This year, **VOTE for COUNCIL when you RENEW your PERMIT**

Role of the RN in clinical practice
PAGE 28

Reshaping primary health care for older adults
PAGE 30

CHEEP & CHEER for better IPC practices
PAGE 36
CONTENTS

PRESIDENT'S UPDATE
4 History in the making

REGULATION
8 CCP learning plan examples
11 June Council meeting: What did Council decide?
12 Vote for your Council candidates
18 Publications ordered by Hearing Tribunals

PROFESSIONAL PRACTICE
24 You asked us: How thorough should my documentation be?
26 CHEEP & CHEER for better IPC practices
30 Reshaping primary health care for older adults
38 Case study: Digital vs. written documentation
39 A study on case studies

CELEBRATING NURSING
5 CNA Order of Merit recipients
14 Highlights from the CARNA Awards Gala
17 The secret to a strong CARNA Award nomination

ARNET
15 ARNET Academic Scholars Class of 2018

NURSING RESEARCH
28 Role of the RN in clinical practice
36 Collaborative problem solving in adult mental health and addictions programs

EDUCATIONAL OPPORTUNITIES
41 NoticeBoard, In Memoriam
41 Online learning modules

CLOSING PERSPECTIVES
46 Leaving the world of status quo

COVER PHOTO: STEVE DEBENPORT/ISTOCKPHOTO.COM
THIS PAGE:
HAYATI KAYHAN/SHUTTERSTOCK.COM (PG. 6)
UTAH778/SHUTTERSTOCK.COM (PG. 32)
VM/ISTOCKPHOTO.COM (PG. 34)
History in the making

This has been a period of major decisions for nursing at both the national and provincial level. It was my privilege to attend the Canadian Nurses Association (CNA) board of directors meeting, annual meeting of members and biennial conference in June. The conference was a wonderful opportunity to learn from truly excellent keynote speakers and concurrent session presenters, but the highlights were the significant business conducted during this year’s meetings. The headline from the annual meeting was CNA’s historic vote to open the door of CNA membership to the entire family of nurses, and in particular licenced practical nurses (LPNs) and registered psychiatric nurses (RPNs). This does not mean that all practical nurses and psychiatric nurses in Canada will immediately become members of CNA, but now LPNs and RPNs who wish to join will have a path to membership.

We were also pleased to see the acclamation of CARNA’s president-elect, Dennie Hycha, as the new Alberta director (member of the board of directors) on the CNA board for the coming two years.

During the CNA annual meeting, members of your Alberta delegation became outraged at the reports coming out of the United States with respect to the treatment of migrant children who had been taken into immigration custody and separated from their families. At our urging, CNA issued a strongly-worded declaration supporting the American Nurses’ Association’s condemnation of this policy. We were delighted to be able to announce on June 13, that the Trump administration had reversed this policy. While we obviously cannot claim credit for this policy change, we were pleased, as the national voice of Canadian nursing on the global stage, to be able to contribute in whatever small way to the intense global pressure. By the time you read this, this situation may have evolved, but I think Canadians and the world can be proud of the way that we stepped up and spoke up.

Finally, closer to home, at our June Council meeting prior to the CNA meetings, one of the most far-reaching decisions by Provincial Council was to withdraw the 2008 standards document on the reporting of blood-borne virus infections. This was, in my view, a great example of right-touch regulation in action. Right-touch regulation is all about applying regulatory force that is proportionate with the risk being mitigated. Given the vanishingly small risk, approaching if not strictly reaching zero, of blood-borne virus transmission to clients by nurses and the invasiveness of this requirement and stigmatizing of nurses living with these viruses, it was clear that the regulatory approach was heavy-handed. The current evidence simply did not justify the previous policy and Council decided to withdraw the document in time for this change to be implemented in this year’s practice permit renewal cycle.

Jerry Macdonald, MN, RN, CCN(C)
780.978.1348
president@nurses.ab.ca
Congratulations CNA Order of Merit recipients!

Four outstanding Alberta nurses were honoured with Canadian Nurses Association (CNA) Order of Merit Awards for their hard work, leadership, innovation and knowledge.

ORDER OF MERIT FOR CLINICAL NURSING PRACTICE

Stacey Dalgleish | MN, NP
Neonatal Nurse Practitioner, Foothills Medical Centre, Alberta Health Services

As a neonatal intensive care nurse, everything that Stacey Dalgleish does matters. In the high-tech environment of the neonatal intensive care unit, Stacey’s knowledge, skill and compassion are immensely valued by colleagues and families alike. Under her gentle care and guidance, her tiny patients grow and thrive, while their parents gain the confidence they need. Her greatest source of pride comes from seeing preterm infants become strong enough to go home with their families. Stacey has always been at the cutting edge of clinical practice, and she takes great pride in sharing her knowledge and expertise with others. She comes to neonatal nursing with extensive academic training and a talent for establishing and implementing best practices. Her research has helped reduce neonatal morbidities and her exceptional speaking and leadership skills have ensured that her knowledge is shared nationally and internationally.

ORDER OF MERIT FOR NURSING EDUCATION

Sandra Goldsworthy | PhD, RN, CNCC(c), CMSN(c)
Associate Dean, Teaching, Learning and Technology,
Associate Professor, Faculty of Nursing, University of Calgary

Sandra Goldsworthy has been a registered nurse for more than three decades and has consistently focused on education, simulation and critical care nursing. Sandra is a whirlwind of ideas and energy who embraces technology to help students learn. Her key interest is in using simulation education to improve patient safety and boost the competence and confidence of new nursing graduates. While she encourages innovation, she is also committed to rigorous research and the ongoing evaluation of new teaching and learning strategies. Sandra is a skillful collaborator who works effectively within and across disciplines. Her research is having a positive impact on simulation education across Canada and internationally in the U.K., Sweden and Australia. The substance and reputation of Canadian nursing education is advanced by her skillful merging of clinical acumen, expertise in teaching and research inquiry.

ORDER OF MERIT FOR NURSING POLICY

Tracy Wasylak | M.Sc., BN, RN, CHE
Chief Program Officer, Strategic Clinical Networks, Alberta Health Services

Tracy Wasylak has transformed the health system and service delivery in Alberta and across Canada in ways that most could not even imagine. Tracy’s greatest policy contribution is in her work to design and implement Alberta’s Strategic Clinical Networks. In her role as a vice president at Alberta Health Services, Tracy was key to implementing the networks to ensure they are designed to be inclusive and work to improve health outcomes for Albertans. Among her most significant accomplishments was her role in developing Calgary’s largest greenfield hospital, the South Health Campus, which opened in 2013. Tracy oversaw operational, financial and clinical services design and implementation. Her collaborative human factors design work helped save over $1 million in costs. Tracy is a true visionary and leader in policy who has greatly influenced the future of health care in Canada.

ORDER OF MERIT FOR NURSING ADMINISTRATION

Brenda Huband | MSA, BScN, RN
Vice President and Chief Health Operations Officer,
Central and Southern Alberta, Alberta Health Services

Brenda Huband is a proven leader with extensive experience in Alberta’s health system. She has worked in remote, rural, regional and urban health settings, focusing on acute care, continuing care, Indigenous health, seniors’ health, public health and administration. Since starting her career, she moved into progressively more senior leadership roles including chief nursing officer, chief operating officer and chief executive officer. Brenda’s work touches lives every day and helps ensure resources are deployed effectively. She helped oversee Alberta’s responses to the 2013 floods and 2016 wildfires, ensuring evacuation and recovery efforts proceeded smoothly and safely. She is currently accountable for all publicly-funded health services in central and southern Alberta, which are delivered to over 2.3 million people.
Streamline the renewal process by having these pieces handy:

- Your MyCARNA user ID (usually your registration number) and password.
- A record of your learning activities from the past year.
- What you’d like to accomplish for your 2019 learning plan. See what makes a great learning plan on page 8.
- Your practice hours from Oct. 1, 2017–Sept. 30, 2018. If you are unsure of your hours, contact your employer(s). Estimate your hours to September 30. If they end up being different than your estimate, you can contact us in October to adjust them.
- Your current employer information, including supervisor’s name and phone number, and the address of your work site.
- Your registration number if you have been registered in another jurisdiction in the past registration year.

Call us if you need help!
1.800.252.9392, ext. 348.

**July 25 – August 18:**
Monday – Friday: 8:30 a.m. – 4:30 p.m.

**August 20 – September 1:**
Monday – Friday: 8:30 a.m. – 7 p.m.

Visit nurses.ab.ca for frequently asked questions, video tutorials and other resources.

### RENEWAL FEES

<table>
<thead>
<tr>
<th>Category</th>
<th>Fee</th>
</tr>
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<tbody>
<tr>
<td>Registered nurse</td>
<td>$641.32</td>
</tr>
<tr>
<td>Nurse practitioner</td>
<td>$719.54</td>
</tr>
<tr>
<td>Certified graduate nurse</td>
<td>$588.82</td>
</tr>
<tr>
<td>Associate/retired member</td>
<td>$42.00</td>
</tr>
</tbody>
</table>

A late fee of $100 will be applied to renewal applications received after September 1.

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While you are signed in to MyCARNA, don’t forget to vote in the Provincial Council election! See the candidates on page 12.
Whether you are planning to practise next year or not, here are the steps you need to take.

Do you have a 2018 practice permit?

**NO**

Will you practise in Alberta between Oct. 1, 2018 and Sept. 30, 2019?

**NO**

To keep receiving CARNAnews and Alberta RN, submit an application for retired/associate membership.

If you no longer wish to receive CARNAnews, submit an application for former membership.

**YES**

Will you practise in Alberta between Oct. 1, 2018 and Sept. 30, 2019?

**NO**

Apply to return to practice eight weeks before you start work or orientation. Learn more at nurses.ab.ca/return-to-practice.

**YES**

Whether you are taking a leave, retiring or relocating to another province, it’s important to let us know you won’t be practising in Alberta.

1. Sign in to MyCARNAnews and Alberta RN.
2. Finish your 2018 MyCCP record.
3. Submit an application for former membership (free) or retired/associate membership ($42) if you would like to receive CARNAnews and Alberta RN.

**NO**

To renew your practice permit:

1. Sign in to MyCARNAnews and Alberta RN.
2. Finish your 2018 MyCCP record.
3. Begin your 2019 practice reflection in MyCCP.
4. Submit your application form and payment.

We will review your application and email you when your renewal is approved or if we need more information.

**YES**

Going on parental leave?

There are a number of different options depending on when you will be on leave. View your options at nurses.ab.ca/parental-leave.
LEARNING PLAN EXAMPLES

We aim to support our members in developing specific, achievable learning plans tailored to each member’s individual needs. Every year, we bring you a sample of real learning plans to inspire and inform members as they create their own learning plans.

Carna’s continuing competence program requirements are simple: complete one learning plan and submit feedback. However, taking the time to sit down, reflect on your practice and identify a skill or an area of knowledge that you want to work on is a lot easier said than done! Carina staff can also guide you through the practice reflection process.

We’d love to hear from you – does this annual feature meet your needs? Have you thought of some way to improve it? Let us know at ccompetence@nurses.ab.ca. You can also email us if you have any other questions or concerns regarding your plan or Carina’s continuing competence program requirements.

### PLAN 1

**Community setting**  
**50 years experience**

| INDICATOR | PRACTICE STANDARD INDICATOR 3.1:  
The nurse practises with honesty, integrity and respect. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>OBJECTIVE</td>
<td>How students can maintain academic honesty, integrity and respect.</td>
</tr>
<tr>
<td>RELEVANCE</td>
<td>Encounters of students failing to maintain academic honesty, integrity and respect, resulting in faculty having to report students to the Academic Integrity Committee, and some outcomes leading to faculty-student conflict needing further resolution.</td>
</tr>
</tbody>
</table>
| ACTIVITY | LEARNING ACTIVITY TYPE: Conference/seminar/workshop presentation  
ACTIVITY NAME: The nurse practises with honesty, integrity and respect  
ACTIVITY EVALUATION: Through an academic attendance and presentation at an International Nursing Congress in Ireland in 2017. |
| ACTIVITY | LEARNING ACTIVITY TYPE: Conference/seminar/workshop presentation  
ACTIVITY NAME: Leadership initiatives: challenges and initiatives for a remote nursing education program  
ACTIVITY EVALUATION: Promoting and enhancing student awareness, morale, motivation, and commitment to teaching and learning—while the students in turn enhanced same through mentoring and preceptorship of other students. |
| EVALUATION | Enhanced my personal—and other colleagues’—motivation and morale as we observed students’ improved academic performance, interest, desire and willingness to be role models, collegiality, teamwork and team spirit. |
Community setting
37 years of experience

**INDICATOR**

**PRACTICE STANDARD INDICATOR 3.4:**
The nurse communicates effectively and respectfully with clients, significant others and other members of the health care team to enhance client care and safety outcomes.

**OBJECTIVE**
I want to learn how to deal with difficult people, be able to identify the challenges and behaviour patterns.

**RELEVANCE**
Patient safety and positive client care outcomes are enhanced by the RN ability to communicate effectively and collaborate with all members of the health-care team.

**ACTIVITY**

**LEARNING TYPE ACTIVITY:** Conference/seminar/workshop presentation

**ACTIVITY NAME:**
- How to deal with difficult people.
- I read the cornerstones on the employer website (Insight).
- Attended annual nsg skills conference.
- Discussion and meeting with RN in my clinic to develop a plan of action.

**ACTIVITY EVALUATION:**
1) Identify difficult families.
2) Self-assessment: communication and listening style.
3) Assess with difficult families.
4) Ask the surgeons to help with ideas or solutions.
5) Remind RN to stay focused on the issue and concern, not the behaviour.
6) Listen more, talk less.
7) Involve the manager.
8) Clarify the grey rules.
9) Identify limits.
10) A better plan enhances better patient care.

**EVALUATION**
I am able to identify the difficult families quicker and am becoming a better listener. A plan with my coworkers confirms my assessment and delivers better patient care. The clinic continues to look at grey areas and to find alternatives.

Research setting
Four years of experience

**INDICATOR**

**PRACTICE STANDARD INDICATOR 3.6:**
The nurse follows ethical guidelines when engaged in any aspect of the research process.

**OBJECTIVE**
I want to better understand and apply the good clinical practice (GCP) guidelines to new research studies I may be involved in within the next year so I can feel more comfortable questioning the integrity/processes of a study, if necessary.

**RELEVANCE**
This is incredibly relevant to my current practice as a clinical research coordinator as I will be the one conducting the research and collecting data for the head researchers to interpret. I want to ensure that there are best practice standards when it comes to our study participants.

**ACTIVITY**

**LEARNING TYPE ACTIVITY:** Participation in/conducting research

**ACTIVITY NAME:**
- Through my position as a clinical research coordinator, I have gained a much better understanding of the GCP guidelines.

**ACTIVITY EVALUATION:**
Working in this role for some time has allowed me to earn the experience needed to understand and apply GCP guidelines, etc. to an actual study.

**EVALUATION**
It has governed my practice by ensuring that this study is completed in a manner that is respectful and does not harm any participants. I have always upheld confidentiality for my patients and have provided them with as much education and support as I possibly can.
Staff/Community Health Nurse: Psychiatric/Mental Health
35 years of experience

**INDICATOR**

**PRACTICE STANDARD INDICATOR 5.6:**

_The nurse regularly assesses their practice and takes the necessary steps to improve personal competence._

**OBJECTIVE**

This is a fairly broad indicator. I would like to narrow it down to techniques of handwashing. As a health-care professional, it is our responsibility to promote and maintain the health of our patients. The single most important infection-control method is handwashing. In my current practice as a front-line forensic nurse, I deal with acutely mentally-ill patients who present with physical issues such as MRSA (methicillin-resistant Staphylococcus aureus), AIDS, Hepatitis C+ and other infectious conditions. Hence I would like to learn about handwashing and its direct benefits to my patients.

**RELEVANCE**

To improve my knowledge and learn new techniques and stay abreast with the latest information on handwashing and good handwashing techniques using soap and alcohol-based hand rubs. Handwashing is very relevant to all nurses who have daily contact with their patients. Reducing the spread of infections and setting a good example to my clients. “Clean care is safer care.”

**ACTIVITY**

**LEARNING TYPE ACTIVITY:** Education courses (credit/non-credit)


**ACTIVITY EVALUATION:** This learning activity helped me build my confidence when giving direct care to the patients. A byproduct of this topic was also to teach my clients to do handwashing after their own activities; for example, before meals, after using the washroom, etc. My co-workers are also very supportive of my information when we interact. We are also fortunate at our workplace that the infection control nurse is readily available for consultation. So on the whole, I have gained confidence and improved my personal attitude towards handwashing and preventing the spread of infections.

**EVALUATION**

I have achieved my objective to gain more information on handwashing. I have learned the difference between “just” handwashing and effective handwashing techniques. Effective handwashing will reduce the chances of spreading infections between patients. Also, I learned the limitations of handwashing. Some microbes will not be eliminated. Wearing gloves alone is not sufficient enough, it has to be accompanied by proper handwashing. Difference between using soap and alcohol-based sanitizers: the amount of time required to effectively handwash. Studies have indicated that about half of health-care professionals use proper handwashing techniques. My newly-acquired knowledge and skills of proper handwashing has made me more confident in providing direct hands-on nursing care. This is important for front-line nurses to decrease the spread of infections. I found this topic useful and informative. It will have a positive influence on the care I provide to my patients.
June meeting highlights

CARNA removes BBVI reporting requirement

CARNA members are no longer required to report a blood-borne virus infection (BBVI) to CARNA. Provincial Council decided to withdraw the document *Registered Nurses with a Blood-Borne Virus Infection: Standard for Reporting and Guidance for Prevention of Transmission of Infection* (2008).

RNs and NPs have a professional obligation to follow infection prevention and control best practices, and we are committed to providing resources to support safe and ethical practice. We are developing a practice advice document that will provide RNs and NPs with guidance on:

- Their role in ensuring and promoting effective infection prevention and control in all practice settings.
- Understanding exposure-prone procedures.
- What to do if they are exposed to blood and body fluid.
- What to do if they have been infected with a BBVI.

If you have questions about your practice related to BBVI, please contact practice@nurses.ab.ca.

Access to opioid-use disorder therapy improved for patients

Alberta nurse practitioners can now prescribe methadone and other drugs to manage opioid-use disorder and methadone for pain management.

CARNA Provincial Council approved revisions to the *Prescribing Standards for Nurse Practitioners* (2018). You can view the revised document at nurses.ab.ca/documents. The standard was updated to reflect Health Canada’s decision to remove the federal requirement for an exemption to prescribe methadone and add NPs to the list of health providers that can prescribe diacetylmorphine.

Before prescribing, NPs must first complete education and preceptorship requirements. They must also prescribe in accordance with best practice guidelines for their area of practice.

NPs have indicated that the ability to prescribe drugs to manage opioid dependence is needed in selected areas of their practice. This change will enable NPs to respond to pressures in the system and support delivery of health care for client populations, while supporting provincial harm-reduction strategies.

Please contact us at nursepractitioners@nurses.ab.ca if you have any questions.

Palliative and end-of-life care document revised

Council has approved changes to the document *Palliative and End-of-Life Care: A Position Statement* to align with best practices and the palliative and end-of-life care provincial framework. You can view the revised document at nurses.ab.ca/documents.

Councillor recognized for outstanding leadership

Congratulations to Calgary/West region Provincial Councillor Tyler Burley on receiving the Vogel Award for his contributions to Council. When selecting the recipient of this annual award, Council considers several criteria including constructive debate and the initiation of new approaches and ideas.

CARNA secures grant to support Indigenous health

We are pleased to announce that we have secured a grant from the Alberta Human Rights Commission which will help us fulfill our commitment to addressing Indigenous health issues in Alberta.

As part of this project, we will be collaborating with expert consultants to create cultural competency and safety training modules for RNs and NPs. The project will also provide training for CARNA staff.
Polls close at 11:59 p.m. on Aug. 31, 2018

What is council?
They are the people who represent you and make decisions about the profession on your behalf.

President-elect

Derrick Cleaver
MPH, BScN, RN

Nicole Letourneau
PhD, MN, RN, FCAHS

Andria Marin Stephens
MN, RN

Edmonton/West

Dawn Krahn
MN, RN

Alycia Lobay
MN, BScN, RN

Caitlin Wiltshire
B.Sc., BScN, RN
HOW TO GET INVOLVED

- Review the candidates in your area.
- Come to a council meeting.
- Considering running for council next year!

Calgary/West

Tyler Burley
MN, BN, SC, RN

Crystal Emery
BScN, RN

Bronwyn White
MN, BN, RN

Northeast

Jeannie Hare
RN

Shelley O’Neill
RN

QUESTIONS?
Please contact Barbara-Ann Sheppard at 1.800.252.9392 ext. 531 or elections@nurses.ab.ca.
Registered nurses from across the province came together for an unforgettable night of toasting the profession. The CARN A Awards of Nursing Excellence Gala on June 7 celebrated the award recipients and nominees for their contributions to nursing. The evening also recognized several RNs for their outstanding academic achievements with ARNET’s annual scholarships.
Congratulations to the ARNET Academic Scholars Class of 2018!

We were honoured to have many of this year’s recipients attend the 2018 CARNA Awards Gala where their outstanding achievements were formally recognized. Congratulations to them and thank you to our donors who made this funding support possible!

**ARNET ACADEMIC SCHOLARSHIP**

- **Morgan Wadams**
  - DOCTORAL, NURSING
  - University of Alberta

- **Michelle Shand**
  - MASTERS, NURSING
  - University of Calgary

- **Cybele Angel**
  - DOCTORAL, NURSING
  - University of Alberta

- **Samantha Delhenty**
  - MASTERS, NURSING
  - University of Calgary

- **Adrienne Rommens**
  - MASTERS, NURSE PRACTITIONER
  - University of Calgary

**ARNET ACADEMIC SCHOLARSHIP**

- **Sadie Deschenes**
  - DOCTORAL, NURSING
  - University of Alberta

- **Jennifer Bell**
  - DOCTORAL, NURSING
  - University of Alberta

- **Alison Thompson**
  - DOCTORAL, NURSING
  - University of Alberta

- **Hong Helen Doan**
  - MASTERS, NURSING
  - University of Alberta

- **Alanna Rutherford**
  - MASTERS, NURSING
  - University of Calgary

- **Amy Lyn Joy Notarte-Morales**
  - MASTERS, NURSING
  - University of Lethbridge

- **Damaris Gaete Ortega**
  - MASTERS, NURSING
  - University of Calgary

- **Kaitlyn Tate**
  - DOCTORAL, NURSING
  - University of Alberta

- **Noelle Sedgwick**
  - MASTERS, NURSING
  - University of Lethbridge

- **Alanna Rutherford**
  - MASTERS, NURSING
  - University of Lethbridge

- **Damaris Gaete Ortega**
  - MASTERS, NURSING
  - University of Calgary

- **Hong Helen Doan**
  - MASTERS, NURSING
  - University of Alberta

- **Alanna Rutherford**
  - MASTERS, NURSING
  - University of Lethbridge

- **Damaris Gaete Ortega**
  - MASTERS, NURSING
  - University of Calgary

- **Hong Helen Doan**
  - MASTERS, NURSING
  - University of Alberta
Recognize an amazing RN, NP or partner in health. Tell us their story at carnaawards.ca.

Questions? Email carnaawards@nurses.ca or call 1.800.252.9392, ext. 435.

DEADLINE: Sept. 30, 2018
The secret to a strong CARNA Award nomination

Make your nomination stand out among the 60+ nominations we receive each year. Here are a few tips on submitting a strong nomination.

Specific examples:
Know your nominee and showcase their achievements, skills and experiences. Use examples of the initiatives and programs the nominee was involved in and how they led to better patient outcomes. Specific examples of actions and outcomes will lend credibility and strengthen the submission.

Well-written and concise:
Ensure your nomination is well-written and concise with correct sentence structure, grammar, punctuation and spelling. Nominations are easier to read without errors.

Nomination timeline

1. Nomination Deadline
   September 2018

2. Committee Review
   Fall 2018

3. Recipients Selected
   December 2018

4. Recipients Announced
   January 2019

5. Awards Gala
   May 2019

Learn more and start a nomination at carnaawards.ca.
A Hearing Tribunal made a finding of unprofessional conduct against CARNA MEMBER #63,395 who administered fentanyl and Gravol IV to a patient without a physician’s order. On a different occasion, the member discharged the patient without a physician’s order and prior to being seen by a physician. The Tribunal issued a reprimand and ordered the member to pass a course in basic medication administration and restricted her to working at one work 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.

A Hearing Tribunal made a finding of unprofessional conduct against CARNA MEMBER #65,735 who failed to maintain appropriate oversight and financial management of the staff social committee fund and allowed $248 collected for that purpose to become intermingled with her personal funds and used for personal purposes, which she repaid when confronted by co-workers about the missing money. The Tribunal issued a reprimand and ordered the member to pay a fine of $250, complete modules on the Code of Ethics and be restricted to working at 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.

A Hearing Tribunal made a finding of unprofessional conduct against CARNA MEMBER #81,810 who, while on sick leave over a period of three months, attended at her place of employment, sometimes dressed in scrubs to inappropriately access the unit. The member inappropriately accessed Pyxis machines at her place of employment on many occasions to pilfer narcotics, including injectable morphine, fentanyl, hydromorphone and meperidine, and falsely used patient names and physician names to cover her theft of narcotics for a great number of transactions in Pyxis. 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 that 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, physician and counselors will report back to a Hearing Tribunal. The member is required to continue drug screening and provide further medical reports to a Hearing Tribunal for two years following successful completion of a 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: #92,853

A Hearing Tribunal made a finding of unprofessional conduct against member #92,853 who initially decided she would not administer medications to residents, which was her responsibility, until directed to do so. She failed to accurately transcribe an order for Tylenol #3, and, on another date, failed to administer a medication. The Tribunal issued a reprimand and ordered the member to pass courses in basic medication administration and in documentation. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

Carna member registration number: #99,955

A Hearing Tribunal made a finding of unprofessional conduct against member #99,955 who failed to document an accurate assessment of a patient’s condition, attempted to administer lactulose orally without a written physician’s order, and who failed to adequately document patient care including: attempts to administer the lactulose orally, attempts to insert an NG tube, the member’s communication with the patient’s physician, and any verbal orders provided by the physician. The member also failed to respond appropriately to a request for assistance from a health-care aide for a patient whose colostomy bag had broken. The Tribunal issued a reprimand and directed the member to pass courses in medication administration and in documentation. The member is restricted to working at her current 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 CARNA practice permit.

Carna member registration number: #101,589

A Hearing Tribunal made a finding of unprofessional conduct against member #101,589 who had submitted an admission of unprofessional conduct under section 70 of Health Professions Act. The member had on several occasions pilfered injectable morphine from the employer, falsified narcotic records to cover the theft of morphine by fabricating patient names or by signing out morphine for patients who did not actually receive that morphine. The member also attended at work when she knew or ought to have known she was not fit to practise safely, as she had consumed two or three bottles of wine in the 24 hours before her shift. The Tribunal issued a reprimand and restricted her to working at her current setting with no permission to access or administer narcotics for a short period of time pending full satisfactory medical reports and drug and alcohol screening. If the satisfactory medical reports are not provided within the time frame, the member shall be prohibited from practice pending satisfactory medical. Once that is provided, 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.
How thorough should my documentation be?

BY DEBRA ALLEN, MN, RN, SENIOR MANAGER, REGULATORY AND PRACTICE

Jane, a registered nurse on a busy surgical unit, completes an assessment on her postoperative client, but documents minimal information on the client record. She documented that vital signs were normal, but not the values of the vital signs.

Will Jane be held responsible if there is a serious change in the client’s condition that was not anticipated or monitored?

Let’s consider Jane’s responsibility for the care she provided. Did she meet documentation expectations? Did the client receive the care they required? The Practice Standards for Regulated Members can help us answer these questions.

The practice standards are the benchmark for RN and NP practice. They outline the requirements to ensure quality nursing care. All RNs and NPs providing care must also adhere to the Documentation Standards for Regulated Members. Let’s dig deeper into the standards to determine if Jane has met her responsibilities.
**STANDARD 1**  
**Responsibility and accountability**  
The nurse is personally responsible and accountable for their nursing practice and conduct.

Jane documented minimally and did not record vital signs data. She may encounter obstacles if she did not document according to her employer’s policies. Accurate documentation is ultimately good risk management. Documentation policies are intended to support RNs by taking into consideration what is adequate documentation in any situation.

Appropriate documentation minimizes the risk something could be missed, could go wrong or not be accounted for in the care provided. RNs concerned with employer documentation policies that seem inconsistent with best practice, or do not appear to support a positive outcome, have a professional responsibility to bring their concern to the attention of their manager or supervisor.

**STANDARD 2**  
**Knowledge-based practice**  
The nurse continually acquires and applies knowledge and skills to provide competent, evidence-informed nursing care and service.

The client’s chart shows what care has been provided and can be used to resolve questions or concerns. Accurate documentation is crucial to demonstrate that nursing care was reasonable and prudent, and met the standards. Documentation also articulates what care was given and why. RNs are expected to apply their knowledge to assess, plan, intervene and evaluate patient outcomes.

Documentation is the permanent record demonstrating the nurse’s accountability and recognizes the professional practice provided by an RN.

In Jane’s situation, the lack of documentation can bring into question whether she actually completed a comprehensive assessment. Also, whether the lack of documentation led to poor communication and ultimately to the lack of monitoring of the assigned postoperative client.

**STANDARD 3**  
**Ethical practice**  
The nurse complies with the *Code of Ethics* adopted by Council in accordance with Section 133 of HPA and CARNA bylaws (CARNA 2012).

The Canadian Nurses Association *Code of Ethics* is organized around seven primary values central to ethical nursing practice.

One of these values is safe, competent and ethical care. It states that RNs must strive for the highest quality of care achievable. Nurses must admit mistakes and take all necessary actions to prevent or minimize harm arising from an adverse event.

Another value, health and well-being, states that RNs must provide care directed first and foremost toward the health and well-being of the person, family or community in their care.

**STANDARD 4**  
**Service to the public**  
The nurse has a duty to provide safe, competent and ethical nursing care and service in the best interest of the public.

Documentation enables care providers to work with the client to provide optimal care. Properly documenting the care provided and the outcomes facilitate continuity of care.

Jane’s lack of documentation could lead to poor communication between members of the health-care team and ultimately the plan of care may not reflect the level of monitoring that is required for the client.

**STANDARD 5**  
**Self-regulation**  
The nurse fulfills the professional obligations related to self-regulation.

The *Documentation Standards for Regulated Members* outlines expectations and regulatory requirements for nurses. The documentation standards assist RNs in producing clear, accurate and comprehensive accounts of client care in any practice setting.

Documentation is not separate from care and it is not optional. It is an integral part of practice and an important tool that nurses use to ensure high-quality client care. Regardless of the format used to document, the client care record is a formal, legal document that details a client’s health care and progress. RN
Routine practices are fundamental infection prevention and control (IPC) measures that apply to all patients and residents, at all times, in all health-care settings to prevent hospital-acquired (HA) infections. Routine practices include, but are not limited to, essential measures such as hand hygiene, point-of-care risk assessments and environmental and equipment cleaning.
Despite the application of routine practices and other IPC interventions by health-care workers, several Covenant Health acute and continuing care health facilities in Alberta faced continued HA transmission of antibiotic resistant organisms (AROs) and Clostridium difficile infections (CDI).

A collaborative discussion between the Covenant Health IPC program and concerned program stakeholders revealed health-care workers were cleaning their hands and shared equipment, patient/resident care environments and patients/residents themselves were being cleaned. However, the actual approaches, practices and processes were performed by a variety of hospital staff members, in a variety of different ways, with varying levels of accountability. There was no mechanism to measure patient outcomes related to HA AROs and CDIs in a comprehensive, integrated way.

To our knowledge, there has not been a health-care initiative that bundles cleaning interventions to include hands, equipment, environment and the patient/resident into a single strategic approach. Care bundles aim to improve standard of care and patient outcomes by promoting consistent implementation of a group of effective interventions. We postulated that if effective implementation of each cleaning intervention alone has the potential to reduce the risk of HA ARO and CDI transmission, then an approach that bundles all relevant interventions could have an even greater impact. Thus, the CHEEP/CHEER project was born!

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**Clean Hands**
**Equipment**
**Environment**
**Patient**

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Before the launch of the CHEEP/CHEER project, the IPC program collaborated with key stakeholders to analyze each cleaning intervention to identify gaps. They developed methods and initiatives to improve the consistency and effectiveness of each intervention and to streamline processes. The following was implemented for each intervention:

**Hands:** Increased hand hygiene education for health-care workers and the addition of an extra compliance monitoring session during the project period.

**Equipment/devices:** Identification of non-critical, shared patient/resident equipment/devices that may not be thoroughly cleaned on a regular basis. Development of a checklist requiring staff to sign-off to indicate cleaning of the identified equipment/device has occurred.

**Environment:** The IPC program worked with the environmental services (EVS) team to understand how EVS conducted their patient/resident room audits. They then worked to identify gaps, improve the audit process and increase the number of audits.

**Patient:** Encouraged targeted, intentional daily patient/resident bathing using a documentation process and cleaning products(s) and processes specific to each unit/facility.

Once the cleaning intervention processes had been established and staff were educated, the CHEEP/CHEER project was implemented at two acute care facilities and two continuing care facilities for six months. In one of the acute care facilities, CHEEP was implemented on only four specific nursing units.

During the project period, IPC staff liaised with the clinical operational leads to provide clinical support, project oversight and direction.

The outcome measures included:

**Hands:** Health-care worker hand hygiene compliance rates.

**Equipment:** Equipment cleaning checklist weekly completion rates.

**Environment:** EVS patient/resident room cleaning audit rates.

**Patient:** Cleaning product utilization rates (only for units using packaged cleansing cloths).

**Overall:** HA ARO and CDI rates during the project period, number of outbreaks.

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**The results**

Overall, health-care worker hand hygiene compliance rates increased. Completion of the equipment cleaning checklist demonstrated that unit equipment/devices were now being cleaned on a regular basis. EVS room cleaning audit rates were greater than 80 percent and product utilization rates, although variable, did indicate increase in use.

Finally, despite infection risk pressures (e.g., patients on each unit with AROs and CDIs) during the project period, the majority of units/facilities saw decreases in HA AROs and CDI transmission compared to the previous six months and during the same six months as the year before. There were no outbreaks of any kind during the project period.
CARN A funded a study titled “The role of the registered nurse in clinical practice.” This study evaluated the direct metrics that result from RN contributions within multidisciplinary teams in a variety of clinical settings.

CARN A sought to examine the RN role in primary and community care settings and interpret the most effective team structure and models of care. The study also analyzes organizational support, funding and technology access, which are key for the future success of the Canadian health-care system.

The following is an excerpt of the full report, which can be found at nurses.ab.ca.
The research questions were:

- What are the best practices for team structures and models of care that include RNs in specific populations (primary/community care, vulnerable populations and rural and remote areas)?
- How are these best practices impacted by funding?
- How are these best practices impacted by technology?
- How are these best practices affecting access to health care?

To answer these questions, peer-reviewed sources were identified in the MEDLINE and CINAHL databases, and grey literature sources were identified through websites of relevant organizations.

**FINDINGS**

- A total of 30 studies were identified, all of which took place in a primary care and/or community care setting.
- Studies that examined the general population in primary care settings (patients with diabetes, COPD, failure, wounds or alcohol related incidents) generally demonstrated the potential value RNs contribute for the improvement of patient outcomes.
- Models of care utilizing RNs were found to improve access to care and patient outcomes for those in rural or remote settings.
- Incorporating technology into a care approach aided in the remote monitoring of patients and improved access to care.

**PRIMARY/COMMUNITY CARE**

Diabetes was the most common condition observed in relation to team structures and models of care utilizing RNs. Practices that employed at least one RN were more likely than those with no RN to have patients with diabetes indicators on target. Overall, primary care teams with greater face-to-face communication were associated with 52 per cent fewer hospital days among patients. A single RN communicating with the primary care physician led to better patient outcomes as opposed to multiple RNs.

**Care and technology in rural and remote communities**

Studies were identified that evaluated models of care and team structures used in rural and remote primary care settings, and programs that used technology to improve delivery or access to care.

A home telehealth (HT) model of chronic disease management for veterans with diabetes consisted of an NP and RN team using a virtual outreach clinic. The program enabled remote monitoring of veterans, allowing RNs to follow the insulin protocol as needed and communicate directly with patients. This project revealed that patients experienced a significant reduction in glycated hemoglobin.

**VULNERABLE POPULATIONS**

Overall, when RNs were leading or playing supporting roles, it generally contributed to positive outcomes for vulnerable populations.

**Older adults:**

One program for older adults with chronic conditions involved at-home sessions with an occupational therapist, an RN and a handyman to address functional goals related to staying in the home. Participants reported a 50 per cent reduction in the number of daily living activities that they had difficulty with. Another study compared a home-based model for older adults utilizing advanced practice registered nurses (APRN) to home health-care services delivered without the aid of an APRN.

**Veterans:**

Researchers compared blood pressure outcomes in a veterans affairs medical centre. Patients who received clinical pharmacy specialist (CPS) directed care from RNs had a greater decrease in systolic blood pressure compared to those receiving physician-directed registered nurse care management (RNCM). This shows that CPSs may be an alternative to physicians for providing prescriber support for RN case management.

**Pediatric:**

A study examined a program with shared medical appointments for children with asthma and their caregivers. The team included an NP, RN behaviourist, an LPN and medical assistant (MA). Sixty-six per cent of caregivers reported that the benefit provided by the RN behaviourist was of very good or excellent quality. Overall, appointment experience was reported to be better by 53 per cent as compared with a usual individual appointment. Another study evaluated the implementation of an APRN-led telemedicine program for a rural community with pediatric diabetes patients. Caregivers reported they were highly satisfied with access to care and quality of services.
including APRN physical examinations through video-conferencing with diabetes specialists.

**Low income:**

One study evaluated a program that integrated medical and behavioural health for those with chronic conditions in a low income, underprivileged community. An RN contacted patients by phone to conduct a baseline assessment and then face-to-face assessment. Then treatment with psychiatrists commenced. Findings showed that 39 percent of patients had slight reduction in depression scores, 44 percent reduced their scores, indicating a return to sub-threshold depression, 15 percent decreased their scores to less than five, indicating remission.

**Intimate partner violence:**

A study examined a multidisciplinary program utilizing RNCM that was designed to help pregnant victims of intimate partner violence (IPV) and provide continuity of care across services and providers. These individuals are often at increased risk for poor outcomes. Clients of this program achieved birth outcomes comparable to the overall population. Clients were also reported to be highly satisfied with their experiences in the program.

**CONCLUSIONS**

The evidence gathered in this review points to the benefits for patients receiving care from RNs as part of a team structure. In 29 of the sources, it was found that the RN participation in provision of care had a positive influence on patients. RNs in various models of care and in partnership with other health-care professionals consistently produced improved outcomes to vulnerable populations.
No one can deny the value of registered nurses’ presence at the hospital bedside. However, this value equation has yet to be realized in the PHC sector of our health system. Only recently have registered nurses, and particularly nurse practitioners, become well-known for their roles in PHC settings.

March 1, 2018 marked the opening of a new NP-led PHC delivery model in Alberta, Collaborative Community Care (C³) for Seniors.

This model of care positions NPs as the responsible primary-care provider for a panel of patients and is reshaping how we think about and deliver PHC. C³ for Seniors combines evidence-based, research-driven, NP-led health care with community-based, non-profit social services and life enrichment programming. The program provides 5,500 older adults in Edmonton with access to PHC services and creates positive health and wellness outcomes for low-resourced older adults.

Four features define this new model and the combination of these features make it unique to Canadian health care.

**Clinical leadership: NPs**
Clinical leadership at C³ for Seniors is provided by NPs. The Director of Health Services is an NP and the other NPs provide leadership for the interprofessional team. The C³ for Seniors model is an exceptional opportunity to showcase the potential for NPs to lead and work collaboratively with interprofessional teams. The program also gives other clinicians the opportunity to see NPs in action, building positive relationships and bolstering the reputation of the NP role within our health system.

**Co-location**
C³ for Seniors has six exam rooms located in the Sage Seniors Association, a centre in downtown Edmonton that offers extensive social services. In this one-stop-shop model, an older adult can access housing and financial assistance, attend an individual counseling session and socialize in the café. Then they can visit the health services area for a refill on their prescription, an annual screening test or a host of other primary care services. The Sage building is ideally located and convenient to access as many community residences catering to older adults are located in central Edmonton.

**Collaborative academic partnership**
C³ for Seniors was proposed and implemented through a partnership between the University of Alberta faculty of nursing and Sage Seniors Association. Through this unique employment agreement, NPs are able to engage fully as primary health care providers and engage in a significantly more comprehensive scope of practice.

NPs practising in the program also have appointments within the faculty of nursing as lecturers. They greatly increase the capacity of the faculty to provide quality clinical experiences for NP students. Since there are few locations where NPs are able to independently manage a panel of patients, many NP graduates lack an opportunity to develop this skill. The C³ model is an exceptional opportunity for NPs to showcase success in primary care and panel management. As NPs are enabled by Sage and the faculty of nursing to practise their full scope, care is more flexible and comprehensive, and not limited by financial and billing constraints.

**Co-creating a service delivery model**
C³ for Seniors is being developed with older adults. We know that patients may be reluctant to change care providers and experience inertia when faced with a new choice. Engaging older adults in discussions during the development of this new model has provided the opportunity to both understand their needs and wants, and give them the chance to learn more about choices in health-service delivery. To date, older adults have been involved in feasibility studies about the model, architectural planning for the space design and interviews with the core health team. More recently, they have been involved in focus groups to make decisions about final health-care team composition, services and hours of operation.

**NEXT STEPS**
C³ for Seniors represents a new way for RNs and NPs to demonstrate their value in reshaping Alberta’s PHC system. The C³ team continues to improve PHC access to the city’s most vulnerable older adults while undertaking a meaningful evaluation of the social and clinical indicators that contribute to health improvements for this population.

For more information about C³ for Seniors, please contact: Tammy O’Rourke, Assistant Professor, faculty of nursing, University of Alberta at 780.492.2699 or torourke@ualberta.ca.
MANAGING CHILDREN’S PAIN REQUIRES A HOLISTIC APPROACH

Teams caring for pediatric patients know pain is multi-dimensional, so they use pharmacological, psychological and physical techniques.

BY KERI SWEETMAN

Leeann Lukenchuk still remembers her first pediatric patient when she was a student nurse more than 30 years ago.

The patient was a two-year-old girl in postoperative care after orthopedic surgery. The nursing students had to pin her down to give her an intramuscular injection and no parent was present. “It was awful. It ended up this child was struggling so much, even with us trying to gently hold her, my instructor had to give her the injection.”

“That’s how we treated pain in children at that time...I like kids,” she thought, “but unless my back is against the wall, I’m not choosing to do this for my career.” Lukenchuk was so upset she vowed to work with adult patients when she graduated from the University of Alberta school of nursing. And she did, for many years.
New techniques in pain management

Fast forward to 2018, and all that has changed. Lukenchuk is now a nurse practitioner who leads the pediatric acute pain service at the Stollery Children’s Hospital in Edmonton. Today, the techniques for managing pain in children are light years removed from the days of intramuscular injections and pinning down patients.

Her acute pain team – currently made up of a full-time NP, a part-time RN and an on-call pediatric anesthesiologist – relies on what Lukenchuk calls the “3 Ps”: pharmacological, psychological and physical techniques.

The pharmacological options include PCAs (patient-controlled analgesia), epidurals, low-dose ketamine infusions and nerve block infusions. For postop pediatric patients, opioids are used short-term, typically in the first 24 to 48 hours, with careful attention to dosing. Psychological interventions target the fear and anxiety of pediatric patients, using distraction, relaxation techniques and, depending on their developmental level, helping children use their imaginations to work through the situation. Physical techniques include repositioning, elevation, warm or cold packs and cuddling.

“We have to remember that pain is multi-dimensional,” says Lukenchuk. “It’s not just the physical tissue damage. It’s everything that goes with it, the emotional, the psychological, the social, the previous experience with pain.”

Children’s pain presents different challenges

Lukenchuk’s team is called in for comprehensive pain assessments when there are pediatric patients whose pain is difficult to manage, either in a postop or trauma situation or with a long-term medically-complex child who has acute pain. Obviously, children or infants offer different challenges than adults.

“You have to remember when you are working pediatrics, it’s anywhere from a day old up until their 18th birthday. So there is a vast variability in physical development, as well as cognition and self-regulation. With each developmental stage, there’s a different capability of the child to express themselves, to understand, cooperate or even just to cope with things.”

Many of the younger children who are in pain will shut down, become very quiet or refuse to cooperate. Others will cry and scream when faced with having blood taken or a dressing changed, especially if they have had a previous bad experience with a medical procedure. Neonatal patients who are intubated will not even have an audible cry, so specialized tools must be used to assess their pain.

It takes a team to manage pain, and parents are key

Parents and caregivers are key to helping the medical team manage their child’s pain. They are advocates for their child and the window into helping the team understand what their child is usually like.

IT’S ALL ABOUT TEAMWORK. “WE TRY TO HAVE THE PHILOSOPHY THAT PAIN IS EVERYBODY’S RESPONSIBILITY.”

LEEANN LUKENCHUK

But in her research for her nurse practitioner master’s degree, and in her ongoing leadership role with the Stollery team, Lukenchuk discovered that many parents weren’t being provided with the information and strategies they need to help the team help their child.

As a result, the focus now is ensuring that parents are the starting point for their child’s pain management. Has the nursing team done an assessment of what the parents do or do not know and what they need to know? Do the parents understand why opioids may be used short-term? Have they been told what will happen on discharge?

“We need to do a more consistent job of all of this in the pre-op preparation,” says Lukenchuk.

She and other Stollery nurse specialists have also developed a pain assessment and management algorithm that is used as a teaching tool for those working with pediatric patients in acute pain. It offers a guideline on how to assess pain in children of all ages, how to intervene with pharmacological and physical treatments, and how to document and reassess the patient after one hour and four hours.

Nurses are always central to the pain management of a pediatric patient because they are the ones providing ongoing care. They are holistic in their care, looking not only at medication, but at how the patient is coping and moving, and anticipating what may need to be done in different situations throughout the day and night.

But, Lukenchuk stresses, it’s all about teamwork. “We try to have the philosophy that pain is everybody’s responsibility. Whether you’re the LPN or the RN or the physio or the child life specialist, we should all be working together to get the best outcome for the kids.”

CARN A part of the Alberta Pain Collaborative.

For more information about pain management: IASP Global Year: iasp-pain.org/GlobalYear
Pain Society of Alberta: painab.ca
Advocacy is a nursing responsibility. It is identified in our Code of Ethics and Entry-to-Practice Competencies. There is a social contract between nurses and the society we serve. Nurses must provide competent and beneficent services to their clients. They are also expected to identify and try to rectify obstructions to fair health care for all members of society.

The Alberta Gerontological Nursing Association (AGNA) is one of CARNAs specialty practice groups. Its mission is to promote quality care to older adults and advocacy is vital to achieving that mission. Recognizing this fact, AGNA established an advocacy committee.

AGNA strives to promote positive changes in attitudes, governmental and health administration policies and in actions towards older adults. To achieve their mission, AGNA needs to advocate to a variety of audiences – the public, registered nurses, nursing education programs, government, non-governmental organizations and even older adults themselves.

The advocacy committee is dedicated to hearing the voices of AGNA members. To gather their perspectives on the issues facing gerontological nurses and their older clients. To build coalitions to effect change.

The committee members represent the diverse practice settings in which nurses work with older adults. Committee members act as champions within their respective settings, mobilizing their colleagues around the issues affecting older adults.
AGNA’S ADVOCACY ACTION PLAN/GOAL→ACTION PLAN

Create awareness and promote the value of gerontological nursing knowledge and skills among RNs and AGNA members.

- Prepare article for peer-reviewed nursing publication.
- Prepare and present webinars to RNs.
- Maintain a website of issues influencing the care of older adults.
- Participate in the yearly AGNA conference.
- Respond to requests for input on CARNA policy documents.
- Submit posters at gerontology conferences on work of the advocacy committee.

Build working relationships with similar associations.

- Initiate and maintain communication with the Alberta Association on Gerontology.
- Co-sponsor local events.
- Support two educational events with colleagues from Mount Royal University and Alberta Health Services specific to orientation of instructors to working with students and older adults in acute care settings.
- Initiate a working relationship with the International Journal of Nursing Student Scholarship to promote support to students who submit a gerontology-focused manuscript.
- Promote certification through liaison with the Canadian Nurses Association during its certification week.
- Work with the Canadian Gerontological Nursing Association to provide education specific to certification examination.

Develop a relationship with government to promote awareness of the needs of older adults and those who work with them.

- Respond to requests for information from the provincial government on behalf of AGNA.
- Develop a home care policy.

Create awareness with students about a career in gerontological nursing.

- Establish a mentoring/succession plan for the committee.
- Address student groups.

LESSONS LEARNED

Volunteers are valuable
AGNA is supported by unpaid volunteers and they have learned to value volunteer time. The committee has no budget and the only resource is a teleconference line for monthly meetings. The committee members have diverse backgrounds and AGNA felt it was important to use their expertise and ensure they can meet their own learning needs.

Plan to succeed
AGNA also learned the value of planning to support the most efficient use of their limited resources. Planning is the key to delivering a successful advocacy initiative as it ensures that the committee activities are coordinated and directed to achieve their goals.

Never assume anything
As nurses working with older clients, the committee realized early in their work that everyone assumes they know what old age is like and what older clients want and need. However, there is only one group of people who really know what matters to them - and that is our older clients themselves.

GOING FORWARD

Increasing member engagement and support for the advocacy committee is a challenge for 2018 and beyond. The committee will need to measure member engagement across all of their advocacy activities to provide a complete picture of the member interactions and how the committee can grow engagement in the future. RN

REFERENCES
Safety
is the watchword in acute inpatient addiction and mental health units. The safety of both patients and staff informs and influences which interventions staff use and when.

De-escalation is a guiding principle of practice in acute clinical settings and is the main focus when determining necessary interventions. De-escalating techniques may include: advising the patient to take a voluntary timeout in his/her room, listening to music, talking with staff, journaling, calling a loved one, going for walks or taking a hot shower to mention but a few.

Collaborative problem solving in adult mental health and addiction programs: A paradigm shift

AUTHOR:
LAWRENCE ONWUEGBUCHUNAM, PhD(C), RN
But, there are times when these therapeutic techniques appear to be ineffective. This is especially true when patients are extremely agitated. Disruptive behaviours like antisocial behaviour, impulsivity, verbal aggression and threatening may necessitate the use of therapeutic seclusion and restraints as last resorts. Historically, these behavioural modification techniques are believed to translate to positive behaviour and reduce aggressive behaviour.

The legitimacy and efficacy of the behavioural modification approach has been questioned by different authors (Pollastri, et al, 2013). Paterson and Duxbury (2007) questioned the validity of using restraints in inpatient acute psychiatry settings and contended that current studies provide only a weak support for its validity.

**A NEW WAY**

A new way of practice calls for a collaborative approach between patients and staff in both the assessment and planning of interventions that are effective, meaningful, address the needs of the patients in the moment, and reduce the use of seclusion and restraint.

The philosophy of collaborative problem solving underscores that people do well “if they can” and not “if they want.” This mindset is a paradigm shift in addiction and mental health units in Alberta Health Services. There is a common belief among mental health professionals that people can change only when they are ready. If they are not ready, any intervention is almost a waste of time.

Collaborative problem-solving philosophy maintains that the issue is lack of skills, not lack of will.

Collaborative problem-solving philosophy maintains that the issue is lack of skills, not lack of will. It takes a significant amount of time to engage in thoughtful deliberations with one dysregulated patient in acute inpatient mental health units. This can be challenging when each nurse has an average of five patients, while at the same time must respond to other necessary requirements like making safety and elopement rounds every 15 minutes and facilitating group therapy.

But, there are challenges. It takes a significant amount of time to engage in thoughtful deliberations with one dysregulated patient in acute inpatient mental health units. This can be challenging when each nurse has an average of five patients, while at the same time must respond to other necessary requirements like making safety and elopement rounds every 15 minutes and facilitating group therapy.

This practical consideration on both the positive impacts of collaborative problem solving and the challenge that comes with it need further and ongoing deliberations on how to make both ends meet. **RN**

**REFERENCES**

It has been a busy day in the baby clinic and Helen has been running behind schedule and trying to catch up all day. At 3 p.m., she finishes her last appointment immunizing a baby and is looking forward to a lunch break. Helen transfers the care of the infant over to her colleague Jodi, but forgets to log off of the electronic medical record (EMR). Shortly after, the mother of the baby Helen just immunized calls for help. Jodi performs an assessment, realizes the baby is having an allergic reaction and immediately implements the appropriate nursing protocol. Once the baby’s condition has stabilized, Jodi shifts her focus to documenting the care she provided. Jodi sees that the EMR is open for access and the baby’s record is visible on the screen.

What should Jodi do?

Jodi must remember that a client record carries the same importance whether the format is paper, electronic or a combination of both. If she does not log Helen out before documenting, she will, in fact, be signing someone else’s name to her work. If Jodi documents under Helen’s profile, then Jodi has not demonstrated accountability for her nursing care. Likewise, if Helen kept herself logged on for others to access, questions about her accountability arise.

Thinking in a digital way

As with any tool, documentation in the EMR is only as complete as the information that is entered into it. Just as RNs are accountable for what is recorded on paper, they are equally accountable for the information they enter in an electronic record.

The technical aspects of the EMR require additional considerations, such as appropriate access to client records, log on/off procedures and signatures. RNs may not always consider the use of technology as a component of nursing care, however, in this technologically-advanced time period, the opposite is true. As many organizations are moving to electronic health and medical records, the EMR is increasingly the platform that houses the patient’s legal documentation record.

The RN’s digital signature complies with legal and regulatory requirements, ethical standards and organizational policies and procedures. There are some instances, outlined in legislation or policy, where a handwritten signature may be required, but otherwise, a digital signature is equal to a handwritten signature in terms of accountability under the law.

Followup according to policy

RNs need to follow employer policy when it comes to logging on and off of an EMR. RNs should also be aware of and follow employer policy when modifying an incorrect entry or signature in an EMR. Depending on policy, it may be necessary to contact the clinical information system support team to correct errors or notify them of incorrect access.

What happened?

Just as Helen was sitting down to eat her lunch, she remembered that she did not log her profile in the patient record. She promptly goes to the computer where she finds Jodi. At the same time, Jodi realizes she is not logged on to the EMR under her profile. Helen and Jodi discuss the situation and they follow employer policy. Helen logs off and Jodi logs on under her own credentials and documents appropriately.

Disclaimer: Our case studies are fictional educational resources. While we strive to make the scenarios as realistic as possible, any resemblance to actual people or events is coincidental.
A STUDY ON CASE STUDIES

What we know now and how we’ll move ahead

It’s been nearly two years since we launched CARNA case studies. Looking back gives us an opportunity to identify what went well and how we can improve. We started the case study initiative to help members understand CARNA’s practice standards and apply them to their practice.

Thank you to the members who read the case studies and provided their feedback. Here are the top 10 things we learned from you:

10. Case studies are one of the most viewed items in CARNA’s monthly enewsletter.
9. More than 1,000 people view each case study.
8. The three most popular case studies were on the topics of taking pictures of clients, professional boundaries and social media.
7. In addition to the enewsletter, you use social media to access, review and share the case studies.
6. Some of you prefer to provide feedback through the star rating, others through a free text box and some of you use both methods.
5. Most case studies receive four or five stars.
4. You share the case studies with your colleagues and use them as instructional material with nursing students.
3. Feedback suggested some members believe the case studies are real life situations.
2. In a survey, the majority said our case studies are realistic and relatable to your practice.
1. Many of you said the case studies helped you understand CARNA’s practice standards, guidelines and policy direction and supported you in your practice.

The most popular case studies

<table>
<thead>
<tr>
<th>Case Study</th>
<th>Views</th>
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<tbody>
<tr>
<td>Taking pictures of clients</td>
<td>2,060</td>
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<tr>
<td>Crossing the line on Facebook</td>
<td>1,687</td>
</tr>
<tr>
<td>Keeping it personal: boundaries on Facebook</td>
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<td>Is avoidance a boundary issue?</td>
<td>1,070</td>
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<tr>
<td>Witnessing vs. obtaining consent</td>
<td>1,068</td>
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<td>Am I a nurse 24/7?</td>
<td>1,057</td>
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<tr>
<td>Hi, I’m your NP, let me tell you about my role</td>
<td>880</td>
</tr>
<tr>
<td>IP&amp;C: it’s in your hands</td>
<td>766</td>
</tr>
<tr>
<td>Camp nursing</td>
<td>642</td>
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<tr>
<td>Caring for yourself</td>
<td>589</td>
</tr>
<tr>
<td>Balancing work fatigue and client safety</td>
<td>563</td>
</tr>
<tr>
<td>It’s all relative</td>
<td>561</td>
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<tr>
<td>Do I need a course for that?</td>
<td>278</td>
</tr>
</tbody>
</table>

Are case studies realistic and relatable?

Responses/TOTAL=141

- Yes: 95
- Somewhat: 35
- No: 11

Have the case studies helped with your understanding of CARNA’s practice standards, guidelines and policy direction and provided support to you in your practice?

Responses/TOTAL=141

- Yes: 109
- Somewhat: 23
- No: 9

We encourage you to look for the case studies in the enewsletter and share them with your colleagues and nursing students. We hope you will discuss them in an open, respectful manner so that everyone may have an increased understanding of the many challenges inherent in our profession and the resources available to you.

Do you have an idea for a case study? Contact the practice advisors at practice@nurses.ab.ca with your thoughts, ideas or questions. We look forward to hearing from you.
Can I access my own personal health information through my employer’s electronic health records system?

Every Canadian province and territory imposes a legal obligation on health-care custodians to protect personal health information (“PHI”). Typically, institutions or health authorities are considered the health information “custodians” or “trustees” of PHI. As custodians, institutions and health authorities are legally required to have policies in place regarding collection, use and disclosure of PHI. An employed nurse is considered the custodian’s “affiliate” meaning that it is legally recognized that a nurse will also be required to collect, use and disclose PHI on behalf of the custodian in accordance with their employment duties.

Although a patient owns the PHI contained within the personal health records, it is the custodian who owns the actual records and is ultimately responsible for implementing measures to safeguard the information. With few exceptions, a patient has a right of access to their own PHI. If a patient wishes to review their own health record, the custodian will normally require the patient to comply with a specific process or policy in order to do so, such as making a written request to the custodian’s privacy officer.

If an employed nurse wished to access their own PHI, it would be considered outside the scope of employment and they would not be acting in the capacity of affiliate. The nurse would be in the same position as any other patient wishing to access their own records. The nurse should become familiar with the custodian’s policies and procedures regarding access. The failure to comply with an employer’s policies regarding confidentiality and access may result in disciplinary action against the employee. Employers periodically conduct audits of their electronic health record systems and are able to investigate whether health records have been inappropriately accessed.

In the case Newfoundland and Labrador Nurses’ Union v. Newfoundland and Labrador (Treasury Board),¹ two nurses were separately disciplined by their employer for inappropriately accessing the personal health records of various family members and a co-worker at the request of the family members and the co-worker. The Court upheld the arbitrator’s finding that not only had the nurses breached the hospital’s policy but had also inappropriately accessed electronic information, which constituted a breach of patient confidentiality. The employer’s policy required that an employee, when not fulfilling a duty and responsibility of employment, obtain written informed consent from the patient to permit access to their PHI. The nurses did not comply with the hospital’s policies and procedures that were in place at the time. One nurse received a twelve-day suspension and the other received a five-day suspension.

Nurses should review the relevant privacy legislation, their professional standards, and institution or health authority’s policies concerning confidentiality and PHI. They must also be careful to practise in accordance with their employer’s code of ethics and the Canadian Nurses Association’s Code of Ethics for Registered Nurses.

Can I access my own personal health information of my family members through my employer’s electronic health records system if they ask me to?

An employed nurse may have access to a patient’s personal health information (“PHI”) in accordance with their employment duties. A nurse wishing to access the records of a family member, even with the required consent, should familiarize themselves with the employer’s policies relating to accessing PHI. The employer, or “custodian” of the health records, will have established a formal process and procedure for requesting access to the PHI that it holds. An employee who does not comply with an employer’s policies regarding access to PHI may be the subject of disciplinary action.

In the case Newfoundland and Labrador Nurses’ Union v. Newfoundland and Labrador (Treasury Board),¹ two nurses were separately disciplined by their employer for inappropriately accessing the personal health records of various family members and a co-worker at the request of the family members and the co-worker. The Court upheld the arbitrator’s finding that not only had the nurses breached the hospital’s policy but had also inappropriately accessed electronic information, which constituted a breach of patient confidentiality. The employer’s policy required that an employee, when not fulfilling a duty and responsibility of employment, obtain written informed consent from the patient to permit access to their PHI. The nurses did not comply with the hospital’s policies and procedures that were in place at the time. One nurse received a twelve-day suspension and the other received a five-day suspension.

Nurses should review the relevant privacy legislation, their professional standards, and institution or health authority’s policies concerning confidentiality and PHI. They must also be careful to practise in accordance with their employer’s code of ethics and the Canadian Nurses Association’s Code of Ethics for Registered Nurses.

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

About CNPS – The Canadian Nurses Protective Society (CNPS®) is a not-for-profit society that offers legal advice, risk-management services, legal assistance and professional liability protection related to nursing practice in Canada to more than 130,000 eligible registered nurses and nurse practitioners.
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About CNPS

Accessing your own Personal Health Information

Ask a CNPS Lawyer

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Newfoundland and Labrador Nurses’ Union 
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www.CNPS.ca

NOTICEBOARD

EDMONTON/WEST

U OF A HOSPITAL CLASS OF SEPTEMBER 1973 REUNION
Sept. 7–8, 2018 | Edmonton uofahospitalsept73.com

PALLIATIVE EDUCATION AND RESEARCH DAY
Oct. 22, 2018 | Edmonton covenanthealth.ca

STRATHCONA COMPOSITE HIGH SCHOOL CLASS OF 1958 REUNION
Fall 2018 | Edmonton jecrozier@shaw.ca

CALGARY/WEST

FOOTHILLS CLASS OF 1988 REUNION
Sept. 21 – 23, 2018 | Kananaskis Leslie-e@hotmail.com or paulamereska@hotmail.com

RECENT ADVANCES IN THE PREVENTION AND TREATMENT OF CHILDHOOD AND ADOLESCENT OBESITY
Oct. 24 – 26, 2018 | Calgary interprofessional.ubc.ca/initiatives/obesity2018

EDUCATION DAY FOR PAIN AWARENESS
Nov. 7, 2018 | Calgary painawareness7.eventbrite.ca

The submission deadline for events and reunions in the Fall 2018 issue of Alberta RN is Sept. 11, 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

Stadnyk, Sharon, a 1972 graduate of the University of Alberta Hospital school of nursing, who passed away on Dec. 31, 2017 in Westlock.

CENTRAL

OPERATING ROOM NURSES OF ALBERTA CONFERENCE

ARNET’S 2018 LANTERN WALK
Sept. 28, 2018 | Red Deer arnet.ca

SOUTH

HOLY CROSS HOSPITAL CLASS OF 1978 REUNION
Sept. 29 – 30, 2018 | Medicine Hat Search “Holy Cross Nursing Reunion” on Facebook

OUTSIDE OF ALBERTA

CANADIAN ASSOCIATION OF NURSES IN ONCOLOGY CONFERENCE
Oct. 26 – 29, 2018 | Charlottetown, PEI cano-acio.ca

HEALTH AND WELLBEING IN CHILDREN, YOUTH AND ADULTS WITH DEVELOPMENTAL DISABILITIES
Nov. 7 – 9, 2018 | Vancouver, BC interprofessional.ubc.ca/initiatives/hw2018

To access our modules, sign in to MyCarna and click Resources > Learning Modules.

Nursing informatics 101

Explore the world of nursing informatics! Learn the difference between nursing informatics vs. health informatics and examine how nursing informatics affects patient-care delivery.

Infection prevention and control

Proper infection prevention and control practices can prevent the spread of harmful microorganisms through contact transmission. Increase your understanding of the infection prevention and control standards, the key principles of hand hygiene, injection safety and more.

Unlock the leader in you

Leadership is the key to our changing nursing practice. But how do you identify yourself as a leader? Unlock your leadership by identifying leadership attributes, reflecting on personal strengths and demonstrating competencies with CARNA practice standards.

The essentials of nursing documentation

Effective documentation can protect you in your practice and is pivotal to privacy, patient safety and continuity of care. This module will highlight the importance of effective documentation and help you improve your practice.
Leaving the world of status quo

The world of Canadian nursing changed in June when the Canadian Nurses Association (CNA) changed its bylaws to include all designations of regulated nurses. The decision at the biennial AGM was emotional, positive and ground-breaking, and based on the reality that we are, as nurses, stronger together.

In my own career, I have worked collaboratively on teams that included RNs, LPNs (or registered practical nurses as they are called in Ontario) and RPNs as well as on interdisciplinary health-care teams. Now, we have a national association that reflects this reality, where nurses can work together to improve patient care and advocate for public policy that addresses determinants of health issues.

One of the most urgent health issues in our country is the misuse of opioids. It is rightly called a “crisis” when 4,000 Canadians died in 2017 because of opioid overdoses. At the CNA AGM, delegates supported two resolutions to address this crisis at the national level. The first one directs CNA to support and advocate that Naloxone and any other opioid overdose prevention supplies are available in publicly-accessible locations. The other directs CNA to advocate for improved followup and harm reduction services for individuals who have received naloxone due to overdose.

NPs are now authorized to prescribe medical-grade heroin due to changes in federal legislation. It is important to point out that there is still a level of monitoring of NP prescribing of controlled drugs and substances through the provincial Triplicate Prescription Program.

Each of us can play a role in addressing the opioid crisis by helping to break the stereotypes about people who use these drugs. The current statistics include people from all walks of life and socio-economic levels.

In Alberta, CARNA has been working to provide tools for our members to use in combatting the opioid crisis. According to provincial government statistics, 589 people died from fentanyl poisoning in 2017 and at least another 125 from other types of opioids. This means there were nearly two deaths a day last year due to opioids.

Decisions made at the December 2017 and June 2018 Provincial Council meetings have resulted in a revised Prescribing Standards for Nurse Practitioners document. Changes to specific sections enable NPs to prescribe Suboxone (buprenorphine-naloxone) to treat opioid-use disorders and include authorization for methadone prescribing.

Each of us can play a role in addressing the opioid crisis by helping to break the stereotypes about people who use these drugs.

That doesn’t obscure the fact that not all addictions are created by a prescription or taking a pill. As Marilou Gagnon said in her blog, The Radical Nurse, addiction is also created by isolation, marginalization, trauma, mental health, colonization and social conditions. Addiction is a symptom of a bigger problem, one that cannot be fixed by prescription monitoring alone. We do know that harm reduction is one of the key ways we can stem the current opioid overdose epidemic and, as nurses, we can advocate for more harm reduction services. Supervised consumption sites are one of these services. The recent announcement that the province was opening three new treatment clinics in Fort McMurray, High Prairie and Bonnyville was another positive development. These clinics will be staffed by RNs and substance-use counsellors with telehealth links to supporting physicians.

These nurses, like every nurse in Alberta, are making a difference in someone’s life. The world has challenges; nursing has solutions.

Joy Peacock, BSN, MSc, RN
Chief Executive Officer
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jpeacock@nurses.ab.ca
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