Revised Medication Guidelines

How will these changes affect your nursing practice?

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what can registered nurses do?

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Hands down, the best part of this job is traveling around Alberta, meeting RNs and NPs and discussing the issues faced in practice. During my last three tours, I had opportunities to talk with many members whose practice is focused on the care of older adults—they spoke with me about some of the joys and frustrations of providing care for older adults in Alberta. The Wentworth Care Facility in Calgary, for example, is working on improving its focus on truly resident-centred care, an initiative that is changing attitudes as well as care delivery. Sometimes, I am told, there is the risk of losing sight of the unique human being before us in the rush to collect data and information for required documentation.

The idea is simple, but powerful: focus on the resident first—and it is making a real difference. For nurses in Standoff, the challenge is lack of staff and structures needed to address the care of dementia patients. At all residential care facilities, I am told that although “aging in place” is an important concept, we have a great deal of work to do in Alberta to make this a feasible reality.

You and I know that the vast majority of older adults live independently in their own home rather than in institutions. And our communities are changing; by 2031, one in five Albertans will be an older adult. The most rapidly growing segment of older adults is over age 85, and over 90 percent of older adults in Alberta live with more than one chronic disease. Dementia is, and will continue to be, a growing issue.

We have just started to grapple with the fact that close to 80 percent of current nursing home residents in Alberta live with dementia. Further, we know that most of us wish to live in our own homes as we age, with appropriate supports as needed. This will require a renewed emphasis on home care—and a much better connection between home care and primary care.

These realities, as well as your feedback over the last year, led CARNA to develop the Older Adults Policy Pillar: Taking Action. The pillar was developed using a rigorous, evidence-informed process including consultation with many of you, as well as with groups representing Alberta’s older adults and interested groups. The Alberta Gerontological Nurses Association (AGNA), one of our specialty practice groups and a leader in promoting excellence in geriatric nursing, was a key stakeholder in the development of the policy pillar.

It is our plan to use this pillar to inform coordinated action to support the health and health care of older Albertans. As a first step, we are planning a stakeholder forum in April to move the pillar’s recommendations and strategies forward. The forum will centre on the four key strategic areas identified in the pillar:

- Optimizing health and well-being of older adults by strengthening health promotion and preventing disease and injury.
- Optimizing community-based care and supports when needed by responding effectively to the needs of older adults.
- Strengthening the provision of continuing care services.
- Building older-adult friendly communities.

CARNA has a number of strengths to draw upon as we move this important work forward. We have the knowledge and commitment of nursing experts—thousands of Alberta RNs and NPs who are already engaged in and focused on improving the health and health care of older Albertans. We have special insight and knowledge into how communities and systems of care can be strengthened and improved to better meet the needs of older adults. We are also very active in the primary health-care policy agenda in Alberta—work that is an essential foundation for improving the health of older adults and all Albertans.

Remember George Burns? He lived to be 100 years old, so he knew what he was talking about when he said: “it’s important to look to the future...after all, that’s where you are going to spend the rest of your life.” With the pillar as our foundation, we will be engaging with you, the public, government and other key stakeholders in dialogue around policies and systems that will help us create that future together.
As we become more skilled in reflecting on our practice, we have a better appreciation for the feedback we receive from others. We all have blind spots and can recognize the value that our colleague’s perspectives bring to our own development. Helping each other understand what we can do better also benefits the quality of the care we provide and helps ensure patient safety. On the flip side, not providing feedback can result in missed opportunities for self-improvement as well as missed opportunities for improved patient care (Altmiller, 2013).

Our practice is governed by standards that outline what is expected of us. These practice standards help us make decisions and provide a measurement for our performance. Several of these standards include indicators that reinforce the expectation that nurses provide feedback to each other.

For example:

* The nurse questions policies and procedures inconsistent with therapeutic patient/client outcomes, best practices and safety standards (PS* 1.3)

When we practise according to this standard, we understand that we have a responsibility for the care decisions we make. We remember times when we have asked ourselves “is this the right intervention?” but do we as readily ask that question of others? When we help others develop insight into their practice, we are ensuring safe, client-focused care is being delivered.

* …communicates effectively and respectfully with…other members of the health-care team (PS 3.4)*

Constructive feedback is a valuable form of communication, and strong communication provides the foundation for a strong team. Some feedback strategies include debriefing after stressful situations to evaluate the effectiveness of team communication, look for areas that might be improved, and openly share their ideas (Altmiller, 2012).

* …collaborates with…other members of the health-care team… (PS 4.2)*

Collaboration requires a willingness to share responsibility for providing safe care. This means that each nurse sees their own role in the success of every other member of the team, and looks for ways to support their practice.

* …effectively assigns care of nursing service and supervises others… (PS 4.3)*

When delegating care to others, the nurse assesses the care required, communicates this clearly, and provides the appropriate level of supervision to ensure that care is provided safely. What may be missed is the important last step: to evaluate the outcome of the care and to provide feedback on what went well and what improvements could be made (Altmiller, 2012). This is important whether supervising other nursing or non-nursing staff as well as students. Nurses demonstrate leadership and mentorship through feedback they provide and help others develop effective feedback techniques that they can integrate into their own practice (Altmiller, 2012).

* …engages in and supports others in the continuing competence process (PS 5.7)*

Feedback helps us improve our practice. Through the continuing competence process, we assess our own practice and determine what we need to focus on for our professional development. By asking those we respect for their input into this decision, we are ensuring that our self-assessment is accurate and that we are focused in the right direction.

* Practice Standard
What can we learn from feedback?

We all love praise. Who doesn’t want to hear how they are doing a great job? But when we focus only on what we do well, we may overlook what we could do better. Digging deeper means taking a risk—and taking risks can be scary.

One study done with nurses on the role of feedback in practice competence (Faraday, 2006) found the following general themes:

- Feedback provides reinforcement and affirmation.
- If feedback isn’t received, we assume “all is well.”
- We value informal peer feedback over more formalized performance reviews.
- Feedback raises our self-awareness and helps us problem-solve when we are uncertain.
- Sharing experiences encourages self-reflection, in this way we learn from others and others learn from us.

These themes highlight the role that others play in our professional development. Giving and receiving feedback is an opportunity to learn and grow. Feedback doesn’t have to be scary; it’s a supportive conversation between professionals that focuses on improvement using a positive and forward-thinking approach (Fowler, 2011). These are the conversations nurses have every day.

When we provide constructive feedback to our nurse colleagues, we are showing our commitment to their learning and reinforcing the importance of what they do. We are also telling them that we value them and their practice, and that we appreciate them as a team member.

This year, challenge yourself to collect and share constructive feedback with your peers!

Want to talk about ways to enhance your feedback?
Competence staff would be happy to help. Contact us at continuingcompetence@nurses.ab.ca or call 780.732.9511, or 1.800.252.9392, ext. 411. RN

REFERENCES

2015 Registration Fees

PROVINCIAL COUNCIL APPROVED AN INCREASE to registration fees for the 2015 practice year to fund an increase in fees paid by CARNA per member to the Canadian Nurses Protective Society (CNPS).

In addition, the CARNA fee increased by 1.4% to account for inflation as approved by council in May 2012. The increase is based on the annual Alberta Consumer Price Index (CPI) as published by Statistics Canada.

The total fee increase, including the CNPS fee increase, 1.4% inflation increase and GST, is $11.03 for registered nurses, $17.86 for nurse practitioners and $11.03 for certified graduate nurses.

<table>
<thead>
<tr>
<th></th>
<th>2014 FEE</th>
<th>2015 FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurse</td>
<td>$555.90</td>
<td>$566.93</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>$603.15</td>
<td>$621.01</td>
</tr>
<tr>
<td>Certified Graduate Nurse</td>
<td>$503.40</td>
<td>$514.43</td>
</tr>
</tbody>
</table>

FOR MORE INFORMATION about the professional liability protection and legal services provided to regulated members by CNPS, please visit [www.cnps.ca](http://www.cnps.ca).

RENEWAL is just around the corner!
Did you know you can get a HEAD START on your Continuing Competence requirement?
Spend less time renewing in the summer by completing your 2014 continuing professional development today!
Log in to MyCarna at nurses.ab.ca/mycarna to get started.
Policy and Practice (P&P) consultants provide support to regulated members through confidential consultation regarding issues that directly or indirectly affect the delivery of safe, competent and ethical nursing care. Consultation calls are confidential and provide direct service to our members and the public. These calls also assist in the identification of trends and issues of importance to registered nurses and the health system.

Methodology
We hired an external consultant to complete an evaluation using a triangulation approach using multiple methods, sources and types of information. The evaluation was carried out in fall of 2013 to identify areas to improve how we support you in your professional practice.

An online survey, individual interviews and review of retrospective secondary data were used to help paint a picture of past and present opportunities and potential improvements.

What did we want to know?
We wanted a greater understanding of the value, use and impact of the support and information provided to individuals and groups calling for a confidential consultation.

What is the awareness and knowledge of P&P within our membership? What are the outcomes of the consultation, and who is the member population that is calling for assistance?

What did we learn?
The evaluation results identified trends, gaps and issues of priority for members. The results also provided a greater understanding of the value and impact of the support and information we provide to those who call for a confidential consultation.

Respondents who called P&P indicated that 77 percent of the time, the information and consultation process changed personal and professional practice.

It is valuable to understand that the consultation process is changing behaviour of RNs.

Level of impact of P&P consultations in percent

Requests for consultation are not related to the growth in the number of Alberta RNs and NPs. The volume of P&P calls has no predictability and appears to be most related to the issues and the changes happening externally in the health system.

Change over time of CARNA membership and P&P calls in percent

Over half of respondents indicated they had concerns related to nursing standards or nursing care in their professional role.

Action taken by total population in percent\(n=2433\)
Who contacts practice consultants

Forty-eight percent of CARNA members in 2013, 2011 and 2004 reported having little or no awareness of the policy and practice consultation unit. The report highlights significant differences in level of engagement, noting factors like:

- age;
- rural vs urban; and
- private vs public workplace.

We found that age is a factor in who contacts a practice consultant. **A significant number of RNs under age 40 are not aware the program exists.** However, RNs over age 40 have a greater awareness and knowledge of the service and are more likely to call for assistance.

**Level of awareness, knowledge and future action related to age in percent**

<table>
<thead>
<tr>
<th>Awareness</th>
<th>Knowledge</th>
<th>Likely to contact P&amp;P</th>
</tr>
</thead>
<tbody>
<tr>
<td>29%</td>
<td>18%</td>
<td>20%</td>
</tr>
<tr>
<td>19%</td>
<td>11%</td>
<td>36%</td>
</tr>
<tr>
<td>30%</td>
<td></td>
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</tbody>
</table>

RNs who self-declared as younger were also more hesitant to call P&P for consultation. They are unsure of the level of confidentiality with the calls and the potential for retaliation from employers of CARNA for discussing practice issues.

**Where a nurse practises geographically also makes a difference to their knowledge of the service and likelihood of calling a practice consultant.** Most members used organizational resources to resolve issues before contacting the confidential consultation service.

**Members working at least 50 km or more away from major centres that have Level 1 Trauma facilities are more likely to call if there is a concern.** There is evidence that demonstrates it is harder to recruit and retain health-care professionals in more rural and remote areas. RN support from peers and organizational supports for patients and practice can become more difficult to access with increasing geographical distance from the supports provided in larger urban centres.

**Level of awareness, knowledge and future action by practice location in percent**

<table>
<thead>
<tr>
<th>Awareness</th>
<th>Knowledge</th>
<th>Likely to contact P&amp;P</th>
</tr>
</thead>
<tbody>
<tr>
<td>26%</td>
<td>17%</td>
<td>33%</td>
</tr>
<tr>
<td>26%</td>
<td>16%</td>
<td>39%</td>
</tr>
</tbody>
</table>

Nurses working in a privately-delivered setting were more likely to call when they had a concern as compared to those working in a public setting. Further analysis showed a correlation between a person’s age and the type of employer.

Nurses working in a privately-delivered health service settings were older than those in public settings. This reaffirms findings of age being related to level of awareness and knowledge of practice consultants.

What happens next?

The results of the evaluation have helped us discover areas of improvement and opportunities to better serve our members.

The health system is complex and organizational/societal changes to the models of health care to different populations are unpredictable. We need to ensure that, as the volume of calls by members for consultation increases, CARNAs are able to quickly respond. We will continue to monitor call response times to continually improve this service.

In 2013, P&P reviewed how issues are identified and defined at the aggregate level. Improving the classification of issues and trending them provides the opportunity to be proactive in developing targeted information and advocating for member issues and public safety.

Given that younger members are significantly less aware of the consultation program, CARNA is working on ways to reach out to that demographic. We want them to be aware of the services available to them and to feel empowered and assisted through the process of professional consultation. We welcome younger members’ suggestions and feedback.

One area of focus is to make practice information more accessible to members. Our website is being updated and we are increasing social media exposure of the consultation services to increase awareness and strengthen engagement with members.

Thank you to the members who took part in this evaluation process.
If you have a question or concern about nursing, either in a practice setting or in general, contact a practice consultant at practice@nurses.ab.ca, 780.451.0043 or toll-free at 1.800.252.9392. **RN**
2012-2013 Summary of CARNA Practice Consultations

By CARNA Policy and Practice Consultants:
Debra Allen, RN, MN; Penny Davis, RN, MN; Donna Harpell Hogg, RN, MS; Pam Mangold, RN, MN; Debbie Phillipchuk, RN, MN.

CARNA policy and practice consultants provide confidential consultation to a variety of individuals and groups regarding issues that directly or indirectly affect the delivery of safe, competent and ethical nursing care. Regulated members of CARNA are the primary users of practice consultation followed by members of the public, employers, administration, other health-care professionals, government and others.

CARNA recognizes that rapid changes take place in the economic, political and socio-demographic environments that impact Alberta’s health-care system. The annual review of practice consultations helps CARNA identify issues that affect nursing practice within this changing environment.

<table>
<thead>
<tr>
<th>Consultation Issue Category</th>
<th>2010 Practice Year</th>
<th>2011 Practice Year</th>
<th>2012 Practice Year</th>
<th>2013 Practice Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope of Practice</td>
<td>201 (20%)</td>
<td>194 (18%)</td>
<td>269 (29%)</td>
<td>404 (30%)</td>
</tr>
<tr>
<td>Legal/Ethical</td>
<td>238 (24%)</td>
<td>291 (27%)</td>
<td>196 (21%)</td>
<td>289 (21%)</td>
</tr>
<tr>
<td>Nursing Practice Standards</td>
<td>218 (22%)</td>
<td>185 (17%)</td>
<td>155 (17%)</td>
<td>224 (16%)</td>
</tr>
<tr>
<td>Information/Networking</td>
<td>96 (10%)</td>
<td>132 (12%)</td>
<td>33 (4%)</td>
<td>147 (11%)</td>
</tr>
<tr>
<td>Safety</td>
<td>111 (11%)</td>
<td>90 (8%)</td>
<td>158 (17%)</td>
<td>126 (9%)</td>
</tr>
<tr>
<td>Health Care Reform</td>
<td>43 (4%)</td>
<td>63 (6%)</td>
<td>-</td>
<td>77 (6%)</td>
</tr>
<tr>
<td>Relationships</td>
<td>18 (2%)</td>
<td>15 (1%)</td>
<td>41 (4%)</td>
<td>42 (3%)</td>
</tr>
<tr>
<td>Transitions/Independent Practice</td>
<td>13 (1%)</td>
<td>64 (6%)</td>
<td>40 (4%)</td>
<td>21 (2%)</td>
</tr>
<tr>
<td>Education</td>
<td>12 (1%)</td>
<td>15 (1%)</td>
<td>3 (&lt;1%)</td>
<td>21 (2%)</td>
</tr>
<tr>
<td>Public Health Issues</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>6 (&lt;1%)</td>
</tr>
<tr>
<td>Graduate Nurse</td>
<td>13 (1%)</td>
<td>12 (1%)</td>
<td>17 (2%)</td>
<td>-</td>
</tr>
<tr>
<td>Internationally-Educated Nurses</td>
<td>17 (2%)</td>
<td>6 (1%)</td>
<td>4 (&lt;1%)</td>
<td>-</td>
</tr>
<tr>
<td>Pandemic</td>
<td>30 (3%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total Consultations</td>
<td>1,010</td>
<td>1,067</td>
<td>916</td>
<td>1,362</td>
</tr>
<tr>
<td>Unable to respond*</td>
<td></td>
<td></td>
<td></td>
<td>186</td>
</tr>
</tbody>
</table>

1 Regulated members include: registered nurses (RN) graduate nurses (GN), certified graduate nurses (CGN), nurse practitioners (NP) and graduate nurse practitioners (GPN).

* Requests received but attempts to follow-up were unsuccessful.
It was evident in many of the consultations that issues in the health-care system affected the circumstances of a practice setting issue and the health-care environment. We believe that sharing information on the trends and issues that have been identified in the review of practice consultations can lead to proactive discussion about the changes that are needed in the health-care system to support RNs and NPs in providing safe, competent and ethical nursing care. It can also identify the gaps where policy development may be needed to guide practice.

Communicating these trends publicly provides an opportunity to advocate for nursing leadership that encourages professional excellence and influences the development of evidence-informed health policy.

Highlights from the 2012-2013 annual review of consultations include:

- The highest number of consultations over the last four years has been related to scope of practice, legal/ethical and nursing practice standards.
- The category with the highest number of consultations was scope of practice, followed by legal/ethical, nursing practice standards, information/networking, and safety.
- The number of consultations for all categories except the safety category has increased.
- Overall the number of consultations has increased.

The issues discussed with the policy and practice consultants were complex and involved multiple factors influencing practice. In some instances, solutions to issues were multi-faceted, required collaboration with others and required a variety of strategies over a period of time to address the issues identified during the consultation.

**SCOPE OF PRACTICE**

Scope of practice issues evolve as the practice settings and roles for nursing practice are pushed by technology and health-system demands.

The majority of calls in this category were related to questions about whether they could or should integrate a new restricted activity intervention into the RN scope of practice in a specific practice setting. Specific examples included questions about:

- RNs administering Botox as a cosmetic procedure in a medical spa or physician office in the absence of an authorized prescriber;
- whether an RN practising in a primary care network could perform a pap test;
- Peg tube reinsertion for a client in home care or a long-term care setting;
- foot care;
- performing a bladder scan;
- splinting a fracture;
- using ultrasound technology to check placement of a PICC line;
- ear syringing; and
- sharp wound debridement.

It is important to note that Botox is a Schedule 1 drug and the administration of this drug by a RN requires that a client be seen by a physician or other authorized prescriber who would then provide a client-specific order for the drug.

Some other examples of interventions that were discussed were questions about when the regulation that will authorize RNs to prescribe in defined practice settings would come into effect and interpreting laboratory data. Other calls were context- and practice-setting specific. For example, how they could become competent when moving into a different practice setting and learning how to perform a new intervention that is common in the new setting.

CARNAs members continue to be concerned about describing the unique contributions of registered nurses and enacting the full scope of practice in their place of employment. They also want to minimize the focus on the overlap on the scope of practice with other health professionals.

In these kinds of questions about scope of practice, resources such as Nursing Intervention Classification (2013) and the Entry to Practice Competencies for the Registered Nurses Profession (2013) along with the document Scope of Practice for Registered Nurses (2011) were used to explain and describe the competency profile of a registered nurse.

A number of consultations focused on clarifying the role and responsibilities of the graduate nurse (GN) and whether the GN could be in the charge role; the length of time required for orientation before the GN could work independently of their mentor; and questions about whether there were any restrictions to the restricted activities a GN could perform.

The CARNAs interpretive document The Graduate Nurse: Scope of Practice (2009) provides information to increase understanding of the scope of practice of graduate nurses and provide guidance for GNs and for RNs in practice settings where GNs are employed. This interpretive document also provides information for managers, administrators, other health-care providers, employers and stakeholders within the health-care system.

Scope of practice questions from nurse practitioners were primarily related to prescribing controlled drugs and substances and the requirements of CARNAs prior to authorizing NPs to prescribe these medications.

**LEGAL/ETHICAL**

Documentation

Clear and objective documentation is ultimately good risk management and the most frequent legal issue identified in the 2013 practice year was about documentation. Regardless of the format used to document, the client care record is a formal, legal document that details a client’s health care and progress.

Documentation concerns included questions about policy for backup of electronic records; application of documentation policies for a paper health-care record and the challenges of applying these same policies to the point of care electronic health record; lack of clear direction on how to co-sign...
medications in the electronic health record; whether to document the name of another staff member in the patient record; questions about policy for the use of abbreviations; and documenting a late entry and the overall concern about the lack of time to document care. A smaller number of consultations related to student documentation and co-signature of documentation by a student with a preceptor or a RN also assigned to the client.

The CARNATA document Documentation Standards for Regulated Members (2013) outlines the professional regulatory requirements that will assist members in producing clear, accurate and comprehensive accounts of client care within any practice setting. Members were also encouraged to consult other relevant resources available from the Canadian Nurses Protective Society (CNPS) at www.cnps.ca.

The increased number of unregulated workers in our health system raised questions about who documents on the patient record. It is the responsibility of all providers to ensure that changing clinical conditions or emerging problems are promptly reported and documented. Often the first step in addressing a concern about who and what is documented in the patient record is to clearly identify what the issue is and then alert the manager about the concerns.

Professional Boundaries

There were several consultations related to the RN’s responsibility for maintaining therapeutic boundaries and included issues such as providing nursing interventions to friends or family members, questions related to conflict of interest, accepting gifts from patients and whether having a social relationship with a patient outside of the practice setting was acceptable.

The CARNATA document Professional Boundaries for Registered Nurses: Guidelines for the Nurse-Client Relationship (2011) provides information and guidance about appropriate professional boundaries for nurse-client relationships.

The guidelines also apply to registered nurses in teaching relationships with students, working with research participants, managing staff and in working relationships with co-workers. The potential for harmful boundary incidents is decreased when there is good understanding of the issues involved.

The ability to establish and maintain therapeutic boundaries with clients is an essential component of safe, competent and ethical nursing care. The obligation to maintain healthy professional boundaries lies with every registered nurse, not with the client.

The values of the CNA Code of Ethics for Registered Nurses (2008) were also an important resource used to explore concerns and provide guidance. The Code of Ethics outlines nurses’ ethical responsibilities and guides them in their reflection of practice decision-making.

Protecting/Disclosing Health Information

RNAs and NPs want to ensure that health information is protected and disclosed in accordance with legal and ethical requirements, while balancing this with reasonable steps to ensure that client records are accessible for continuity of care for clients.

In this review, questions regarding the RN responsibility to protect the confidentiality of health information in a variety of settings continued to be asked consistent with the trend identified in previous annual reviews of consultations. There were concerns with how information was shared, how much information was to be shared, questions about security with texting and use of email in sharing health information, clients asking to read their own health-care record and the length of time required for retention of records.

The CARNATA document Privacy and Management of Health Information: Standards for CARNA’s Regulated Members (2011) builds upon the Practice Standards for Regulated Members and the CNA Code of Ethics for Registered Nurses to identify standards for maintaining privacy and confidentiality as well as the management of electronic records, including their information, protection, privacy and security.

One example of the direction provided in this document is that client records must remain accessible for a period of 10 years following the date of last service. For minors, the record must be accessible for a period of 10 years or two years past the patient’s age of majority, whichever is longer.

A variety of additional resources were also referred to such as consultation with the Canadian Nurses Protective Society and consultation with the Office of the Information and Privacy Commissioner of Alberta when considering legal implications of disclosing health information. CARNATA has also developed a self-directed learning resource called Privacy Education Modules that is posted on our website at www.nurses.ab.ca/privacy.

Other

Throughout the 2013 practice year, other legal/ethical questions raised were:

- the need for additional liability protection;
- liability risks associated with the performance of particular, and in some instances high-risk, nursing interventions;
- use of the title of RN and NP;
- informed consent; and
- questions about performance management process.

NURSING PRACTICE STANDARDS

The Practice Standards for Regulated Members (2013) are foundational in supporting nurses in their practice, giving them a framework to ask questions in a proactive way and identify concerns, issues and solutions in their practice setting. The practice standards represent criteria against which the practice of all regulated members will be measured by CARNATA, the public, clients, employers, colleagues and themselves.

Medication Management

Medication practice questions merged with questions about scope of practice, responsibility and accountability, and safety.
Regardless of the starting point for the consultation, ultimately the advice given was grounded in the CARN A medication guidelines and the instruction in this document on the various components of safe and effective medication management in the practice setting.

The concerns related to medication practices included: co-signing for medications, verbal orders, transcribing a medication order, phoning in prescriptions, administering medications poured by someone else, addressing break-through pain and prn range dose medication orders, the implementation of protocols that included either over-the-counter medications or Schedule 1 medications, providing repeat prescriptions and nurses recommending the use of over-the-counter medications to clients.

The number and variety of questions and concerns related to medication practices verified that the review of the Medication Administration Guidelines (2007) that was already in progress was timely and relevant. Nurses needed and wanted guidance and answers from CARN A to their questions on medication practices. The revised document was approved by Provincial Council in January 2014 and the title was changed to Medication Guidelines to be more inclusive of all aspects of medication management. Revisions to the document included:

- providing clarity to the section on range dose;
- providing explicit information about over-the-counter medications;
- a guideline regarding implementation of a protocol that includes a Schedule 1 medication;
- adding guidance on using two-identifiers to identify the client prior to medication administration; and
- adding sections related to current best medication practices on medication reconciliation, infection control practices and prevention.

Also noted were a number of questions about responsibility and accountability when being a volunteer. Several consultations were related to public health issues with questions being asked about flu immunization in a pharmacy setting as well as general flu immunization program questions.

As physician assistant pilot projects were introduced and implemented late in the 2013 year, a small number of consultations were received where questions were related to practising with a physician assistant and the role and responsibilities of the different health-care providers. CARN A posted a question and answer information sheet about physician assistants on their website to provide answers, direction and clarity around accountability for nurses in this situation.

INFORMATION/NETWORKING

Questions arising in this category related to a variety of topics with the largest number of consultations being questions about the registration process that were subsequently referred within the CARN A office. Other consultation questions included: requirements for CPR in the workplace, hours of work and salaries, continuing education courses and certification requirements.

Safety

Safety concerns related to staffing included shortages of staff, changes to staff mix and unsafe practitioners. Concerns were raised specifically in regards to decreasing the overall staffing number, changing the staff mix to a greater number of non-regulated staff, and a perception that the focus had become one of doing the task rather than the knowledge and skill required to assess and make sound decisions.

Another concern related to safety was a lack of resources. Nurses shared that they had to leave patients unattended, no room was available to isolate a patient who was infectious, employer policies were out-of-date and there was lack of availability of physicians to attend clients.

Other concerns were reassignment of nurses to a different practice setting due to shortage of staff and disruptive behaviour of staff. Several of the concerns related to medication management and medication errors that had not been reported and not using the seven rights of medication administration; changing a treatment plan without consultation; medication administration by unregulated health-care providers; and not observing a patient taking their medication.

There were a few consultations about fitness to practice. Some of the concerns that were identified in the review of consultations were poor judgment, lack of critical thinking, inability to prioritize care, problematic substance use and working with a disability. Fitness to practice is defined as all the qualities and capabilities of an individual relevant to his or her capacity to practise as a registered nurse, including but not limited to, freedom from any cognitive, physical, psychological or emotional condition and dependence on alcohol or drugs that impairs his or her ability to practice nursing (CNA, 2008). The same coping skills we teach clients are relevant in our own lives and it is important to identify if you need help.

In responding to the identified concerns, the CARN A document Working Extra Hours: Guidelines for Registered Nurses on Fitness to Practise and the Provision of Safe, Competent, Ethical Nursing Care (2011) was used to assist in problem-solving and the development of practical approaches.

General concerns about safety included questions about how to submit a complaint to CARN A when concerned about the practice of a nurse; concern about the poor performance of a RN or NP under supervision; not following through with orders; lack of responsibility and accountability in the care (or lack thereof) that was provided; and concerns with the practice of other health-care providers.

GROUP CONSULTATIONS

In addition to the consultations listed above, more than 500 individuals across Alberta participated in 19 group consultations or discussions facilitated by CARN A policy and practice consultants in response to complex issues that arose within practice settings.
This year’s AGM was held at the CARNA office on Jan. 22, 2014, prior to the regular meeting of Provincial Council on January 23–24.

In addition to the 23 eligible voting members in attendance, over 30 people watched the live webcast of the AGM. Three resolutions were submitted, with one carried by the 23 voting members in attendance. Provincial Council will consider the resolution Voting at Registration at their next meeting in May 2014.

RESOLUTION ADOPTED

That, resolutions passed at CARNA annual general meetings will be put to CARNA members through an electronic process to give direction to Provincial Council.

CARNA Provincial Council is required, according to CARNA Bylaws, to consider resolutions that receive a majority vote at the AGM and report its decisions to members. Provincial Council is to determine:

- if the resolutions merit amendment of council policy
- if they are inherent in directions already delegated to the chief executive officer, or
- if there are compelling reasons not to implement the resolutions

Council encourages members to submit resolutions at the AGM because they provide:

- a forum through which regulated members are able to raise issues of importance
- proposals for policy direction for College activities

CARNA President Shannon Spenceley

MEDICATION GUIDELINES APPROVED

Provincial Council approved the revised Medication Guidelines (January 2014).

This document provides regulated members with a framework for decision-making based on current best practice and additional clarity about medication practices, protocols and OTC (over-the-counter) medications. The revisions were based on a literature review; a scan of similar documents by other colleges; and feedback solicited from employers, educators, specialty practice groups, the United Nurses of Alberta and a random sample of 1,000 members. In addition, CARNA had sought a legal opinion on the interpretation of regulations and legislation related to RNs recommending OTC medications and dispensing sample medications.

The revised guidelines updated the previous CARNA document dated 2007 and may prompt a review of medication policies and protocols in health-care organizations. Read more on page 16.

APPROVAL OF NP ENTRY-TO-PRACTICE EXAMS

Provincial Council approved the exam offered by the Pediatric Nurse Credentialing Board (PNCB) as the registration exam for entry-to-practice nurse practitioner applicants to the pediatric stream in Alberta effective April 1, 2014.

Council approved the adult-gerontology exam offered by the American Academy of Nurse Practitioners Certification Program (AANPCP) as the registration exam for entry-to-practice NP applicants.
to the adult stream in Alberta effective May 1, 2014.

Council also approved recognition of equivalent PNCB pediatric NP exams and AANPCP adult-gerontology exams as meeting the NP exam requirement for CARNA registration in the case where the applicant has passed the exam in the United States and holds current American certification as an NP.

These decisions follow a comprehensive analysis of NP exam options recommended by the Council of Canadian Registered Nurse Regulators and undertaken by a psychometrician reporting to the national NP Exam Ad Hoc Committee.

PROPOSED CHANGES TO CARNA ELECTION PROCESS

Provincial Council approved revisions to Bylaw 10 Election Process for posting on the CARNA website to provide an opportunity for member feedback. Council will vote on final ratification of the revised Bylaw.

The proposed revisions change the timing of the annual Provincial Council election from July to May and significantly shorten the campaign period as follows:

- Election campaigning end date will change to May 15 (was July 10).
- The election polls will be open May 1–15 (was June 1–July 10).
- All references to the Elections and Resolutions Committee (ERC) will be changed to Nominations Committee to reflect the dissolution of ERC and the creation of the Nominations Committee.

See the result of the vote at bit.ly/2014PCElection

REVISIONS TO THE CONTINUING COMPETENCE PROGRAM

Council approved two recommendations submitted by the Competence Committee:

- Developing examples of draft learning plans to facilitate understanding by initial registered nurse applicants of their professional responsibilities in relation to CCP.
- Eliminating specific indicators in MyCCP which have consistently led to confusion between one’s professional accountability to meet practice standards and a concurrent responsibility to annually prioritize a focus for one’s development of their professional practice. The two indicators which will be excluded for the purposes of CCP are the following:
  - 5.1 The nurse maintains current registration.
  - 5.9 The nurse ensures their fitness to practice.

NEW SPECIALTY PRACTICE GROUP

The Canadian Orthopaedic Nurses Association (CONA) – Alberta Chapters was recognized as a CARNA Specialty Practice Group, bringing the total number of SPGs to 17. Both Calgary and Edmonton have a local chapter of CONA.

Learn more about CONA at www.cona-nures.org

CNA MEMORIAL BOOK

Provincial Council nominated Dr. Christine Newburn-Cook for consideration by the Canadian Nurses Association for inclusion in the Memorial Book. Dr. Newburn-Cook, a University of Alberta professor from 1996-2011, demonstrated her commitment to international nursing through building research capacity in Pakistan and establishing the internationally-recognized Health Research Data Repository.

The Memorial Book was established by CNA in 1988 to honour deceased nursing leaders and recipients are selected annually. Their names and a 150-word biography are inscribed in the Memorial Book.
A Hearing Tribunal made a finding of unprofessional conduct against a graduate nurse who posted inappropriate comments about a patient on Facebook. The patient was not named, but there was sufficient detail for staff to recognize the patient. The member was given a reprimand and required to complete the e-modules on the Code of Ethics.

CARN A Member

A Hearing Tribunal made a finding of unprofessional conduct against a member who, on one night shift, failed to document the decision made with the other nursing staff that shift to not do hourly physical checks on a patient who was supposed to be on close observation while in a seclusion room. The Tribunal issued a reprimand.

CARN A Member

A Hearing Tribunal made a finding of unprofessional conduct against a member who failed to document over four shifts the administration of Zopiclone to four patients and Gravol to one patient. The Tribunal issued a reprimand.

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inappropriately administered medication to the patient without checking whether it was the right medication, dose, route, time, reason or patient; inappropriately handled the patient with the result that the patient got elbowed in the face by the member; inappropriately laid hands on the security guard, causing him distress; inappropriately pushed the charge nurse; and spoke to her co-workers in an inappropriate and disrespectful manner. During another incident, the member spoke to a patient in a rude, disrespectful manner; spoke about the patient to the member’s co-worker in a very derogatory manner. During a third incident, when a colleague offered to assist the member by giving a patient oral medication, the member treated the colleague disrespectfully when she essentially told the colleague to ‘shut up’ and the member was unnecessarily harsh in her treatment of a patient when the member insisted on giving the patient I.M. medication to calm her down, even after she had calmed down and agreed to take oral medications from another nurse. The Tribunal issued a reprimand and accepted the member’s undertaking to not practise. In the event the member wants to return to nursing, she must first complete course work and pay a fine, undertake counseling and then provide satisfactory performance evaluations from her next employer, focusing on her interpersonal skills. Conditions shall appear on any current or future practice permit.

**CARN A Member**

**Registration number: 70,065**

A Hearing Tribunal made a finding of unprofessional conduct against member #70,065, who on one shift failed to document adequately on a patient and whose communication with that patient was inappropriate and upsetting to the patient, in that the member told the patient about the member’s daughter’s health issues, which was perceived by the patient to mean that the patient should ‘buck up’; and who was confrontational with the patient later that day about coming back to the department, suggesting that she should not be there, when in fact, the patient was in the department on the instructions of other staff. The Tribunal issued a reprimand and ordered the member complete the e-modules on the **Code of Ethics**. A condition shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARN A practice permit.

**CARN A Member**

**Registration number: 74,895**

A Hearing Tribunal made a finding of unprofessional conduct against member #74,895, who behaved inappropriately and disrespectfully toward co-workers when, on at least one occasion, he invaded a co-worker’s personal space and touched her without permission and during that same interaction spoke disrespectfully to the co-worker; he showed two co-workers obscene pictures on his cell phone; and he spoke to co-workers in a manner which has been described as vulgar, profane and offensive. The Tribunal issued a reprimand and a fine of $1,000. In addition, the member was ordered to undergo counseling focused on improvement of his communication skills and behaviours toward co-workers and all other persons in the workplace, and provide a satisfactory report from the counselor. The member was ordered to create and submit to the Tribunal and his employer a Workplace Communication/Behaviour Improvement Plan. The member is restricted to working for his current employer pending two satisfactory performance evaluations from the employer and two self-evaluations focused on his communication and interpersonal behaviours in the workplace. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARN A practice permit.

**CARN A Member**

**Registration number: 77,276**

A Hearing Tribunal accepted a section 70 admission of unprofessional conduct of member #77,276, who admitted to wrongfully pilfering narcotics from his employer, including injectable morphine, dilaudid and fentanyl and admitted to fraudulently using names of patients on the narcotic record to cover the theft of narcotics. The Tribunal gave the member a reprimand and accepted an undertaking to not practise as a registered nurse pending proof from a physician and counsellor that he 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 CARN A practice permit.

**CARN A Member**

**Registration number: 77,883**

A Hearing Tribunal made a finding of unprofessional conduct against member #77,883, who administered 5000 units of Heparin to a patient in error instead of the correct dose of 2500 units, and initially changed his charting to falsely indicate he had administered 2500 units when confronted with the error, and failed to report the medication error to the physician or the NP in a timely manner; and who caused a patient undue distress and discomfort when doing an I.V. start, and failed to document adequately regarding the I.V. start; and who caused a patient undue pain and distress when attempting to administer a suppository, and documented that he had given the suppository when he had not done so; and who placed an Oximierz over a patient’s mouth rather than nose, and failed to chart adequately regarding that patient. The Tribunal issued a reprimand and ordered the member to pass courses in interpersonal aspects of nursing, initiation of I.V. therapy (theory and lab), professional ethics and complete the e-modules on the **Code of Ethics**. The Tribunal also restricted the member to working at his current employment site pending two satisfactory comprehensive performance evaluations. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARN A practice permit.

**CARN A Member: Ariel Banjao**

**Registration number: 85,868**

A Hearing Tribunal made a finding of unprofessional conduct against Ariel Banjao #85,868 who, while working as a registered nurse in a hospital, assaulted a patient. The Hearing Tribunal issued a reprimand and cancelled the registration and practice permit of the member.
BY PAM MANGOLD, RN, MN

In January 2014, CARNA Provincial Council approved the revised CARNA Medication Guidelines. This document replaces the 2007 document Medication Administration Guidelines for Registered Nurses. We review our documents on a regular basis to ensure that they:

• are current and evidence-informed;
• are aligned with best practice;
• address changing needs, values and conditions that impact RNs in their practice;
• are consistent with relevant legal and regulatory requirements; and
• incorporate feedback obtained from our members and stakeholders.

A request for feedback on this document was sent to 1,000 random CARNA members. The request for feedback was also included in the AB RN Online enewsletter, the regional coordinators’ monthly Take Note enewsletter, and on the CARNA website. In addition, feedback was sought from the College of Physicians and Surgeons of Alberta, the Alberta College of Pharmacists and CARNA’s legal counsel.

What we heard from you:

• 75 per cent indicated that the guidelines are relevant and applicable to their practice setting.
• 86 per cent indicated that the guidelines provided information that they can use in their practice setting.
• 85 per cent stated that CARNA’s position was clear and that the guidelines were easy to read.
• Only 50 per cent of respondents agreed that all medication issues had been addressed in the 2007 document.

Feedback and review of best practices identified that clarification was needed regarding range dose orders, over-the-counter (OTC) medications and the use of protocols that included a Schedule 1 medication. As well, medication reconciliation, two client identifiers and infection prevention and control should be included in the revised document. All feedback was considered and incorporated into the revised 2014 document.
The top three revisions:
The three major areas strengthened and revised in the document were on the topics of range doses, OTC medications and implementing protocols.

Range doses:
The range dose section was modified to provide clarity about administering a medication within the timeframe ordered. For example, a medication order states:

Morphine 2mg-4mg IV q3h prn for pain

The RN, based on a comprehensive assessment and discussion with the patient, decides to administer 2 mg of Morphine IV for pain. If after one hour, the patient continues to report pain, the RN should not administer another 1–2 mg of Morphine based on this same order as the order identifies the timeframe as q3h, not q1h. Problems can occur when the unused dosage of a range dose order is used as a breakthrough pain medication order. In this example, administering another 1–2 mg of Morphine based on the same order is not permitted because of the accountability and risk for acting outside of the timeframe of the order and because it creates uncertainty as to when the next prn dose of Morphine could be administered. The RN must either use another existing break-through pain medication order or contact the authorized prescriber for further medication orders to address the patient’s pain.

Over-the-counter medication:
The revised document has added a section on OTC medication. The legal opinion that CARNA received outlines that while there is no legislation which specifically prohibits an RN from recommending an OTC medication, there is also no clear legislation that authorizes it. Therefore, it is prudent that RNs understand their responsibility to ensure that they have considered all of the factors relevant to making an OTC medication recommendation. Whenever possible, RNs need to support systems that allow patients to make informed decisions and self-select their OTC medication.

If nurses are involved in recommending or assisting patients in the selection of OTC medications or are implementing a protocol that contains an OTC medication, they are accountable for their decisions. They must:
- follow practice setting policies;
- involve the interprofessional team in setting up the policy framework; and
- have the knowledge, skill and competency to do so.

The safe recommendation of OTC medication requires processes that support the patient to make informed decisions about OTC medications. The RN involved requires knowledge and education regarding the actions of the specified medication and the possible interactions with current medications or complementary therapies, health conditions or diet.

Protocols:
CARN A has been asked by members and stakeholders for clarity regarding the implementation of protocols that contain a Schedule 1 medication. As part of the review of this document, a legal opinion was sought to confirm that our guidance for RNs on this issue was still legally sound. The legal opinion confirmed that relevant legislation and regulations support that an RN must have a patient-specific order from an authorized prescriber to implement the Schedule 1 medication within a protocol. The revised document includes this information. When an RN has determined that a specific patient meets the criteria outlined in a protocol and this protocol contains a Schedule 1 medication, the RN must contact the authorized prescriber for a patient-specific order. This authorization often occurs simultaneously as the RN implements other activities within the protocol.

Other general changes:
- The title was changed to Medication Guidelines to be more inclusive of all aspects of medication management and not just a focus on the administration of medications.
- Seven medication rights of medication administration were included instead of five. Although the literature is mixed on how many medication rights there now are, respondents felt that the right reason and right documentation needed to be added to the existing five rights.
- Sections were added related to current best medication practices such as medication reconciliation, infection control practices and prevention, and the need to use two identifiers to identify the client prior to medication administration.
- The section on administration of medications by others now includes a paragraph on administration of medications by student nurses.
- A guideline was added to clarify that pre-pouring medications is not best practice.

Where can I find this new medication guideline document?
To review the whole document, please visit our website at nurses.ab.ca/Resources>Document List>Medication Guidelines RN

If you have any questions regarding the revised Medication Guidelines, please do not hesitate to contact one of the CARN A policy and practice consultants at practice@nurses.ab.ca.
Medication Reconciliation: Working together in Alberta

BY: IAN CREURER BSP, ACPR; CHRISTINE LAZZER BSc, MPH; DAWN MCDONALD BSP, AC; GINGIE WELSH MPhil, BA

STORY #1

“You are a registered nurse working in an emergency department; an elderly patient has arrived by ambulance, pale and short of breath. The EMT hands you three prescription bottles he retrieved from the patient’s kitchen windowsill. You check the computer and find the chart from this woman’s recent hospitalization for congestive heart failure. The five prescriptions she was discharged with, and the bottles in front of you, are only a partial match. It’s Sunday evening, her doctor’s office is closed, and the prescriptions were filled at two different pharmacies. You ask her what medications she takes, and she says, “A small blue pill after breakfast and two big white ones at bedtime.”

(Adapted from the Institute for Healthcare Improvement, 2011)

This story shows how the exchange of information between health-care providers can impact the care a person receives.

Albertans with health issues typically interact with multiple health-care providers, and each provider may have some, but not all, of the information about the medications the person is taking. Medication-related decisions still need to be made and medication advice is still required with whatever information is available. Patients often expect that all health-care providers are looking at the same information and that the information is accurate and current. However, this may not be the case, partly due to the complexity of health-care provision and differences in record keeping, and also because the patient may have information that has not been shared.

Creating a “Best Possible Medication History” (BPMH) is a key step to bridging this gap. Building upon existing medication history-taking practice, a BPMH can bring together pieces of information from various providers, more rigorously verifying and validating the information about medications being taken, including vitamins, herbal products and over-the-counter medications. Then, a check can be performed with the patient or their family member or caregiver to determine how they are actually taking their medications, which may not be the same as how the medications were prescribed or dispensed.

Once this BPMH is available, any differences between what has been prescribed and what the patient is taking can be identified, resolved or reconciled, documented and communicated to other health-care providers to ensure information is updated, accurate, and available to everyone involved in a patient’s care. Providing the patient with a copy of the current medication list and explaining why
it is important when seeking health care encourages their participation in medication safety.

Creating a BPMH, reconciling differences, and documenting and communicating complete and accurate medication information is known as Medication Reconciliation (MedRec). MedRec is a structured process in which health-care providers work together with patients, families and care providers to ensure accurate and comprehensive information is communicated consistently across transitions of care.

The MedRec process helps community health-care providers access information once patients have been discharged from the hospital and are in their care. The use of MedRec can also reduce medication errors and adverse events (Pronovost, et al., 2003) (Vira, Colquhoun, & Etchells, 2006). MedRec improves communication between different health-care providers in community settings, and, if implemented when the patient is admitted to the hospital, tremendously improves the information available to AHS staff and physicians.

The common link between these care settings is the patient. Encouraging them to play an active role in their own care by maintaining an accurate medication list will improve their care in their most vulnerable moments.

Registered nurses are in an excellent position with their training, expertise and role as patient advocates to play an integral role in the MedRec process. This can include working with your patient to create an accurate medication list and being the communication link between the patient and the other health-care team members.

### STORY #2

“Recently, a patient was readmitted with symptoms of Syncope and dehydration, similar to their previous admission. During this admission, the registered nurse, familiar with the patient from the last admission, became concerned about the patient’s home medication use and asked for the medication vials to be brought in. While reviewing the home medications, the nurse quickly discovered the patient had been doubling her diuretic dose by taking BOTH Lasix and Furosemide without realizing they were the same medication.”

(Adapted from a story shared by a registered nurse within Alberta Health Services, 2014)

**THIS** story is an example of the role registered nurses play in capturing the complete BPMH and working with patients to ensure that information about medications is communicated with everyone on the health-care team. As noted in the CARNA Medication Guidelines, safe medication management requires, among other things, participating in the MedRec process and educating clients about their medications as part of managing their health (CARNA, 2014).

MedRec should occur in all settings, including primary care and health-care facilities. Creating a BPMH or completing the MedRec process will assist all health-care providers in having access to better information about the patients who move through the health-care system. This will reduce work for health-care providers and, most importantly, will improve patient safety. Work is underway to identify electronic solutions that support MedRec. Ongoing evaluation is also taking place to determine the impact on patient safety.

Alberta Health Services (AHS) is partway through a four-year plan to implement MedRec in all AHS care settings by the end of 2015. A phased approach is being used, beginning with MedRec at admission and eventually including MedRec at transfer and discharge. The goal is to enhance patient safety by having MedRec incorporated into everyday practice within AHS.

For MedRec to be successful in Alberta, active, consistent participation by all key stakeholders is needed. This includes the public, patients and health-care providers in primary care, and community and hospital settings. As partners in patient safety, all have a vital role in closing the communication loop, ensuring everyone has the right information.

To date, AHS has implemented a MedRec policy that provides a clear definition and focuses on communication between health-care providers and patients, families and caregivers. A communication and education strategy has also been established with AHS, to create awareness and understanding of the role each member of the care team plays in MedRec. This includes resources and education modules that are available to those inside and outside AHS (http://www.albertahealthservices.ca/medlist).

We would like to acknowledge the support and contribution of the MedRec Implementation Coordinating Committee at AHS in writing this article.

### REFERENCES


Undergraduate and graduate nursing students now have the opportunity to publish their scholarly papers from completed course assignments!

The International Journal of Nursing Student Scholarship (IJNSS) helps students link their nursing education to practice and promotes ongoing professional development. The journal aims to facilitate interprofessional/collaborative learning; foster an interest in research and its dissemination; and promote innovations in health-care practice.

Students can submit papers that have not been previously published on topics such as multinational, transcultural, and/or global aspects of nursing care in the context of both health and illness. Nurse educators are also encouraged to promote the scholarship and work with students in submitting for the journal.

Submissions will also be accepted in related health disciplines if the work is applicable to the discipline and nursing profession in particular or to health and human services in general. Book reviews and reviews of AV material, which will not be refereed, are also welcome.

Why publish your work in the IJNSS?

> **Peer Review:** Work submitted that meets the specified requirements undergo peer review.
> **Open Access:** The journal is accessible online for free.
> **Fast Publication:** Your paper may be published within eight to 10 weeks.

Please use the American Psychological Association (APA, 6th ed.) style guidelines and limit paper to no more than 22 double-spaced pages in length.

**FOR MORE INFORMATION**, please visit http://ijnss.journalhosting.ucalgary.ca/

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**Letter to the Editor**

I AM WRITING IN SUPPORT OF PETER HUBBARD’S 2014 article about *What Can Be Done About Horizontal Violence*. I applaud this candid article and his moral courage to speak out against the horizontal violence that is occurring in nursing. Hubbard provides an excellent example of how one can be a leader in nursing and become part of the solution to address horizontal violence. Hubbard’s article is important because it is one of numerous examples of literature that demonstrate how horizontal violence is still a significant issue for nursing. Nurses must realize that creating a solution for horizontal violence cannot solely depend on the actions of nursing managers; it has to be a collaborative effort between all nurses. According to CNA’s 2009 position statement on *Nursing Leadership*, leadership is a shared responsibility amongst all nurses. I agree with CNA’s position on leadership and believe that every nurse can be a leader by being morally courageous and speaking out against horizontal violence. That being said, it is important to note that there may be various environmental, organizational, or personal barriers that can prevent nurses from acting against horizontal violence.

Despite the possible barriers, I still challenge every nurse to be part of the solution by engaging in self-reflection. Some guiding self-reflection questions could be:

- How did I treat my work colleagues/nursing students today?
- Did my behaviour and actions align with the moral excellence that is expected in nursing?
- How did I participate in a healthy workplace today?
- Is there anything that I can improve on?
- Is there anything that I’m afraid to speak out against, and for what reason?

Although self-reflection is only one step towards addressing horizontal violence, it is an activity that all nurses can possibly participate in.

Allison Norris, RN
Edmonton

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**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.
Most Canadian provinces and territories have enacted legislative protection for those who apologize for their actions. British Columbia was the first to bring in an Apology Act in 2006, with others following suit quickly afterwards. Some provinces enacted a statute called the Apology Act, whereas others amended existing legislation, e.g. an Evidence Act, to include protections for apology. Apology provisions tend to be very brief and do not specify any particular subject matter of apology to which they apply.

The key concepts embedded in the statutory provisions to protect apology are that:

- saying sorry does not constitute an admission of fault or civil liability;
- an apology is inadmissible in any judicial or quasi-judicial court proceeding as evidence of fault or liability; and
- the insurance coverage for the person or entity offering an apology is unaffected by an apology.

For health care professionals, the significance of apology legislation arises when a critical incident occurs. Despite great efforts, patients can be harmed by the provision of health care services. Afterwards, health care providers and administrators must ensure patients are informed of what happened if the incident meets the criteria set out in legislation governing critical incidents or adverse events.

Historically, offering an apology was fraught with difficulty for several reasons, one of which was fear of an inference of legal liability when none was intended or warranted. Nurses and other health care professionals have stated they empathized with their patients very much after a critical incident and wanted to express sympathy but were discouraged from doing so for fear that it would be interpreted as an admission of guilt. Other reasons included fear of loss of insurance coverage or liability protection if an apology was offered and the fact that the persons disclosing to a patient may not be those who were involved in the incident, for example, a hospital administrator apologizing on behalf of a nurse employee. The nurse would then not have any control over what was said. Conversely, if an employee undertook to offer an unauthorized and possibly inappropriate apology, the employer might have been placed in legal jeopardy. Patients had reported that it added insult to injury in the aftermath of a critical incident when no apology was forthcoming; it seemed that no one cared.

A meaningful apology can assist patients, affected families, and health care professionals to heal after the event. There are many ways in which early resolution between parties is encouraged in the justice system. Apology legislation is one such way, and is seen as one element of provincial and territorial patient safety legislation.

Nurses must be mindful that apology legislation does not disentitle a patient from launching a civil action or making a complaint to a regulatory body. The burdens and
standards of proof remain unchanged, as do the legal remedies. Therefore, an admission of fault should be avoided, primarily because:

- experience has shown that the actual cause of an adverse event is often not what it first appears to be and indeed may never be established. By admitting to an error or breach of a practice standard too soon, nurses may be taking responsibility for something that ultimately will be found to have another cause or an unknown cause;
- although an apology may not be admissible as evidence of fault or liability, it could still be admitted as evidence for another purpose, for example, to show what nurses did in response to the adverse event, such that the fact an apology was made would still be before the Court; and
- an apology may be admitted as evidence if the protections for apologies in a particular jurisdiction do not apply to the legal proceeding underway.

Courts and tribunals have considered the effect of legislative provisions protecting apology. When an apology has been made in the course of a legal proceeding covered by that jurisdiction's apology legislation, the apology has been insulated from use as evidence of fault by the party who apologized. However, the fact an apology was offered has been used in some cases as evidence of what the parties did. The fact an apology was made can also be recorded in the written reasons for the legal decision. An example of how a tribunal considers the fact an apology was made comes from a situation in which a patient complained about a registered dietician's care. The tribunal acknowledged the purpose of the provincial Apology Act and did not infer guilt from the registered dietician's apology, saying in its decision:

...it is worthy to note that the intent of this Act, at least in part, was to promote the openness of health professionals in dealing with patients or family members. We prefer to view the [registered dietician's] letter in this light rather than as an admission of guilt. In our opinion, the words of the [registered dietician] showed that she acknowledged the seriousness of the situation and expressed remorse "if" she failed to deal with the [patient] in a sensitive manner.²

**Best Practices Regarding Apologies**

- the legislative requirements and your employer's framework for critical incident investigations and disclosures should guide your actions during and after an adverse event
- in collaboration with other members of the treatment team, it is part of the nursing role to help your patient understand what is happening to him or her when a critical incident or adverse event is unfolding.³ Do not speculate to the patient about information that is unknown to you. Regret or sympathy may be expressed at this time but care providers should refrain from accepting or assigning blame.
- understand the possible implications for yourself prior to apologizing to a patient, if you are asked to do so

Please contact CNPS at 1-800-267-3390 if you have questions and visit our website at www.cnps.ca.

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1. Apology is generally defined in legislation as including expressions of sympathy or regret, a statement that a person is sorry or any other words or actions indicating contrition or commiseration.
3. infoLAW®, Reporting & Disclosure of Adverse Events (Vol. 17, No. 1, October 2008).

**Related infoLAW of interest:** Patient Safety. Available at www.cnps.ca

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www.cnps.ca 1.800.267.3390 info@cnps.ca
May 12 to 18 is National Nursing Week

Celebrate ALBERTA’S RNs AND NPs by taking our ARNET Nursing Week Challenge.

If you fulfill one, go ahead, take another.

Recognizing Alberta's nurses feels great, doesn't it?

Happy Nursing Week

Celebrate your profession—introduce yourself as an RN to everyone you meet this week!

Know an RN that is pursuing continuing education? Give some words of encouragement and support!

Offer encouragement to a new grad—welcome them to your profession!

Show your support of nursing—make a donation to ARNET! www.arnet.ca

Send your nurse mentor a thank you note. You'll both be glad you did!

Sometimes it's the little things that make a BIG difference. Thank someone who took the time to help!

Did a nurse educator make a difference for you? Say thanks through a tribute donation to ARNET! www.arnet.ca

Your education and experience makes the difference—Give yourself two thumbs up for how awesome you are!

Buy an RN a coffee—then sign up as an ARNET Monthly Donor for the very same amount! A little bit combines to make a BIG difference! www.arnet.ca

When you are a nurse, you know that every day you will touch a life or a life will touch yours.

I am a nurse: it’s not what I do, it’s what I AM.

www.nurses.ab.ca  Spring 2014  Volume 70  No 1  Alberta RN 23
This year, the CARNA Awards Selection Committee was faced with the task of selecting eight award recipients out of 67 exceptional nominees. All nominees displayed excellence in the field of nursing and deserve recognition.

We are pleased to announce the recipients and nominees of the 2014 CARNA Awards of Nursing Excellence!

ADMINISTRATION
Audrey Beer
Lise Brisebois Blouin – RECIPIENT
Jola Hanhart
Jo Heggerud
Colleen McKinstry
Lauraine Newton
Michela Smith
Jane Squire Howden
Christopher Wood
Sandra Young

CLINICAL PRACTICE
Kristine Abana
JoLynn Ajtai
Diane Anderson
Victoria Ashmead
Charlotte Blust
Siobhan Butcher
Karen Effe
Cathi Garon
Sandra Hala
Beverley Hanowski
Jenna Haugrud
Jane Honish
Maxine Jenne
Jaclyn Jewett
Sharon Kelly – RECIPIENT

EDUCATION
Kim Bateman
Beverley Berry
Kathryn Crooks
Carol-Anne Doll
Manal Kleib
Linda McCracken
Anita Mitzner
Sharon Moore – RECIPIENT
Lucia Pfeuti
Janice Rae

RESEARCH
Theresa Green
Shahirose Premji
Shannon Scott – RECIPIENT

RISING STAR
Megan Lamane – RECIPIENT
Tom Shaoxian
Lindsay Sykes
Renae Tekrony
Rodney J. Williamson

LIFETIME ACHIEVEMENT
Marian Anderson
Kim Cholewa
Patricia Jensen Jeffery
Linda Ogilvie
Dorothy Phillips
Marjory Stockwell
Lorraine Way – RECIPIENT
Arlene Weidner

PARTNER IN HEALTH
AHS Edmonton Zone EMS
Ann Kirby – RECIPIENT
Viking Physician Group

COMMITTEE’S CHOICE
Dorothy Phillips – RECIPIENT

Recipients and nominees will be honoured at the CARNA Awards of Nursing Excellence Gala:

MAY 8, 2014
DOUBLETREE BY HILTON HOTEL
WEST EDMONTON
6 P.M. | Champagne reception
7 P.M. | Dinner and Awards
Individual tickets | $75 + GST
Table of eight | $560 + GST

Tickets are available at www.carnaawards.ca

The 15th annual CARNA Awards of Nursing Excellence Gala is supported by

Insurance Meloche Monnex
THE 15TH ANNUAL CARNA AWARDS GALA
MAY 8, 2014 DOUBLETREE BY HILTON HOTEL WEST EDMONTON 16615 109 AVE. NW, EDMONTON

TOP 4 REASONS TO ATTEND
THE 15TH ANNUAL CARNA AWARDS Gala

1. CELEBRATE NURSING EXCELLENCE
   Cheer on your fellow nurses as they are honoured for their dedication and pursuit of the highest quality of nursing.
   This year, we received more nominations than ever before!

2. SUPPORT RN & NP EDUCATION
   The Alberta Registered Nurses Educational Trust (ARNET) joins our annual Gala with an exciting fundraising opportunity, a photo booth, and carnival masks!
   Honour this year’s ARNET scholarship award recipients!

3. GREAT ENTERTAINMENT
   Join everyone’s favourite Master of Ceremonies, Fred Keating, accompanied by the music of Jan Randall, acapella tunes, and dazzling visuals at the new DoubleTree by Hilton Hotel West Edmonton (previously the Mayfield Inn).

4. YOU’RE PROUD OF WHAT YOU DO!
   This evening is dedicated to you! Enjoy a fabulous night out and strut in that outfit you never get to wear at work!
   Champagne reception at 6 p.m. Awards and Gala dinner at 7 p.m.

67 NOMINEES

THE 15TH ANNUAL CARNA AWARDS GALA
MAY 8, 2014 DOUBLETREE BY HILTON HOTEL WEST EDMONTON 16615 109 AVE. NW, EDMONTON
Breastfeeding is the natural way to feed a newborn; its importance as a public health priority is well-established. In 2000, CARNA Provincial Council endorsed the World Health Organization and the United Nations Children’s Fund position statement: Protecting, Promoting, and Supporting Breastfeeding: The Special Role of Maternity Services as well as the International Code of Marketing of Breast-milk Substitutes and subsequent WHO Resolutions. In doing so, CARNA recognized the significance of breast milk and the strategic role that registered nurses (RNs) play in ensuring its value in maternity care. However, there are no maternity facilities in Alberta that have implemented the UNICEF and WHO policies and practices.

The Baby-Friendly Hospital Initiative (BFHI) is an international program developed in 1991 by WHO and UNICEF. It focuses on how health-care providers can support breastfeeding and feeding practices, which are major contributors of positive health outcomes for women and children.

The BFHI is founded on The Ten Steps to Successful Breastfeeding. These evidence-based practices outline the minimum standard of care for newborn infants. Maternity facilities can meet the standards, and become designated with the BFHI status through providing educational opportunities for staff and implementing the BFHI practices.

The Breastfeeding Committee for Canada changed BFHI to Baby-Friendly Initiative (BFI) to create an integrated initiative for hospitals and community health centres that reflect the continuum of care required for breastfeeding support in Canada.

Maternal-child health-care facilities must demonstrate an 80 per cent compliance with the Ten Steps, and adherence to the International Code of Marketing of Breast-milk Substitutes and all subsequent WHO Resolutions, in order to be designated as a Baby-Friendly Facility. Once designated, facilities are reassessed every five years to ensure continual adherence to these standards. Since 1991, over 22,000 facilities in 157 countries worldwide have earned the BFHI designation. As of January 2014, there were more than 35 designated facilities in Canada, more than 20 in Québec, 15 in Ontario, and additionally, all of Toronto Public Health, one in Saskatchewan, and two in British Colombia. A handful of facilities have begun the process of earning the BFI designation in Alberta.

The Canadian Maternity Experiences Survey in 2006 revealed 90 per cent of women intended to breastfeed and 90.3% did start to breastfeed. However, 21 per cent added liquids other than breastmilk within one week of delivery and 25.5% within two weeks. In 2006, the Canadian exclusive breastfeeding rate at six months was 13.8%, and in Alberta the rate was 15.3%. The 2009/2010 Alberta Health Service statistics show exclusive breastfeeding at six months in Alberta was 29 per cent. An examination of factors between delivery and two-week post-partum was looked at in the Canadian Maternity Experiences Survey. The findings revealed a low adherence to best practice care for women and infants, despite the fact that evidence indicates that BFI is associated with improved breastfeeding outcomes. Designated facilities show increased rates of breastfeeding initiation and exclusivity for six-month outcomes.

Families who receive care at a BFI-designated maternity facility will be assured of consistent evidence-based information, education and skill from all health-care providers. Baby-Friendly designation is an assurance to families of best practice policies, procedures and guidelines implemented to...
support the WHO recommendation of exclusive breastfeeding for six months and sustained breastfeeding for up to two years with the introduction of age-appropriate foods. Families who are supported throughout the continuum of pregnancy to post-partum will be prepared to make informed decisions on the type of infant feeding that is best for them and their newborn. RNs who are educated on the BFI are well-positioned to influence a mother’s perception about her ability to successfully breastfeed her infant and meet the international guidelines for six months of exclusive breastfeeding.

CANA requires each RN to reflect on their practice. Is there an opportunity to lead a collaborative team to implement the BFI at your facility? The BFI process, materials and support are available on the Breastfeeding Committee for Canada and the Alberta Breastfeeding Committee websites. Earning the Baby-Friendly Initiative designation within your maternity facility would fill the gap between knowledge and practice that currently exists in some maternity facilities in Alberta. Ensuring best practices is an important step towards improving maternal and infant lifelong health in Alberta.

REFERENCES


THE TEN STEPS

STEP 1 Have a written breastfeeding policy that is routinely communicated to all health-care providers and volunteers.

STEP 2 Ensure all health-care providers have the knowledge and skills necessary to implement the breastfeeding policy.

STEP 3 Inform pregnant women and their families about the importance and process of breastfeeding.

STEP 4 Place babies in uninterrupted skin-to-skin contact with their mothers immediately following birth for at least an hour or until completion of the first feeding or as long as the mother wishes: encourage mothers to recognize when their babies are ready to feed, offering help as needed.

STEP 5 Assist mothers to breastfeed and maintain lactation should they face challenges including separation from their infants.

STEP 6 Support mothers to exclusively breastfeed for the first six months, unless supplements are medically indicated.

STEP 7 Facilitate 24-hour rooming-in for all mother-infant dyads: mothers and infants remain together.

STEP 8 Encourage baby-led or cue-based breastfeeding. Encourage sustained breastfeeding beyond six months with appropriate of complementary foods.

STEP 9 Support mothers to feed and care for their breastfeeding babies without the use of artificial teats or pacifiers (dummies or soothers).

STEP 10 Provide a seamless transition between the services provided by the hospital, community health services and peer support programs.

Canada Compliance with the International Code of Marketing of Breastmilk Substitutes. REFERENCE: Breastfeeding Committee for Canada Website. Breastfeedingcanada.ca
CHILDHOOD OBESITY HAS BECOME ONE OF THE PRIMARY PEDIATRIC HEALTH ISSUES OF THE 21ST CENTURY. GLOBALLY, CHILDHOOD OBESITY RATES HAVEsteadily increased over the past four decades. CURRENTLY, APPROXIMATELY ONE-THIRD OF ALL CANADIAN CHILDREN AGED FIVE TO 17 ARE OVERWEIGHT OR OBESE (Roberts, Shields, de Groh, Aziz, & Gilbert, 2012).

ASSESSING WEIGHT IN PEDIATRICS

In pediatrics, growth charts are used to track height and weight over time. For children over two years old, body mass index (BMI) should be calculated and plotted on a growth chart annually. BMI is considered to be in a healthy range when it falls between the 3rd to the 85th percentile for age and gender. Generally a BMI above the 85th percentile may be considered overweight and above the 97th percentile may be considered obese, depending on the age of the child and the growth charts used.

Regular measuring allows health providers to recognize potential issues and begin discussion about weight and health with the family. What growth charts classify as overweight or obese may be different from parental perceptions of their child's weight. Many parents do not recognize their child as being overweight and may not be aware of the potential negative effects extra weight can have on their child's health.

CO-MORBIDITIES OF OBESITY

Obesity can have adverse effects on virtually every organ system of the body. It is associated with neurological, endocrine, cardiovascular, pulmonary, gastrointestinal, and musculoskeletal complications. Obesity can also be associated with mental health issues such as poor self-esteem, anxiety, depression, social stigma and bias.

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FIGURE 1: Contributing factors of Pediatric Obesity

FIGURE 2: Co-morbidities of Pediatric Obesity

Reprinted and modified with permission from the authors (Ebbeling, Pawlak, & Ludwig, 2002).
WEIGHT BIAS AND STIGMA

Children with obesity may often experience overt forms of bias and stigma such as bullying and teasing. Rebecca Puhl, director of the Yale Rudd Center for Food Policy & Obesity, is a leader in research on weight bias and stigma and the resultant impact. She has said that “efforts are needed to bring attention to the issue of weight bias and its negative consequences for individuals with obesity, as well as initiating stigma reduction efforts in training and clinical practice.”

EDUCATION IN WEIGHT MANAGEMENT

It is our responsibility as nurses to support the management of pediatric obesity. Identifying children who have extra weight and respectfully starting a meaningful conversation about potential health impacts with families is vital.

Explain the child’s growth pattern and relate it to health in a way that is meaningful to the parent. For example, if a child’s BMI is at the 88th percentile, you might say “It looks like your child’s weight is slightly high compared to their height”. Because BMI percentile is only an indicator of potential health problems, it is important to explain why it may be a potential health concern. An effective explanation may be: “It is important to monitor growth to make sure a child is not gaining more weight than is needed for their height, as extra weight may lead to health problems.”

Nurses should encourage parents to discuss weight issues with their primary care provider and reinforce healthy living messages with families. Success in weight management involves changing behaviour to support a healthy lifestyle: what you eat, how you eat, how you move, how you cope and enjoy life. Lifestyle changes need to be determined collaboratively with the family. Weight management shouldn’t focus only on a number on a scale. It is critical to assess motivation and readiness to change within the family. Attempting to implement a change before the child or family is ready may create resistance and decrease the likelihood of positive sustained action.

Resources have been developed to assist clinicians in beginning a conversation about this topic; some are available on the AHS Chronic Disease Management Resource Centre (www.albertahealthservices.ca/7468.asp), and through the Canadian Obesity Network (www.obesitynetwork.ca).

MULTIDISCIPLINARY, FAMILY-CENTRED WEIGHT MANAGEMENT

Community-based programs provide an excellent opportunity to enhance a healthy lifestyle through fitness, nutrition and recreation. Health-care providers may encourage a child and family to engage in a community program as a first step in maintaining their health. Additional resources beyond community programming may be needed to support families with children who are overweight or obese.

Due to the complexity of pediatric obesity, a multi-component strategy addressing multiple contributing factors is required. Collaboration between nurses, primary care providers, and other health-care professionals is needed to provide optimal support.

Registered dietitians who have additional training in pediatric weight management are available in each AHS zone throughout the province. These registered dietitians provide multi-component pediatric weight management care in collaboration with the child’s primary care provider.

To effectively support families in addressing the many complex aspects of pediatric obesity, three Pediatric Centres for Weight and Health (PCWH) specialty clinics are available in Calgary and Edmonton. Access to this service requires referral by a physician or nurse practitioner; this referral form may be obtained at www.albertahealthservices.ca/8358.asp.

Please send any questions or comments to: provincialbariatricresourceteam@albertahealthservices.ca

REFERENCES


HEALTHY LIVING MESSAGES

- **EAT** age-appropriate servings of vegetables and fruits daily according to Canada’s Food Guide
- **MINIMIZE** sugar-sweetened beverages, with the goal to eliminate
- **PREPARE** more meals at home
- **EAT** at the table as a family, at least four to five times each week
- **FOLLOW** ‘healthy feeding relationships’ principles: parent decides what, when and where to eat; the child decides whether and how much to eat
- **ENCOURAGE** lower calorie snacks (e.g., raw vegetables, fruit), reduce/eliminate high calorie and processed foods (e.g. sweets, chips, chocolate)
- **PARENTS** are role models in a healthy family lifestyle
- **ENGAGE** in regular physical activity according to Canadian Society of Exercise Physiology Guidelines
- **LIMIT** recreational screen time to two hours each day
- **ESTABLISH** healthy sleep habits
Albertans have growing expectations about how their health information is managed and a growing interest in having access to their own health information. In February 2014, Alberta Health and Alberta Health Services launched a promotional campaign that will raise public awareness about Alberta Netcare and MyHealth.Alberta.ca – the health-care provider and the personal health record tools available in our province.

**CAMPAIGN TOPICS**

1. **Information collection and protection**
   The purpose of the campaign is to make sure that Albertans understand how their health information is collected and protected, and that in the future they will have access to some of their Alberta Netcare information through MyHealth.Alberta.ca. The campaign first focuses on Alberta Netcare, explaining that it is the tool that clinicians use to access their key health information. It outlines their rights as a patient to know who is viewing their health records, and the right to access those health records if they wish.

2. **MyHealth.Alberta.ca features**
   The second part of the campaign focuses on MyHealth.Alberta.ca, both its current offering and future state. As a made in Alberta resource, the campaign encourages Albertans to make MyHealth.Alberta.ca their first stop for answers to their health questions. It hosts thousands of pages of reliable health information and a number of tools that can help your patients make educated decisions about their health care.

   In late 2014, a Personal Health Record (PHR) will be added to MyHealth.Alberta.ca which will serve as Albertans’ portal into their provincial health records. The first information pieces that will be available through PHR are a medication profile (drugs dispensed in community pharmacies) and a patient summary which could include hospital visits, surgeries, and other health highlights available in Alberta Netcare. The PHR will also enable uploads from health and wellness monitoring devices like blood pressure monitors and fitness bracelet devices.

**Resources for patient questions**

Your patients may come to you with questions about information in the campaign, as you are the person they trust most and are their first point of contact with the health system. To support you, we have developed:

- a webpage for Albertans dedicated to the campaign and helping them understand how eHealth will support their health care,
- a webpage for health-care providers dedicated to the campaign and providing resources to answer questions that Albertans might ask you, and
- an information pamphlet that you can either print or request copies from Alberta Health free-of-charge.

These information pieces will be useful to have on hand for interested patients in your location. For more information please visit: [www.MyHealth.Alberta.ca/eHealthforproviders](http://www.MyHealth.Alberta.ca/eHealthforproviders) or contact PHP@gov.ab.ca
The Alexandra Community Health Centre (the Alex) is a non-profit organization that provides primary health-care services to some of Calgary’s most vulnerable citizens. When Christopher Wood, RN, MHA began his role as Director of Health Programs for the Alex in September 2013, he saw an organization with great passion – but also potential for improved performance.

With 27 physicians providing part-time care and a dedicated interdisciplinary team, Wood knew he needed a way to harness the energy and get everyone pulling in the same direction. He also knew it would be optimal not to reinvent the wheel, but to find an evidence-based strategy that would still allow for innovative thinking.

Wood learned of the Alberta Screening and Prevention (ASaP) provincial initiative, which focuses on supporting primary care providers and team members to offer a screening and prevention bundle to all their patients through enhanced opportunistic and planned outreach methods, targeting patients who do not present for screening care. Wood immediately considered registered nurse Josephine Leung for this initiative.

“Josephine was providing continuity of care in our family clinic – she was a constant for patients,” says Wood. “It was a natural fit to empower her to proactively manage the patient population as our RN-POET (proactive office encounter technician).”

Leung attended the ASaP Improvement Facilitator training, where she learned about:

• Patient panel identification (i.e., identifying a list or roster that represents the number of unique, unduplicated patients with an established relationship with a primary care provider).
• Electronic medical record (EMR) system optimization.
• Strategies for offering screening to patients at any appointment (“opportunistic screening”).
• Strategies for using the patient panel to identify and contact patients due for screening (“outreach screening”).
• General quality/process improvement methods and how to measure improvement.

As the Alex has had three different EMR systems over its history, Leung’s first challenge was the organization of patient panels. Once she determined which patients were actually “active,” she was able to start working with the physicians to establish their unique patient panels.

“We learned that accurate patient panels are quite manageable, and we’re encouraging the reception team to increase continuity of care by booking patients with their own providers,” explains Leung. “We’ve also started having case rounds, where we bring the care team together to align treatment goals and strategies.”

Through her improvement facilitation training with ASaP, Josephine has also been working to optimize the use of the EMR.

“The first step is to ensure that our health-care providers are entering data in the correct place in the system and using consistent naming conventions when scanning documents to add to the patient’s record. This will help them to be able to accurately identify patients who are due for screening,” says Leung. “Those who come in frequently will be offered appropriate preventive care at any appointment.”

Due to their patients’ unique living situations, reaching out to invite patients in for preventive screening can be challenging. The Alex is also exploring different communications strategies to reach their homeless clients.

Wood and Leung know that there is still work to be done, but they are excited and hopeful. As Leung shared, “I feel that we’re moving toward more responsible care. The background work and improved knowledge of the basic use of the EMR is giving our primary-care providers the information they need to more effectively maximize opportunities for preventative screening.” RN
CORRECTION:

In the Winter 2014 issue of Alberta RN, the designation “RN” was inadvertently placed beside current fourth-year nursing student Peter Hubbard’s name in his article “What can be done about horizontal violence?” We apologize for any inconvenience this error may have caused.
Engagement. We use the word all the time. CARNA President Shannon Spenceley spoke about it in her video blog (view at www.expertcaringmatters.ca) and it’s a priority for CARNA Provincial Council. But what does it really mean when we are talking about registered nurses and CARNA?

To me, engagement means a community of individuals working together on an issue towards a mutually desirable outcome. And CARNA is committed to making it easier for you to engage with your regulatory college and professional association. I’d like to share with you three examples of recent engagement by registered nurses and nurse practitioners which demonstrate the tangible value of a nursing community engaged with its professional association and regulatory college.

First, after hearing many members bring up medication administration issues during practice consultations, CARNA recognized the need to review the Medication Administration Guidelines (2007). After asking for member input into this document, we identified that clarification was needed regarding range dose orders, over-the-counter (OTC) medications and the use of protocols that included a Schedule 1 medication. All feedback was considered and incorporated into a revised document approved by CARNA Provincial Council in January. In this instance, members engaged with the organization by contacting the practice consultants, by providing feedback, by serving on provincial council or by consulting the document. Whatever the type of engagement, both the individual and the organization gained value.

Second, we heard from many concerned members about the introduction of physician assistants (PAs) in Alberta. As a result, we developed and distributed a Q&A for RNs working with PAs and have also been providing feedback to AHS about specific practice concerns including proposed processes for the co-signing of orders by the supervising physician.

Third, while the workforce transformation project has been in the media and the subject of our work with other health-care organizations, members have also expressed their concerns to CARNA. In response, we wrote four open letters to members (to date) to update you on specific actions we have taken. In September 2013, the president and I met with former AHS President and CEO Chris Eagle and Chief Health Professions Officer Deb Gordon. More recently, CARNA has participated in three meetings of the Workforce Transformation Project Evaluation Council and shared your concerns and feedback with senior AHS officials. Stay tuned for more updates.

Although we’ve been keeping our eyes and ears open to issues, the more members engage with CARNA, the more value we can provide for each other. For many of our members, engagement is limited to renewing their registration each year and some find it difficult to find the value of their college and association. I’d like to see us change that. Over the past year, we’ve made strides in expanding opportunities for members to engage how, when and where it suits you. I challenge each of you to find a way to engage this year and I’ve provided a few suggestions. • Connect with your regional Provincial Councillor to discuss ways you could bring the voice of the nursing profession to health policy discussions in Alberta
• Contact a practice consultant to discuss a practice issue
• Contact your regional coordinator to organize an education session at your workplace
• Participate in a focus group – we have many coming up this next year for special projects so check your email inbox for opportunities
• Celebrate nursing excellence at the CARNA Nursing Awards Gala on May 8, 2014 to celebrate nursing excellence (do you know any of the nominees? See who they are on page 24)
• Attend the May 8–9, 2014 Provincial Council meeting
• Apply to serve on a CARNA Committee, where you can make decisions affecting registration, continuing competence, conduct and more. Recruitment for committees is coming this summer

With so many different ways to contribute your expertise and professional opinion, I hope you’ll find an opportunity that speaks to you or simply fits your schedule.

Henry Ford said: “Coming together is a beginning, staying together is progress, and working together is success.” Only you can ensure that our profession flourishes.

Mary-Anne Robinson, RN, BN, MSA
Chief Executive Officer
780.453.0509 or 1.800.252.9392, ext. 509
mrobinson@nurses.ab.ca
not following CARNA on social media yet?

Here’s what you’ve been missing:

Being the FIRST to hear about:
- Updates to documents, bylaws and other information that affects your practice
- Current events, news and interesting stories and articles
- New CARNA blog entries
- Meetings, conferences, webinars and other events

Touching stories from real Alberta RNs
We asked Alberta RNs, “What’s your favourite memory of working during the holidays?” Over the holiday season we shared some of the moving memories and traditions Alberta RNs submitted. View our Facebook photo album “RN holiday memories” to read the stories.

CONTESTS!
In the past year, we’ve given away:
- Oilers tickets
- Merchandise from the CARNA online store, expertcarewear.ca
- Several gift cards including: Starbucks, Tim Hortons, iTunes and Cineplex Odeon
- A day at the spa
- Dinner for two

During Nursing Week (May 12–18, 2014) we’ll be giving away a PRIZE EVERY DAY! Be sure to follow us on Facebook and Twitter for a chance to win.
ATTENTION
SOUTH HEALTH CAMPUS
EMPLOYEES:

Don’t commute to work.
GO FOR A WALK.

Brookfield Residential offers a range of homes less than 10 minutes away from the new South Health Campus — on foot, on picturesque trails and pathways. (It’s not really commuting at all)

5
MINUTE
DRIVE

McKENZIE
TOWNE
TOWNHOMES
from the $320’s
STACKED TOWNHOMES
from the $250’s

10
MINUTE
STROLL

CRANSTON
TOWNHOMES
from the $320’s
STACKED TOWNHOMES
from the $250’s
SIDE-BY-SIDE HOMES
from the $300’s
SINGLE FAMILY HOMES
from the $340’s
RIVERSTONE ESTATE TOWNHOMES
from the $450’s

5
MINUTE
HOP

AUBURN BAY
TOWNHOMES
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STACKED TOWNHOMES
from the $250’s
SIDE-BY-SIDE HOMES
from the $310’s
SINGLE FAMILY HOMES
from the $360’s

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