MINI but MIGHTY
Camp connects children who have heart disease
PAGE 21

End PJ Paralysis movement is making one small change to nix hospital inactivity
PAGE 25

Woman struggling with chronic pain becomes passionate advisor
PAGE 30

Changing policy on BBVI reporting
PAGE 33
# CONTENTS

## PRESIDENT’S UPDATE

**4 OUTGOING:**
Closing the door on two rewarding years

**5 INCOMING:**
Opening a window to the future of nursing

## REGULATION

**6 Changes to the CARNAC executive team**

**7 Provincial Council election results**

**10 Renewal recap 2019**

**11 Provincial Council highlights:**
Meeting of Sept. 20–21, 2018

**12 Publications ordered by Hearing Tribunals**

## CELEBRATING NURSING

**8 Nursing excellence gala**

## PROFESSIONAL PRACTICE

**14 Case study: Sharps gone astray**

**16 You asked us: Conscientious objection and nursing care**

## EDUCATIONAL OPPORTUNITIES

**15 Education sessions just for new nurses**

**44 NoticeBoard, In memoriam**

## NURSING NEWS

**29 Albertans now required to be notified when affected by privacy breaches**

**33 Mandatory disclosure of infection with blood-borne pathogens: Changing policy**

## NURSING RESEARCH

**37 Keeping older adults connected. Social connectedness: What does it mean? What are its influencing factors?**

**40 Are Alberta nurses prepared for digital health?**

## ARNET

**45 We are ARNET**

**47 ARNET donors**

## CLOSING PERSPECTIVES

**46 Protecting the public, evolving the profession**

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**This page:**

Nicole Climie/Pembina Ridge Photography (PG. 21)

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Closing the door on two rewarding years

Well, here we are: my final president’s message. I can hardly believe two years is already up; it has seemingly flown by. But it has certainly been an active, productive two years. Here are just a few of the key things CARNA has accomplished, and some of the important work still going on.

• I was privileged to begin my term in October 2016 during CARNA’s centennial. In fact, the centennial galas in Calgary and Edmonton were the highlight of the year for me.

• On May 1, 2017, after a comprehensive executive search, CARNA began a new chapter with our new Chief Executive Officer, Joy Peacock. Joy’s commitment to resonant, servant leadership has brought a refreshing new tone to the work environment within CARNA, while also helping her navigate unforeseen challenges with aplomb.

• In 2017, Provincial Council took decisive action on two significant resolutions adopted at that year’s annual general meeting. One was to advance the ability of nurse practitioners to prescribe both buprenorphine/naloxone (Suboxone®) and methadone in the treatment of opioid use disorders. The other was to expand gender identification options in CARNA’s member registry.

• Throughout 2017 and 2018, CARNA began a long journey towards reconciliation by embracing Indigenous health as a key strategic goal. In June 2017, we assembled a panel of Indigenous registered nurses from across the province to participate in a traditional talking circle. The talking circle provided recommendations at both an operational and governance level. Responding to one recommendation, Council established an Indigenous Advisory Committee (IAC) to provide advice on how to respond to the Truth and Reconciliation Commission’s Calls to Action that are germane to nursing. The IAC includes members of three First Nations treaty areas as well as Métis members. Its first report was received by Provincial Council in June and was discussed more fully in September. This work is ongoing.

• Over the past two years, CARNA has updated processes for the Nursing Education Program Approval Board to make education program approval more effective, less onerous for Alberta’s educational institutions and better aligned with the principles of right-touch regulation.

• In December 2017, CARNA was invited to appoint a councillor to serve on the Rural Health Professions Action Plan board as that organization evolves from a physician focus to a broader perspective on all health professions serving rural Albertans. This is just one tangible example of how CARNA is influencing health policy in Alberta.

There is still some unfinished business. Throughout my term, CARNA’s proposed amendments to the Registered Nurses Profession Regulation have been a key focus of interactions with government at all levels, including my own visits with the minister of health. While the regulation changes had been dormant for quite a while, we were pleased government made them a priority this summer. We now hope to have cabinet approval in time for them to come into force in Spring 2019. These changes will not only expand Albertans’ access to health care by permitting RNs to prescribe medications and order diagnostic tests when appropriate to the practice setting, but will also give CARNA more flexibility to fully enact our public protection mandate in a rapidly changing world.

In summary, the past two years have been an enormous privilege, a great honour and a tremendous opportunity to contribute to our profession. In a rapidly changing world.

OEING PRESIDENT’S UPDATE

…the past two years have been an enormous privilege, a great honour and a tremendous opportunity to contribute to our profession.

In summary, the past two years have been an enormous privilege, a great honour and a tremendous opportunity to contribute to our profession. Looking back at the long list of past presidents, I am humbled to have been selected to join that august company and I hope I have lived up to their example.

I now pass the torch of leadership on to Dennie Hycha. I have worked alongside Dennie for two years and I can truly say she is as passionate about nursing and as compassionate towards the public we serve, as anyone I have known. She is also a level-headed, clear thinker who will lead Council well. Thank you Dennie, and all the best to you in your term as president.

Jerry Macdonald, MN, RN, CCN(C)
I have always considered it a privilege to be a registered nurse. Throughout my career, I have witnessed the power of nursing leadership – the ability to make a difference in the lives of our clients and their families – the honour to work with fellow nurses who have inspired me with their commitment and passion for their profession.

As nurses, we may not think of ourselves as leaders until we step into formal leadership positions within our work setting. But, as author Stephen Covey succinctly said, “Leadership is a choice, not a position.” As registered nurses and nurse practitioners, each of us can choose to lead. We can embrace our role as problem-solvers, making evidence-informed decisions that ultimately improve client care. We can develop innovative solutions to the issues we see in our practice settings.

Nursing has always been about teamwork. We are leaders when we contribute fully within the health-care team and collaborate with our colleagues to provide client-centred, evidence-informed care. I think of this as small “l” leadership where every nurse who touches the lives of individuals and their families can be a leader and model professional excellence within our sphere of nursing practice in all practice domains.

As your regulatory college and professional association, CARNA is a mechanism for nurses in Alberta to get involved in big “L” leadership. We are working to transform the health system to improve access to quality health care for Albertans and to help maintain their confidence in their health system. We are also finding new ways to be open and transparent in the work we do as a regulator.

There is no doubt that our health system and our profession are changing. We have the opportunity, both as individuals and collectively as a profession, to influence the direction of those changes. As surveys have repeatedly shown, nursing is one of the most trusted professions. The public relies on us to advocate effectively in their best interest.

Technology has profoundly affected the way people access information, engage with each other and interact with their environment. It is changing the way health care is delivered and that change is accelerating. All health professions are being affected by the explosion in knowledge and the ability of the public to access it. Nurses are optimally positioned to not only use technology, but to also identify when technology can be a solution to problems and barriers.

Regulation is not a static field either. For example, the proposed changes to the Registered Nurses Profession Regulation under the Health Professions Act are progressing and, once approved, will usher in changes that will affect registered nursing practice across Alberta. The changes will also give CARNA more flexibility in regulating the profession according to the principles of right-touch regulation.

Another priority for CARNA is working towards being a strong, collaborative advocate in promoting the health of Indigenous peoples and addressing Indigenous health issues within Alberta. We have taken important steps forward but we know we are on a journey and have a ways to go. With the guidance of our Indigenous Advisory Committee, Council is finding meaningful ways to engage with Indigenous nurses and communities and we will continue to focus on this essential work.

As registered nurses and nurse practitioners, each of us can choose to lead. Nursing has always been about teamwork.

Another way nurses can demonstrate leadership is to become involved with your professional college and association and that includes serving on Provincial Council. I want to thank outgoing CARNA President Jerry Macdonald for his thoughtful and capable leadership over the past two years. I look forward to working with Provincial Council and with you, the members of CARN A, during my term as president and anticipate our achievements in the years ahead.

Dennie Hycha, MN, BScN, RN
403.783.1504
president@nurses.ab.ca
Changes to the CARNA EXECUTIVE TEAM

We are very pleased to share some changes to CARNA’s executive team structure with you.

Joy Peacock has assumed the role of Registrar in addition to her position as Chief Executive Officer.

Shelley MacGregor is our new Chief Officer, Registration and Conduct and Deputy Registrar.

We welcomed a new Chief Human Resources Officer, Deryck Litoski, to our team on September 18.

Our Chief Operating Officer, Jeanette Machtemes, retired on September 27. Damon Mayes, formerly Chief Information Officer, has taken over Jeanette’s portfolio and his title has changed to Chief Operating Officer.

Margaret Ward-Jack, Chief Public Affairs Officer, will be retiring in December.

The Executive Team also includes Sandra Young. She remains Chief Professional Practice Officer and is now also the second Deputy Registrar.

We would like to thank Jeanette and Margaret for their dedicated work over the years with CARNA and wish them all the best!

We are confident these changes will best support our organization as we work towards being a right-touch regulator committed to continuous improvement and innovation. RN
Congratulations to the following councillors who began their terms on Oct. 1, 2018.

**President-elect**
Nicole Letourneau  
PhD, MN, RN, FCAHS

**Calgary/West**
Tyler Burley  
MN, SC, RN

**Edmonton/West**
Bronwyn White  
MN, RN  
(appointed for a one-year term to fill Nicole Letourneau’s vacant position)

**Central**
Dwayne Nagy  
RN  
(acCLAIMED)

**Northeast**
Ashna Rawji  
MN, RN  
(appointed)

Jeannie Hare  
RN
NURSING EXCELLENCE GALA

An elegant evening of inspiration and celebration.

Guests will enjoy:
• a cocktail reception
• red carpet award ceremony
• gourmet dinner with wine
• live entertainment by the Two-Bit Bandits

Friday May 10, 2019
Hotel Arts, Calgary
$85 per guest

The celebration only lasts an evening, but the memories will last a lifetime!
Tickets on sale now at CarnaAwards.ca
Q: I have an independent foot-care practice and have been using paper charting but am considering starting to chart in a Word document on my laptop. Is this appropriate?

A: In every Canadian province or territory, there is legislation to protect the privacy of personal health information (PHI). These laws create obligations as to how the PHI that is normally found in health records can be collected, used and disclosed. These laws also provide guidelines for storing and securing such information.

Usually, this legislation requires the appointment of a “custodian” or “trustee” that has the responsibility to ensure that all the requirements of the privacy legislation are met. For nurses who are employees of a healthcare organization, their employer typically takes on that role. However, nurses in independent practice are often considered the legal custodians of the health information and must ensure that the manner in which they collect and store patients’ PHI follows applicable privacy legislation.

In privacy laws, the specific requirements dealing with the storage and security of PHI vary between jurisdictions. However, as a general guideline, the custodian must ensure that the PHI is secure regardless of whether paper or electronic records are used. This may include putting in place a number of safeguards to prevent improper access to PHI. As for electronic records, privacy standards typically require the encryption of electronic files and communications to ensure the security of PHI in the possession of the custodian. Encryption is a process of encoding a message or information in such a way that only authorized parties can access it. Implementing password protection on computers is another minimum safeguard.

In certain jurisdictions, there are additional requirements regarding the electronic storage of PHI. For example, some jurisdictions require that electronic records have the ability to be audited or to create a record of user activity. Because of these requirements, word processing applications like Microsoft Word may not be appropriate. As a nurse in independent practice, you should ensure that your electronic record-keeping follows your regulatory body’s standards and all relevant legislation.

THIS PUBLICATION IS FOR INFORMATION PURPOSES ONLY. NOTHING IN THIS PUBLICATION SHOULD BE CONSTRUED AS LEGAL ADVICE FROM ANY LAWYER, CONTRIBUTOR OR THE CNPS. READERS SHOULD CONSULT LEGAL COUNSEL FOR SPECIFIC ADVICE.

CNPS beneficiaries can call 1-844-4MY-CNPS (1-844-469-2677) to discuss privacy issues with a CNPS legal advisor, who is a lawyer.

CNPS. More than liability protection.
RENEWAL RECAP 2019

35,985 submitted their application before the deadline
(Almost 49% renewed in the last 10 days)

5,789 PHONE CALLS to the renewal help line with an average wait time of 63 seconds

3,237 renewed on the last day

How was your overall experience?
TOTAL RESPONSES: 1,635

- 38.3% very good
- 38.7% good
- 12.7% neutral
- 8.5% poor
- 1.8% very poor

Shop our bookstore!
With over 600,000 active titles, the CARN A Online Bookstore is the largest health sciences and scientific/technical book wholesaler in Canada. Plus, a portion of your sale is invested into CARN A and your profession!

Start shopping at lb.ca/carna.
New standards for nursing education
Provincial Council approved standards and criteria that the Nursing Education Program Approval Board uses to assess education programs. These standards are current, evidence-informed and were developed using right-touch regulation principles.

Provide feedback on new infection prevention and control standards
Council agreed the new draft document, Infection Prevention and Control Standards, is ready to go to the next stage of document development, which is consultation with members and stakeholders. We would greatly appreciate your feedback on the document through a quick survey at nurses.ab.ca/documents-in-review.

Medication guidelines revised – medical cannabis in home care
Council approved revisions to Medication Guidelines (2015) allowing regulated members to assist with the administration of cannabis for medical purposes in settings outside of the hospital. These guidelines are aligned with other Canadian nursing regulators and allow members to assist with cannabis for medical purposes within the home care setting.

Meeting of Sept. 20–21, 2018
Operational plan and budget approved
Council approved the budget and operational plan for 2018-2019. In addition to our regulatory work and the ongoing activities in our role as a professional association, here are some of the major initiatives we are taking on:

- Preparing to implement the revised Registered Nurses Profession Regulation.
- Cultivating Indigenous cultural awareness within CARNA and with our membership.
- Launching a nursing leadership campaign.
- Launching a learning management system with new educational opportunities for members.
- Moving to our new building and selling our existing building.
- Redesigning the CARNA website.

UPCOMING PROVINCIAL COUNCIL MEETING
Dec. 6–7, 2018
12 ALBERTA R N FALL 2018 VOLUME 74 NO 3 nurses.ab.ca

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. Publications are not intended to provide comprehensive information about the complaint, findings of an investigation or information presented at the hearing.

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

CARNA MEMBER
REGISTRATION NUMBER:  #43,811
A Hearing Tribunal made a finding of unprofessional conduct against member #43,811 who breached patient confidentiality by making remarks about a patient who was not under the member’s care to other staff who also were not caring for the patient. The member then refused to care for patients of the physician who had reported the confidentiality breach to the manager. The member wrote over the entry of another staff on the narcotic sheet. The member failed to properly account for a vial of fentanyl when she failed to document correctly that she had returned it to the medication cupboard and not administered it to the patient. The Hearing Tribunal issued a reprimand and ordered the member to pass courses in documentation and nursing informatics and complete emodules on the Code of Ethics. The member has to submit medical reports confirming her fitness to practise. The member is restricted to one approved employment site pending a satisfactory performance evaluation. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARN A practice permit.

CARNA MEMBER
REGISTRATION NUMBER:  #68,478
A Hearing Tribunal made a finding of unprofessional conduct against member #68,478 who, while in the charge nurse role, failed to adequately document her assessment and management of a patient. The Tribunal issued a reprimand and directed the member to pass courses in documentation and nursing informatics, and provide one performance evaluation. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARN A practice permit.

CARNA MEMBER
REGISTRATION NUMBER:  #78,966
A Hearing Tribunal made a finding of unprofessional conduct against member #78,966 who made an admission of unprofessional conduct under Section 70 of the Health Professions Act. While working as an RN in a rural community in southern Alberta, the member pilfered injectable hydromorphone wastage on multiple occasions for their own personal use under the guise of administering the narcotic to a patient. They resigned their position in the face of an internal investigation and audit which revealed multiple discrepancies in administration, documentation and wastage of hydromorphone of a patient. The Tribunal issued a reprimand and required the member to attend treatment, including being subject to random drug screening, and provide satisfactory medical reports confirming she is fit to practise. Thereafter, the member is restricted from working at an approved setting, must undergo supervised practice and must provide a satisfactory performance evaluation. The member then must provide annual satisfactory medical reports for two years, confirming her fitness to practise. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARN A practice permit.

CARNA MEMBER
REGISTRATION NUMBER:  #86,299
A Hearing Tribunal made a finding of unprofessional conduct against member #86,299 who was illegally in possession of narcotics, namely morphine, when he knew or ought to have known it was against the law and in contravention of the Controlled Drugs and Substances Act. The member also violated a condition that had been placed on his nurse practitioner practice permit by the registrar, restricting him from prescribing controlled drugs and substances when, on numerous occasions, he prescribed controlled substances to clients. The Tribunal issued a reprimand. The Tribunal took into account the fact that he had been suspended for violation of the condition for 11 months prior to the hearing and included that suspension as part of the sanction. From the date of the hearing, the Tribunal accepted the member’s undertaking to not practise pending approval of a new work setting from which two performance evaluations are required. Any practice permit as an NP for the next three years will be subject to the condition “restricted from prescribing controlled drugs and substances.” If the member does not want to work as an NP, he may obtain a registered nurse practice permit. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARN A practice permit.

CARNA MEMBER
REGISTRATION NUMBER:  #92,724
A Hearing Tribunal made a finding of unprofessional conduct against member #92,724 who made several medication errors. The member also engaged in inappropriate conversations regarding religion, despite being advised not to do so, with a client with a mental health diagnosis. The member failed to respond appropriately when a member of the health-care team reported a client was threatening suicide. The member
Carna Member Registration Number: #100,462

A Hearing Tribunal made a finding of unprofessional conduct against member #100,462 regarding four incidents. The member failed to notify the physician of a critical INR result. The member misrepresented the facts to management when the member failed to disclose, when questioned, that he had unauthorized access to the manager’s locked office, and that he had removed and attempted to use the vein finder which had been located in the office. When caring for an outpatient, the member misrepresented the facts regarding his actions to management and failed to adequately document regarding a specific issue. Finally, the member failed to adequately manage a patient’s respiratory condition when the member reduced the O₂ rate temporarily to check the patient’s response, which is not standard nursing practice and which resulted in lowering the O₂ saturation to an unacceptable level temporarily. The member failed to intervene appropriately when the O₂ saturation rate fell to 57 per cent and then to 22 per cent. The member failed to complete or document his ongoing assessments and failed to adequately document the administration of three doses of Narcan®. The Hearing Tribunal issued a reprimand and directed the member to pass four courses: documentation, responsible nursing, respiratory system nursing care and assessment, and to complete modules on the Code of Ethics. The member is also restricted to working at an approved employment site pending completion of satisfactory performance evaluations. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

Carna Member Registration Number: #95,360

A Hearing Tribunal made a finding of unprofessional conduct against member #95,360 who failed to ensure that RhoGAM was administered to a patient as required by employer guidelines. The member breached the privacy of approximately 127 patients when she independently conducted an audit of client records to determine staff compliance with employer guidelines regarding the administration of RhoGAM. The member, on her day off, inappropriately met a patient at a lab, gave her medication samples, and for that patient and another who happened to also be at the lab, the member inappropriately used priority lab requisitions for those two patients to cut ahead of other patients waiting in line. The Tribunal issued a reprimand and required the member to pass courses in nursing process and in responsible nursing, and complete modules on the Code of Ethics and on privacy. The member is restricted to working in her current setting pending a satisfactory performance evaluation. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

Search jobs at arncareers.madgexjbp.com.

And... it’s FREE for job seekers!
Desirée just moved to a small, isolated community that doesn’t have a provincial home care program. She is a registered nurse at a not-for-profit agency which delivers home care services to members of the community. Her role includes providing nursing interventions and education about health and infection prevention strategies.

On a hot summer day, she is seeing many members of the community in their homes. One of the agency’s services is to provide containers for used medical sharps to community members who may need them. If the individual does not have a means of transportation, the agency will pick up full sharps containers and take them to the medical clinic for safe disposal. The RN is responsible for exchanging the sharps disposal containers during a visit.

Desirée has completed her home visits for today and while carrying the two sharps containers by their handles into the staff entrance of the medical clinic, the bottom of one container falls to the floor scattering the contents everywhere. Desirée feels a jabbing sensation and looks down to see one needle with the syringe attached lodged in her leg and also notices two additional puncture wounds.

Desirée puts her nursing bag and the remaining sharps container down. She puts on a pair of gloves and removes the needle from her leg. She realizes that the sharps container has not broken but separated, so she places the lid back on the base and presses it firmly into place. Once she’s confident it’s secure, she picks the sharps off the floor and places them into the container. She places both sharps containers in the designated area for disposal.

Desirée knows she needs to clean her wounds and report this incident. She is also worried about the risks to her health. The small agency she works for doesn’t have an occupational health nurse (OHN) or an infection prevention and control (IP&C) nurse. She is new to this workplace and unaware if there is a policy about possible exposure to blood and body fluids. The manager has already left for the day and she doesn’t want to bother her at home.

Desirée returns to her office to access the computer and look for information on what next steps to take after an exposure to blood and body fluids. She follows employer policy on reporting incidents and reviews the employer’s policy on blood and body fluid exposure which lists the Blood and Body Fluid Exposure Resources for Health-care Professionals website (bbfeab.ca) as a resource for the post-exposure pathway to follow. Desirée finds out that it is the responsibility of her supervisor or a health-care professional with expertise in blood and body fluid exposure to contact the clients about obtaining consent for source testing. She decides to contact her manager as soon as possible in order to adhere to the recommended two-hour post-exposure window to ensure potential post-exposure prophylaxis for HIV or hepatitis B is started as soon as possible.

Desirée’s manager advises her to follow the post-exposure pathway and seek care from a physician or nurse practitioner as soon as possible to her wound and discuss the potential risk for a blood borne pathogen infection from this exposure. Desirée calls Health Link to find out where the best place for her to seek care for this exposure.

The next day she meets with her manager and co-workers to discuss and put into place processes and interventions to prevent a similar situation from occurring in the future.
Documentation: Principles and pitfalls
Sometimes finding the time to document can be challenging, but proper documentation is vital to patient safety, privacy and continuity of care. Join us as we outline the basics of effective documentation and provide resources to support you in quality health-care record keeping.

Where is the line? Professional boundaries and why we need them
Boundaries aren’t always black and white. In this session, we’ll help make the line a little clearer by defining professional boundaries and identifying:
> expectations for professional relationships
> differences between boundary crossings and boundary violations
> what to do when professional boundaries are in question
> professional boundaries and social media

Bullying in nursing: Recognition and recommendations
It’s hard to believe bullying happens in a caring profession like nursing. Join us as we share what you can do to prevent bullying in your workplace, how to recognize bullying and how to take action when it happens.

Are you a team player?
As a registered nurse, you will have the opportunity to work alongside a variety of professionals in the health-care team. Join us as we discuss:
> basic characteristics required for interprofessional practice
> foundational concepts of leadership
> your responsibilities as a member of the interprofessional team

We’re offering free online education sessions with topics perfect for nurses in their first year of practice! Advance your nursing knowledge and learn about CARNA resources while you network with other new nurses.

Learn more and register for these sessions at nurses.ab.ca/events.

Topics include:

Documentation: Principles and pitfalls
Where is the line? Professional boundaries and why we need them
Bullying in nursing: Recognition and recommendations
Are you a team player?
Historically, the term “conscientious objection” was recognized in the context of war where those who would not serve their country were sometimes penalized with a jail sentence. As nurses, we are often faced with a conflict of values because of the nature of our work. Our ethical concerns lead to advocacy for client care, however, nurses may object, due to their own personal values, to the care the client has chosen to receive. For nurses, conscientious objection means informing their employer they need to refrain from providing care because a practice or procedure conflicts with a deeply-held moral or ethical value.

Our conscience tells us that only one course of action is right and moral discord occurs when these characteristics are violated. As medicine advances, treatment options become available that may challenge our values. Conversely, clients may refuse treatment options which may also challenge our values.
Conscientious objection must carry genuine moral weight rooted in ethical beliefs and is not based on prejudice, self-interest, discrimination, lifestyle preference, fear or convenience.

Do I have a right to refuse care due to conscientious objection?

The Canadian Nurses Association (CNA) Code of Ethics states nurses should not abandon those who need nursing care.

Balancing the best interests of clients and providing care while honouring religious and moral beliefs can be difficult. Nurses have the right to refuse care based on strongly-held religious, moral and ethical beliefs, but client welfare must be considered at all times. Refusing care may mean that a client won’t receive care if there is no other option available to them. It may place undue strain on other nurses because they will provide care. Nurses need to anticipate what may challenge their ethical beliefs in a particular practice setting and communicate with their employer so that the provision of care is not interrupted.

What are my responsibilities if someone else has a conscientious objection?

Some employers have written policy that outlines the rights and accommodation of those with a conscientious objection. Colleagues and managers need to be sensitive when another staff member identifies their right for conscientious objection. Early awareness of potential conflicts allows for strategic assignment of client care to prevent situations that may compromise a nurse’s religious, moral and ethical beliefs. Individuals shouldn’t be subjected to harassment or discriminatory action due to their refusal to provide care.

Criteria for conscientious objection

> Providing care would seriously damage the health professional’s moral integrity by constituting a serious violation of deeply held conviction.
> The objection has a plausible moral or religious rationale.
> The treatment is not considered an essential part of health professionals’ work.
> The burdens to the client are acceptably small.
> The client’s condition is not life-threatening.
> Refusal does not lead to the client not getting the treatment, or to unacceptable delay or expenses.
> Measures have been taken to reduce the burdens to the client.
> The burdens to colleagues and health-care institutions are acceptably small.

In addition, the claim to conscientious objection is strengthened if:

> The objection is founded in nursing’s own values.
> The medical procedure is new or of uncertain moral status.

Conscientious objection is complex as it is rooted in ethical values that aren’t always clear. Nursing leadership can support nurses when their ethical values collide with provision of care by ensuring client care isn’t interrupted. A clear, consistent and fair process for managing conscientious objection, when it is identified, protects the nurse and the client.

REFERENCES


Take a minute and remember what summer camp was like as a kid. You might have taken a bus out of town to the camp. Or maybe your parents dropped you off and you were a little nervous to be away from them. Maybe you went for walks, played sports, maybe you met other kids like you there, and maybe you made new friends. What if you didn’t have the option to go to camp? What if you couldn’t go because the camp wasn’t equipped to take care of you?

For a group of children with congenital heart disease, Little Heart Heroes Mini Camp has given them an opportunity like no other. The day camp is for children aged four to seven and was born out of the original Heart Heroes Camp initiative created by University of Alberta pediatric resident Devin Chetan last year.
A change in practice

Not only is the camp beneficial for campers and their families, but medical professionals can learn from the situation as well. Being in a separate environment from the Stollery Children’s Hospital gives doctors and nurses a new view of their patients. This connection outside of the medical setting gives them a changed perspective of the children. Instead of seeing the kids as patients, these dedicated doctors and nurses are privileged to see them focus on enjoying their childhood. Brenneis credits the camp for showing her the importance of having a holistic approach towards her nursing practice. She believes this element of practice can be just as important as providing traditional medical care.

The Little Heart Heroes Camp programs have changed Brenneis’ career and given her a broader perspective on nursing. For RNs like Brenneis, taking the time to care for patients can sometimes be the most beneficial to families when times are the toughest. Nursing is much more than giving medication, checking vital signs and making sure children get appropriate rest. Through compassionate encounters, nurses can make a significant difference in the lives of their young patients. “That’s what nursing is all about,” says Brenneis, commending the camp for opening her eyes and changing her practice to have a more holistic approach.

One special patient

In this unique situation, registered nurses contribute to the growth and recovery of the children. Treatment involves much more than physical care; it includes socialization while building confidence and independence. Brenneis and the Little Heart Heroes team are passionate about ensuring the children they treat are given opportunities to just be kids for a while.

Unfortunately, many of these kids require medical supervision and complex treatments. This makes it difficult to participate in community programs because they don’t have the appropriate equipment to keep the children safe. The Heart Heroes programs were created specifically for children with congenital heart disease. The camps create a space for kids to feel independent and understand that other children like them experience similar obstacles.

There is no cost to the children’s families thanks to the Little Heart Heroes Fund and its partnership with the Stollery Children’s Hospital. “We don’t want anyone to be excluded due to financial reasons,” says Jennifer Brenneis, RN and director of the Little Heart Heroes Fund on the inclusivity of the camp. For most of these kids, this is the first time they will be away from their parents. No need to worry though! Families can be assured their children will be safe and secure at the camp knowing doctors and nurses are nearby (acting as camp counsellors) to provide medical care.

Brenneis, the Little Heart Heroes team and a group of volunteers at Little Heart Heroes Mini Camp give these children an opportunity to socialize with others who have similar stories, promote independence and encourage a positive atmosphere.
One particular patient had a journey that resonated with Brenneis. A young boy had bounced between the ICU and the pediatric cardiology and GI sciences units for 10 months out of the past year. Brenneis cherishes the time she spent with this patient. “I would come home from work every day and my heart would just be so full ‘cause he was the best kid ever.” He got very ill and didn’t want to get out of bed but, “to see him so happy at camp and playing and overcoming all the adversity that he faced” opened her eyes to emotional aspects of care. To see kids just live their childhood and enjoy time with their friends fills Brenneis with so much happiness.

The camps encourage children to remain hopeful, confident and just enjoy their childhood.

Impact of the camp
Feedback from the camp in the first year was incredibly positive. Parents and campers are unbelievably thankful for the camp and its opportunities. Families shared their experiences on social media and reinforced the positive effect of the camp on the children. The campers go through an unreal amount of difficulty that most young children don’t need to worry about. Kids at the Little Heart Heroes Mini Camp are especially strong and resilient for their age. Being in this environment shows volunteers how brave the kids can be despite the obstacles they face. For a small amount of time, all of a sudden, these kids “just get to be kids for a little bit,” Brenneis praises the impact of the camp. The children support one another in a special way. By encouraging each other and bonding over similar experiences, the kids thrive even in the face of adversity.

How to help
Fellow RNs participate as volunteers at the camp to provide optimum care for campers. Through volunteering and being active within the camp, nurses gain an enlightened perspective of their patients, understand the concerns of families and learn about nursing practice outside of medical facilities.

At this time, the camp would like to keep volunteers exclusively to medical staff for the duration of the program. Individuals who would like to support the camp and make a difference can donate at littleheartheroes.ca. This is especially important because the camp is solely run on donations. If individuals are interested in volunteering, the Little Heart Heroes Fund will be hosting some social events with opportunities in the following months. Information regarding these events will be posted on Facebook and Twitter. RN

Nursing is much more than giving medication, checking vital signs and making sure children get appropriate rest. Through compassionate encounters, nurses can make a significant difference in the lives of their young patients.
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GET UP, GET DRESSED & GET MOVING

End PJ Paralysis is making one small change to nix hospital inactivity

BY ALEX BOYD, CARNA COMMUNICATIONS COORDINATOR

PATIENTS LOSE ONE TO FIVE PERCENT OF THEIR MUSCLE STRENGTH FOR EVERY DAY THEY STAY IN BED. AS THEY REMAIN INACTIVE, THEIR ABILITY TO CARRY OUT DAILY ROUTINES LIKE BATHING, DRESSING, GETTING OUT OF BED AND WALKING DETERIORATES...
A new movement is sparking change, and it all started by asking the simple question: What if patients could wear their own clothes?

The End PJ Paralysis movement is tackling inactivity by helping patients get up, get dressed, get moving and even get back home sooner. The concept is simple, but the effects are profound. PJ paralysis is the negative physical and psychological effects patients experience when they spend lengthy periods of time being inactive, in hospital gowns. Enabling patients to get dressed encourages them to get out of bed and be more active. These patients then feel healthier and happier, leading to quicker recoveries. “It’s really a focus on respecting and honouring the dignity of patients,” says Paul Wright, registered nurse and Calgary zone manager for patient and family centred care.

The End PJ Paralysis movement was started by registered nurse Brian Dolan of the United Kingdom’s National Health Service and has spread globally, including here in Alberta. With a helping hand from social media, the initiative has grown quickly. The program kicked off in Alberta in April 2018 and there are now units piloting across Alberta Health Services (AHS), including 10 units across five sites in the Calgary zone.

“It’s not a prescriptive practice,” says Wright, explaining what makes the movements so successful. “We don’t need a policy to allow patients to wear their own clothing, which is very unique in large health-care organizations when it comes to new initiatives.”

WHAT DO HOSPITAL GOWNS HAVE TO DO WITH INACTIVITY?

“While open-back hospital gowns are great for easy access for health interventions, they lack respect and dignity for patients,” says Wright. Wearing only hospital gowns makes a person feel less human, more vulnerable and constantly reminds them they’re ill.

Wright relates a story heard by a patient advisor, “For every week I’m in the hospital, it takes four weeks to feel like myself again.”

Allowing patients to wear day clothes while in hospital enhances dignity, autonomy and encourages them to be active. Getting patients back to their normal routine as quickly as possible, including getting up and out of bed, reduces their risk of infection, loss of strength and mobility and will ultimately lead to a quicker recovery.

This movement is also enabling family members to contribute to the care of their loved ones by bringing in items such as day clothes, well-fitting shoes and toiletries. “It’s also about encouraging families to become involved so we’re all active key players in patient health,” says Wright.

The effects of PJ paralysis are especially detrimental to older adults. Every 10 days of bed rest is the equivalent of 10 years muscle aging in those over 80. For an older person, a loss of muscle strength can make the difference between going home and going to an assisted care facility. The difference between dependence and independence.
Collaboration with colleagues and families is key to maximizing patient outcomes. For example, Wright found the infection prevention and control (IP&C) team has been a valuable partner to the movement through advising how patients in isolation can reap the benefits of the initiative while maintaining IP&C best practices. Wright also encourages consulting with colleagues to better inform patients on how to dress when going for diagnostic tests. “What makes the initiative unique,” stresses Wright, “is it can be adapted to fit any environment and every unit integrates it a little differently.”

**IMPROVING THE PATIENT EXPERIENCE**

End PJ Paralysis puts the focus on quality of patient time and experience. Nurses are innately involved in care planning and are positioned to lead the way in shifting the focus from care FOR patients to care WITH patients. “Nurses are the backbone of the healthcare system,” Wright shares. “We have the ability to impact a patient’s care all the time, because we are with them 24 hours a day.”

Nurses play an important role in championing End PJ Paralysis in their workplace and with patients and families. “End PJ Paralysis is about encouraging, empowering, supporting and optimizing the health of patients,” says Wright. “It’s encouraging them to be themselves and letting us see who they are as a person.”

Follow the movement and share your experiences with the hashtag #endPJparalysis.

**RESOURCES**

- #EndPJParalysis. Retrieved from endpjparalysis.com

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**WORKING TOGETHER TO BREAK DOWN BARRIERS**

The concept of End PJ Paralysis is very simple, but there are a few barriers.

Laundry for one. Unfortunately, AHS does not provide laundry services for patients in all care settings. “We want staff to support the initiative,” says Wright, “but we do not expect them to do laundry.” This is where family involvement plays a big role. Patients need to rely on family members to take their belongings home to wash.

What about those who don’t have clothing to wear? Patients don’t always have access to clean clothes or family and friends who can support them. Fortunately, End PJ Paralysis was able to partner with AHS’s volunteer resources department who provide clean clothing and personal items, and support patients who don’t have the means. “It just goes to show... it takes a diverse team to make a program like this successful,” says Wright.

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**Words of wisdom from one patient to another:**

- Wear clothes that are comfortable and easy to put on and take off.
- Loose-fitting clothes are best.
- Wide legs and arms are easier to put on, especially if they need to go over dressings.
- Avoid tight cuffs at the feet and hand; they are more difficult to put on and take off.
- Shorts are ideal for patients having knee surgery.
- Don’t forget to bring any mobility aides such as a walker, cane or wheelchair that you use at home.
- Clothing with zippers are very easy to take on and off.
- Bring clothing that can be easily washed.
- Remember you’re dressing for comfort and ease of use!

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**The effects of PJ paralysis are especially detrimental to older adults. Every 10 days of bed rest is the equivalent of 10 years muscle aging in those over 80.**

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**End the effects of PJ paralysis**

The effects of PJ paralysis are especially detrimental to older adults. Every 10 days of bed rest is the equivalent of 10 years muscle aging in those over 80.
Albertans now **required to be notified** when affected by privacy breaches

As of Aug. 21, 2018, there are new privacy breach reporting requirements that impact Alberta registered nurses and nurse practitioners. In the event of a privacy breach* where there is a risk of harm to an individual, health custodians** are now required to notify the individual, the information and privacy commissioner and the minister of health.

When assessing if there is a risk of harm, consider if health information:
- has been or may be accessed by a person
- has been or may be disclosed to a person
- has been misused or will be misused
- could be used for identity theft or to commit fraud
- could cause embarrassment
- could cause physical, mental or financial harm
- could damage an individual’s reputation

Affiliates, which include but are not limited to a custodian’s employees, service providers or information managers, must also notify the custodian when a privacy breach occurs.

There are also new offence and penalty provisions if a health custodian fails to report a breach or does not take reasonable steps to maintain safeguards to protect health information. This includes administrative, technical and physical safeguards. A person who is found guilty of one of these offences is liable to fines.

Visit oipc.ab.ca under “how to report a privacy breach” to find a breach report form, a guide to completing the form and responding to a privacy breach, and a “train the trainer” slide deck. RN

* Any loss of individually identifying health information or any unauthorized access to or disclosure of individually identifying health information in the custody or control of the custodian.

** An organization or entity defined in section 1(1)(f) of the Health Information Act or designated in section 2 of the Health Information Regulation including nurses, physicians, dental hygienists, dentists, chiropractors, optometrists, opticians, pharmacists, Alberta Health Services, Covenant Health and Alberta Health.
ADVOCATING FOR
PAIN
SUFFERERS

Woman struggling to manage chronic pain turns
passionate advisor for other patients

BY KERI SWEETMAN

After more than 25 years of feeling victimized by the medical system, Tracy Fossum was finally set on a path to manage her terrible chronic pain by a nurse.

Fossum advocates for chronic pain patients in Alberta through her organization HELP_AB. She was in her mid-30s before she found proper treatment after suffering for years from severe daily migraines, fibromyalgia and other painful conditions. Unfortunately, her story is all too common for chronic pain sufferers. Studies vary on the percentage of people who suffer from chronic pain, but estimates range from 11 to 47 per cent.

“It doesn’t matter what causes a person’s chronic pain, whether it’s a genetic condition like mine or if it was an accident or injury. What we almost always hear is the same—they don’t feel believed, they don’t feel heard,” says Fossum. “They develop an adversarial relationship with the medical system within a few years.”
Fossum, who lives in the Edmonton area, has childhood memories of daily headaches, digestive issues and trouble regulating her temperature. It was the 1970s and many physicians didn't believe children got migraines or experienced pain the same way adults do. Even at a young age, she felt dismissed by the family doctors, pediatricians and neurologists she saw. By the time she was a teenager, her medical condition had deteriorated and she had serious side effects from various medications to treat her condition.

By her late 20s, Fossum had graduated from college despite her medical issues and had a job in the agriculture sector. She also had two young children, but her partner had left. When her fibromyalgia worsened, she had what she calls a “catastrophic physical meltdown.” She was forced to give up her job and move back home with her parents so they could help with her children.

“One of the things we forget in chronic pain is that it’s a price paid by the whole family. My parents were very supportive, but it was a huge burden. There was so much fear and pain, anger, hopelessness and frustration. My children were also paying the price.”

Finally, Fossum went looking for help again. She connected with a now-defunct organization of retired nurses, doctors and mental health professionals who offered advice on how to navigate the health-care system. That’s where she met the nurse who pointed her in a new direction.

The nurse went through Fossum’s medical history and saw that a neurologist had recommended that she try to manage her pain with opioids. At the time, Fossum and her family doctor had rejected the idea. “I had always been told that anyone who takes opioids will end up addicted, and I was terrified of them,” says Fossum.

The nurse stood her ground. She took the time to educate Fossum about the role of opioids in pain management and urged her to find a pain clinic with doctors and nurses who understood chronic pain.

Fossum finally got lucky – she found a new family doctor who began managing her pain with opioids and became her coach and cheerleader. The clinic also had a nurse assigned to patients with complex health issues and she became an important part of Fossum’s team. “Each time before I saw the doctor, I would talk to the nurse. I felt heard and I felt like I had somebody who was on my side at last.”

Today, she still depends on opioids and support therapies. She can’t work full-time and some days are harder than others, but she has become an effective advocate for chronic pain patients in Alberta. She launched HELP_AB about six years ago to offer support and education to other patients.

With the help of other teammates with chronic pain, HELP_AB runs support groups in seven Alberta communities. The groups offer specific help to people with fibromyalgia, migraines, arthritis and other conditions. They are also providing a voice for chronic pain patients affected by the panic over the illegal opioid crisis, which has made many doctors reluctant to prescribe the drugs even to those who need it.

Last June, Fossum joined Alberta Health Service’s chronic pain working group as a patient advisor, serving alongside doctors, nurses and others trying to develop a province-wide strategy to tackle the issue. Two priorities for Fossum are developing a directory of resources for doctors and nurses when dealing with chronic pain issues in their patients, and creating better access to support therapies such as physiotherapy and mental health help, especially in remote communities.

Fossum believes nurses are key to overcoming barriers faced by chronic-pain patients. “We need to invest in nursing,” she says. “If we do not get more nurses available in clinics with a background and education in chronic pain, we will find it hard to improve anything.”

TRACY FOSSUM
In June 2018, CARNAs Provincial Council made a decision to abandon the mandatory reporting of blood-borne virus infections (BBVI). Prior to Council’s decision, CARNa required that all registered nurses and nurse practitioners infected with a BBVI notify the registrar. RNs in Alberta were required to report their status during their initial registration and annual renewal.

Council’s decision to change this requirement is in keeping with CARNa’s commitment to right-touch regulation and being a relational regulator. Right-touch regulation is based on seven principles stating that regulation should be:
1. proportionate
2. appropriate to the risk posed
3. consistent
4. targeted (focused on the problem and minimized side effects)
5. transparent
6. accountable
7. agile
Routine practices should always be applied regardless of the perception of risk of the procedure or the health status of a client. The risk of BBVI transmission is remote due to advances in knowledge of risk reduction measures.

Over time, it became increasingly obvious that the role of CARNA as a regulator, and the ethics of this standard, required an evidence-based approach that would benefit members, clients and the public...
the right to be free from compulsory testing and disclosure of HIV status.”

There is strong consensus in the literature that the risk of transmitting a BBVI is remote, and will continue to decrease as more effective methods of prevention and treatment are developed. It is important to balance the health-care provider’s right to confidentiality and freedom from unjust discrimination with the patient’s right to a safe environment, informed consent and protection from harm. RNs and NPs have the right to confidentiality of health information and are expected to meet all the elements of the Canadian Nurses Association Code of Ethics for Registered Nurses and CARNA Standards of Practice for Regulated Members, which include expectations and responsibilities for informed consent and fitness to practise. Despite this expectation, mandatory BBVI reporting requirements fail to consider the harms of disclosing a stigmatizing illness and unjust discrimination due to a medical condition.

IN THEIR 2013 ARTICLE, “MANDATORY Disclosure of Infection with Blood-Borne Pathogens: Implications for Nursing,” McGinn, Caine and Mill refuted the need for nurses to report BBVIs to regulatory nursing bodies. The authors argued that there was no evidence for mandatory reporting and therefore CARNA’s policy created another layer of stigma and discrimination. As a result, CARNA’s standard was likely to have a negative impact on health-care providers living with a BBVI. The consequences of this standard extended beyond the individual. Health-care providers might avoid testing for BBVIs due to fear of negative repercussions, including stigmatization and discrimination. This fear might be further amplified because health-care practitioners are a “significant source of stigma and discrimination” toward individuals living with HIV.

Following the publication of their article, McGinn, Caine and Mill contacted CARNA with their concerns about mandatory BBVI reporting. As members of the Canadian Association of Nurses in HIV/AIDS Care (CANAC), they had also worked to develop a CANAC position statement for the support of nurses living with HIV, which was released in November of 2015. It became clear that CARNA’s annual mandatory reporting requirement could not be justified by the existing evidence.

Council’s decision to withdraw the standard is evidence-informed and aligns CARNA with the approach taken by other Canadian nursing regulators and health profession regulators in Alberta. It is an example of right-touch regulation in action. RN

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Keeping older adults connected

Social connectedness: What does it mean? What are its influencing factors?

AUTHOR:
HANNAH O’ROURKE, PhD, RN

THERE IS A LOT OF emphasis on maintaining social connectedness for older adults, in Canada and internationally. Clinicians, family members, policy-makers and older adults with and without chronic illness have described how feeling connected to others is a basic human need that is essential to their health and quality of life.

However, the term can be confusing. Some people have used the term to describe having more contact with other people, but others (myself included) use the term ‘social connectedness’ to refer specifically to a feeling of connection to others.

Having (objective) contact might be related to a (subjective) feeling of connection for some people. However, others can live far from other people and services or spend most of their time alone yet still feel very connected. On the other hand, some people are surrounded by others, but feel disconnected or like an outsider.
Increasing contact with others won’t necessarily help an older adult feel more connected in a way that is meaningful to that person. This highlights the importance of understanding what a feeling of social connectedness is, how we can identify it, and what should be considered in order to promote this distinct feeling.

What, then, are the measurable indicators of social connectedness? What are the different factors that could be considered in order to promote the distinct feeling of connection for older adults?

The three main aims of this study were to:

> Identify the key components of definitions used in research to describe feelings of social connectedness.
> Identify the key indicators or measures that could be used in future research and practice to assess social connectedness.
> Create a comprehensive overview of the factors that researchers have hypothesized could affect social connectedness, for further evaluation in research and practice.

THE APPROACH

We completed a scoping review and searched seven databases in February 2015. The search strategies were designed in consultation with a health science librarian. We included articles that referred to older adults, focused on a feeling of social connectedness and were written in English. From 1,180 titles/abstracts, 26 articles (reporting on 23 separate investigations) met the criteria. We extracted information related to the type of article and characteristics of the sample (analyzed with frequencies), as well as narrative definitions or descriptions of the features of social connectedness, and of factors that may affect it for content analysis.

HIGHLIGHTS OF THE FINDINGS

The articles either described the concept of social connectedness, development of a measure of social connectedness, or were empirical studies focused on social connectedness to better understand it, test associations with it or evaluate interventions. The majority (87 percent) of studies focused on community-dwelling older adults, and none focused on the cognitively-impaired.

Based on our content analysis of the definitions and descriptions of social connectedness, we identified the aspects of social connectedness that were described in at least 50 percent of the articles. We then integrated these aspects into a definition of social connectedness:

“Found on a continuum opposite loneliness, social connectedness is a subjective evaluation of the extent to which one has meaningful, close and constructive relationships with others (individuals, groups, and/or society). The indicators of social connectedness include: (1) Caring about others and feeling cared about by others and (2) Feeling of belonging to a group or community.”

(O’Rourke and Sidani, 2017, p. 45)

We identified many possible factors that could influence social connectedness. Modifiable factors are those things that a clinician or researcher could affect; areas that are difficult to change may be used to help identify people who may benefit most from interventions to promote social connectedness (e.g., older adults that live alone). Modifiable factors that researchers think could be influenced to promote social connectedness included social network features, group memberships, social participation, social support, technology use, self-reported health status (how people feel about their health) and mental and emotional well-being. However, it would be very helpful to have more testing of these factors, to see which actually affect social connectedness for different populations of older adults.

IMPLICATIONS FOR PRACTICE

Knowing that social connectedness is the opposite of the (well-understood) concept of loneliness helps to identify people who would benefit from interventions to promote social connectedness: it is not necessarily the isolated, but the lonely, who should be the targets of such interventions. The influencing factors identified several areas that could be targeted to help older adults feel more connected. Targeting these areas, for example by enhancing quality of the social network, can be tried in practice, but also need to be evaluated with more research to see how well different strategies work.

For further information about this study:


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AS MEMBERS OF A self-regulating profession, nurses are expected to continually advance their knowledge throughout their careers in response to changing trends in their practice environments. With the expanded use of information and communication technologies (ICTs) in health care, nurses are required to attain, maintain and enhance their knowledge and skills in informatics. Growing this area of knowledge ensures safe and competent practice in today’s digitally-connected health-care environments.

We conducted a cross-sectional survey to determine RN and NP self-perceptions of their informatics competencies and factors associated with informatics competency development.

We asked respondents’ opinions on informatics as a mandatory competency – “Do you think informatics should be a mandatory competency in nursing; yes or no, and if no, tell us why.”

Are Alberta nurses prepared for digital health?

AUTHORS:
MANAL KLEIB, PhD, RN,
AMELIA CHAUVETTE, RN, PhD STUDENT
LYNN NAGLE, PhD, RN, FAAN
The survey included the Canadian Nurse Informatics Competency Assessment Scale (C-NICAS), a newly-developed instrument based on the Canadian Association of Schools of Nursing entry-to-practice nursing informatics competencies for registered nurses. Nineteen of the items represented key domains of competency: information and knowledge management, professional and regulatory accountability, and ICT use in the delivery of patient care. Two items represented foundational or computer literacy skills.

**FINDINGS**

Results from 2,844 completed surveys showed that practising nurses perceived their overall informatics competency slightly above the mark of competent. Perceptions of competency were:

- highest on foundational ICT skills
- slightly lower on competencies related to professional regulatory accountability and use of ICTs in the delivery of patient care
- lowest on information and knowledge management competencies

A number of variables were significantly associated with informatics competency including:

- age
- educational degree
- work setting
- previous informatics education
- access to Internet
- use of health technology
- access to supporting resources such as super users
- informatics training
- quality of training and support
- having an informatics role
- continuing education in informatics

The quality of informatics training and support offered by employers contributed most to variance in mean scores of total and sub-domains of informatics competency.

A little over 90 per cent agreed that informatics should be a mandatory competency. Those who did not agree (8.7 per cent) provided important insights, which were organized into four themes.

**Practice setting**

“Unfortunately, there is no consistency in programs that are used in various fields throughout the health-care spectrum. I work in an outpatient clinic and we need three different programs to retrieve information about one patient... Until systems are coordinated and universal, mandatory competencies are both unreasonable and unfair.”

“Need to be introduced to what is needed on individual job basis, differing needs in different areas, generic competency would be a waste of time.”

**Training and support**

“I think it’s an employer responsibility to educate nurses on their systems. The systems are varied from site to site.”

“The expectations of nursing are already high. There is a large population of nurses that is not very competent in using computers and Internet. I do however feel it should be a mandatory part of nursing education of upcoming nurses and will eventually become a more common expectation.”

**Professional practice**

“Due to my age, it is time-consuming to bring up the computers and I really feel nursing spends too much time on the computers and not enough on the patient...”

“I think nursing should focus on NURSING and not on computer training.”

**Informatics as a competency**

“I don’t feel it should be mandatory competency because it is too broad of an area. As far as confidentiality and ethics go, we are registered nurses and accountable for our own actions. We need better education so less mistakes are made and have a better understanding of the different systems.”

“Informatics! Is that even a real word? Yes, I use Netcare but the majority of nurses I know don’t. Sorry I don’t really know what this informatics is.”

**CONCLUSIONS AND RECOMMENDATIONS**

In today’s digitally-connected health-care environment, it is vital to address informatics education and support needs now and in the future. We must also take into consideration factors impacting competency development. This study showed that while nurses’ overall competency is promising, targeted education on information and knowledge management and ICT use would increase their ability to fully utilize digital health to support clinical practice.

This is particularly important in light of the upcoming province-wide large-scale implementation of a new clinical information system, Connect Care. We encourage decision makers in health-service organizations and professional/regulatory colleges and associations, nurse educators and nurses to use the C-NICAS to increase nursing informatics capacity in Alberta and Canada. RN

This study was funded through an establishment grant from the Faculty of Nursing at the University of Alberta. We also acknowledge CARNA’s support of this research.

**REFERENCES**

Date: November 14, 2018  
Time: 8:30 am - 3:45 pm

A Foundation for Strength & Balance

Do you work with seniors and want to know more about preventing seniors’ falls? Join us for a free, full-day of learning and networking.

» Learn about specific types of strength and balance exercises that are proven to reduce falls risks.
» Walk away with program examples and strategies to support older adults to maintain an active lifestyle.

Featuring talks by Kathryn Coutts, Nora Johnson, Leslie McEwan, Deanna Trazaciakowski, and Monica Morrison.

Attend in-person at the University of Alberta, via telehealth, Skype, or by phone (please indicate your choice in your email).

To register, email injury.prevention@ahs.ca, subject line: Practitioners’ Day Registration.
NOTICEBOARD

EDUCATIONAL OPPORTUNITIES

CALGARY/WEST

PRACTICAL MANAGEMENT OF HOSPITALIZED PATIENTS WITH LIVER DISEASE
Nov. 17, 2018 | Calgary
cumming.ucalgary.ca

FAMILY PRACTICE REVIEW AND UPDATE COURSE
Nov. 19 – 22, 2018 | Calgary
cumming.ucalgary.ca

NURSE PRACTITIONER ASSOCIATION OF ALBERTA CONFERENCE
April 6 – 7, 2019 | Calgary
albertanps.com

EDMONTON/WEST

PATIENT AND PROVIDER EXPERIENCE SUMMIT
Nov. 29 – 30, 2018 | Edmonton
royalalex.org/summit2018

Carna AGM
March 6, 2019 | Edmonton
nurses.ab.ca

Carna Provincial Council Meeting
March 7–8, 2019 | Edmonton
nurses.ab.ca

The submission deadline for events and reunions in the Winter 2019 issue of Alberta RN is Dec. 3, 2018. Go to nurses.ab.ca for a complete and up-to-date listing of events and reunions or to submit an event for publication.

IN MEMORIAM

Selin, Joanne (née Skolrood), a 1996 graduate of the University of Calgary, who passed away on Aug. 5, 2018 in Calgary.

Every RN has a story to share about their practice, projects, accomplishments or research. Tell us about your team, your practice and what you’ve learned at AlbertaRN@nurses.ab.ca.
We are going through some changes, but we remain committed to promoting excellence in nursing by assisting Alberta’s RNs and NPs in their pursuit of lifelong learning and education.

Visit our website for details and ways you can help us OR how we can help you!

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Protecting the public, evolving the profession

CARNAs dual mandate means that we exist to protect the public and we also strive to evolve the nursing profession through relational engagement opportunities, continuing education and the promotion of nursing excellence. This is a period of significant change with the anticipated approval of the new Registered Nurses Profession Regulation and our upcoming move to a new building. These changes created the impetus to rebrand CARNAs to better reflect our identity as a collaborative, relational, principle-based, innovative, dual-mandate organization.

Our new look and feel is focused on articulating how the organization delivers on its mandate. It represents a contemporary CARNAs one that embraces change while upholding its core values. The gender-neutral colours align with the relational aspects of CARNAs while touching on the diversity of nursing as a profession. The new tagline highlights our dual mandate: Protecting the public, evolving the profession.

Members tend to be more familiar with our regulatory mandate than our professional association role. One of our association priorities is supporting nursing excellence through continuing education, learning and professional development opportunities for our members. We are enhancing the services we provide by creating an integrated curriculum platform and new learning management system. Our learning platform will present courses creatively, be available anytime/anywhere and be more meaningful and personal. The platform incorporates e-learning designs such as micro-learning modules (very short modules you can download individually), gamification, accredited courses (in collaboration with the Canadian Nurses Association), just-in-time learning and knowledge translation and policy implementation. This will be in addition to our “You Asked Us” series, case studies and our First Year in the Profession education sessions.

We are also working hard to improve member experiences, particularly when it comes to registration renewal, continuing competence and e-commerce transactions. Our new learning platform will include an online system that provides an easy-to-use platform for members to record their continuing competence program requirements. At the same time, we are planning an extensive review to determine ways of consolidating our information systems to be more seamless, efficient and user-friendly.

Our Nursing: A Call for Leadership initiative is another association project. As part of this work, we have invited two speakers to provide sessions on nursing leadership at our annual general meeting in March 2019 and are developing resources for members.

CARNAs is also spear-heading re-establishment of Alberta’s Nursing Leadership Network (NLN). NLN was established in 2015 to bring together a network of nurse executives representing service providers, regulators, professional associations, educators and policy-makers/funders. Its purpose was to engage in strategic dialogue and advise the deputy minister of Alberta Health regarding the advancement and optimization of the nursing profession to improve the health of Albertans and to play a key role in health-system transformation. Originally sponsored by Alberta Health, NLN has not met for several years. We are looking forward to re-engaging with this powerful, collective voice for nurses in the province.

Another priority is the indigenization of CARNAs, ensuring that our culture embodies cultural humility, safety and competence. We are implementing operational recommendations from Provincial Councils Indigenous Advisory Committee, holding staff training sessions and reviewing policies and procedures. An Indigenous Cultural Competency in Nursing module for members is being developed, partially supported by the Alberta Human Rights Commission. An Indigenous cultural artist has been contracted and will also act as our subject matter expert. Above all, we want to develop new relationships with the province’s Indigenous nurses and communities and have hired an Indigenous cultural advisor to assist us.

When it comes to our regulatory mandate, CARNAs is embracing right-touch regulation, using principles rather than rules. It is about using the right amount of regulation needed and using it only when necessary.

There is more to CARNAs than renewal, fee collection and investigations. As a relational regulator, we want to improve the way we engage with our members and highlight the resources we offer.

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