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NoticeBoard/Reunions

A nursing perspective
Volunteer Opportunities Post-RN Program Closure
Committed to Competence
Review of Policy and Practice Consultations
Volunteer Opportunities Post-RN Program Closure
Alberta RN (USPS #009-624) is published
President’s Update

A welcome privilege

IT is an exhilarating and humbling experience to begin one’s term as CARNA president. On one hand, I am looking forward to working with colleagues on Provincial Council on behalf of our profession and enthused about the opportunities which lay ahead. On the other hand, the challenges facing registered nurses (RNs) and the health system in Alberta have never been greater.

It is hard to believe how much can change in just a few years. When I started my term as CARNA president-elect on Oct. 1, 2007, there were nine regional health authorities. The economy was booming and Alberta was concerned about managing growth. Today, there is one health authority and the Alberta economy is groaning from the impact of the worst global recession since the dirty ’30s.

Perhaps the most startling development has been the “about face” on the nursing shortage. In March 2009, there were more than 1,400 vacant RN positions. A few months later, there was a hiring freeze, the RN vacancies disappeared and Minister of Health and Wellness Ron Liepert was stating publicly that he didn’t believe there was a nursing shortage in Alberta.

Well, CARNA is well aware that the nursing shortage is real. With an aging nursing workforce and the loss of new graduates who can no longer find positions in Alberta, the shortage is poised to get worse. The situation is particularly concerning given the fall influenza season with H1N1. CARNA will continue to advocate for building, not reducing, the capacity of the RN workforce.

One of my priorities is to ensure that CARNA continues to advocate for quality practice environments so that RNs are empowered to fully use their knowledge and skills for the benefit of the public.

These are unsettling times. The restructuring of the health system, with its elimination of nursing manager positions and the dismantling of valued programs in the former health regions, is demoralizing for many CARNA members. One thing we do know is that moods are catching. We can help each other by trying not to inflict our negative emotions on our co-workers or our clients. At a time when it seems as if our profession is not valued by senior management, it is even more important that we individually and collectively personify professional, competent and value-added registered nursing care. Wearing your RN pin and being proud to introduce yourself as a registered nurse can also help.

I have sometimes heard CARNA members ask the question “What does CARNA do for me?” With apologies to President John F. Kennedy, the real question is “What can you do for CARNA?” CARNA’s work, which is all about giving us the ability to govern our own profession, depends on the participation of nurses just like you and me. I sincerely hope that you will consider becoming more involved with your college. You could run for Provincial Council, serve on a regulatory committee, attend a provincial council meeting as an observer, or simply commit to keeping current by reading Alberta RN and CARNA’s electronic newsletter or visiting the CARNA website.

I am looking forward to meeting you and representing our profession in the years ahead. I am proud to be your president and, above all, very proud to be an RN.

Joan Petruk, RN, MHS
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Letter to the Editor

I too had alarm bells ringing when I read about reporting blood-borne virus infection (BBVI) status on our annual registration. It is totally inappropriate for registration to be the time to report this fact. It will be impossible to maintain privacy when the matter is handled in such a ham-handed way. A private consultation with a CARNA representative is the proper way to go if someone is knowingly practising with a BBVI. Even then, once the information is on our records, we are at the mercy of computer systems that can be hacked. RNs were in the forefront in objecting to a computerized provincial health record for our patients, due to privacy concerns. Why are we abandoning that viewpoint for our own membership?

This matter is sorely in need of review. It should not have been sprung on the membership so close to our annual registration. The fact that it was speaks volumes about what the CARNA leadership is willing to garner in terms of criticism. I would expect this of our provincial government... CARNA not so much.

Jackie McDonald, RN, BScN
St. Albert

EDITOR’S NOTE: CARNA fully supports your emphasis on the need for a private consultation between a member diagnosed with a BBVI and a CARNA representative. The CARNA deputy registrar will follow-up individually with members who report infection with a BBVI to help clarify whether the member is participating in exposure-prone procedures or has the potential to practise exposure-prone procedures (e.g. emergent situations) in the workplace and for referral to the local medical officer of health.

Member reporting of BBVI at registration is limited to an additional yes/no question added to the pre-existing “Eligibility for Registration” section of the practice permit application. All personal member information collected by CARNA is considered confidential and is managed according to requirements of the Personal Information Protection Act (PIPA) and the Health Information Act (HIA). CARNA has implemented additional processes to manage BBVI reporting and any information related to BBVI will be handled confidentially by the CARNA office of the deputy registrar.

CARNAn has opted to introduce mandatory reporting as a practice standard. This policy decision has been under consideration by CARNA since December 2006, with extensive consultation at every step of the way. BBVI reporting, assessment and follow-up ensures a high standard of public safety during the delivery of care with the opportunity for support and guidance of members with BBVI. The process provides an objective and consistent assessment of the risk to patients.

RN

Have you renewed your registration?

The deadline for registration renewal was September 1. Members who send in their registration information after this date are subject to a $50 late fee and are not guaranteed to receive a new practice permit before the current one expires on Sept. 30, 2009. Members who have not submitted their registration renewal before September 30 will not be eligible to practise as an RN on October 1.

Members are encouraged to renew online to ensure their forms and fees are received in time. Registration information, including requirements and fees, is also available on the CARNA website at www.nurses.ab.ca.

If you have any questions about your current registration or renewing your registration, contact CARNA’s registration department at 780.451.0043 or toll-free at 1.800.252.9392.
CARNA 2009 Election Results

Dianne Dyer is CARNA’s new president-elect. She will serve a two-year term before assuming the post of president for a two-year term.

The following registered nurses, with the exception of Kevin Huntley, were elected for a three-year term, beginning Oct. 1, 2009. Huntley will serve a one-year term in accordance with CARNA bylaws.

**PRESIDENT-ELECT**
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RN, BN, MN
Practice Consultant, Professional Practice and Development
Alberta Health Services—Calgary

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**CALGARY/WEST REGION**
Kerry Hubbauer
RN, BN
Clinical Systems Specialist
Alberta Health Services—Calgary

**CALGARY/WEST REGION**
*Kevin Huntley*
RN, MN, NP
Nurse Practitioner, Acute Care
Foothills Medical Center

**NORTHEAST REGION**
Carol Ulliac
RN, BScN, MN
Manager
Boyle Healthcare Centre


**Election Summary**
More than 21 percent (4,893) of eligible voters voted in the 2009 Provincial Council election in the Edmonton/West and Calgary/West CARNA regions. The positions of president-elect and provincial councillor for Northeast Region were elected by acclamation.

<table>
<thead>
<tr>
<th>REGION</th>
<th>NUMBER OF BALLOTS Mailed</th>
<th>NUMBERS AND PERCENT OF BALLOTS RETURNED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edmonton/West</td>
<td>12,046</td>
<td>2,585 (21.5%)</td>
</tr>
<tr>
<td>Calgary/West</td>
<td>10,925</td>
<td>2,308 (21%)</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>22,971</strong></td>
<td><strong>4,893</strong></td>
</tr>
<tr>
<td>Spoiled Ballots:</td>
<td></td>
<td>6 (&lt;1%)</td>
</tr>
</tbody>
</table>

CARNA thanks the following out-going Provincial Council members for their contributions:
Margaret Hadley, President, 2007–2009
Cheryl Deckert, Edmonton/West, 2006–2009
Maureen Jamison, Calgary/West, 2006–2009
Debra Ransom, Northeast, 2006–2009
Committed to Competence: Collecting feedback to improve your nursing practice

Collecting feedback can give you valuable insight into how your nursing performance is perceived by others. The feedback you get can support you in specific aspects of your practice and provide you with opportunities for change and professional growth. Receiving and giving appropriate and meaningful feedback encourages effective teamwork and contributes to safe, competent, ethical nursing practice.

Collecting feedback is a core element of reflective practice and a requirement of the CARNA Continuing Competence Program. Feedback may be received in many forms. It may be formal or informal, written or verbal. Feedback can include praise for your nursing practice from clients and others through verbal comments and thank you cards or recognition of your practice or education through certificates, awards or letters of commendation. It may take the form of formal performance review. The most significant form of feedback to improve performance and strengthen nursing practice is constructive feedback. Constructive feedback is objective and non-judgmental and is based on observations of practice.

Asking for feedback

Your nursing colleagues, managers, supervisors, non-nursing health professional colleagues, clients and their families are good sources for feedback. When asking for specific feedback about your nursing practice, choose someone whose judgment you trust, who understands your role responsibilities, who can observe your practice, who will be open and honest about your nursing skills and performance and who will respect your confidentiality.

Tips for requesting feedback:
- Prepare the information you want to discuss ahead of time.
- Select a time and place without distractions for your conversation.
- Briefly indicate what you would like to cover and why it is important. Be clear about what you want the feedback on. The clearer you are, the easier it will be for others to give you feedback.
- Use your self-assessment to guide the discussion. Be specific about your abilities, identified strengths, areas for growth, learning and enhancement.

Receiving feedback

Document the feedback you get, who gave it to you and the date you got it. Worksheets are available on the CARNA website to help you record and organize the feedback you receive. Like all continuing competence documents, remember to keep your feedback records for five years.

Tips for receiving feedback:
- Take time to listen carefully.
- Be open to the feedback.
- Try to understand and consider what is being said by rephrasing.
- Ask questions about how this person sees your behaviour.
- Ask for suggestions on how to enhance your practice and grow professionally, such as “Is there some aspect of my practice I can improve?”
- Decide how you will use the feedback in the development of your learning plan. Did the feedback provide you with new perspectives or ideas? Maybe the feedback is very different from what you anticipated and, as a result, you might change your learning plan based on the feedback.

Giving feedback

Busy workplaces and/or lack of comfort or skill in asking for or giving feedback can be barriers to getting and giving feedback. Take the time to support your colleagues and provide guidance and feedback to others relating to their nursing practice. When you give feedback you are sharing your nursing experiences and knowledge to support your colleagues in their practice.

Tips for giving feedback:
- Direct your feedback towards what is specifically asked.
- Be specific in your comments. Use concrete words to describe your observations—avoid interpretation.
- Be supportive and constructive in your comments, using a respectful tone.
- Remain neutral. Avoid judgment, labelling, empty praise or criticism.
- Focus on behaviour that can be changed and is within the person’s control.
- Be attentive to feelings and non-verbal cues. Ask “Are you OK?” throughout the conversation.
- Stay focused on action. Focus on performance (behaviour), not personality.

If you have questions about giving or getting feedback or other aspects of the Continuing Competence Program, contact CARNA staff at 780.451.0043/1.800.252.9392 or via e-mail at continuingcompetence@nurses.ab.ca.
The CARNAs competency profile for registered nurses (RNs) identifies a comprehensive list of the competencies and interventions RNs may perform in their practice and focuses on knowledge, analysis, decision-making and critical judgment—the hallmarks of RN practice.

The CARNAs document Entry-to-Practice Competencies for the Registered Nurses Profession references the two classification systems that describe the competency profile for RNs in Alberta. International Classification of Nursing Practice and Nursing Intervention Classification (NIC) readily identify a very comprehensive list of RN competencies at the level of specific nursing interventions. The classification includes interventions that RNs do on behalf of clients, both independently and collaboratively, and as part of direct and indirect care. The interventions listed in NIC encompass a broad range of nursing practice, some requiring specialized education and skill competency that cannot be performed without appropriate certification.

Competency Profile for Registered Nurses

The full scope of practice for RNs refers to all competencies and interventions that a group of professionals are educated and authorized to perform, rather than what an individual RN can do in a specific practice setting. The Health Professions Act and the Registered Nurses Profession Regulation govern the profession of registered nursing in Alberta. The broad legislated practice statement encompasses all activities within the profession of registered nursing, whether an RN practises as a direct-care provider, educator, manager/administrator or researcher. Because the scope of practice of RNs is so broad and varied, no single RN could be expected to competently perform all of the interventions within the regulated scope of practice. For example, while it is within the scope of practice for RNs to initiate an intravenous to treat hypovolemia, not all RNs will have the competence to do so.

Questions are often asked about whether an intervention is within the scope of an RN and/or our other nursing colleagues, registered psychiatric nurses (RPN) and licensed practical nurses (LPN), when assigning care. It is helpful to think about the difference between the concepts of what an RN, RPN or LPN “can do” and what they “should do.” In many instances, interventions may be within the legislated scope of practice of an RN, RPN and LPN (“can do”), but are not necessarily appropriate for all RNs, RPNs or LPNs, in all settings, to carry out (”should do”). In considering if an RN can provide an intervention versus if they should, take into account:

- that the decision on who provides the intervention is driven by the needs of the client not the desire or convenience of a health-care professional
- support, such as experts, are in place
- what best evidence indicates to support the decision
- who is available for consultation

Why CARNAs is utilizing NIC

NIC provides a comprehensive and detailed description of more than 500 nursing interventions, organized in an easy-to-use structure (logical taxonomy), as well as by nursing specialty. NIC is internationally recognized, research-based, continually updated and a new edition is published every four to five years.

The following example will provide a brief introduction to NIC and its application in your daily practice.

RNs use the intervention Laboratory Data Interpretation as it provides critical analysis of client information to assist with clinical decision-making. NIC describes the activities RNs engage in when applying this intervention to their practice. The activities listed for this intervention make the invisible work of knowledge, analysis, critical thinking and application of the knowledge of laboratory data, recognized and visible. For example, RNs not only observe if the lab results are within normal values, but if the values are abnormal. Using their knowledge, RNs synthesize this information to determine why the results are abnormal and the critical thinking checklist begins; RNs considering any possible contributing factors (i.e. new medications, discontinued medications, overall influences of pharmacokinetics and other recent interventions such as use of contrast for studies, possible co-morbidity that may contribute to data findings, stressors both physiological and/or psychosocial, and the client’s gender and age). RNs then monitor, inform the client and consult as appropriate based on their analysis of the “big picture” of the clients’ condition.

RNs engage in this process repeatedly throughout their shift as they continually assess, plan, implement and evaluate the care that their clients need. While many interventions RNs perform are clearly visible, nursing practice is guided by a knowledge base and decision-making that is not directly observable.

NIC provides language for RNs to use to describe their scope of practice in a specific practice setting with a specific client population.

If you wish to discuss scope of practice questions related to your practice setting, please contact the CARNA’s policy and practice consultants at 780.451.0043.
Carna policy and practice consultants perform individual and group consultations with members and others. Individual consultations are reviewed annually to identify trends and issues for registered nurses (RNs) and where policy development may be needed to guide practice or to advocate for change.

An underlying theme throughout all consultations was the increasing challenge for nurses to balance the needs of their clients with the demands of the health system and ensuring their own fitness to practise. The increasing complexity of consultations, identified in the current and previous reviews, is expected to continue given the ongoing changes within the health system.

### Review of Policy and Practice Consultations 2007-2008

<table>
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<tr>
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<td>Legal/Ethical</td>
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<td>Information Networking</td>
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<td>21 (2%)</td>
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<tr>
<td>Relationships</td>
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<td>25 (2%)</td>
</tr>
<tr>
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<td>33 (3%)</td>
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<td>Internationally-Educated Nurses</td>
<td>7 (0.7%)</td>
<td>N/A</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>978 (0.7%)</strong></td>
<td><strong>1,017</strong></td>
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</table>

### Nursing Practice Standards

#### Medication practices

Many consultations related to aspects of medication practices such as medication reconciliation; review or development of clinical pathways; medical protocols or other clinical decision support tools to guide practice; the RN role in client education and management of over the counter medications; and the dispensing of drug samples in clinics or physician offices. Members are encouraged to review the Carna Medication Administration: Guidelines for Registered Nurses (2007) for guidance to support the provision of safe and effective medication administration in a variety of practice settings.
Unregulated care providers

There were also consultations related to unregulated care providers and their role in medication assistance in long-term care centres. RNs must apply the standards described in the CARNA, CLPNA and CRPNA joint document *Decision-Making Standards for Nurses in the Supervision of Health-Care Aides: Restricted Activities and Activities of Daily Living* (2003) to determine the appropriateness of teaching and assigning a task to an unregulated care provider that involves the administration of a medication to a resident. Regularly scheduled medications may be given to a resident by an unregulated care provider, but the RN is accountable for appropriately assigning the task according to the standards, determining the level of supervision required, assessing the process of delivery of the medication by the unregulated care provider and assessing the outcomes of the intervention on the resident’s overall health status on an ongoing basis.

Examples of medication administration tasks that RNs may consent and supervise unregulated care providers to perform include:

- the application of creams and ointments
- the insertion of vaginal or rectal suppositories
- the administration of an injection if it is determined to be an activity of daily living as per the joint document (e.g. administration of insulin to a stable diabetic client)

Some members asked specific questions about the role of unregulated care providers in the assessment of residents in assisted living facilities to determine the appropriateness of administering PRN medications. The administration of a medication that is ordered as a PRN means that the medication is given only when a resident requires it. Pro re nata (PRN) means “when necessary.” A complete PRN prescription must include the frequency with which a medication may be given, such as “HS, PRN” or “Q4H, PRN,” and the purpose of the medication (e.g. for sleep, pain, nausea). RNs make decisions whether to administer a PRN medication based on their assessment of client need.

Some residents in assisted living facilities may, at times, lack capacity to make informed decisions regarding their care needs. In addition, these settings may not have nursing staff present on a 24-hour basis. Unregulated care providers may consult by telephone with a RN who may or may not know the resident and their needs for care. The ongoing assessment of health-care needs, the development of a care plan, evaluation of a resident’s health status and the ongoing effectiveness of medications are emphasized to be areas of responsibility of the RN. Personal care aides do not have the knowledge to perform comprehensive assessments of residents, monitoring and care coordination activities. A direct assessment by an RN is required to appropriately determine if a PRN medication is indicated for a particular resident. Residents’ medication regimen should be reviewed regularly and RNs should advocate for regular scheduling of a medication when PRN use is consistently requested or required for a resident.

Documentation

Poor or inadequate documentation of care, documentation concerns in the electronic health record and documentation expectations of RNs in a variety of settings, such as the triage area in emergency rooms, are examples of issues brought forward by members.

Quality documentation is ultimately good risk management for the client receiving care, for the staff providing the care and for the organization. The frequency of documentation and amount of detail documented are dictated by a number of factors, including:

- the regional/facility documentation policies and procedures
- the complexity of the client’s health problems
- the degree to which the client’s condition puts him/her at risk
- the degree of risk involved in the treatment or care

These factors warrant consideration in determining documentation expectations for RNs in any practice setting. Members are encouraged to review the CARNA document *Documentation Guidelines for Registered Nurses* (2006) for guidance that will assist RNs in producing clear, accurate and comprehensive accounts of client care in any setting.

Legal and ethical

Issues brought forward were diverse and complex. Concerns related to:

- moral distress experienced by RNs when there are insufficient and/or inappropriate human and material resources available to deliver safe patient care (e.g. inappropriate management and follow-up of a patient with chronic pain)
- professional boundary questions (e.g. using patient contact information for purposes other than providing health services)
- performance of restricted activities not authorized within the RN scope of practice (e.g. writing a prescription on behalf of a physician) or supported by employer policy in a particular practice setting
- inappropriate documentation practices
- unmet registration requirements (e.g. providing nursing services without a valid practice permit)

RN are encouraged to reference the following resources for legal and ethical concerns:

- **CARNRA Nursing Practice Standards** (2003). The standards apply at all times to all nurses regardless of their role, provide guidelines to assist nurses in decision-making, support nurses by outlining practice expectations of the profession, inform the public and others about what they can expect from practicing nurses and are used as a legal reference for reasonable and prudent practice.
- **Canadian Nurses Association Code of Ethics for Registered Nurses** (2008). The code provides nurses with guidance for ethical decision-making and practice in everyday situations, serves as a means for self-evaluation
and reflection regarding ethical nursing practice and provides a basis for peer review initiatives.

- CARNADocument Professional Boundaries for Registered Nurses: Guidelines for the Nurse-Client Relationship (2005). The document provides guidelines for professional behaviour and identifies warning signs that a therapeutic relationship may be compromised. The maintenance of healthy therapeutic relationships between clients and registered nurses is the responsibility of the RN.

- CARNADocument Health Professions Act: Standards for the Performance of Restricted Activities (2005). The document provides direction to RNs regarding their legislated scope of practice and guidance to explore the integration of new interventions within the RN scope of practice in a particular setting.

- The Canadian Nurses Protective Society offers legal liability protection related to nursing practice to eligible RNs, by providing information, education and financial and legal assistance.

All documents listed are available through the CARNADocument Library and can be downloaded from the Resources section on the CARNADocument website at www.nurses.ab.ca.

**Scope of practice**

The issues brought forward related to clarifying the roles and responsibilities of RNs, new graduate nurses, internationally-educated nurses (IENs), nursing students and undergraduate nursing employees (UNEs). This trend is similar to what was reported in the previous review of consultations. Employers continue to be challenged by staff shortages and are exploring new ways to utilize nursing staff.

Employers asked questions related to utilizing IENs in other roles while they work towards meeting eligibility requirements for full licensure as an RN. Some were concerned about understanding the scope of practice of the new graduate nurse employed in particular settings, such as ICUs and diagnostic imaging departments. Other questions regarding RN scope of practice were related to the potential integration of new interventions in the scope of practice of RNs in a particular setting (e.g. performing PAP tests in primary care settings). There were also questions related to changing the setting in which a particular intervention is generally performed (e.g. providing home IV therapy instead of providing IV therapy in an ambulatory clinic or in an acute care setting).

Under the Health Professions Act, a graduate nurse is a regulated member on the temporary register and has a temporary practice permit. This register includes new graduates and IENs who are in the process of meeting registration requirements. Through regulations, CARNA authorizes its regulated members, including members on the temporary register, to perform a number of restricted activities. Employers are encouraged to provide comprehensive orientation and mentoring for nurses on the temporary register and may place limits on the independent performance of restricted activities until all registration requirements have been met. Nurses on the temporary register should not be assigned as the nurse in charge or left alone in a practice setting unless they have the necessary clinical experience and competencies to assume this role and its responsibilities.

A UNE is a nursing student who has not completed their nursing education program leading to initial entry-to-practice as an RN and has been hired to provide nursing care. Nursing students in a nursing education program leading to initial entry-to-practice as an RN are not regulated by CARNICROA. They are considered unregulated workers when providing nursing care in either a clinical practicum or as an undergraduate nursing employee. CARNAJROA has identified in regulations the activities that these nursing students will be authorized to perform under supervision. The Standards for Supervision of Nursing Students and Undergraduate Nursing Employees Providing Client Care (2005) outlines the requirements for employers, nursing education programs and registered nurses as regulated members and how they must approach the supervision of care provided by nursing students. **RN**

### GROUP CONSULTATIONS

Between Oct. 1, 2007 and Sept. 30, 2008, policy and practice consultants engaged in a total of 33 group consultations with 1,223 participants. Participants were primarily CARNADocument members practising in a variety of roles and settings. Group consultation topics included: the application of the Nursing Practice Standards in relation to assignment of care; medication administration and clinical documentation; RN and NP scope of practice; RN responsibilities in the charge role in continuing care settings; privacy and confidentiality of health information; and ethical nursing practice in continuing care and home care.

### CONSULTATIONS AVAILABLE BY PHONE, E-MAIL, FAX AND IN PERSON

CARNADocument policy and practice consultants provide confidential consultations to RNs and others who seek assistance with issues that directly or indirectly affect the delivery of safe, competent, ethical nursing care.

To reach a CARNADocument policy and practice consultant, call 780.451.0043 / 1.800.252.9392.
Volunteer Opportunities

Nursing Education Program Approval Board

Two RNs needed
Term beginning Feb. 1, 2010

Members of the Nursing Education Program Approval Board (NEPAB) are appointed by CARNA Provincial Council. The board is comprised of registered nurses, nursing educators, employers and members of the general public. NEPAB reviews and approves nursing education programs in Alberta leading to initial entry-to-practice as a registered nurse. The authority to approve education programs leading to initial entry-to-practice as a nurse practitioner was recently delegated to NEPAB. Work to develop the requirements and processes for nurse practitioner education program approval is underway.

Qualifications
• experienced RNs involved in direct nursing practice as a front-line nurse manager, clinical specialist, advanced practice or preceptor for nursing students
• reside in either urban or rural (large and small) centres
• not currently serving as a member of another CARNA committee/board or Provincial Council

Expectations of Members
• complete a five-year term
• attend two-to-three day meetings held quarterly
• commit to preparatory time for meetings
• adhere to the code of ethical conduct and maintain confidentiality
• participate in the reviews of and render decisions about nursing education programs
• make decisions in the best interest of the public, nursing education and the registered nursing profession

Questions
If you have questions about the work of the board or the expectations of members, please contact:
Lori Kashuba, NEPAB Consultant
780.451.0043/1.800.252.9392, ext. 425
nepab@nurses.ab.ca

How to apply
Visit www.nurses.ab.ca to download an application form or contact:
Ruby Sutton
780.453.0522/1.800.252.9392, ext. 522
rsutton@nurses.ab.ca

Application deadline: Oct. 1, 2009

Volunteer Opportunities

Why you should volunteer for a CARNA committee

Self-regulation means that registered nurses, not the government or any other outside group, determines our standards of practice and our professional ethics. Through this privilege, we demonstrate accountability to the public, to ourselves and to this incredible profession.

For self-regulation to remain effective, it requires registered nurses to take an active role.

Visit www.nurses.ab.ca for an up-to-date list of committees seeking volunteers. Choose an opportunity that appeals to your interests, experience and availability and apply online.

Post-RN Program Closure

The University of Alberta will no longer accept students to the post-RN baccalaureate program, effective as of the September 2011 term. Diploma-educated nurses wanting to obtain their degree who have not enrolled at the university prior to this term will have to attend other post-secondary institutions.

If you were admitted to the program on or after 2002, but have an inactive student status, you can be readmitted to the program and will have until July 1, 2014 to earn your degree. During the transition to full program closure, the following courses will be offered online: NURS 301, NURS 410, NURS 415 and NURS 470. Grande Prairie Regional College and Red Deer Regional College will offer NURS 475 for students in those regions.

RNs with inactive student status are asked to call Nursing Undergraduate Student Advisor Ian Payne to devise a schedule of study that will ensure you finish all degree requirements before July 2014. Payne can be contacted by e-mail at ipayne@ualberta.ca.

The post-RN baccalaureate program at the university has played an important role in nursing for Alberta RNs. Since its inception in the early 1970s, the program has made significant contributions to advancing nursing knowledge in the province. The University of Alberta continues to value good access to the program for diploma-prepared nurses during the phase out.

As of Jan. 1, 2010, a baccalaureate degree in nursing will be the minimum educational preparation required for new RNs. Diploma-educated nurses who are licensed as RNs by CARNA prior to Jan. 1, 2010 are not required to obtain a baccalaureate degree.
Meet the Registrar Team

The CARNA registrar team is made up of five registered nurses, one registrar and four deputy registrars. Each oversees a distinct area of registration, ranging from internationally-educated nurses to continuing competence, to entry-to-practice and renewals and special registers. Together, the team holds 13 post-secondary diplomas, degrees and masters and has a combined total of XX years of nursing experience. Each is dedicated ensuring to advancing the profession of registered nursing in Alberta.

The Registrar

Cathy Giblin

Cathy Giblin is registrar/director for registration services. Registration services is responsible for assessing eligibility of and processing applications from Alberta, Canada and internationally-educated applicants for temporary, initial and annual practice permits. The team works to protect the safety and health of Albertans by ensuring that only qualified, competent candidates are authorized to practise as GNs, RNs, CGNs or NPs.

“It’s important to me to ensure that processes are efficient and accurate so that members can get registered and continue to practise,” says Giblin.

Before joining CARNA in December 2008, Giblin was the director of regional nursing affairs for the former Capital Health region. Giblin graduated from the University of Alberta in 1988 with a bachelor of science in nursing. Shortly after graduation, she moved south, practising in California, Connecticut, Louisiana and Pennsylvania. In 1998, she graduated from the University of Pennsylvania with a masters’ degree in organizational dynamics.

Giblin’s clinical career has always centred on adult critical care. With this focus, she practised as a staff nurse, a non-regulated staff trainer, a front-line manager and a clinical director. She has also managed a project that remodeled care delivery on in-patient hospital units and was very involved with implementing unit and institutional shared governance models.

“The most gratifying part of my career was at the bedside. I witnessed amazingly happy, sad and scary human experiences and was given the opportunity and privilege to ease my patient’s fears to make a difficult time more bearable,” says Giblin.

In 2008, Giblin was the recipient of the CARNA Award for Nursing Excellence in Administration. She is described by colleagues as “an intense defender and avid supporter of the nursing profession.”
Jean Farrar  RN  
Deputy Registrar – Internationally-Educated Nurses  

As deputy registrar for internationally-educated nurse (IEN) registration, Jean Farrar leads a team involved in the assessment of IEN applicants for registration in Alberta, including whether additional education will be required for an applicant to be eligible for registration. Her work involves development, implementation and evaluation of regulatory policies and processes for registration. Farrar says the most frequently asked questions are “What are the registration requirements and assessment processes for IENs?” and “How does nursing education and practice around the world differ from Alberta and Canada?”

Farrar joined CARNA in January 2008. Since then, she has seen major challenges in IEN registration activities and significant accomplishments by her team, managing the growth in volume of applications, the complexities of the assessment process and in maintaining focus on CARNA’s mandate of ensuring public safety through consistent application of the legislation regulations and eligibility requirements for registration.

Farrar obtained her bachelor of science in nursing from the University of Saskatchewan and a masters of education in educational administration from the University of Alberta. She is proud to be a member of a profession focused on people that requires strong intellect, critical thinking and caring skills all bundled together. Her career has taken her to varying practice areas, including direct care, teaching and front-line management. Throughout her career, she says, “nursing has been very good to me.”

Terry Gushuliak  RN, BA, BScN, MN  
Deputy Registrar – Continuing Competence  

Speaking with Terry Gushuliak, her passion for the nursing profession is evident. This passion extends to her work as head of the Continuing Competence Program where she helps to plan, develop and implement program elements to support registered nurses in their ongoing professional development.

“Nurses are entrusted with human life,” says Gushuliak. “It is incumbent on us, as nurses, to ensure our interventions are the very best they can be.”

Through the Continuing Competence Program, Gushuliak helps RNs meet their legislated responsibility for continuing competence. She takes pride in knowing that her work helps to support safe patient care for Albertans. It is important to Gushuliak to directly link program requirements with active practice.

“I treasure opportunities to talk to individual nurses and stay in touch with what is happening on the front line,” says Gushuliak. “Staying in touch with the day-to-day realities of nursing helps to keep the Continuing Competence Program meaningful.”

Gushuliak’s nursing career and appreciation of the human experience has taken her to remote regions of the world. Time spent in Papua New Guinea and abroad are experiences she describes as “profound.”

Whether practising abroad or at home in Canada, Gushuliak is committed to supporting RNs with tools to help them maintain their competence.
Rosie Thornton  RN, BScN, M.Ed
Deputy Registrar – Entry to Practice and Renewals

IN January 2009, Rosie Thornton joined the CARNA team as the deputy registrar for entry to practice and renewal. She has the responsibility of registration and renewal for the more than 32,000 registered nurses in this province, as well as oversight of the Canadian Registered Nurses Exam.

“Working with the dedicated registration team members is a pleasure and a privilege,” says Thornton.

A passion for health and well-being led Thornton to her career as a nurse. She graduated from the University of Alberta in 1994 with a bachelor of science in nursing. In 2001, she obtained her master’s degree in adult education from St. Francis Xavier University in Nova Scotia.

In addition to contributing to fulfilling CARNA’s mandate of protecting public safety through legislative and policy implementation, Thornton has had a very rewarding and challenging career involving clinical practice, nursing education, management and quality assurance. She is honoured to have been instrumental in inspiring and mentoring students in the pursuit of their own nursing careers and impressing upon them the intrinsic value and worth of all people who require assessment, care and support throughout the lifespan.

“Working with colleagues at CARNA has been an exciting and rewarding journey,” says Thornton.

Barbara Waters  NP, BScN, MN
Deputy Registrar – Special Registers

AS deputy registrar for special registers, Barbara Waters works primarily with nurse practitioners (NPs) and nurses in self-employed practice. Through her work, Waters supports CARNA’s mandate of public safety through regulatory policy and process development and review that is guided by interpretation of the applicable legislation and regulation for registered nurses. She also supports members in understanding the application of the legislation, regulation and CARNA policies in relation to their individual nursing practice.

Waters is a strong advocate for advance nursing practice and the nurse practitioner role. She continues active practice as an NP with Alberta Health Services and Health Canada, First Nations Inuit Health. Waters is a founding member and past-president of the Nurse Practitioner Association of Alberta, a founding member and past-chair of the Nurse Practitioner Council of Canada and is currently serving a term on the executive of the Canadian Association of Advanced Practice Nurses.

“The role of nurse practitioners will continue to grow significantly,” says Waters. “There is great potential to improve the quality of care and access to that care.”

Inspired by her mother’s love of nursing, Waters obtained her Diploma of Nursing at the University of Alberta Hospital in 1990 and her Bachelor of Science in Nursing (1998) and Master of Nursing (2002) from the University of Alberta. Waters says, “I have a passion for nursing and have had a rich career working in a variety of settings with different populations, been involved in promoting and developing the nurse practitioner at the local to national level and am enjoying new learning opportunities and challenges with my current role at CARNA.”
### Tips for increasing error reporting

Voluntary error-reporting is an important way for health-care providers to learn about:

- **Risks:** Hazardous conditions hidden in processes.
- **Actual errors:** Errors that occur during the delivery of patient care.
- **Causes of errors:** Underlying weaknesses in systems and processes that explain why an error happened.
- **Error prevention:** Ways to prevent recurrent events and, ultimately, patient harm.

Error reporting is a fundamental component in a safety culture, but persuading health-care workers to submit reports is no easy task because of the potential barriers to reporting. In fact, data from over 600 hospitals in the Agency for Healthcare Research and Quality’s 2009 *Hospital Survey on Patient Safety Culture* showed that half of respondents did not report a single error, event or hazard in their facility during the past 12 months.

| People’s reactions to errors vary. | A nurse sent an alpha-numeric page to a pharmacist requesting an additional ampul of digoxin for a patient. The pharmacist did not understand the request, so she went to the unit to investigate. The physician had prescribed digoxin 0.0625 mg IV daily for the patient and the pharmacist had previously dispensed an ampul containing 0.5 mg/2 mL with directions on the outer zip lock bag to administer 0.25 mL. The nurse had misread the prescribed dose as 0.625 mg and administered the entire ampul containing 0.5 mg. She had requested the additional ampul so she could administer the rest of the “0.625” mg dose of digoxin to the patient. As the pharmacist and the nurse spoke about the error and the monitoring the patient would require, the patient’s physician approached. The nurse was comfortable telling the physician that there had been a problem with the patient’s digoxin, but she spoke in a hushed tone. The nurse then added that she would have to tell him the rest of the details after the charge nurse moved out of earshot. Luckily, the patient, who was already on telemetry, showed no signs of toxicity over the next several days. Despite encouragement from the pharmacist, the error was never reported within the hospital. Thus, the opportunity for other clinicians and managers to learn from this mistake was lost because something, perhaps fear of reprisal, prevented this nurse from involving her charge nurse after she made an error. Regardless of potential disincentives to report internally, some highly-functional external error-reporting systems exist today, including the ISMP Medication Errors Reporting Program. By utilizing these reporting systems, errors can be shared with others to help prevent the same error from happening again. Regardless if the reporting system is internal or external, there are six best practice categories that impact the frequency and quality of reports.
- **Trustworthy.** Those who receive and act on error reports must earn the trust of reporters and prove that the program is sensitive to reporters’ concerns, particularly fear of punishment for making and reporting errors. Feelings of trust are fostered by leaders who demonstrate an unequivocal passion for safety, acknowledge the high-risk nature of health care and human fallibility and use errors to assess system performance. What is needed is a just culture where workers are encouraged to provide essential safety information without fear of being judged or treated unfairly in the wake of an error. Within a just culture, managers and staff can openly communicate about errors and at-risk behaviours and, together, promote system improvements and safer behavioural choices.
- **Confidential.** Those who receive reports must keep the identity of reporters, workers involved in the errors and the location of the events confidential to prevent undue embarrassment or undesirable attention. Anonymity when reporting is not recommended as those who receive the report would not be able to talk to the reporter or others involved in an error to learn about the causative factors. Removing identities after the error has been fully investigated is an option.

Continued
Clear and easy. Those who receive reports must pay attention to the format and length of the required report. If the expected report is too long, it will stifle reporting. If the report is too short, you may not get enough information to make it useful. A narrative description of the event should focus on the specifics of the event. It should be brief and factual, not accusatory or blaming. For example, a reporting format for medication hazards or errors should ask whether the event involved missing information about the patient or drug, communication problems, labelling and packaging problems, drug storage problems, environmental problems and so on. This way, the probing questions shift a lot of the analytical work away from the reporter and make it easier for him or her to uncover some of the causative factors that led to the error. Event reporting mechanisms should also be flexible enough to include both formal and informal ways of accepting information, including oral, written and electronic submissions.

Rewarding. Occasional recognition for playing a positive role in patient safety through reporting should be acknowledged by those who receive reports and other organization leaders. Of course, as implied in the following category, the biggest reward of all is to know that the report resulted in effective system-level action and increased safety for the patient and employee.

Credible and useful. Few things impede reporting more than perceived inaction and failure to use the information contained in a report to improve safety. Thus, those who receive reports must provide rapid, useful and understandable feedback to staff, across departmental lines, keeping them informed about how their reports are being used to improve systems and processes.

Reinforces the imperative to report. Those who receive reports must establish mechanisms for mentoring new staff about the error-reporting process. Additionally, the importance of reporting hazards and errors should be stressed with all staff by including clear expectations for reporting activities in all job descriptions and performance evaluations.

Elements that encourage error and hazard reporting

Trustworthy
- Patient safety is clearly reflected and communicated in the organization’s mission, vision, values and strategic goals.
- Leaders’ decisions demonstrate a visible and unequivocal passion for safety and the prevention of patient harm.
- Leaders are visible in work areas to learn firsthand about the barriers to safe care and to make themselves available for discussions about patient safety.
- Leaders demonstrate positive attitudes about the organization’s capabilities and clearly demonstrate their belief that the workforce is doing their very best.
- Leaders use errors to assess system performance and organizational tolerance to risk.
- Leaders acknowledge the high-risk nature of health care and human fallibility.
- Leaders are preoccupied with the risk of system failure, not individual failure.
- Leaders demonstrate a thirst for knowledge about risk, errors and patient harm.
- Leaders share responsibility for errors when they occur.
- Leaders do not unjustly discipline individuals who report or commit errors or deviate from established policies, procedures or best practices under the mistaken belief that the deviation is justified and insignificant.
- Leaders have developed guidelines to identify and prioritize events that are appropriate and useful for conducting a root cause analysis.

Confidential
- Confidentiality is guaranteed for reporters, individuals involved in errors, location of events and patient identities.
- The information collected during the investigation of an error, for the purposes of safety and quality, is protected from legal discovery.

Clear and easy
- Staff is provided with clear definitions and multiple examples of the types of errors, near misses and hazards that should be reported.
- The format used to collect information about events has been tested for clarity and ease of use and is edited as needed before implementation.
- The error reporting process (with examples) is covered during orientation for all staff.
- Informal and easy methods for reporting hazards, near misses and errors should be used (e.g., web-based or telephone hotline reporting).

Rewarding
- Pathways have been established for thanking and rewarding staff who report errors or hazards.
- Pathways have been established for thanking and rewarding care settings for demonstrating measurable improvements in patient safety.
- Staff is able to see demonstrable results and system-based actions taken by the organization based on the information received in reports.
It wasn’t too long ago that health-care professionals felt too embarrassed or ashamed to divulge a medication error. Some were so fearful of legal and personal reprisal that they followed an unwritten, unspoken, but clearly understood rule – silence is golden. But times have changed. Most now realize that disclosure and open discussion of errors allows us to better analyze a hazard and design systems and processes that are resistant to errors. Many can clearly see the value of reporting hazards before errors actually reach patients. In fact, many are beginning to see greater liability in not reporting errors than in reporting them. By following the steps provided, hospitals can optimize reporting systems and their capacity for learning about the human, technological, organizational and environmental factors that determine and improve patient safety. RN


Credible and useful

- Leaders act on error and hazard reports by fixing system-level vulnerabilities and coaching staff around safe behaviour choices.
- Leaders (including the board) support system enhancements suggested by staff to reduce the risk of harmful errors.
- Leaders empower staff to correct safety hazards (in conjunction with appropriate communication with leadership).
- Leaders consistently provide feedback to staff regarding the actions planned and taken to prevent errors.
- Methods have been established for sharing the lessons learned from error analysis and root cause analysis (e.g. storyboards, newsletters, staff meetings, educational presentations, daily safety huddles).
- Methods have been established for meaningful cross-departmental sharing of memorable error stories and error-reduction strategies.
- Methods have been established to share meaningful data to demonstrate safety problems and ensure that actions taken have been successful in reducing risk, error and/or patient harm.
- External reporting is encouraged so that patient safety organizations can disseminate useful information to others and work to address problems at the regulatory, standards, and industry level.

Reinforced imperative

- New staff is taught the error-reporting process during orientation and work closely through the process with their preceptor/mentor.
- New staff is required to report at least one safety hazard during their orientation period.
- Error and hazard reporting are included as core elements in all job descriptions and performance evaluations.

Up to 90 percent of your patients will experience at least one episode of low back pain during their lifetime. The most common type of low back pain is non-specific and has no identifiable cause. In most cases, the pain usually resolves within two weeks, however 20 percent to 44 percent of patients will experience further episodes within a year and over three-quarters will have a reoccurrence at some point in their lives. A small minority will develop chronic low back pain.

The Toward Optimized Practice program released the clinical practice guideline Evidence-Informed Primary Care Management of Low Back Pain to provide health-care professionals with information on diagnosis, evaluation, management, treatment and prevention of low back pain. The guideline also offers advice and answers to common patient questions and describes what to look for to spot serious conditions and psychosocial issues that could lead to low back pain.

Visit www.topalbertadoctors.org/cpgs/ to download the following resources:
- Clinical Practice Guideline: Evidence-Informed Primary Care Management of Low Back Pain
- Patient Handout: Chronic Low Back Pain
- Patient Handout: Acute Low Back Pain
- Companion Document: Clinical Assessment of Psychosocial Yellow Flags
- Companion Document: What Can be Done to Help Somebody Who is at Risk?
With our deepest appreciation!

The Alberta Registered Nurses Educational Trust Board of Directors expresses their sincere thanks and appreciation to Dr. Marion Allen and Dr. Judith Hibberd for their generous and tireless commitment to our charity and to our province’s registered nurses. During her term on the ARNET board, Allen served as the chair of the Allocations Committee; Hibberd helped ensure our financial viability as chair of the Finance Committee. Their vision, leadership and ongoing commitment to nursing education has benefited all Albertans.

example, when I was in nursing school, you put a thermometer into a person’s mouth to take their temperature. Now, you put it into their ear and it doesn’t even touch the body. Continuing education for nurses is absolutely essential.

What do you wish nurses and the community knew about ARNET and the financial management of the charity?

From some of the feedback we get, it seems to me that some nurses don’t really understand where the money is coming from or that we are a charity. Like every other charity, ARNET relies on the generosity of our donors, support of our fundraising activities and the growth of our investments. I would like people to know how well our money is managed. Our finance committee closely monitors the company we have hired to manage our investments. We also have two public representatives on the finance committee to ensure that we have advice from both inside and outside the registered nursing profession. Their assistance and perspective ensures the long-term viability of our charity, even through these turbulent investment times.

Now that your term of office is complete, what will you remember most about your time as an ARNET board member?

The tremendous commitment from other board members. The ARNET board is committed to what it is doing. We are sometimes faced with very difficult decisions, but we always somehow manage to come to an agreement. We have had some marvelous leadership in Betty Gourlay and then Arlene Johnston, Joanne Penner Herron and now Sheila Elliott. We have been very lucky to recruit such amazing leadership and members. Each one has contributed to ARNET’s success.

Why do you choose ARNET as one of your charities?

I truly believe that what we are doing is very important work and I’m prepared to put my time, energy and my own financial contribution into it. I really believe in promoting the continuing education of nurses. It is a very worthwhile charity.

Prior to her departure, Hibberd reflected on her nursing career and her work with ARNET. Here is what she had to say:

Why did you choose nursing as a career?

I started out in the secretarial field and didn’t find that very satisfying. When I had my appendix removed, I was exposed to nurses and what nurses do. Since then, my nursing career has provided me with opportunities that I never would have imagined!

Why did you become involved with ARNET?

The financial and business aspect of nursing has always been of interest to me. ARNET provided a perfect opportunity to blend my interest in financial management with my dedication to continuing education.

Why is continuing education important for nurses?

The knowledge that is required of nurses is expanding all the time and we are also rejecting old knowledge at the same time. New drugs, new treatments, even new diseases. It’s absolutely essential that nurses continually update their knowledge. For

Dr. Judith Hibberd   ARNET Board of Directors

Invest in the heart of health care

Investing in RN education is investing in a healthy future for Albertans. Your generosity as an ARNET donor ensures that we can maximize educational funding for Alberta RNs. We have a variety of donation options and a charitable tax receipt is issued for all donations to ARNET. Every gift is another step towards a healthier and happier tomorrow for all Albertans.

For more information on ARNET or to donate today, go to www.nurses.ab.ca/ARNET.
Bridging Spirituality and Health

The Canadian Association for Parish Nursing Ministry held its 11th annual conference on May 21–24, 2009. Alberta RNs (l to r) Darlene Dawson, Kathy Dempsey-Glegloff, Leslea Brodie, Nadine Murphy, Dawn Friesen, Barbara Whidden, Joanne Penner Herron, Tamara Zujewskyj, Mary Gaye Pinches, Adeline Eggen, Rosealine Begalke and Linda Saunders attended the conference that focused on the role parish nurses play in their communities.

A parish nurse is an RN who feels called to ministry and affirmed by a faith in community to promote health, healing and wholeness. Parish nurses promote the integration of faith and health in ways that reflect in the community, including health advocacy, health counselling, health education and resource referral.

For more information on parish nursing, visit www.capnm.ca.
As a young girl, I never imagined I would be a nurse. I remember watching my mother get dressed into her white uniform and drive to the hospital day after day. When she returned, she would talk about her day, including the friendships she had with her fellow nurses and how the patients gave her a purpose in life. I could see that being a nurse was much more to her than a just a job, but I never really understood the reasons why.

It was not until about a year or so into my post-secondary education that I really started to explore and figure out what it was I wanted out of my future career. Weighing all of my options, the idea of becoming a nurse came to mind. Maybe it was my part-time job at the Misericordia Community Hospital or recalling my mother’s words of elation or a combination of both that made my mind. Shortly thereafter, I attended the Stollery Children’s Hospital Miracle Gala. One of the speakers at the event was the father of a child who spent a great amount of time at the children’s hospital. When he described the impact the nurses had on his family’s life, as well as his eternal gratitude, I knew I wanted to do something that would make that kind of difference for someone someday.

I felt both nervous and extremely excited as I stepped onto the unit during the first few days of clinical practice. Standing in my perfectly pressed uniform, watching the nurses hurry about and listening to the ringing of patient call bells, the idea of becoming a nurse finally became my reality. Looking around at my fellow classmates, I could see that they were just as nervous as I was. What will I be able to do? Will I be confident? Will the nurses be friendly and helpful? Will my patient be open to a conversation with me? These questions flooded my mind as I received my first patient assignment.

Upon entering my patient’s room, a wave of calmness came over my mind and body. I thought to myself “I can do this!” I extended my hand to shake hers as I introduced myself and sat next to her bedside. We began talking about her day and she was quick to tell me that it was nice to have a visitor, as her family did not visit over the weekend. She seemed excited to tell me about her children and grandchildren, as well as her husband and their cat.

During our visit, a respiratory therapist came in to perform an arterial blood gas test to evaluate the patient’s eligibility for at-home oxygen. She had had the test done before and told me it was very painful. She looked up at me, with fear in her eyes, and asked “can you hold my hand, dear?” As I took her hand in mine, I felt that she trusted me and valued my companionship for the afternoon. She further reinforced these feelings when she continued to hold my hand after the test was complete and we continued our conversation. In these moments, I felt what my mother had spoken of so many times before. On that Monday, in that hospital room, I was there for a woman in pain who just needed someone to hold her hand. The feeling of knowing I had helped her, even if in a small way, made me feel that I had made a difference in her life.

Driving home that afternoon, I connected with how it feels to be a nurse. To have someone trust you, to need you and to be grateful for your assistance creates a feeling of pure satisfaction that cannot be understood until it is experienced. This experience helped me to overcome my initial fears and insecurities about being a student nurse. It has also taught me to enjoy the clinical experience and to be as open as possible to different areas of practice. Whether the unit is medicine, surgery, or paediatrics it always comes back to the little things. Although I was only able to talk to my patient and offer some general comfort, I still made a difference, which, I think, is the core of nursing as a profession. RN
Publications ordered by Hearing Tribunals

Publications are submitted to Alberta RN by the Hearing Tribunal as a brief description to members and the public of members’ unprofessional behaviour and the sanctions 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: Janet Antonio
Registration number: 62,318

A Hearing Tribunal made a finding of unprofessional conduct against Janet Antonio, member #62,318, who broke or wasted 32 vials of morphine (10 mgm/ml) over a six week period; failed to adequately account for the 32 breakages and wastages when asked to do so by her employer; and failed to follow the employer’s policy which required narcotic wastages to be witnessed. The member failed to attend at the hearing. The hearing proceeded in the member’s absence on proof of service of a Notice to Attend. The tribunal issued a reprimand and suspended the member, pending proof of residential treatment, full medical assessment and counselling; after which the member may apply to work in a setting with no access to alcohol or controlled substances or have a supervised practice where she is expected to administer controlled substances. In either setting, the Hearing Tribunal will receive further reports from physicians and counsellors and results from screens for alcohol and controlled substances. The member was ordered to pay a $5,000 contribution toward costs of the investigation and hearing. 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: 69,834

A Hearing Tribunal made a finding of unprofessional conduct against member #69,834, who contravened an order of the Professional Conduct Committee that required the member to abstain from personal use of narcotics. The tribunal issued a reprimand and accepted an undertaking to not practise as a registered nurse, pending proof of residential treatment and proof from physicians and a counsellor that she is safe to return to practice. 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 have 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 the 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.

CARNA Member
Registration number: 73,675

A Hearing Tribunal made a finding of unprofessional conduct against member #73,675, who failed to adequately assess and document three residents in her care. When she did document, she failed to note that the entries were “late entries.” She also told a co-worker she had taken thyroid medication from a resident’s medication supplies for her own use. In addition, she slept during her break in a public place in the presence of staff and a visitor and failed to sign for medications and narcotics, despite prior warnings. The Hearing Tribunal reprimanded the member, requiring her to complete courses in medication administration and charting. Her supervisor must submit reports regarding the member’s practice to CARNA at six and 12 months after the hearing. Conditions shall appear on the member’s practice permit. Failure to comply with the order may result in suspension of CARNA practice permit.

Have you read our NEW electronic newsletter?

If not, you can read it online at www.nurses.ab.ca. Just click on the link under the What’s New section of the homepage. The AB RN Online e-newsletter notifies members about information that impacts practice and other important updates.

Didn’t get your copy?
AB RN Online is distributed monthly to CARNA members with a valid e-mail address listed in their member profile. Add your e-mail address anytime by logging into the Member’s section at www.nurses.ab.ca.
BY LINDA BRIDGE, RN

Being present in people’s lives when they were faced with life changing events has been a privilege. It has provided me with glimpses of their deepening awareness of what’s really important in life. What I’ve noticed is that these people don’t focus and talk about their “things;” they talk about their family and friends – their relationships.

These opportunities have helped move me along my own path of self awareness and self examination. I want to improve my relationships, present and future. From everything I’ve read, it seems that to achieve this goal I need to become more aware of my feelings and actions. Somehow I will need to examine and then get past my deep-seated emotions to develop better relationships.

Over the years, I have developed the skill of covering up my feelings and pushing them aside. I thought that by not responding to how I was feeling, I could have better interactions and therefore better relationships. This didn’t work because I was still reacting. I may have calmed my emotions and curbed my responses, but underneath my calm exterior I would be hurt, angry or scared. These emotions controlled how I was thinking and continued to affect the quality of my interactions and my life.

I now realize that I need to take myself out of the picture to be able to hear conversations from a different angle. To truly let things be as they are has been a difficult lesson. I’m not covering things up or keeping my emotions inside to pile up anymore. I’m actively choosing a different way of letting go and not taking things on as emotional baggage. Events are occurrences with no emotions attached to them until I put them there.

Recently, I was helping to organize a family reunion. My parents, aunts and uncles had decided to pass the torch to my generation and let us take on this responsibility. Planning went well, with only a few minor glitches here and there with my siblings and cousins and their respective committees – then came the actual weekend of the reunion. I found myself subjected to my aunts’ fretting and fussing over every detail of the weekend. “The coffee’s too strong,” “what’s the agenda for the pictures?” and the list went on. I felt like I was 15-years-old again and couldn’t be trusted with the job I had been given to do. As I was about to react I thought to myself “this is not about me!” This is about my aunts’ concerns and worries. I do not have to take it on. I let out a big breath and decided not to react. I did not beat myself up and let them influence my feelings. I could truly appreciate that it was not about me. It worked well. I felt relaxed and in control. As I answered my aunts’ concerns and carried on with what I was doing, there was no inner angst or frustration like there would have been in the past. I felt good.

In the future, when I feel slighted or hurt by someone’s actions or words, I will continue to ask myself what is true for me. Am I just assuming their intent? If not and they did mean to insult or hurt me it is still my choice to let their words or actions cause me emotional pain. I can choose not to take it on and to not react.

I am amazed at how much calmer I feel as I keep my thoughts truly focused on what is happening in the moment. I can say to myself “this is not about me. This is right or wrong, good or bad. This is where this person is at in their life right now. They are simply trying to get their needs met.”

Being focused and engaged with people becomes easier as I move along in my journey. I truly have no fear of my reactions or of theirs. There is not a massive field of land mines to navigate around any longer. An occasional emotional bomb may still go off, but I’m able to shield myself simply by looking at and responding to the situation differently. For me the process of self-awareness creates room for improved and healthier relationships. I like how I feel when I’m more alert to my patterns of thought, emotion and behaviour.

Improved relationships are becoming truer for me and I am thankful for the lessons I’ve learned from those I was privileged to care for.

TFTT #73 © Linda Bridge
CIHI article
a paediatric mental health nurse, the whole family is my patient. When they come to me, they are usually experiencing a crisis or a heightened level of anxiety. Often, they express frustration with statements like “How many times do we have to share our story?” or “Can’t you just fix him and we’ll pick him up later?” These statements reveal their fear, anger and hopelessness. In a calm and supportive manner, I assure the patient or family member that I understand their unique situation and, as a nurse, I am capable of handling what is to come, whether it is a physical escalation by the patient or an emotional breakdown by a parent or sibling.

In the position statement Mental Health Services, the Canadian Nurses’ Association defines mental health concerns as including “a number of issues, from addictions and substance abuse, depression and anxiety to psychosis.”
In children, mental health issues can arise from dealing with divorce, death, peer pressure or other stressful life events. As a paediatric mental health nurse, I must gain the trust of the patient and their family to re-establish a healthy balance or structure that allows the child to grow and learn to cope with peers, school, parents and other life stresses in a healthy manner. This trust is necessary to effect lasting change.

The stigma of mental illness, anxiety and hopelessness surrounding hospital admission can create barriers to gaining trust. Rapport building activities set the tone of the relationship between me, the patient and the family. Many times, I will have to adjust my interaction style as I move from talking with a parent experiencing anxiety to a frustrated teenage sibling and then to the child patient—all in the same encounter. A change toward better mental health will have more chance of success when the adults and older siblings adopt these changes ahead of the child.

This sometimes is a hard task to accomplish because there are sometimes cultural and engrained generational patterns that have to be altered.

In my career as a paediatric nurse I have learned that:
- Providing assessments and care to a child is difficult without some consideration of the family functioning and the support system in place.
- The ability to gain the trust of a child is critical to ensuring lasting change.
- A healthy balance of structure, nurturance and discipline are needed for a child’s maturation to occur.
- Understanding how cultural, gender, age and social influences impact the mental health of the child is important to provide coping strategies for the child and their family.
- A basic understanding of developmental stages is important so that the patient’s areas of growth can be identified and care planned accordingly.

Paediatric mental health nursing is the most challenging and rewarding practice area that I have had the privilege to learn. I have the honour to help shape a child’s perspective of adults and the world around them. As a nurse, I want to see patients and families succeed and get better. Having compassion, empathy and hope for my patients and their families has allowed me to grow as a nurse, as a father and as a human being.

Paediatric mental health nursing is the most challenging and rewarding practice area that I have had the privilege to learn.

CRAIG MUELLER

Mental Health Statistics

- Surpassed only by injuries, mental disorders in youth are ranked as the second highest hospital care expenditure in Canada.
- 10–20% of youth age 12–19, in Canada, are affected by a mental illness or disorder.
- Today, approximately 5% of male youth and 12% of female youth in Canada, age 12 to 19, have experienced a major depressive episode.
- 3.2 million Canadian youths aged 12–19 are at risk for developing depression.
- Canada’s youth suicide rate is the third highest in the industrialized world.

SOURCE: Canadian Mental Health Association

Want to learn more?

Visit the CARNA Library for resources on paediatric mental health, including the following books:
In Memoriam

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

Duncan, Elissa, a 1973 graduate of the University of Alberta faculty of nursing.
Jamieson, Susan, a 1974 graduate of the Royal Alexandra Hospital school of nursing.
Piper, Doris, a 1999 graduate of the Lethbridge Community College school of nursing.
Reddick, Robert, a 1990 graduate of the University of Alberta faculty of nursing.

Accolades

Dianne Tapp appointed as new dean of nursing

On July 1, 2009, Dr. Dianne Tapp began her five-year term as the new dean for the faculty of nursing at the University of Calgary. Tapp had served as interim dean since Jan. 1, 2009 and was previously the associate dean, vice dean and acting dean for the nursing program.

Before joining the faculty of nursing in 1998, Tapp practised as a cardiovascular nurse and clinical nurse specialist in outpatient mental health. Her research interests include family nursing practice, cardiovascular health promotion, family health and qualitative research methods. “I am looking forward to sustaining the momentum we have been generating in the faculty as the next five years promises to be a period of transformative change in health care in Alberta. The faculty of nursing is poised to play a key role in supporting and advancing nursing leadership in health care,” says Tapp.

Carna’s advertising campaign launched this summer in Edmonton, Calgary and in rural communities. The goal of the campaign is to increase understanding of how the knowledge, education and skills of Alberta’s RNs contribute to safe, quality patient care.

Look for the advertisements on the side of buses and in newspapers.
To learn more about CARNA’s ongoing advocacy efforts and for ways you can help, visit www.nurses.ab.ca.

Alberta needs RN Expert Caring
6TH ANNUAL DIVERSITY AND WELL-BEING CONFERENCE
From Monologue to Dialogue: Promoting Health Literacy with Diverse Populations
CONTACT: 403.943.0205, diversity.services@albertahealthservices.ca.

GLOBAL PERSPECTIVES ON CHRONIC DISEASE
Prevention and Management Conference
CONTACT: www.cdmcalgary.ca.

LIFE SUPPORT WELLNESS RETREAT FOR NURSES AND HEALTH-CARE PROFESSIONALS
CONTACT: www.yourlifeunlimited.ca.

THE CANADIAN HEALTHCARE SAFETY SYMPOSIUM 9
Pathways and Bridges to Change

3RD INTERNATIONAL CANCER CONTROL CONGRESS
Nov. 8–11, 2009. Italy.

CARNA SPECIALTY PRACTICE GROUPS
Contact your CARNA regional coordinator or go to www.nurses.ab.ca and click on “Member Info.”

THE CANADIAN FAMILY PRACTICE NURSES ASSOCIATION
This association was established for family practice/primary health-care nurses who would like to network and exchange information with their nursing colleagues across Canada. Visit www.cfpna.ca or contact Marilyn Howlett at 403.971.0597, howlett@cfpcn.ca for more information.

Go to www.nurses.ab.ca for an up-to-date listing of reunions or to submit an event for publication in Alberta RN.

Reunions

University of Alberta Hospital School of Nursing
Class of 1969 • 30-Year Reunion
CONTACT: Susan Collins, 403.283.0839.

University of Alberta Hospital School of Nursing
Class of 1978 • 30-Year Reunion
CONTACT: Cathy Loughlin, 403.239.2413, rothbone@shaw.ca, susanschafer@shaw.ca.

University of Alberta Hospital School of Nursing
Class of 1974 • 35-Year Reunion
Oct. 15–18, 2009
CONTACT: Debbie Elliott, 780.481.5467, elliott3@shaw.ca, Suzanne Kent, 780.458.8468, suzanne.kent@albertahealthservices.ca.

University of Alberta Hospital School of Nursing
Class of 1990 • 20-Year Reunion
CONTACT: Amy Meyers, 780.433.6297, ameyers@shaw.ca.

University of Alberta Hospital School of Nursing
Class of 1999 • 10-Year Reunion
CONTACT: heekela@gmail.com.

Go to www.nurses.ab.ca for an up-to-date listing of reunions or to submit an event for publication in Alberta RN.
2010 Awards promo
September is a month that always gives me a sense of urgency. There is the rush to get the kids ready for school and the exhilarating sense of new beginnings created from my own memories of new teachers, new friends and new experiences. This year, there is even more to consider as we head into the fall facing the unknown impact of the H1N1 influenza virus.

The Public Health Agency of Canada, along with the World Health Organization and U.S. Center for Disease Control, is monitoring the progress of the H1N1 flu season in Australia, trying to predict the course it will take in Canada. If the virus becomes more virulent, we could be facing a worst case scenario. At this point, nobody knows what is going to happen.

The province’s pandemic plan anticipates nurses and doctors will be off sick at the same rate as the general population – between five per cent and 20 per cent may need to stay home, depending on the severity of the outbreak. Even if there isn’t an increase in the severity of H1N1 illness, the virus is expected to infect greater numbers of people than regular influenza because it’s a new virus and the population has little immunity to it. In any case, the health system is expected to be even busier than usual this flu season.

CARNAs is very concerned about the capacity of the health system to handle this pressure. The hiring freeze combined with Alberta Health Services CEO Dr. Stephen Duckett’s stated goal to change the staff mix in hospitals so that there are fewer nurses and increasing reliance on less costly workers is alarming in the face of the pandemic. We have expressed our concerns to government and the employer and will continue to advocate for appropriate levels of RN staffing.

In the meantime, the Public Health Agency of Canada is urging Canadians to identify a “flu buddy” willing to help care for them should they get sick with human swine flu this fall. They are also urging members of the public to talk with family, friends and neighbours and figure out how we might help each other during the H1N1 pandemic. It will be particularly important to identify and stay in touch with elderly or vulnerable people who may need help, particularly those living alone. These people will need help to obtain medications and food supplies.

Experts are suggesting a number of things that we can do to prepare ourselves and our families. First of all, stockpile up to four weeks of food, water and prescription drugs. You should have a good supply of medication in case it’s difficult to get or attend an appointment with your doctor. It is important to develop a communication plan with family and friends. You will need to have child care plans for kids if schools or child daycare facilities are closed. In any case, you should make sure that you know your employer’s pandemic plan and what will be expected of you.

All authorities are emphasizing the importance of hygiene, particularly hand-washing and coughing into your sleeve, for everybody all the time. People with H1N1 should be considered contagious as long as they display symptoms and possibly up to seven days after they get sick. Children, especially younger children, could be contagious for longer periods according to the Center for Disease Control.

We sometimes don’t pay attention to practising what we preach, but an RN who gets diagnosed with H1N1 is going to have to take the time off work required to ensure that they don’t infect patients and co-workers or put themselves at risk of serious complications. As an RN, you are a vital part of Alberta’s health system and your children, family members, co-workers and friends need you too. I sincerely hope that the H1N1 flu pandemic fizzles out and becomes one of those “might have happened” events. If not, I hope that you will take care of your own health with the same degree of care that we work so hard to provide for others.

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