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CARNA Provincial Council

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Alberta RN is published nine times a year by:
College and Association of Registered Nurses of Alberta
11620-168 Street
Edmonton, AB T5M 4A6
Phone: 780.451.0043
Toll free in Canada: 1.800.252.9392
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www.nurses.ab.ca
Managing Editor: Margaret Ward-Jack
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mcrone@interbaun.com
Please note CARNA does not endorse advertised services, products or opinions.

US Postmaster: Alberta RN (USPS #009-624) is published monthly except June, August and December by the College and Association of Registered Nurses of Alberta. 90 U.S. Agent: Transborder Mail, 4708 Caldwell Rd E, Edgewood, WA 98372-9221. Alberta RN is published at a rate of $40 per year. Periodicals postage paid at Puyallup, WA and at additional mailing offices. US Postmaster: Send address changes (covers only) to Alberta RN, 90 U.S. Agent: Transborder Mail, PO Box 6016, Federal Way, WA 98063-6015. ISSN 1481-9988
Canadian Publications Mail Agreement No. 40062713

Return Undeliverable Canadian Addresses to:
Circulation Dept., 11620-168 Street, Edmonton, AB T5M 4A6.
E-mail: carna@nurses.ab.ca

Alberta RN is printed on recycled paper.
**President’s Update**

*A New Year, New Challenges and New Opportunities*

Leadership can be thought of as a capacity to define oneself to others in a way that clarifies and expands a vision of the future. (EDWIN FRIEDMAN)

This definition of leadership seems very applicable for registered nurses (RNs) in 2009 as reorganization of the province’s health system continues. In mid-December, Alberta Health and Wellness released *Provincial Service Optimization Review: Final Report*, prepared by McKinsey & Company which forms the basis of the provincial government’s evolving health reorganization strategy. While you can download a copy of the report from the government website, here is a brief overview of the reports four themes and 14 recommendations:

- **Matching intensity of services to patient need**: shifting inpatient and ER services to outpatient care centres; shifting selected services from long-term care to supportive living and home care; repatriating selected inpatient services back to home regions; and increasing use of short-stay and other mental health alternatives
- **Enhancing access to high-quality services in rural areas**: merging and converting selected facilities into advanced ambulatory centres; empowering paramedics to provide more on-site care; and expanding regional telehealth programs
- **Enhancing the capacity and effectiveness of Alberta’s workforce**: a targeted recruitment and retention strategy; considering changes to the benefits structure, salary guidelines and/or reimbursement schemes to enhance productivity and collaboration among health professionals; increasing workforce efficiency by matching work to skills; and building incentives for providers to work in rural areas
- **Improving coordination of care**: making better use of multidisciplinary teams; new organizational structures to improve linkages across the delivery system; implementing a lean operational system to streamline flow of patients, information and other components; and integrated IT systems

CARN A has lobbied for some of these changes, such as greater optimization of the RN workforce and increased use of multidisciplinary teams, but there are other recommendations with potential to have a negative impact on work environments. However, this state of flux in the health system also offers opportunities for RNs to work to full scope in many areas of practice.

In a transitional period like this, it is particularly important to retain the current RN workforce. As I travel throughout the province, it is clear that recognizing the contribution of RNs and appreciating the work that they do is the key component to retention. This message was clearly articulated by the nurses I met at the Fireside Chat held in Calgary in October. It was a pleasure for me to visit CARN A’s South Region in November where I met members in Medicine Hat, Fort Macleod, Lethbridge, Raymond, Milk River and at the Blood Tribe Department of Health in Standoff. In November, I also had the opportunity to meet with nurses who work for the following First Nations communities in Alberta: Alexis, Siksika, Keewin, Beaver Lake, Piikani (Brocket), Enoch, Swan River and Kapawe’no. In every community, members were hospitable and eager to share their stories of nursing as well as their perspective on health and nursing issues.

In all these practice settings, RNs are demonstrating leadership and advocating for quality patient care. Working together, we can make 2009 the year RNs become recognized as the leaders we are. **RN**

*MARGARET HADLEY, RN, MN*
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**Alternate Complaint Resolution Update**

Highlights of the December meeting of Provincial Council will be published in the February issue of *Alberta RN*. In the meantime, I wanted to highlight one of Council’s decisions. In response to a request from the United Nurses of Alberta, Provincial Council reconsidered its exclusion criteria for use of the Alternate Complaint Resolution (ACR) process for RNs with these problems. The exclusion criteria outline characteristics of complaints that cannot be referred to ACR. Most nursing jurisdictions in Canada have more than one level of discipline since their Acts have options for other disciplinary mechanisms that the Health Professions Act does not have. The majority can hold members accountable for an addicted nurse’s unprofessional conduct through another disciplinary level, not only at a discipline hearing. Alberta’s Health Professions Act establishes only one level of discipline and that is to hold members accountable for their unprofessional conduct through a hearing. All other options are non-disciplinary, including ACR. Provincial Council decided to reconfirm the existing exclusion criteria guidelines for referral of complaints to ACR. In addition, Council directed staff to implement an education strategy regarding substance abuse in the workplace and CARN A’s role in addressing conduct related issues while supporting members in their return to optimal health and wellness. CARN A will also be pursuing discussions with key stakeholders in addressing support for RNs with substance abuse issues.
MAKING YOUR VOICE HEARD:
CARN A Advocacy and Government Affairs

BILL 46 – Amendments to the Health Professions Act

ON Nov. 18, 2008 CARN A sent a letter to Minister of Health and Wellness Ron Liepert outlining concerns with Bill 46, the Health Professions Amendment Act. The legislation broadens the mandate of health professional colleges to include monitoring and enforcing their members’ compliance with professional standards of practice. The proposed amendments also mandate colleges to require that members have plans to address care, custody and access to patient records. The bill was introduced in the Legislature on Nov. 6, 2008 and passed third reading on November 21.

CARN A’s concerns relate to the following four areas:

• omission of amendments requested by CARN A and forwarded to the ministry earlier to protect the title “graduate nurse,” the initials “GN,” the title “graduate nurse practitioner” and the initials “GNP”
• the requirements for colleges to store and manage abandoned patient records
• lack of clarity on the overall purpose of a new section in the Act authorizing a council to appoint inspectors
• the minister’s authority to obtain information about health professionals from professional colleges

CARN A is also requesting clarification on the link between these amendments and the development of a provincial health provider directory by Alberta Health and Wellness. CARN A has conferred with the Alberta College of Pharmacists and the College of Physicians and Surgeons to address issues of common concern.

BILL 52 – Health Information Amendment Act

CARN A is also reviewing the significance of Bill 52, the Health Information Amendment Act on the profession of registered nursing. The bill expands the scope of the Health Information Act, which regulates the collection, use and disclosure of health information in Alberta and gives individuals the right to access their own information and request corrections. According to Alberta Health and Wellness, Bill 52 is designed to provide a legislative framework for Alberta Netcare, Alberta’s provincial electronic health record, as well as the electronic health record information systems of others. In December, Information and Privacy Commissioner Frank Work noted several concerns with the proposed amendments as tabled in the Legislature. CARN A is particularly mindful of its obligation to safeguard the privacy of member information. The bill was introduced in the Legislature on November 24 and referred to the all-party Standing Committee on Health.

Vision 2020

IN December, Liepert outlined a number of actions related to the goal of matching workforce supply to demand for services, one of the five goals listed in the health plan titled Vision 2020, Health Care for Today and the Future, Phase One. CARN A will be watching for indications of meaningful activity on the minister’s proposed actions which include the following:

• Introduce targeted near-term and long-term recruitment and retention strategies to attract and retain staff, with a special focus on health-care aides and nurses.
• Address barriers that currently limit health-care providers from working to the full extent of their education, skill and experience.
• Support health-care providers by implementing revised processes and tools, such as automation that will help them do the job they have been trained to do. This in turn will improve overall productivity and system effectiveness.
• Promote team-based care by continuing to focus on the development of models such as, but not limited to, Primary Care Networks.
• Increase the percentage of health-care professionals working full-time to improve consistency of care and productivity.
• Change reimbursement incentives to align with new models of care.

The other four goals in Vision 2020 are:

• providing the right service, in the right place, and at the right time
• enhancing access to high quality services in rural areas
• improving coordination of care and delivery of care
• building a strong foundation for public health

Alberta Ombudsman wants your input

The Alberta Ombudsman is conducting an investigation of the out-of-country health services program and is inviting anyone who has concerns about the program to contact us. Numerous complaints have been received and the investigation will focus on the administrative fairness of the program’s processes. The program applies to planned health services obtained outside of the country, not travel emergencies. It will conclude in spring 2009. If you or one of your patients has experiences dealing with the program, please contact the Alberta Ombudsman office at www.ombudsman.ab.ca, 780.427.2756 or toll-free at 310.0000.
Letters to the Editor

Interprofessional practice goes beyond the hospital setting

I had the opportunity to read the October 2008 issue of Alberta RN. Of special interest was the article “Interprofessional Practice.” The author lists the many different professionals involved in the delivery of care to the victim of a motorcycle collision. What tweaked my interest was not who was on the list, but who was not. Interprofessional practice goes beyond the hospital setting. I am pretty sure that the collision did not happen at the hospital; therefore the patient probably required treatment and transportation by paramedics from Emergency Medical Services. When the patient was later Medevac’d to Alberta, I would hazard the guess that this was performed by flight paramedics.

On April 1, 2009 Emergency Medical Services will become the responsibility of the province. This in and of itself may well not have earth shattering changes within the hospital setting, but it is my hope that it at least raises the level of awareness that paramedics are a part of the interprofessional team.

As the spouse of an RN, I benefit from reading Alberta RN. Keep up the good communication.

Sincerely,
David Dufour, B.H.Sc. EMT-P
Palliser Health Region

Disposable is not re-usable

I graduated from an Edmonton hospital school of nursing in 1981 and earned my bachelor of science in nursing in 1990. I have worked in a variety of roles and settings over the years and it was never common practice to reuse needles and syringes nor was it ever condoned. Even in 1981 we knew there was a risk, however infinitesimal, of passing on a blood-borne infection, such as hepatitis B, from one patient to another.

Disposable is not re-usable. Needles and syringes are to be used once and discarded. There is to be no sharing of needles and/or syringes between patients. This is a basic principle of asepsis. As a professional nurse, I take great exception to those who might give the impression that reusing needles is a common practice. I have always prided myself in providing nursing care that meets national standards. The fact that there has been reuse of needles and syringes in institutions and offices needs to be addressed immediately, but for anyone to imply that it is common practice does a grave disservice to the nursing profession and shatters patient confidence.

Claudette Gourdine, BScN
Edmonton


Carna encourages all registered nurses to visit www.nurses.ab.ca to review the standards and to implement those standards relevant to their practice settings.

MEMBERS WANTED

General Faculties Council Practice Review Board – University of Alberta

The General Faculties Council Practice Review Board reviews cases where faculty believes a student demonstrated inappropriate behaviour at a practicum placement. Any situation related to unsafe, unethical or incompetent professional practice or appeals of decisions made by a dean and/or discipline officer are heard by the Board.

Qualifications
• current CARNA member in good standing
• a minimum of five years clinical experience
• Edmonton resident
• excellent communication skills
• able to maintain confidentiality and objectivity
• available for hearings when scheduled

This is a voluntary position with no remuneration, however board members receive free parking and meals are provided during a hearing.

How to Apply
Carna will forward a list of interested members to the University of Alberta. Those interested are asked to send their contact information to:

Lella Blumer
Manager, Registration
780.453.0505 or 1.800.252.9392, ext. 505
lblemur@nurses.ab.ca

Deadline: Feb. 16, 2009
Committed to Competence: How to change your indicators during the practice year

Did you know you can change your nursing practice standards indicators or nurse practitioner competency indicators at any time during the practice year? There are several reasons why you would change your professional development focus during the practice year. Perhaps you changed your role or practice setting or another learning need becomes more of a priority. You might change your indicator because the resources/learning activities to achieve your objective are not available or your practice hours are limited because of a leave of absence.

To change your professional development indicators during the practice year:
1) record the change on your self-assessment and complete a written learning plan for your new indicator
2) report the change to CARNA by:
   - updating your Member Profile on the CARNA website at www.nurses.ab.ca
   - indicating the change on your next application for renewal
President-elect and Provincial Council members

Registered nursing is a self-regulating profession. As part of self-regulation, we need RNs with your knowledge, experience and dedication to maintain the regulatory framework that defines us and helps shape the future of nursing in this province.

The Elections and Resolutions Committee is seeking candidates to serve as president-elect or as a provincial councillor. One provincial councillor is needed in each of the following CARNA regions:

• Northeast
• Edmonton/West
• Calgary/West

If you care about the profession of registered nursing, you have what it takes to be a member of Provincial Council. You can make a difference and know that your vision will be reflected in the decisions of your professional body. Orientation to the role of president-elect and provincial councillor will be provided.

President-elect

WHAT’S INVOLVED?

The president-elect position is a four-year commitment. The first two years will be served as president-elect and the second two as CARNA president.

OPPORTUNITIES FOR YOU

■ represent the registered nursing profession to government, the public and other stakeholders
■ play a crucial role in self-governance for Alberta’s RNs
■ incorporate the RN perspective in the development of health policy for Albertans
■ lead national nursing policy through membership on the board of the Canadian Nurses Association
■ expand networks with provincial and national nurse leaders

PRESIDENT-ELECT COMMITMENT

■ serve as president-elect for a two-year term
■ requires time commitment of 15–20 days annually; including attending:
  • four two-to-three day meetings in Edmonton
  • an orientation meeting at the beginning of your term
  • the CARNA annual general meeting and two-day conference
■ chair the Audit Committee
■ act on behalf of president in the president’s absence

PRESIDENT’S COMMITMENT

■ serve as president for a two-year term
■ requires a time commitment of approximately 0.5 F.T.E; including:
  • chairing the annual general meeting and attending the two-day conference
  • chairing four two-to-three day Council meetings per year in Edmonton
  • chairing Provincial Executive Committee meetings (usually via teleconference)
■ develop and maintain effective relationships within Provincial Council
■ represent CARNA at Canadian Nurses Association board and other meetings
■ develop and maintain effective relationships with government, media and other stakeholders
■ act as spokesperson for CARNA

QUALIFICATIONS

■ RN
■ resident of Alberta

Provincial Council Member

OPPORTUNITIES FOR YOU

■ play a crucial role in self-governance for Alberta’s RNs
■ work collaboratively to address nursing issues
■ meet nursing colleagues who share your passion for nursing at the provincial and national levels
■ develop and expand your leadership abilities as you help govern the nursing profession in Alberta
■ work with leaders who are shaping nursing in Alberta
■ learn from the knowledge and nursing experience of colleagues on Council

PROVINCIAL COUNCILLOR COMMITMENT

■ serve as a provincial councillor for three years
■ prepare for Council meetings
■ time commitment of 15–20 days annually, including attending:
  • an orientation session at the beginning of your term
  • four two-to-three day Provincial Council meetings in Edmonton
  • the annual general meeting and two-day conference
  • committee meetings, special meetings and/or retreats as necessary
■ participate actively in discussions, while respecting other opinions
■ commit to Council decisions
■ link with the public and the membership to bring their input to Council
■ act on behalf of, and be accountable to, the public and the membership as a whole rather than specific areas or groups

QUALIFICATIONS

■ RN
■ resident of the CARNA region in which you are nominated

Nomination forms available at www.nurses.ab.ca or contact Diane Wozniak at 780.453.0525, toll-free 1.800.252.9392, ext. 525 or e-mail at dwozniak@nurses.ab.ca.

NOMINATION DEADLINE: April 1, 2009
Want to share your opinion?
Reunite with an RN friend?
Chat with other RNs?
Connecting and sharing is now easier than ever with the new CARNA Facebook group.

The RN exclusive group offers news of upcoming events, a message board and links to relevant CARNA information. Upload your photos, share your stories, post video and much more.

In January, a pilot group of 8,000 members will be invited to join the CARNA Facebook group. If you do not receive an e-mail notice and want to join, go to the CARNA website at www.nurses.ab.ca and click on the Facebook icon.

Send us your suggestions!
Want to see something added to our Facebook group? Write on the wall or send us a message. Your participation is key!

Not on Facebook? To join the CARNA Facebook group you’ll need a Facebook profile. If you don’t already have one, you can sign up using your e-mail address. It’s free and anyone can join.

Each month Alberta RN will publish tips and helpful hints to help you navigate and participate in the CARNA Facebook Group. This month we look at how to set up a Facebook account.

How to set up a Facebook account:

1. Visit www.facebook.com to create your account.
2. Enter your name, a valid e-mail address, choose a password, select your gender and enter your birth date. (This information will remain private unless you choose to publish it)
3. Next, you’ll receive e-mail confirmation of your account activation. Click on the link in the e-mail and you’ll become the newest member to the world’s largest social networking site.

Facebook and Professional Boundaries

Social networking is a powerful tool, but it is a tool that can be misused and sometimes even abused. CARNA reminds members to:

- respect the privacy of patients
- adhere to employer policies regarding Internet use
- use a personal e-mail address (e.g. jsmith@gmail.com)
- set appropriate privacy settings

Remember that anything posted on a social networking site is in the public domain.
Speak Up

In the November issue of Alberta RN, we asked RNs working part-time or casual to tell us what is holding them back from working full-time. Here is what some of you had to say:

**Taxes.** I presently work the equivalent of a 0.8 position and earn as much as a full-time nurse. I refuse to claim overtime. I do work overtime on occasion, but I want time off in lieu because taxes take too much. That’s why I don’t work full time – and I love what I do. Thanks for asking.

~ Candice

**The reason** I work part-time is because I am burned out. With nursing shortages, high demands, increasing acuity of patients and missed breaks, my nursing job has led to burnout – and I just turned 30. I love being a nurse. I enjoy the patient care and I want to make a difference. I actually think that by offering part-time and casual positions our career is attractive. The goal should be the retention of nurses, offering incentives and making our career attractive.

If nursing was a more attractive career, more primary bread winners would be interested. How about increasing our baseline staff numbers so that we can accommodate for the more acute patients, provide adequate and safe care, get our breaks and not get burned out?

~ Lana

**The reason** I have stuck to part-time is that my employers have always been very inflexible regarding our shift rotation and scheduling. I had to fight and beg for many years to be allowed to work only weekends and nights. Because nurses are still mainly female, we are usually the ones to take care of children. Because our shifts start so early and are long, full-time work is not an option when you have children. Try to find a sitter for a 14-hour day. Working full-time, 12-hour shifts switching from days to nights and back again is hard on anyone. It takes a toll on your physical and mental health.

Full-time hospital shifts also mean giving up many weekends, holidays and time with family. While most of the world is having Christmas dinner or celebrating the end of the work-week, nurses are slogging away at work. In order to have any quality time with family/kids, many nurses are forced to go casual.

I think there needs to be more flexibility on the part of management. Allowing staff more choice in the rotations/schedule they work, would keep more of us in the workplace more often. Allowing job sharing would also provide more coverage for down times.

~ Rhonalee

Visit www.nurses.ab.ca and check out Speak Up to have your say on this topic and others. Your post could appear in an upcoming issue of Alberta RN.

See page 11 for this month’s Speak Up topic.
Let’s help them _stay_…

in nursing!

**BY PAMELA R. CANGELOSI**

NURSES HAVE ALL HEARD THE PHRASE “WE EAT OUR YOUNG” and some laugh it off. I don’t laugh. There is no excuse for the miserable treatment we sometimes give new colleagues. Nurses cry out for more help and then sabotage those who come. Is it any wonder why so many new graduates leave nursing?

Nursing literature has many references to the value of mentors. Reflecting on my own experiences and hearing the stories of colleagues has convinced me that effective mentors are what make the difference between leaving nursing or staying to build a satisfying career. What would have happened to me if I had not had my mentors? Most likely, I too would have left nursing.

The current nursing shortage is well known by nurses and the general public. The recent rise in nursing-program enrolment is heartening. However, this increase in students is not a complete answer. The limited supply of faculty qualified to teach the swelling numbers of students and the retention of these graduates after successful completion of the licensing exam are major deterrents to reducing the shortage. Will these new graduates remain in nursing or will they encounter such dissatisfaction with their newly chosen field that they leave shortly after they enter?

Rewards and frustrations of nursing

Most nursing students express a true desire and eagerness to help others and realize the potential rewards nursing has to offer. The actions of a nurse can be the deciding factor in the course and outcome of a client’s hospital stay. Acutely ill clients recover, go home and even return to thank the nurses.

Camaraderie can transform relationships between nurses and other health-care professionals, between faculty and students and between nurses and clients. More mature students often cite prior life experiences, even pivotal moments, that led them to change course and pursue nursing.

Unfortunately, many become disillusioned before they even graduate. These students experience a lack of respect from some staff nurses and faculty. They realize their exposure to disease is real and that they have to be very strong physically and emotionally to withstand the rigors of clinical nursing. They also hear grumbling about low wages, long hours and unrealistic workloads. Is it any wonder their enthusiasm wanes?
What keeps nurses in nursing?
Reflecting back on those I have known who left nursing for other careers, I contemplated what has kept my colleagues and me in the profession for so many years. We have found fulfillment in nursing, but how do we help students and novice nurses find satisfaction in nursing?

My entry into nursing began as a licensed practical nurse (LPN). As a neophyte LPN, I was “in charge” of the care of 60 residents in a long-term care facility. I worked long hours with no registered nurse (RN) on duty, frightened and convinced that someone would suffer due to my inexperience. Is it any wonder that I left after a few short months?

I moved to a job on a busy medical-surgical unit in an acute-care hospital, where more experienced nurses were present. I thought I could learn from them. However, while many of the nurses were friendly, many more were not and they offered little of their time to teach a novice. An orientation program was in place, but it consisted only of classroom learning. On the clinical unit, I received my assignment and the name of an RN who was to “cover my IVs,” but it was customary for the shift to go by and not see “my RN.” Until I met Maureen, I was not certain I would stay in nursing.

Maureen, a baccalaureate-prepared nurse, showed me how to care for a dying patient and how to be present for a family in grief. I learned from Maureen how to prioritize and juggle several tasks at once and not appear frazzled. From Maureen, I learned how to implement the true art and science of nursing.

As a result of Maureen’s influence, I returned to school for a BSN and eventually a PhD. One BSN professor, Robyn, patiently unraveled the intricacies of community health nursing. She listened to the problems I encountered on home visits and guided me in finding solutions. She even assisted me in designing a practical way to complete a family assessment. Best of all, Robyn never appeared rushed or frustrated with her students.

As a doctoral student, I received such complex and lengthy assignments that they seemed impossible to complete. I encountered foreign ideas, constant deadlines and projects that stretched me beyond former limits. I wondered if the stress of juggling career and family was worth it, until I met Jessica, an experienced nurse educator.

Jessica showed me not only how to conduct a research study, but how to enjoy the process as well. She patiently answered innumerable questions and her interactions with me reminded me why I was doing this. As a new faculty member, I learned from Jessica what service, research and scholarship entail and how I could balance these responsibilities with effective teaching and even a family.

My students know what I mean when I advise them to find their Maureen, Robyn or Jessica. As leaders in nursing, we must mentor our students and new nurses. Only through our role modeling and mentoring will they decide to stay in nursing and find satisfaction in the multiple roles nursing has to offer. Maybe then the nursing shortage really will begin to ease.

I know why I stay in nursing; my mentors showed me the way. They taught me how to competently care for patients, other nurses and myself. I hope I have done the same for others. I want to mentor those who are trying to find their way, so they too will stay in nursing.

I refused to claim overtime. I love what I do.

As a mentor, I was able to provide support and guidance to my students and new nurses. Only through our role modeling and mentoring will they decide to stay in nursing and find satisfaction in the multiple roles nursing has to offer.

GENERATION GAPS:
For the first time in recent history, the workforce spans four generations. Different strategies are required to entice and motivate members of each generation, requiring an understanding of each’s unique characteristics, values and perceptions of the ideal workplace.

GENERATIONAL VALUES:
• Typically, members of the veteran generation (born between 1922 and 1945) value hard work and self-sacrifice and respect authority.
• The baby boomers (born between 1946 and 1964) tend to question authority and value status and are sometimes workaholics.
• The generation Xers (born between 1965 and 1980) tend toward self-reliance, value career security over job security and are more interested in achieving work/life balance.
• The youngest generation in the RN workforce, generation Y (born after 1980), is made up of people who tend to be more goal-oriented, desire immediate feedback and favour meaningful work.

SOURCE: Canadian Institute for Health Information
Eliminating Unsafe Abbreviations to Improve Patient Safety

Ambiguous medical notations, including the use of abbreviations, symbols and dose designations, are one of the most common and preventable causes of medication errors. Audits by Capital Health and the David Thompson Health Region showed that dangerous abbreviations are used in at least 21 percent of medication orders.

Although abbreviations are commonly used in medication ordering, it is not just a prescriber issue. This unsafe culture of practice is perpetuated, often inadvertently, by the many ways all health professionals communicate about medication orders.

Hazardous medication ordering practices are the focus of a provincial initiative led by HQCA to improve patient safety.

Always use **whole numbers**

**Risk to Patient Safety:** .X mg can be misread as X mg (whole number) dose

**Recommend Practice:** Use a leading zero for doses less than one (e.g. 0.1 mg)

Consider how the use of hazardous abbreviations is perpetuated in your practice, including:

- pre-printed order sets and standing orders
- clinical pathways and protocols
- notes in patient records
- electronic medical records/clinical information systems
- publications you author
- teaching messages and materials used with students and colleagues

Order your bookmarks to help stop error-prone communication. The bookmarks featured are available, free-of-charge, through the HQCA.

**To order, contact:**

Dale Wright, Quality and Safety Initiatives Lead
T: 403.355.4439
F: 403.297.8258
E: dale.wright@hqca.ca

*Larger orders may be subject to courier costs.*
Hope is a small word, but it has such power. As I ponder over what’s to come in the new year, I cling to that small word and all it represents. It buoys me and carries me along with its audacity – its promise.

I have been challenging myself to dream, to dare to be different and to hope. When I allow myself to be touched by these things the world opens up. The energy or power from hope’s touch is intense. As hope enters my life its warmth embraces and nourishes me.

Hope is much more than a positive attitude. Hope is understanding that there are endless possibilities ahead and the only limiting factor is me, when I get in my own way. Hope is believing anything is possible. It is not waiting to see something happen and then believing it, rather it is believing and then not being scared to see it unfold. This is the audacity that hope has. Hope has the guts not to be defeated by the fear.

There are times when I find myself letting go of my hold on hope. My problems seem too large and insurmountable – the path too difficult and lonely. I find myself wallowing in “woe-is-me” and I feel overwhelmed by my fears.

It is the same sensation I get when I’m at work and everyone is going on and on about the hopelessness of the system and how terrible working conditions are. I feel myself drowning in the negativity and I know I can’t stay there.

I struggled with how to deal with this sense of powerlessness when I got caught in the negatives. I wanted my energy back. I wanted to feel at peace, not this frantic sense of upheaval that pervaded my world.

Being caught up in the negatives was my way of trying to bring some sense of order over the situation, but unfortunately my fretting and fussing were actually making me feel more chaotic. When I could get back to being in the moment and deal with the realities not the “what ifs,” I was calmer and felt more in control.

So now when I find myself caught up in the negative stuff I take a step back and ask myself this question. Do I have what I need right at this moment to do my job? Or pay the bills? Or deal with the situation? If the answer is yes then I can let the worry and the “what ifs” go.

As I understand and deal with my personal fears, I notice that I do not face that sense of hopelessness as often. And when I visit that place of hopelessness I recognize it for what it is and understand how it links to the negatives in my life.

Now, I am gathering my courage and strength to practice the fullness of hope. I strive to keep hope in my daily life – to be infected with hope not hopelessness. This is how I want to live life. This is the legacy I wish to share, to pass on, to believe in myself and to excite and inspire others. This is my legacy of hope.

The best of hope and joy to all of you in 2009.

TFFT #44 © 2007 Kathy Knowles and Linda Bridge
AN OPEN LETTER TO ALL CURRENT AND PROSPECTIVE NURSING HOME CAREGIVERS,
THEIR SUPERVISORS, FUNDING AGENCIES AND SENIORS’ GROUPS
BY SIEGLINDE ROONEY ON BEHALF OF HER MOTHER EMMA SCHULDT

Emma Schuldt on her 100th birthday.

I have a simple request.
I am three months shy of my 102nd birthday and live in a nursing home.

Not because I want to be, but because my daughter, who cared for me for over 28 years, is no longer able to look after me with the safety that my severely frail and osteoarthritic body requires. She nursed me through two cataract surgeries, two knee replacements, second degree burns, a leg ulcer, a fractured rotor cuff and an pneumonia. While my family and I would prefer I live at home, my daughter, at almost 70-years-old, did not receive the needed respite from taking care of me 24-hours-a-day, 365 days-a-year and was no longer able to lift me without endangering her own back and health. So I find myself a resident in a nursing home.

My ailments, all too common for someone of my age, are also those of many of my fellow residents. I have macular degeneration, hearing loss, osteoarthritis, peripheral vascular disease, and I can no longer walk. I am unable to attend to my personal needs. I cannot get out of the building without assistance and I am, for all intents and purposes, a virtual prisoner in my room. Family photographs are constant reminders of a former, far happier existence. Aside from my daughter, who comes for three-to-four hours a day to take me for long walks in my wheelchair, I have few visitors.

A dirty window and partially open shade allow me to see a tree outside my window. The TV and telephone must suffice to bring the outside world into my room.

I am that old lady at the end of the hallway who has trouble adjusting to her new teeth and who needs your help with her
personal care. Please know I do not call for help frivolously and understand that my critical lifeline to your care is ready access to the call bell. When you forget to pin it to my blanket or leave it where I cannot reach it, you deprive me of my crucial link to obtain help. This simple act of forgetting subjects me to unnecessary stress and anxiety, forcing me to call out from my room at the end of the hall, where you often cannot hear me.

Some of you have a “calling” for the nursing profession and are, what I consider to be, naturals. For others, your work is merely a job, not a career. It is attitude, thoughtfulness, common sense, along with good training, that make the crucial difference for me and my fellow residents who must rely on your goodwill to take care of our frail, handicapped bodies in as stress free an atmosphere as possible.

Some of you treat me with great kindness, dignity and respect when you take care of my needs. You take the time to say my name. You help minimize my acute embarrassment of no longer being able to take care of myself. You touch me gently and tell me everything that you will and need to do so that I can co-operate and help you where I’m able. You hug me, stroke my hand and help me understand with soothing words. From time to time, you cheerfully pop into my room to ask how I am or if I need anything. You make me feel that my isolated existence is still worthwhile. You are my periodic sunshine.

Alas, some of you treat me as roughly and coldly as the towels you use to dry me after my weekly bath. You forget that my skin is paper-thin and my bones are fragile. You fail to realize that what works for your younger body, doesn’t work for mine. When I’m having a difficult, uncomfortable night and have to call you once too often for your liking, you threaten me with your raised finger. Your words and actions diminish my being, making me feel useless and burdensome. You frighten me, scare me and make me wonder why you ever chose your profession as it seems to give you so little pleasure. I dread the nights when you are assigned to my floor.

I do not whine or ask for much at this stage in my life. However, I do ask that you never leave my room without ensuring that I have my call bell in my hand. My thanks must be verbal, but my gratitude for not being forgotten or ignored, being dealt with gently and kindly and called by my name is eternal.

I wish it were within my power to reward you appropriately and to insure that your pay is commensurate with the very difficult, frequently back-breaking work that you do. I fear that time will only come when our elected officials must place relatives, or even themselves, into nursing homes. I hope that then they will come to appreciate the true magnitude of the urgent need for adequate health care and nursing home funding. I doubt that I will live long enough to see that day. RN

NOTE FROM THE AUTHOR:

For many years of my retirement, I took care of my mother on my own—this is our cultural background and family dynamic—you take care of your own for as long as possible.

After agonizing over the decision, I placed my mother on the wait list for long-term care. We had discussed each step of the process with my mother as they came up, but when it came to the actual transition into a facility it was extremely difficult and heartbreaking.

During her first few weeks at the facility, we had issues with food, the call bell and some less-than-friendly staff. I addressed each occurrence with the nursing staff. We continue to have issues with food, the call bell, some less-than-friendly staff, inadequate staffing, as well as others. I now address each issue, repetitive as it is, with the new nursing manager as we try to insure that the jointly developed care plan is followed.

I am aware that the issues raised in this letter are, unfortunately, not unique. The staff is incredibly stressed, overworked, underpaid and a number admit that they don’t know how much longer they can carry on.

I chose to speak up publicly in hopes that the care aspect might be addressed by the nursing profession. If nothing else, to send the message to current and future nursing staff that their care makes a profound difference in the lives of those for whom they care and that their patients are really grateful for their tender ministrations.

~ SIEGLINDE ROONEY
CARNA has partnered with Workopolis, Canada’s number one job site, to connect Alberta’s RNs and Alberta employers through a quick, easy-to-use job board—ARN Careers.

Unlike general job boards, ARN Careers is specifically focused on the registered nursing profession in Alberta. CARNA members now have a resource dedicated exclusively to helping them find the right position. Alberta employers are linked with qualified, professional candidates to fill open positions. The result is better service and results for both job seekers and employers.

As with all Workopolis career sites, ARN Careers is free for job seekers. Whether you are actively looking for a job, casually searching or would just like a place to store your resumé, ARN Careers is the place for you. Employers pay a small fee to post jobs—an extremely cost-effective recruitment strategy. Revenues from ARN Careers will generate an income stream that can be invested into CARNA services.

Benefits for **job seekers:**

*Complete control over the confidentiality of job seeker information.* ARN Careers takes your privacy seriously. Job seekers can be assured they have complete control over the accessibility of their resumé and profile at all times. There are several levels of privacy for job seekers to choose from:

- display details of full resumé and contact details to all registered employers
- display only resumé without contact information to registered employers
- do not include resumé in searchable database for registered employers

*Job search agents bring the jobs to you.* Job seekers can set up to five personalized job search agents that will notify you of job opportunities that meet your predetermined career-related needs. You can apply directly to the positions, saving valuable time!

*The search for your perfect job just got easier.* ARN Careers gives you the flexibility to search our job database using 10 different search criteria. Filters include keyword search, location, job stream, job type, company, salary/hourly rate and more! With filters in place you can be assured you only see the jobs you want.

Benefits for **employers:**

*Post jobs and search candidates 24/7.* ARN Careers is available wherever you are. Employers have the ability to post jobs in minutes with an extremely easy-to-use posting interface. For those employers who wish to search our specialized job seeker database, purchase access to tap into the hottest bed of RN talent.

**POSTING JOBS IS FREE*** UNTIL JAN. 31ST, 2009

*(free to Alberta employers)*
Discipline summaries are submitted for publication in *Alberta RN* by the Hearing Tribunals as a brief description to members and the public of the member’s unprofessional behaviour and of the sanction ordered by the Hearing Tribunal. Publication is not intended to provide comprehensive information of the complaint, findings of an investigation or information presented at the hearing.

**CARNa Member**

A Hearing Tribunal made a finding of unprofessional conduct against a member who on one night shift while in charge, videotaped co-workers engaging in a wheelchair race; and failed to prevent staff nurses from acting in an unprofessional manner of taking photos of themselves dressing up as patients in hospital gowns, nasal prongs and arm slings and pretending to give each other injections; which video and photos were posted by a third party onto the member’s Facebook account. The Tribunal issued a reprimand.

**CARNa Member**

Registration number: 56,136

A Hearing Tribunal made a finding of unprofessional conduct against member #56,136 who occasionally stole ativan and imovane and regularly stole Tylenol 2, all from his employer. The member had previously been to a hearing several years ago for similar conduct. The Tribunal ordered a reprimand and accepted the member’s undertaking to not practise pending proof of completing of residential treatment for substance abuse, and reports confirming fitness to practise. Thereafter the member may apply to return to work to complete 960 hours under supervised practice with ongoing requirements for drug and alcohol screening and further medical reports for the period of the supervised practice and the next 24 months. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNa practice permit.

**CARNa Member**

Registration number: 82,531

A Hearing Tribunal made a finding of unprofessional conduct against member #82,531 who, while still a graduate nurse, intentionally administered to a palliative patient, two doses of morphine 20 mg which exceeded by five mg each the physician’s order of 15 mg per dose; falsely documented that she had administered 15 mg.; and deceived two RN co-workers to obtain co-signatures for wastages of five mg each when there was no wastage. The Tribunal took into account the four-month unpaid suspension already imposed by the employer, as punishment. The Tribunal also took into account the fact that the only reason the behaviour was discovered was that the member told the patient’s family and her charge nurse what she had done. The Tribunal also took into account the member’s statement at the hearing which demonstrated insight. The Tribunal issued a reprimand, and ordered the member to prove that she has passed a course in each of professional ethics, basic medication administration and charting. The Tribunal confirmed that the member has passed all three courses and therefore no conditions shall appear on the member’s practice permit.

**CARNa Member**

Registration number: 59,853

A Hearing Tribunal made a finding of unprofessional conduct against member #59,853 who stole morphine from her employer; on one occasion failed to document an assessment, medications administered and other nursing care; falsely documented on the narcotic administration record that she had disposed the wastage when she had not; failed to follow the employer’s policy and procedure when she asked co-workers to co-sign wastage; and although she knew the patient had dementia and therefore would always answer ‘yes’ when asked if she had chest pain, over a 10-month period the RN administered morphine for ‘chest pain’ to the patient on many occasions knowing the patient may not have chest pain; and falsified patient records when the RN recorded the patient had ‘chest pain.’ The Tribunal gave the member a reprimand; ordered the member to pass courses in medication administration and responsible nursing by a deadline; and accepted an undertaking to not practise as an RN pending proof from a physician and counselor that she is safe to return to practise at which time, the member has a choice to return to either a practice setting where there is no access to narcotics or controlled substances, or do a supervised practice in a setting where the member is expected to administer medications, including narcotics and controlled substances. In either setting, the member’s employer will report back to a Hearing Tribunal. The member is required to continue drug screening and provide further medical reports to a Hearing Tribunal. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNa practice permit.
“He’s the guy in the white shirt,” says the receptionist, pointing to the emergency area at Edmonton’s Northeast Community Health Centre. That’s all the direction needed to find Lloyd Tapper among the bustle of staff moving purposefully around the ER nursing station. For one thing, he’s not in a brightly coloured top like the other nurses and he’s not in scrubs and a mask like the doctors. In his crisp white dress shirt and black dress pants, Tapper stands out. He also stands out as the province’s only nurse practitioner working in an urban emergency department. It’s a position that the 38-year-old has held for nearly four years and from day one he’s worked to define his role, beginning with a departure from standard medical garb.

“I initially when I introduced the role, I wanted to make sure I had an opportunity to develop it, but not based on any traditional nursing or medical models,” says Tapper, “so that the added value of the role could be identified as different, but working in complete collaboration with the entire health-care team.”

Nurse practitioners are still relatively new. There are only a few hundred in the entire province – men and women who are stepping beyond the scope of the traditional nursing practice and into areas usually limited to doctors. Tapper is authorized by the College and Association of Registered Nurses of Alberta through the Health Professions Act to assess, diagnose, treat and refer patients. Registered nurses work under the Act as well, but are not authorized to diagnose, prescribe or refer patients to medical personnel. “If I am a registered nurse, I cannot call a cardiologist and say I want to refer this patient to your clinic. With my licence, I can pick up a phone and refer that patient to be seen by that service.”

For cases beyond his expertise, he consults with, or defers to, attending ER physicians or the appropriate referral service. “If you go to your family doctor and your problem is beyond him, he’ll refer you to a specialist or possibly an emergency physician. If it’s outside the emergency physician’s area, he may also consult with a specialist. At a time when access to
health-care services is limited, the focus is on matching the client’s concern with the appropriate health-care provider. That’s what makes me different,” says Tapper.

It’s 7:30 on a Monday morning. Tapper starts the day with a review of charts left by ER physicians over the weekend. As he briefs himself, he outlines his career path for me. (The man’s a born multi-tasker.) Originally from Newfoundland, a fact no longer detectable in his speech, Tapper trained to be an aircraft mechanic, but he couldn’t find a job in his field. In the mid-to-late-’90s, he noticed men were finding more and more employment in non-traditional careers, and, following the trend, he decided to enrol in nursing at St. Clare’s school of nursing in St. John’s.

The seemingly radical career shift had its roots in an earlier self-discovery. “In the time I was working on airplanes, I realized that I liked people more than parts. I went to air cadets and started teaching kids principles of flight and leadership. By the time I finished, I really didn’t want to be an aircraft mechanic.”

He graduated from St. Clare’s in 1997. He worked as an emergency and general surgery nurse in Kitimat, B.C., then as an emergency room nurse at the University of Alberta Hospital in 1999. Somehow he found time to finish a certification program in emergency nursing at Mount Royal College in Calgary and earn his master’s degree in nursing, while working full-time. When Tapper joined the Northeast Community Health Centre’s emergency department in 2004, he had seven years of emergency nursing experience and training to draw from.

It’s now 8 a.m. – time for the IV therapy clinic, a service Tapper adopted as part of his scope of practice. He personally follows every patient in the clinic to make sure their care is continuous, stable and streamlined. Every Monday he follows up with the patients who have been receiving intravenous antibiotic treatments over the weekend. Depending on the results of their blood work and his hands-on medical examination, Tapper determines whether they can be prescribed oral medication.

Since these patients have had to come to the ward three times a day, all weekend for IV antibiotics, the change is a welcome relief. So is having a scheduled appointment, instead of waiting to see an ER doctor who is rushing between critical cases.

Today, Tapper has three patients to check up on. Blair, 53, came to the emergency room after his leg swelled to three times its normal size and Mike, 44, a paraplegic athlete, is suffering from an infection caused by pressure on his legs from his wheelchair. Tapper sees them individually, greeting each with “Hi, I’m Lloyd. It’s very nice to meet you.” He discusses their symptoms thoroughly, gives advice, suggesting an update...
on tetanus shots for Blair and advising Mike to try padding his wheelchair and avoid contact sports in the short term. Both are now well enough for antibiotic pills, but before passing out prescriptions, Tapper discusses their costs and possible side-effects. “My job is about the little things,” he says.

Next in line is Brad, 42, who is concerned about numbness in his foot after twisting his ankle. Tapper determines that nothing is broken, recommends ice and ibuprofen and asks whether Brad needs a note to excuse him from work while he rests. Then Tapper leans over and plucks a package of cigarettes from Brad’s shirt pocket, exposed as he bent to put on his shoes. “Have you thought about quitting or cutting back?” he asks. “Because if you want to, we can help.”

Brad seems surprised, but he listens. He leaves with written instructions on how to ice his ankle and a booklet on how to stop smoking with information on the tobacco reduction clinic that Tapper developed for the Northeast Community Health Centre a year ago. It’s an example of how Tapper tries to go that extra mile.

“An emergency nurse practitioner is not about dealing with major trauma situations,” says Tapper. “That’s more the role of emergency physicians with years of specialized training. What I can offer is health promotion, illness prevention and continuity of care.”

Tapper’s interactions with his patients reflect that focus. He gives Shawn, a young roofer with a very sore back, instructions on proper icing techniques and a prescription

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**Nurse Practitioner Streams of Practice**

CARNA registers NPs in one of three streams of practice based on educational preparation and clinical practice: family/all ages, adult and child.

**Family/All Ages**

NPs registered in the Family/All Ages category provide generalized medical care for all age groups and for a wide variety of medical conditions. Practice settings include remote areas, family practice or primary care networks and generalized outpatient or emergency departments.

**Adult**

NPs registered in the Adult category provide care for individuals over the age of 18. Practice settings include either a generalized adult practice where they see adults with a variety of medical conditions, or adults in a specialty area of practice.

**Child/Child (Neonatal)**

NPs registered in the Child category provide care for individuals under the age of 18 in either a generalized practice where they see children with a variety of medical conditions, or children in a specialty area of practice. With the Child category, some NPs have specialized education relevant to neonatology and are restricted to working with the neonate population only.

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**Number of Nurse Practitioners in Alberta**

<table>
<thead>
<tr>
<th>Year</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
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<td></td>
<td>190</td>
<td>206</td>
<td>257</td>
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</table>
Requirements for NP licensure

In September 2007, Provincial Council approved changing the minimum educational requirement for entry on the NP register from baccalaureate preparation to a master’s in nursing degree or equivalent. Applicants who do not meet the educational requirement may still be eligible for registration under the substantially equivalent competence requirement, outlined in Section 4 (2), (3), (4) and (5) of the Registered Nurses Profession Regulation.

CARRA has submitted a request to government to revise the Regulation to reflect Council’s decision.

Section 4 (1) of the Regulation currently states that an applicant for licensure as an NP in Alberta must meet the following requirements:

a) have successfully completed a baccalaureate degree in nursing satisfactory to the Registration Committee (see note at left)

b) have completed 4,500 hours of RN practice satisfactory to the Registration Committee

c) have successful completion of an NP education program approved by the Council

d) be registered on the registered nurse register; and

e) have passed any exam respecting NP practice approved by CARRA Provincial Council.

Update

At the December 2008 meeting, Provincial Council selected and approved the written examinations for purposes of licensing NPs in Alberta. NP examinations are currently utilized in all Canadian jurisdictions other than Alberta. Look for specific details on Council’s decision on the CARRA website and in the February issue of Alberta RN.
CARNAG Archivist Lorraine Mychajlunow

The Nursing Sisters and Nursing Officers Association Edmonton unit awarded a certificate of appreciation and honorary membership to CARNAG Librarian and Archivist Lorraine Mychajlunow at their annual Remembrance Day luncheon.

Mychajlunow was recognized by the unit for helping strengthen and distinguish nursing sisters and nursing officers. Her contributions include ongoing preservation and development of the CARNAG Museum and Archives, nursing sister and nursing officer collections, instigating key archive and museum displays about wartime and peacekeeping nursing care and supporting promotion of Canadian sisters and officers in Alberta RN.

Mychajlunow joined CARNAG in 1991.

RN Library

The latest books, documents and audio-visual titles acquired by the CARNAG Library.

To reserve these and other titles, CARNAG members can contact the library Monday through Friday, 9 a.m. to 4 p.m. at 1.800.252.9392, ext. 533, or visit www.nurses.ab.ca any time to access the library catalogue and CINAHL (Cumulative Index to Nursing and Allied Health Literature database).


PART 2: Reducing at-risk behaviours

In the November issue of Alberta RN, we published part one of a feature on at-risk behaviours titled “Patient safety should NOT be a priority in health care: Why we engage in at-risk behaviours” in which it was suggested that patient safety should be a value associated with every health-care priority and activity, not a priority that can be rearranged based on changing demands. Unfortunately, human behaviour runs counter to making patient safety a value because the rewards for risk-taking are often immediate and positive, while the punishment (patient harm) for risk-taking is often remote and very unlikely. As a result, even the most educated, diligent and careful practitioners learn to master dangerous shortcuts and engage in at-risk behaviours.

This month, we explore the system-based causes of at-risk behaviours and ways to reduce their occurrence.

System-based causes. At-risk behaviours often emerge because of system-based problems. Unnecessarily complex processes create conditions that foster the development of at-risk behaviours. For instance, nurses who must obtain medications from four different storage units (an automated dispensing cabinet, refrigerator, patient specific bin containing pharmacy dispensed drugs and a locked storage unit in the patient’s room) are more inclined to gather all their patients’ medications at one time and place them in a more readily accessible area, like their uniform pocket. Problems with technology are another source of at-risk behaviours. For example, if a nurse must back out of the electronic medication administration record to access information about a particular drug or a corresponding laboratory value in an electronic database, he/she is more inclined to skip this step when behind in the administration of medications.

When patient harm results, we have a natural tendency to immediately focus on individuals who engaged in the at-risk behaviours. We are getting better at identifying the system-based causes of an event that promote at-risk behaviours. But too often, we overlook one of the most deeply seated roots of system problems – an organizational culture with a high tolerance of at-risk behaviours.

To uncover whether your culture is tolerant of at-risk behaviours, ask yourself “Does my organization tend to punish safe behaviour, and/or reward at-risk behaviour?”

Consider the following:
- What’s your reaction to a pharmacist who takes the time to fully investigate a missing medication request during the busy morning hours, especially when compared to another pharmacist who unquestioningly sends the drug to the requesting unit? What if you’re the nurse waiting for the drug or the pharmacy supervisor who now has to help enter the backlog of orders that resulted from investigating the missing medication? Would the efficiency of sending the missing medication quickly, without question, offer more positive reinforcement than fully investigating the reason for the missing dose, which might prevent a serious medication error?
- How would you react to a physician who asks for help to locate his patient’s MAR so he can make sure no medications have been accidentally discontinued on transfer? What if you’re the nurse manager who must help find the MAR, while managing other important priorities? What if you’re the nurse who’s using the MAR? Would the physician be appreciated more if he didn’t try to find the MAR?
- What’s your reaction to a nurse who takes longer than most to administer medications because he/she asks colleagues to independently double-check selected high alert drugs before administration? What if you’re the person who is asked to help while you have other pressing demands?
- Are the nurses who do not “bother” others praised and respected for their ability to “work independently and efficiently”?
- Are the nurses who, without complaint, seem to accept the lion’s share of new admissions greatly valued by their managers, despite the fact that corners must be cut in order to manage the workload?
- Are your best (and safest) performers “rewarded” with extra work? Is the most vocal person about a particular safety problem “rewarded” with primary responsibility to fix it?

If you look closely at the behaviours where you work, you will find many examples in which practitioners receive positive rewards, attention and prestige from coworkers and managers for engaging in at-risk behaviours and negative rewards for safe behaviours.

Discipline is unproductive. You might believe the most convenient way to control at-risk behaviours is to create a policy and enforce it. However, using disciplinary measures for a policy breach will not result in a commitment to safety; instead, it serves only to remind the recipient of the top-down control, resulting in temporary behavioural changes. The solution is not to punish those who engage in at-risk behaviours,
but to uncover the system-based reasons for their behaviour and decrease staff tolerance for taking risks.

**Increase awareness.** To improve safety, it’s more important to reduce staff tolerance of at-risk behaviours than to increase their compliance with specific safety rules. So the best place to start is to increase staff awareness of at-risk behaviours. Although perceptions of risky behaviours vary among people, you should be able to identify some common at-risk behaviours by analyzing error reports, especially sentinel events or near sentinel events, where more information about causative factors is available.

See Table 1 for examples of common at-risk behaviours. For each at-risk behaviour, a corresponding safe behaviour should be readily apparent or documented. While staff who report errors may not divulge at-risk behaviours without prompting, keep in mind, risk-taking is not involved in all errors.

**Learn what supports the behaviours.** The most important step after identifying at-risk behaviours is to uncover the upside down consequences that lead staff to believe there are more positive than negative rewards for the at-risk behaviours. It is also important to look at the corresponding safe behaviours that are rewarded negatively. Of course, the purpose for this step is to reduce or eliminate the positive consequences for at-risk behaviours and promote positive rewards for safe behaviours.

### TABLE 1: Examples of at-risk behaviours

<table>
<thead>
<tr>
<th>Information About the Patient and the Drug</th>
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<tbody>
<tr>
<td>Preparing more than one patient’s medications at one time.</td>
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<tr>
<td>Not checking patient identification using two unique identifiers before administering medication.</td>
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<tr>
<td>Prescribing/dispensing/administering medications without complete knowledge of the medication.</td>
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<tr>
<td>Not taking the MAR to the patient’s bedside when administering medications.</td>
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<tr>
<td>Administering routine medications before pharmacy review of the medication order.</td>
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<tr>
<th>Communication and Teamwork</th>
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<tbody>
<tr>
<td>Rushed handoffs with next shift/covering colleague.</td>
</tr>
<tr>
<td>Not speaking up because of intimidation when there is a question or concern about a medication.</td>
</tr>
<tr>
<td>Use of error-prone abbreviations/apothecary designations/dangerous dose designations.</td>
</tr>
<tr>
<td>Illegible handwriting; writing over erroneous orders.</td>
</tr>
<tr>
<td>Reluctance to consult others or ask for help when indicated.</td>
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<tr>
<th>Product Labelling, Packaging, Storage and Distribution</th>
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<tbody>
<tr>
<td>Removing medications from unit-dose packages prior to reaching the patient’s bedside.</td>
</tr>
<tr>
<td>Not labelling or poor labelling of syringes/solutions/bowls/other medication packages.</td>
</tr>
<tr>
<td>Obtaining medication by “grab-and-go,” not fully reading the label before dispensing/administering.</td>
</tr>
<tr>
<td>Leaving medications at the bedside or in unlocked storage areas.</td>
</tr>
<tr>
<td>Keeping unused medications from discharged patients to administer to other patients.</td>
</tr>
<tr>
<td>Borrowing medications from one patient to administer to another patient.</td>
</tr>
<tr>
<td>Failure to dispense medications in unit doses or patient-specific doses.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Culture, Environment and Staffing Patterns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managing multiple priorities while carrying out complex processes (e.g., transcription, administration).</td>
</tr>
<tr>
<td>Admitting overflow patients to inappropriate units/areas.</td>
</tr>
<tr>
<td>Sacrificing safety for timeliness.</td>
</tr>
<tr>
<td>Failure to report and share error information.</td>
</tr>
</tbody>
</table>

**Motivate through feedback and rewards.** The next step is the most difficult; to align individual and group motivation with avoiding the undesired at-risk behaviours.

Often, motivation is misdirected by an explicit or unspoken organizational priority for efficiency and productivity. These outcomes are often achieved by cutting corners that seem insignificant. It is possible to inadvertently reward risk-taking and under reporting of at-risk behaviours and errors when incentives are based solely on efficiency and productivity. If reporting an at-risk behaviour or error makes someone (especially a group) lose a reward, under reporting results. Emphasis on specific behaviours that lead to patient safety will allow staff to feel more positive about identifying and reporting at-risk behaviours.

**Emphasis on specific behaviours that lead to patient safety** will allow staff to feel more positive about identifying and reporting at-risk behaviours.
and the organization facilitates these safe behaviours, practice is needed to make the safe behaviour a habit and part of an uncompromised value system. Ongoing support, encouragement, recognition, reward programs and other positive regard, especially from peers, also go a long way. Be sure that everyone who meets safe behavioural criteria is rewarded. It’s better for many to receive a small reward than for one person to receive a large reward.

**Conclusion.** Many health-care organizations have made patient safety a priority that deserves their utmost attention right now. But priorities can easily shift, and once again, patient safety could take a back seat to other important dimensions of quality leaving tragic patient injuries in its wake. Health-care organizations must make patient safety a sustained value, never subject to compromise and always driven by the ongoing quest to identify the system-based causes of errors and the at-risk behaviours that contributed to them. Such a quest could result in a vision of safety in which all health-care providers truly know what it means to be accountable for safety.


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### Economic downturn puts pressure on educational support for RNs

The October downturn in the investment markets, coupled with dramatically increasing numbers of applications for charitable support, is impacting ARNET’s ability to support the educational programs.

We rely on our investments and the generosity of donors to fund RN educational supports. Like other charities, our investments are impacted as a result of this economic downturn, meaning we have significantly less money that we are able to distribute in the upcoming year.

ARNET needs to grow our financial resources so we can continue to advance nursing knowledge through the provision of educational funding to foster nursing excellence.

We urge you to donate to ARNET today. Not only will you be helping other RNs be the best they can be by delivering better care to families and communities, you are helping to ensure the nursing profession is healthy and vibrant for future generations.

**Please go to** [www.nurses.ab.ca](http://www.nurses.ab.ca) **and show your support!**

### In 2008 ARNET distributed over $750,000 to more than 1,700 nurses in support of their continuing education goals.

While the amount of educational support our charity distributes each year continued to grow, the number of individuals requesting support continues to escalate. Last year, we received education funding requests in excess of $1.8 million!

### ARNET Needs You

We’d like to hear from you how you think ARNET could raise more funds to support more RNs or if you would like to get involved!

**Send your comments and suggestions to** kburns@nurses.ab.ca

### Scholarship Alert

Applications for ARNET’s annual scholarships are now being accepted. For more information or to download an application, visit [www.nurses.ab.ca/arnet](http://www.nurses.ab.ca/arnet) or contact the ARNET office at 1.800.252.9392, ext. 427.

**Deadline for applications is March 1, 2009.** All applicants will be notified in writing of their application status by April 15, 2009. Previous ARNET scholarship recipients are eligible to apply.
Alberta boasts a greater proportion of untreated hypertensive individuals than any other province and the Canadian Hypertension Education Program (CHEP) hopes that registered nurses (RNs) can help reverse this trend. CHEP recognizes that staying current on hypertension is challenging given the broad scope of nursing practice, ever increasing workloads and rapid changes in science. In 2008, the CHEP updated its recommendations for the management of hypertension for the ninth year in a row.

In a survey of Canadian RNs conducted in 2007, more than 95 per cent of respondents were confident in taking a blood pressure reading, but almost half were unaware of the current hypertension definition. (See Test Your Knowledge.) To help all primary care health professionals in Alberta stay current, CHEP has launched a provincial initiative in partnership with CARN and other Alberta-based health-care organizations to disseminate current hypertension information and approved educational materials. Materials have been developed for health-care professional education, peer education and patient education and include handouts, PowerPoint slide sets, pocket booklets and videos.

Alberta faces some unique challenges in delivering health care. Often individuals who have relocated from other provinces or countries have not accessed the health-care system and have undiagnosed or untreated hypertension. RNs are in frequent contact with hypertensive patients and can play a critical role in preventing and controlling hypertension in Alberta through screening, education and management. CHEP also plans to offer special training programs for those nurses interested in helping educate other health-care professionals or patients in their communities.

If you are interested in learning more on the initiative, or to order materials go to www.hypertension.ca/chep/information-dissemination-form

5 KEY ACTIONS you can take to help Albertans prevent and manage hypertension:

1. **Assess blood pressure of all Albertans at all appropriate encounters.** Ensure your family, friends, co-workers, neighbours and clients have had recent blood pressure assessments.

2. **Encourage hypertensive patients to use approved devices and proper technique to measure blood pressure at home.** Blood pressure measured at home provides a better estimate of the risk for heart disease and stroke.

3. **Assess and manage other cardiovascular risks in all hypertensive patients**, including smoking, unhealthy eating, inactivity, abdominal obesity, dyslipidemia and diabetes. Ninety per cent of those with hypertension have other cardiovascular risks—often in multiples.

4. **Encourage patients to take attainable steps to achieve a healthy lifestyle.** Sustained lifestyle modification is the cornerstone for the prevention and management of hypertension and cardiovascular disease. A diet that is high in fresh fruits and vegetables, and low in saturated and trans fats, sodium and alcohol is important as is 30-60 minutes of regular physical activity most days of the week, attaining and maintaining a healthy body weight and waist circumference and having a smoke free environment.

5. **Ensure your patients understand their healthy blood pressure target.** Achieving a healthy target is sustainable using both pharmacotherapy and lifestyle modification. With very few exceptions, patients with hypertension require a combination of lifestyle change and usually two or more medications to bring their blood pressure to recommended levels (<140/90 mmHg in most; <130/80 mmHg in patients with diabetes or chronic kidney disease). In patients with diabetes achieving the <130/80 mmHg target reduces cardiovascular death and events by more than 50 percent compared to the <140/90 mmHg target.
Test Your Knowledge on Hypertension

1. What is the standard definition of hypertension (SBP/DBP in mmHg)?

☐ True  ☐ False

See answers below

HYPERTENSION FACTS

Hypertension is the leading risk for death in the world\(^1\) as a result of being a major cause of ischemic heart disease, stroke, kidney disease and dementia.\(^2,3\)

Two-thirds of stroke and half of ischemic heart disease are caused by increased blood pressure.\(^1\)

Between 4 and 5 million adult Canadians are currently diagnosed with hypertension.

Nine in 10 Canadians are likely to develop hypertension if they live an average lifespan.\(^4\)

REFERENCES:


Answers to Test Your Knowledge

1. **140/90 mm Hg**

   In a survey of Canadian nurses conducted in 2007 by CHEP to evaluate nurses’ knowledge on hypertension related issues, more than 95 percent of nurses were confident in taking a blood pressure reading, however almost half were unaware of the current hypertension definition of 140/90 mm Hg

2. The results of the same surveys indicated that the majority of respondents were not aware that patients with white coat hypertension do not have a higher risk for heart disease and stroke than those with normal blood pressure.

About CHEP

CHEP is a national program with a mission to improve cardiovascular outcomes through health-care professional education on hypertension management and control. CHEP strives to assist Canadian health-care providers so Canadians will benefit from the world’s lowest rates of hypertensive diseases. Each year, CHEP best practice recommendations are developed for practitioner education. The recommendations committee consists of nurses, pharmacists, physicians and specialists.

The CHEP-Alberta dissemination initiative is supported by the following organizations:

- College and Association of Registered Nurses of Alberta
- Canadian Council of Cardiovascular Nurses of Alberta, Northwest Territories and Nunavut Division
- Alberta College of Family Physicians
- Alberta Pharmacists’ Association
- Alberta College of Pharmacists
- Heart and Stroke Foundation of Alberta, Northwest Territories and Nunavut
- Kidney Foundation of Canada, Southern Alberta Branch and Northern Alberta and Territories Branch
- Libin Cardiovascular Institute of Alberta
- Alberta Provincial Stroke Strategy
- Canadian Hypertension Education Program and Blood Pressure Canada

For more information, contact:

Nicole M. Kelly

nmkelly@ucalgary.ca

T: 403.220.7103

F: 403.210.3818

http://hypertension.ca/chep/
IN MEMORIAM

Our deepest sympathy is extended to the family and friends of:

Westfall, Diane, a 1974 graduate of the St. Joseph’s Hospital school of nursing, who passed away on Sept. 30, 2008 in Sherwood Park.

Bromley, Sybil Mary, a 1978 graduate of the Grant MacEwan/University of Alberta collaborative baccalaureate program, who passed away on Oct. 10, 2008 in Edmonton.

Don’t Miss the 2009 Tri-Profession Conference

Advance program available online
To register, visit www.buksa.com/strength
Early bird deadline: April 21, 2009

Come and learn about how the culture of practice settings and the workplace impact how we work with colleagues who may be:

- from a different health profession
- accustomed to a different practice setting
- trained in different workplace norms
- part of a different generation
- a member of a different social/demographic group

Call for abstracts available online. Submission deadline: Jan. 9, 2009

Moving?
Update your registration profile online

Members can now make changes to their address, telephone number and employer information by logging on to the member’s only section at www.nurses.ab.ca.

If you change your family name, please forward your request to CARNa by mail along with the supporting documentation.

According to the Health Professions Act, members have a responsibility to notify CARNa as soon as possible of any changes related to their personal information such as address, telephone number and employer information.

If you have any questions, contact CARNa toll free at 1.800.252.9392 or 780.451.0043 in Edmonton.
ACCELERATING PRIMARY CARE 2009
CONTACT: www.capitalhealth.ca/primarycare

EFFECTIVE HEALTH LEADERSHIP
Applying lean systems thinking
CONTACT: www.buksa.com

CARNA CALGARY/WEST REGION
NURSES’ DINNER
Nursing 24/7: A Pajama Party
CONTACT: Chris Davies, 403.932.7243, cdavies@nurses.ab.ca, Sarah Kopjar, 403.282.4095, skopjar@shaw.ca

2009 TRI-PROFESSION CONFERENCE
Strengthening the Bond – Culture, Collaboration and Change
CONTACT: www.buksa.com/strength

AOHNA CONFERENCE 2009
Education, Expertise, Empowerment
CONTACT: http://www.cohna-aciist.ca/

CANADIAN GERONTOLOGICAL NURSING ASSOCIATION BIENNIAL CONFERENCE
CONTACT: http://cguna.net

THIRD NATIONAL COMMUNITY HEALTH NURSES CONFERENCE

FIFTH INTERNATIONAL MULTIDISCIPLINARY ACADEMIC CONFERENCE
Spirituality and Health: Working Together For Optimal Health
CONTACT: www.cme.ucalgary.ca

CNA NURSING LEADERSHIP CONFERENCE
CONTACT: Debbie Ross, 1.800.361.8404, ext. 214, dross@cna-aiic.ca

EXPANDING OUR HORIZONS
Moving Mental Health and Wellness Promotion into the Mainstream
CONTACT: Michael Murray, michael_murray@charity.demon.co.uk

A MEDLEY OF ORTHOPAEDIC KNOWLEDGE
The 32nd annual National Canadian Orthopaedics Nurses Association Conference
CONTACT: Norma Stubbert, 250.767.9648, registration@cona2009.ca

ENGAGING REFLECTION IN HEALTH PROFESSIONAL EDUCATION AND PRACTICE
CONTACT: admin@reflectivepractice.ca, www.reflectivepractice.ca

CHNA LEVEL I INTRODUCTION TO ENERGY-BASED NURSING
CONTACT: Debbie Freeman, dlfreem@shaw.ca, www.chna.ca

CAND HEALTH FUSION CONFERENCE
CONTACT: www.cand.ca

ICN 24TH QUADRENNIAL CONGRESS
Leading Change: Building Healthier Nations
CONTACT: www.icn.ch/congress2009.htm

HEALTH IN TRANSITION CONFERENCE
Researching for the Future
CONTACT: www.healthintransition2009.org.au

INTERNATIONAL

INTERESTED IN FORMING A NAVIGATOR/CARE COORDINATOR SPECIAL INTEREST GROUP?
If you are a nurse navigator, patient navigator or care coordinator working in any clinical area and are interested in networking with colleagues in similar roles, contact Janet Bates, 780.643.4480, janetb@cancerboard.ab.ca or Sally Turco, 780.735.2260, sallyturco@caritas.cha.ab.ca

CARRA SPECIALTY PRACTICE GROUPS
Contact your CARNA regional coordinator or go to www.nurses.ab.ca.

Submission deadline for events listed in Alberta RN March 2009 is February 1.
Go to www.nurses.ab.ca for an up-to-date listing of events or to submit an event for publication in Alberta RN.

Reunions

Red Deer College
Class of 1997 • 10-Year Reunion
Spring 2009
CONTACT: Danielle Tkachenko, 403.329.0109, dtkachenko@shaw.ca.
Reunion organizers are requesting volunteers for planning and updated personal contact information.

University of Alberta
Faculty of Nursing
Class of 1978 • 30-Year Reunion
CONTACT: Cathy Loughlin, 403.239.2413, rothbone@shaw.ca, or Susan Schafer, 403.239.2496, susanschafer@shaw.ca.

Submission deadline for reunions listed in Alberta RN March 2009 is February 1.
Go to www.nurses.ab.ca for an up-to-date listing of reunions or to submit an event for publication in Alberta RN.
After years of advocating for more education seats, CARN A is elated that employers, educators and government all agree that we need to educate more RNs. Our task now is to ensure that the investment in more nursing seats meets the needs of Albertans for safe, competent and ethical nursing care and creates a workforce prepared for the ongoing and rapid evolution of knowledge and practice.

The nursing shortage has increased the pressure on nursing educators from government and employers to redesign educational programs. Government departments want more graduates in less time to maximize public investment in educational funding. Government has also expressed a strong interest in the design of common and progressive nursing curricula that would facilitate nurses who need orientation and/or remedial education. Thus educators find themselves competing for opportunities which allow their students to gain clinical experience in multiple settings and in a meaningful way. All basic level nursing education programs are also required to meet CARN A Entry-to-Practice Competencies for the Registered Nurses Profession (2006) to graduate qualified registered nursing students who will not only pass the required national licensure exam, but are prepared to comply throughout their career with nursing practice standards, code of ethics and continuing competence requirements. In short, expectations on nurse educators are high, numerous and sometimes inconsistent.

Despite the conflicting demands and the growing shortage of faculty members as large numbers of professors approach retirement, Alberta nursing educators are responding with significant initiatives to the complex array of influences on health-care education. Some examples include accelerated or after-degree programs for students who have completed previous undergraduate degrees and ladderling initiatives that allow graduates from LPN and paramedic programs to transition to baccalaureate of nursing programs. Programs developed in partnership with clinical practice leaders such as paid internships substitute for a required clinical course, contribute to the summer workforce and provide students with a rich clinical learning experience. Valuable practicum experiences have been developed with community agencies to provide nursing students with experiences in interprofessional and multicultural practice settings. The rural nursing focus and gerontological focus of Medicine Hat College is but one example of several programs that build on local characteristics and strengths.

In November, CARN A coordinated a meeting of the deans and directors from each of Alberta’s nursing education programs and invited senior decision makers from the departments of health and wellness, employment and immigration and advanced education to attend. Our objectives were to clarify expectations for RN education, to understand our distinct roles in expanding capacity for new graduates, to share information on current initiatives and to identify what more needs to be done. What was clear to all was the need to create a better understanding among all stakeholders of what can be realistically expected of a new graduate educated as a generalist. The pressing need to address the shortage of nursing faculty was also clear. All agreed that employers need to be included in the discussion to contribute to the development of meaningful strategies that will retain future new graduates in the workplace and in the profession. We agreed to meet again early in the new year to build our partnership.

I am confident that there is a will among all stakeholders to meet the challenges of preparing qualified registered nursing graduates tempered with an appreciation that the road ahead is both exciting and daunting. Nursing education, like the nursing shortage and health care itself, needs a coordinated, integrated approach to inform policy decisions by CARN A, employers, government and educators. CARN A’s hope is that, collectively, we can ease the pressures on our current RN members by finding a way to prepare a greater number of nursing graduates at a basic level who are continuous learners in a rapidly changing health care environment and equipped to respond to the increasing expectations placed on RNs.

Mary-Anne Robinson, RN, BN, MSA
Executive Director
Phone: 780.453.0509 or 1.800.252.9392, ext. 509
E-mail: mrobinson@nurses.ab.ca
Who will you recognize for nursing excellence?

If you know someone who sets a standard for nursing excellence, you’re invited to nominate them for a CARNA Award of Nursing Excellence.

Nominations are now being accepted for:
> Nursing Excellence in Clinical Practice
> Nursing Excellence in Education
> Nursing Excellence in Research
> Nursing Excellence in Administration
> Rising Star
> Lifetime Achievement

Don’t forget to recognize a community partner.
Many volunteers and organizations support your practice everyday and deserve recognition. Nominate outstanding members of the public who partner with the nursing profession for the Partner in Health Award.

Visit www.nurses.ab.ca for award criteria, tips for a successful nomination, to submit your nomination online or to request a hard copy of the nomination form.

Nominations close Jan. 30, 2009

All nominees are recognized in the April 2009 issue of Alberta RN and their names included in the program of the Awards Gala at the Edmonton Mariott at River Cree Resort and Casino on April 16, 2009.