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CARN A Provincial Council 2013–2014

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Volunteer Nurse brings new life to the workplace

Managing disruptive behaviour in the workplace

Closing perspectives: What’s in it for you?

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As I conclude my term as your president, I reflect back on these two years with a sense of honour and privilege. This has been a challenging and turbulent time with many difficult decisions for Provincial Council and multiple health system changes as well as many enriching and proud moments.

As Abraham Lincoln once said: “I am not bound to win, but I am bound to be true. I am not bound to succeed, but I am bound to live up to what light I have.” I ran for president to try to bring my ‘light’ and experience to advancing our profession in the public interest and to bringing the voice of RNs, NPs and the public to the decision-making tables at all levels. As president, I have met with you at every opportunity; met with health system, government, community and union leaders on your behalf; represented you at the Canadian Nurses Association (CNA) table; and raised issues in the press.

As I have said many times, we cannot stand back in silence and watch changes occur around us. The public expects us to advocate for quality and safety at every opportunity. CARNA has supported primary health care in Alberta and across Canada through active participation on government committees, working groups, meetings and our public messaging. Provincial Council has advocated for your role and contributions in all settings and questioned system changes like Workforce Transformation and funding cuts to ensure that patient/client safety is front and centre and maintained.

As a council, we have made significant decisions including governance changes and approval of new entry-to-practice competencies, RN and NP practice standards, and proposed changes to RN regulations. Under Alberta legislation, council must approve the entry-to-practice examination for Alberta nurses. We approved the introduction of the new NCLEX examination and accepted governance oversight responsibility to ensure effective implementation by 2015.

Finally, significant system challenges were encountered this year during registration renewal and Provincial Council has affirmed that CEO Mary-Anne Robinson place a priority on addressing them. The goal is to have a markedly improved system for next year.

There have been many proud professional moments for Alberta nurses over the last two years. Provincial Council awarded Queen Elizabeth II Diamond Jubilee medals to six deserving Alberta nurse leaders and four Alberta nurse leaders won national awards at the CNA Awards Gala in Ottawa. Several outstanding Alberta RNs, NPs and teams were presented with Awards of Excellence at the annual CARNA Awards Gala event. Hundreds of Alberta RNs and NPs received Long Service Awards celebrating over 30 and 40 years of dedicated service to our profession and the public.

So where do we go from here? We must continue to seek positive solutions, celebrate our successes openly and advocate for change with conviction, courage and passion. Your ideas and experience comprise a powerful toolkit for positive change. The health system may be filled with uncertainty but I am certain that you have the expertise, knowledge and skills to make a difference. Clearly identify yourselves as RNs or NPs in all settings and stand up and say “this is what I do every day to ensure quality and safety.” Never underestimate your contributions and what you have to offer. Others are privileged to work with you and to learn from you. You ARE valued by those you touch, by those you lead and by those you mentor.

To support your efforts, Provincial Council has selected three priorities for the next three years. They focus on advancing your professional voice and excellence in self-regulation (our unified mandate), new ways to engage with you as members and maximizing and profiling your professional contributions to the health system.

I ran for president to try to make a difference in these challenging and controversial times. Thank you for your support and guidance. As I pass the ‘torch’ on to Dr. Shannon Spenceley, I do so with pride and respect as I know she will fulfill the role of president and your leader with grace and excellence.

Dianne Dyer, RN, BN, MN
Past-President

The three strategic directions approved by Provincial Council in July:

- strengthen CARNA membership understanding and participation in self-regulation and the advancement of professional excellence
- continue CARNA’s unified mandate (regulation and association) by increasing government’s and member’s support for the mandate
- maximize the unique contributions of our profession to improve the health of Albertans
Welcome to Provincial Council

The following registered nurses began their terms of office on Provincial Council on Oct. 1, 2013.

**President**

**Shannon Spenceley**  
RN, PhD  
Assistant Professor  
Faculty of Health Sciences  
University of Lethbridge

**President-elect**

**Donna Wilson**  
RN, PhD  
Professor  
Faculty of Nursing  
University of Alberta

**Edmonton/West Region**

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RN, BScN, MN  
Continuing Faculty  
Grant MacEwan University

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**Central Region**

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Acute Inpatient Mental Health Services  
Red Deer Regional Hospital

**Northwest Region**

**Gerald Macdonald**  
RN, BScN  
Coordinator Chronic Disease Management Northwest  
Alberta Health Services North Zone

**Calgary/West Region**

**Jeanne Besner**  
CM, PhD, MHSA, BScN, RN  
Director  
JFB Workforce Consultants Ltd.

Thank you to all candidates who let their name stand for this election.

**CANA thanks the following out-going Provincial Council members for their contributions:**

Lisa Barrett,  
Central (2010-2013)

Margaret Spilchen,  
Edmonton/West (2010-2013)

CANA thanks RN Shawna Cunningham for serving as volunteer teller for the election.
Letters to the Editor

New AHS staffing models cause for concern

I am a nurse who works in front-line health care in Edmonton.
Albertans should be very worried and even frightened by the changes taking place in hospitals and health-care centres everywhere in Alberta.
The “new staffing model” that is introduced by Alberta Health Services replaces skilled, trained nurses, who are members of a regulated profession with health-care aides who are unskilled, poorly trained, and completely unregulated.
How are you supporting us skilled, trained nurses for this unsafe practice?
It is hurting the quality and safety of health care given to our patient by nurses who are members of a regulated profession. This is disrupting the lives and jobs of nurses like me.
This has been happening in nursing homes and long-term care facilities for a long time already. Our family had personally experienced the effects of this lack of quality of health care in these facilities when our mother had to be placed. Now this poor practice has been upgraded to include major surgical hospitals. Hundreds of nurses have already been replaced by untrained aides and we understand this is going to impact thousands of jobs all over Alberta.
Everyone in health, including the people making these decisions, know relying on unskilled and poorly trained aides will increase the danger to patients and mean far worse health outcomes. It’s completely irresponsible of Alberta Health and Alison Redford’s government to let this happen.
The nurses I work with will proudly wear white uniforms and RN pins so that the patients where we work will know who is qualified to give nursing care— and who is not.
Albertans need to tell their politicians that this kind of attack on our health-care system does not make sense and is not acceptable.

Donna F., RN
Edmonton, AB

OUR REPLY
Dear Donna:
Thank you for your letter sharing your concerns about the impact of staffing changes at Alberta Health Services (AHS). CARNA is very concerned about health workforce changes and their potential impact on patient safety and patient outcomes in the acute, community and long-term care sectors.
I am in the process of scheduling a meeting with AHS Chief Executive Officer Dr. Chris Eagle and Senior Vice-President/Chief Nursing and Health Professions Officer Deborah Gordon to share the significant questions CARNA provincial council and staff have heard from members like yourself.
Your personal experience with your mother’s care is another example we can use to illustrate the serious implications of insufficient numbers of regulated nursing staff in long-term care.
We support full RN scope of practice and advocate for valuing unique RN contributions within the health system. Wearing an RN pin is one important way we can raise public awareness of the work we do and I am pleased to hear that you and your colleagues are making a point of wearing your pins. Another way we raise awareness is to keep bringing the research about the positive impact that RN care has on patient outcomes such as reduced length of stay, fewer infections, and fewer readmissions in our communication with government, employers and other stakeholders. We are expecting to meet with Minister of Health Fred Horne in the near future and will be bringing this information forward.

Sincerely,
Mary-Anne Robinson, RN, BN, MSA
Chief Executive Officer

EDITOR’S NOTE:
The meeting with AHS took place Sept. 5, 2013 and we posted on our website and sent an e-mail to all members about the outcome of this meeting. At the time of publication, the meeting with Minister of Health Fred Horne is scheduled for late September. We will continue to keep our members informed of the outcomes of these meetings, so keep an eye on your email inbox and check for updates on our website at www.nurses.ab.ca > News > Health Policy Issues & Resources > Health Workforce Transformation
Letters to the Editor (cont’d)

RN pride takes a hit at renewal

I am a dedicated RN. I graduated in 1987— that makes me an RN with more than 25 years of experience. I take pride in the work that I do; always have. I had worked retail (still do), as a waitress in the service industry, had volunteered at the Zoo, also had worked as an RN in Critical Care. The latter, for more than 17 years of my career. Moving on then to work with Health LINK Alberta and now I am currently working with Senior’s Health – Transition Services. I had been on many Occupational Health & Safety committees, even had won an award for my commitment to my workplace, as well as long-service awards.

This letter is with regards to completing my registration renewal for 2014.

I had heard that the renewal process had been frustrating for many of my friends and co-workers, but I’ve got lots of computer skills. “How bad could it be,” I thought.

Well, I have been on the computer trying to complete my registration from early this morning. I’ve gotta tell you, that it is now five hours later and my file is not completed... I am not yet registered for 2014.

My point is that CARNAG is MY association. I have gladly paid my yearly registration fees, knowing that it is MY responsibility to be registered. I need to do so in order to perform my JOB, with pride, with love and compassion the very same way that I live each day of my life outside of work, as well.

Today, I am not so proud of CARNAG. I expect to be respected by my association when I am attempting to renew my registration as an RN. I find otherwise is the case. I had called the ‘help line,’ thinking they will ‘help.’ However, after waiting for 1 hour and 23 minutes, I was just really upset. The customer service person “couldn’t get into the system either.”

How does CARNAG expect the RNs to function in the workplace with Pride? Respect? Compassion? when we start our year off this way?

I am told that there are 35,000 RNs in Alberta trying to renew their registration and the deadline date had been extended. I say “the system must be designed to support 35,000 nurses, if that’s what we have.” I’m told “250 people can be on the system at one time” in order to renew for the new year.

That’s not good enough, I say, lets ‘ramp it up,’ let’s show the CARNAG members they are valued and respected.

Please put my registration fee towards upgrading this computer system for next year, because this is ridiculous and very disrespectful to your membership.

Thank you for printing this letter, as I know I’m writing on behalf of many RNs in Alberta.

Nadine Evanoff, RN

An argument for paper renewal

While technology progresses at light speed, registered nurses are continuously working to catch up. Our most recent CARNAG practice permit renewals have no doubt tested our patience. While it is imperative that we continue to do things electronically, would it be harmful to allow a few paper renewals? There are a small percentage of registered nurses who would be grateful to have the option of renewing ‘the old-fashioned way.’ Why not? Some of our most highly respected and experienced RNs struggle with ‘catching up.’ The stress I witness among this population of RNs seems unnecessary. Canada Revenue Agency still allows paper tax returns for those few that want to... Just a thought.

Sindhu Koickel, 20-some-computer-savvy RN, BScN

Tell us what you think

Do you have an opinion about an article in Alberta RN magazine or a general comment on nursing or health care?

Send it to AlbertaRN@nurses.ab.ca.

Letters should be a maximum of 300 words and may be edited for length and clarity. Please include your name and city.
TO ALL CARNA MEMBERS

I apologize

I would like to offer my sincerest apologies for the inconvenience and frustration you’ve experienced in trying to renew your registration. I know that system problems and jammed phone lines, combined with our inability to respond to the overwhelming volume of calls and emails, made it difficult and time-consuming for many of you to complete your renewal application. As CARNA’s CEO, I take responsibility for the hurdles many of you faced; I know we let you down.

Late fee waived

Your feedback and feedback from staff made it very clear that you were doing your best to renew on time, but many of you simply couldn’t. It made sense to at first extend, and then finally to waive, the late fee entirely this year to alleviate some of your anxiety. On September 6, we let about 9,700 members know the late fee was waived. These members had either submitted their application (~5,200) but were anxiously waiting to hear from us on their status, or had not yet managed to submit an application at all (~4,500).

Thank YOU

Thank you for doing your best to meet the requirements for renewing your permit by the deadline and for supporting each other. More than 30,000 of you did submit your application by September 6, some with little or no difficulty and some who encountered error messages, spent hours trying to submit a payment or enter info in MyCCP, or waited on hold while trying to mind young children. I’d like to especially thank those of you who, after struggling through the process, took the time to express your gratitude to staff that provided you with assistance. Those kind words were more valued than you’ll ever know.

Renewal should not be this difficult

I agree with those of you who expressed concern and frustration; renewal needs to be easier. I am committed to fixing the system failures, finding improvements to make the process more user-friendly, and making this a better overall experience for you. We have received solid suggestions from many of you and are looking at the following solutions:

• having more staff available to help you
• extending the hours of online and phone support
• greatly improving MyCCP
• exploring the implications of staggered registration

I am listening.

The feedback we have received so far by email, phone, social media and in person has been recorded and will be part of our evaluation before tackling next year’s renewal. I invite you to continue to provide input on how we can make improvements.

Sincerely,

Mary-Anne Robinson, RN, BN, MSA
Chief Executive Officer
What learning objective did you set for yourself this year? Do you remember it as you go about your day? Summer is a busy time of the year and sometimes we may feel hurried to complete our MyCCP records before the renewal deadline. We might not have the energy to put into planning our learning needs for the coming year. Sometimes it’s easiest to just create a broad learning objective and hope everything we do will fit into it. However, if we do this, we may be selling ourselves short and limiting our potential for professional growth. And as nurses, we tend to strive for excellence in our nursing practice, so we must find a way to be true to our learning objectives without burning ourselves out at work and then at home making learning plans.

Each new practice year brings the opportunity to think about how we want to develop as nurses. When we reflect on our practice, we consider the expectations that others have of us and the expectations we have of ourselves. We note where our strengths lie and where we have room to grow. This reflection is the foundation of the learning objective(s) that we set for ourselves to guide our professional development in the coming year.

Luckily, reflecting on our practice isn’t limited to once a year. In our constantly changing health-care environment, it’s expected that our learning goals will change. What others expect from us has also changed, as reflected in the new Practice Standards for Regulated Members. Even if we do start out with clear objectives, we might find that we are redefining what we need to focus on. We are not limited to the learning objective we initially set for ourselves this year. If we realize that another learning objective will be better for our development, we can log in to our MyCCP record at any time and change it!

Maybe, once the excitement of summer has faded into fall, we might find time to further reflect on our nursing practice. If that’s the case for you, and if you want help with your learning objective or any part of your learning plan, CARNA staff would be pleased to help.

Contact us at continuingcompetence@nurses.ab.ca or call 780.732.9511 (toll-free 1.800.252.9392, ext. 411).

Committed to Competence
Make time for practice reflection throughout the year

CARRA sends quite a lot of information to its members—monthly e-newsletters, Take Note, webinar e-mails, Council highlights, renewal notices and more. The majority of our emails are sent through an email service called Constant Contact.

Our priority is to ensure that members are receiving their renewal notices and other communication relating to their registration and their practice. Currently, CARRA is experiencing difficulty communicating this information to members who have unsubscribed from our emails through Constant Contact. Therefore, it is important that our members do not use the SafeUnsubscribe feature at the bottom of these emails. Legally, we must include this option. Please follow these instructions to manage the information you receive from CARRA without missing important emails about registration or your practice.

1. **Currently receiving our emails?**
   a. Click Update Profile/Email Address at the bottom of one of our emails such as the latest AB RN Online or Take Note.
   b. Manage your subscriptions by selecting the emails you would like to receive.
   c. Please do not select “Unsubscribe me from ALL mailings.” This will prevent you from receiving renewal emails.

2. **Not currently receiving our emails?**
   a. Visit this link and enter your email address: http://bit.ly/carnaemails
   b. Follow the instructions and manage your subscriptions by selecting the emails you would like to receive.
   c. Please do not select “Unsubscribe me from ALL mailings.” This will prevent you from receiving renewal emails.
Where do my fees go?

The *Health Professions Act* requires CARNA to protect and serve the public interest, including a continuing competence program and conduct process to protect public safety. Registration fees account for more than 85% of the revenue to finance the administration and processes required to support nursing regulation and professional practice.

### Registered Nurse (RN) Fee

<table>
<thead>
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<th>FEE APPLICATIONS</th>
<th>RN % TOTAL FEE</th>
<th>NP % TOTAL FEE</th>
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<tr>
<td>CARNA Operating Budget</td>
<td>79.50%</td>
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<td>CNA Fee</td>
<td>10.38%</td>
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<tr>
<td>CNPS Fee</td>
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<tr>
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<td>Capital Contribution</td>
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<tr>
<td>CARNA Legacy Fund</td>
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<td>0.09%</td>
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<tr>
<td><strong>Registration Fee</strong></td>
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<td><strong>100.00%</strong></td>
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<tr>
<td><strong>GST</strong></td>
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<td><strong>Total Fee</strong></td>
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### Nurse Practitioner (NP) Fee

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**What is “Capital Contribution” and “CARNA Legacy Fund”?**

### Capital Contribution

Every year since 2005, a portion of registration fees have gone towards a capital reserve. Capital fees go towards the replacement and preventative maintenance of capital assets, such as infrastructure or information technology. By maintaining a capital reserve, we are able to replace, maintain and invest in the tools necessary to keep CARNA running.

### CARNA Legacy Fund

Every year since 2005, $0.50 of your registration fee has gone towards the Legacy Project. CARNA’s centennial celebration takes place in 2016 and the Legacy Project fund will help us celebrate 100 years of nursing in Alberta with our members. The fund will also support registration for CARNA members at the CNA 2018 Biennial conference to be held in Alberta.
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.

To find out more about sanctions and publication, go to www.nurses.ab.ca/sanctions.

Carna Member
Registration number: 77,537
A Hearing Tribunal made a finding of unprofessional conduct against member #77,537 who for approximately two and a half years intentionally deceived her employer and co-workers when she said that she had cancer and was in treatment for cancer, and wrote three fraudulent letters apparently signed by physicians, when in fact they were not, requesting workplace accommodations for herself and submitted those letters to her employer. The Tribunal issued a reprimand and ordered the member to complete e-modules on the code of ethics; provide a report from a psychiatrist confirming fitness to practice; provide three satisfactory performance evaluations; be restricted to working for her current employer pending completion of the performance evaluations unless she receives permission to work elsewhere from a Tribunal; provide confirmation that she is in counseling with a psychologist or physician; and provide annual reports from that counselor for five years. 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: 81,757
A Hearing Tribunal made a finding of unprofessional conduct against member #81,757 who breached a patient’s confidentiality by discussing personal health information with the patient’s mother without authorization and who posted cartoons and comments on a website that the member described on the website as “Dark Humour inspired by mental health experiences,” many of which cartoons and comments may have been interpreted by some as a lack of respect or lack of compassion toward persons with mental illness and others. The Tribunal issued a reprimand and ordered the member to write a paper on confidentiality, and complete on-line modules on the code of ethics. 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: 85,861
A Hearing Tribunal accepted an admission of unprofessional conduct from member #85,861 pursuant to section 70 of the Health Professions Act and proceeded to a hearing. The unprofessional conduct was the wrongful taking of morphine tablets and vials, dilaudid tablets and vials, and oxycodone both from the employer and from patients’ personal supplies on the medication cart on numerous occasions for two and a half months. The Tribunal issued a reprimand and accepted an undertaking to not practise as a registered nurse pending proof from a physician and counselor that the member 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 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.

Carna Member
Registration number: 87,496
A Hearing Tribunal made a finding of unprofessional conduct against member #87,496 who on several occasions called in sick at one employer and worked some of her sick days as a registered nurse for another employer. The Tribunal issued a reprimand and ordered the member to pay a $500 fine, pass a course in responsible nursing and complete e-modules on the Code of Ethics. Conditions shall appear on the member’s practice permit. Failure to comply with the order may result in suspension. RN

Fast Fact about... Conduct

Complaints can’t be reported anonymously. According to the Health Professions Act, a person who makes a complaint must do so in writing and sign the written complaint.
Congratulations to Mary Lamoreauz of Edmonton and Tahira Alarakia of Calgary who each won a new Apple iPad Mini! Both names were randomly drawn from the more than 4,000 RNs and NPs who beat the rush and renewed their practice permits before August 15.

**iPad winners**

Senior Research and Policy Analyst with the Canadian Centre on Substance Abuse has funding from Alberta Health to conduct research with health-care professionals in Alberta regarding prescription drug misuse. CCSA recently released *First Do No Harm: Responding to Canada’s Prescription Drug Crisis*, and this research will certainly build on this strategy. CCSA is collaborating with the Coalition on Prescription Drug Misuse (CoOPDM). Alberta Professional groups confirmed participating in the study are the College of Physicians and Surgeons of Alberta, the Alberta College of Pharmacists, and the Alberta Dental Association and College and CARNA.

Have you read CARNA’s AB RN Online electronic newsletter?

If not, you can read it online at www.nurses.ab.ca. Just click on “Read the latest edition of AB RN Online e-newsletter” on the CARNA 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 email address listed in their member profile. Update your email address anytime by logging into the member’s section at www.nurses.ab.ca/MyCARNA. Also, make sure you aren’t opted-out of our emails by following the instructions on page 8.
In May 2013, CARNA approved Alberta Nursing Informatics Group (ANIG) as a Specialty Practice Group. CARNA recognizes Specialty Practice Groups “as valuable to the promotion of the profession, to enhancing quality of care and standards of practice, and to the development of knowledge and competency through sharing among peers (CARNA, 2013).” Informatics is considered a core competency for safe clinical practice. Offering opportunities for nurses to network and share with colleagues about this new specialty practice area in nursing is much needed in Alberta as investments in health-care technology continue to increase at an exponential rate.

ANIG seeks to:
- provide provincial networking opportunities for informatics nurses, allied health professionals, key informatics stakeholders and nurses with a special interest in nursing informatics in Alberta
- promote awareness and involvement of registered nurses, nurse practitioners, and other allied health professionals in informatics initiatives and projects across Alberta
- empower registered nurses, nurse practitioners and other allied health professionals to provide input into informatics initiatives to improve usability and functionality of informatics systems across Alberta
- encourage registered nurses, nurse practitioners and other allied health professionals to contribute to the development of innovative informatics solutions to health policy challenges across Alberta
- provide information on informatics educational and professional development opportunities in Alberta, and to facilitate continuing professional development in nursing informatics
- disseminate best practice information and research on nursing informatics to support effective decision-making in clinical, community and administrative settings

EXECUTIVE TEAM, ALBERTA NURSING INFORMATICS GROUP

The ANIG executive team consists of four volunteer members who took the lead to initiate and move ANIG through the approval process required by CARNA. The next steps involve officially inviting potential members who have expressed interest in joining the group for a meeting and holding elections.

The ANIG team invites you to join ANIG and be part of this important initiative to advance nursing informatics in Alberta. As an ANIG member, you will have access to ANIG’s webpage where you can view, print or download practice information of interest. You have the opportunity to network with professional nurses who have a passion and commitment for excellence in nursing informatics. Your contribution is invaluable to the success of ANIG. You can express your commitment by being fully engaged, attending meetings and joining subcommittees, once established (McNamee, 2012).

ANIG membership consists of RNs, nurse practitioners and RPNs. Associate members from a variety of other professions are also welcome. Annual membership is $20 per year. However, as it is ANIG’s inaugural year, it will be waived for 2013. You may join ANIG anytime during the year.

For questions regarding ANIG membership or to apply for membership, please contact: AlbertaNursingInformatics@gmail.com

REFERENCES:
5 reasons to start a nursing specialty practice group

1. You are in a defined area of nursing practice that isn’t already represented by one of our current specialty practice groups (SPGs). See below for the full list of current SPGs.

2. You have a social concern that affects nursing practice.

3. You would like to provide networking opportunities to a group of nurses in your defined area of practice.

4. You would like this group to be able to provide input into CARNA decision-making on relevant issues.

5. You would like to help develop knowledge and competency throughout sharing among peers and enhance quality of care and standards of practice.

How can CARNA support your SPG?

Carna will provide an initial grant to help get your SPG off the ground and will let you know of any members who are interested in your SPG. The CARNA Provincial Office may be used for meetings during office hours. You can request space for an exhibit at the CARNA AGM. Your SPG can use CARNA publications for promotion of your group and use the website for dissemination of information.

In order to be recognized by CARNA as a specialty practice group, an application process must be completed. Please contact Policy and Practice Consultant Penny Davis at pdavis@nurses.ab.ca.

CONSIDER JOINING ONE OF THE CURRENT SPECIALTY PRACTICE GROUPS!

Visit www.nurses.ab.ca > Member Info > Specialty Practice Groups for contact information.

If you are interested in receiving information from and being contacted by an SPG, please update your profile by logging into mycarna.nurses.ab.ca, selecting a Specialty Practice Group from the list and clicking “Add.”

Private Practice
Alberta Association of Registered Nurses in Private Practice
http://www.privatepracticenurses.ca/

Parish Nursing
Alberta Association for Parish Nursing Ministry
http://www.aapnm.ca/

Gastroenterology
Alberta Chapters of the Canadian Society of Gastroenterology Nurses and Associates
http://www.csgna.com/

Gerontology
Alberta Gerontological Nurses Association
http://www.agna.ca/

Neonatal
Alberta Neonatal Nurses Association
http://www.annna.ca/

Informatics
Alberta Nursing Informatics Group
albertanursinginformatics@gmail.com

Occupational Health
Alberta Occupational Health Nurses Association
http://www.aohna.org/

Rehabilitation
Alberta Rehabilitation Nurses Interest Group

Community Health
Community Health Nurses of Alberta
http://www.chnaalberta.org/

Emergency
Emergency Nurse Interest Group of Alberta
http://www.nena.ca/

Neuroscience
Neuroscience Nurses of Alberta
http://www.cann.ca/

Nurse Practitioners
Nurse Practitioner Association of Alberta
http://www.albertanps.com/

Oncology
Oncology Nurses Interest Group of Alberta

Operating Room
Operating Room Nurses of Alberta Association
http://ornaa.org/

Peri Anaesthesia
Peri Anaesthesia Nurses of Alberta (Northern Chapter)
http://www.pananac.net/
Peri Anaesthesia Nurses of Alberta (Southern Chapter)
http://www.panasac.ca/
Change is in the Air: Monitoring our Progress

Revisions to the Registered Nurses Profession Regulation
In July, CARNA met with Alberta Health to discuss a number of issues with draft 3. We are now waiting for draft 4.

NP prescribing of controlled drugs and substances
In November 2012, Health Canada removed federal barriers to nurse practitioners prescribing controlled drugs and substances.
In July, stakeholders validated CARNA’s proposed education requirements to authorize NPs to prescribe controlled drugs and substances in Alberta. These education requirements will ensure all Alberta NPs have the same core competencies upon graduation.

Learning From Experience (LFE) Research Project
In August, CARNA implemented changes to the internationally educated nurse (IEN) application process based on the analysis of IEN applicant data received over four years.
The goal of the Learning from Experience project is to improve the efficiency of the IEN registration process while upholding CARNA’s commitment to public safety and to the principles of fairness and transparency.

National Nursing Assessment Service (NNAS) Project
A national team representing each of the 22 participating regulatory bodies involved with the NNAS project has met twice this quarter to ensure consistency with complex application requirements such as language proficiency testing and criminal record checks. Operational planning is underway at CARNA with an emphasis on preparing for establishment of a service agreement between CARNA and the NNAS.
This project was established to coordinate a consistent national approach to the assessment of internationally educated nurses’ eligibility for registration/licensure by Canadian provincial and territorial nursing regulatory bodies.

Jurisprudence requirement
Development of an engaging and educational jurisprudence module is well underway thanks to support from CARNA members!
We are following a rigorous and structured process to identify which parts of the legislation and standards to include in a meaningful and sound assessment of competence in jurisprudence.
The jurisprudence requirement is intended to demonstrate that RNs have knowledge and understanding (competence) of the legislative framework that governs registered nursing practice in Alberta.

The new RN exam
The transition to the NCLEX is underway and includes the following:
• A call for registered nurses to volunteer to participate as subject matter experts in various aspects of exam development.
• National webinars were completed in English and French in early December 2012.
• A Canadian NCLEX conference took place on April 22, 2013 in Toronto.
• In September 2013, a call went out to Alberta RNs in their first year of practice to participate in a practice analysis survey. The survey is scheduled to be distributed on October 14 and close in late November. A report of the findings will be released in early 2014.
• A workshop for educators will be held on Oct. 22, 2013 in Calgary to provide information to educators who prepare students to take the NCLEX exam.
To access the latest NCLEX information including the call for volunteers, webinar, FAQ and more, visit www.nurses.ab.ca/NCLEX2015
Who are Physician Assistants (PAs)?

PAs are a new category of health-care provider being introduced in Alberta through an Alberta Health Services (AHS) demonstration project. They are unregulated workers who work under the supervision of physicians and provide direct patient care.

Where will they be working?

Up to 14 PAs are to be hired for the demonstration project. They will work in a variety of settings across the province of Alberta including rural PCNs, hospitalist programs, specialty clinics, low-risk maternity units, general surgery units and ICUs. It is expected that PAs working with PCN physicians will also work with staff in hospitals and long-term care sites just as the physician would.

Can I accept a treatment or medication order from a PA?

Any treatment or medication order from a PA must be signed by the supervising physician before it is carried out. It is the responsibility of the PA to ensure that the order is co-signed by the supervising physician in a timely manner.

What should I know about the PA and their practice?

Registered nurses who are working with PAs should have full access to information on:
- the competencies of the individual PA they will be working with
- the role and responsibilities of the PA including what they can and cannot do, and
- contact information for the supervising physician

Each PA and their supervising physician have a practice agreement. It is important that you have information on the provisions in the practice agreement and updates as the practice agreement changes. It is our understanding that the practice agreement may change over time so your unit needs to develop a process for communication of those updates and changes to the practice agreement.

What about the patient/client?

It is the patient’s right to be informed and make decisions about who will care for them. According to the College of Physicians and Surgeons of Alberta (CPSA) standards of practice, there must be client consent if the physician supervises an unregulated care provider in the provision of care. The supervising physician and the PA are responsible for getting consent from the patient/client and it needs to be documented so that you know which patient/clients have provided their consent to having care provided by the PA.

Who does the PA report to?

The supervising physician is responsible for the supervision and oversight of the PA. As supported by our Practice Standards for Regulated Members, CARNA members would question policies and procedures inconsistent with therapeutic client outcomes, best practice and safety standards and discuss these with your manager or supervisor.

How do we work with these PAs?

CARNA has suggested to AHS that there be an ongoing process for management, staff, the PA, supervising physician and those responsible for the initiation of this demonstration project to address and work through issues related to the implementation of this project. Research has indicated that most errors and miscommunication occurs at patient care transition points. It will be important for staff to understand the day-to-day responsibilities of the PA when on the unit; when they should refer to the PA and when to the supervising physician; and what the responsibility of the PA will be for follow-up when they leave the unit. We believe there needs to be robust discussion of these issues to ensure continuity of care and patient safety.

Who can I talk to if I have questions?

If you have any questions, please do not hesitate to contact one of our policy and practice consultants by calling 1.800.252.9392 or emailing practice@nurses.ab.ca.
Earlier this year, it was discovered that a number of patients with cancer had received more dilute, and therefore less potent, chemotherapy solutions than intended due to the presence of overfill* in the intravenous (IV) bags used to prepare and administer the chemotherapy drugs.1 This incident has been the subject of intense scrutiny, and the findings of a formal review (which readers are encouraged to read) have recently been released.2 As a result of the incident, attention has been drawn to the processes for preparing and labelling IV medications and to the management of overfill of the base solution (e.g., 0.9% sodium chloride) in IV bags purchased from manufacturers. This bulletin highlights variables in the medication-use process (especially during medication preparation) that may affect the total dose or concentration of medication delivered and provides interim guidance to health-care facilities with examples of when and how to incorporate overfill into existing processes.

**Medication Incident**

A group purchasing organization awarded a contract to a new supplier for the provision of admixed cyclophosphamide and gemcitabine to hospitals. A discrepancy in labelling for the gemcitabine preparation between the previous supplier and the new supplier led a hospital to ask the new supplier for clarification. It then became apparent that there was a misunderstanding about how the medication was being used. The new supplier was expecting that each full bag would be administered to a single patient when the hospitals covered by the supplier contract were using each gemcitabine bag as a multidose product (i.e., a reconstituted medication solution), apportioning the medication from a single bag among several patients.

### Methods of Preparing IV Medications and Effects on Final Volume and Concentration

In general, the preparation of an IV medication involves diluting the drug with a base solution (e.g., 0.9% sodium chloride) in an IV bag. In practice, there are several different preparation methods (practitioner-based and manufacturer-based methods described below). The preparation method used affects the total volume and concentration of the final product.

**Practitioner-based methods**

1. A medication for IV use is added to a manufacturer’s IV base solution product (e.g., 0.9% sodium chloride in a bag). This is the simplest preparation process that can be used by practitioners (e.g., front-line nursing and pharmacy staff), typically for the admixture of intermittently administered solutions (i.e., when the entire bag will be infused to a single patient over a short period of time [e.g., 30 minutes]). This method may also be used for medications administered by continuous infusion. The final volume consists of the combined volume of the manufacturer’s IV base solution, the overfill volume added by the manufacturer, and the volume of the medication.

2. In a second method, a volume of the IV base solution equal to the volume of the medication to be added to the IV bag is withdrawn from the manufacturer’s IV base solution bag. The medication is then added to the remaining volume in the IV bag.

This method is typically used when the volume of medication to be added is large relative to the size of the IV bag. For example, before addition of 150 mL of sodium bicarbonate IV solution for injection to a 1000 mL bag of dextrose 5%, a volume of 150 mL of the base solution is withdrawn from the bag. The final volume in a bag prepared by this method consists of the combined volume of the manufacturer’s IV base solution (after removal of a volume equal to that of the medication to be added), the overfill volume added by the manufacturer, and the volume of the medication.

**NOTE:** With each of these two practitioner-based methods, the total dose of medication is known, but the concentration cannot be calculated because the volume of overfill of the IV base solution is not known.

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* The bags used for intravenous (IV) administration of drugs are made of material that allows the solution contained inside to evaporate during storage. A small volume of solution, called overfill, is added to the IV solution bags at the time of manufacture to ensure that the bag contains the labelled volume at the expiry date. As noted by reviewers of this bulletin, the overfill volume can also allow for priming of IV lines. The amount of overfill added is based on the type of solution and the size of the bag.
3. A third method involves adding the medication and IV base solution to an empty IV bag. With this method, there is no overfill. This method may be used when both the total amount of drug in the IV bag and the concentration must be accurately known.

**Manufacturer-based methods**

1. A medication for IV use is manufactured in large quantities to a specific concentration (amount of drug per unit volume [e.g., millilitre] of solution). The required volume of this solution, in addition to overfill containing the medication at the same concentration, is added to an empty IV bag. This method is used for commonly manufactured premixed medications approved by Health Canada.

   **NOTE:** With this method, the medication concentration in the bag (amount of drug per unit volume) at the time of manufacture is the same as the concentration appearing on the label. However, the final product contains more drug than the label indicates due to overfill. For example, a bag labelled as containing 20 mmol of potassium chloride in 100 mL contains the labelled 20 mmol plus the amount of potassium chloride in the overfill volume.

2. A supplier (e.g., a compounding company) may use one of the three practitioner-based methods described above to prepare individual doses of IV medications.

**Next Steps**

The choice of preparation method for any admixed IV product affects the total dose of drug and its concentration in the IV bag. Health-care organizations must develop approaches to determine the best preparation method for various situations. To further complicate matters, variables related to other processes within the medication-use system (e.g., medication administration) can also confound or offset the variances generated during dose preparation, further affecting the actual dose delivered to the patient. Table 1 highlights the sources of variability within the medication-use system. With this broader view of the variabilities in medication dosing in mind, it is important to balance the benefits of process changes against any additional risks that such changes may present to patients. In particular, changes that increase the manipulation of products or the complexity of processes can pose new risks that may outweigh the benefit of added accuracy in dosing. In situations where either the dose or the timeframe over which the dose is to be administered is determined to be critical, then the information about dose, volume, and concentration that appears on the label should be designed to guide processes for administration (including use of equipment such as infusion pumps).

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**TABLE 1:**

**Examples of Sources of Variability in Medication Doses Received by Patients**

<table>
<thead>
<tr>
<th>Source of Variability</th>
<th>Description of Variability</th>
</tr>
</thead>
</table>
| **Manufacturer**            | • Regulations allow for variances in manufactured doses of a medication.  
                               • Overfill volumes vary among manufacturers.  
                               • Amount of evaporative fluid loss may vary from one IV bag to another. |
| **Medication Preparation**  | • Admixture practices may vary among practitioners or facilities. |
| **Medication Administration** | • Individual practitioners use different administration practices (e.g., for management of “dead volume,” the medication that remains in IV tubing). |
| **Equipment**               | • Regulations allow for variances in the volume infused by infusion pumps (rate at which medication is administered).  
                               • Most large-volume infusion pumps are unable to recognize primary and secondary infusions as separate entities and rely on gravity principles to determine which source the pump will draw from.* |
| **Prescribing**             | • A patient’s weight may fluctuate, which will affect weight-based dosing.  
                               • For some drugs, the dose for a particular patient is selected from a dose range.  
                               • The practices, processes, and equipment used to determine dose administration in a clinical trial may differ from the practices, processes, and equipment used in a particular practice environment. |

* Setting the total volume of a secondary infusion that is to be infused will not prevent the pump from drawing additional volume from the secondary bag. In other words, if the fluid level in the secondary bag is at a height above the fluid level of the primary bag, the pump will continue to draw from the secondary source.
**Recommended Practices**

**For Medications Administered by Continuous IV Infusion**

Medications administered by continuous IV infusion are typically titrated to a desired effect (e.g., pain relief with opioids, maintaining blood pressure with vasopressors, anticoagulation with heparin). To avoid variations in concentration (i.e., to ensure consistency in the dose delivered), it is important to ensure consistency in the medication preparation process from one bag to the next. Consistency is required regardless of whether the admixture is prepared within the pharmacy or when necessary, by a front-line practitioner in the patient care area.

- For admixtures prepared by practitioners, standardize the processes for preparing medications intended for continuous infusion. Clearly communicate these methods to help ensure that concentrations will be consistent regardless of personnel.

**For Single-Dose IV Medications Administered Intermittently**

For any single-dose medication, it is important that the specified dose be administered. In this situation, the directions for administration may vary depending on how the medication is prepared.

- When it is critical that the entire IV bag be administered, the product label should clearly specify this requirement. For example, if 160 mg of carboplatin has been added directly to the IV bag without withdrawal of any solution before admixing, the label could read as follows:

  **Carboplatin 160 mg (16 mL) + 0.9% Sodium Chloride 100 mL + OVERFILL INFUSE ENTIRE CONTENTS FOR FULL DOSE**

**Key Messages**

- Identify specific medications and situations for which added accuracy in dose or concentration is needed and the level of accuracy required.

- When the rate of administration is critical, as for some IV medications given intermittently by infusion pump, ensure that information about the rate of administration is built into relevant protocols, including smart infusion pumps.

**For Prepared IV Medications Intended for Multiple Doses**

The admixture of IV medications for multiple doses (e.g., bulk preparation) can create additional critical points for accurate medication dosing. For example, an error occurring early in the process (e.g., during medication reconstitution) may have an impact on the dose of medication received by multiple patients. Therefore, pharmacies that prepare IV medications intended for multiple doses should consider proactively evaluating their processes and take any necessary precautions to mitigate any identified risks.

- The following considerations increase complexity if multidose formats are being prepared:
  - IV bags containing the manufacturer’s base solution contain a variable amount of overfill, and specific concentrations of drugs can be prepared only by starting with an empty bag or other container.
  - Hospital-based formulas for multidose formats must incorporate appropriate dilution (based on the manufacturer’s instructions for preparing drug ingredients that require reconstitution) to ensure accurate final concentrations. For example, 1 g vials of gemcitabine require dilution with 25 mL 0.9% sodium chloride to generate a final volume of 26.3 mL and concentration of 38 mg/mL.

- Variables related to other processes within the medication-use system (e.g., medication administration) can also confound or offset the variances generated during dose preparation, thereby affecting the dose delivered to the patient.

- Share this bulletin to communicate information about overfill and to alert practitioners about the variations that exist and the ways in which standardized processes within the practice setting can be designed to minimize variability.

- For hospitals that administer chemotherapy, consider completing the 2012 ISMP International Medication Safety Self Assessment for Oncology to heighten awareness of medication safety practices related to chemotherapy medications.

For more information, visit: https://mssa.ismp-canada.org/oncology.

- Health Canada has met with ISMP Canada and will continue to engage in collaborative efforts to address issues associated with the labelling of IV bags.
Conclusions

The chemotherapy incident that has impacted many patients in Canada is being investigated by numerous committees and reviewing agencies. The report from the formal review in Ontario, released just recently, identified communication gaps about the presence of overfill in IV bags as one of the contributing factors to the incident. Heightened awareness of overfill in IV bags and of variability within the medication-use system offers opportunities for health-care organizations to review their processes. Understanding the various methods of preparing IV medications is fundamental to identifying ways to optimize practices for the safe preparation, labelling and administration of IV medications.

ALERT: Drug Shortages Highlight the Need for Independent Double Checks

ISMP Canada recently received a medication incident report describing errors in the revision of a master formula for total parenteral nutrition (TPN) at a health-care organization that led to neonates receiving amounts of trace elements that were greater than intended. Trace elements are chemicals that the body requires in only minute amounts, including, for example, zinc, selenium, and manganese. In the incident reported to ISMP Canada, the health-care organization had responded to a shortage of its usual zinc product by revising the TPN master formula to accommodate a new zinc formulation with a different concentration. Calculation errors were made during this process but were not discovered until a few months later. Fortunately, it appears that no adverse effects have occurred. The health-care organization is conducting an extensive review to discover the underlying contributing factors.

ISMP Canada has previously reported on the value of independent double checks in reducing the risk of medication incidents. Independent double checks have typically focused on high-alert medications; however, this incident illustrates the value of such checks when alternative products (such as those with different doses or concentrations) are introduced into standard or established processes. The organization has distributed an interim safety alert to its practitioners about the merits of independent double checks based on previous ISMP Canada recommendations. The health-care organization wanted to share this alert with other facilities to prevent a similar incident from occurring, especially given the current drug shortage situation, a setting in which the risk of a medication error is heightened.

REFERENCES

Acknowledgements

ISMP Canada gratefully acknowledges expert review provided by Charlene Haluk-McMahon BSP RPh, Medication Safety Officer, Windsor Regional Hospital, Windsor, ON; C. Jude Handley, Program Support Partner - Medication Safety, Peterborough Regional Health Centre, Peterborough, ON; Sandy Jansen BScPhm RPh MHS, Director, Pharmacy Services, London Health Sciences Centre, London, ON; and Moira Wilson BSc(Phm), Director of Pharmacy, Horizon Health Network, Saint John, NB.

REFERENCES

THE 15TH ANNUAL CARNA AWARDS

leader
passionate
hard-working
outstanding
quality
valuable
model
role
distincted
extraordinary
extraordinary
shining example
dedicated
committed
special
professional
compassionate
excellence
respected
mentor
Do you know a nurse who is a leader? A role model? A shining example of professional excellence? Recognize amazing colleagues with a nomination for a CARNA Award of Nursing Excellence.

Why nominate?

It’s a way to declare for all to hear...

we value your achievements.

Meet the selection committee

Bernice Heinrichs
Red Deer-based Bernice has been practising for an amazing 39 years in clinical and administrative roles. This will be her second year judging the nominations. She says “My broad experience in a variety of roles… prepares me to be fair and objective…”

Amanda Newton
Amanda has 13 years of practice and a PhD under her belt to help her select suitable CARNA Award recipients. Her education background includes both education and research. “I would like to use (this committee) as a way to contribute to nursing in Alberta… outside of my research.”

Brenda Rennie-Koch
Brenda is serving her second year on the Awards Selection Committee. She currently practises in Vegreville with 10 years of nursing experience in administrative and clinical settings.

Candice Wheeler
Candice has six years of experience as a front-line RN. Serving on a committee interested her because she has “a desire to get more involved with the nursing community.” This is Candice’s second year with the Awards Selection Committee.

Mystery judge
We’re still in the process of selecting a final Committee member. Thank you to everyone who submitted an application to be a part of this rewarding experience.

Nominations are now open!

Deadline for nominations is Dec. 5, 2013

Visit www.carnaawards.ca to begin your nomination today.
Two years ago, when I was diagnosed with advanced lung cancer in the ED of a large urban hospital, I asked a nurse if I could borrow her cell phone. Without hesitation, she handed me her Blackberry—this simple gesture was a first indication of the solidarity I’d come to feel with the nurses whose kindnesses have helped me heal.

One such healing encounter came 10 days later, and I believe it changed the course of my treatment. I was on the surgical day unit, awaiting the insertion of a catheter. I was petrified, not only because of the cancer, but because one oncologist had said my trapped lung would never reexpand and the tube would be permanent.

Strange as it may sound, this prognosis was more difficult to absorb than the cancer. If it were true, I would never be able to fly to see my mother again, nor would I be able to swim, which had long been my way of replenishing.

I had that sick, pit-in-the-stomach feeling as I watched the surgeons sweeping by. My heart was pounding and I was inwardly shaking—I knew I was experiencing a stress response and that, in some cases, stress can inhibit the function of certain white blood cells—the very ones needed to shut down cancer cell proliferation.

And then the pre-op nurse summoned me to her office. I felt an immediate sense of connection with her as she asked my concerns. Only one of the oncologists I had met thus far had shown real empathy. I’d tried to understand this as a positive: the oncologists’ primary concern wasn’t me as a patient, but instead the specific mutation of non–small cell lung cancer that was eating away at my lung and the most appropriate chemotherapy for it. I respected this focus, but I missed the human connection.

The pre-op nurse, sitting in that quiet office outside the frenetic waiting room, was the first person to extend a lifeline I could actually grasp. When she asked about my concerns, I blurted out, “I really want my lung to reexpand.” I was afraid she might say, “That will never happen.” Instead, she said, with a conviction that went right through me, “Picture your lung reexpanding during the procedure.”

Not only did she give me hope, she gave me a way to participate in my own treatment. I followed her advice, and at that terrifying moment when the catheter was inserted into my lung, I envisioned my lung coming back.

Later, when I would drain my lung, I’d think of her words, picturing my lung reexpanding. Her faith that this could happen, and that I could help the process, continues to inspire me to this day.

From this nurse, I learned the true power of envisioning. I began to apply her words in other ways: I pictured the cancer flowing out of me; I pictured myself swimming again in the ocean, or getting on a plane again to visit my mother. Later, when I learned more about cancer, I pictured my NK cells and the chemotherapy surrounding my tumor with love and light.

When my lung fully reexpanded and the tube was removed, I knew this nurse had played a crucial part in bringing about this positive outcome. She’d believed with me, and her belief counterbalanced the negative prediction of the first oncologist.

By several months into my treatment, my relationship with that oncologist had almost fully come undone. After a particularly difficult encounter having to do with my request for the release of lung scan results so that I could determine if it would be safe for me to visit my mother by airplane, I went to the surgical day unit with the hope of seeing that pre-op nurse. I was certain I’d be turned down, but the receptionist said she’d find her. As I waited, I wondered if she would remember me.

She did, and that short encounter was one of my most healing at the hospital. She celebrated with me the great news that my lung had reexpanded, and she expressed unwavering faith in my ability to help myself. She also encouraged me to spend time meditating in the healing garden of the hospital, which I now do regularly. I felt flowing from her a sense of empathy that allows healing at its deepest level.

It has been over two years since I’ve seen this nurse, but her compassion is with me every day, helping me heal. She is as much a part of my treatment as my beloved new oncologist.

Some days, I wish she had clinic hours. But then, I hear her kind voice echoing in my mind, and I feel renewed. I am reminded each day that nurses change lives.

Nila Webster lives in Revere, Massachusetts. Contact author: nila.webster@comcast.net. Reflections is coordinated by Madeleine Mysko, MA, RN: mmysko@comcast.net. Illustration by Annelisa Ochoa.
WITHOUT THE CONSTANT INTERVENTION OF SUSAN WOODING, NURSE JEAN LEACOCK WOULDN’T EXIST. YET EVEN WITH SUSAN’S SUPPORT, NURSE LEACOCK ONLY COMES TO LIFE ONE DAY A WEEK, WHEN SUSAN GIVES JEAN HER TOTAL ATTENTION.

Every Thursday, from mid-May to September, Susan travels five minutes by car – and 100 years back in time – from her Calgary home to Heritage Park Historical Village, one of North America’s largest living history museums. There, at least for the duration of her volunteer shift, she turns the clock and her mindset back a century to 1912. Drawing on a potent mix of historical research, authentic props, period costuming and a previously untapped flair for acting and improvisation, Susan convincingly transforms herself from a personable, urban public health nurse into no-nonsense, slightly haughty Nurse Leacock, the efficient one-woman force behind a cottage hospital in turn-of-the-century Calgary.

Susan never dreamed her professional career would include a stint as a dramatic impersonator when she graduated from Kingston General Hospital School of Nursing in 1973. Still, throughout her 40 years of nursing, she’s played a variety of nursing roles in wide-ranging locales. She started on the surgery floor at Kingston General, worked overseas as a nurse on a military base in West Germany, returned to Canada as a nurse with the Dept. of Military Veteran in Winnipeg and later moved to the Dept. of Veterans Affairs at Colonel Belcher Hospital in Calgary. For the past 29 years she’s found her niche in the public health field, currently as a post-partum nurse at Calgary’s North Hill Community Health Centre. “I love it; I spend a lot of time cuddling babies,” she says.

As she’s moved around, Susan kept one constant in her life: a strong commitment to volunteerism. About three years ago, she became a special events volunteer at Heritage Park, where she was intrigued by a retired nurse who worked summers as an interpreter in the cottage hospital located in the park’s Historical Village. “She wore a full white uniform and I saw how she captivated visitors’ imagination with her information about turn-of-the-century medicine,” Susan recalls. “She impressed me and I thought, hey, I could do that, but as a volunteer!”

Over the winter, Susan kept thinking about this new way of volunteering and when the Historical Village re-opened in the spring, Nurse Leacock was born. Susan was given the opportunity to flesh out the character...
and background of this addition to the village’s population and decided the new nurse would be a fictional niece of Dr. Rosamond Leacock, a very real figure from Alberta’s medical annals who made history as the first female physician/pathologist at the Calgary General Hospital. (An interesting side note about her surname: she was also the sister of humorist Stephen Leacock.)

NOW that her imaginary nurse had a name and family connections, Susan had a new puzzle to solve: what would Nurse Leacock do day-to-day at her cottage hospital? Heritage Park has built its international reputation on the accuracy of its interpreters and costumed “townsfolk” such as Nurse Leacock, whose dress and activities so realistically simulate the past that history seems to come alive, and Susan knew she’d have to match those high standards whenever she was “in character” as Nurse Leacock. But not surprisingly, Susan’s knowledge of early 20th-century medicine and nursing practices were limited, so she got busy researching.

“I probably shouldn’t admit this,” says Susan, who goes on to do just that, “but Google became my best friend for historical research.” Susan also looked to her alma mater, Kingston General Hospital. Although KGH ended its training program for nurses in 1974, the Museum of Health Care is now located in a former student-nursing residence on its grounds, and she’s found its treasure trove of medical history very helpful. “I also do a lot of digging into history books. There’s a very informative site binder in the cottage hospital explaining the significance of its artifacts and that often sparks ideas for further research online. And ‘Jean’ also frequently consults an 1880 medical reference book in the cottage.”

For Susan, discovering what nursing was like in 1912 is still a work in progress, but that’s half the fun. Thanks to her various research sources (which now also include contributions from park visitors, who share real-life anecdotes with Nurse Leacock), she’s acquired a solid knowledge of turn-of-the-century illnesses and treatment, which she uses to create health situations that Nurse Leacock must respond to. For example, she’s learned that the common illnesses of the time were typhoid, consumption (pulmonary tuberculosis), gout, cholera, whooping cough, scarlet fever and Bright’s disease (a catch-all term used at the time to describe symptoms of various kidney diseases).

She also found that in 1912, nurses were often the first responders when townsfolk were injured, since doctors were scarce and generally divided their time between a number of communities, making their rounds on a once weekly schedule. So a nurse might find herself caring for someone kicked by a horse, burnt by a wood stove or who’d broken bones in a fall while mending a roof in the doctor’s absence. She (and all the early nurses were unmarried women, “unclaimed jewels” Jean calls them, since a wife’s place was in the home, serving her husband, raising children and running the household) would also help deliver babies, in between running errands to keep the cottage hospital running smoothly, such as picking up treatment supplies from the local apothecary.

A DAY in the life of Nurse Leacock begins before Susan leaves home, as she dons her floor-length starched white uniform and cap. All are meticulously true to the period, created by the Park’s costume designer. “It was researched to the nth!” Susan emphasizes. “Right down to the buttons, which are authentic, not modern replicas. And there are so many of them! I have to be a bit of a gymnast to get all the back buttons done up. It feels restrictive, but Nurse Leacock thinks it’s ‘character-building.’”

During her short drive, Susan switches her mind from the world of cellphones, computers and modern conveniences to horse-drawn buggies, herbal remedies and homes-turned-into hospitals where surgeries were performed on the sturdy oak dining room table. “During my day as Nurse Leacock, I truly live in 1912. Nothing must come out of my mouth, whether I’m talking to other townsfolk, interpreters or answering visitors’ questions, that doesn’t relate to the early 1900s. As I close the car door, I take a deep breath and say to myself, ‘OK Nurse Leacock, it’s 1912! Let’s see what needs to be done at my cottage hospital!’”

Susan now has many options to draw on as she creates a typical workday for Nurse Leacock. “One year I did a lot based on typhoid treatment; another year my big focus was scarlet fever. That was lots of fun since many visitors remember the outbreaks and quarantines and share stories.” Within the basic framework of her many historically authentic scenarios – (she might treat colds, fevers, mix up a mustard
plaster for chest infections, or counsel townsfolk on how to avoid infection during a scarlet fever scourge) – she also keeps things lively by inventing emergency situations. “Oh no! The nice young gentleman from the Atlas lumber yard broke his leg in an accident with the horse wagon!” she might say in a stage whisper. “I must get ready to treat him!”

Nurse Leacock usually begins by cleaning and disinfecting her work space, perhaps with the new-formula bleach developed in the 1910s that made it affordable and easy to use. She’s up-to-date on the new germ theory popularized by Louis Pasteur and Joseph Lister, and if it’s a day when handsome young Dr. Skinner (a.k.a. Steven Kellier, a U of C undergrad student) is scheduled to visit, she might sterilize his surgical equipment with Lister’s much-loved carbolic acid. She also hand washes soiled bandages, hanging them to dry in the sunshine.

Nurse Leacock is anxious for Dr. Skinner’s arrival since she has a lineup of patients that she’s treated who still need surgery. Henry Higgins shot himself in the leg while cleaning a gun and needs the bullet removed, young Abner has a deep wound from careless wood-chopping and poor Mrs. O’Leary really needs to have those infected tonsils taken out. And wouldn’t you know it… the cottage supply of laudanum (opiate from poppies for pain control) and chloroform (used as an anesthetic for surgery) is low, so Nurse Leacock must dash over to Gledhill’s Drug Store to replenish supplies.

And so it goes, as the efficient Nurse Leacock handles everything from serving as an assistant in surgery to serving the doctor’s tea. Susan admits she often felt awkward during the first season she brought Nurse Leacock to life, but now she fully embraces the role. “My friends say I missed my calling,” she jokes. “But I’m a nurse; I wasn’t an actor! Fortunately Heritage Park has a great drama coach and he really brought out my latent talent. But that first year, he spent a lot of time urging me to get into it, stir things up, get people talking! I worried about being over-the-top but that’s what really engages visitors and draws them in to ask questions and learn.”

SUSAN also finds clues about the social etiquette of the early 1900s and how her character would interact with the public and her peers by doing something Nurse Leacock could never do – she watches TV. She loves the Murdoch Mysteries series, set in Toronto circa 1910 and she’s also getting tips from a biography of Florence Nightingale by C. Woodham-Smith.

But today’s not Thursday, and although Susan would love to keep talking about Nurse Leacock (“She’s a riot; I have so much fun being her.”) it’s back to 2013 and she mustn’t be late for her real job. Her two personae may seem very different, but nursing is nursing, no matter what the era, and Susan feels a strong connection with her alter-ego.

“We’re both involved in caring for our community and inspiring people to better self-care. Nurse Leacock spends a lot of her time teaching others about prevention and healthy habits, and I do the same today. There’s a real joy in seeing people grasp the concepts and making learning fun. But now I really must go. I have babies waiting to be cuddled!” RN
Managing **disruptive** behaviour in the health-care workplace

When it comes to disruptive behaviour, you would be hard-pressed to find someone in health care who does not have a personal story to tell about experiencing it, witnessing it or having to deal with its effects. The Health Quality Council of Alberta’s newly-released framework, *Managing Disruptive Behaviour in the Healthcare Workplace*, focuses on disruptive behaviour and its impact on patient safety, employees and organizations.

**Definition**

Defining disruptive behaviour is difficult because it is influenced by individual ideas of respectful behaviour. Essentially, it is disrespectful behaviour that disturbs the workplace or potentially impacts safety and quality of patient care.

There is a range of behaviour in the workplace – most social interactions are respectful but some interfere with smooth functioning of the workplace and on rare occasions may involve illegal conduct. One of the most common forms of disruptive behaviour is inappropriate forms of communication, which includes both verbal (e.g., yelling, threats, public shaming) and nonverbal communication (e.g., making faces, glaring, rolling eyes). Bullying and harassment are also serious problems.
Causes and effects
Disruptive behaviour may be caused by personal factors such as personality traits and lack of coping strategies, or work-related factors, such as the stressful nature of health-care work and the culture of the organization.

There are many consequences of disruptive behaviour. Individuals can experience psychological issues or stress-related illness, as well as reduced job satisfaction. The work unit and the organization can also be impacted through weakened professional relationships, low morale, negative organizational culture, and the financial consequences of absenteeism and retention issues. Patients can also suffer adverse effects due to reduced communication and collaboration between health-care providers such as treatment delays, improper or ineffective treatment, and loss of trust and confidence in care providers.

Strategies for improvement
In a stressful environment such as health care, it is important to set expectations of behaviour that apply to everyone in the workplace, create policies and procedures to deal with disruptive behaviour, and hold everyone accountable for their actions. Health-care providers need support in developing skills and tactics to deal with stress in a proactive and positive manner. The HQCA framework describes actions that both individuals and organizations can take to set expectations, prevent and respond to disruptive behaviour. The HQCA has also created an online toolkit which provides templates, checklists, tools and other resource material.

Disruptive behaviour can have a significant impact on employee satisfaction, organizational efficiency and patient care. An organization-wide shift to a healthy workplace environment where everyone feels respected and confident can result in health-care workers who remain approachable under stress, respond positively to conflict, treat team members and colleagues with respect, and ultimately become the best caregivers they can be for the patients who rely on them.

Access resources
Managing Disruptive Behaviour in the Healthcare Workplace – Provincial Framework and the accompanying toolkit are available on the HQCA’s website at www.hqca.ca. For a hard copy of the framework, or for more information about this topic, email info@hqca.ca or call 403.297.8162.

The Health Quality Council of Alberta is an independent organization legislated under the Health Quality Council of Alberta Act with a mandate to promote and improve patient safety and health service quality on a province-wide basis.  

RN
BY SHEENA STEWART

As health advisories go, the one this past summer released by the Public Health Agency of Canada went by largely unnoticed. Issued in July, the advisory alerted Canadians to the identification of nearly 30 cases of measles across six different provinces— including Alberta. Most of those cases were travel related, and involved travelers bringing measles back with them to Canada. A few small news articles followed, but by August most people had forgotten all about it. Except for experts and epidemiologists, who recognize that outbreaks like these should remind everyone that measles is not only poised for a resurgence, but already gaining headway in some parts of the world. And that’s exactly why RNs and NPs should be encouraging more people to take vaccinations seriously.

“Measles is complicated for a number of reasons,” explains Dr. Martin Lavoie, Alberta’s deputy chief medical officer of health. “Measles has been largely eliminated from the Americas because of immunizations. But there are other parts of the world where measles continues to be a serious problem. And when you realize that measles is one of the most highly transmissible diseases on the planet, and we have so much travel between countries, unless we maintain a near perfect immunization coverage rate, measles will find a way in.”

How infectious is it? “It’s probably second only to smallpox in terms of transmissibility,” he explains. “So if someone with measles walked into a room and walked right out, that room would be contagious for an hour or two because it’s airborne, and it floats in the air for a while.”

He points to the 2011 measles outbreak in Québec as a cautionary tale of how virulent measles can be, noting that during that outbreak 776 cases were reported in the province. “That was the worst one in North America in decades,” he recalls. “It lasted much of the year, and that was in a place where the immunization rates were relatively high. All it needs is enough people who are susceptible and it can start spreading.”

At present, a massive outbreak in the Netherlands is being closely watched by health-care professionals and researchers, who are keenly aware of the threat it poses.

Call to ARMS

Recent measles outbreak reminds us of the importance of immunizations
Even though this summer’s outbreak pales in comparison, it did create an opportunity for public health nurses to discuss the importance of vaccinations with clients. “We’re always educating our clients about how vaccinations can protect their children,” notes Joanne Coldham, RN and program manager for vaccination services in Alberta Health Services’ Calgary zone. “What an outbreak like this most recent one does is bring forward questions and concerns that might otherwise not be shared. It allows us to have a discussion with them and creates a window for them to come in and get vaccinated.”

Unfortunately, that’s a discussion that likely needs to happen more often, since Alberta’s immunization rates are far from perfect. In 2012, Alberta had an average MMR (measles, mumps, rubella) vaccination rate of 84.3 per cent – with the lowest rates reported in the province’s south zone at 78.4 per cent and the north zone at 79.4 per cent. “Unfortunately, in order to give us the herd immunity that will protect us from international transmission, we need to have our rates between 97 and 99 per cent,” says Lavoie. “And we’re not there yet.”

Herd immunity is a term used to describe the protection that comes from large numbers of people in a given population being immunized against disease. This, in turn, affords a measure of protection to those individuals who have not been vaccinated against the disease and who can’t be because of certain health conditions.

The reasons behind our less-than-perfect vaccination rates are complex. In some instances, religious beliefs prevent people from immunizations, such as in many of the small Dutch Reform communities that dot the countryside throughout southern B.C. and Alberta. In other instances, people are unable to vaccinate because of allergies to the components used to make the vaccines or because of medical conditions or diseases like cancer. But increasingly, health professionals are seeing parents who choose not to vaccinate because of myths or misconceptions surrounding vaccinations and the associated fears that go along with it.

“There are people who have refused to immunize because they’re afraid of the vaccinations,” says Dr. Lavoie. “When what they really should be afraid of is measles, because it is not a benign disease. It has serious complications that can last a lifetime. Too often, people forget that you can die from this.” According to the Centres for Disease Control and Prevention (CDC), about 30 per cent of measles cases develop one or more complications, with ear infections and pneumonia being the most common. The CDC also notes that pneumonia is the complication that most often results in the death of young children.

The myths and misconceptions surrounding immunization are something public health nurses encounter regularly. Coldham explains that when public health nurses are faced with clients who have fears or concerns about vaccinations, they take a gentle approach to offering information and assurances. “A lot of times people are trying to work through misinformation, including about how early is too early to vaccinate. We’ll hear that you shouldn’t vaccinate until your child is two because they’ll get protection from breast milk. And we know that breast milk is awesome,” she laughs, “but it can’t do that!”

When public health nurses are working with clients who have concerns, they use a process that acknowledges their fears and apprehensions, and then directs them to good information that’s based on solid research and proven best practices. They also try to show them where their information may be untrue. “Some people are willing to listen, and some people aren’t,” she admits. “And if someone doesn’t want to
hear it right now, we try to leave the door open so that they know we’re happy to discuss it whenever they are ready. Sometimes people just need time to go away and think about it.”

Although public health nurses will make sure that clients understand the risks of choosing not to vaccinate, in Alberta vaccines are not mandatory – which means that education and awareness are key. Especially when so many new parents simply don’t understand what the diseases we vaccinate against are all about. “Even with whooping cough – a lot of times parents don’t know what it is or what the risks of it are,” notes Coldham. “Once they have a better understanding, they usually choose to vaccinate.”

Both Coldham and Lavoie stress the importance of helping to educate and inform. “When health professionals – and especially RNs – have one-on-one encounters with patients, they can have a very profound impact on their behaviour, including immunizations,” says Lavoie. “Nurses are so well-positioned to be able to talk about immunizations and how important they are, and share the truth about how vaccinations work and why immunization is so important. We don’t lose infants and kids to many diseases that were once deadly thanks to immunization. And we need people to understand that immunizations are extremely safe and extremely effective at protecting us from disease.”

That’s why it’s so critical for people to understand the risks that go along with not vaccinating. Coldham encourages RNs and NPs who have witnessed what can happen when people contract diseases that can be vaccinated against to share those experiences with not only clients, but with colleagues as well. “Even some nurses don’t see these diseases up close in clinical settings, in part because vaccinations are so effective,” stresses Coldham. “When nurses see what those diseases really look like and how they impact patients, they see why vaccinations are so important. We need nurses with that experience to help other nurses understand what we’re up against.”

When nurses have questions about immunizations, Lavoie and Coldham encourage them to seek out information and to visit websites like Alberta Health Services, the CDC and the Canadian Pediatric Society. Lavoie also stresses how important it is for all health professional to talk about immunizations whenever they have a chance, even if it’s not part of their practice area, and to understand that we all have a role to play in public health.

“If we’re all consistent with what we say and in our messaging about immunization, we can make a measurable difference in the health of our patients and their families,” notes Lavoie. When people choose not to vaccinate, they’re really relying on others to do it for them explains Coldham. That’s something both she and Lavoie say is contrary to what it means to live as part of a community. “When we live in a society, we have a responsibility to our friends, our co-workers and our neighbours that we won’t expose them to a deadly disease,” stresses Lavoie. “Immunizations are one of the best tools we have to stay healthy and to keep others healthy too.”

The WAKEFIELD effect

How a disproven research paper lowered immunizations rates around the world

In 1998, Dr. Andrew Wakefield released a research paper claiming a link between the administering of MMR vaccine and autism and bowel disease. Over the next several years, other researchers tried – and failed – to duplicate his results. In 2010, the British General Medical Council proved three-dozen separate charges against Dr. Wakefield, and ruled that he had “failed in his duties as a responsible consultant.” The Lancet immediately retracted his 1998 publication, Dr. Wakefield’s work was labeled an “elaborate fraud,” and he has been barred from practising medicine in the U.K.

Despite this, many people around the world continue to use the disproven link between MMR vaccine and autism as a reason not to vaccinate. Since the publication of his paper, vaccination rates in several countries have declined dramatically. By 2008, 10 years after the study was first published, measles became endemic for the first time in the U.K. and the United States reported the most cases since 1996.

Several celebrities, including actress Mayim Bialik, who was once television’s Blossom and now plays Amy Farrah Fowler on the sitcom The Big Bang Theory, and former Playboy cover girl Jenny McCarthy have spoken publicly about their opposition to vaccinations. McCarthy, herself the mother of a child with autism, has been so outspoken in her anti-vaccine stance, that when The View announced her hiring as a co-host, health professionals around the world voiced concerns. Toronto Public Health tweeted that McCarthy “cites fraudulent research on vaccines and it’s irresponsible to provide her with (The View’s) platform,” and tweeted a link to a fact sheet debunking vaccine myths (link http://www.toronto.ca/health/immunization_children/truths_vaccines.htm).

New Yorker science writer, Michael Specter, joined in the criticism, saying ABC “should be ashamed of themselves for offering McCarthy a regular platform on which she can peddle denialism and fear to the parents of young children who may have legitimate questions about vaccine safety.”

Although many people, including celebrities, still support Wakefield’s theories, it is hoped that the discrediting of his research will encourage others to begin looking to more reputable sources for information.
Better patient information, better care decisions.

Over 8,900 nurses have access to Alberta Netcare, and we’re hoping to increase that number this year. Alberta Netcare is a valuable information tool that can help you provide the very best care to your patients.

When asked, nurses tell us they value Alberta Netcare for its wealth of information collected from all parts of the province. In addition to numerous categories of transcribed reports, you will find lab test results, diagnostic images and reports, medication profiles, hospital admittance and discharge reports, surgical reports and summaries of continuing care clients.

Health information is collected from service locations across Alberta, and presented as a single integrated patient record at the point of care. This record is more complete than local records maintained at each facility, and allows you to see your patients’ interactions with the rest of the health system. With access to Alberta Netcare, you have a clearer picture of your patients’ health needs, which enhances your ability to make decisions about their care. Information is up-to-date, often available moments after the lab result or diagnostic exam has been completed. This supports quick decision-making and can reduce delays for your patient.

Alberta Netcare supports the registered nursing profession’s focus on safe, competent, ethical care and the achievement of optimum quality of life for Albertans. As RNs and NPs continue to take on progressive leadership roles within the health care sector, the quality and potency of the information they have readily available will become more and more critical.

For more information or to register:

If you work for Alberta Health Services or Covenant Health please speak with your manager about registering for access. A registration form and additional information for AHS staff can be downloaded from this webpage: https://portal.albertanetcare.ca/cha/Resources/ANP-AHS-User-Reg.pdf (you must be logged into the network to view).

If you work for a physician office please have the physician or office manager contact the Alberta Netcare Deployment team for more information to begin the enrollment process.

If you work in another health setting such as private homecare services, occupational health, a remote nursing station, a First Nation’s health facility or have a private practice, please contact the Netcare Deployment team to discuss your eligibility.

Alberta Netcare Deployment team:
phone 1.866.756.2647 toll-free, in Edmonton 780.642.4082, email: health.ehrdeployment@gov.ab.ca.

Alberta Netcare adds additional data to support seniors’ care

As of June 2013, Alberta Netcare offers the following three types of summaries of Alberta Health Services Continuing Care (community) clients:

1. **Continuing Care Summaries** of clients are posted across the province and includes the following:
   - client demographics and contact information
   - allergies
   - episode of care and case manager information
   - overview of current and recent programs and services.

2. **Resident Assessment Instrument-Home Care (RAI-HC) profiles** are available from the North, Edmonton, Central and South zones. These profiles provide an overview of the following assessment findings:
   - activities of daily living status
   - mental health
   - ability to communicate
   - health conditions
   - physical functioning
   - special treatments the client is receiving

3. The **Care Plan Summary – Continuing Care** is available for clients in the North, Edmonton, Central and South zones. Although each source system varies slightly, content typically includes:
   - client demographics and contact information
   - allergies
   - goals of care
   - client/staff safety risks
   - best possible medication history
   - care plan problems and interventions
   - standardized assessment scores
   - mobility/transfer information
   - equipment/supplies
   - treatments or special care requirements and
   - service authorizations

All of this information can be found in the Summary Reports section of Alberta Netcare Portal. For more information about the summaries, or to register for access to Alberta Netcare, please contact the Deployment team at: 1.866.756.2647.
Like many nursing education programs, Red Deer College (RDC) has been exploring innovative approaches to retaining faculty members. In fall 2012, RDC introduced faculty navigators (FNs) based on evidence suggesting that supporting staff in the transition from clinical expert to educator is an effective method of supporting retention. The goal of the pilot project was to identify whether having a dedicated faculty member to help new staff in their transition and development would improve retention and instruction quality.

The pilot project had two components: one-on-one interaction between the new employee and the FN and “Community of Practice” discussions.

One-on-one Interaction
At the beginning of the academic year the FN met with each new faculty member to discuss their teaching assignment, goals and strategies, as well as how the faculty navigator could support them. These interactions were intended to ensure that individual needs could be addressed in a way that was meaningful for the new staff member. They also established the relationship between the FN and the new employees. Throughout the term, the FN engaged in other individual interactions such as direct observation in the classroom or clinical area and guidance discussions for specific situations. The FN had flexible hours so new faculty members could connect whenever an issue arose.

Community of Practice
Community of Practice discussions were held every three weeks or so from September 2012 to April 2013. The FNs identified discussion topics, recommended pre-readings and facilitated the actual discussions. In the fall term, the discussions focused on skill development such as “getting started,” “giving feedback” and “difficult conversations.” By January, the discussions were about the transition of the new faculty member to their role as educator in the new “learner-centred” environment at RDC.

Results
Information collected at the end of the academic year shows participants were more confident in and had a better understanding of their role. They felt that they focused less on their own learning curve and more on student learning.

To better understand the impact of a faculty navigator, RDC will conduct a formal research project in the 2013 to 2014 academic year.

For more information about the program at RDC please contact the authors at elizabeth.hagell@rdc.ab.ca; sheila.mckay@rdc.ab.ca

Supporting nursing educators to improve retention
Red Deer College introduces faculty navigators

BY SHEILA A. MCKAY, RN, MN
ELIZABETH HAGELL, RN, M.Ed.

RN
Thank you to everyone who supported and helped make the ARNET FUN-raising activities this year a huge success! Over $10,000 was raised for registered nursing education!

ARNET Directors Jeanne Besner (left) and Sara Webster don fascinators as their “other hat.”

ARNET Board Chair Sheila McKay (right) and Alison Landreville doing their best to support nursing!

ARNET Board Member Shannon Spenceley (left) and ARNET Director Lynn Judd stepping up to get their chance to support ARNET!

Thank you to all our sponsors who made these events possible. Please consider supporting them in return!

ADROIT INVESTMENT MANAGEMENT
DIVA | SALONAPA
INLIV | Leduc Co-op Liquor Store
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WCM | WEST EDMONTON MALL

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Calgary Pro Painters
Grand&Toy

Hyatt Regency Calgary
Metafore
Peloton Cycling
Complete this crossword by using clues found throughout this issue of Alberta RN!

ACROSS
3. Unwelcome behaviour in the health-care workplace
6. ‘_________ _________’ makes a difference
8. CARNA’s new online apparel store
9. Medications identified as risk for overfill
11. New specialty practice group: ‘Alberta Nursing _______ Group’

DOWN:
1. New Provincial Council member for Central Region
2. Online program used to enter continuing competence activities
4. Important factor in preventing outbreak of measles
5. Charity dedicated exclusively to Alberta RNs
7. Historical nurse at Heritage Park portrayed by RN Susan Wooding
10. Position introduced to help retain faculty members at Red Deer College
12. RN regulatory body and professional association
IN MEMORIAM

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

Bradley, Karen (née Shami), a 1969 graduate of St. Mary’s General Hospital school of nursing, who passed away on January 6, 2013 in Calgary.

Brittain, Kathleen (née Walker), a 1950 graduate of Calgary General Hospital school of nursing, who passed away on July 2, 2013 in Medicine Hat.

Clarke, Elaine (née Skene), a 1939 graduate of Holy Cross Hospital school of nursing, who passed away on July 22, 2013 in Edmonton.

Cooper, Patricia (née Giebelhaus), a 1958 graduate of Royal Alexandra Hospital school of nursing, who passed away on June 16, 2013 in High River.

Holmes, Patricia (née Alcock), a 1947 graduate of University of Alberta, who passed away on May 18, 2013 in Edmonton.

Hoogveld, Moira (née Moran), a 1976 graduate of Confederation College of Applied Arts & Technology in Thunder Bay, ON, who passed away on June 8, 2013 in Calgary.

Onofrychuk, Laura (née Champagne), a 1983 graduate of Misericordia Hospital school of nursing, who passed away on July 22, 2013 in Edmonton.


Seland, Donna (née Wolstenholme), a 1962 graduate of University of Alberta Hospital school of nursing, who passed away on Feb. 4, 2013 in Calgary.

Shiflett, Betty (née Vanghoj), a 1946 graduate of Calgary General Hospital school of nursing, who passed away on June 3, 2013 in High River.

Yeoman, Zelda (née Clark), a 1955 graduate of Winnipeg General Hospital school of nursing, who passed away on Jan. 27, 2013 in Calgary.
We are a top employer with 50 years of caring for elderly and disabled people in the Edmonton area.

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I’d like to first say how grateful I am for the feedback you’ve sent in response to the apology about renewal. Some of you made me flinch, some of you made me smile, and many of you made me feel proud. As an organization, we wanted to increase member engagement and we did: not under the circumstances we had hoped for, but engagement nonetheless. Ultimately, the experience has renewed my commitment to strengthen nursing in Alberta by increasing your respect and trust for your college and association and increasing your pride as a registered nurse. This brings me to what lies ahead for CARNA, for registered nursing in Alberta and for you, as an RN.

In her farewell message, Past-president Dianne Dyer refers to the three strategic directions set by Council for the next three to five years. By now, Council will have reviewed the operational plan that will serve to animate these directions in our next fiscal year beginning October 1st. These long-term goals let all us imagine what CARNA can look like, feel like and be like and provide direction on what we need to do to get there.

We can’t hope to make any headway on this journey without leveraging CARNA’s strengths, the most notable being your expertise and ongoing commitment to professional excellence. In short, we need you to be engaged in the issues of your college, association and profession and for CARNA to be engaged in the significant issues you face as an individual practitioner.

What does “engaged” look like for you? The findings of the member survey conducted in 2011 indicate that the answer is, “It depends.” You identified a continuum of engagement possibilities between you and CARNA: focus groups, professional and educational events, responding to a survey, writing a letter to the editor, connecting via social media, providing feedback on nursing guidelines or staying informed by reading a publication.

Most of the activities and initiatives planned for this fiscal year depend on your engagement at some level to succeed. For example, the success of an advocacy campaign to influence health policy for older adults not only depends on government and public relations, but on providing you with the tools to advocate for your patients and clients in your own practice setting.

We will develop tools and resources to help you communicate and demonstrate RN scope of practice and build on previous campaigns to promote the value and understanding of the RN role in health care. The Alberta Government is expected to submit a fourth draft of CARNA’s proposed revisions to regulations governing nursing, which will entail further review and negotiation. While legislation may seem far removed from everyday practice, once proclaimed, it will lead to significant milestones in the evolution of nursing practice such as authorizing RNs to prescribe Schedule 1 drugs and order laboratory tests.

A smooth transition to the new RN exam in 2015 involves scheduling workshops for educators to prepare them and their students, soliciting nurse participation in the practice analysis, test item development and to updating on our progress.

We will be looking to members, employers and other stakeholders during a comprehensive review of all options available for registration renewal, including the suggestion many of you have made for staggered registration.

If we ever hope to achieve a shared vision for nursing in Alberta, we will need to work with all of you who are willing to take on an active role in the success and sustainability of our profession. It means as an organization, we need to develop a deeper understanding of your values, by listening, sharing experiences and joining in the dialogue. I hope you can put aside any skepticism you might have and do the same for the organization so that we find common ground to stand on.

No staff member or provincial councillor can answer, “What does CARNA do for me?” I encourage you to take baby steps or giant steps, or anywhere in between depending on where you find yourself right now, and find out what we can do together. RN

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