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CARNA Provincial Council 2013–2014

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COVER:
BACK, LEFT TO RIGHT: Susan Bargunde, Beverly Bell, Michelle Smith, Regan Westgate
FRONT, SEATED: Olga Lumba
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In my first few months as your president, I find that I am spending quite a lot of time on planes. I always smile when I hear the part in the security briefing where they say “in the event of a sudden change in cabin pressure, oxygen masks will fall from the ceiling...” – and – I’m supposed to “breathe normally.” I get it, fear can get in the way of what needs to be done, but breathe ‘normally?’ I doubt it.

All this traveling has had a tremendous reward: talking to registered nurses in many parts of the province. Wherever I go these days, nurses are very concerned about the turbulence in the health system. Many are speaking to me about their fears – in particular about the workforce transformation project and related changes in the AHS workplace, and what those changes may mean for registered nurses, and for the patients they care for.

I hear about other fears, however, that concern me a great deal: registered nurses tell me they are afraid to speak up – on either side of the ‘transformation’ issue. Some said the message they hear is that it is not acceptable to raise concerns about workplace changes – that they need to just go along and not make trouble. Others see some potentially very positive things about the proposed model of collaborative practice – but the message they hear from colleagues is that it is not acceptable to raise even positive observations. As RNs, we must have the courage to raise our voices about patient safety and high quality care. We must, as colleagues and leaders in the workplace, support one another in speaking up – even if what we have to say isn’t what others may want to hear. We need to talk to each other, clearly state our concerns or kudos – and make sure they are added to the discussion.

Fear, it would seem, may be getting in the way of doing what needs to be done. What needs to be done? A great deal of work to create truly collaborative practice in the health-care system. We know that collaborative teams with clear roles for members, shared accountability and a shared vision of coordinated, patient-centred care is hands-down the model of care that produces the best outcomes for patients, and the best workplaces for health-care providers. But you can’t get there from the top down. We must set the expectation that change in our workplaces will be an ongoing, collaborative discussion, not a one-shot project. We can’t wait to ask for input – we must take and create every opportunity to provide it. We also have to expect robust evaluation, enter into the work of change with an open mind, ask hard questions and keep asking them. All of us have to be vigilant, focused and clear that the ultimate purpose for change has to be improved patient care. We have to ask each other: how do we participate in creating a workplace where people feel safe to speak up and challenge each other? Surely it has to start with refusing to perpetuate a culture of fear. You and I are more powerful than we know.

As your president, I am taking this same approach in all discussions around the transformation initiative. I am committed to ensuring that the voices of registered nurses – from all perspectives – are heard. CARNA will be taking an active role in the evaluation of the initiative going forward – this is an important step to ensuring that change achieves what we all must expect. So is my message to strap on your mask and breathe normally? Certainly not. We need to take a deep breath, speak up and insist that transformation brings a truly collaborative model of care that enables registered nurses to fully enact our role and use our knowledge and skill to improve the health of Albertans.

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Upcoming Provincial Council Meetings

- Jan. 22, 2014 (Annual General Meeting)
- Jan. 23 – 24, 2014
- May 7–9, 2014
- Sept. 25 – 26, 2014

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**Which council positions are open?**

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<th>REGION</th>
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*As CARN did not receive nominations from Northwest and Calgary/West in the 2013 election, a provincial council member is needed from those two regions to serve a two-year term. The term has been adjusted to maintain a one-third turnover rate.*

**For more information** about the role of provincial councillor, contact Provincial Councillor Sheila McKay, at 403.346.1994 or email at smckay@nurses.ab.ca. You can also watch *Your Professional Voice in Alberta* and *Nursing: A Self-Regulated Profession* at nurses.ab.ca/webinars.

**NOMINATION FORMS AVAILABLE AT:** nurses.ab.ca or contact Diane Wozniak at 780.453.0525, toll-free 1.800.252.9392 or email at dwozniak@nurses.ab.ca.
Letters to the Editor

RE: Renewal

I AM WRITING IN SUPPORT OF THE LETTER SUBMITTED BY Nadine Evanoff in Alberta RN, Fall 2013 issue, describing her experience with registration this year. I feel like Ms. Evanoff was in my head as her feelings are exactly my feelings. I did write to CARNA online regarding my frustration with this system. I also acknowledge the timely apology from the CEO on the flip page.

However, at the end of the day, apology or not, I want to complete my registration with minimum fuss and time and want to be respected in the process. This is not the first time problems with the online registration have been identified, however, there must have been a great deal more discontent this year that resulted in the apology from the CEO, because I certainly don’t remember an apology any other time.

If CARNA can’t get this right, go back to paper. This is not our first year yet we have been having problems since the beginning. I can’t express the feeling of stress that comes over me even thinking of completing another registration and this year almost was my last. I really can’t keep subjecting myself to the punishment of online registration with CARNA and I don’t understand what the difficulty is. I register online with CRNBC and I’m done in less than 20 mins. I want to continue working as an RN, as a 30+ grad I enjoy every day of work, however, the registration process is seriously forcing me to consider whether the registration process is worth the stress. I’m dumbfounded that CARNA can’t get it right.

Lastly, there is merit to Sindhu Koickel’s letter to the editor in the same issue, and maybe the decision makers in CARNA should have the courage to offer both forms of registration and really listen to the members they serve.

Persa Kovich

ONE OF THE MANY FACTORS CONTRIBUTING TO THE frustration with renewal is that September is a really bad month to have to do it.

Parents are preparing for children to go to school and university. It is a time when many nurses are either returning from vacation, on vacation or planning to go on a trip and registration renewal is one more issue to worry about. And the difficulties encountered this year really added to the pressure.

I suggest changing the registration date to early spring, perhaps February or March; I think that a lot of nurses would appreciate that. Perhaps you could take a vote on it.

Maria Walsh, RN, Calgary

Re: New AHS staffing models cause for concern.

I REALIZE IN NURSING, AS IN ANY HEALTH-CARE related field, finances are always an issue and every administrative person is always looking for ways to reduce costs. That issue must always be monitored to maintain quality care which we all expect.

RNs are expected to perform at a different level of expertise than health-care aides (HCAs) since they all have different roles. That does not give RNs the right to condescending and rude to other groups of caregivers.

I have worked and been in settings where I preferred to rely on “unskilled, poorly trained, and completely unregulated” health-care aides rather than “skilled, trained regulated health professionals” (RNs).

We as RNs need to carry out our responsibilities to the best of our abilities and also allow others to carry out theirs without degrading their contribution. We are not the “be all, end all” in health care, because there have been times I was truly ashamed to be associated with the RN designation.

Let’s improve our practice to look better instead of cutting others down.

Volker Johnas, RN, GNC(C)

IN RESPONSE TO DONNA F.’S LETTER WRITTEN TO THE editor in Fall 2013 edition of Alberta RN magazine regarding “New AHS Staffing Models Cause for Concern”:

Donna speaks about how health care aides (HCAs) who are unskilled, poorly trained, and unregulated, are replacing skilled, trained nurses.

I am an RN with 35 years of experience, who has spent my career in Alberta caring for its residents, patients, and clients and for the last eight years training HCAs.

It is partially true what Donna has said about HCAs. They are unregulated; that is, they have no governing body that registered nurses do (CARNA) or licensed practical nurses do (CLPNA).

The HCAs we train are skilled and very well trained in best-practice techniques.

They take a five-month course approved by the Alberta Government where they have theory and lab practice. They are taken into clinical settings where they practise in a one-week designated supportive-living facilities clinical and a four-week long term care clinical, supervised by highly-trained LPNs and RNs with a vast variety of experience and skill.

They do not pass the course unless they have shown competency, skill and safety.

The important thing to remember is that they are trained to be aides, assisting with activities of daily living,
Letters to the Editor (cont’d)

and are not qualified or competent to take over registered nurse positions.

They are trained to practise within their scope, and are very aware of the Alberta legislation which clearly outlines their scope of practice, namely:

Government Organization Act:

Health Professions Act:

The problem lies within the system. Are the HCAs Donna is talking about practicing with a certificate from an approved educational institute?

If HCAs with certification are hired to do the job they are trained to do, they are an asset to the health-care team and are the front line, hands-on advocates for their clients, residents and patients.

They are taught to observe, report and record while doing care on stable clients with predictable outcomes. They are not taught to assess. They are not taught how to implement care (they do not create care plans) and are not taught to evaluate the care and patient outcomes that our regulated health-care professionals, i.e. registered nurses, are educated and trained to do.

I fully support RNs and their crucial and critical role on the health-care team. They are vital to maintain the high level of care that is required for positive patient outcomes within the health-care system in this province. Unfortunately, they are being stretched beyond their limits, caring for larger numbers of acute care patients, supervising many units of long-term care residents in designated supportive living facilities, and managing large caseloads in home-care settings, as well as supervising health-care aides, who are front-line workers in all these settings.

Although health-care aides are not trained to replace registered nurses, they are a huge asset to the health-care team.

Betty N., RN

I WOULD LIKE TO ADDRESS DONNA F’S CONCERNS RE RN’S being replaced by “unskilled workers.”

I believe that we nurses have contributed to this problem ourselves. Since we belong to a union – which we need – we get many benefits which a number of nurses abuse. I know that nurses get sick, however there are many nurses who call in sick when they are actually not sick and we only need to read the publications ordered by the Hearing Tribunals to see evidence of this. (Alberta RN, Fall 2013)

When a nurse calls in sick, her salary has to be paid; if she is replaced, the salary of her replacement must be paid. If the nurse works in critical care and another nurse cannot be found at regular pay, then a nurse will be called and paid double time. I am not making this up, I know a number of nurses who are regularly called in on overtime. Given that nurses are paid over $40/hour, that means that it can cost well in excess of $120/hour to cover that shift for one nurse. If we consider how many nurses are off sick throughout Alberta on any given shift, that adds up to a very significant amount of money.

If I were a patient, of course I want the most skilled compassionate nurse taking care of me.

If I were a manager, I would most certainly want the patients/clients on my unit to receive the best professional care. However as a manager responsible for a budget, wanting to find ways to reduce costs and hiring less costly employees such as unskilled workers would be a possible solution. I challenge frustrated nurses to consider this and start a movement to get “delinquent” nurses to change their ways.

Maria Walsh, RN, Calgary
Committed to Competence

Worried about being audited?

Nine RNs selected for audit share their plans

A challenge that our members may face when completing their continuing competence learning plan is not knowing how much information to include. You might have asked yourself throughout the process, “How much should I write?”, “What information is relevant?” or “Is this enough detail?”

A benefit of self-directed learning is the freedom to decide what your own needs are and how you will meet them. There is no set word count or amount of detail required in your learning plan—it simply must show that the activities you participated in throughout the year have contributed to your practice and helped you to meet your learning objective. One nurse may feel one or two activities are enough; another may complete six or more activities and still feel they could learn more. This is perfectly okay!

The 2013 annual random audit showed that 95 percent of member plans submitted met review criteria. But beyond that, many of the learning plans demonstrated an incredible commitment to achieving practice excellence through professional development.

Nine Alberta RNs who were selected for review have agreed to share their learning plans from this year as a teaching tool for other nurses. These nurses have between 10 and 36 years experience and work in public health, cardiology, surgery, long-term care, critical care, obstetrics and integrated supportive-living. We thank them for sharing their learning plans. Read the examples for guidance—each plan is unique but all share the same characteristics: they were relevant to the nurse’s particular practice, described what the nurse wanted to learn, how they learned it, and explained how this made a difference in their practice. They all varied in the amount of detail yet each met continuing competence requirements. Hopefully you find them helpful!

Examples of continuing competence plans

### ZK

**YEARS OF EXPERIENCE:** 22  
**PRACTICE SETTING:** Cardiology

**INDICATOR SELECTED:** 4.2 – The registered nurse uses communication and team building skills to enhance client care.

**OBJECTIVE:** Effective communication. Interpersonal Communication Skills. Effective team building skills and overall enhancing communication skills and strategies to interact with staff members and patients.

**RELEVANCE:** Communication is one of the most important aspects involved in my work.

**ACTIVITIES:**  
- *Education course April 24/13:* Art of Accountability  
- *Education course May 28/13:* Pathway to Resolution  
- *Education course June 6/13:* Enhancing Team Effectiveness  
- *Education course June 26/13:* Communication Cornerstones – Back to Basics  
- *Education course June 18/13:* Success in Change and Transition

**EVALUATION:** The courses I attended outlined understanding effective communication. Interpersonal communication skills discussed included identifying barriers to communications and how to overcome them. The courses I’ve taken were great team-building stepping stones. Points covered included ensuring that messages are given in a clear, concise and correct manner enhancing my communications skills and strategies with my interaction with team members.

### NP

**YEARS OF EXPERIENCE:** 10  
**PRACTICE SETTING:** Public Health

**INDICATOR SELECTED:** 4.3 – The registered nurse is accountable for the supervision of other health-care team members, and nursing students when appropriate, and uses the Decision-Making Standards for Nurses in the Supervision of Health Care Aides: Restricted Activities and Activities for Daily Living and CARNA standards for the supervision of care provided by nursing students and undergraduate nursing employees to guide practice.

**OBJECTIVE:** I wish to be a positive mentor, giving constructive criticism and adjusting my level of supervision to promote confidence in the student’s ability. I want to learn how to inspire students to learn about the principles of community health.

**RELEVANCE:** I will be sharing the responsibility of being a preceptor to a nursing student. In my history as a public health nurse, I have shared the responsibility of being a preceptor to two nursing students and have had active roles in their evaluation process. My experience as a preceptor has been limited and my confidence as a preceptor is low.

**ACTIVITIES:**  
- *Journal articles/books/manuals Oct. 18/12:* Throughout the Fall semester and my student experience, I referred to the “Preparing to be a Preceptor: A Handbook for Preceptors NESA BN Program.” I especially used the handbook prior to the preceptorship and when reflecting during evaluation times.

*Consultation with experts/peers Nov. 16/12:* For my student experience I was partnered with a colleague...
to share in the preceptor responsibilities. Throughout the semester, we kept a journal of our experience.

Consultation with experts/peers Nov. 16/12:
Consulted with colleagues throughout the semester.

EVALUATION:
By taking the role of preceptor, it allowed me to take time and focus on the nursing process. It allowed me to appreciate the resources available and to identify the impact my role as a public health nurse has on my community. I was happy to be part of the learning process for my student and I was proud to see her transformation to confident and empowered nurse.

YEARS OF EXPERIENCE: 36
PRACTICE SETTING: Long-term care

SM

INDICATOR SELECTED: 4.2 – The registered nurse uses communication and team-building skills to enhance client care.

OBJECTIVE: To improve my communication with all team members

RELEVANCE: A new admin structure in the organization with positions created to support safe quality care for the residents.

ACTIVITIES: Workplace presentation June 13/13:
Risky Business “Having Those Difficult Conversations”
Journal article May 7/13:
Helping People Win at Work – Blanchard & Ridge, 2009
Journal article Jan. 16/13:
Leadership Training for Managers:
An Alderian Approach – Preiss and Molin-Ray:
2007 Journal of Leadership Activities
Conference/seminar/workshop Jan. 16/13:
Professional Communication (CARNA)

EVALUATION:
Confirmed the need for appropriate and timely communication with all members of the health-care team especially during times of change. Meet with staff on a regular basis to provide and receive feedback. Has provided more tools and ideas to communicate with staff in challenging times. Use Situation Leadership tools (flash cards) to engage staff. Confirmed why employee engagement is so important to the clients/residents we serve. Decrease resident/family concerns brought forward and improved satisfaction surveys.

YEARS OF EXPERIENCE: 22
PRACTICE SETTING: Public health

SZ

INDICATOR SELECTED: 1.4 – The registered nurse engages in and supports others in the continuing competence process.

OBJECTIVE: I want to fully embrace and participate in the CC program. I expect to learn how to more effectively report my CC activities, goals and objectives and in turn learn how to support my colleagues and nurses new to the profession.

RELEVANCE: In the past couple of years I have enjoyed and taken an interest in mentoring student nurses and new nurses. I believe that by setting a great example of how to document and plan my CC learning plan and activities for myself, I can help other nurses.

ACTIVITIES: Conference/seminar/workshop March 1/13:

EVALUATION:
Attended a CCP workshop/presentation early in the 2013 practice year
Conference/seminar/workshop March 13/13:
Professional development conference. Topic relevant to current practice.
Journal article/book June 4/13:
Literature search on continuing competence in nursing. Chose to review seven (7) journal articles.
Consultation with experts/peers May 31/13:
Informal interview of colleagues on how they organize, plan, embrace and document their CCP. This occurred throughout the practice year.
Consultation with experts/peers Nov. 30/13:
Each time I orientated a new casual nurse to the program, part of my orientation included mentioning the CARNA CCP program.
Internet research July 23/13:
Looked up each provincial nursing association site and read about their specific CCP model and program.

I believe I have come to fully embrace the CCP process by choosing this indicator. I was able to support as well as glean knowledge to help me attain this goal. I had never done a literature search before and found this a very interesting tool. I enjoyed reading about other continuing competence programs in Canada, the US and abroad for a new perspective. All of the articles I read support a continuing competence program for nurses as well as other health-care professionals.

I felt this was a bit of an ambiguous indicator to choose at first, but then embraced it and found almost every activity I engaged in professionally was relevant to this indicator. What it did was, in fact, put my CCP in the forefront of my mind. I was able to ask myself questions: How is this relevant to my CCP? How can I help others in their CCP? In the end, I appreciated the broadness of the indicator and ran with it. I engaged in activities I had never done before like a literature search. Looking forward to the next year!

YEARS OF EXPERIENCE: 33
PRACTICE SETTING: Integrated supportive living

RLM

INDICATOR SELECTED: 1.2 – The registered nurse follows current legislation, standards and policies relevant to the profession or practice setting.

OBJECTIVE: Complete McMaster Case Management Education (Program) Outreach Education
P.I.E.C.E.S Training Program (Rosehaven Provincial Program)

RELEVANCE: It is a new provincial initiative to improve case management throughout the province. Taking the education will allow me to be current with what AHS and the province expects of case managers.

ACTIVITIES: Education course Oct. 9/13:
McMaster AHS Case Management Education Level I, II & III
Conference/seminar/workshop March 26/13:
P.I.E.C.E.S. Training Program (Rosehaven Provincial Program) Outreach Education
Conference/seminar/workshop June 7/13:

EVALUATION:
The McMaster AHS Case Management Education directly related to my current practice. It helped me evaluate my communication with the team members,
responsibility to provincial standards, has had me reflect on my roles and responsibilities within case management, and how to be more effective in involving other disciplines in my practice. I use ideas from this education in my day-to-day practice, and it gave me a desire to seek more education around my specific practice.

**LM**

**YEARS OF EXPERIENCE:** 27  
**PRACTICE SETTING:** Cardiology  
**INDICATOR SELECTED:**  
1.5 – The registered nurse participates in quality improvement controls.  
**OBJECTIVE:** I want to learn and participate in improving a research feasibility tool.  
**RELEVANCE:** This is relevant to my practice because research is very expensive. If a site does not have the patient population to support the study objective, recruitment is too low, thereby lowering the study power.  
**ACTIVITIES:** Committee/advisory group Oct. 22/13: I volunteered to be a member of a focus group within the Alberta Clinical Research Consortium (ACRC) to refine tools and templates regarding a study feasibility checklist.  
**EVALUATION:** I am now at the stage to implement the budget tool. This tool could prove to be a fiscal asset.

**BSB**

**YEARS OF EXPERIENCE:** 29  
**PRACTICE SETTING:** Surgery  
**INDICATOR SELECTED:**  
2.2 – The registered nurse uses appropriate information and resources that enhance patient care and achievement of desired patient outcomes.  
**OBJECTIVE:** To understand prostate cryotherapy  
**RELEVANCE:** We have been admitting more patients for this procedure on our unit.  
**ACTIVITIES:** Internet research March 21/13: Research paper by Donnelly & Saliken Prostate Cryosurgery  
Inservice/workplace presentation March 7/13: Attended post-operative Day 1 patient information class  
**EVALUATION:** More comfortable doing post-op teaching with this procedure.

**DDJ**

**YEARS OF EXPERIENCE:** 24  
**PRACTICE SETTING:** Obstetrics  
**INDICATOR SELECTED:**  
1.7 – The registered nurse regularly assesses their practice and takes the necessary steps to improve personal competence.  
**OBJECTIVE:**  
1. To better understand the emotions of the grieving person and to know when it is appropriate to refer them for further support  
2. Continue looking up information on different conditions that affect pregnancy such as Von Willebrand’s Disease and Polycystic Ovarian Syndrome.  
**RELEVANCE:** 1. I will be able to provide support and get patients more help than I can provide, when appropriate.  
2. I want to be knowledgeable about a patient’s conditions when talking to them about their miscarriages because all patients use the RN in our clinic as a resource for pregnancy issues as well as other health issues.  
**ACTIVITIES:** Internet research June 30/13: Polycystic Ovary Syndrome, author Dr. D. Cahill, consultant senior lecturer on obstetrics and gynaecology from netdoctor.co.uk.  
Internet research July 15/13: Pregestational Metformin Use and Abortion Rates in Patients with Polycystic Ovarian Syndrome P. Kovacs, MD, Medscape.com  
Internet research July 15/13: Conception, pregnancy and Childbirth Von Willebrand Disease, Canadian Hemophilia Society, hemophilia.ca  
Journal articles/books Aug. 25/13: Surviving Miscarriage by S. McLaughlin, PhD  
**EVALUATION:** After reading the book and articles I feel better prepared to answer questions from patients about their medical conditions in relation to miscarriage. I also have a better understanding of grief as related to miscarriage and see the wide range of what can be normal. This should allow me to feel more confident in my evaluation of each individual’s progress so I can make a decision as to the need for a mental health referral.

**ABK**

**YEARS OF EXPERIENCE:** 11  
**PRACTICE SETTING:** Critical care  
**INDICATOR SELECTED:**  
1.5 – The registered nurse participates in quality improvement controls.  
**OBJECTIVE:** To learn about more evidence-based practice and role of researchers in providing quality patient care and improving outcomes.  
**RELEVANCE:** Evidence-based practice is important to my role as this provides a proof of actions resulting in good outcomes.  
**ACTIVITIES:** Education course Oct. 26/12: Nursing research course from Athabasca University  
Education course Dec. 7/12: Philosophical Knowledge and Advanced Nursing Practice  
Education course April 19/13: Theoretical Knowledge and Advancing practice nursing  
Education course July 2/13: Applied statistics for nursing research from University of Calgary  
**EVALUATION:** This activity helped me in learning how evidence-based nursing effectively enhances the quality of nursing care. RN
TOP FOUR MYTHS about... CONTINUING COMPETENCE

➤ MYTH: The continuing competence program doesn’t need to be completed every year.
➤ FACT: The main purpose for the continuing competence program is to make sure that nurses continue to develop their professional practice and provide safe, competent care. This is why the continuing competence program (CCP) is an important annual requirement for registration renewal. Each year, you have the opportunity to demonstrate the activities and reflection that you have completed to keep your knowledge, skills and judgement relevant and up-to-date.

➤ MYTH: Credit hours are a more effective way to achieve continuing competence.
➤ FACT: Current evidence suggests that self-evaluation, supported by feedback from others, is essential for developing as a professional. As well, the continuing competence program was intentionally created for members to develop their own learning plans in order to be flexible and relevant to their specific role and practice setting. The program also recognizes that non-traditional approaches to learning can be effective learning methods that may not be recognized through the use of credit hours.

➤ MYTH: If I call CARNA with a question or raise a concern, I will get audited.
➤ FACT: Members selected for audit are randomly selected by a computer each year.

➤ MYTH: The CCP review is a lot of extra work.
➤ FACT: Members who are selected for review usually don’t have to do anything extra. They just complete and report their learning plan during renewal like they normally would. If a member’s learning plan is found to be incorrect or incomplete after review, they are given the information and support they need to meet their CCP requirements and the opportunity to demonstrate their improvement in their new learning plan. That’s it! Plus, the vast majority of RNs and NPs who are audited do well and meet the requirements the first time.

IN CONCLUSION: The continuing competence program exists to promote nurses professional development and ensure client safety; members are randomly selected for audit; even if you are selected, you probably have to do nothing more than complete and report your plan as usual. RN

Sixth edition of NIC now online

A new edition of Nursing Interventions Classification (NIC) is available on MyCarna with an easy to read two-colour design!

What’s new in the sixth edition?

23 additional interventions include:

✦ Central Venous Access Device Management
✦ Commendation
✦ Healing Touch
✦ Dementia Management: Wandering
✦ Life Skills Enhancement
✦ Diet Staging: Weight Loss Surgery
✦ Stem Cell Infusion
✦ and many more

133 revised interventions are provided for 49 specialties, including five new specialty core interventions.

To access NIC, log in to MyCarna and select Resources.
Carna Member

A Hearing Tribunal made a finding of unprofessional conduct against a member who put derogatory comments about her manager in a private Facebook email to a friend. Another staff member was able to access the email when searching the Facebook account that the member had left open on a computer at a patient’s bedside. The Tribunal issued a caution.

Carna Member

A Hearing Tribunal made a finding of unprofessional conduct against a member who, out of curiosity, intentionally touched the breast of an anesthetized patient who had breast implants, when she had no legitimate reason to do so. The member had already completed the e-modules on the Code of Ethics prior to the hearing. The Tribunal issued a reprimand.

Carna Member

Registration number: 71,248

A Hearing Tribunal made a finding of unprofessional conduct against member #71,248 who removed forms with identifier labels of four patients from the hospital and did charting on those four patients in a public restaurant during her lunch break, where a customer noticed a patient name on one of the labels. The Tribunal issued a reprimand and ordered the member to pass a course in responsible nursing and complete the e-modules on the Code of Ethics and the CARNA module on privacy. A condition shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

Carna Member

Registration number: 84,827

A Hearing Tribunal made a finding of unprofessional conduct against member #84,827, who failed to follow the orders regarding administration of tube feeds for a patient; failed to document adequate assessments of the patient or adequate rationale when the member was deviating from the orders regarding administration of tube feeds for the patient; and who, after resigning from the facility, inappropriately accessed and used personal contact information from the patient’s record to phone the patient’s husband to request that he write a letter of support for the member saying the member had provided good care to the patient. The Tribunal issued a reprimand, directed the member to pass a course in responsible nursing, and be restricted to working for one employer pending a satisfactory performance evaluation. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

Carna Member

Registration number: 88,525

A Hearing Tribunal made a finding of unprofessional conduct against member #88,525 who failed to follow the orders regarding administration of tube feeds for a patient; failed to document adequate rationale when the member was deviating from the orders regarding administration of tube feeds for the patient; and who, after resigning from the facility, inappropriately accessed and used personal contact information from the patient’s record to phone the patient’s husband to request that he write a letter of support for the member saying the member had provided good care to the patient. The Tribunal issued a reprimand, directed the member to pass a course in responsible nursing, and be restricted to working for one employer pending a satisfactory performance evaluation. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.
Medical-Surgical Nursing: 
At the Heart of Practice

MEDICAL-SURGICAL NURSING CONFERENCE
Brought to you by the Canadian Association of Medical and Surgical Nurses (CAMSN)

Friday, June 20, 2014
Calgary, Alberta
MacEwan Conference & Event Centre

For the most up-to-date conference information:
Visit our website: www.medsurgnurse.ca or find us on Facebook.

CALL FOR ABSTRACTS:
Are you a medical-surgical nurse with an interesting practice or research project that you would like to share? Submit an abstract of the poster description in 150 words or less to noelle.rohatinsky@usask.ca.

This is a great opportunity to showcase the complex and diverse world of medical and surgical nursing.
Increasing numbers of nurses are using smartphones and other mobile devices to communicate with colleagues and patients by telephone, text message or email and even to photograph wounds or skin conditions. Understanding the risks involved in using mobile devices may prevent potential adverse personal and professional consequences.

**Risk Management Considerations**

**Privacy Breaches**

Unauthorized disclosure of a patient’s personal health information (PHI) is a risk because mobile devices, such as smartphones, generally store and retain data on the device itself. Also, mobile devices are vulnerable to loss and theft because of their small size and portability.

Nurses have a professional and legal obligation to protect the privacy of patients’ PHI. This is commonly accomplished through the use of strong passwords and encryption to safeguard electronic PHI being communicated through mobile devices. Employers generally have policies that require the use of such safeguards. Without encryption, any emails, voicemails, pictures or text messages containing a patient’s PHI could be inappropriately accessed or disclosed if the mobile device is lost, stolen or inadvertently viewed by a friend or family member. Unauthorized disclosure can also occur during the wireless transmission of personal data.

There have been several reported privacy breaches in Canada involving mobile technology in the healthcare sector. Recently, a nurse lost an unencrypted USB key that contained the personal health information of approximately 83,500 patients who had been immunized for H1N1. The memory stick was not encrypted. This incident resulted in an investigation by the privacy oversight office and a class action lawsuit. In another case, a nurse working for a large teaching hospital had her laptop stolen from her car. The laptop contained records of approximately 20,000 patients. It was determined that the laptop was not encrypted, despite the hospital’s stated policy. These cases highlight that encryption is now the expected safeguard for data protection on mobile devices.

**Workplace Integration**

Some employers have prohibited the use of personal mobile devices during work hours or in certain areas of the workplace, while others provide nurses with employer-owned mobile devices for clinical use. More commonly, healthcare employers are implementing bring-your-own-device (BYOD) programs in which employees are permitted or even encouraged to use their own mobile devices in the workplace. Employers with BYOD programs will generally implement corresponding policies, protocols and systems that enable healthcare practitioners to use wireless devices to securely interact with other healthcare practitioners and to access patient records. However, the use of personal mobile devices without secure workplace integration, support (including the implementation of adequate encryption modalities) or knowledge can create an increased risk of a privacy breach and other adverse consequences.
Managing Expectations

In some cases, nurses, including nurse practitioners, are using their mobile devices to communicate directly with patients, both during and after hours. In addition to managing the privacy and security concerns associated with these communications, nurses are reminded to manage patient expectations about permitted purposes of these communications, how quickly they will respond to enquiries and what to do if the nurse is unavailable. Reasonable limits and response times can then be clearly communicated to patients.

Infection Control

Studies have found high bacterial contamination, (including MRSA), on mobile devices, which are likely to have originated from the hands of the healthcare workers. Since mobile devices are frequently handled and carried into multiple patient rooms, nurses are reminded to disinfect them often.

Consider Implementing the Following Precautions for the Security of Mobile Devices

- Use employer-issued mobile devices, where available, instead of your own device.
- Limit the use of your device for recording, transmitting or storing patients’ PHI, unless there are clear organizational policies permitting this practice.
- Work with your employer’s information technology department, if using your own device, to ensure your device has features and software that comply with your employer’s BYOD policies.
- Follow employer policies and only use employer-issued mobile devices for taking photographs or videos of patients for clinical purposes.
- Have and use strong password and encryption capabilities.
- Limit the amount of PHI stored on your device or, de-identify the PHI it contains.
- Turn off or do not enable WiFi and Bluetooth on any device containing or having access to patients’ PHI without confirming the connection is secure and protected.
- Transfer patient health care information recorded on your mobile device to the patient’s record as soon as practical, then use wiping software to permanently erase the information from your device.
- Use the time-out feature on your device, such that it automatically locks when not in use.
- Store your mobile device in a secure location; avoid leaving it unattended or allowing others to have access to it.
- Confirm whether your device has the capability to remotely erase data stored on the device, in the event that it is stolen.

Please contact CNPS at 1-800-267-3390 if you have questions regarding the professional implications of the use of mobile devices in the workplace and visit our website at www.cnps.ca.


3. Order HO-007 and Order HO-008, Office of the Information and Privacy Commissioner of Ontario, online: www.ipc.on.ca.


THIS PUBLICATION IS FOR INFORMATION PURPOSES ONLY. NOTHING IN THIS PUBLICATION SHOULD BE CONSTRUED AS LEGAL ADVICE FROM ANY LAWYER, CONTRIBUTOR OR THE CNPS®. READERS SHOULD CONSULT LEGAL COUNSEL FOR SPECIFIC ADVICE.
Hi, I’m your registered nurse.

Make yourself known

In these times of restructuring and transformation, it’s crucial to make yourself known as a valuable, skilled registered nurse (RN) or nurse practitioner (NP).

Let patients know who you are
Clearly introduce yourself as an RN or NP to your patient or client, their families and your coworkers. It’s not enough to say, “Hi, I’m Mary and I’m your nurse.” Clearly state that you are a registered nurse or nurse practitioner.

Why should you identify yourself as an RN in the workplace?
• To increase awareness of RN expertise
  Alberta’s health-care system is going through some major changes and it’s important for the public and other health-care professionals to see the skills, knowledge and value of RNs to the system. Help the public and your coworkers recognize you as an RN and distinguish the work you do.
• Because you deserve the recognition
  Not only did you put in a lot of time and hard work into becoming an RN, you continue to learn and develop as nursing practice evolves. Show you are proud of the advanced knowledge and skills you possess and continue to acquire, and your commitment to excellence in the work you do every day. Let people know you’re an RN and that RN means expert caring.

What else can you do to promote your profession?
• Wear your RN pin
  If you forget to introduce yourself as an RN, your pin will let patients and colleagues know.
• Visit our online store, Expert Care Wear
  You can find clothing and other merchandise like travel mugs that show your RN pride at work and at home. See page 47 for more information about the store and visit www.expertcarewear.ca.
WHAT IS HORIZONTAL VIOLENCE?

Sometimes referred to as lateral violence, bullying, or disruptive behaviours, horizontal violence affects nearly half of all nurses and/or nursing students (Stanley, Martin, Michel, Welton, & Nemeth, 2007) and the number keeps growing. This trend continues despite zero tolerance policies.

When the subject of bullying is mentioned, it may conjure up images of young school kids behaving badly in the school yard. While some might say this is something that stops when childhood ends, it would seem this phenomenon continues into adulthood and into the workplace, including the nursing workplace.

Longo and Sherman define horizontal violence as “...an act of aggression that’s perpetrated by one colleague toward another colleague.” Some forms of horizontal violence are as subtle as gossiping about the victim, criticizing them in front of others, or keeping important information from them to keep them at a disadvantage. The more overt forms can include yelling or even physical violence.

THE IMPACTS OF HORIZONTAL VIOLENCE

- DECREASED HEALTH
  The toll it takes on nurses includes increased stress and decreased job satisfaction, negatively affecting the mental and physical health of nurses, which results in more sick days.

- LOWERED RN RETENTION
  The cycle of negative effects from workplace bullying creates problems in recruitment and retention of nurses.

- NEW GRADS QUITTING
  Horizontal violence is something that new nurses tend to deal with more than other nurses. The phrase “nurses eat their young” has been around for decades, referring to how new nurses experience more workplace bullying compared to other nurses. As students
rotate through units where this bullying is present, they may decide to avoid those units upon graduation making recruitment of graduates difficult. One study claims “60 percent of new graduates will leave their first positions within six months...” due to poor treatment by coworkers and that 50 percent of that number will actually quit the nursing profession.

**INCREASED COSTS**

The financial implications of workplace bullying are substantial. The cost of training new staff is staggering with some estimates as high as $100,000 per new hire. This is just one expense incurred by horizontal violence. The combined financial costs can be billions of dollars each year.

**DECREASED PATIENT SAFETY**

In an environment where pressure to perform with skill and accuracy is already high, the added pressure caused by workplace bullying can create conditions that put patients at risk by increasing likelihood of errors in patient care. Errors can lead to poor patient outcomes including harm to the patient or even death. Some forms of horizontal violence are as subtle as keeping important information from a coworker to keep them at a disadvantage. This can potentially endanger a patient.

The impacts of horizontal violence in the nursing workplace are far-reaching, affecting the social, professional, physical and psychological domains. It affects the victim and the bully, the novice and the veteran nurse, patients, patients’ families, and the taxpayer. Because this issue is so extensive, with many serious implications for the nursing profession and health care in general, it is important to understand some of the contributing factors.

**WHY DOES IT HAPPEN?**

**OPPRESSION THEORY**

Nursing is traditionally a profession dominated by females in a traditionally patriarchal society. As well, nurses traditionally work in a hierarchal system, having to report to physicians. Because of these factors, nurses have been described in literature as being an oppressed group. It is characteristic in such groups for bullying behaviours to develop as the oppressed begin to bully others out of frustration and feelings of powerlessness. As others are exposed to bullying, the feelings of frustration and powerlessness spread and cause more bullying.

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**CLIQUES AND PERSONALITY TRAITS**

Certain personality traits can lead to bullying behaviour such as the need to be in control or poor self-esteem. Cliques have been cited as a contributing factor to horizontal violence in that they can serve as a power base for individuals to gain control. Other personality traits such as lack of confidence can cause some student nurses and recent graduates to be more prone to bullying by others. Unfortunately, the behaviour can be learned and may be perceived as a normal part of the profession so the students experiencing bullying may go on to bully others, similar to children who have been raised in an abusive household going on to abuse their own children later in life.

**INACTION**

Bad behaviour will continue as long as good people do nothing. This is a major contributing factor to why bullying continues to be a problem in nursing. Victims are often reluctant to come forward for fear of revenge or punishment. Managers, even if they witness the bullying, may not realize the extent of the problem. Even management may be caught up in the mentality that horizontal violence is just a part of nursing. This further discourages victims to speak up. Managers may choose not to act or even protect the bully, as the bully may hold a high position and bringing the situation to their superiors may prove difficult. As well, the managers may not deal with horizontal violence appropriately because of a lack of training or education regarding team-building or conflict resolution skills.

Coworkers are also guilty of inaction. Many nurses choose not to act because they believe it is a problem for someone else to solve or do not want to get involved. Horizontal violence continues because of silence. Ignoring the problem will only exasperate the problem and hurt the profession.

Nurses must take responsibility for identifying and taking action to stop workplace abuse; from students to veteran nurses to managers. By taking responsibility, nurses may be motivated to change the status quo.

**HOW CAN HORIZONTAL VIOLENCE BE PREVENTED?**

**POLICY**

In Alberta, nurses are accountable to practise according to the Practice Standards for Regulated Members of the College and Association of Registered Nurses of Alberta. The document states that a nurse: “...practises with honesty, integrity and respect and complies with the Canadian Nurses Association (CNA) Code of Ethics (2002), ...reports unskilled practice or professional misconduct to appropriate person, agency or professional body, ...advocates for practice environments that have the organizational and human support systems.” A closer look at the CNA Code of Ethics tells us that a nurse must contribute to safe and supportive work environments, support students in their learning, and actively work toward maintaining a safe, ethical, team-like work environment. Taking these standards into consideration, it is easy to see that anyone involved in workplace bullying is in contravention of both the Standards and the Code. Clearly, the policies under which nurses work ask for ethical behaviour, yet the problem...
 persists. While a zero tolerance policy is crucial in working to eliminate horizontal violence, it is evident more needs to be done.

**RESPONSIBILITY OF NURSES**

Managers must take responsibility for ensuring their unit is bully-free. They can do this by listening to and supporting their staff, asking for input from staff, and selecting preceptors who will uphold a zero-tolerance policy for horizontal violence. The institution should provide further education to managers, or hire managers with higher education better suited to deal with these problems.

Improved methods of reporting horizontal violence need to be implemented that protect the victim, such as anonymous reporting and legislation protecting whistleblowers. Managers need to enforce policy currently in place when made aware of violations. Nurses in the workplace need to be informed and reminded of policies against horizontal violence through methods such as posters and fact sheets, and receive education about what it is and what to do about it.

Overall, it is imperative that each nurse take responsibility for this problem and work toward eliminating bullying in their work environment.

Take action when you see horizontal violence. Report it, document it. Access resources that tell you how to deal with the problem.

Also, take a moment to review your own behaviors. When you are tired, could your words be taken as unkind? What is your demeanour towards your students or coworkers and how do they typically respond to you? It may be a hard realization to come to, but one big step towards eliminating bullying in the workplace is for the bullies themselves to become more aware of their behaviours and try to change them.

**MENTORSHIP**

One study done by Hewett, et al. shows that following a mentorship program implemented in California, nurse turnover and vacancy rates dropped significantly. Not only did the study show improvement in retention of nurses but patient outcomes improved as well with occurrence of falls being reduced by 50 per cent, and pressure ulcer occurrence by 20 per cent. It is estimated that the hospital where the program was implemented saved $1.4 million by retaining nurses as a direct result of the program.

Policies currently in place are an excellent foundation for eliminating horizontal violence in the nursing workplace. More action needs to be taken by institutions, management and individual nurses to ensure workplace environments are safe, supportive and ethical. Proper communication, actions, education, awareness campaigns and mentorship programs can encourage better compliancy with current policies.

Horizontal violence is damaging not only to individuals, but to society as a whole through debilitation of our health-care system. With the amount of money required to operate our current health-care system and a shortage of resources and personnel, horizontal violence is simply unaffordable. Solutions need to be implemented to eliminate horizontal violence in the workplace. Managers and institutions have a responsibility to create and maintain a bully-free workplace. There is a shared responsibility by all nurses regardless of position to do their part to ensure current policies are upheld.

As awareness and a sense of responsibility for horizontal violence increases, we, as nurses, can implement changes to make elimination of this serious issue a reality. **RN**

REFERENCES

save the date

~ MAY 8, 2014 ~

CARNA AWARDS OF NURSING EXCELLENCE

Gala

join in the celebration of our profession
on Thursday, May 8, 2014 at the new
DoubleTree by Hilton Hotel West Edmonton
in celebration of our profession and to honour recipients
of the 2014 CARNA Awards in the following categories:

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

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

REGISTRATION OPENS SOON.
Visit www.carnaawards.ca for more information.
No one understands the importance of listening better than registered nurses and nurse practitioners. For us, taking the time to listen to patients is the most critical first step in providing expert care.

As your regulatory college and professional association, we are committed to making listening and engaging a part of everything we do, including the 2012–2013 annual report—which will be our first completely web-based publication. We’re designing it with the goal of making it easier to learn about what we’re doing and what we’re working towards, while creating opportunities for readers to tell us about what matters to them. The full annual report will be available soon at www.nurses.ab.ca/annualreport.

This past year, we made progress on several ongoing projects and initiatives that will help shape the future of our profession:

- Implementing NEPAB Site Visits
- New NCLEX RN Exam
- Jurisprudence Requirement of Registration
- IEN Learning from Experience Research Project
- NP Prescribing of Controlled Substances
- Primary Health Care
- Family Care Clinics
- RN Regulation Changes
- Social Media and Website Redesign

**REGISTRATION TRENDS**

46,210 registration phone calls

From March 4, 2013—when we launched our new phone system—to Sept. 30, 2013, CARNAB handled 46,210 registration phone calls from applicants and members. We also responded to more than 10,000 registration-related emails during the practice year.

CARNAB staff provided registrants with support and guidance on the CCP process through individual consultations, 2,200 telephone conversations, email correspondences and group meetings.

A total of 120 Continuing Competence education sessions were held across the province, with more than 1,190 attending.

**PRACTICE CONSULTATION TRENDS**

<table>
<thead>
<tr>
<th>CONSULTATION ISSUE CATEGORY</th>
<th>2013 PRACTICE YEAR</th>
<th>2012 PRACTICE YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope of Practice</td>
<td>404 (30%)</td>
<td>269 (29%)</td>
</tr>
<tr>
<td>Legal/Ethical</td>
<td>289 (21%)</td>
<td>196 (21%)</td>
</tr>
<tr>
<td>Nursing Practice Standards</td>
<td>229 (17%)</td>
<td>155 (17%)</td>
</tr>
<tr>
<td>Information/ Networking</td>
<td>147 (11%)</td>
<td>33 (4%)</td>
</tr>
<tr>
<td>Safety</td>
<td>126 (9%)</td>
<td>158 (17%)</td>
</tr>
<tr>
<td>Health Care Reform</td>
<td>77 (6%)</td>
<td>-</td>
</tr>
<tr>
<td>Relationships</td>
<td>42 (3%)</td>
<td>41 (4%)</td>
</tr>
<tr>
<td>Transitions/Independent Practice</td>
<td>21 (2%)</td>
<td>40 (4%)</td>
</tr>
<tr>
<td>Education</td>
<td>21 (2%)</td>
<td>3 (&lt;1%)</td>
</tr>
<tr>
<td>Public Health Issues</td>
<td>6 (&lt;1%)</td>
<td>-</td>
</tr>
<tr>
<td>Graduate Nurse</td>
<td>-</td>
<td>17 (2%)</td>
</tr>
<tr>
<td>Internationally-Educated Nurses</td>
<td>-</td>
<td>4 (&lt;1%)</td>
</tr>
<tr>
<td>Pandemic</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1,362*</td>
<td>916</td>
</tr>
</tbody>
</table>

*NOTE: 1,548 requests were initially received, but for 186 of these, attempts to contact the requestors were not successful.*
200 complaints were received during the practice year—reflecting approximately 0.6% of the total practicing membership of 36,718.

Of those 200 complaints, 80 complaints—or 40%—were managed in ways other than an investigation.

72 complaints, or 36% were resolved within 30 days of receipt by being settled or dismissed in accordance with the Health Professions Act.

There was a 6% increase in complaints from co-workers about disrespectful behaviours from colleagues in the workplace.

A slight increase in breaches of confidentiality was noted; in particular breaches related to Netcare and other electronic records.

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WHEN DAINA KELM FIRST HEARD ABOUT A NURSING POSITION AT EDMONTON SOUTHSIDE PRIMARY CARE NETWORK (PCN) TWO YEARS AGO, SHE DIDN’T KNOW WHAT THE ORGANIZATION DID. NOW, SHE CAN’T STOP BRAGGING HOW SHE LOVES HER JOB TO HER FRIENDS.

“I love working for the PCN because it fosters an environment of interdisciplinary care. They really encourage us to work as a team. They put us in the right environment where we are working with physicians who also believe in primary care,” says Daina, who is based out of the Canora Medical Clinic in Edmonton as a primary care nurse.

Daina says there is respect among all clinicians, whether they are social workers, dietitians, exercise specialists, nurses, nurse practitioners or respiratory therapists.

She says she is continually asked by physicians for her insight on patients. “Through our PCN, we have such a collaborative approach, I’ve never felt more part of a team in my life.” Daina says.

Nurse practitioner Donna Paradowski says she was blown away at her first staff meeting. The PCN gathers all of its 75 employees on the first Friday of the month for an update on what is happening within the organization. Staff spends the remainder of this Friday in interdisciplinary meetings and educational sessions to ensure they are kept up-to-date of the latest knowledge within their field.

“I love the opportunity to network and I feel I have a voice. You can sit among the 70 employees and you can raise a concern. We’re included in the planning of the organization’s future goals. Right from the ground up, you have a role as an employee. You are actually contributing to the vision,” says Donna.

Nurse practitioner Sheri Fielding, the PCN clinical director, suggested Donna become involved in creating a high-risk lower-leg assessment clinic. The clinic provides care to individuals who are at risk of developing chronic disease-related ulcers.

When she’s not working in the high-risk lower-leg assessment clinic, Donna spends the remainder of her week at Ermineskin Medical Clinic seeing all patient population age groups.

“It’s great being able to work with nurses at Edmonton Southside Primary Care Network say interdisciplinary teamwork leads to a rewarding, dynamic environment. By Tamara Vineberg
other disciplines because I’m not a genius on every aspect of health. A lot of people have different concerns and problems. We problem-solve together on where to go from here,” adds Natasha Jiwani, a registered nurse.

Demand for services has increased since the clinic opened in September 2012. According to the Health Quality Council of Alberta, 30 per cent of Alberta patients have chronic illness, and medical costs associated with chronic illnesses account for 60 per cent of health-care costs.

Natasha says she finds her job rewarding because she can build relationships with patients and continually see their growth and improvement.

“It’s a very dynamic job. I’m able to do so much that I didn’t think [was] possible. This position allows me to work to my full scope of practice as a registered nurse,” says Natasha, who works as a primary care nurse at Urban Medical Clinic.

She can spend more than an hour with diabetic patients educating them about their chronic disease. The next hour could be spent focusing on a prenatal visit.

The PCN’s belief in its employees has paid off. Edmonton Southside is listed as one of the Best 50 Small and Medium Employers in Canada by Aon Hewitt and Queen’s School of Business. The full list will be published in PROFIT magazine’s February issue.

Becoming a Best Small and Medium Employer is a very detailed and competitive process. PCN staff completed a survey last spring, which ranks employers through employee opinion and is a measure of employee engagement with the organization.

Daina says the easy access and direct communication with management also helps.

“They support our education. I am getting education assistance funding once a year to pay for half of a course,” says Daina, who is currently enrolled in Athabasca University’s post-master’s nurse practitioner diploma program.

Engaged employees are committed to the success of their organization and are motivated to perform their best. Highly engaged organizations can expect to experience higher staff productivity and high levels of client satisfaction.

Edmonton Southside PCN’s focus on employee engagement can be seen at all levels within the organization.

“They encourage me to be the best nurse practitioner that I can be. I certainly feel that I found my home at the PCN,” says Donna.

RN
BY SHEENA STEWART

After a holiday season packed with good cheer and great food, for many people the New Year represents a chance to get back to a healthier way of life. But a group of nurses at Edmonton’s Grey Nuns Hospital are turning their quest to get healthy into a competition that will jump-start better eating habits and encourage exercise. And they’re aiming to make the kind of life-long changes that will inspire their patients and coworkers to follow their lead.

Biggest Loser – Unit 51 Edition is the brainchild of Tara Houston, 34, an RN at the Grey Nuns who started her own fitness journey back in 2009. “I went to a new doctor and she weighed me and I was 198 pounds,” recalls Houston. “I remember she wrote the word ‘obese’ on my file and I was shocked. I decided to do something about it.”
Participants realize how important it was and think about disease prevention. "As nurses, we’re supposed to encourage patients to make healthier choices for nurses take care of their own health."

That interest sparked the idea for a Biggest Loser-style challenge, based on the popular reality TV show, that would encourage her coworkers to get on board with a healthier lifestyle of their own. She also hoped the challenge would help participants realize how important it was for nurses take care of their own health. "As nurses, we’re supposed to encourage patients to make healthier choices and think about disease prevention. We should be doing those things too."

Although committing to a healthier lifestyle can be hard for anyone, it can be especially hard in a hospital setting. “You come in every day and there’s a box of doughnuts or muffins sitting there at the desk. It was a big challenge for me and I thought maybe if we do this together, it will be easier for everyone.”

After asking around to gauge interest, Houston and her RN friend Michelle Smith, 32, put together the first Biggest Loser-style challenge in July 2012. They decided to make it a 90-day challenge. A notice in the staff room soon generated a group of 15 people who each paid a $50 entry fee to participate. Although people were free to follow their own diet and exercise plan, Houston created a Facebook page where the participants could share recipes and motivational pictures. “Even though people were in it to win, it was really about supporting each other,” says Smith. “And we stressed that it was a lifelong journey.”

In the end, 12 people completed the challenge with some participants making lifestyle changes that have stayed with them permanently. Estelie Fries, 49, was the winner of that first challenge, losing 17 pounds and going from a size 8 to a size 4. And she’s made the changes she adopted during the challenge part of her life. “I still eat healthier, which for me means brown rice and quinoa instead of white rice. And I’m Asian so that was a big change,” laughs Fries, a mother of two. She’s learned to eat six smaller meals a day, eat lots of vegetables and has traded ice cream for yogurt. She’s also made exercise a part of her life, something she, Houston and Smith all agree is critical to success.

“It’s not just about what you do in the kitchen,” notes Houston. “You have to get moving too.” For Houston and Smith, exercise involves working out regularly with a personal trainer – something that’s not always easy to do when you’ve had a long day at work caring for other people. “Sure, there are times when you just want to go home,” admits Houston. “But once you’re there you get a second wind and you want to keep going.”

Both note that in addition to the fitness benefits of exercise, physical activity is also a great way to deal with the stress that goes along with the profession. “Some days are tough,” acknowledges Smith. “But on those really bad days I get to the gym and just run all that negativity out. It’s a great outlet and it lets you leave all that stress at the gym so you don’t bring it home.”

Fries preferred the freedom to exercise at home, in her own space. “I dug my equipment out of my basement and actually use it now,” jokes Fries. “I feel better when I exercise and I think I’ve shown that you can do this at any point in your life. Age is not an excuse. And doing it with other people made it easier to stick with it.”

Response to the first challenge was so positive, that a second round of the Biggest Loser – Unit 51 Edition was held in early 2013, with 20 participants from across the hospital joining the challenge. In total, the winner took home a prize of $1,000 with the second and third place winners taking home $150 and $100 respectively. The next challenge is planned for January 2014.

“We’ve had people asking about when we were going to do another challenge since the last one ended,” marvels Smith. “We had thought about doing it before the holidays, but people told us they wanted to make that fresh start in the New Year, so that’s what we’re doing.”

Whether people are getting fit on their own or with support, both Houston and Smith agree that planning is key. “I set aside a couple of hours on the weekend and I figure out what I’m going to eat, Monday to Friday,” says Houston. Along with helping her stay in control of what she’s eating, that planning also helps her save money and resist the temptations that show up at work. And it allows her to indulge when she wants.

“I eat healthy all week long, and have one meal a week that lets me have whatever I want,” explains Houston. Smith takes a similar approach, and the result...
is that neither feels deprived. “If I want wings, I have them or if I want a glass of wine that’s okay too,” says Smith. “I just don’t do it every day.”

Houston and Smith say the challenge has also helped educate participants about healthy eating. “People think they’re eating healthy, but you look at the stir-fry they bring to work and it’s slathered in a sticky, sweet sauce,” says Houston, who has spent hours reading nutrition information online and is happy to share her sources with participants. Smith also finds herself reading labels more closely, and making choices based on nutrition. “I’m a lot more aware of what I’m putting in my body.”

Learning about nutrition is something they say all nurses should make time to do. “As nurses, we have a responsibility to learn what it means to eat healthy,” stresses Houston. “There’s been such an increase in obesity and we’re seeing more and more bariatric patients or patients that are so heavy, it takes four or five nurses to turn a patient. Sometimes I see nurses get judgmental about that, and really, how can we judge if we’re eating doughnuts and cookies at the desk? We’re supposed to be promoting health, and that should start with ourselves.”

S
ince beginning her fitness journey, Houston, who has now lost a total of 40 pounds, has done two things she never imagined possible – riding in the 2011 Enbridge Ride to Conquer Cancer, a 220 km cycling event in the Rockies, and the MS Ride for the Cure in 2013. “Physically I couldn’t have done it before, but I also didn’t have the confidence before. Now I tell myself, ‘you rode a bike for two days. What’s 30 minutes on a treadmill?’”

Although the challenge is intended to kickstart weight loss, its main goal is to get nurses to take charge of their own health. “Ultimately, it’s about being healthier and being a role model to your family, your coworkers and your patients,” says Houston. Smith agrees, noting that “If you’re making healthier choices and feeling better about yourself, you’re a winner no matter what the scale says.” RN

Obesity experts and researchers have known for many years that shift workers and people who work odd or irregular hours often struggle with their weight. In large part, this is because while you sleep, your body secretes serotonin and dopamine. When you don’t get enough sleep, your body will crave sugary foods that can stimulate the release of the missing serotonin and dopamine your body didn’t get a chance to make. Add to that the fact that inadequate sleep increases the release of ghrelin, a hormone that stimulates appetite and slows the release of leptin, a hormone that helps you feel full after eating, and you can see why working nights can leave you feeling hungry and craving sugar. You can read more at: http://www.nursetogether.com.

As if the hunger and cravings shift workers often experience weren’t enough, research suggests that lack of sleep actually slows your metabolism while simultaneously reducing insulin production. A 2012 article in *Time* magazine profiled Dr. Orfeu Buxton’s groundbreaking study on sleep deprivation, weight gain and insulin levels. Buxton, an assistant professor in the division of sleep medicine at Harvard Medical School, led a study that involved having 21 men and women have their sleep-wake cycles disrupted over a five-week period.

Buxton and his colleagues not only began depriving the subjects of adequate sleep, but gradually changed the sleep patterns and other routines to simulate shift work and jet lag. The results showed a metabolic slow down of eight percent—enough to cause a 10 lb weight gain in the course of a year. Multiply that by decades in professions such as nursing or the airline industry where shift work is commonplace, and you can imagine the long-term implications for weight gain. That same study suggests that the impact on circadian clocks can lower insulin production in the pancreas and raise blood-glucose levels—setting the stage for Type II diabetes.

So what’s the best way for shift workers to combat the effects of sleeplessness? In addition to getting as much sleep as you can, when you can (aim for seven to eight hours at a time), most experts recommend trying to maintain as much of a routine as possible. It’s also important to plan for night shift hunger by staying with a regular eating schedule and bringing healthy, nutritious snacks that will satisfy your appetite and keep blood sugar stable. And don’t forget to make time for exercise, which can help combat stress and promote better sleep.
Nurses around Alberta play a critical role in supporting parents and caregivers in enabling the healthy development of Alberta’s children. Nurses are uniquely positioned to support the uptake of the consistent and standardized information found in the *Healthy Parents, Healthy Children* resources. They can also help promote the use of these resources amongst colleagues.

As an expecting or new parent, access to credible information is essential. Unfortunately, while information is abundant, it can be very confusing—even overwhelming—for parents to attempt to discern what is credible guidance, and what is not.

Alberta Health Services’ new *Healthy Parents, Healthy Children* initiative makes things simple by providing reliable, up-to-date information about pregnancy and being a parent. The *Healthy Parents, Healthy Children* resource package includes two new, province-wide, books (available online, or in limited quantities as printed books), as well as webisodes and additional tools and supports online, and both a Twitter and Facebook presence.

All resources were developed in partnership with Albertan parents, clinicians, childhood development experts, and other key stakeholders from across the province. As a result of this collaboration, the resources are as relevant and accessible to parents as they are to the health-care providers supporting these parents every day.

**AHS looks forward to sharing these resources with you.** Please visit healthyparentshealthychildren.ca today; like AHS on Facebook at Healthy Parents, Healthy Children; or, follow AHS on Twitter @AHS_HPHC

Registered nurses in Alberta are also invited to provide feedback on these resources. To access the online survey, please visit healthyparentshealthychildren.ca and click “survey for Professionals” at the bottom of the screen.


For more information or to provide comments, please contact hphc@albertahealthservices.ca.

Registered nurses and other health-care professionals can access the online resources at www.healthyparentshealthychildren.ca, and may consider incorporating the learnings into daily practice situations, such as:

- while supporting expectant parents in prenatal education settings
- as a teaching tool in the labour, delivery and postpartum settings
- when providing health education to families with young children
- when delivering student and staff education and program planning
- participating in and promoting the social media campaign

**Healthy Parents, Healthy Children**

Resources developed *with parents & providers for parents & providers*
In the spirit of Nursing Week, registered nurses on the Pediatric Oncology ward at the Stollery Children’s Hospital in Edmonton paid tribute to the “Lady with the Lamp,” nursing pioneer Florence Nightingale.

Registered nurse Shirley Perry helped organize the dress-up event and photo shoot, saying the nurses chose to pay homage to Florence Nightingale because they “look up to her as a leader” and that her quotes still have meaning in today’s nursing environment.

“The quote about never making excuses really made an impact on us,” says Perry. “In these times of change, more of us need to stand up and say, ‘patient care comes first.’ Florence was up against horrifying conditions, and yet she continued to provide good nursing care to people, and that’s all we want to do as well.”

Born in Florence, Italy in 1820, Florence Nightingale is widely thought of as the “founder of modern nursing,” who practised what we would refer to as modern-day nursing during the Crimean War. She got her nickname “The Lady with the Lamp” from an article in The Times, a British daily newspaper, which published:

“She is a ‘ministering angel’ without any exaggeration in these hospitals, and as her slender form glides quietly along each corridor, every poor fellow’s face softens with gratitude at the sight of her. When all the medical officers have retired for the night and silence and darkness have settled down upon those miles of prostrate sick, she may be observed alone, with a little lamp in her hand, making her solitary rounds.”

Florence Nightingale’s legacy shines through the years, beginning as the namesake of the first official nurses’ training program, the Nightingale School for Nurses, which opened in 1860.

Nightingale’s compassion, dedication to providing quality care to her patients, and her diligent administrative work have set the standard to which these modern nurses strive to achieve. RN
SEAMSTRESS: Brooke Carson Hallman, Charleston, South Carolina.
INSPIRATION: Joan Perry, RN and Director of Volunteer Services, Roper Saint Francis Healthcare Center, Charleston, South Carolina.
PHOTOGRAPHER: Stephen Wreakes, Medical Photographer, University of Alberta Hospital.
Aggregate Analysis of Oxytocin Incidents

Oxytocin is a valuable, time-tested drug and one of the most commonly used medications during labour and delivery.¹ It acts on the smooth muscle of the uterus to stimulate contractions. In Canada, its uses include the induction of labour in patients with a medical indication for the initiation of labour; the stimulation and reinforcement of labour; and to control postpartum bleeding and hemorrhage.²

As a high-alert medication, oxytocin bears a heightened risk of causing significant patient harm if used in error.³ For example, use of this drug to induce labour has been associated with significant adverse effects to both the mother (e.g., arrhythmias, uterine hyperstimulation, postpartum hemorrhage) and the fetus (e.g., bradycardia, hypoxia, hyperbilirubinemia, retinal hemorrhage).¹,² This bulletin shares information about incidents involving the use of oxytocin that have been voluntarily reported to the Canadian Medication Incident Reporting and Prevention System (CMIRPS). It includes an overview of the incidents and highlights major themes identified through a multi-incident analysis to raise awareness about continuous improvement opportunities for management of this medication.

Methodology and Overview of Findings

Reports of incidents involving oxytocin were extracted from the ISMP Canada medication incident database and the National System for Incident Reporting (NSIR)* database.⁴ The multi-incident analysis methodology described in the Canadian Incident Analysis Framework⁵ was applied for this analysis.

Tables 1 and 2 summarize the reported severity of outcomes of the medication incidents from these sources. In total, 74 incidents from the ISMP Canada medication incident database and 20 incidents from the NSIR database met the inclusion criteria.† One incident from the ISMP Canada database was excluded because of insufficient detail, leaving a total of 93 incidents for the multi-incident analysis. The data reviewed for this analysis spanned the periods from February 2003 to April 2013 for the ISMP Canada medication incident database and from October 2009 to April 2013 for the NSIR.

TABLE 1: Reported Severity of Outcomes of Oxytocin Incidents from the ISMP Canada Medication Incident Database

<table>
<thead>
<tr>
<th>REPORTED SEVERITY</th>
<th>NO. OF INCIDENTS**</th>
</tr>
</thead>
<tbody>
<tr>
<td>No error</td>
<td>4</td>
</tr>
<tr>
<td>No harm</td>
<td>59</td>
</tr>
<tr>
<td>Harm</td>
<td>7</td>
</tr>
<tr>
<td>Death</td>
<td>0</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>73</td>
</tr>
</tbody>
</table>

TABLE 2: Reported Severity of Outcomes of Oxytocin Incidents from the National System for Incident Reporting (NSIR)

<table>
<thead>
<tr>
<th>REPORTED SEVERITY⁶</th>
<th>NO. OF INCIDENTS**</th>
</tr>
</thead>
<tbody>
<tr>
<td>No adverse outcome categories: reportable circumstance, near miss, none</td>
<td>14</td>
</tr>
<tr>
<td>Adverse outcome categories: mild, moderate, severe, death</td>
<td>6</td>
</tr>
</tbody>
</table>

Findings of the Multi-Incident Analysis

Analysis of the incidents from the ISMP Canada database identified a number of themes (Figure 1). The following sections provide details about the main themes, including the subthemes, and the potential contributing factors. Selected incident examples are also provided. Analysis of the smaller dataset from the NSIR database supported the ISMP Canada database themes identified.

MAIN THEME: Incorrect Drug

In reported incidents, both the administration of a drug mistaken for oxytocin and delays in administering oxytocin led to patient harm. Furthermore, the selection of oxytocin when another medication was intended has also resulted in an adverse outcome.
INCIDENT EXAMPLE
A bag of Ringer’s lactate containing oxytocin was infused instead of plain Ringer’s lactate at the time an epidural infusion was being set up. The error was discovered when the patient complained of abdominal cramps, and regular monitoring of the fetal heart rate showed a low heart rate. The oxytocin solution was replaced with plain Ringer’s lactate, but the fetal heart rate did not return to normal. As a result an emergency caesarean section was performed.

Two subthemes were associated with incorrect drug errors involving oxytocin.

SUBTHEME: Selection of incorrect vial
The incidents included in this subtheme involved mix-ups between manufacturers’ vials (or ampoules) of oxytocin and vials of other medications. Examples of medications that were confused with oxytocin at the drug-selection step included atropine, fentanyl, epinephrine and dopamine. Look-alike packaging and storage proximity were identified as potential contributing factors for vial mix-ups involving oxytocin.

SUBTHEME: Selection of incorrect practitioner-prepared bags or syringes
Incidents included in this subtheme involved mix-ups of bags or syringes prepared on site by healthcare practitioners. A number of potential contributing factors were identified. First, oxytocin is a clear and colourless liquid, so once it has been added to an intravenous (IV) bag or syringe, it is virtually impossible to distinguish from prepared IV bags or syringes of other colourless solutions. Second, inadequate labelling or identification increases the likelihood of incorrect drug selection and resultant errors (e.g., in a patient with multiple IV lines, misidentification of the oxytocin bag resulted in the pump for another drug being programmed with the oxytocin rate). Third, the presence of multiple syringes containing medications in the labour and delivery setting also increases the risk for selection of the incorrect syringe.

MAIN THEME: Incorrect Dose
To reduce the risk of adverse effects on the mother and the fetus when oxytocin is being used, frequent maternal and fetal assessments with appropriate dose titrations are necessary. Administering a dose of oxytocin higher or lower than intended can cause significant harm to both mother and fetus.

INCIDENT EXAMPLE
A miscalculation of an oxytocin dose resulted in the patient receiving a higher dose than intended. After delivery, the infant required brief resuscitation.

Two subthemes were identified: oxytocin dose too high and dose too low (including omission of doses).

SUBTHEME: Dose too high
A number of factors were identified that may have contributed to oxytocin errors involving a dose that was too high. For example, a lack of standardized oxytocin dosing protocols necessitates complex dose calculations at the bedside and may increase the likelihood of these types of errors. Other potential contributing factors included confusion related to units of measure (e.g., milliunits per hour versus millilitres per hour) and inadvertent administration of the drug without use of an IV pump.

SUBTHEME: Dose too low and dose omission
A variety of scenarios led to doses being administered that were too low. Dose omissions involving oxytocin also occurred. Potential contributing factors included the lack of a standardized dose titration protocol, improper connection of the IV line, and confusion among multiple IV lines for different drugs.

MAIN THEME: Incorrect Route
Incorrect route errors, especially mix-ups between IV oxytocin and epidural analgesia administration, can lead to significant patient harm. Given that epidural analgesia is frequently used during labour and delivery, mix-ups between these routes are a distinct possibility and have been reported.
Aggregate Analysis of Oxytocin Incidents (cont’d)

INCIDENT EXAMPLE
A patient in labour was receiving epidural analgesia for pain control. As the pain control was suboptimal, the nurse went to ‘top up’ the epidural with what she believed was a syringe containing bupivacaine. After administering the ‘top up’, the nurse questioned whether oxytocin had been inadvertently given epidurally instead of bupivacaine. Both medications were previously drawn up in syringes and were unlabelled, thus resulting in the confusion. After birth the mother and the baby were discharged without complications. A review of the incident concluded that the correct medication was likely given.

Lack of proper labelling of the syringes was identified as a potential contributing factor in these incidents. The interconnectivity of epidural and intravenous systems continues to be a contributing factor in wrong route errors.

MAIN THEME: Other Findings
Incidents in the category for other findings did not directly lead to harmful errors, but are nonetheless important because they represent deviations from best practices and may increase the risk of errors over the long term. Two subthemes were identified: infusion of oxytocin without a primary line and incorrect drug storage or disposal.

SUBTHEME: Infusion of oxytocin without a primary line
In a number of incidents, oxytocin was administered as a primary infusion. This mode of administration is contrary to established guidelines, which recommend that oxytocin be administered as a secondary infusion with a primary line,7 to ensure patency of the line in the event that the oxytocin infusion must be discontinued. Potential contributing factors included lack of knowledge of guidelines and protocols for administering oxytocin and lack of experience with using this medication.

SUBTHEME: Incorrect storage or disposal
A number of the reported incidents involved improper storage or disposal of oxytocin. Although none of the incidents included in this subtheme led directly to patient harm, improper storage and disposal of oxytocin may lead to error-prone situations and may increase the likelihood of drug-selection errors.

Conclusion
Reporting medication incidents is important both for raising awareness of opportunities to enhance medication safety and for monitoring the effects of system changes. The multi-incident analysis described here focused on medication incidents involving oxytocin. The analysis identified a number of themes and associated contributing factors, as well as opportunities for system improvements. Of note, the results of this analysis are consistent with observations from a similar analysis, which investigated healthcare insurance claims.8

ISMP Canada has created an operating room medication safety checklist and is currently working to address some of the contributing factors identified from this analysis in collaborative projects including:

• Development of labelling and packaging guidance for manufacturers9
• Evaluation of strategies for safe management of multiple intravenous infusions10

It is hoped that the findings from this analysis will support and augment additional local, provincial and national quality improvement initiatives. RN

REFERENCES
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Ph#:

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☐ Visa  ☐ MasterCard

Card#:  Expiry:

Cardholder name:

Signature:

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Attention wound care nurses and other members of CARNA: Would you or someone you know be interested in joining a Wound Care Specialty Practice Group? If yes, please email Edna Harder Mattson at hmattson@mymts.net

The submission deadline for events and reunions in the Spring 2014 issue of Alberta RN is Feb. 10, 2014. Go to www.nurses.ab.ca for a complete and up-to-date listing of events and reunions or to submit an event for publication or posting.

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IN MEMORIAM

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

Cochrane, Dorothy (née Pullishy), a 1973 graduate of Lethbridge Community College, who passed away on Oct. 5, 2013 in Edmonton.

Grout, Helen (née Williams), a 1940 graduate of the Misericordia Hospital school of nursing, who passed away on Sept. 22, 2013 in Edmonton.

Gschaid, Angieline (née Joss), a 1980 graduate of Lethbridge Community College, who passed away on Aug. 20, 2013 in Lethbridge.

Herd, Lana (née Davies), a 1984 graduate of Mount Royal College, who passed away on Aug. 29, 2013 in Rumsey.

Hughes, Sharon (née Willis), a 1962 graduate of Calgary General Hospital school of nursing, who passed away on Aug. 2, 2013 in Calgary.

John, Mary (née Samuel), a 1996 graduate of the University of Calgary school of nursing, who passed away on July 18, 2013 in Calgary.

Lawrence, Frances (née Smyth), a 1938 graduate of Salvation Army Grace General Hospital school of nursing in Winnipeg, who passed away on Sept. 5, 2013 in Edmonton.

Miller, Mary (née Sainsbury), a 1960 graduate of the Winnipeg Children’s Hospital school of nursing, who passed away on Sept. 16, 2013 in Edmonton.

Molesky, Margaret (née Dunn), a 1943 graduate of St. Joseph’s Hospital school of nursing in Toronto, who passed away on Oct. 21, 2013 in Edmonton.

Wilton, Ruth (née Jeannette), a 1963 graduate of Hotel Dieu Hospital school of nursing in Windsor, ON, who passed away on Aug. 24, 2013 in Calgary.

Wood, Margaret (née Carter), a 1955 graduate of the Grey Nuns Hospital school of nursing, who passed away on July 13, 2013 in Calgary.

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In Memory

Marguerite Schumacher

1920 – 2013

Carna President 1963 – 1965
Honorary Member Since 1981

Marguerite Schumacher received her basic nursing education in Winnipeg, a bachelor of science in nursing degree from Western Reserve University in Cleveland, Ohio, and a master’s degree from Teacher’s College, Columbia University in New York.

Over her career, she became director of nursing at Grace Hospital in Winnipeg. In 1958 she was appointed advisor to the schools of nursing in Alberta and held this position for the next 10 years. Marguerite then became co-ordinator of the health sciences division at Red Deer College and was appointed dean of the Faculty of Nursing at the University of Calgary in 1973.

Marguerite chaired many AARN committees, served as a member of the executive board and was president from 1963 to 1965. She was a member of the board of the Canadian Nurses Association from 1963 to 1972 and was president from 1972 to 1974.
Registered nurses and nurse practitioners in Alberta have reason to feel hopeful by the historic implementation of the Alberta Health Act on Jan. 1, 2014. Not only does the Act introduce provincial legislation consistent with the core principles of the Canada Health Act, it also embeds many of the core values embraced by our profession in the decision-making in the health system.

Patient-centred care and advocacy are fundamental to our everyday practice and are embedded in the standards of practice and code of ethics of registered nursing. The Act also establishes a Health Advocate’s Office which has the potential to throw some light on the challenges regularly encountered by patients and families in accessing the care they need, when they need it by the care provider best suited to provide.

Registered nurses and nurse practitioners understand that the success or failure of a patient’s plan of care is closely linked to the level of engagement by the patient, their support network and other care providers in the plan. We are educated and skilled at integrating a patient’s personal physical, emotional and psychological circumstances in the development of the plan of care regardless of the limitation of their family or social supports.

Does the Alberta Health Act signal a fundamental change in health-care delivery? Or does it offer us the chance to open a door where patients can become more fully engaged in their health? I believe it presents an opportunity for us to reinforce the core values of registered nursing by developing tools, resources and support mechanisms which foster patient and family engagement in their care, accompanied by mechanisms to support this engagement; tools beyond the traditional, like Google Health, telehealth, and other phone and online support networks.

It can lead to further enabling of the patient’s already existing family support network through regular team-family meetings and cultivating supportive relationships with our patient’s families and communities over time. Ideally, we can extend those relationships beyond a single episodic visit to a clinic or stay in a hospital and nurture those relationships between patient and care provider in the primary health-care setting over a lifetime. This means sharing information with patients and families, working on a care plan together, learning to trust our health-care colleagues and understanding that as health professionals, we all want to do the right thing for the patient. It means being open to patient involvement and attuned to their hopes, aspirations and readiness to be partners in healthy living. RNs and NPs are well-suited to the task.

Principles without a commitment by people to act on them are empty words. This is why RNs and NPs need to be engaged in the implementation of the Alberta Health Act and not sit on the sidelines. The proclamation of the Act is just the beginning. The government has indicated that the development of Health Advocate regulations to define the duties of the Health Advocate, the requirements for complaint reviews, and the requirements regarding records management and confidentiality are scheduled to begin in January. These are areas that RN expertise and front-line experience can knowledgeably inform. Individually and as a profession, we can also contribute to the development of the Health Charter intended to define what Albertans can expect from the health system and roles and responsibilities within the system.

As your regulatory college and professional association, CARNA is committed to being involved in the process. We have joined with the College of Physicians and Surgeons of Alberta and the Alberta College of Pharmacists in requesting a meeting with the Ministry of Health to discuss the Health Advocate role, the Charter and the regulations. While we don’t know yet how much consultation will occur on the regulations, I urge you to seek opportunities to participate.

The key to making the Alberta Health Act a living commitment to every person, family and community is strong leadership and nurses need to actively participate. Because this is about what nurses believe in, because this is what our patients need.

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