have seen one of the end results of all the work CANNT does, and am eager to be a part of that and other CANNT initiatives. I also look forward to gaining knowledge and experience in raising awareness of CANNT at the local and provincial levels.

NOTICE BOARD

- Ottawa Supper Clubs—contact Janet Graham, Nephrology Unit, Ottawa Hospital, Ottawa, **jgraham@ottawahospital.on.ca**
- March 12, 2015. World Kidney Day.
- April 19–22, 2015. ANNA National Symposium for Nephrology Nurses, Managers, and Advanced Practice Nurses, Disney's Coronado Springs Resort. Website: **www.annanurse.org**
- September 16, 2015. Nephrology Health Care Professionals Day.
- September 26–29, 2015. EDTNA/ERCA: 44th Annual International Conference, Dresden, Germany. **queries@edtnaerca.org**
- October 22–24, 2015. CANNT 48th National Symposium, Reaching New Heights, Vancouver, British Columbia. Website: **www.cannt.ca**

CANNT 2014 · Pursuing the Power Within! October 23–25, 2014, Niagara Falls, Ontario

From October 23–25, the CANNT Board of Directors and CANNT 2015 Planning Committee hosted 538 colleagues in Niagara Falls at the beautiful Scotiabank Convention Centre and Marriott Gateway on the Falls Hotel. CANNT 2014 marked the largest group of participants since 2008!

Our esteemed planning committee created a leading-edge program featuring local expertise and colleagues from across Canada. Concurrent sessions and plenary presentations reflected the theme of "Pursuing the Power Within", offering both evidence-based and experiential knowledge to conference attendees. Seven workshops, six plenary sessions, 40 concurrent sessions, 36 poster presentations, and 44 exhibitor booths assisted the committee in achieving their goals. One of the many highlights this year was a dedicated day for pediatric programming called "Using the Power Within to Empower Others!" We had 40 attendees involved in this stream. Another highlight this year was the attendance of 31 technologists and technicians who enjoyed a full conference of programming and, for the very first time—an offsite excursion for techs only to a local brewery.

The conference plenary talks were outstanding. The conference opened with two personal patient stories: Graeme Caswell—an accomplished university student living with the effects of illness, dialysis and organ transplantation—and Michelle MacKinnon—the mother of a beautiful young son, and how she and her family honour his legacy. Donna Rothwell shared her insights on "the essence of professionalism and interprofessional practice", and Barbara Fry of Halifax stirred incredible energy within the delegates with her message "A Call to Action: Powering Up Your Professional Practice". Messages of humour and motivation are always appreciated by delegates… and Barbara Bancroft and Mike Lipkin did not disappoint with their messages of "Unstress for Success" and "Star Power – How to Inspire and Lead Others, One Conversation at a Time", respectively.

More than 260 delegates attended the Evening of Entertainment at the exquisite "Ravine Vineyard" ….one cannot go to the vineyard without being inspired and experiencing the healing power of relaxation! Adding to the evening's success were the double-decker buses that transported attendees to the vineyard.

Continued commitment on behalf of the corporate sponsors played a large part in the success of the conference and we are always grateful for their generous support, as outlined below:

Platinum ($10,000+)
Amgen
Baxter
Bellco Canada
Fresenius Medical Care
Roche
Takeda

Gold ($7,500–$9,999)
Pfizer
NxStage Medical Canada Inc.

Bronze ($2,500–$4,999)
BD Medical
CardioMed
Charles River
Chief Medical
High Purity Water Services
RPC Rabrenco

The Board of Directors of CANNT is grateful to all who travelled from across Canada to participate in this year's conference. We trust that our host city of Niagara Falls delivered an exceptional experience for everyone.

The Board of Directors is also grateful to the CANNT 2014 Planning Committee for its dedication and commitment to creating a fantastic conference. Our thanks are extended to the following committee members:
Anita Amos, RN, BScN, CNeph(C) – Co-Chair
Cindy Bryson, RN, BScN, CNeph(C) – Co-Chair
Jovina Concepcion-Bachynski, RN(EC), MN, CNeph(C), NP-Adult
Arden Gibson, RN
Celine Menezes, RN, MScN – Pediatric Day
Linda Mills, RN, CNeph(C)
Rosaleen Nemec, RN, BScN, CNeph(C) – Pediatric Day
Martin Ruaux, BScN, MHM
Richard Sit, Renal Technologist
Kelly Taylor, RN
Colleen Wile, RN, CNeph(C) – Board Liaison


Collect "CANNT CASH"
$20 OPPORTUNITIES:
$50 OPPORTUNITIES:
$100 OPPORTUNITIES:


Pursuing the Power Within


Hyperoxaluria


Reaching New Heights

Reaching New Heights

CANNT 2015 • OCTOBER 22-24

VANCOUVER, BRITISH COLUMBIA

www.cannt.ca

Reaching New Heights

CANNT 2015 • OCTOBER 22-24
VANCOUVER, BRITISH COLUMBIA

Reaching New Heights through Innovation and Excellence in Nephrology.

CANNT invites you to join us in Vancouver in 2015!

STEAM WORKS

Evening of Entertainment

Get all the details at ...

www.cannt.ca

The patient perspective—A story of Paired Exchange Renal Transplant

By Lori Kraemer

***Editors' Note**: In this issue we are pleased to publish this story of living-donor paired exchange renal transplantation, eloquently written by Lori Kraemer. We are grateful to Lori and her family for sharing their experience with the CANNT Journal.*

INTRODUCTION

I was blessed with receiving the Gift of Life on April 3, 2013. I will be forever grateful to my two kidney donors, one of which is my husband, Don. Don and I were involved in a unique program called the Living Donor Paired Exchange (LDPE) Program that is coordinated through Canadian Blood Services. This is our story.

DIAGNOSIS

My diagnosis with Polycystic Kidney Disease (PKD) came at the age of 19, which was an incidental finding while I was undergoing an upper and lower GI series. I was shocked to receive this news, because I had never heard of PKD. Of significance, I was adopted at the age of 4.5 months of age, and did not know my biological family. Because of this, I was unable to trace my medical history to find out from where I inherited this genetic disease. I met my husband Don in 1993 while attending our last year of college. We married in 1995 and I had two pregnancies—both complicated by hypertension (twin daughters in 1999 and a son in 2001). Immediately following the birth of our twins I came to realize that my condition of PKD would have a major effect on my health due to hypertension. It was at this point in time that I made the choice to delve deeper into my medical history.

In 2002, a registry in Toronto found my birthmother for whom I had been searching for almost four years. We were reunited and I discovered that she did not have any knowledge of PKD in the family. My biological mother also would not tell me who my birthfather was. To this day, I still have no knowledge of my birthfather's medical history or identity. My birthmother and I knew each other for about a year before our relationship ended abruptly, as she parted ways with me once again, for reasons I do not know. After the loss of my biological mother, my husband and I moved around a lot. I felt fine and, being young, I felt invincible. I did not keep in touch with my doctor or attend appointments as I should have. Looking back to this time in my life, I realize that I was in a "denial" stage and should have been more compliant, better managing my blood pressure.

Lori Kraemer is a wife, a mother, and a resident of Ontario, Canada, who is living with Polycystic Kidney Disease (PKD). Lori is also the recipient of a renal transplant through a unique program that improves access to living donation in Canada. This is Lori's story.

Lori and Don Kraemer.

END STAGE RENAL DISEASE

My life would completely change in August 2010. In retrospect, my health had started to deteriorate over the months leading up to this. I was very sick and tired much of the time. My skin had become very itchy and I had developed severe muscle cramps in my legs. Loss of appetite and insomnia had also become a problem. I had often attributed these symptoms to just being run down as a result of being a busy mother. These symptoms would progress to the point where I could no longer keep water down and would vomit frequently. I was admitted to the Intensive Care Unit in Grand River Hospital in Kitchener, Ontario, with Stage 5 kidney failure, with a creatinine level of 2400. I was informed that I would need to begin emergency dialysis. I realized during my stay in ICU that this was the very place where my [adopted] father had died. I came to the conclusion that I did not want to die in the same place he did. I also did not want to leave my husband to raise our three kids alone. At that moment, I made a choice that I would fight this disease and not allow it to take my life.

Having started hemodialysis in an emergency situation, a central line was placed for access. That was a daily reminder that I could not escape nor ignore my health anymore. Once I was stabilized on hemodialysis (HD), I found out that I would need to follow the renal diet. I was devastated, but was determined to change and I found my dietitians were wonderful in helping me to recognize that the renal diet was not the end of the world. Starting in-centre hemodialysis was extremely difficult for me, as I was grieving the loss of my former lifestyle and trying to adjust to my new reality. By the end of 2010, I had fallen into a routine and began to feel better, thinking more positively about the changes in my life. I felt very blessed to be alive. HD wasn't entirely a negative experience—both my husband and I lost some weight and became more health conscious because of the renal diet.

This disease has not only affected me, but it has affected my entire family. Dialyzing on the evening shift, I missed being with my children to tuck them into bed at night. My in-laws had to move in with us, as we needed someone to help care for our children while Don was at work and I was attending HD. They were of great support, but living together with extended family under the same roof came with its challenges. Eventually we realized that a move to a community closer to the HD unit was inevitable. Therefore, we sold our home and relocated during the mid-winter break. This would, unfortunately, require uprooting our children from school, which was not only heartbreaking for us, but also very difficult for them. Not everyone enjoys going to the hospital for their dialysis treatments. Personally, I needed to be around other people who were going through the same thing that I was going through, so I chose to do in-centre HD. I enjoyed the social aspect of HD, and I made HD my "me" time, enjoying reading a good book or listening to music on my MP3 player.

I have made many wonderful friends in the in-centre HD unit. The staff and other patients became like a second family to me and are very caring and compassionate people. I would always look forward to having some great laughs with the nurses and other patients while at my treatments. For me, meeting others who had chronic kidney disease and finding support was vital. I enjoyed participating in the Kidney Connect Support Group Meetings held monthly and also joined the Renal Community Council. Thanks to programs offered by the Kidney Foundation of Canada my family enjoyed attending family Christmas parties and renal information events. I also became a part of a support group that met locally for those who have PKD (offered through the PKD Foundation of Canada).

Thanks to my dialysis unit's social worker in the early part of 2011, I was made aware of a family camp nestled in the Muskoka area called Lions Camp Dorset. Camp Dorset gave us the opportunity to enjoy a holiday, while at the same time being able to do my HD treatments right at the campgrounds in a medical facility with treatments carried out by the nursing staff who were familiar to me from my home HD unit.

KIDNEY TRANSPLANTATION

The year 2011 would bring hope for my husband and I, as we began testing to see if we would be a match for Don to be my living kidney donor. I will never forget the day when Don shared his hope and desire to donate one of his kidneys to me. We held hands while he sat beside my hospital bed and we reflected on the past 15 years of our marriage, having three children to raise, and the uncertainty of what the future held for us, as a family, with my newly-diagnosed end stage renal disease (ESRD). We had very high hopes that Don could donate a kidney directly to me because we already knew that we were both blood type O. I was referred to the transplant clinic at St. Joseph's Hospital in Hamilton, Ontario, that January.

Together we underwent four months of tests and investigations to ensure we were both fit for transplant as donor and recipient. I was approved in late November and placed on the wait list for a deceased donor kidney. However, in our area of Ontario, the average wait time for a deceased donor Type O kidney was 4+ years. Don and I were devastated to learn this.

Unfortunately, Don's weight was still at a BMI of 35 despite having lost 100 pounds, so he was not medically cleared to donate. A medical panel would eventually review his case by means of compassionate plea before finally giving the approval to proceed.

In early 2012 we received the disappointing news that our cross-match results revealed that we were not compatible, due to my multiple pregnancies and the antibodies that I had developed. However, we were advised about the LDPE Program. Through this program, the living donor anonymously donates a kidney to someone on the deceased donor list. In return, their loved one will receive a kidney from an anonymous donor. We readily agreed to this option and signed the consent forms in March 2012.

This program has three to four matching cycles per year in order to try to match potential donors to recipients. As we had just missed one cycle at the time of signing the consent forms, we would need to wait until June for the next cycle. As we waited, we wondered how our family would react to our plan and the need for both of us to simultaneously undergo major surgery.

We worried about how we would address questions from our children, especially concerns of losing both of their parents if something went wrong. These questions weighed heavily on our minds since we had both lost our fathers at a young age. My biggest fear was that Don felt he was pressured into this decision and this was a question asked by a social worker during one of our pre-transplant visits. Don made it clear any time this concern came up that under no circumstances did he feel pressured and that it was his and only his choice to make. He would also add, "Our kids need their mother". His reply would bring me to tears as I was so touched beyond words that he would risk his life for me. I always replied: "But they also need their father too".

The next matching cycle occurred in June, however no match was found. We felt like we were on an emotional rollercoaster. Fortunately we got the call we were praying for in October 2012, when the matching cycle revealed that we could proceed to transplant. Don was asked if he would travel out of province to donate one of his kidneys in a paired exchange and he confirmed that he would. We began making plans for him to travel. We enlisted the help of our family—my Mom to stay with me and my Dad to travel with Don out of province. As we waited for a date for our surgeries, we were faced with the risk of cancellation. We knew that any changes to decisions or health would risk breaking the exchange cycle and ability for the transplant to proceed.

During the waiting period, additional labwork was repeated and a 24-hour home BP monitor was booked. We sensed doing this test one more time might determine whether or not he would be able to donate. While the monitor was on, the batteries for the device failed prematurely. Don was at work when this happened and I was at dialysis. It was the only time in this journey that both of us needed to keep our blood pressures in check with a machine at the same time!

While his BP record was good, Don had gained 20 pounds while we were waiting. We were advised that we could move forth with the surgery, but he was encouraged to lose more weight, as he was at increased medical risk for surgery due to his size. Moreover, Don was warned that in the long-term he could be at increased risk of hypertension and Type 2 Diabetes with a single kidney if his weight were too high. I fought back tears having to come to grips with the risks involved for my husband. I did not want to lose him—suddenly, the risks seemed too high. There was also some concern that the out-of-province hospital to which Don was to travel would not operate on him due to his size, as standards were program- and surgeon-specific. However, Don was very determined to lose the necessary weight and ultimately succeeded in doing so.

In the end, our paired exchange chain was very small, which allowed all surgeries to take place in Hamilton. Under normal circumstances, the prospective donor would be required to travel to where the recipient was located. Fortunately for us, this was not required of Don. Our surgeries were booked for April 2013. By mid-March, I was prescribed two of the immunosuppressant medications needed when preparing to receive a live donation. I worried this might lead to infection or illness that might delay the transplant, but I knew it was required in order to prevent rejection. Finally the date arrived and I was admitted to hospital the day prior to surgery. It was so emotional saying goodbye to Don that night. My last words to him were, "Please don't die"! He calmly replied, "It's not my time, I still have much to do in life" and… "I love you".

The next morning, the news of Don's successful surgery was such a relief for me as I was wheeled into the OR. My surgery was also successful, with minimal post-op pain. It was amazing to have a new kidney! I was out of bed and up walking the next morning and it felt great. I could not wait to see Don and will never forget the overwhelming emotion and sense of relief I experienced when he was wheeled in to my room for the first time—verification that he was okay.

POST-TRANSPLANT

After my transplant, someone inspired me to name my new kidney. I loved the idea and chose the name April. Today, "April" is doing really well. I do have a lot of adverse effects from the immunosuppression, but it is a huge relief to be dialysis-free. Don and I have the distinction of being the first couple from the Kitchener-Waterloo Region to participate in a cross-Canada LDPE Program. We are faced, however, with the high likelihood of PKD being passed down to our children. While being worked up for my transplant we chose to have our children tested for PKD, as they have shown early signs of the disease. Ultrasounds have confirmed the presence of kidney cysts in our twin daughters. All three of our children are being monitored at Sick Kids Hospital in Toronto and we are working towards slowing the progression of the disease to the best of our ability.

I now enjoy the simple things in life that I used to take for granted, and I am so happy to be alive. My focus is now on living with a positive outlook, and I am very passionate about spreading awareness about PKD and the importance of organ donation, particularly live donation. I thank my husband and my anonymous donor every day. I also pray and hope daily that my donor is doing well and that the recipient of Don's kidney is also doing well. I feel very blessed to have him in my life. He not only helped give me the Gift of Life, but someone else—my anonymous donor—did too. I have two heroes, and will be forever grateful.

CONTACT HOUR: 2.0 HRS

Deprescribing: Is there a role in hemodialysis?

By Angela Wright, Stephanie Lovering and Marisa Battistella

OBJECTIVES

After reading this article, readers will be able to:

1. Define the terms deprescribing and polypharmacy.
2. Identify characteristics of medications that could be deprescribed.
3. Compare and contrast different tools described in the literature for deprescribing in elderly patients.
4. Describe the potential role of deprescribing in hemodialysis patients.

WHAT IS DEPRESCRIBING?

Deprescribing is a relatively new term that can be defined as "the process of tapering, stopping, discontinuing, or withdrawing drugs, with the goal of managing polypharmacy and improving outcomes" (Thompson & Farrell, 2013). This process typically involves a comprehensive assessment of a patient's current medications and includes determination of the patient's care goals, discussion of the risks and benefits of each therapy with the patient, as well as monitoring and follow-up for clinical outcomes after any medication is withdrawn, tapered or discontinued (Iyer, Naganathan, McLachlan, & Le Couteur, 2008).

WHY DEPRESCRIBING?

The ultimate goal of deprescribing is to manage polypharmacy and improve patient outcomes (Thompson & Farrell, 2013). Polypharmacy is defined as "the use of multiple medications or the use of more medications than are medically necessary" (Maher, Hanlon, & Hajjar, 2014). The use of more than five chronic medications is generally considered polypharmacy (Viktil, Blix, Moger, & Reikvam, 2006). Data from a 2013 Canadian Institute of Health Information study suggests that taking more medications increases the risk of experiencing adverse events (Cross, 2013). Seniors taking one or two medications were shown to have a 6% chance of experiencing a medication-related adverse event (Cross, 2013). This risk increased to 13% in those taking more than five medications (Cross, 2013). Data from other countries also suggest that more than 10% of hospital admissions are due to adverse drug events, with 30–55% of these deemed to be preventable (Scott, Gray, Martin, & Mitchell, 2012). The risk of experiencing an adverse drug event reaches 82% for those using seven or more medications, as compared to 13% for those using two medications (Scott et al., 2012). Polypharmacy has also been associated with other negative outcomes such as decreased adherence to medication regimens and an increased risk of falls, hospital admissions and mortality (Scott, Gray, Martin, Pillans, & Mitchell, 2013). Therefore, interventions aimed at reducing polypharmacy may decrease the risk of a patient experiencing these negative outcomes. Deprescribing is an example of one such intervention and has been shown to decrease polypharmacy and improve in patient outcomes in the elderly.

WHICH MEDICATIONS SHOULD BE CONSIDERED FOR DEPRESCRIBING?

Polypharmacy results from both appropriate and inappropriate prescribing of medications. Appropriate prescribing includes medications prescribed for a clear clinical indication based on current practice guidelines, where the medication is considered effective and safe for the patient (Scott et al., 2013). Patients with multiple medical conditions are, therefore, exposed to polypharmacy by the appropriate use of medications to treat these comorbidities. However, when considering which medications to deprescribe, the focus needs to be on those that are inappropriately prescribed for the patient. Inappropriate prescribing of medications contributes to polypharmacy by multiple mechanisms.

These include the extrapolation of disease specific clinical practice guidelines to populations where it may not be applicable, neglect in the re-assessment of chronic medications and the misinterpretation of adverse effects as

ABOUT THE AUTHORS

Angela Wright, BSc Phm, PharmD, University of Toronto, Leslie Dan Faculty of Pharmacy

Stephanie Lovering, BSc Phm, PharmD, University of Toronto, Leslie Dan Faculty of Pharmacy

Marisa Battistella, BSc Phm, PharmD, ACPR, Pharmacy Clinician Scientist, Assistant Professor, Leslie Dan Faculty of Pharmacy, University of Toronto, Clinical Pharmacist-Nephrology, University Health Network

Email: ***marisa.battistella@uhn.ca***

new disease states requiring more medications (Scott et al., 2013). An example of inappropriate prescribing is the use of benzodiazepines in the elderly. Benzodiazepines are used in these patients for the treatment of anxiety, agitation and insomnia despite evidence of safety concerns in the elderly population (Kruse, 1990). They are associated with many side effects such as increased risk of falls, sedation, cognitive impairment, dizziness and confusion (Chen et al., 2010). These adverse events are more pronounced in the elderly due to their decreased ability to metabolize and excrete these medications (Kruse, 1990). Therefore, benzodiazepines are widely recognized as unsafe in the elderly and should be considered for deprescribing in these patients.

Other considerations for deprescribing include the patient's medication experience and current care goals. These patient specific factors should also be used to guide deprescribing. Medications that the patient does not use and medications that no longer meet the patient's current care goals (e.g., preventative medication in the palliative setting) should also be considered for deprescribing. With a comprehensive assessment of a patient's current medications, those that lack the evidence for efficacy, that pose safety concerns to the patient, that the patient is not using or that do not comply with the patient's goals of care would be identified and could be deprescribed.

WHAT IS THE EVIDENCE FOR DEPRESCRIBING?

Deprescribing has been described across the literature as a method to reduce inappropriate prescribing and polypharmacy in the elderly. These studies include the elderly, as polypharmacy is highly prevalent among this population. Patients older than 65 years are often under-represented in clinical trials and are at higher risk of adverse events from medications due to multiple comorbidities, worsening renal function and polypharmacy (Scott et al., 2013). Despite these concerns, evidence-based clinical guidelines are commonly extrapolated and applied to these patients, contributing to inappropriate prescribing and polypharmacy.

The available literature on this topic has demonstrated that the use of specific tools and algorithms to guide deprescribing can effectively reduce polypharmacy in the elderly (Garfinkel, Zur-Gil, & Ben-Israel, 2007; Garfinkel & Mangin, 2010; Gallagher, O'Connor, & O'Mahony, 2011). These interventions have also been associated with decreased referral rates to acute care facilities, mortality rates and medication costs, as well as improvements in patients' perception of their global health (Garfinkel et al., 2007; Garfinkel & Mangin, 2010; Gallagher et al., 2011). Furthermore, they do not seem to be associated with an increased risk of long-term adverse outcomes (Garfinkel et al., 2007; Garfinkel & Mangin, 2010; Gallagher et al., 2011). The tools that have been described in these studies fall into two distinct groups: general tools to guide an overall re-assessment of the patient and specific tools designed to target re-assessment of specific medications within a patient population (Garfinkel et al., 2007; Garfinkel & Mangin, 2010; Gallagher et al., 2011).

Garfinkel et al. (2007) applied the "Good Palliative-Geriatric Practices" algorithm to assist with deprescribing in a group of elderly nursing home patients in Israel. This algorithm is a tool designed to facilitate an overall re-assessment of the efficacy and safety of a patient's current medications. It includes a determination of the patient's care goals, a review of the evidence to support the efficacy and safety of each medication and involvement of the patient in deprescribing decisions. They concluded that their intervention was associated with a 90% success rate for deprescribing (discontinuation of drug). The one-year mortality rate was 45% in the control group, but only 21% in the study group ($P < 0.001$). The patients' annual referral rate to acute care facilities was 30% in the control group, but only 11.8% in the study group ($P < 0.002$). The intervention was associated with a substantial decrease in the cost of drugs.

Garfinkel and Mangin (2010) used the "Good Palliative-Geriatric Practices" algorithm in a community dwelling elderly population and were able to discontinue 58% of medications that patients were using with an 81% success rate and no long-term consequences. They also identified that 88% of patients reported global improvement after deprescribing.

A tool that has been used to guide the appropriate use of medications in the elderly is the STOPP/START criteria. This tool was developed based on the evidence for efficacy and safety of multiple medications in the elderly. The STOPP criteria represent medications that should be deprescribed, or have their doses reduced in the elderly population, while the START criteria include medications that should be initiated. Gallagher, O'Connor, and O'Mahony (2011) randomly assigned elderly inpatients to an assessment using the STOPP/START criteria or to usual care in an attempt to determine the effect of the STOPP/START criteria in improving appropriate medication use. They found that the use of the STOPP/START criteria improved medication appropriateness and decreased medication underutilization in their population. Using the STOPP criteria to guide deprescribing resulted in a 91% decrease in the number of patients using inappropriate medications.

Overall the available evidence suggests that interventions aimed at deprescribing or improving medication appropriateness are effective in reducing polypharmacy in the elderly. This is also associated with improved patient outcomes and improvements in overall well-being.

DEPRESCRIBING IN HEMODIALYSIS

Polypharmacy is highly prevalent among the hemodialysis population. Patients receiving hemodialysis have multiple comorbidities and have the highest pill burden of all chronically ill patient populations with an estimated daily average of 12 medications (Chiu et al., 2009). They are, consequently, at a high risk of experiencing adverse drug events and other negative outcomes due to polypharmacy. Therefore, deprescribing could be considered as a method to reduce polypharmacy and improve outcomes in hemodialysis patients.

Selecting medications for deprescribing in hemodialysis could follow a similar thought process as previously described by focusing on medications that lack evidence for efficacy and have safety concerns, while taking the patient's preference and care goals into consideration. As hemodialysis patients are rarely included in clinical trials, and are at an increased risk of drug toxicity from certain medications that are not adequately removed by dialysis, there is uncertainty about the role of many therapies in this patient population. For example, quinine is commonly used for the prevention and treatment of leg cramps in the hemodialyisis population despite no official indication for this use. The available evidence suggests a lack of efficacy of quinine for this indication, with very few hemodialysis patients studied (El-Tawli et al., 2010). Quinine has also been associated with numerous side effects including dizziness, nausea, vomiting, thrombocytopenia and cardiac arrhythmias, which prompted a Health Canada warning against the off-label use of quinine to treat leg cramps (Raymond & Wazny, 2011). Due to these safety concerns, quinine could be considered for deprescribing in the hemodialysis population.

At this time, no deprescribing tools have been evaluated in the hemodialysis population. These tools have only been validated for use in the elderly population and may not be directly applicable to hemodialysis patients. However, in 2012, 43% of end stage kidney disease patients in Canada were over the age of 65 and, consequently, these tools could be considered for the high prevalence of elderly dialysis patients (Canadian Institute for Health Information, 2014).

CONCLUSION

In summary, deprescribing is a patient-centred process that incorporates an evidence-based discontinuation of inappropriate medications to decrease polypharmacy and improve patient outcomes. Deprescribing initiatives have been successful in safely reducing polypharmacy and improving patient outcomes in the elderly. Given the high prevalence of polypharmacy among the hemodialysis population secondary to the burden of co-existing diseases, deprescribing should be considered in this patient population to decrease their pill burden and reduce the risk of medication related adverse events.

REFERENCES

Canadian Institute for Health Information, (2014). *Canadian organ replacement register annual report: Treatment of end-stage organ failure in Canada, 2003 to 2012*. Retrieved from: https://secure.cihi.ca/free_products/2014_CORR_Annual_Report_EN.pdf

Chen, L., Farrell, B., Ward, N., Russell, G., Eisener-Parsche, P., & Dore, N. (2010). Discontinuing benzodiazepine therapy: An interdisciplinary approach at a geriatric day hospital. *Canadian Pharmicists Journal, 143*(6), 286–295.

Chiu, Y., Teitelbaum, I., Misra, M., de Leon, E., Adzize, T., & Mehrotra, R. (2009). Pill burden, adherence, hyperphosphatemia, and quality of life in maintenance dialysis patients. *Clinical Journal of the American Society of Nephrology*, *4*(6), 1089–1096.

Cross, C. (2013). Introducing deprescribing into culture of medication. *Canadian Medical Association Journal*, *185*(13), E606.

El-Tawli, S., Al Musa, T., Valli, H., Lunn, M., El-Tawil, T., & Weber M. (2010). Quinine for muscle cramps. *Cochrane Database of Systematic Reviews*, 12:CD005044.

Gallagher, P., O'Connor, M., & O'Mahony, D. (2011). Prevention of potentially inappropriate prescribing for elderly patients: A randomized controlled trial using STOPP/START criteria. *Clinical Pharmacology & Therapeutics*, *89*(6), 845–854.

Garfinkel, D., & Mangin, D. (2010). Feasibility study of a systematic approach for discontinuation of multiple medications in older adults. *Archives of Internal Medicine*, *170*(18), 1648–1654.

Garfinkel, D., Zur-Gil, S., & Ben-Israel, J. (2007). The war against polypharmacy: A new cost-effective geriatric-palliative approach for improving drug therapy in disabled elderly people. *Israel Medical Association Journal, 9*,430–434.

Iyer, S., Naganathan, V., McLachlan, A.J., & Le Couteur, D.G. (2008). Medication withdrawal trials in people aged 65 years and older: A systematic review. *Drugs Aging, 25*(12), 1021–1031.

Kruse, W.H.H. (1990). Problems and pitfalls in the use of benzodiazepines in the elderly. *Drug Safety, 5*(5), 328–344.

Maher, R.L., Hanlon, J., & Hajjar, E. (2014). Clinical consequences of polypharmacy in elderly. *Expert Opinion on Drug Safety*, *13*(1), 57–65.

Scott, I., Gray, L., Martin, J., & Mitchell, C. (2012). Minimizing inappropriate medications in older populations: A 10-step conceptual framework. *The American Journal of Medicine*, *125*(6), 529–537e1-e4.

Scott, I.A., Gray, L.C., Martin, J.H., Pillans, P.I., & Mitchell, C.A. (2013). Deciding when to stop: Towards evidence-based deprescribing of drugs in older populations. *Evidence Based Medicine*,*18*(4), 121–124.

Thompson, W., & Farrell, B. (2013). Deprescribing: What is it and what does the evidence tell us? *Canadian Journal of Hospital Pharmacy*, *66*(3), 201–202.

Raymond, C.B., & Wazny, L.D. (2011). Treatment of leg cramps in patients with chronic kidney disease receiving hemodialysis. *CANNT Journal*, *21*(3), 19–21.

Viktil, K.K., Blix, H.S., Moger, T.A., & Reikvam A. (2006). Polypharmacy as commonly defined as indicator of limited value in the assessment of drug-related problems. *British Journal of Clinical Pharmacology, 63*(2), *187–195.*

CONTINUING EDUCATION STUDY QUESTIONS **CONTACT HOUR: 2.0 HRS**

Deprescribing: Is there a role in hemodialysis?

By Angela Wright, Stephanie Lovering and Marisa Battistella

1. Deprescribing involves all of the following EXCEPT:
   a) initiating medications
   b) tapering medications
   c) withdrawing medications
   d) discontinuing medications
2. The primary goals of deprescribing include:
   a) decreasing polypharmacy and increasing adverse drug events
   b) decreasing medication adherence and improving patient outcomes
   c) decreasing polypharmacy and improving patient outcomes
   d) decreasing medication adherence and increasing adverse drug events
3. Polypharmacy is defined as the use of:
   a) > 1 medication
   b) > 5 medications
   c) > 12 medications
   d) > 20 medications
4. Which of the following is NOT an outcome associated with polypharmacy?
   a) increased adverse events
   b) increased falls
   c) increased hospitalizations
   d) increased medication adherence
5. All of the following contribute to polypharmacy EXCEPT:
   a) appropriate prescribing for multiple comorbidities
   b) ongoing re-assessment of patients' medication needs
   c) misinterpretation of adverse effects as new disease states requiring more medications
   d) extrapolation of clinical guidelines to inappropriate populations
6. Which of the following should be considered when thinking about deprescribing a particular medication?
   a) efficacy
   b) safety
   c) patient specific goals of therapy
   d) all of the above
7. Deprescribing tools have demonstrated an association with decreased:
   a) falls
   b) referral to acute care facilities
   c) referral to long-term care facilities
   d) patient perception of their global health
8. Deprescribing tools described in the literature were validated in which patient population?
   a) hemodialysis
   b) elderly (over 65 years)
   c) adult (18 to 65 years)
   d) pediatric
9. Which of the following tools provides an algorithm for overall patient assessment in the elderly?
   a) Beers' criteria
   b) STOPP/START criteria
   c) Good Palliative-Geriatric Practices
   d) all of the above
10. Which of the following is a reason to consider deprescribing in hemodialysis patients?
    a) high prevalence of polypharmacy
    b) patients excluded from clinical trials (questionable evidence for efficacy)
    c) increased risk of side effects
    d) all of the above

CONTINUING EDUCATION STUDY ANSWER FORM

CE: 2.0 HRS CONTINUING EDUCATION

Depresscribing: Is there a role in hemodialysis?

Volume 25, Number 1

By Angela Wright, Stephanie Lovering and Marisa Battistella

Post-test instructions:

- Select the best answer and circle the appropriate letter on the answer grid below.
- Complete the evaluation.
- Send only this answer form (or a photocopy) to:
  CANNT National Office,
  P.O. Box 10, 59 Millmanor Place,
  Delaware, ON N0L 1E0
  or submit online to **www.cannt.ca**
- Enclose a cheque or money order payable to CANNT.
- Post-tests must be postmarked by December 31, 2015.
- If you receive a passing score of 80% or better, a certificate for 2.0 contact hours will be awarded by CANNT.
- Please allow six to eight weeks for processing. You may submit multiple answer forms in one mailing, however, you may not receive all certificates at one time.

CANNT member – $12 + HST ($13.56); Non-member – $15 + HST ($16.95)

POST-TEST ANSWER GRID

Please circle your answer choice:

1.	a	b	c	d
2.	a	b	c	d
3.	a	b	c	d
4.	a	b	c	d
5.	a	b	c	d
6.	a	b	c	d
7.	a	b	c	d
8.	a	b	c	d
9.	a	b	c	d
10.	a	b	c	d

EVALUATION

	Strongly disagree				Strongly agree
1. The offering met the stated objectives.	1	2	3	4	5
2. The content was related to the objectives.	1	2	3	4	5
3. This study format was effective for the content.	1	2	3	4	5
4. Minutes required to read and complete:	50	75	100	125	150

Comments: _____

_____

_____

_____

COMPLETE THE FOLLOWING:

Name: _____

Address: _____

_____

CANNT member? ❑ Yes ❑ No Expiration date of card _____

Practice innovation: Collaboration with community partners to improve home dialysis safety in the province of Ontario

By Brooke Cowell

INTRODUCTION

The Ontario Renal Network (ORN) has prioritized seven strategies to drive innovation, quality and value in Ontario's Chronic Kidney Disease (CKD) system. Frontline providers play a pivotal role in achieving provincial strategic priorities. With a targeted goal to have 40% of all new dialysis patients on an independent dialysis option (home dialysis) within six months of initiating renal replacement therapy, one of the ORN's top priorities is to ensure that the infrastructure is available to support CKD patients. As patients transition from hospital to the home for care, there is a professional duty to ensure that care in the community not only be provided, but also be provided safely. Foreseeing the growth in independent dialysis, the ORN identified emergency preparedness as one of the key initiatives required in order to achieve this key strategic priority.

THE FRONTLINE CHALLENGE

When nurses at St. Joseph's Healthcare, Hamilton (SJHH), were asked by patients if paramedics would know how to disconnect them from their hemodialysis machine in case of an emergency, they were concerned. In many jurisdictions across the province, paramedics had been required to disconnect patients on an emergent basis in the community without any training, and with limited supplies. As strong advocates for safe patient care, the SJHH nurses and community paramedics worked together to change the system and improve patient safety for dialysis patients in their region.

SYSTEM CHALLENGES

In Ontario, although hospital nurses and paramedics work closely together, they are separate entities and funded by different provincial sources. Hospitals are funded by the Ministry of Health and Long Term Care, while paramedics are funded through local municipalities. As separate and independent entities with varied governance structures and strategic priorities, system misalignment between hospitals and community organizations is a reality. Moreover, professional practice legislation in Ontario limits paramedics' practice by requiring the development and approval of Medical Directives approved by the Base Hospital Group Medical Advisory Council of Ontario for provision of care beyond current competencies. Despite these challenges, frontline staff and leaders decided to challenge the standard of care; not only for their local needs, but also to pave the way for home hemodialysis patient safety across the province of Ontario.

THE JOURNEY TO IMPROVEMENT

At SJHH, the team believes that managing transitions in care through collaboration with other interprofessional teams is essential. Therefore, in order to resolve our patients' concerns, SJHH approached the Centre for Paramedic Education and Research (CPER) to discuss potential solutions. As willing and equal partners, the working group determined that in order to close the gap the paramedics would require access to the necessary supplies, education, and certification. To that end, SJHH staff began by adapting existing education curricula to meet the specific needs of paramedics who might encounter a home hemodialysis patient in an emergency situation. Following this, a formalized education plan incorporating a 'train the trainer' approach was developed and implemented. Training and certification was then carried out over a nine-month period of time, with more than 1,200 paramedics successfully completing the certification program.

The working group also identified the need for paramedics to have quick access to the essential supplies and equipment needed to safely disconnect a patient from the hemodialysis circuit in case of an emergency in the home. This led to the development of individual, standardized "Emergency Disconnect Kits" that were provided to all home hemodialysis patients, who were instructed to have it available on their machine for ready access at all times should he or she need to be disconnected by trained paramedics.

Address for correspondence: *Brooke Cowell, RN, BScN, Nurse Manager, Dialysis CAHS, Independent Home Therapies, St. Joseph's Healthcare, Hamilton, ON King Street Campus*

Email: ***bcowell@stjoes.ca***

THE OUTCOME

More than 1,200 paramedics in the regions of Hamilton, Niagara, Halton and Brant were trained and certified, and are now the first group in the province of Ontario who are authorized to safely disconnect patients from home dialysis equipment. Procedures and equipment are in place including a standardized "Emergency Disconnect Kit" attached to each patient's machine. SJHH nurses believe this will reduce infection and complication risk should an emergency disconnection need to be performed on any of their 180 home dialysis patients. In June 2014, the ORN reviewed the outcomes and mandated the expansion of this quality improvement initiative provincially, as a key initiative to support the growth of home hemodialysis in Ontario.

BROADER SYSTEM IMPLICATIONS

The delivery of dialysis is changing in the province of Ontario, and it is predicted that more patients will receive their dialysis in their home in future. This change will be most successful if patient risk can be minimized. To that end, the infrastructure needed to support patients in home dialysis therapy is being built in Ontario, and this quality initiative is evidence of that. Patients at SJHH are now reassured that when they commence independent home hemodialysis there is a safety net for emergency disconnection by trained paramedics in the event that a call is placed to 911 for emergency assistance.

Finally, as the expansion of independent dialysis occurs and the home hemodialysis population grows, the number of calls placed to paramedics will increase. Expansion of this initiative has been mandated by the ORN, and the program developed by SJHH and the CPER is a model that will be readily transferable to other regions. Frontline health care providers are frequently the first to identify patient safety issues. This affords them an opportunity to be catalysts for system change. This innovative quality improvement project has demonstrated that collaboration across disciplines and organizations can successfully address gaps in care and result in systems change.

Demande d'adhésion

Prénom _____

Nom de famille _____

Adresse à domicile _____

Ville _____

Province _____ Code postal _____

Téléphone (D) (_____) _____ - _____

(T) (_____) _____ - _____

Courriel _____

Employeur _____

Adresse de l'émployer _____

Ville _____

Province _____ Code postal _____

Adresse de correspondance ❑ domicile ❑ travail

Acceptez-vous que l'ACITN ajoute votre nom et votre adresse sur des listes d'envois qu'elle juge pertinentes et appropriées?
❑ Oui ❑ Non

Avez-vous consentez à l'utilisation de votre e-mail pour toute correspondance avec l'ACITN?
❑ Oui ❑ Non

❑ Nouveau membre ou ❑ Renouvellement

Numéro de l'ACITN (si renouvellement):_____

Frais d'adhésion (TPS #100759869)
Les frais d'adhésion sont deductibles d'impots.
❑ Un an : 70,00 $ + TVH/TPS
❑ Deux ans : 130,00 + TVH/TPS
❑ Tarif étudiant : 35,00 + TVH/TPS*
**La demande doit inclure une preuve d'inscription à plein temps*
AB/BC/SK/MB/NT/NU/QC/YT : 5 % TPS; ON/NL/NB: 13 % TVH; PE: 14 % TVH; NS : 15 % TVH

Je joins $ _____
payable à l'ACITN.

Mode de paiement :
❑ Chèque ❑ Mandat de poste ou chèque visé
❑ Visa ❑ Mastercard

Nom du titulaire de la carte : _____

Numéro de la carte : _____

Date d'expiration : _____

Signature : _____

❑ J'ai obtenu la désignation CNeph(C)/cdt

❑ Je suis membre de l'ACI

Demandeurs de l'Ontario seulement
Faites vous partie de l'AOIA?
❑ Oui ❑ Non

Statut professionel
❑ Infirmière(ier) autorisée(sé)
❑ Infirmière(ier) auxilaire autorisée(sé) / infirmière(ier) auxilaire
❑ Technicienne/technicien
❑ Technologue
❑ Autre (spécifier) _____

Années d'éxperience en néphrologie _____

Domain de responsabilité
❑ Soins directs
❑ Administration
❑ Technologie
❑ Enseignement
❑ Recherche
❑ Autre (spécifier) _____

Milieu de travail
❑ Soins actifs
❑ Unité d'autosoins
❑ Services de santé indépendants
❑ Secteur privé

Plus haut niveau d'instruction?

Infirmière(ier)	*Autres*
❑ Diplôme	❑ Diplôme
❑ Baccalauréat	❑ Baccalaureat
❑ Maîtrise	❑ Maîtrise
❑ Doctorat	❑ Doctorat

Je poursuis présentement des études

Domaine infirmière(ier)	*Autre domaine*
❑ Certificat	❑ Certificat
❑ Baccalauréat	❑ Baccalauréat
❑ Maîtrise	❑ Maîtrise
❑ Doctorat	❑ Doctorat

Secteur de pratique spécialisé
❑ Insuffisance rénale progressive (pré-dialyse)
❑ Transplantation
❑ Hémodialyse
❑ Péritonéale
❑ Pédiatrie
❑ Autre (spécifier) _____

Poster à **ACITN**
Adresse postale :

CANNT/ACITN
P.O. Box 10, 59 Millmanor Place, Delaware, ON N0L 1E0
Téléphone (519) 652-6767 Télécopieur (519) 652-5015

CANNT Nominations

CALL FOR NOMINATIONS 2015

The nominations committee is calling for nominations for the position of:

President-Elect
Vice-President Quebec
Vice-President Atlantic
Website/Treasurer

Eligibility for office: Member in good standing.

GENERAL REQUIREMENTS:

Each candidate must:

- ✓ Understand the responsibilities of each position.
- ✓ Be willing to commit the required amount of time to fulfil the duties of office.
- ✓ Be willing to work within parliamentary procedure, which is used to ensure an efficient and fair voting procedure by self-governing organizations.
- ✓ Will submit a National Officer Candidate Information Form available online at **www.cannt.ca** or from the National Office (see address below).

POSITION DESCRIPTIONS:

1. **President Elect:** President-Elect: Elected by membership for a period of one year after which he/she will become President, then Past-President. Assists the President in the overall administration of the Association while becoming familiar with the operation of CANNT in preparation to assume the presidency. The total commitment would be for a three-year period.
2. **Vice-President Quebec:** Regional Vice-President: Elected by membership for a two-year period. Promotes and facilitates the goals and objectives of the Association throughout the region. The Vice-President represents his or her region's concerns and acts as a liaison between the Board of Directors and the membership.
3. **Vice-President Atlantic:** Regional Vice-President: Elected by membership for a two-year period. Promotes and facilitates the goals and objectives of the Association throughout the region. The Vice-President represents his or her region's concerns and acts as a liaison between the Board of Directors and the membership.
4. **Website /Treasurer:** Website Coordinator/Treasurer: Elected by membership for a two-year period. The Coordinator updates the website, as needed, and is responsible to the Board of Directors to maintain and report on the financial standing of the organization.

Deadline for nominations is May 15, 2015. Information on candidates will be available online after May 15, 2015, and voting will take place online.

Please submit nominations online at **www.cannt.ca** or to:

CANNT
PO Box 10, 59 Millmanor Place
Delaware, ON, N0L 1E0
Telephone: (519) 652-6767
Toll Free: (877) 720-2819
Fax: (519) 652-5015
Email: **cannt@cannt.ca**

NOMINATING FORM

Position:

_____

Name of Candidate:

_____

Membership Number:

_____

Nominated by*:
1. Name:

_____

2. Membership Number:

_____

**Nominations can only be made by current members.*

***I agree to let my name stand for office and if elected, I agree to serve my term of office.*

_____
Signature of candidate**

Date: _____

Guidelines for authors

The Canadian Association of Nephrology Nurses and Technologists (CANNT) Journal invites letters to the editor and original manuscripts for publication in its quarterly journal. We are pleased to accept submissions in either official language—English or French.

Which topics are appropriate for letters to the editor?
We welcome letters to the editor concerning recently published manuscripts, association activities, or other matters you think may be of interest to the CANNT membership.

What types of manuscripts are suitable for publication?
We prefer manuscripts that present new clinical information or address issues of special interest to nephrology nurses and technologists. In particular, we are looking for:

- Original research papers
- Relevant clinical articles
- Innovative quality improvement reports
- Narratives that describe the nursing experience
- Interdisciplinary practice questions and answers
- Reviews of current articles, books and videotapes
- Continuing education articles.

How should the manuscript be prepared?
Form: The manuscript should be typed double-spaced, one-inch margins should be used throughout, and the pages should be numbered consecutively in the upper right-hand corner. More formal research or clinical articles should be between five and 15 pages. Less formal narratives, question and answer columns, or reviews should be fewer than five pages.

Style: The style of the manuscript should be based on the **Publication Manual of the American Psychological Association (APA),** Sixth Edition (2009), available from most college bookstores.

Title page: The title page should contain the manuscript title, each author's name (including full first name), professional qualifications [e.g., RN, BScN, CNeph(C)], position, place of employment, address, telephone, fax numbers and email address. The preferred address for correspondence should be indicated.

Abstract: On a separate page, formal research or clinical articles should have an abstract of 100 to 150 words. The abstract should summarize the main points in the manuscript.

Text: Proper names should be spelled out the first time they are used with the abbreviation following in brackets, for example, the Canadian Association of Nephrology Nurses and Technologists (CANNT). Generic drug names should be used. Measurements are to be in Standards International (SI) units. References should be cited in the text using APA format. A reference list containing the full citation of all references used in the manuscript must follow the text.

Tables/Figures: Manuscripts should only include those tables or figures that serve to clarify details. Authors using previously published tables and figures must include written permission from the original publisher. Such permission must be attached to the submitted manuscript.

How should the manuscript be submitted?
Email your manuscript to: **cannt.journal1@gmail.com** or **cannt.journal2@gmail.com**
Include a covering letter with contact information for the primary author and a one-sentence biographical sketch (credentials, current job title and location) for each author.

How are manuscripts selected for the CANNT Journal?
Each manuscript will be acknowledged following receipt. Research and clinical articles are sent out to two members of the **CANNT Journal** manuscript review panel to be reviewed in a double-blind review process. All manuscripts may be returned for revision and resubmission. Those manuscripts accepted for publication are subject to copy editing; however, the author will have an opportunity to approve editorial changes to the manuscript. The criteria for acceptance for all articles include originality of ideas, timeliness of the topic, quality of the material, and appeal to the readership. Authors should note that manuscripts will be considered for publication on the condition that they are submitted solely to the **CANNT Journal.** Upon acceptance of submitted material, the author(s) transfer copyright ownership to CANNT. Material may not be reproduced without written permission of CANNT. Statements and opinions contained within the work remain the responsibility of the author(s). The editor reserves the right to accept or reject manuscripts.

Checklist for authors
✓ Cover letter
✓ Article

- Title page to include the following:
  - title of article
  - each author's name (including full first name)
  - professional qualifications
  - position
  - place of employment
  - author to whom correspondence is to be sent, including address, phone, fax number, and email address
- Text of article, with abstract if applicable, **double-spaced, pages numbered**
- References (on a separate sheet)
- Tables (one per page)
- Illustrations (one per page)
- Letters of permission to reproduce previously published material.

Lignes directrices à l'intention des auteurs

Le Journal de l'Association canadienne des infirmières et infirmiers et des technologues de néphrologie (ACITN) vous invite à faire parvenir articles, textes et manuscrits originaux pour publication dans son journal trimestriel. Nous sommes heureux d'accepter vos documents soumis dans l'une ou l'autre des langues officielles, anglais ou français.

Quels sont les sujets d'article appropriés ?
Nous acceptons les articles portant sur des manuscrits récemment publiés, des activités de l'Association ou tout sujet d'intérêt pour les membres de l'ACITN.

Quels types de manuscrits conviennent à la publication ?
Nous préférons des manuscrits qui présentent de nouveaux renseignements cliniques ou qui traitent des enjeux propres aux champs d'intérêt des infirmières et infirmiers et des technologues en néphrologie. Nous recherchons plus particulièrement :

- Exposés de recherche originaux
- Articles cliniques pertinents
- Rapports sur des approches innovatrices en matière d'amélioration de la qualité
- Textes narratifs relatant une expérience de pratique infirmière ou technologique
- Textes sous forme de questions et de réponses sur la pratique interdisciplinaire
- Revues d'articles courants, de livres et films
- Articles en éducation continue.

Comment les manuscrits doivent-ils être présentés ?
Forme : Le manuscrit doit être présenté à double interligne avec une marge de 1 po et une numérotation consécutive des pages dans le coin supérieur droit de la page. Les articles plus formels de recherche ou d'études cliniques doivent compter de 5 à 15 pages. Les articles moins formels, tels que textes narratifs, questions-réponses ou revues, doivent compter moins de 5 pages.
Style : Le style du manuscrit doit être conforme au manuel de publication de l'Association américaine de psychologie (AAP), 6e édition (2009), offert dans la plupart des librairies universitaires.
Page titre : La page titre doit inclure le titre du manuscrit ainsi que les renseignements suivants : nom de chacun des auteurs (incluant prénoms au complet), titres professionnels (c.-à-d., inf., B.Sc. Inf., CNéph[C]), titre du poste occupé, nom de l'employeur, adresse, numéros de téléphone et de télécopieur et adresse courriel. L'adresse privilégiée de correspondance doit aussi être indiquée.
Résumé : Sur une page distincte, les articles formels de recherche ou d'études cliniques doivent être accompagnés d'un résumé de 100 à 150 mots, reprenant brièvement les principaux points du manuscrit.
Texte : Les sigles, abréviations ou acronymes doivent être écrits au long la première fois qu'ils apparaissent dans le texte, suivis de l'abréviation entre parenthèses; p. ex., Association canadienne des infirmières et infirmiers et des technologues de néphrologie (ACITN). Les noms génériques des médicaments doivent être employés. Les unités de mesure doivent être indiquées selon le Système international d'unités (SI). Les références doivent être citées dans le texte en utilisant le format de l'AAP. Une liste de références comprenant la bibliographie complète de toutes les références utilisées doit suivre le texte.

Tableaux/Figures : Les manuscrits ne doivent inclure que les tableaux et figures (incluant schémas, illustrations, croquis, etc.) visant à clarifier certains détails. Les auteurs qui utilisent des tableaux et des figures qui ont déjà fait l'objet d'une publication doivent fournir l'autorisation écrite de l'éditeur d'origine et la joindre au manuscrit soumis.

De quelle manière doit-on soumettre les manuscrits ?
Veuillez envoyer par courriel votre manuscrit à :
cannt.journal1@gmail.com ou **cannt.journal2@gmail.com**
Veuillez inclure une lettre de présentation en précisant les coordonnées de l'auteur principal ainsi qu'une notice biographique d'une phrase (incluant titres de compétences, titre du poste actuel et lieu de travail) pour chaque auteur.

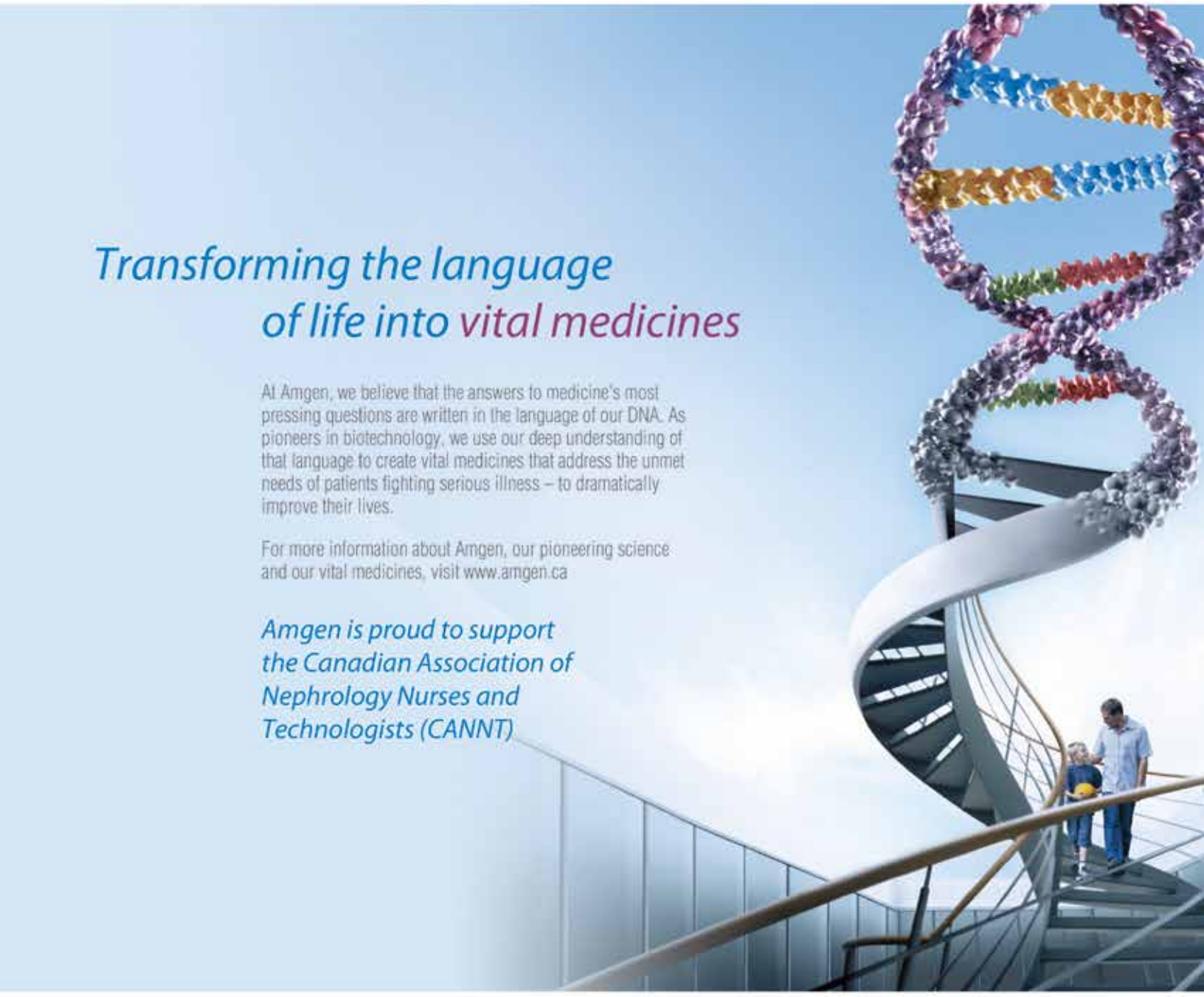
Quel est le processus de sélection des manuscrits pour publication dans le Journal de l'ACITN ?
À la réception de chaque manuscrit, un accusé de réception est envoyé. Les articles de recherche et d'études cliniques sont envoyés à deux membres du comité de révision du **Journal de l'ACITN** afin d'être révisés suivant un processus à double insu. Tous les articles peuvent être retournés aux auteurs pour révision et nouvelle soumission par la suite. Les manuscrits acceptés pour publication peuvent subir des changements éditoriaux; toutefois, les auteurs pourront approuver ces changements. Les critères d'acceptation pour tous les manuscrits comprennent l'originalité des idées, l'actualité du sujet, la qualité du matériel et l'attrait des lecteurs.

Les auteurs doivent prendre note que les manuscrits seront considérés pour publication à la condition qu'ils ne soient soumis qu'au **Journal de l'ACITN.** Sur acceptation du matériel soumis, les auteurs transfèrent leur droit d'auteur à l'ACITN. Aucune reproduction n'est permise sans l'autorisation écrite du **Journal de l'ACITN.** Les déclarations et opinions émises par les auteurs dans leurs articles, textes ou manuscrits demeurent leur responsabilité. La rédactrice en chef se réserve le droit d'accepter ou de refuser tout manuscrit.

Aide-mémoire à l'intention des auteurs
✓ Lettre de présentation
✓ Article
- Page titre incluant les renseignements suivants :
  - Titre de l'article
  - Nom de chaque auteur (incluant prénoms au complet)
  - Titres de compétences
  - Titre du poste actuel
  - Nom et adresse de l'employeur
  - Nom de l'auteur à qui la correspondance doit être envoyée (incluant adresse, numéros de téléphone et de télécopieur et adresse courriel)
- Texte de l'article avec résumé, s'il y a lieu à **double interligne et pages numérotées**
- Références (sur une feuille distincte)
- Tableaux (un par page)
- Figures (une par page)
- Lettre d'autorisation pour tout matériel ayant déjà fait l'objet d'une publication

AMGEN®

Pioneering science delivers vital medicines™



Transforming the language of life into vital medicines

At Amgen, we believe that the answers to medicine's most pressing questions are written in the language of our DNA. As pioneers in biotechnology, we use our deep understanding of that language to create vital medicines that address the unmet needs of patients fighting serious illness – to dramatically improve their lives.

For more information about Amgen, our pioneering science and our vital medicines, visit www.amgen.ca

Amgen is proud to support the Canadian Association of Nephrology Nurses and Technologists (CANNT)