Carna Centennial Conference

Registered Nurses: Making a Difference for Albertans

March 16-18, 2016
Join us at the CARNA Centennial Conference, *Registered Nurses: Making a Difference for Albertans*, taking place March 16-18, 2016 at the Delta Edmonton South in Edmonton, AB!

In addition to celebrating the contributions registered nurses have made in the past century, this conference will focus on what registered nurses and nurse practitioners are doing now to influence the health system of the future. Plenary and concurrent sessions, workshops, posters and oral abstract presentations will highlight significant contributions made by nurses in research, education, administration and direct care.

**Making a Difference: Partners in Care**

Working in partnership is about developing inclusive, mutually beneficial relationships that improve the quality and experience of care. This includes the individuals, families and their providers of care working together in partnership, as well as partnerships between various health-care providers, policy makers, educators, researchers and administrators.

**Making a Difference: Improving Quality Care through Nursing Practice**

RNs/NPs at all levels and in all locations are in a unique position to improve the quality of health care; that is, contributing to safe, effective, timely, appropriate, patient-centred care that is efficient, acceptable and accessible.

**Making a Difference: Roles of RNs/NPs in the Health System of the Future**

Registered nurses have been making a difference in the health system as educators, administrators, researchers and in direct care for over a century. Now, a larger world view about the future role of RNs and NPs is becoming evident. Today’s registered nurses aren’t just looking after the sick—they are functioning in many nursing roles and are empowered to help lead the transformation in health and health care that is occurring today. Simply put, registered nurses are changing the health-care system.
Speakers

Neil Pasricha
Author of *The Book of Awesome* and 1000awesomethings.com

Neil, a self-described “average guy,” has reached over 50 million people with his blog and best-selling books and next year he will challenge us to appreciate small pleasures and share the contagious spirit of workplace happiness in order to unlock our potential as leaders in the health-care system and beyond.

Paul Brandt
Country music singer

Paul Brandt is the most awarded male Canadian Country Music artist in history, and since his million-selling debut album, has been sharing his story of humble beginnings and big dreams with audiences across Canada and around the world. A former pediatric registered nurse, Paul has an honorary Doctor of Fine Arts from the University of Lethbridge in addition to his many industry accolades and awards.

Caroline Alexander
Chief nurse for NHS England (London Region)

Caroline graduated as a nurse in 1987 from Edinburgh University and has an MSc in Nursing Studies from South Bank University. She took on the Director of Nursing and Quality within NHS East London and the City initially and then within NHS North East London in 2012. Caroline was the Chief Nurse for NHS London for six months until she joined NHS England in her current role. Caroline is the Senior Responsible Officer for Compassion in Practice Area Action Four – Building and Strengthening Leadership.

Register on or before February 16, 2016 and save with early bird pricing!

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March 16-18, 2016
Delta Edmonton South
Edmonton, AB

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Eating Disorders Can Be Tricky

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Eating Disorders Can Be Tricky

CAMP
One of the great things about our profession is the diverse range of opportunities in the career path of a registered nurse. Yet, that wonderful diversity makes it more difficult to describe RN roles in clear terms that accurately and unambiguously reflect our contributions to health and health care. In this very column, you have heard me describe the essential contributions of RNs in continuing care, acute care and primary care – as well as the critical contributions of NPs in community-based care settings providing comprehensive primary health care.

Each description boils down to one foundation: using evidence, nursing knowledge, judgment and skill to gain a comprehensive understanding of responses to health and illness, and then using what we learn to assist those we serve in improving, maintaining or restoring health and well-being – we do this in every encounter, in all settings, and in close collaboration with the patient, family and care team. Knowledge depth and breadth varies based on experience and educational preparation, but these are the ‘bones’ of nursing’s essential contribution to health and health care, regardless of role or setting. And the most frustrating thing for nurses? When barriers that don’t make any sense erode their ability to make that contribution.

Case in point: the clinical nurse specialist (CNS). These are master’s prepared nurses that also have in-depth nursing knowledge and expertise in meeting complex health needs in a particular clinical area or population – most often those living with complex and lifelong conditions. These advanced practice nurses focus mainly on clinical care with patients, but are also deeply invested in education, research, consultation and clinical leadership in the practice setting. So, if you are a member of the public, or a politician, what does that really mean to you? Maybe a bit of research can help answer that question.

A few years ago, a study was conducted by the Royal College of Nursing in the U.K. to record the complex activity of clinical nurse specialists working in the field of rheumatology over one year (RCN, 2010). This study revealed that CNSs positively improved symptom management with fewer medication side effects, and patient satisfaction of care was also high. They also reported that the CNS was key in providing clinical expertise not only to patients and families, but to other professionals on the team. Finally, this study also showed that the CNS provided tremendous savings to the system. For example, outpatient work done by CNSs over one year saved approximately $145,000 CDN, and approximately $350,000 per nurse was saved by freeing up consultant appointments! Evidence also demonstrates that advanced practice nurses providing proactive care in the community adds great value for Ontario citizens (good outcomes at the same or less cost than usual care), especially for those with complex chronic conditions and social vulnerability (Browne, 2012). CNSs should be in high demand – but that’s not what I hear.

I recently spoke with two “nurse clinicians” who work in youth mental health and addictions. They are educated to be “clinical nurse specialists,” but are unable to enact that full role because the clinical area that they practise in doesn’t allow for such a designation. They find it disheartening that their role is constructed in a way that doesn’t allow them the time or autonomy to be able to enact their full range of knowledge: for example, to independently follow up on complex patients. Instead, these patients are referred to scarce psychiatric medical specialists – when most of their needs could be better met by the CNS. And when our revised regulation is passed and these advanced practice nurses can be further equipped with the ability to prescribe within their specialized areas of practice – imagine the enhanced access their patients could have to the care they need, when they need it. These CNSs see multiple ways, every day, that they could add value to their patients, and to the care team, but are constrained from doing so by having to conform to the limitations of the nursing role for which their area is funded. Many others tell me that the CNS role is viewed as a “frill” that is trimmed when money gets tight.

I understand that health-system leaders are facing a budgetary crunch – we’ve been here before. We need to leverage the knowledge base of all nurses not in spite of, but BECAUSE of the economic challenges of the moment. Fiscal constraint can be a big motivator for searching for new ways to add value for our patients, and for our care teams.

All registered nurses must be enabled to fulfill the roles the system needs them to play. Artificial barriers to full practice must be removed, and health-system leaders must resist the temptation to save costs by cutting first, and then figuring out how to use the team members that are left. So, if you are a member of the public, or a politician, what does that really mean to you? It means that the knowledge of all registered nurses – in all our many roles – is a big part of the solution for Alberta’s health-care system.

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Primary health care vs. Primary care

I enjoyed reading the “Collaboration in Caring – A New Approach to Health Care” in the summer 2015 issue of Alberta RN. The article is very timely. I agree that we are experiencing “a gradual shift towards a more collaborative style of health care” that includes health-care providers, patient/client and family members. I am beginning to witness more and more of this approach to care within primary care clinics which is very encouraging.

The one concern I have is the description of primary health care in the second paragraph. I think the first two sentences of this paragraph do not accurately reflect the proper distinction between primary care and primary health care. The June 2015 Canadian Nurse magazine article, on page 18, does an excellent job of describing the difference. I think it is important that the language used to describe these terms be accurate and consistent across all nursing organizations to help reduce the level of misunderstanding I frequently experience when discussing these topics with my nurse co-workers and friends. I would appreciate seeing clarification related to this terminology in a future Alberta RN magazine especially since primary health care is an important focus of the Canadian Nurses Association’s strategic plan for 2015-2019.

Adele R., Calgary, AB

EDITOR’S NOTE:
Thank you Adele for bringing this issue up. As suggested in your letter, we would like to clarify our definition of primary health care in relation to how it is defined by other organizations, as well as the distinction between it and primary care.

There are various definitions of primary health care and primary care and often the terms are used interchangeably. We define these terms as follows:

- Primary care refers to the first contact people have with the health-care system to seek out services for diagnosis, treatment and follow-up for a specific health problem, or to access routine screening such as an annual check-up. Primary care is a core component of primary health care.
- Primary health care extends beyond the traditional health-care system to include services that influence health such as income, housing, education and environment.

The June 2015 issue of Canadian Nurse magazine defined primary health care as: “Primary health care focuses on the way services are delivered and emphasizes that people should be at the centre of health care.”

Although different, both definitions arrive at the conclusion that the way care is provided should be based on the needs of the individual or population. Unfortunately this meaning, and the difference between primary health care and primary care, did not come across in the Alberta RN article “Collaboration in Caring.” As primary health care is an important health policy initiative that CARNA advocates, we will be more diligent in ensuring the correct definitions and distinctions between each in the future.

For more information on CARNA’s platform regarding our Primary Health Care Strategy, please visit our website at nurses.ab.ca.
Alberta Health is currently reviewing stakeholder feedback submitted during the consultation undertaken this summer on CARNA’s proposed revisions to the Registered Nurses Profession Regulation. This Regulation governs all RN and NP practice in Alberta under the Health Professions Act and creates a framework for scope of practice, registration requirements, continuing competence and conduct processes for RNs and NPs.

Proposed changes to the registration process include:

- a new requirement to show competence in nursing jurisprudence
- future nurse practitioners will require master’s level education to register as an NP
- temporary registration will have a maximum duration of two years
- supervision will be required for those on temporary register according to CARNA policy
- removal of option to waive the registration exam

Proposed changes to practice include:

- RN prescribing of medications in specific practice settings
- CARNA is working with Alberta’s education institutions that deliver nursing programs to ensure the development of an RN prescribing and ordering of diagnostic tests education program.
- The Nursing Education Program Approval Board (NEPAB) has developed draft standards and criteria that will be used to approve the RN prescribing and ordering of diagnostic tests education program.
- CARNA anticipates that the RN prescribing and ordering of diagnostic tests education program will be reviewed for approval and admitting students as of Sept. 1, 2016.
- authorization for RNs to order diagnostic tests according to the standards for restricted activities
- authorization for NPs to order radiation therapy in accordance with standards of practice
- a student from another country in a clinical practice experience in Alberta must be authorized by an Alberta educational institution, delivering an approved program, to participate in the practice experience
- RNs will be able to supervise unregulated workers performing psychosocial interventions

The Continuing Competence program is expanded to include these three components:

- practice reflection
- continuing professional development
- competence assessment

The current Regulation was proclaimed in November 2005, and CARNA has been working with Alberta Health since 2010 on the proposed changes.

### Next steps

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<td>Provincesl Council approves final draft of RN Profession Regulation and Standards documents</td>
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<td>CARNA implementation of changes to registration processes, practice and continuing competence</td>
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<td>RN prescribing and ordering of diagnostic tests education program will be reviewed for approval and admitting students</td>
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If you have specific questions about RN prescribing, or any other proposed revisions please ask to speak to one of our Policy and Practice Consultants at 780.451.0043 or toll-free at 1.800.252.9392 or send an email to practice@nurses.ab.ca
After a meeting on August 27 in Edmonton, leaders of United Nurses of Alberta and the College and Association of Registered Nurses of Alberta have begun formal discussions about a co-operative awareness campaign that would emphasize the unique contributions made to health care by registered nurses.

As a union and regulatory college respectively, UNA and CARNA have different missions, but both organizations have a similar perspective on the essential role that must be played by RNs as key members of the professional health-care team, according to UNA President Heather Smith.

“We see great value in building public awareness and member engagement around the huge contribution RNs and nurses of all types make as highly educated professionals trained in observation and critical thinking,” said Smith, who attended the August 27 meeting along with UNA First Vice-President Jane Sustrik.

CARNa CEO Mary-Anne Robinson was unable to attend the meeting but supports working with UNA on this important initiative. “We hope we can find ways to build understanding in the health-care system and among the public of the unique contributions of Alberta’s RNs,” said Robinson.

“We need to make the invisible visible,” observed CARNa Policy and Practice Director Carolyn Trumper. “The Uniquely RN project CARNa undertook this spring showed that RNs currently feel invisible and under-appreciated in the workplace.”

Among the initial steps planned by the UNA-CARNa working group will be a collaborative look for messages and images that work for both organizations, the use of that messaging in a future structured awareness campaign and the use of focus groups to test the reception of proposed messages among nurses and the public.

CARNa members are encouraged to offer their thoughts on messages and strategies for raising awareness about the unique qualifications and contributions of registered nurses.

**THE Uniquely RN Initiative**

Last year, CARNa heard from a number of registered nurses who expressed concern about the lack of visibility of their daily contributions to patients within and across the health-care system. They told us they had become almost invisible and that they were having challenges in describing their contributions as many of the tasks they perform look the same as what other health-care professionals also do.

Between November 2014 and January 2015, CARNa engaged more than 2,500 members in a discussion about what makes the RN unique among the broadening range of health-care providers, and what value the RN brings when scopes of practice overlap with other health-care providers.

We learned RNs think it is very important to ensure the differentiating qualities of the RN are articulated and to demonstrate the value of those qualities in terms that resonate with decision makers, employers, RN leaders and the public.

To start you thinking about your own visibility as a RN—do you introduce yourself as a “nurse” or a “registered nurse”? Does your correspondence have your professional designation along with your academic one(s)? These tactics are a great way for each RN or NP to help improve their visibility within the workplace.
Eating better and moving more can help Albertans decrease their risk of developing heart disease

Vascular disease is a growing problem

Vascular diseases are the major cause of death and disability. Vascular diseases (including heart disease, stroke, diabetes, kidney and peripheral vascular disease) affect the lives of more than 300,000 people in Alberta. The World Health Organization reported 89 per cent of deaths in Canada are the result of vascular diseases. The risk factors of vascular disease are known and can be prevented or controlled. Vascular disease is the result of high blood pressure, high cholesterol, detrimental nutrition or alcohol use, physical inactivity, obesity or tobacco use.

Diet and exercise make a difference

A healthy diet and lifestyle can reduce the risk of heart disease, heart attacks, and stroke. Conditions that lead to heart disease, including high cholesterol, high blood pressure, obesity, and type 2 diabetes can all be influenced by diet and lifestyle. Research has shown that eating the daily recommended amounts of vegetables and fruit helps to manage weight and reduces the risk of heart disease, stroke and certain types of cancer. Less than 50 per cent of Albertans get enough servings of vegetables and fruit per day.

Talk to your clients/patients

Are your clients getting enough vegetables and fruits in their diet each day? Look for ways they can increase their servings of vegetables and fruits to the recommended seven to 10 servings per day. Aerobic exercise is equally important for cardiovascular health. Ask your clients how much they exercise and if it is aerobic activity—the recommended amount is 150 minutes of aerobic activity per week for adults.

Reaching these goals may not be immediately attainable for various reasons in a client’s life. Explore ways that you, as a registered nurse or nurse practitioner, can help them. RN

For more information, visit the Alberta Health Services website, which contains many resources that can help you in your practice: http://www.albertahealthservices.ca/10589.asp.

The Power of Clinical Language: Unlocking the Potential of Clinical Documentation with Provincial Terminology Services

> Oct. 16, 2015 | 12–1 p.m.

This presentation will outline the process of standardizing clinical language as part of documentation in electronic systems. This webinar will also explore the benefits and opportunities to support patient care when clinical language is standardized into a structured format and supported by processes, people, technology and governance.

Caring for the Caregivers

> Oct. 21, 2015 | 12–1 p.m.

One in four Albertans provide unpaid care for a loved one living with illness, disability or age related challenges. As health providers and professionals, nurses can help to prevent caregiver burnout and depression by identifying, supporting and facilitating caregiver access to timely and appropriate resources and referrals.

This webinar will highlight the demographics of caregivers in Alberta, the impact of caregiving and some of the caregiver experience. It will look at some of the support strategies that nurses can incorporate into practice and the supports and programs that are available through the Alberta Caregivers Association.
The revised Camp Nursing: Guidelines for Registered Nurses was approved by CARNA Provincial Council in June 2015. RNs refer to these guidelines quite often in the spring and summer. Just as you will see increased fundraising efforts for various camps such as those run by, for example, the Tim Horton Foundation, you will also see an increase in job postings for camp nursing positions. Camp nurse positions may be paid or be volunteer. The camp nurse needs to be prepared for a challenging, demanding and multidimensional role and this document provides guidelines for the practice of RNs in the role of a camp nurse in a camp setting.

**What do you mean by “camp”?”**

For the purposes of these guidelines, a camp is defined as “a recreational place away from a usual residence which provides different opportunities and experience for children or adults.” The length of time for a camp can be as short as day or overnight but can be much longer. Camps can be held in an urban or rural setting and accommodation may be in a facility, in tents or in the wilderness. Camps serve different purposes but generally they are a community that encourages achievement, builds self-esteem, promotes healthy living, fitness and activity or it may just be the chance to experience a different environment that is healing in itself. Some have a theme, while others target campers with specific interests, such as music or horseback riding. Others specialize in accommodating children and adults with a particular disability or illness.

The goals of RN practice at a camp are generally to:

- prevent accidents and illness
- promote health
- treat accidents and illness
- builds self-esteem, promotes healthy living, fitness and activity or it may just be the chance to experience a different environment that is healing in itself.

**Is camp nursing right for me?**

There are many things to consider when determining if a camp environment is one in which you are prepared to practise. You are encouraged to:

- review the camp’s philosophy and objectives
- ask questions about the type of campers and the resources available, and
- review the policies and procedures the particular camp has created to address the health-care needs of the campers.

You must also have appropriate professional liability protection to practise as a camp nurse. You should also ask the camp organization if their insurance covers you and what is excluded in the camp insurance policy for the camp nurse in the event of any lawsuit. Always consult with the Canadian Nurses Protective Society (CNPS) regarding what professional liability protection is available for you (1.800.267.3390).

**The nitty gritty about camp nursing**

You will need to become familiar with the expected health needs of campers and what nursing services you will be required to provide. Review the camp health policies and procedures manual prior to the commencement of camp – this will help you understand the breadth and scope of practice required when at a particular camp. Current knowledge in first aid and CPR is recommended.

Always consult with the Canadian Nurses Protective Society (CNPS) regarding what professional liability protection is available for you (1.800.267.3390).

Usually, all campers and camp staff members complete a health form, provide contact info and have a signed consent for treatment.

The beginning of camp is a busy time for all staff. Depending on the type of camp, you may need to meet each camper and camp staff member at the beginning of the camp term to determine routine health needs and potential health risks. This is an opportunity to determine their baseline health status, review the health assessment form and the medications they have brought with them.
Documentation is an integral part of providing nursing care regardless of the practice setting, as outlined in CARNA’s Documentation Standards for Regulated Members (2013). As a camp nurse, you will need to record any nursing care provided for a camper or camp staff member.

The health record may contain a health history, list of special needs such as allergies, medications, specific nursing care, limitations to various activities, and contact information for parents, family, guardians, significant others, the primary care provider, etc.

If you find a discrepancy in information of underage campers’ needs, this should be discussed with the parents or guardians. Camp staff and counsellors need to be informed of conditions that may pose increased risk in certain activities.

You may find you are the only health-care professional on staff. As a camp nurse, you are responsible and accountable for having the knowledge, skills, critical thinking and judgment to address the health-care needs of the campers. You will not only need to manage both predictable and unpredictable outcomes of interventions, but should be competent to address a wide variety of conditions, such as simple first aid to potentially serious medical emergencies.

Campers and staff are in prolonged and close contact with each other, so the camp setting is usually at a higher risk for the spread of infections. You will act as a role model and an educator of infection prevention and control methods such as hand washing, coughing into the arm at the elbow and not sharing cups, straws, etc. There will also be policies and procedures for you to follow on infection prevention and control standards, and policy for disease outbreaks.

Protocols can apply to a range of campers who meet certain conditions or criteria. The camp may have protocols for minor injuries, acute inflammatory conditions, major trauma, and emotional and mental health needs. Before implementing a protocol, you will need to assess and determine if a specific camper with an identified health condition meets the criteria outlined in the protocol. You will also need to have the necessary knowledge, skill and competence to perform the interventions within a protocol. More information on protocols can be found in the CARNA Medication Guidelines (2015).

Confidentiality is just as important at camp as in other health settings. Any communication about the health of a camper should be in accordance with privacy policies and legislation (e.g., the Health Information Act, the Personal Information Protection Act of Alberta, the Freedom of Information and Protection of Privacy Act).

Medication management in camp

Campers, including healthy campers, can bring a variety of medications with them that you may be required to administer. You will need to practise safe and effective medication management and use the seven rights of medication administration. Up-to-date resources about medications and treatments to be given at the camp setting are necessary and should be obtained. If you are unclear about a medication, you will need to contact parents or guardians to clarify any medication discrepancies or instructions. When a camper requires an OTC, you only recommend or administer OTC medication when there is supporting practice setting policy in place.

Medications used at camp should be stored and disposed of safely. The camp should have a policy on how to store medications. You may find medications in different places such as a first aid kit and so an inventory list may be required. Stock medication that is no longer useable – for example, out of date, soiled, evaporated, etc. – should be disposed of safely.

RNs make camp safe and fun!

The role of the camp nurse is highly valued by campers, families, parents, camp staff and administrators. As more children and adults with chronic conditions are able to attend a camp, the camp health centre has become more than a first aid station. Today’s camps are often staffed by professional RNs who are prepared for a challenging and multidimensional role. Camp nurses who are prepared well in advance of the camp will be able to provide safe, competent and ethical care to children and adults in a fun-filled, natural environment.
Publications ordered by Hearing Tribunals

Publications are submitted to Alberta RN by the Hearing Tribunal as a brief description to members and the public of members’ unprofessional behaviour and the sanctions ordered by the Hearing Tribunal. Publication is not intended to provide comprehensive information of the complaint, findings of an investigation or information presented at the hearing.

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

Carna Member

A Hearing Tribunal made a finding of unprofessional conduct against a member who on four shifts administered a lower dose of narcotics to a patient than had been ordered, and failed to adequately document her reasons, or notify the physician. The Tribunal issued a reprimand.

Carna Member

Registration number: 27,875

The Hearing Tribunal made a finding of unprofessional conduct against member #27,875 who, while working as a clinical nurse specialist from February 6, 2012 to January 31, 2013, worked a large number of hours from home without permission and failed to create and maintain records for hours worked at home, worked as overtime, and taken as overtime compensation. For this finding of unprofessional conduct, the Hearing Tribunal issued a reprimand and ordered that the member complete course work, pay a fine, and submit a letter from the member’s supervisor reporting on the member’s current practice which must be satisfactory to the Tribunal. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of the member’s CARNA practice permit.

Carna Member

Registration number: 47,537

The Hearing Tribunal made a finding of unprofessional conduct against member #47,537 who, while working in home care, used a scalpel to do sharp instrument debridement on a wound. This was not within her scope of practice and without a physician’s order. She failed to document adequately and failed to use appropriate sterile technique. For this finding of unprofessional conduct, the Hearing Tribunal issued a reprimand and an Order that the members write a paper and submit one satisfactory practice evaluation covering at least 300 nursing practice hours. 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: 51,285

A Hearing Tribunal made a finding of unprofessional conduct against member #51,285 who breached confidentiality when she accessed the clinical records of a person when she was not authorized to do so for her own personal use. The member, who had identified herself as an RN, inappropriately made accusations of a personal nature about that person to the person’s manager at the person’s employer in an attempt to discredit the person. The member made remarks to that person’s manager implying that if the manager did not cooperate with the member, the member would discredit his business with the member’s co-workers and the member’s employer. The Hearing Tribunal issued a reprimand and ordered the member to pay a fine and pass the course Responsible Nursing, and complete the e-modules on the Code of Ethics and on privacy. 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: 65,681

A Hearing Tribunal cancelled the registration of Lily Choy #65,681 who was convicted of a serious criminal offence.

Carna Member

Registration number: 71,968

A Hearing Tribunal made a finding of unprofessional conduct against member #71,968, who failed to follow employer policy and protocol when removing a Central Venous Access Device on a patient when she failed to maintain current certification for the removal of central lines; failed to provide adequate information to the patient prior to removal of the line; failed to complete adequate documentation of the removal of the line; failed to place the patient in the correct position and had the patient sitting upright in a wheelchair; failed to take baseline, pre- and post-procedure vital signs; failed to apply adequate pressure to the insertion site following removal; and failed to apply adequate pressure to the insertion site for at least five minutes following removal. A couple of months later, the member was unable to demonstrate to the clinical nurse educator appropriate, safe technique for the removal of either a PICC or a non-tunneled central venous catheter. The Tribunal issued a reprimand and directed the member to pass courses including the Clinical Skills Refresher; Cardiovascular System Nursing and Responsible Nursing. The Tribunal restricted the member to working at her current setting for a short period, pending approval of supervised practice; and thereafter the member must provide two satisfactory performance evaluations from the supervised practice. 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: 71,981

A Hearing Tribunal made a finding of unprofessional conduct against member #71,981 who, while working in acute care nursing, failed to complete and document an adequate pain and palliative assessment.
For this finding of unprofessional conduct, the Hearing Tribunal issued a caution and ordered a supervisor’s report on the member’s current practice as to documentation as well as pain and palliative assessments. A condition shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

CARN A Member
Registration number: 76,611
A Hearing Tribunal made a finding of unprofessional conduct against member #76,611, who communicated in an inappropriate manner with a young adult palliative patient, which caused the patient and the patient’s mother distress; who failed to comply with the patient’s request to have his Fentanyl patches held in place for 30 seconds on application, as per the manufacturer’s instructions; who was inappropriately confrontational in her discussion with the patient about his Facebook posts in which he raised concerns about the member’s nursing care; and who told the patient in an inappropriate manner that she thought a mental health referral might be beneficial, thereby causing the patient distress. The member also failed to provide appropriate care to the palliative patient when on another day she advised the patient he could wait for the night RN to reapply his Fentanyl patch if he did not like the member’s method; failed to apply the Fentanyl patches using the appropriate technique; and failed to inform herself of the appropriate application of Fentanyl patches after the patient had expressed concerns about the member’s method of application. The Tribunal issued a reprimand and directed the member to pass a course on interpersonal aspects of nursing; write a reflective paper on appropriate communication as an RN; and be restricted to working at her next employment site pending approval of the Tribunal and two satisfactory performance evaluations. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

CARN A Member
Registration number: 78,429
A Hearing Tribunal made a finding of unprofessional conduct against member #78,429 who, while caring for an unstable diabetic patient, left an insulin syringe at a patient’s bedside and failed to follow hypoglycemic protocols. As well, the member failed to follow the employer’s medication administration policy when the member failed to check for drug incompatibility between Hydromorphone and Piperacillin Tazobactam, and injected the Hydromorphone into a pre-mixed mini-bag containing Piperacillin Tazobactam. The Tribunal issued a reprimand, and directed the member to take several courses on medication administration. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

CARN A Member
Registration number: 79,279
A Hearing Tribunal made a finding of unprofessional conduct against Member #79,279 who made an admission of unprofessional conduct under section 70 of the Health Professions Act. The unprofessional conduct was that on numerous occasions over an 18-month period, the member pilfered injectable Morphine, Fentanyl and Hydromorphone from his employer; falsified narcotic records to cover his pilfering of narcotics by signing out medications to patients to whom he did not actually administer the narcotics; and self-administered the pilfered Morphine, Fentanyl and Hydromorphone while on duty. The Tribunal issued a reprimand and accepted an undertaking to not practise as a registered nurse pending proof from a physician and counselor that he is safe to return to practice at which time, the member has a choice to return to either a practice setting where there is no access to narcotics or controlled substances, or do a supervised practice in a setting where the member is expected to administer medications, including narcotics and controlled substances. In either setting, the member’s employer will report back to a Hearing Tribunal. The member is required to continue drug screening and provide further medical reports to a Hearing Tribunal. Conditions shall appear on the member’s
practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

CARRA Member: Vida Abel
Registration number: 82,777

The Hearing Tribunal made a finding of unprofessional conduct against member Vida Abel #82,777 who, while working a night shift in a continuing care setting and being assigned the charge nurse role, failed to respond to staff requests to assess a certain resident; used inappropriate and uncaring communication with a certain resident who was crying; failed to adequately assess and document care for a certain resident; and left the workplace setting before the end of shift without notifying management, without providing report to oncoming staff, and without providing support for the remaining staff. For this finding of unprofessional conduct, and for the fact that the member failed to participate in CARNA’s investigation process as well as failed to attend the Hearing, the Hearing Tribunal cancelled Vida Abel’s practice permit, and ordered Vida Abel to pay a fine in the amount of $10,000 as well as pay costs of CARNA’s investigation and the hearing fixed at $10,000. Conditions shall appear on Vida Abel’s practice permit.

CARRA Member
Registration number: 84,040

A Hearing Tribunal made a finding of unprofessional conduct against member #84,040 who made an admission of unprofessional conduct under section 70 of the Health Professions Act as it related to an addiction illness. The member told untruths about why the member had missed a scheduled shift and then attempted to cover up the untruth by accessing Netcare and creating a falsified emergency record which the member then submitted to the manager. The member pilfered one bottle of 100 Percocet from a patient who was being discharged, replaced the bottle with Acetaminophen pills and the member then told co-workers that the patient left this bottle behind. The member pilfered two tablets of Oxyno, accessed a co-worker’s computer account and used the co-worker’s initials to document these tablets as wastage when they were not. In addition, from approximately 2013 to 2015, on numerous occasions the member pilfered narcotic wastage and falsified narcotic records. The Tribunal issued a reprimand and accepted the member’s undertaking to not practise pending medical clearance. Upon return to work the member may do a supervised practice or work in a setting with no access to controlled substances. In either case, the member is required to undergo drug screening and provide further medical reports. The member was also ordered to complete the e-modules on the Code of Ethics and a course in Responsible Nursing. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

CARRA Member
Registration number: 84,285

A Hearing Tribunal made a finding of unprofessional conduct against member #84,285 who contravened the Order in the decision of the Hearing Tribunal of a previous hearing regarding the member, when the member provided from her employer a performance evaluation that identified concerns about the member’s practice. The Tribunal issued a reprimand, and ordered the member to pass the clinical skills refresher course, and be restricted to working at her current employment setting until she had arranged a supervised practice, and then provide a satisfactory performance evaluation from the supervised practice. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

CARRA Member
Registration number: 84,682

A Hearing Tribunal made a finding of unprofessional conduct against member #84,682, who on one shift failed to ensure the required 15-minute checks were done on a patient who was in restraints, and failed to document her assessments of, or interventions with, that patient. The member also failed to ensure that required assessments were completed on two other patients who were in restraints, and failed to document her assessments or interventions on those patients. The Tribunal noted that the member had completed several courses on her own initiative, prior to the hearing. The Tribunal issued a reprimand and ordered the member to provide a fitness to practice letter from her physician annually for three years after the hearing, notify the Hearing Tribunal of her next employment site, and be restricted to working at that site pending three satisfactory performance evaluations. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

CARRA Member
Registration number: 85,790

A Hearing Tribunal made a finding of unprofessional conduct against member #85,790 who on numerous occasions over a period of approximately two years pilfered narcotics that were intended for disposal, including oral and injectable Morphine, Hydromorphone, and injectable Fentanyl from her employer; pilfered narcotics from patients’ personal medications that they had brought to the facility with them for the purpose of disposal; falsified narcotic records to indicate wastage of narcotics that were not actually wasted according to the facility protocols, but pilfered by the member; and ingested or injected the pilfered narcotics while on duty. The Tribunal gave the member a reprimand and accepted an undertaking to not practise as a registered nurse pending proof from a physician and counselor that she is safe to return to practice, at which time the member has...
a choice to return to either a practice setting where there is no access
to narcotics or controlled substances, or do a supervised practice in
a setting where the member is expected to administer medications,
including narcotics and controlled substances. In either setting, the
member’s employer will report back to a Hearing Tribunal. The member
is required to continue drug screening and provide further medical
reports to a Hearing Tribunal. Conditions shall appear on the member’s
practice permit. Failure to comply with the Order may result in
suspension of CARNA practice permit.

Carna Member
Registration number: 86,111

The Hearing Tribunal determined RN Registration #86,111 engaged in
unprofessional conduct when, on the insistence of the patient for more
analgesic, she administered 10 mg of Morphine two hours apart, which
exceeded the physician’s order of 5-10 mg IV q4h prn. In addition, after
not working in the recovery room for at least five months and having
a co-worker call in sick at the last minute, on one shift the member
administered 0.2 mg Dilaudid to two patients from the same syringe
and failed to adequately document her care of a patient, including
vital signs, pain assessment and discharge from the recovery room.
The Hearing Tribunal ordered the member to take the following courses:
Basic Medication Administration, Documentation in Nursing and
Pharmacology Nursing and in addition, she was to provide a satisfactory
performance appraisal from her current employer confirming she is
practising to the standard expected of a registered nurse. All the
requirements of the Order had been met by the member at the Hearing.

Carna Member
Registration number: 90,278

The Hearing Tribunal made a finding of unprofessional conduct against
member #90,278 who, while working in Acute Care, failed on numerous
occasions to accurately document narcotic administration; and, failed to
adequately advocate for a patient who had been prescribed a Nicotine
patch and wanted to go outside for a cigarette. For this finding of
unprofessional conduct, the Hearing Tribunal issued a reprimand and an Order to complete course work on documentation, medication
administration, and interpersonal aspects of nursing as well as to
submit 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: 90,903

A Hearing Tribunal made a finding of unprofessional conduct against
member #90,903 who administered and documented that she had
administered a higher dose of Coumadin than was ordered for a patient
on two separate occasions. The member made another medication error
on a different shift, when she gave to a patient at the same time, not
only his correct medication pouch for 1700h, but also gave him, in error,
his medication pouch labeled for 0800h. The member breached patient
confidentiality when she took a medication incident and investigation
report containing patient information home with her. The Tribunal
issued a reprimand and ordered the member to pass courses in
Basic Medication Administration and Pharmacology. In addition, the
member was restricted to working for her current employer, pending
one 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: 91,137

A Hearing Tribunal made a finding of unprofessional conduct against
Jacky Man #91,137 who stole the credit card from a health-care aide
co-worker from her purse at work; over a period of approximately
two months, fraudulently used the credit card he had stolen from his
coworker to make some 27 separate purchases totalling more than
$900; and caused his health-care aide co-worker significant emotional
distress, inconvenience, and other harm during and after she discovered
someone had stolen and run up debt on her credit card. On more than
one occasion, the member had wrongfully taken food items from the
canteen at work without paying right away, or at all; had rifled through
coworkers’ lunch bags without their knowledge or consent, and
inappropriately used his position of authority as a registered nurse
when he asked a health-care aide to lend him money for food. The
Tribunal issued a reprimand. The Tribunal also ordered the member
to pay a $5,000 fine, serve a one-month suspension, do a period of
supervised practice and thereafter obtain permission from the Tribunal
to work in his next work setting, and be restricted to working in that
approved setting pending three satisfactory annual performance
evaluations. Conditions shall appear on the member’s practice permit.
Failure to comply with the Order may result in suspension of CARNA
practice permit.

Carna Member
Registration number: 93,137

The Hearing Tribunal made a finding of unprofessional conduct against
member #93,137 who, while working in community health care, made
vaccine administration errors when immunizing children, resulting, in
some cases, of the administration of immunizations when they were not
required and, in another case, the need for an additional immunization;
failed to provide appropriate care and follow-up for a TB patient; and
posted inappropriate comments on Facebook about her former employer
and supervisor. For this finding of unprofessional conduct, the Hearing
Tribunal issued a reprimand and an Order that the member write a
paper and undergo two practice evaluations. Conditions shall appear
on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.
Publications ordered by Hearing Tribunals (cont’d)

CARN A Member
Registration number: 95,102

A Hearing Tribunal made a finding of unprofessional conduct against member #95,102, who neglected to restock a client’s medication box resulting in her missing doses of medications; who acted inappropriately when she instructed an unregulated support worker over the telephone to access a client’s antiretroviral medications from the member’s office, from more than one medication vial, and pour the dosages of medications from the vials for that evening and for the next morning; to give the a.m./p.m. medication box to the client to take those antiretroviral medications that the unregulated support worker had just poured; and to sign off that the client had taken those medications. The member failed to provide adequate leadership and supervision to unregulated support workers when she failed to ensure there were adequate or any policies in place to guide the unregulated support workers in handling or management of client medications; failed to ensure that any of them had special knowledge, skill, or training in medication administration; expected the unregulated support workers to sign off that clients had taken specific medications; expected the unregulated support workers to recognize if a client was not getting the correct medications, and take steps to remedy that medication problem; and blamed the unregulated support workers when a client missed doses of her medications. The member failed to provide adequate leadership and supervision to unregulated support workers who did not have any special knowledge, skill, or training in medication administration, when the member inappropriately expected them to manage the q12h Morphine and prn Seroquel for a client who was potentially suicidal, suffering from an addiction, and who was only ordered Morphine by the physician on the understanding that the facility would control her Morphine, and she would not be allowed to self-administer it; and the member blamed and chastised the unregulated support workers who were on duty when one of them gave the client two doses of Morphine and six Seroquel to take on an overnight pass. The Tribunal issued a reprimand, and ordered the member to pass a course in medication administration, complete the e-modules on the Code of Ethics, write a paper on the supervision of unregulated workers, and undergo education from a tutor on the role of the RN in supervision of unregulated workers. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit. RN

RENEWAL RETROSPECTIVE

Registration renewal is complete! How did it go in 2015?

32,500 out of 37,000 members submitted their renewal applications by the Sept. 1, 2015 deadline.

220 members came into the CARNA office to renew in person.

3,611 members renewed on the LAST DAY, Aug. 31, 2015.

8,000 PHONE CALLS were made to the renewal help centre.

How did your renewal go? Tell us at abrn.ca/renewal15feedback
Nurses interact with the police in a number of different ways. They may be asked to respond to inquiries from police or provide a copy of a patient’s chart because they have assessed and treated patients who are alleged victims or suspected perpetrators of crimes. In some instances, a nurse’s own conduct or the conduct of her colleagues may be the subject of a police investigation. In addition, there are times when a nurse may, in the interest of the patient or others, consider initiating contact with police to report information about a particular patient. In these situations, nurses find themselves balancing their obligation to maintain patient confidentiality with their commitment to the public good.

The criminal justice system is complex and its intersection with health care can lead to challenging legal, professional and ethical issues. Nurses should therefore understand their ongoing obligation of patient confidentiality, when they may disclose personal health information (PHI) to police, how much information to disclose, when they need to refer a police inquiry to higher authority and when it would be prudent to decline to respond to police inquiries.

Duty of Confidentiality

Nurses are well aware that they owe a duty of confidentiality to their patients. Disclosure of a patient’s PHI without patient consent may lead to a civil action against the nurse, a complaint to his or her employer, or a complaint with the nurse’s regulatory body or the privacy commissioner.

Nurses who provide professional services as employees of health care establishments may not be authorized to make decisions about disclosing PHI to police. Typically, privacy legislation deems health care professionals to be “custodians” or “trustees” of PHI, except when they are employees of other custodians/trustees, such as hospitals. The authority to disclose information to police normally rests with the custodian, which authority may be delegated to a privacy officer or specific employees (typically, managers). Nurses who practice as employees and who are not designated by their employer to respond to requests for access to PHI should consult with those individuals when considering a disclosure of PHI to police. Nurses who are custodians of PHI or who have the authority to make decisions about access to PHI on behalf of a custodian should be satisfied that they clearly understand the circumstances in which information can be disclosed under privacy legislation, as well as any relevant employer policy or directive.
Exceptions to Duty of Confidentiality

There are select exceptions that authorize the disclosure of PHI in the absence of express patient consent. Nurses who provide their services as employees should ensure they understand how these exceptions apply in their jurisdiction and that they have authority before relying on them. These exceptions include:

**Court Orders (search warrants and subpoenas)**

A search warrant is a written order issued by a judge or justice of the peace granting police the legal authority to enter a specified place during a specified timeframe to search for and seize evidence, which may include health records. A health care provider who has custody and control of the information covered by a search warrant is legally required to turn over the requested portions of the records. Only the specific information or records listed in the warrant should be disclosed and the custodian generally retains a copy of the PHI disclosed pursuant to a warrant so that a complete record remains available for treatment purposes.

A subpoena is a written command or summons requiring the attendance of someone as a witness at a legal proceeding. The subpoena document will specify a place and time when testimony on a certain matter will be required. Failure to obey a subpoena may result in legal consequences for the nurse, including arrest. A subpoena generally does not permit a nurse to disclose PHI without patient consent, before providing testimony in the legal proceeding.

**Public Safety**

In the course of carrying out their duties, nurses may gain access to information that they might consider relevant to law enforcement. There are limited circumstances in which it is permissible for health care professionals to act upon this information. For instance, health privacy legislation generally permits custodians/trustees to disclose PHI where there are reasonable grounds to believe that the disclosure is necessary to eliminate a risk of death or serious bodily harm. For example, in Alberta, the Health Information Act permits disclosure where there is a “clear and imminent threat of serious bodily harm or death”. This exception is also recognized at common law and in professional codes of ethics for nurses. Although now well recognized, this exception is one that can be most difficult to apply. Disclosure beyond the strict circumstances set out in the governing act can lead to a complaint of breach of privacy and loss of a patient’s therapeutic trust. Failure to disclose can lead to a complaint that not enough was done to prevent a devastating event. When time permits, it is prudent to seek legal advice before deciding whether to disclose PHI to prevent harm to an individual. Employer policies may also provide guidance.

**Legislative Duties**

Legislation governing PHI includes provisions expressly permitting the disclosure of PHI when mandated by other legislation. The provisions contained in other legislation may require disclosure to police or lead to police involvement.

For instance, health care facilities in some jurisdictions also have a duty to report select information regarding patients presenting with gunshot wounds and/or stab wounds to the police. The obligation to report typically rests with the health care facility, not the individual health care provider. Nurses who are employees should ensure that they follow institutional policies with respect to these mandatory reporting obligations.
Most Canadian provinces and territories have also adopted legislation requiring health care professionals to report suspected cases of child abuse and neglect. This duty to report is personal to the health care professional. It is generally triggered when a person has a reasonable suspicion or belief that a child has suffered or may suffer abuse or neglect. Whether there is a duty to report also depends on the age of the child and what is considered abuse or neglect; criteria which are jurisdiction specific. While the report must typically be made to a governmental agency (e.g. Children’s Aid Society), nurses should be prepared for an ensuing police investigation initiated by the governmental agency involved.

**Police Investigation Involving a Patient**

Health privacy legislation in some provinces/territories may require or allow custodians to disclose PHI related to a police investigation. It is generally a condition that the investigation be authorized by legislation, which would limit the type of police investigations in which disclosure is permissible or required. However, general information such as whether a patient is in the facility, the location of the patient in the facility and the general status of the patient (fair, poor, critical, etc.) can generally be disclosed, provided the patient does not object. Reporting the discharge of a patient to police is not contemplated or specifically permitted in the health privacy legislation. If employed, nurses who are approached during the course of a police investigation are encouraged to consult a privacy officer or manager who has authority to make such decisions on behalf of the health care establishment. Legal advice or intervention may be necessary to ascertain if the particular investigation is authorized by legislation or if the police request appears to be overreaching. Where disclosure is permitted but not required, employer policies generally provide guidance as to when and how disclosure is made.

**Police Investigation of the Nurse**

Examples of criminal charges laid against nurses include theft of narcotics, theft of patient or institutional property, assisted suicide, criminal negligence, threatening harm, physical assault, sexual assault and homicide. Typically, a nurse would be the subject of a police investigation prior to the laying of charges. This, however, may not always be apparent. During an investigation, the police may seek to interview nurses about their conduct, the conduct of their colleagues or the circumstances surrounding a particular incident. They may also request a statement. It can often be difficult to delineate this information from patient information which can only be disclosed without patient consent in specific circumstances. Moreover, information given to the police by an individual may be introduced as evidence against that individual at a subsequent trial. It is therefore prudent to seek legal advice before answering questions or providing statements to police and it is appropriate to request that inquiries be deferred for that purpose.

**Limiting Disclosure**

Even when nurses consider it in the public interest to disclose PHI in these circumstances, confidentiality should be preserved to the maximum possible extent. Both the amount of information disclosed and the number of people to whom disclosure is made should be restricted to the minimum amount necessary to prevent the feared harm.
Consider the Following When Interacting With Police

- The confidentiality of PHI must be maintained, unless disclosure is expressly authorized by patient consent or legislation;
- Police may ask questions or seek evidence; however, they may not have the right to receive the requested information;
- Police are not likely, nor are they qualified, to provide you with legal advice regarding your obligations or ability to disclose PHI;
- Consider asking police to obtain a search warrant or to identify the legal authority allowing the disclosure of PHI;
- If employed, nurses should know who at their health care establishment has the authority to make disclosure decisions, including after hours;
- Consider whether a court order, warrant or subpoena provides sufficient authority for the information being sought and consult with legal counsel, if necessary;
- When required to release PHI to police, provide a copy of the information rather than the original; if disclosure of the original is required in a search warrant or subpoena, retain a copy for health care purposes;
- Document any oral or written disclosure in accordance with the requirements contained in the applicable provincial or territorial health privacy legislation;
- Where a nurse has been charged with a crime or is the subject of an investigation, refrain from making any statement to police before obtaining legal advice; and
- Be polite and professional at all times.

CNPS beneficiaries with questions about disclosing PHI to police are encouraged to contact CNPS for advice.

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1. Nurses may be custodians, for instance, if they are self-employed, if they operate a clinic or if they provide occupational health services.
4. For example, Ontario’s Personal Health Information Protection Act, 2004, SO 2004, c 3, ss 43(1)(e) and (h), Nova Scotia’s Personal Health Information Act, SNS 2010, c 41, s 38(1)(l) and Manitoba’s The Personal Health Information Act, SM 2008, c 41, CCSM c P33., s 22(2)(o).

Related infoLAW® of interest: The Nurse as a Witness. Available at www.cnps.ca

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One of Dr. Valerie Grdisa’s first nursing roles was as a pediatric nurse working with children dying of AIDS, at a time when health-care professionals could refuse to work with patients living with AIDS. “I was caring for this little four-year-old patient named Ryan, and I would sit on his bed and read him books,” she recalls. That gesture created a trust with her young patient that allowed her to perform necessary nursing interventions. The experience also taught her that nursing is about taking every moment to assess the whole person and less about task completion. It’s a lesson that has stayed with her throughout her career.
Today, as the Senior Nursing Advisor (SNA) with Alberta Health, Dr. Grdisa provides strategic advice and professional nursing expertise to the ministry executive team on a wide range of health policies and programs related to the nursing profession and its role in the broader health-care continuum. In collaboration and consultation with stakeholders, she develops strategies for clinical standards; nursing education; primary, home and community care; and other health-system priorities.

It’s a role that also allows her to work closely with Alberta’s nurses to ensure they never lose sight of the difference they can make in the lives of their patients.

**The importance of primary health care**

“We all know that a high performing health system puts primary care at its centre, because that’s what patients and families access first – primary care providers,” explains Dr. Grdisa, who sits with CARNAs CEO Mary-Anne Robinson on the provinces Primary Health Care Steering Committee.

“Primary health care is all about how the needs of Albertans are met by the team, and I fundamentally believe that we are sub-optimizing nursing as a workforce in primary care,” notes Dr. Grdisa. She knows that good health care is about delivering the right care, at the right time, in the right place, by the right provider. “And I don’t think that right now in Alberta we have the right configuration.”

That’s one of the reasons she’s the Chair and Executive Lead of the Health Human Resource Strategy and Plan, which aligns with provincial initiatives like the Primary Health Care Strategy and the Addictions Mental Health Strategy.

“When we think future forward, we need to build service delivery models that are based on population health needs,” she notes. “Right now, most RNs work in acute, in-patient or ambulatory care, so we’ll need to develop a strategy to transition them into also being a significant portion of the workforce in primary care. It’s one of the many things we’ve been working with CARNAs on so we can align our efforts to move toward that paradigm shift.”

**Nurses as leaders and patient advocates**

Over the course of her career, Dr. Grdisa has seen firsthand the important role nurses play in the health-care system. “CARNAs more than 37,000 members, and when you put all the nurses in the province together, we are approximately 50,000 strong. We collectively represent nearly 50 percent of the health professions workforce and interact with patients and families in every type of practice setting, at every stage of the care continuum and at every stage of their lives – 24/7.

And we need to learn to grab on to that power. We are the integrators, collaborators, communicators and coordinators. Our patients count on us.”

She wants nurses to be courageous, so that when they see things that are impacting patient safety, quality or patient experience – they say something. “If I see that some of the processes and practices are getting in the way of making sure my patient is discharged with the best possible outcome, then I need to speak up and know that my comments will be respected and valued. And nursing leadership needs to empower those people who are speaking up and listen to what they are saying.”

As Chair of the Nursing Leadership Network, Dr. Grdisa is trying to help ensure that all stakeholders are on the same page about what matters for our profession. Launched in January 2015, the network has identified three priorities that the profession needs to work on.

“Too often, we’re being defined by the task we complete. I hope we move away from that, because nurses are knowledge workers, who have skills, knowledge and experience that enables us to be critical thinkers. The patient conditions we face are highly complex, and we need to be able to think and analyze and problem solve and respond to their broader needs that are not always related to a task or a condition.”

**RN leadership’s role in supporting innovation and collaboration**

Grdisa notes that because nursing leadership exists at all levels of an organization, it’s important there be an alignment of transformation efforts all the way to the bedside.

“It needs to flow both ways, because often it’s the nurses at the bedside who have the solutions,” she explains. “Solutions have to work for patients in each practice setting and you need to have nurses brave enough to say, ‘I get it, and maybe 60 percent of this makes sense, but the rest doesn’t - at least not here.’”

She notes operational leaders need to speak up too. “When things don’t make sense, or all of a sudden there’s a process improvement that complicates things, then leadership needs to speak up. Because you’re speaking up on behalf of your patients and you’re supporting your staff to focus on patient-centred care while managing and prioritizing the flurry of change initiatives.”

Nursing leaders are also critically important in creating collaboration. “We know the best teams are flat in terms of hierarchy. And collaboration only happens if there’s respect and trust and a mechanism to communicate with each other. And that takes good leadership at all levels.”
Expanding opportunities for nurse practitioners (NPs)

When it comes to the value of NPs, Dr. Grdisa speaks from experience. “I received my graduate education as an NP in Stony Brook, Long Island, N.Y. and was the director of the NP programs at the University of Toronto in the mid-2000s. I’ve practised as an NP in acute, ambulatory and community settings, so I know what it means to be an NP.”

She explains that the U.S. currently has 205,000 NPs with 86.5 percent working in primary care. “It works out to about one NP for 1,500 Americans. Here in Alberta, we have only 449 NPs, which works out to one NP for 9,440 Albertans.” It’s a number she would like to see grow.

Since taking on the role of SNA, Dr. Grdisa has met with over 200 NPs across the province. “Right now, in consultation with NPs, we’re trying to identify what would need to happen to integrate them across the health-care system. We need to get NPs to collectively champion their value proposition, deploy NPs to areas of need, and introduce funding mechanisms that support NP practice beyond what AHS currently funds. And we need to remove organizational and legislative barriers to where they can work in the system.”

She acknowledges that one of the biggest challenges is that with only 449 NPs across the province, most people have not been cared by, or worked with, an NP. “There really needs to be some kind of communication and public awareness strategy around the optimization of health resources and the impact NPs have now, and in the future.”

The impact nurses make on patients and the health-care system

For Dr. Grdisa, the impact RNs have on the system and their patients can’t be overstated. “Ultimately, we are the provider that’s addressing the individual’s response to their condition, illness and situation. We see their response to medication adminis-

tration or to pain or to the loss of health and well-being. We are the ones who put that whole-person picture together.”

Unfortunately, she believes that often the value of nursing is underplayed, in part because nurses themselves don’t understand the full extent of the impact they have. “We need to embrace nursing science and evidence and I think every nurse should understand analytics and their impact on outcomes at all levels: patient, organization and health system.”

She would also like to see nurses generate new knowledge and evidence. “Nursing knowledge generators can’t just be people working in universities. Nursing knowledge development needs to happen at every level and at every stage of our career path. And if we have true nursing leadership, then we should create opportunities for nurses to create and influence policy.”

What drives her

Dr. Grdisa brings nearly three decades of experience from a variety of health and social care roles in practice, management, research, policy and education to her role as SNA. She spent more than a decade advising organizations in areas such as care system redesign, clinical innovations, inter-professional collaboration, process improvement and complex change management. After completing her doctoral studies at McMaster University, she has held faculty appointments at eight Canadian universities. She currently holds adjunct faculty appointments at the University of Alberta, University of Calgary and University of Lethbridge. In the three years prior to becoming SNA, she was also the project director for several key Alberta initiatives.

Over the years, Dr. Grdisa’s belief in why nursing matters has never wavered. “I became a nurse because I wanted to be able to help patients and families solve problems or to support them, manage their chronic condition or their response to illness and coordinate their transitions in care. That’s what matters to people. And that’s still what matters to me.”

Doing what’s right drives her passion for her work. “Standing by what’s right for Albertans and patients and families sustains me. It’s right to optimize the entire workforce and get the right providers meeting the needs of Albertans. It’s right to advance chronic disease management and to create the conditions for RNs to optimize their knowledge, skills and experience.”

Mostly, she is driven because she cares – for patients, for nurses and for all Albertans. Much in the same way she cared for Ryan, her four-year-old AIDS patient who died just a few days after Christmas.

“After he died, his mom gave me a little angel ornament. And every single Christmas since, I have hung that angel on my tree and thought about that child and what I was able to offer him. For him, it wasn’t about the tasks or procedures – I was there to comfort him. For me, that’s the essence of nursing. I think we forget sometimes what a privilege it is to be able to do that for another human being. We should celebrate that we are the people that bring our patients and their families through those moments.”
A night of celebrating nursing excellence and the achievements of Alberta’s registered nurses

THURSDAY, MARCH 17, 2016
5:30 p.m. CHAMPAGNE RECEPTION
6:30 p.m. DINNER AND AWARDS
Delta Edmonton South

PURCHASE TICKETS AT CARNAAWARDS.CA
PEACE OF MIND

Model of dementia care accepts and embraces patient’s reality

MARY

is sitting on the couch in the common area in front of the television, surrounded by other residents of the supportive living facility. Lynn, the licensed practical nurse (LPN), walks over to see how she is doing. Worried and agitated, Mary asks where her husband Robert is. Lynn, like all of Mary’s caregivers, knows Robert passed away seven years ago, and hearing this information always sends Mary into a state of frustration, sadness and confusion.

Lynn smiles and gently places her hand on Mary’s arm. “Robert is at work right now, Mary. Remember, he works at the construction yard just outside the city?”

Mary, still concerned, asks when he would be back.

“In a little while,” Lynn explains “Let’s watch a show and have lunch while we wait for him.”

Lynn knows Mary won’t remember this information by the afternoon, and will ask where he is again tomorrow. But for now, Mary relaxes as she turns her attention back to the TV.*

THIS IS MARY’S REALITY—her husband is still alive and at work. It’s so real to her that when told about his passing, she experiences the same intense grief and sorrow she did seven years ago. In her world, it is happening here and now.

* This is a fictional example. Any similarities to real people is purely coincidental and unintentional.
Caregivers including LPNs and registered nurses (RN)s are taught that when caring for people living with dementia, it’s best to bring them back to the present. But this can be stressful for both patient and caregiver. Is there a way to reduce the confusion and suffering experienced by people living with dementia and improve their quality of life? The answer is yes, and an Alberta RN is helping put it into practice.

**A NEW WAY OF THINKING ARRIVES IN CANADA**

Dr. David Sheard first introduced his innovative Butterfly model of dementia care in the United Kingdom 20 years ago. The model is based on the belief of the importance of offering emotional care to patients and the understanding that we must recognize and respect the reality of people living with dementia. Over the past two decades, more than 100 Butterfly Care homes have been introduced across the U.K. These homes aim to create a less institutional care setting by removing uniforms, painting walls in bright, cheerful colours, and having staff eat meals with residents. Most importantly, the model is focused on accepting the residents’ reality as truth. The result is a care setting that feels more like a home than a medical facility, so that residents actually feel at home in the places they live.

Now Edmonton is about to become the first Canadian city to adopt that model within a supportive living centre. Registered nurse Jennifer Chan is leading the adoption of the dementia model at Lifestyle Options Retirement Communities in Edmonton. She is the Director of Care/Clinical lead at the facility.

“The new model is very different than how I was taught; we do so well in our clinical care, but that’s just half of it,” Jennifer says. “There’s also the other side, which is the social aspect. We ask, is the person happy? Is she living how she wants to live at that moment or are we forcing her to live how we want her to?”

Although the Butterfly model has been enthusiastically embraced in the U.K., it wasn’t an easy sell here in Canada. Dr. Sheard has visited Canada and spoken at several conferences over the past five years in an attempt to educate health professionals and garner the support he needed to implement the model here.

“The things I talk about, including getting rid of those barriers, getting rid of uniforms, changing the environment, changing the whole approach to activity, can feel like a tsunami for people who have been doing their best in a very traditional culture,” explains Dr. Sheard. He explains that although it can be a difficult transition for health-care professionals, nurses are particularly well-suited to help lead this new model of care. “The key is that nurses have to move from being a detached professional – which they have been trained in, to be clinical, to have empathy but not show too much emotion – to what I call an attached professional, one who understands attachment theory and the need to apply it in dementia care.”

Jennifer is optimistic about the change. “It’s a true person-centred approach and I want this model to succeed. However, the road is not going to be easy. It takes a village to do this, so everyone needs to be involved and buy into it. LPNs were taught clinically how to manage dementia, but we are teaching them a new way of dealing with it socially. Everyone is really excited.”

**RIGHT NOW, 47.5 MILLION PEOPLE WORLDWIDE ARE LIVING WITH DEMENTIA.**

By 2030, that number is expected to increase to 75.6 million and by 2050 will reach a staggering 135.5 million.

A GROWING CONCERN

The new model is being introduced at a critical time for dementia care, as health-care systems around the world cope with increasing numbers of dementia cases. And as populations age, the incidence of dementia is expected to rise. Right now, 47.5 million people worldwide are living with dementia. By 2030, that number is expected to increase to 75.6 million and by 2050 will reach a staggering 135.5 million.

Dementia not only causes frustration and distress for the patient, but the caregiver as well. A recent study conducted in Southern Alberta found that caregivers of people living with dementia experience a high level of moral distress, described as “when nurses and caregivers know the right thing to do, but can’t do it, perhaps because of a lack of time or resources.”

Examples of “moral distress,” included common practices such as using medication to manage dementia behaviours which can reduce the patient’s quality of life. Participants described instances of seeing other staff being rude to residents, not talking with residents even when providing care, or treating residents like children. Caregivers also spoke of the moral distress of rushing care, when a rushed approach upset the person living with dementia, and of residents being isolated and unstimulated.

Study participants said that caring for people living with dementia left them feeling frustrated, physically and emotionally exhausted, powerless, inadequate and sad, which was rooted in the emotional connection they had with the residents they cared for. This has serious implications in a health-care sector that is already experiencing staffing shortages and high turnover, and may impact the quality of nursing care.

Although the new model of care will not automatically address issues such as overmedication and staff shortages,
Dr. Sheard has seen how effective it can be in improving the quality of life for people living with dementia. The simple act of taking time to converse with patients, of being respectful and providing care with dignity, and ensuring that the patients are well-connected and entertained could reduce the amount of distress for both caregiver and patient.

LIVING THE LIVES OF THEIR RESIDENTS

Changes are happening fast at Lifestyle Options Retirement Communities. “We are getting rid of uniforms. No more scrubs,” explains Jennifer. “This is the residents’ home. When we come here in our street clothes, we could just be their neighbour or their friend.”

Staff will sit down and eat meals with the residents. “They need to know the meal experience of the residents. And that’s how they can improve it,” Jennifer continues. “For example, they might clear away dishes when some of the residents at the table are still eating. So how would they know how that feels when they don’t sit there? How do they know that the food is good if they aren’t eating it themselves?”

She acknowledges that one of the biggest changes may cause some apprehension for both families and staff. Under the new Butterfly model, all staff—including cleaning staff—will now acknowledge residents when they enter their room, whether it’s a simple greeting and small talk, or sitting down to begin a conversation. So if a member of the housekeeping staff enters a room to tidy up, they may engage the resident and lose time cleaning in favour of time spent talking.

“The difficult part of getting staff buy-in is to let them know that this is okay,” says Jennifer. “Of course, a minimum level of cleanliness and tidiness will always be maintained. But let me ask you – is your home always meticulously clean? No, neither is mine! Most homes aren’t. We need to remember that this is someone’s home.”

IT ONLY TAKES A MOMENT TO CHANGE A LIFE

Dr. Sheard wants nurses and all health-care professionals to understand how much of an impact they can have on the lives of people living with dementia. “You can change the moment for someone with dementia. Regardless of the bureaucracy, regulation, or management style of leadership in your organization, if you are a nurse working directly with people who suffer from dementia, you can make a difference today. It takes a moment to turn a task into something where you share a memory, you comment about colour that somebody is wearing, you mention something about the environment or day, you share something that’s going on in your life with them. Anybody can do that in a moment.”

REFERENCES

dementia care matters.com

Right at home

NETHERLAND’S GATED MODEL VILLAGE MAINTAINS NORMALITY OF DAILY LIFE FOR PEOPLE LIVING WITH DEMENTIA

On first glance, the picturesque village of Hogewey, located about 20 km outside of Amsterdam, looks much like any of the quaint towns and villages that dot the Dutch countryside. It has a town square, a theatre, supermarket and café, gardens, a park and sidewalks lined with flowers and trees. But Hogewey isn’t your typical town. In fact, the entire town is a nursing home for people living with dementia.

Opened in 2007, Hogewey is home to 152 residents and approximately 250 staff and health-care workers. Each resident lives in one of 23 homes that accommodates approximately six people, with one health-care worker on site at all times to help with cleaning and other necessary tasks. Residents are grouped according to their previous lifestyles, with former tradespeople sharing a “homey” residence that offers comfort food and simpler surroundings, and those that were used to a more affluent lifestyle living together in more stylish “goose” accommodations and eating more sophisticated cuisine. In total, there are seven lifestyle choices available.

Each resident has their own bedroom and is free to stroll through the village, and visit the stores and cafés. The entire village is focused on creating a sense of normalcy for residents, allowing them to live a lifestyle they recognize and placing them in familiar surroundings. The goal is to reduce the confusion and sadness that more clinical settings can create for people living with dementia.

Residents take day trips to nearby towns and shopping malls, and people from surrounding towns and villages are welcome to frequent Hogewey’s shops and cafés. And during the Dutch version of Halloween, children from nearby towns go door-to-door asking for candy in exchange for singing songs—a tradition most residents remember fondly.

Funded in part by the Dutch government, Hogewey costs about the same as other care facilities, with residents paying a portion of the expenses based on their income. The Hogewey concept has caught the attention of dementia care specialists around the world, and many similar homes are currently being built across Europe, the United States and here in Canada.

hogeweyk.dementiavillage.com/en/
Venous thromboembolism (VTE) prophylaxis, also known as thromboprophylaxis, reduces the risk of deep vein thrombosis, pulmonary embolism, and associated complications, including death, in high-risk patients. VTE prophylaxis is recommended for acutely ill, hospitalized medical patients at risk of thrombosis.1

Anticoagulants, the pharmacologic agents of choice to prevent VTE, are considered high-alert medications. By definition, therefore, anticoagulants bear a heightened risk of causing significant patient harm when they are used in error.2 As part of ongoing collaboration with a provincial death investigation service, ISMP Canada received a report of a fatal incident that involved continuation of VTE prophylaxis with enoxaparin for a patient discharged to a long-term care (LTC) facility from an acute care setting. The findings and recommendations from this case are shared to highlight the need to build routine reassessment of VTE prophylaxis into the process for discharging patients from the acute care setting and upon transfer to another facility or to primary care.

Medication Incident

An elderly woman with a history of falls was admitted to acute care from a retirement home for treatment of a urinary tract infection. This admission followed several hospital stays over the preceding months during which enoxaparin 40 mg subcutaneously daily had been prescribed for VTE prophylaxis because of decreased mobility, and then appropriately discontinued when the patient was discharged from hospital. During the most recent hospital stay, enoxaparin at the same dose was again prescribed for VTE prophylaxis. After approximately three weeks, the patient was discharged to an LTC facility. The enoxaparin was continued as a result of its inclusion on the discharge medication list from the acute care facility.

Within the first few weeks at the LTC home, the patient experienced two unwitnessed falls. After the first fall, she suffered a bleeding scalp wound, which prompted transfer to the local emergency department for assessment. The wound was glued, but head computed tomography (CT) was not performed. The patient was transferred back to the LTC facility without any recommendations to change her medications; in particular, the enoxaparin was continued. Over the next week, the patient became more agitated and aggressive resulting in pharmacologic treatment of her behavioural symptoms with regularly scheduled and as needed psychotropic medications. She then experienced a second unwitnessed fall and was again transferred to acute care. On investigation, a large intracranial hemorrhage was found and the patient died later that day in hospital; anticoagulation was deemed to be a contributing factor.

Background

The American College of Chest Physicians (ACCP) guidelines for prevention of VTE in nonsurgical patients recommends thromboprophylaxis with anticoagulants for acutely ill, hospitalized medical patients at increased risk of thrombosis.1 Known risk factors for VTE in this population include the presence of certain comorbid conditions (e.g., active cancer, heart and respiratory failure), previous thromboembolism, reduced mobility, and known thrombophilia.1

When prophylaxis is required, the recommended anticoagulants are low-molecular-weight heparins (LMWH), including enoxaparin, dalteparin, and tinzaparin, as well as low-dose unfractionated heparin or fondaparinux.1 The Padua Prediction Score is an assessment tool that incorporates these known risk factors and helps define the risk for VTE in hospitalized medical patients.3 A similar risk stratification tool has been developed for use in LTC; however...
the LTC assessment tool has yet to be validated.⁴ Without further evidence of benefit for VTE prophylaxis following acute care, the American College of Chest Physicians recommends against continuing VTE prophylaxis in immobile, nonsurgical patients after their acute hospital stay.¹

Discussion

An analysis of the incident summarized above identified the following potential contributing factors:

- The discharging hospital included enoxaparin on the discharge medication list. It was not clear if an assessment of the patient’s medications (including enoxaparin) occurred prior to discharge.
- The LTC facility continued the patient’s enoxaparin after transfer back from acute care. It is unclear if a medication review occurred after transfer.
- Pharmacologic management of her behavioural symptoms in long-term care likely increased the patient’s risk for falling, resulting in the head injury.
- After evaluation in the emergency following the first fall, a head CT was not done to rule out a more serious head injury. There was no indication that enoxaparin was to be discontinued. In addition to enoxaparin, the patient was also on acetylsalicylic acid 80 mg daily for stroke prophylaxis, both of which may have increased the risk of bleeding and contributed to the intracerebral hemorrhage.
- It is unclear if the continued use of enoxaparin was re-assessed by the LTC facility after return from the emergency department.
- Limited evidence exists concerning the best way to manage VTE risk in medical patients after discharge from acute care,¹ requiring practitioners to make decisions on a case-by-case basis.

Recommendations

The following recommendations are intended to reduce the risk of similar incidents, specifically for patients discharged from an acute care setting, although these learnings may also be applicable to rehabilitation and complex continuing care units.

Acute Care Setting

- Incorporate a standard process to facilitate medication reassessment before a patient leaves the acute care setting. An example of such a process is the preparation of a Best Possible Medication Discharge Plan (BPMDP).⁵ The BPMDP can assist with reconciliation of medications, such as those used for VTE prophylaxis, and improve communication with the receiving facility or practitioners, when a patient is transferred to another facility or returns to home.⁵
- If VTE prophylaxis is recommended to be continued, outline the rationale in the discharge plan.

LTC Facilities, Primary Care and Home Care Practitioners

- Conduct medication reconciliation for all new admissions and readmissions to LTC facilities, as well as for patients returning to a primary care or home care practice in a timely manner. A Best Possible Medication History should be completed and the need to continue each medication carefully evaluated. Ideally, an indication is listed with each medication to strengthen communication between all care providers.
- If there is an indication for thromboprophylaxis, this should be clearly captured as part of the resident’s/client’s documentation and a specific review date of the need for ongoing VTE prophylaxis should be scheduled and conducted if a defined period of use is not clearly prescribed.
- Consider a medication-related cause whenever a fall occurs or if there is any change in the clinical status or behaviour of the resident/client.

For acute care facilities:
Incorporate a standard process for reassessment of all medications, including VTE prophylaxis, before discharge from the acute care setting.

For LTC facilities, primary care and home care practitioners:
Conduct medication reconciliation with each admission/readmission in a timely manner. Reassess the risks and benefits of VTE prophylactic regimens at transfer points (e.g., acute care to long-term care) and periodically thereafter.
Conclusion
The incident described in this bulletin highlights the importance of continually reassessing the need for VTE prophylaxis, especially at transitions of care, such as discharge from an acute care setting. Evidence and guidelines confirm the benefits of VTE prophylaxis in certain patients during a hospital stay for an acute illness, but the balance of benefits and risks may become unfavourable once the patient is discharged. Clear documentation from the acute care facility can assist the receiving facility and health-care providers, as well as family caregivers, when determining whether thromboprophylaxis is still warranted. Until clear guidance to continue thromboprophylaxis after acute care is available, health-care organizations and practitioners across the spectrum of care are urged to share and consider the strategies presented in this bulletin to ensure the safe use of VTE prophylaxis and improved communication among health-care providers.

ISMP Canada will be integrating the learning from this case in an update of the Hospital Self-Assessment for Anticoagulant Safety. This assessment is available on a complimentary basis to all facilities across Canada after sign up at https://mssa.ismp-canada.org/hsasas/

A transition toolkit such as the one developed by ISMP Canada www.ismp-canada.org/transitions/, offer a checklist approach that can be used to facilitate medication reassessment and patient engagement for selected discharges at the acute care facility. Such toolkits aim to decrease the frequency of therapeutic duplications and omissions and the use of unnecessary medications, as well reduce confusion for patients and/or caregivers.

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References

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Important Information from Health Canada about Acetaminophen Safety

Health Canada has announced new action to improve acetaminophen safety and minimize the risk of liver damage. This action is in light of a Health Canada review that assessed acetaminophen and liver injury in the Canadian context. ISMP Canada is working with Health Canada to co-chair a Steering Committee of stakeholders that is initiating a collaborative educational approach to remind consumers about safe use of acetaminophen. Health Canada has also announced that additional steps to improve acetaminophen safety will be taken in the upcoming months. This will include strengthening the acetaminophen labelling standard for non-prescription products. For complete information, including Health Canada’s Information Update, a summary of the acetaminophen safety review and an information page on acetaminophen, visit the Health Canada website. Additional information on acetaminophen safety is also available on ISMP Canada’s consumer website, SafeMedicationUse.ca under Spotlight on Acetaminophen.

Navigating Safely through a Sea of Health Information

Stay Informed
To receive ISMP Canada Safety Bulletins and newsletters visit:
www.ismp-canada.org/stayinformed/
This bulletin shares information about safe medication practices, is non-commercial, and is therefore exempt from Canadian anti-spam legislation.

Contact Us
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PHONE: 1.866.544.7672
ARNET’s Name a Centennial Scholarship campaign and Nurses on the RuN event support the educational funding that our charity distributes to CARNAs. While we distributed over $850,000 in educational funding support this year, the reality is that we were only able to support 56 percent of the total financial supports requested by CARNAs! With your help, ARNET can constantly build and secure financial resources in support of continuing education for current and future generations of Alberta’s RNs and NPs. By supporting education for RNs, our charity can ensure better health care for all Albertans.

If you need help financing your educational studies, ARNET provides two distinct educational funding options for CARNAs: Educational Reimbursement and competitive ARNET Academic Scholarships. Please note that we’ve made changes to our educational supports for 2016 based on your feedback.

To request education funding assistance or offer your support of our charity, please visit arnet.ca

### ARNET Educational Reimbursement

ARNET provides reimbursement assistance to CARNAs who invest in their own nursing education. The ARNET Educational Reimbursement fund provides funding assistance to offset the costs of self-paid educational programs including:

- **Registration fees for conferences and workshops**
  
  Application deadline dates are: February 28, April 30, June 30, August 15 and November 30.

- **Tuition and exam fees for Specialty Nursing Certification programs**
  
  Application deadline dates are: May 30 and November 30

Our new 2016 applications will be available at arnet.ca in early December.

- **Tuition fees for degree level studies: post-RN baccalaureate, masters, nurse practitioner and doctoral level studies**
  
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Through the generosity of ARNET donors, generations of Alberta’s nurses have achieved their educational goals...creating a legacy of nursing excellence in our province. With your help, we can ensure that future generations can carry on this proud tradition. You can help build a Centennial Scholarship through your donation today.

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nursesontherun.ca
Eating for two?

Helping women manage pregnancy weight gain

Gaining weight during a pregnancy is a natural occurrence. However, based on factors such as the mother’s pre-pregnancy BMI, social conditions, genetics and other health issues, women may gain too much or too little weight during pregnancy, which can result in complications for both mother and baby.

Health Canada developed guidelines around gestational weight gain. Weight gain above or below these guidelines can negatively impact maternal and infant health outcomes.

According to Health Canada, women who gain more weight than the recommended guidelines tend to give birth to babies on the upper end of the weight spectrum. Babies whose birth weight is more than 9.9 lbs face higher risks of longer labour and birth, birth trauma, birth asphyxia, caesarean birth, and increased risk of perinatal mortality. These babies also may be at increased risk for type 2 diabetes later in life.

Conversely, women who gain less weight than recommended may have a baby born pre-term or at a low birthweight. These infants face more risk of neonatal morbidity and mortality, physical and cognitive disabilities, and chronic health problems later in life.

These guidelines are intended to be used with good clinical judgment and discussions between women and their health-care providers about nutrition and physical activity.

Unfortunately, a large number of women continue to receive inadequate advice and fail to gain within the recommended weight range. An evaluation of health-care provider and women’s knowledge, attitudes and behaviours of gestational weight gain in Alberta found that although 96 per cent of women indicated that their weight was measured and recorded at each prenatal visit, only 42 per cent of women reported that their health-care provider discussed a weight gain target for their pregnancy.

As a strategy within Alberta Health Services, the Healthy Pregnancy Weight Gain project aims to support expectant women by providing resources and education needed for a healthy pregnancy.

To promote healthy pregnancy weight gain amongst pregnant women, the project team recently distributed provincial resources across Alberta to health-care providers that service expectant women.

To order copies of these and other resources for free, please visit

www.datagroup.ca/online2
User ID: healthypublic
Password: healthy2013

Additional resources including key actions and messages for health professionals, nutrition guidelines for primary care and the PARmed-X for pregnancy are available at http://www.albertahealthservices.ca/7501.asp.

The Health Canada Gestational Weight Gain guidelines for health professionals and source material for information stated here can be found at http://www.hc-sc.gc.ca/fn-an/nutrition/prenatal/ewba-mbsa-eng.php.
**ONLINE CARNA EDUCATION SESSIONS**

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CARN A REGIONAL COORDINATORS

**THE ROLE OF THE CHARGE NURSE**
Oct. 15, 2015. 6:30-8 p.m.
ltran@nurses.ab.ca or 
bjohnson@nurses.ab.ca

**ETHICAL PRACTICE**
Nov. 19, 2015. 6:30-8 p.m.
ltran@nurses.ab.ca or 
bjohnson@nurses.ab.ca

**DOCUMENTATION OR PATIENT CARE: WHAT MATTERS?**
Oct. 28, 2015. 1-2:30 p.m.
rcopper@nurses.ab.ca
Dec. 1, 2015. 6:30-8 p.m.
ltran@nurses.ab.ca or 
bjohnson@nurses.ab.ca

**PROFESSIONAL COMMUNICATION**
Oct. 21, 2015. 10-11:30 a.m.
bperry@nurses.ab.ca
Dec. 3, 2015. 6:30-8 p.m.
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bjohnson@nurses.ab.ca

**NURSING: A MULTIGENERATIONAL PROFESSION**
Oct. 19, 2015. 10-11:30 a.m.
rcopper@nurses.ab.ca

**HORIZONTAL VIOLENCE**
Oct. 15, 2015. 9:30-11 a.m.
vmutschler@nurses.ab.ca

**SOCIAL MEDIA**
Oct. 15, 2015. 1-2:30 p.m.
pshackleford@nurses.ab.ca

**PROMOTING CULTURALLY SAFE PRACTICE ENVIRONMENTS**
Nov. 16, 2015. 1-2:30 p.m.
pshackleford@nurses.ab.ca

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**NOTICEBOARD**

**CALGARY/WEST**

**THE NETWORK OF RARE BLOOD DISORDER ORGANIZATIONS – ALBERTA EDUCATION DAY**
http://conta.cc/1FNATGy

**NATIONAL LYMPHEDEMA CONFERENCE**
http://canadalymph.ca/

**CURRENT OBSTETRICAL MANAGEMENT SEMINARS**
cumming.ucalgary.ca/cme

**CAG2015: FROM POSSIBILITY TO PRACTICE IN AGING**
http://cag2015.ca/

**PAIN AWARENESS EDUCATION DAY**
canadianpaincoalition.ca

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**EDMONTON/WEST**

**SPORTS MEDICINE CONFERENCE**
http://uab.ca/pd

**WOUND CARE CONFERENCE**
Marlene.Varga@covenanthealth.ca

**CONTINUING EDUCATION WORKSHOP FOR FOOT CARE NURSES**
www.devonfootcare.com

**4TH ANNUAL PRACTICAL EVIDENCE FOR INFORMED PRACTICE (PEIP) CONFERENCE**
www.acfp.ca

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The submission deadline for events and reunions in the Winter 2016 issue of *Alberta RN* is Nov. 6, 2015. Go to nurses.ab.ca for a complete and up-to-date listing of events and reunions or to submit an event for publication.

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**IN MEMORIAM**

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

**Chinell, Gurtey (née Laventure),** a 1953 graduate of Hôpital Sainte-Croix school of nursing, who passed away on May 31, 2015 in Red Deer.

**Davey, Monique,** a 1995 graduate of the University of Alberta, who passed away on June 27, 2015 in Edmonton.

**Hatch, Kathleen (née Smith),** a 1948 graduate of the University of Alberta Hospital school of nursing, who passed away on Nov. 3, 2014 in Edmonton.

**Lemermeyer, Ann (née Boustede),** a 1958 graduate of the Ballarat Base Hospital in Ballarat, Australia, who passed away on May 26, 2015 in Edmonton.

**Macmillan, Kathryn (née Smith),** a 1978 graduate of the University of Alberta Hospital school of nursing, who passed away on April 25, 2015 in Nepal.

**McBride, Helen (née Mills),** a 1953 graduate of the Holy Cross Hospital school of nursing, who passed away on May 1, 2013 in Qualicum Beach.

**Plowman, Diane (née Dahm),** a 1975 graduate of Red Deer Junior College, who passed away on May 31, 2015 in Edmonton.

**Smith, Connie (née Ball),** a 1981 graduate of the University of Alberta Hospital school of nursing, who passed away on July 20, 2015 in Calgary.
In early September, we had our first look at the preliminary results of the NCLEX-RN, the national licensure exam for registered nurses introduced in January 2015. For some provincial regulators and nursing education programs, the results provided occasion to breathe a sigh of relief. For others, the results triggered responses ranging in intensity and falling anywhere between disbelief and disappointment. I congratulate all the candidates who passed the exam, and applaud the Canadian educational jurisdictions who realized exam pass rates above 80 per cent, surpassing the national pass rate of the U.S. Unfortunately, Alberta’s preliminary pass rate of 69.4 per cent sits slightly below the national pass rate of 71 per cent.

Am I satisfied with Alberta’s pass rate? Definitely not. Alberta candidates should expect to achieve results equal, if not better, than candidates in other provinces. I suspect all Albertans expect the same, too.

Am I surprised by Alberta’s results? Yes and no. For years, I’ve heard employers, seasoned nurses and others lament the inability of new nurses to “hit the ground running.” What we should lament and need to fix is that novice practitioners are expected to take on full patient loads of acutely ill patients in over-crowded hospitals and further, within months to orient new staff or act as charge nurse.

Am I confident in the exam’s reliability in assessing a candidate’s ability to apply their nursing knowledge, skill and judgement and provide safe care to Albertans in today’s health environment? Yes. The nursing care activities tested are based on the experiences of 12,000 newly licensed nurses during the first six months of practice in Canada and the U.S. The NCLEX-RN tells us whether an applicant has the ability to assess and respond to changes in vital signs, perform comprehensive health assessments, assess a client’s need for pain management, perform calculations needed to safely administer medications, and maintain client confidentiality and privacy. As a regulator, CARNA needs this evidence to reassure and protect the public.

These exam results signal an urgent need for change, in Alberta and across the country. As a profession we need to continue to advocate for health system transformation while ensuring our entry-level nurses have the foundational skills not only to meet licensure requirements but to become the expert, knowledgeable and confident nurse leaders our health system urgently needs.

The reality is that new nurses today are being hired into chaotic environments with fewer seasoned nurses to support them. Nursing literature has consistently pointed to issues with the transition from student to professional practice. In the ‘70s, Marlene Kramer’s nursing research into transition to practice called it “reality shock.” In the ’90s, the research of Judy Boychuk-Duchscher unequivocally showed that novices felt ill-prepared, experienced high levels of stress, disappointment in the realities of professional practice, and feelings of isolation in the workplace.

What do I say to the three of 10 candidates who did not pass the NCLEX-RN? First, don’t give up. We’ve seen that writers who failed the examination in their first attempt are passing the exam at a much higher rate in their subsequent attempts than their U.S. and international repeat-writer counterparts. Second, don’t rush into the second attempt. Take the time to prepare and access the resources available to you on the website of the exam’s developer, the National Council of State Boards of Nursing.

What can we learn from these preliminary exam results? We have jurisdictions and individual nursing education programs across the country that achieved above-average pass rates on the new exam. In Alberta, we have 100 years of nursing experience in leading development of regulatory standards and excellence. I’m confident in our ability to work together with employers, educators, government to increase the rate of success of our graduates, not only on the exam, but on their successful entrance into the workplace and progression from novice to expert.

There is no one solution. Earlier this year, the Canadian Council of Registered Nurse Regulators (CCRNR) issued a request for expressions of interest from experts in the field of competency development to help define a new and improved regulatory approach and supporting process for the development of entry-level registered nurses. In addition, CCRNR has initiated a collaborative project to review the regulator’s role in nursing competencies throughout a nurse’s career. These initiatives attest to our profession’s constant drive to improve. I’m confident that educational programs and employers have, or will now be moved to develop, related initiatives to support new and seasoned registered nurses. Together, we while continuing to advocate for change in health care delivery, and better utilization of nursing expertise and support for new graduates. RN

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look back at the past 50 years of AARN/CARNA newsletters
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Dr. Jaggi Rao
780.437.7189

In Calgary call:
Dr. Tom Woo
403.286.6888

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