Exploring practices of **harm reduction**

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How PHNs are **making a difference** in **population health**

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Which **single charity** covers many worthy causes?

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President’s Update

Pushing the boundaries of practice

As your president, I meet at every opportunity with registered nurses (RNs) and nurse practitioners (NPs) across Alberta. I hear consistent messages and concerns. Some RNs and NPs are struggling every day to accurately and confidently articulate and fulfill their distinct and appropriate roles on health-care teams. There is role confusion, tension and ambiguity between RNs, licensed practical nurses (LPNs) and other disciplines. NPs in some settings are described as simply replacing and performing the work of the general practitioner or resident without acknowledgment of the full potential and contributions of this role. As a profession, we have advanced nursing knowledge, education and skills, and must achieve our full potential to ensure safe, quality services for Albertans.

Nurse managers and administrators have talked to me about their unique challenges, too. They face constant financial pressures and targets. Expectations are that they must mitigate patient safety risks and improve access while constrained by workforce shortages and the pressures of ever increasing demands. Decisions may lead to unfortunate compromises that can negatively impact work environments and quality outcomes.

On a positive note however, system challenges like these can open doors for RNs, NPs and our profession as a whole. Opportunities include a greater voice at health-care policy and decision-making tables, expanded roles and employment opportunities, and an enhanced positive image of our profession at all levels.

Evidence shows that if we work to full scope in all settings as collaborative and effective team members, we can achieve positive life-changing outcomes for the public we serve. Working in acute care, we can reduce net costs and adverse outcomes especially when health-care needs are complex and unpredictable. In long-term care, our work is associated with outcomes such as fewer pressure ulcers, hospitalizations, and urinary tract infections. We address the full range of patient or client responses to actual or perceived health issues and provide holistic interventions. Of course, procedures and treatments must be safely performed by RNs and NPs for the complex, high needs, critically ill and injured. However, our role in all settings goes far beyond the tasks to comprehensive assessments and outcome evaluations and ensuring the individual’s goals and choices are integrated into the collaborative team’s plan.

To demonstrate our critical thinking skills, I encourage all RNs and NPs to talk out loud when assessing a patient or client whenever possible. Describe what you see and hear, your assessment findings and the next steps. Doing so not only demonstrates your knowledge and skills but also enhances your image as an expert and leader to the team and your patients/clients.

So what defines our role in health-care teams? Our role is that of leader, role model and expert practitioner. We bring to the team our knowledge of health promotion and wellness, community engagement and the social determinants of health. Kouzes and Pozner (2007) talked about nursing leadership as modeling the way, inspiring a shared vision and enabling others to act (2009). The CNA position statement on nursing leadership states that “Leadership is about the competent and engaged practice of nurses, who provide exemplary care, think critically and independently, inform their practice with evidence, delegate and take charge appropriately, advocate for patients and communities, insist on practising to their full and legal scope of practice and push the boundaries of practice to innovate at new levels” (page 1).

Now is the time for RNs and NPs to challenge the status quo and make a visible difference. We must redefine our roles and staffing models if required, speak confidently and openly about what we do and should be doing, and continue to demonstrate leadership and advocacy at every opportunity. Primary health care is the provincial strategy going forward, a strategy which CARNA supports. Our knowledge, expertise, and leadership as RNs and NPs are essential to achieving success. I want you to know that CARNA will vigorously work on your behalf to advocate for change, visible nursing leadership at all levels and for the public good As Johann Wolfgang Goethe once said: “Knowing is not enough: we must apply. Willing is not enough: we must do”.

Dianne Dyer, RN, BN, MN
780.909.7058
president@nurses.ab.ca

Connect with Dianne: @DMDyer1
Subscribe to her blog at www.carnapresident.ca

Next meeting of Provincial Council: Jan. 24-25, 2013
Join the president on January 22 for a live webinar on the role of provincial council.
The nursing profession needs you!

President-Elect and Provincial Council members

An effective Provincial Council needs members from a variety of practice areas with different levels of education and experience.

What are the qualifications?
• Ability to think broadly and strategically about your profession
• Understanding of nursing and health-related issues
• Solutions focused
• Resident of the region in which you run

Why should you run for office?
• Make regulatory decisions that affect nursing practice
• Apply your leadership skills
• Influence health policies
• Promote your profession

Which council positions are open?

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* President-elect (two-year term as president-elect followed by a two-year term as president).
** Due to a resignation, a provincial council member is needed in Edmonton/West for a one-year term. The term has been adjusted to maintain a one-third turnover rate among councillors.

For more information about the role of president-elect or provincial councillor, contact: Janet Lapins, chair of the Elections and Resolutions Committee, at 403.381.1397 or email at jlapins@nurses.ab.ca.

Nomination forms available at www.nurses.ab.ca or contact Diane Wozniak at 780.453.0525, toll-free 1.800.252.9392 or via email at dwozniak@nurses.ab.ca.
May 15, 2013
Hyatt Regency Calgary

Carna members are encouraged to submit resolutions prior to the annual general meeting. A resolution is a statement of position on an issue. It can relate to any area of nursing practice, including direct care, education, administration, research. Resolutions can also relate to the role of CARNA or the role of RN and NPs in health care.

Resolutions that are received by April 30, 2013 and approved by the Elections and Resolutions Committee will be posted on the CARNA website. Although written resolutions are accepted from the floor at the meeting, advance posting of resolutions allows all members to consider them before the meeting.

Resolutions carried at the annual general meeting are non-binding and will be considered by CARNA Provincial Council at a subsequent meeting.

For more information contact:
Janet Lapins, Chair, Elections and Resolutions Committee
P: 403.381.1397
jlapins@nurses.ab.ca
Submit your resolution to:
Diane Wozniak
11620-168 Street
Edmonton, AB T5M 4A6
P: 780.453.0525/1.800.252.9392, ext. 525
F: 780.452.3276
dwozniak@nurses.ab.ca

There are two parts to a resolution:

1. Address the issue/problem.
2. Provide solutions or ideas to address the issue/problem.

Address the issue
Each resolution must address only one issue. Provide factual information, beginning with the statement “Whereas.” This portion contains all of the background information and may use cited material.

Provide solutions or ideas to address the issue/problem
Begin this section with “Resolved that,” and follow with a solution/idea to address the issue.

Please reference all materials used to support writing your resolution.
Change is in the Air: Monitoring our Progress

In the Fall issue of *Alberta RN*, CARNA CEO Mary-Anne Robinson mentioned a number of key projects and initiatives that signal important changes for our profession and our association (Closing Perspectives, p 46). In this issue, we provide an update on the progress of some of the priorities mentioned in her column.

### Work with Alberta Health on the changes to the Registered Nurses Profession Regulation

In November 2012, CARNA initiated consultation with stakeholders on the draft document *Registered Nurse Competencies for Prescribing and Ordering Diagnostic Tests*. A related standards document, *Standards for Registered Nurse Prescribing and Ordering Diagnostic Tests*, has already been revised based on stakeholder feedback.

In August 2012, CARNA submitted drafting instructions to Alberta Health for revisions to the *Registered Nurses Profession Regulation*. This is the first step in changing a regulation. Alberta Health indicated they would be reviewed after the close of the fall session of the Legislature.

### Preparation for Health Canada’s proposed new regulations authorizing NPs and other health-care providers to prescribe controlled substances

The New Classes of Practitioners Regulations (NCPR) under the *Controlled Drugs and Substances Act* in the *Canada Gazette, Part II*, was proclaimed November 21 by Health Canada.

These changes remove federal barriers nurse practitioners face in prescribing controlled drugs and substances. Even though regulatory changes have been approved at the federal level, there is still work to be done before NPs can prescribe controlled drugs and substances in Alberta. As with any legislative changes in regulated practitioner practice, enactment takes time. This work is expected to begin early in 2013.

CARNA and the other Canadian nursing regulatory bodies are also working together to develop a process that ensures public protection and compliance with labour mobility requirements.

### The new RN exam

In November, the National Council of State Boards of Nursing (NCSBN) circulated a call for Canadian nurse volunteers for the NCLEX Item Development Program, a key component in creating and maintaining high quality examination items for the new RN exam. In 2015, the NCLEX-RN will be used to measure the competencies needed to perform safely and effectively as an entry-level registered nurse in Canada. The development of the NCLEX examination depends on qualified registered nurse volunteers from all jurisdictions that use the NCLEX for entry to practice.
In December, NCSBN hosted a webinar for educators wanting to prepare students for the Computer Adaptive Test format of the NCLEX-RN. A Canadian NCLEX conference is planned for the spring 2013.

Jurisprudence requirement
In September 2010, CARNA Provincial Council delegated oversight for developing a jurisprudence requirement to the Registration Committee. The jurisprudence requirement is intended to demonstrate that RNs have knowledge and understanding (competence) of the legislative framework that governs registered nursing practice.

Staged implementation is planned for June 2014, following a pilot phase in the fall of 2013. The initial focus is on new registrants, including new graduates, transfers-in from within Canada and international applicants. This will grow to include renewing registrants and it will be incorporated into the continuing competence program.

Next steps for the project include selecting of a vendor to develop a jurisprudence module for RNs. The module is expected to incorporate references to the HPA, RN regulations, Nursing Practice Standards with CNA Code of Ethics for Registered Nurses and Health Professions Act: Standards for the Performance of Restricted Activities (Oct 2005).

Learning from Experience research project
The goal of this research project is to improve the efficiency and quality of the assessment decision-making process regarding IEN applications for registration. Retrospective review of the currently held application data and registration outcome of IENs will be used to inform application assessment policies. The revised assessment policies will be implemented during a two-year pilot phase, followed by an evaluation.

Data entry is complete and data analysis is currently underway. Synthesis of the data and policy review will be completed in the first few months of 2013 and registration representatives from other Canadian nursing jurisdictions have been invited to a symposium to discuss the implications of the findings.

Funding for the project is provided by Alberta Health as part of the Federal Internationally Educated Health Professionals Initiative (IEHPI).

Older Adults Care Policy Pillar
CARNAs policy pillars will be positions on identified issues which are used as a platform for advocacy efforts and political action. In a member survey conducted in late 2011, members identified older adults care as one of the highest priorities for public policy advocacy and Provincial Council subsequently approved the topic of older adults care for the first pillar. In January 2013, council will be reviewing recommendations for an older adults care policy based on a literature review, environmental scan, and stakeholder interviews and focus groups conducted over the past year.

NOTE: During the course of the project, considerable feedback was received about changing the reference from seniors care to older adults. Hence, the Seniors Care Policy Pillar has been changed to the Older Adults Care Policy Pillar. RN
Errors with Prefilled Saline Syringes When Used to Reconstitute or Dilute Medications

This alert shares concerns about the use of prefilled saline (0.9% sodium chloride) syringes for reconstitution or dilution of injectable medications. The purpose of this bulletin is to heighten awareness among Canadian practitioners about the medication errors that can occur with this practice and to provide recommendations to prevent such errors.

Background

Prefilled saline syringes are indicated for flushing vascular access devices, a purpose for which syringes may have advantages over vials. For example, they are ready to use, which may reduce the risk of contamination during manipulation, and they are available in several volumes.

In 2006, ISMP (US) reported that prefilled saline syringes were being used for reconstitution or dilution of medications, with the medication being withdrawn from the vial back into the syringe.1 ISMP alerted practitioners to the increased risk of medication error if syringes used in this way were not appropriately relabelled. This problem can be of particular concern if a high-alert medication is involved. One example provided in the ISMP report was dilution of an opioid in a prefilled saline syringe. Without relabelling, the syringe containing diluted opioid could be mistaken for a syringe containing saline (as labelled), an error that could have potentially fatal consequences if the contents are erroneously administered to a patient.1

ISMP Canada recently received an incident report describing a newly identified risk for error if prefilled saline syringes are used to reconstitute medications: potential inaccuracy of the resulting dilution and therefore inaccuracy of the intended dose.

Incident Example

Stannous gluceptate, an agent used in diagnostic imaging, is supplied in powdered form. Reconstitution of a single vial of this agent for certain tests requires 3 mL of preservative free saline. The specific dose to be administered is based on the patient’s body weight, and after reconstitution, the final volume to be administered is measured to the nearest tenth of a milliliter.2 When the diagnostic imaging department of the reporting hospital switched its supply of saline from vials to prefilled syringes and staff started using the syringes for reconstitution of stannous gluceptate, they noticed a decline in the quality of images produced, with re-imaging required for some patients.

Contributing Factors

When the hospital undertook a review to identify possible reasons for changes in image quality, it noted the following findings:

- The prefilled saline syringes that the hospital was using (BD PosiFlush3) are specifically indicated and intended only for flushing in-situ vascular devices and maintaining catheter patency, consistent with other prefilled saline syringes currently on the market.
- Volumes provided in prefilled saline syringes may be “approximate” and are inappropriate for reconstitution of medications requiring precise dosing, such as stannous gluceptate.
- Staff believed that the volume was accurate for reconstitution.
- The observed changes in image quality coincided with the change
to exclusive use of prefilled saline syringes for reconstitution of stannous gluceptate.

The facility implemented several changes to address the situation, including restricting the use of prefilled saline syringes to the flushing of vascular access devices and reinstituting the use of saline vials in the diagnostic imaging department. Education was also provided on best practices for reconstituting the diagnostic agent. As a result of these interventions, the number of poor radiographic images was substantially reduced.

**ISMP Canada’s Recommendations**

When contacted by ISMP Canada, several manufacturers of prefilled saline syringes confirmed that their products are indicated specifically for flushing venous access catheters or lines. Although the syringes may be convenient, their use for reconstitution of medications introduces the risk of errors into the medication administration process, particularly when a precise volume is required. ISMP Canada has compiled suggestions shared by the facility that reported this incident, findings provided by other organizations that have undertaken reviews of the use of prefilled saline syringes, and information from ISMP (US) and presents the following recommendations to enhance the safe use of prefilled saline syringes.

**Healthcare Organizations and Practitioners**

- Do NOT use prefilled saline syringes for reconstitution or dilution of medications or other injectable agents. Implementing this recommendation may necessitate re-evaluation of various products, to ensure that practitioners have appropriate options for required reconstitution or dilution of medications.
- Keep prefilled saline syringes in their outer packaging until immediately before use, and discard any prefilled saline syringes found open or outside of the manufacturer’s outer packaging.
- Alert all practitioners to the potential risks associated with using prefilled saline syringes for reconstitution or dilution of medications (e.g., by sharing this bulletin widely).

**Manufacturers**

Prefilled saline syringes with gradations may be visually similar to other parenteral syringes. To promote the safe and appropriate use of prefilled saline syringes, manufacturers are encouraged to consider the following:

- Ensure that the indication for use of prefilled saline syringes is prominently displayed on all labels (including outer package and syringe label).
- Clearly indicate on the label if the volume may not be precisely measured.

**Conclusion**

Prefilled saline syringes are indicated for flushing lines and should NOT be used for reconstitution or dilution of medications, for the following two reasons:

(i) such use may lead the practitioner to withdraw the medication into a syringe that is labelled sodium chloride 0.9%, resulting in an incorrectly labelled container once the medication has been added; and (ii) the volume may not be precise.

It is hoped that this bulletin will alert practitioners and organizations about the potential for error when prefilled saline syringes are used for reconstituting or diluting medications.

**Acknowledgements**

ISMP Canada gratefully acknowledges the expert review of this bulletin by (in alphabetical order):

- Linda Dueck RN, Surgical Educator, Alberta Health Services, Lethbridge, AB;
- Barbara Duncan RN BScN, Clinical Educator, B5ICU/CCNRT, Trauma, Emergency and Critical Care Program, Sunnybrook Health Sciences Centre, Toronto, ON; Sandra Knowles BScPhm, Drug Safety Pharmacist, Sunnybrook Health Sciences Centre, Toronto, ON; Melissa Lo BSc(Pharm) ACPR, Regional Medication Safety Systems Coordinator, Lower Mainland Pharmacy Services, Fraser Health, Providence Health Care, Provincial Health Services Authority, and Vancouver Coastal Health, British Columbia; Kim Streitenberger RN, Quality Manager, Paediatric Intensive Care and Cardiac Critical Care Units, The Hospital for Sick Children, Toronto, ON.

**REFERENCES**

3. BD PosiFlush SP syringe [product insert]. Mississauga (ON): BD Medical; [no date].

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.

CARRA Member
Registration number: 40,552

A Hearing Tribunal made a finding of unprofessional conduct against member #40,552, who made an inappropriate comment to a physician about what she called the ‘funny looking colour’ of the skin colour of two other physicians who were present at the time she made the comment and who made inappropriate and disrespectful statements regarding a patient to a co-worker to the effect that the patient was manipulative and the co-worker should not be ‘taken in’ by him. The Tribunal issued a reprimand and after taking into account the member’s personal circumstances, ordered the member to pay a $500 fine, pass a course in professional ethics, complete the eight e-modules on the code of ethics and be restricted to working at her current work setting pending a satisfactory performance evaluation commenting on her communication with others. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

CARRA Member
Registration number: 53,303

A Hearing Tribunal made a finding of unprofessional conduct against member #53,303 who sent a letter to two people (PPIC and the chairman of the facility’s board) regarding a manager at a facility in which she inappropriately expressed her subjective personal negative opinions regarding the manager; used language which was highly inflammatory, rude and disrespectful to describe the manager and his behaviour; and made an allegation regarding how the manager got his job, which was false. She failed to bring her concerns about the manager’s actions to the attention of management through appropriate communication channels. The Tribunal issued a reprimand, and ordered the member to write a reflective paper on addressing concerns in the workplace; and to complete the eight 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 of CARNA practice permit.

CARRA Member
Registration number: 57,001

A Hearing Tribunal made a finding of unprofessional conduct regarding member #57,001 who exceeded the scope of practice when he manipulated an endoscope and who made inappropriate remarks to his colleagues with innuendos regarding male genital size; told another RN words to the effect that she could do a procedure on him (the member) anytime; and asked that colleague if she thought a married female patient might be interested in him (the member); and who crossed professional boundaries when he made inappropriate remarks to a patient regarding the circumstances of the patient’s finger amputation; about having dinner together (with the member), going to Vegas, tattoos, and the patient’s piercings. This was the second time before a Tribunal for similar incidents. These incidents all occurred prior to the time of the member’s first hearing for similar incidents. The Tribunal took into account the significant sanction from his previous hearing that the member had already complied with. The Tribunal issued a reprimand and ordered the member to pay a $2,000 fine and complete the eight e-modules on the code of ethics.

CARRA Member
Registration number: 71,147

A Hearing Tribunal made a finding of unprofessional conduct against member #71,147 whose communication style on one shift with a patient was unsatisfactory in that the patient perceived the member as rude, abrupt and uncaring; who continued in an attempt to persuade the patient to accept the dose of morphine and gravol despite the patient indicating she did not want the injection; and who administered a dose of morphine in such a manner as to leave the patient’s arm swollen. The Tribunal issued a reprimand and ordered the member to provide a performance evaluation from her employer which must satisfy the Tribunal that the member’s communication with patients is respectful and compassionate. The member provided a satisfactory performance evaluation at the hearing.

CARRA Member
Registration number: 71,376

A Hearing Tribunal made a finding of unprofessional conduct against member #71,376 who on one shift failed to do a patient blood glucose every four hours as ordered; failed to adequately assess the patient’s condition throughout the shift; and failed to chart adequate assessments of the patient’s condition throughout the shift; and who on another shift failed to chart adequately on her patient. The Tribunal issued a reprimand, and directed the member to pass courses in documentation and assessment; and be restricted to working in her...
A Hearing Tribunal made a finding of unprofessional conduct against member #72,324 who failed to provide adequate care or do adequate assessments, or chart adequately on numerous patients. The Tribunal issued a reprimand and directed the member to complete the eight e-modules on the code of ethics and to write a reflective paper on assessments and documentation; pass courses in professional ethics, responsible nursing and assessment; and provide a medical letter confirming his ongoing fitness to practice; and be restricted to working for his current employer pending three satisfactory performance evaluations. 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: 75,267

A Hearing Tribunal made a finding of unprofessional conduct against member #75,267 who was inappropriately involved in the preparation, giving advice about and signing a Will, a Personal Directive and an Enduring Power of Attorney for a client; and who was inappropriately involved in the preparation, giving advice about and signing an Enduring Power of Attorney for a second client and who failed to document adequately regarding a client. The Tribunal issued a reprimand and directed the member to pass a course on documentation, write a satisfactory paper on scope of practice, and be restricted to working at her current place of employment pending a satisfactory performance evaluation. 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: 77,883

A Hearing Tribunal made a finding of unprofessional conduct against member #77,883 who failed to do adequate ongoing assessments of a patient throughout the shift; and who failed to chart adequate assessments of a patient throughout the shift. The Tribunal issued a reprimand and directed the member to pass courses in documentation and assessment. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

CARN A Member
Registration number: 79,224

A Hearing Tribunal made a finding of unprofessional conduct against member #79,224 who forged a prescription for Tylenol #3 by adding it to an existing prescription already signed by her physician and who presented the forged prescription at a pharmacy in an attempt to have it filled. The Tribunal gave the member a reprimand and accepted an Undertaking to not practice as a registered nurse pending proof from a physician and counselor that she is safe to return to practice at which time, the member has a choice to return to either a practice setting where there is no access to narcotics or controlled substances, or 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: 82,477

A Hearing Tribunal made a finding of unprofessional conduct against member #82,477 who failed to document adequately on a patient. The Tribunal issued a reprimand and required the member to pass a course in documentation. 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: 83,804

A Hearing Tribunal made a finding of unprofessional conduct against member #83,804 who wrongfully accessed health records in Netcare on multiple occasions for several persons including herself, her relatives, and friends who were neighbours. The Tribunal issued a reprimand and ordered the member to pass a course in responsible nursing, write a paper on confidentiality, and provide proof that she has completed eight 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 of CARNA practice permit.

CARNA Member
Registration number: 84,654

A Hearing Tribunal made a finding of unprofessional conduct against member #84,654 who while working as the nurse in charge started an intravenous, without a physician’s order, on another RN who was on duty, thereby wrongfully using her employer’s property such as IV supplies; and then allowed the other RN to run an IV of saline on herself when on duty. The Tribunal issued a reprimand.
CARN A Member
Registration number: 85,690
A Hearing Tribunal made a finding of unprofessional conduct against member #85,690 who left a palliative patient unattended in the bath and without any access to call for assistance and regarding another patient, administered Hydromorphone to patient on three occasions in error, rather than the Morphine as ordered; failed to sign the medication in the Medication Administration Record (MAR) once; failed to document a pain assessment of the patient either prior to or following administration of the prn pain medication; and when she became aware of the medication error, she failed to advise the patient’s family physician of the medication error, failed to advise the patient’s family of the medication error, and failed to document an assessment of the patient in the notes on the chart. The Tribunal issued a reprimand and ordered the member to pass courses in assessment, documentation and responsible nursing and do the eight e-modules on the code of ethics; and be restricted to working for her current employers (unless she obtains permission from the Tribunal to work elsewhere) pending satisfactory performance evaluations from her employers. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit. RN

Publications ordered by Hearing Tribunals (cont’d)

Share your nursing practice articles with us!

Are you proud of your contribution to the program or services your team provides? Would you like to share your clinical practice, education, research or administrative expertise with other registered nurses? CARNA would like to help you spread the word!

We are looking for fresh nursing content for Alberta RN magazine. With an audience of more than 34,000 registered nurses and nurse practitioners, your message can really make an impact in the Alberta nursing community.

Articles should not exceed 800 words in length and be written in a plain language style. Submissions should include a brief cover letter with information on the author’s background and why the topic is relevant to registered nurses in Alberta. We encourage you to submit high-res photos, data tables and illustrative graphics.

Send your stories and photos to albertarn@nurses.ab.ca. The editorial deadline for the Spring 2013 issue is Feb. 15, 2013.

NOTE: The editor reserves the right to edit all articles and makes the final decision on publication suitability. CARNA reserves copyright for all articles published in Alberta RN magazine.
**Annual General Meeting**

The 2013 AGM takes place in the Hyatt Regency Calgary on May 15, 2013, following the Provincial Council meeting on May 13 and 14. This is the first time in many years a provincial council meeting has been held in Calgary. Join us to hear what we’ve accomplished in the past year and what we’re working towards. CARNA represents you, so we welcome you to our Open Forum to ask questions or raise issues for council to consider.

To register for the Provincial Council meeting and/or AGM, go to www.nurses.ab.ca and click on the About Us tab. Select Provincial Council. The agenda is posted three weeks before the meeting.

**THE 14TH ANNUAL CARNA AWARDS OF NURSING EXCELLENCE**

**Gala**

Join the College and Association of Registered Nurses of Alberta in celebration of our profession and to honour recipients of the 2013 CARNA Awards in the following categories:

- Rising Star
- Lifetime Achievement
- Research
- Administration
- Education
- Clinical Practice
- Partner in Health
- Committee’s Choice Award

In addition, ARNET will award its most prestigious scholarships, including the CARNA TD Insurance Meloche Monnex Scholarship Fund.

**Hyatt Regency Calgary**

700 Centre St. SE

**Live Tweeting**

The 14th annual CARNA Awards Gala will feature live Tweeting with the hashtag #RNGala. Follow CARNA on Twitter @AlbertaRNs.

**New**

CARNA has revamped the CARNA Awards website! Visit www.carnaawards.ca to check out the nominees, past recipients and gala photos from the past few years. You can also check out www.youtube.com/CARNAVideo to watch the inspiring recipient speeches at last year’s gala.

**THE 14TH ANNUAL CARNA AWARDS**

**Wednesday, May 15, 2013**

6:00 p.m. | Reception
7:00 p.m. | Dinner and Awards

**Dress Code**

Formal or business attire

**Gala**

Join the College and Association of Registered Nurses of Alberta in celebration of our profession and to honour recipients of the 2013 CARNA Awards in the following categories:

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Protecting Patient Rights

Nursing jurisprudence in action

BY FAY ORR
ALBERTA MENTAL HEALTH PATIENT ADVOCATE

Every year, about 7,500 Albertans with mental disorders are involuntarily detained in hospitals throughout the province for examination, assessment, treatment and care. Many of these patients will spend from a few hours to several days in emergency departments before being admitted onto psychiatric units. A smaller number may spend time on general medical units to receive non-psychiatric medical treatment. While nurses play an invaluable role in the treatment and care of patients living with a mental illness, they also have legal responsibilities to involuntary mental health patients. Understanding these legal responsibilities and how they play a role in the care of patients are part of the registered nurse’s commitment to be competent in jurisprudence—the application of principles of law as they relate to the practice of nursing.
Although some civil liberties are suspended when they are admitted to hospital, involuntary mental health patients retain a number of important rights. Along with possessing clinical competencies for the care of these individuals, a nurse is accountable for complying with legislation affecting their care, including the Mental Health Act (MHA) of Alberta. The MHA provides the authority, protocols and timelines for admitting, detaining and treating persons suffering from serious mental disorders. While nursing staff on psychiatric units may be well-aware of their legal responsibilities, nurses in other parts of the hospital may possess less familiarity. It is important that the care of the patient never be compromised because of a lack of understanding of legal obligations on the part of the RN. This may begin with simply realizing that a lack of understanding exists and seeking advice or expertise to best support the patient.

**Nursing jurisprudence:**

the application of principles of law as they relate to the practice of nursing.

The MHA states it is the duty of the “hospital board” to provide patients with information about their rights. In practice, it is the responsibility of primary health-care providers to ensure patients are properly informed.

Did you know it is the responsibility of the staff to make sure a formal patient is properly informed of their options and rights? A “formal” patient is someone who has been issued two admission or renewal certificates. They must be told, in simple language, the reason for the certificates and given a copy of them. The patient must also be told about the right to apply to a review panel for the cancellation of the certificates. Hospitals designated under the MHA to admit involuntary patients should have a procedure to ensure patients are told of their rights at the appropriate time.

If a patient is considered competent to make treatment decisions, they have the right to consent to treatment – or refuse it.

Other patient rights include:
- the right to a lawyer
- the right to appeal review panel decisions to the Court of Queen’s Bench
- the right to contact the office of the Mental Health Patient Advocate with any concern or question about their rights, detention, treatment or care

The office of the Mental Health Patient Advocate provides rights information, conducts independent investigation of complaints and helps patients and families navigate the mental health system with the support of health care providers such as registered nurses. In turn, RNs can contact the office of the Mental Health Patient Advocate in order to be better informed about the requirements of the MHA.

The office hears from about 750 patients a year. Complaints range from concerns about legislated rights to the lack of privileges to allegations of physical assault. All complaints are investigated, though the Advocate will maintain a complainant’s anonymity, if asked. Nurses may file a complaint with the Advocate if they have a concern about one of their patients. For example, the Advocate has received complaints from nurses about the techniques security officers used to restrain a patient.

The Alberta Mental Health Patient Advocate office may be a useful resource to registered nurses and other hospital staff who want to know more about their role in protecting the rights of patients living with a mental illness. RN

Learn more about nursing jurisprudence from the webinar “What in the world is jurisprudence?” available at www.nurses.ab.ca/webinars

More information about the Mental Health Patient Advocate and patient rights is available online at www.mhpca.ab.ca
ARE you considering completing certification in your specialty practice area? A recent study found that certification in a specialty area of nursing practice provided nurses with a sense of personal pride of accomplishment, increased practice confidence, and enhanced professional credibility (Schroeter, Byrne, Klink, Beier, & McAndrew, 2012). In Canada, the Canadian Nurses Association (CNA) offers certification for 19 practice areas. Initial certification involves the successful completion of the specialty practice exam and is then maintained through ongoing practice in the specialty area and continuing education. Nurses must apply to renew their certification every five years. More than 1,800 nurses in Alberta, and more than 17,000 nurses throughout Canada, can put a CNA certification after their name (CNA, 2012).

Through CARNAs Continuing Competence Program, nurses demonstrate their commitment to lifelong learning and pursuit of excellence in nursing practice. In addition to the personal and professional benefits of certification, educational activities undertaken towards maintaining your certification can be entered in your MyCCP learning plan to provide evidence of ongoing professional development. Enhancing your knowledge and skills in your nursing practice is the goal of CARNAs Continuing Competence Program and achieving specialty certification can help you meet this goal.

For detailed information about specialty certification in your practice area go to: www.cna-aiic.ca/en/professional-development/specialty-certification/

REFERENCES

Welcome (back) to Provincial Council!

Lloyd Tapper, MN, NP (pictured) is filling a vacancy for Edmonton/West Region. Tapper previously served on council between 2008-2010.

Provincial Council regretfully announces the resignation of public member Murray Donaghy. We wish him the best of luck in his future endeavours.

Strong Response to MyCCP Evaluation Survey
Carna appreciates the feedback received from the more than 7,700 nurses who responded to the MyCCP evaluation survey. The information collected will be reviewed and used to inform the ongoing development of the CCP. If you have questions about the survey or any aspect of the program, please contact continuingcompetence@nurses.ab.ca or call 780.732.9511 (toll-free 1.800.252.9392 ext. 411).

RN Volunteer Opportunity: Invigilators for the Canadian Registered Nurse Exam (CRNE)
Read more about this opportunity and apply at www.nurses.ab.ca > Member Info > Call for Members
TONIGHT IT IS QUIET AND THE NEIGHBORHOODS seem empty and desolate. Our team is driving the streets in a needle exchange van, a mobile harm reduction service operated by Streetworks in Edmonton. We follow a regular route, stopping at times and places that are familiar to our clients. We also make stops upon request; clients call us when they are too ill to make it to our regular stops, afraid to leave their children or partners alone at home, or are without access to transportation.
After a routine stop, a woman named Debra calls to request our services. Debra had been trying to cut down on her illicit drug use, a difficult task in the face of continuous poverty, lack of adequate housing support and painful memories. We hadn’t seen Debra in a while and we recalled her ability to care for and nurture others and identify injustices. She is incredibly independent. Debra rarely speaks about her childhood and adolescence, and when she does, she alludes to a school system in which she was marginalized and a child welfare system that placed her with families that made her feel uncomfortable. Debra began to work the streets when she was 11 and continued into her 20s, when she met Michael. This relationship gave her a place to recover from the experiences of her youth. Debra had two sons with Michael and she raised them for several years. She fondly speaks about being a mother and how much she loved the time she had with them. Eventually, life became challenging again and her years of living and working on the streets haunted her. She has told us about the continuous judgments made about her by others because of her involvement in the sex trade. Debra rarely seeks health care; there are too many questions, too many judgments about her ability to abstain from drug use.

Tonight, she wants to know how to treat a festering sore on her arm and whether or not she needs antibiotics. She had tried hard to manage the infection on her own, but the pain and fever are visible in her eyes.

On our way home, we wondered what sustains us in our practice. Is it the ability to deliver health services and respond to health concerns? Is it the opportunity to reduce harm? Or is it that we build a sense of community and caring for not only our clients, but also ourselves? Or was it that we learned early in our work that harm reduction must be the standard of care and not an exception? For us, harm reduction speaks to our work with clients in the immediacy of providing care and through the involvement of people who use illicit drugs to shape policies and programs that affect their lives.

HARM reduction is often equated with providing condoms and sterile needles and syringes for illicit drug use. However, we also educate about safe injection practices and ways to reduce risk and provide access to primary (including prenatal) care, immunizations and referrals.

Harm reduction is not aimed at fixing problems or providing solutions. It is understanding people living in complex social environments who use illicit drugs. It acknowledges that people experience drug use as a chronic and relapsing condition. A key focus in harm reduction is to reduce immediate harm, while reflecting a philosophy and strategies that propose a value shift (International Harm Reduction Association, 2006). As a philosophy, harm reduction informs policies and programs that reduce the broad range of harms associated with drug use, including homelessness and poverty (Pauly, 2007). The immediate goal of reducing harm is important while also addressing the root causes of inequities. In this way, “harm reduction is increasingly being seen as a key component of a human-rights based approach to drug policy” (Barraet, 2012, p. 18).

We have worked within a harm reduction practice for a long time now. CARNA recently supported the principles of harm reduction outlined in the CNA discussion document Harm Reduction and Currently Illegal Drugs Implications for Nursing Policy, Practice, Education and Research (2011) (http://www.cna-aiic.ca/en/on-the-issues/harm-reduction/). The practice of harm reduction also finds legal support in the recent Supreme Court decision on safe injection sites. It allows us to help people prevent harm to their bodies (by decreasing the spread of communicable diseases, such as HIV and Hepatitis C), to prevent the spread of disease (through providing clean needles and proper needle disposal), and to protect and improve the health of the community people live within. We advocate for services that are meaningful, ethical and responsive to the needs of people who use illicit drugs. We offer access to health care and places for people to inject safely and receive care if needed. We attend to the intersections of health with the legal system, emphasizing that health is a human right that requires economic and social supports.

We often hear about the lack of services for people who use drugs in rural areas, where needle exchange programs and other harm reduction...
strategies are inaccessible (Parker, Jackson, Dykeman, Gahagan, & Karabanow, 2012). These programs are also absent in prisons. The criminalizing of youth drug use is a particular concern. There is an absence of non-judgmental and non-stigmatizing programs for young people.

**WHILE** people who use illicit substances encounter barriers to accessing appropriate and timely health care, they do visit emergency rooms and are admitted to general wards in acute care facilities. In these instances, registered nurses in tertiary care facilities are well-positioned to implement harm reduction measures. These measures include appropriate assessments, referrals, and advocacy. People use illicit drugs in hospitals, which often leads to “expulsions and/or high rates of leaving against medical advice when withdrawal is inadequately managed” (Rachlis, Kerr, Monater, & Wood, 2009, p.1). As registered nurses we can advocate for our clients, so they are not punished for drug use while admitted for care. It too is important that we argue for the “need to reflect an understanding that systems of power/ oppression that operate across the axes of race, class, gender, ability and so on, are interlocking; to focus on drug use to the exclusion of other factors is problematic” (Smye, Browne, Varcoe, &Josewski, 2011, p. 10).

Registered nurses in almost any practice setting encounter people who use illicit drugs and they may find themselves caught between ethics and current evidence on one hand and policy and practices at the other hand. Registered nurses are in positions to advocate for evidence-informed harm reduction policies and programs, a role that is increasingly important in the face of Canadian drug laws and law enforcement. CARNa and CNA support the roles of RNs and NPs in the full range of harm reduction services, including providing non-judgmental and non-stigmatizing care to people who use illicit drugs and to collaborate with people to achieve the health they desire and to address the social determinants of health as a root cause for health inequities.

**NOTE**: In December 2012, the Canadian Nurses Association (CNA) and the Canadian Association of Nurses in AIDS Care (CANAC) released a joint position statement on harm reduction stating:

*The Canadian Nurses Association (CNA) and the Canadian Association of Nurses in AIDS Care (CANAC) recognize harm reduction as a pragmatic public health approach aimed at reducing the adverse health, social and economic consequences of at-risk activities. Harm reduction is most commonly used in relation to public health programming with people who use psychoactive substances, but it can also be applied to programs that address alcohol use, sexual practices, cycling, driving, gaming and others.*

*We believe that harm reduction does not require at-risk practices be discontinued while focusing on promoting safety, preventing death and disability, and supporting safer use for the health and safety of all individuals, families and communities.*

(Full statement at www.canac.org)

**REFERENCES**


Public health nurses provide preventative programs, promote health, mobilize communities.

They visit new mothers and babies recently home from the hospital; administer vaccinations and provide health information and resources at health-care clinics; and provide health education support and health-promotion strategies in our schools. They are public health nurses, and in a province with a growing demand for acute-care services, they offer up some relief in the form of prevention and health promotion programs that encourage healthy living, help reduce chronic and communicable diseases and influence healthy child development.

"Public health nurses are uniquely positioned to make significant connections with families and communities across Alberta," explains Cheryl MacLeod, lead, School and Well Child Services for Alberta Health Services in Calgary. "We have the skill sets to put strategies into action that can prevent future health concerns and influence healthy outcomes for our families and communities."

An important connection is made when public health nurses visit families with newborns within 48 hours of hospital
discharge. They provide early assessment, care and referral of maternal and infant health issues, including breastfeeding support. “By supporting the breastfeeding experience of mothers and babies during these early months, mothers will breastfeed their children longer. This improves infant and child health and reduces health-care costs in the long term.”

“If we can intervene and support parents early enough, we can help individuals achieve healthier outcomes while also lessening the pressure on our health-care system,” says Cheryl.

A report by the Chief Medical Officer of Health called Let’s Talk About the Early Years shows the strong connection between early childhood and life-long health and well-being. According to the report, “those in early childhood need a safe, nurturing, and loving environment to reach their full potential,” a statement supported by public health nurses.

Public health nurses routinely see families with infants and children at two, four, six, 12 and 18 months for well baby visits in health-care clinics, and again around four years of age before they start school. “In our relationships with families, we assess infant health issues and provide nutrition support and referrals to physicians and community agencies,” says Mary McIntyre, area manager, Public Health – South Calgary Health Centre and Rural South. “We assess children’s growth and development and share anticipatory guidance that is appropriate for the child’s age and the families’ circumstances. We also talk to families about coping and parenting, and connect them with resources in their own communities.”

Effective public health programs can have a significant impact on our provincial health-care system’s bottom line. For instance, community-based vaccination clinics are a cost-effective and efficient way of providing vaccines and reducing vaccine preventable diseases. Public health nurses also work with families in this setting to ensure they have the support required to raise happy, healthy children. “We know families are healthier when they are connected to their communities and have support. If we see that specific support is needed in a community, we can work with them to fill in the gaps in services,” says Cheryl.

Mary believes public health nurses are catalysts to help mobilize stakeholders to pull together and make community-wide changes. A mother who came into a community health centre told the nurse her infant had to wear soiled diapers longer than was ideal because she couldn’t afford to change them more frequently. The nurse collaborated with her peers and Calgary’s Interfaith Food Bank to launch a “diaper drive,” asking parents in the community to bring leftover packages of diapers to their local health units, which were distributed to the families that needed them. This allowed the community to connect with their local health centre in a new and meaningful way, enriched a pre-existing partnership with the Interfaith Food Bank and improved clients’ access to diapers.

“We work with our communities so they engage and take ownership to address the challenges they see around them,” says Mary. “It is the role of public health to look at a community’s strengths and resources and facilitate how they can come together. We are their advocates.”

These grassroots relationships allow public health nurses to create unique partnerships and collaborate with others to advocate for their community. In a Calgary school, the school nurse...
saw increasing numbers of high school students coming to school hungry. Some students wouldn’t have anything to eat for 24 hours. The magnitude of the issue was beyond the school’s ability to address it on their own. The nurse brought together local agencies with the school, helping all of the players to better understand the issue. Ultimately, that collaborative group led to a food securing agency refining its service delivery model to include high schools across the city. “The public health nurse was pivotal in stakeholders coming together to address the issue of students having access to nutritious food, which in turn means these students are better able to learn and achieve greater success,” says Mary.

Obviously, health promotion is central to public health nursing practice. “Public health professionals are best able to offer health promotion strategies because we have existing relationships within communities,” says Mary. This speaks to the crucial role of public health in community development, health equity, social justice and the social determinants of health.

The Canadian Nurses Association National Expert Commission (NEC) released a paper in 2012 that included recommendations for a new model of care that emphasizes wellness and an examination of the social economic determinants of health such as poverty and education levels. The NEC’s study findings showed a need to “accelerate the transition from acute care to community-based care” and that Canadians need “clearer guidance when it comes to healthy living.”

Public health nurses are strategically situated to provide this guidance. Given the multiple points of connection a public health nurse has with clients, and with the current emphasis on healthy child development, comprehensive school health approaches and prevention of chronic illness, public health nursing is well positioned to provide leadership in the community health system, says Cheryl.

“If we can intervene and support parents early enough, we can help individuals achieve healthier outcomes while also lessening the pressure on our health-care system.”

CHERYL MACLEOD, LEAD, SCHOOL AND WELL CHILD SERVICES, ALBERTA HEALTH SERVICES

Public health nursing in Alberta

The role of Alberta’s public health nurses is to emphasize health promotion and illness and injury prevention. Public health services include prenatal education; home visits and support for families following birth of a baby; breastfeeding support; parent support; newborn metabolic screening; screening for domestic violence; health promotion; guidance for infant care and safety; travel health services; immunization and communicable disease follow up. Public health nurses work in partnership with other health service providers as well as community agencies and groups. For example, in school environments, public health nurses work in partnership with licensed practical nurses to meet student vaccination needs.

SOURCE: www.albertahealthservices.ca > Programs & Services > Public Health Nursing
Since February 2012 CARNA has offered free, online webinars and tutorials as resource and education tools for registered nurses, nurse practitioners and students enrolled in nursing education programs. Webinars were presented by CARNA staff members, all experts in their different nursing fields. The wide variety of topics meant webinars appealed to many members and the live question and answer opportunities allowed for two-way communication between CARNA and the nursing community. The following webinars are now available for viewing at www.nurses.ab.ca/webinars:

- Best Practices Resources
- Horizontal Violence
- Nursing Leadership
- Supporting RN Practice and the Complaint Process: A Balance
- Privacy and Confidentiality for RNs
- What in the world is jurisprudence?
- Nursing: A self-regulated profession
- How we handle complaints of unprofessional conduct

How have members responded to these webinars? From 200 to 600 people participate in live webinars, including registered nurses, nursing students and Canada-wide health-care organizations.

Webinar survey feedback shows us that webinars have consistently met members’ expectations based on how they were promoted. A majority of survey respondents agreed or strongly agreed that the information presented was useful and easy to understand; the expertise of the presenter was evident; participating was easy; and the online format worked well for their situations.

Coming in 2013

In 2013, CARNA will offer a new series of webinars on topics such as nursing professionalism, the conduct hearing process, continuing competence and renewal, governance and more.

Invitations for webinars will be sent to members via email.

UPCOMING

There was a buzz in the halls of Springbank High School during the September career fair. Two University of Calgary nursing students, Patrick Schmaltz and Tyler Hume, arrived to deliver an important message to the high school students: nursing is a great career choice for men and women.

The road to acceptance as nurses has not been an easy one for men. According to Evans (2004), men have played important roles in nursing history, but their involvement has been largely ignored. Social and political factors influenced the scope of male nursing practices in both North America and Europe.

Historical accounts from as early as 3000 AD show men took part in what would be defined as nursing: providing care to the sick and injured. In the mid-1800s, Florence Nightingale (often referred to as the founder of modern nursing) set out to establish nursing as strictly a female profession. A family-based model of health care emerged—the dominant father role played by male doctors; the maternal role played by female nurses; and the child role played by patients.

In early 20th century Britain, nursing was formally segregated by gender with the development of nursing as a self-regulated profession. Under the Nurses Act of 1919, men and women registered separately, and males were banned from the General Register. Male nurses were assigned to nursing roles in mental asylums because of their ability to physically subdue violent patients.

In 1937, Edward Glavin created the Society of Registered Male Nurses in England, a huge step forward for men’s rights. However, Europe was far ahead of North America in this area. It was not until 1971 that a similar association was formed in the U.S. Québec did not allow men to register as nurses until 1969, and six years later, allegations surfaced in Alberta that male nursing students were not being accepted into schools of nursing.

Many female nurses resisted the introduction of men in nursing. One fear was that male nurses, if allowed in the profession, would take away the executive and managerial level positions from females. They were not entirely wrong—in 1973, men represented two percent of the entire nursing population of Canada, yet they represented five percent of directors/assistant directors while only three percent of female nurses held similar positions.

This disparity isn’t confined to administrative roles. In 1995, very few men were working in paediatrics, maternal/newborn or community nursing, opting instead to work in
Over the past decade, Alberta has seen a steady increase in the percentage of males becoming registered nurses. The percentage of men rose from four percent of all Alberta nurses in 2005, to five percent in 2011.

When compared with the other Canadian jurisdictions, Alberta lies in the middle of the pack. In 2010, the Canadian provinces/territories with the highest percentage of male nurses were Québec, Northwest Territories and Yukon at approximately 10 percent each. At the low end are PEI and Nova Scotia with two percent and four percent, respectively.

Regulated Male Nursing Workforce by Province/Territory of Registration, Canada, 2010

<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Yukon Territory</td>
<td>10.4%</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>10.0%</td>
</tr>
<tr>
<td>Québec</td>
<td>9.8%</td>
</tr>
<tr>
<td>British Columbia</td>
<td>6.5%</td>
</tr>
<tr>
<td>Manitoba</td>
<td>6.5%</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>6.0%</td>
</tr>
<tr>
<td>Newfoundland/Labrador</td>
<td>5.2%</td>
</tr>
<tr>
<td>Ontario</td>
<td>5.0%</td>
</tr>
<tr>
<td><strong>Alberta</strong></td>
<td><strong>4.8%</strong></td>
</tr>
<tr>
<td>New Brunswick</td>
<td>4.6%</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>4.1%</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

Patrick and Tyler are looking to enhance gender equality in nursing. The two nursing students are founding members of the Nursing Guys Club (NGC) at the University of Calgary starting in 2011. They promote positive messages about male nurses and their health-care role. Through these efforts, these two men hope to provide a community of support and strengthen the diverse culture of students at the University of Calgary.

CARN A is also making efforts to raise awareness of opportunities to bring more males into the registered nursing profession. On Oct. 24, 2012, Calgary/West Regional Coordinators Chris Davies and Beverlie Johnson hosted a nursing practice group to give RNs, students and potential nursing students a forum to talk about men in nursing.

- What are the biases that males face when choosing nursing as a career?
- What are the benefits of having men in nursing?
- What are the challenges that men face in their nursing careers?
- What can be done to encourage men to choose nursing as their career choice?
- How can we support males who have a career in nursing?

Twenty people attended this nursing practice group and took part in a lively and meaningful discussion. Some of the main points of discussion included:

- Men in nursing want to be perceived as registered nurses who provide safe, competent and ethical care.
- Men in nursing would like to see more male nurse leaders profiled in the public.
- School counselors should be better-informed about opportunities in nursing for men to increase awareness.
- The public should be better-informed about what RNs do, which would increase awareness that male RNs have an important role in health care and are educated and skilled.
- A campaign to actively recruit men into nursing would increase diversity among RNs, similar to the campaign that the Calgary Police Service is currently conducting to hire more women in policing.
- There should be more research into gender issues in the nursing workforce and how to address them.

REFERENCE

You've heard “lift with your knees” is the best way to protect your back, but there are a number of ways to prevent back pain.

Don’t work too hard!
Overexertion is the leading cause of back injury for Alberta registered nurses. Excessive effort when performing certain tasks, such as lifting, pushing or carrying can lead to overexertion. Using your leg muscles is ideal because they are stronger than back muscles, and using your leg muscles distributes the weight throughout your body. Also avoid twisting or arching your back while lifting.

Eighty percent of adults experience back pain at some time in their lives. The good news is that back pain rarely leads to serious injury. Even better news: aside from using proper lifting practices and devices when possible, there’s something else you can do to prevent back pain.

What’s the big secret?
For many years people believed that bed rest was the best remedy for back pain sufferers. Researchers have discovered that exercise is what your sore back really needs. Physical activity helps to maintain and stretch back muscles to avoid stiffness in your spine.

This doesn’t mean that you have to enroll in a yoga class or start hitting the gym. All you need is gentle exercise to improve the flexibility and strength of muscles in your back. Find something you can enjoy that fits your lifestyle – try taking your dog for a walk, a dance class with a friend and taking stretch breaks. It can be as simple as taking a walk on your lunch break.

When regular activities cause back pain
Injuries can also result from normal activity. Sudden movement causes stress to the body, such as walking, climbing, bending, etc. For example, bending over too far to tie your shoe can cause you to pull a muscle. Use proper posture when performing activities to protect your back from injury. Also, staying active helps strengthen back muscles so your back can be more resilient and less vulnerable to the range of motion required in many daily tasks.

These activities can also help relieve stress and anxiety, which are common among back pain sufferers. A little bit of exercise will go a long way towards getting you started on your journey to a healthy back. So get moving and don’t take back pain lying down!

716 claims
The number of claims from RNs in Alberta relating to back pain or back injuries accepted by WCB since 2010.

Of those claims, 74% included time lost from work.

Leading causes of back issues for RNs?

<table>
<thead>
<tr>
<th></th>
<th>Overexertion</th>
<th>Bodily motion</th>
<th>Falls</th>
<th>Other*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage</strong></td>
<td>68%</td>
<td>20%</td>
<td>4%</td>
<td>8%</td>
</tr>
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</table>

* Other includes: repetitive motion, transportation accidents, etc.

In Canada, musculoskeletal (back) injuries are the most prevalent work-related disability, accounting for nearly half of time-loss injuries.

Nursing has the highest prevalence of work-related back injuries world-wide.
More than 25% of Canadian nurses reported working with back, buttock, neck or shoulder pain most or all of the time.

Six tips for proper lifting

1. Place your feet shoulder-width apart for good balance
2. Bend your knees and engage your leg muscles
3. Keep the load close to the centre of your body
4. Lift gradually and smoothly, don’t jerk—and engage your core muscles for balance and back support
5. Pivot with your feet, don’t twist your back while lifting
6. Coordinate your lift when working with a partner

Snow shoveling is an aerobic activity

Exercise is great for your back, but with strenuous activity comes risk of strain—and shoveling is no exception. To avoid aggravating back pain, WebMD has some simple rules for safe shoveling:

- **Push snow.** Don’t lift it unless you absolutely have to. And if you have to lift snow, use the stronger leg muscles for support, not the back.
- **Don’t throw snow over your shoulder or to the side.** The back is least able to tolerate torque and twisting.
- **Shovel early and often.** This keeps the amount of snow that has to be removed to a minimum. Plus, getting at the stuff quickly keeps it from freezing or partially melting and becoming harder to remove.
- **Use the proper equipment;** from a snow shovel (not a garden one) to boots.
- **Limit snow-shoveling sessions.** Most of us don’t put in more than 30-60 minutes of exercise (at a time), and snow shoveling should follow suit.

Source: www.webmd.com/heart and www.backactive.ca

Nurse your back pain by treating it to regular physical activity.

For more information and tips on how to care for your back, visit backactive.ca

Top three factors contributing to musculoskeletal injuries in nurses from high-claim hospitals:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workload</td>
<td>25%</td>
</tr>
<tr>
<td>Physical work environment</td>
<td>16%</td>
</tr>
<tr>
<td>Staffing</td>
<td>15%</td>
</tr>
</tbody>
</table>

The absenteeism rate related to illness and injury for full-time registered nurses was **83% higher** than was the rate for the full-time Canadian workforce in 2002 (8.6% compared to 4.7%).

More than 25% of Canadian nurses reported working with back, buttock, neck or shoulder pain most or all of the time.

Source:
Did you know a donation to ARNET supports many worthy causes?

From cancer research, support for the elderly, improved patient care, mental health and addictions supports, infant health, disease management and more—many charitable causes rely on the expertise and advanced education of registered nurses and nurse practitioners.

One hundred percent of your donation to ARNET remains within Alberta and ensures that Alberta’s registered nurses and nurse practitioners have the supports required for specialized nursing education to meet the challenges within today’s changing health-care environment.

As the only charity exclusively supporting Alberta’s RNs and NPs, our donors know that their donations are making a direct impact on their communities.

As you consider your annual charitable donation plans, we hope that you consider a donation in support of registered nursing and the Alberta Registered Nurses Educational Trust.

Alberta Registered Nurses Educational Trust
11620-168 Street
Edmonton, AB T5M 4A6
1.800.252.9392/780.451.0043, ext. 523
www.arnet.ca

In Alberta there are charities to support cancer research, long-term care for elderly and disabled, mental health and addictions support, infant health, disease management, diabetes and so much more.

**Only one charity in Alberta** supports all of these causes.

**100% of donations to ARNET stay in Alberta.**

**Only 3% of ARNET’s expenses go to administrative costs.**

To compare with other charities, go to the Canada Revenue Agency website: http://www.cra-arc.gc.ca/chrts-gvng/menu-eng.html.
IN MEMORIAM
Our deepest sympathy is extended to the family and friends of:

Aunger, Leelah (née Lee), a 1957 graduate of Moncton Hospital school of nursing, who passed away on Sept. 25, 2012 in Nanaimo.

Bissett, Faye (née Zilkey), a 1966 graduate of Misericordia Hospital school of nursing, who passed away on Sept. 26, 2012.

Bracko, Shirley (née Reid), a 1951 graduate of Royal Alexandra Hospital school of nursing, who passed away on Oct. 1, 2012 in Calgary.

Bruneau, Sharon, a 1969 graduate of Toronto Western Hospital school of nursing, who passed away on Aug. 26, 2012 in Edmonton.

Cameron, Betty Ann, a 1945 graduate of St. Boniface General Hospital school of nursing, who passed away on Sept. 9, 2012 in Calgary.

Erickson, Olga “Audrey” (née Dilay), a 1948 graduate of St. Boniface General Hospital school of nursing, who passed away on Sept. 7, 2012 in Calgary.

Florence, Jeanette Tsan-Ying, a 1967 graduate of the University of British Columbia, who passed away on Aug. 24, 2012 in Edmonton.

Friesen, Kalsie (née MacIntyre), a 2004 graduate of Mount Royal University, who passed away on Sept. 22, 2012 in Fernie, BC.

Gregoire, Patricia, a 1985 graduate of Branson Hospital school of nursing in Oshawa, ON, who passed away on Sept. 29, 2012 in Fort Saskatchewan.

Hagen, Joan, a 1975 graduate of Grant MacEwan, who passed away on July 15, 2012 in Spring Lake, AB.

Ireland, Shirley Mae, a 1954 graduate of Misericordia Hospital school of nursing, who passed away on June 12, 2012 in Perryvale, AB.

Mattiello, Tammy, a 1991 graduate of the University of Alberta Hospital school of nursing, who passed away on Jan. 12, 2012 in Edmonton.


Schram, Patricia (née Broadfoot), a 1958 graduate of Regina General Hospital school of nursing, who passed away on July 14, 2012 in Edmonton.

Segeren, Jeanne (née DeBruin), a 1946 graduate of Deaconess Hospital school of nursing in Spokane, who passed away on Sept. 26, 2012 in Calgary.

Sidebottom, Mildred, a 1958 graduate of Victoria Public Hospital school of nursing in Fredericton, NB, who passed away on Sept. 4, 2012.

Siska, Leslie Jo, a 1991 graduate of Confederation College of Applied Arts & Technology in Thunder Bay, who passed away on Sept. 29, 2012 in Lethbridge.

Have you read
CARNAs 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.

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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.
Our priority is to ensure that members are receiving their renewal notices and other communication relating to their registration and their practice.

CARNA sends quite a lot of other information to members—monthly e-newsletters, Take Note, webinar emails, Provincial Council highlights and more. Many of those emails are sent through an email service called Constant Contact.

Currently, CARNA is experiencing difficulty communication information to members who have unsubscribed from our emails by using the SafeUnsubscribe feature. The SafeUnsubscribe is a mandatory feature of most mailing services to allow recipients to opt out. We hope you will not use it.

Here are the steps you can take to manage your CARNA email subscriptions without missing important emails about registration or your practice:

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Jan. 16, 2013. Edmonton. pdavis@nurses.ab.ca

EVERY NURSE TAKING ACTION ANNUAL SYMPOSIUM

WESTERN AND NORTH-WESTERN REGION CANADIAN ASSOCIATION OF SCHOOLS OF NURSING (WNRCASN) 2013 CONFERENCE

CENTRAL

9TH ANNUAL INTERPROFESSIONAL RESEARCH CONFERENCE

SOUTH

CARNA DAY
Jan. 17, 2013. Lethbridge. pshackleford@nurses.ab.ca

CALGARY/WEST

PANASAC 2013 WORKSHOP (PERI-ANESTHESIA NURSES ASSOCIATION, SOUTHERN ALBERTA CHAPTER)

The submission deadline for events and reunions in the Spring 2013 issue of Alberta RN is Feb. 15, 2013. Go to www.nurses.ab.ca for a complete and up-to-date listing of events and reunions or to submit an event for publication.

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It’s no secret that I am passionate about primary health care. One of my first messages in Alberta RN focused on my belief in the importance of primary health care (PHC) in helping patients receive timely access to the services they need for diagnosis, treatment and management of their health conditions. I believed then, and still believe now, that PHC holds the promise of creating a health-care system that is more responsive, more efficient and more compassionate.

In part, my interest in PHC is the result of my own experiences as a registered nurse. I began my career as a public health nurse in Manitoba, where I saw how important it was for patients to get timely access to the right health-care services and support. I later went on to establish the first PHC unit within the provincial department of health, and later assumed the position of director of primary care and program integration with the Winnipeg regional health authority.

But, in large part, my interest in PHC derives from the fact that its focus on putting patients first, listening to their needs and concerns, and helping them access the health-care provider that is right for them, mirrors the registered nursing profession’s commitment to delivering expert, compassionate care. PHC supports the core tenets of our profession.

It is for all of these reasons that I was so honoured to be invited to sit as a member of the Government of Alberta’s Primary Health Care Strategy Working Group. The group was tasked with guiding the development of a provincial Primary Health Care Strategy and offering advice and insight relating to PHC. It’s an important part of Alberta’s ongoing, long-term commitment to make primary care available to more Albertans.

In 2003, the province introduced the Primary Care Network (PCN) model to improve access to family physicians and other health-care providers. Since then, 40 physician-led PCNs have been established across the province, encompassing almost 2,500 family physicians and approximately 600 other health-care providers – including registered nurses and nurse practitioners. The work of those RNs and NPs has helped demonstrate the value of the primary care approach, and paved the way for future PHC models of care.

One of those models is already in place. Earlier this year, the government announced plans to open Family Care Clinics (FCC) across the province to further enhance Albertans’ access to primary care. To date, three FCC clinics have opened – one each in Slave Lake, Calgary and Edmonton. It is expected that more FCCs will open in communities across Alberta in the coming years and will be tailored to meet the needs of each community.

As a champion of primary care, I am heartened by Alberta’s investment in these PHC models. I am particularly impressed by Minister Horne’s enthusiasm and commitment to the PHC approach and his recognition of the important role RNs and NPs can play in primary care. The skill, knowledge and experience that RNs and NPs bring to their work make them ideally suited to primary care. From patient care and health promotion, to program development and case management, RNs and NPs will play a critical role in developing and delivering expert primary care to Albertans.

Members of the Primary Health Care Strategy Working Group were chosen based on their in-depth knowledge and expertise in PHC delivery, administration, research, education, and community development – not because of their involvement with any particular organizations. Although the experiences and insights of the group are varied, we are united by our commitment to creating a PHC system that will give Albertans the access, expertise and services they deserve.

I was especially delighted to see Muriel Davidson, a nurse practitioner with the Slave Lake Family Care Clinic, appointed as the group’s co-chair. Her invaluable first-hand PHC experience will ensure members understand the challenges and opportunities primary care models offer to patients and health-care providers.

It is exciting to realize that we are in the process of shaping a future where every Albertan has access to the care they need, and where there will be a greater understanding and synergy between health-care providers. I am grateful for the opportunity to contribute to the group’s ongoing work and look forward to updating you on our progress.
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