RN brings FOUR-LEGGED THERAPY to stressed students

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From rural roots to scrubs and flight suits

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Examining the effects of workplace bullying

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CORRECTION:
In the Fall 2017 issue of Alberta RN, the 2017–2018 CARNA Provincial Council list included Christine Davies as a Calgary/West Provincial Councillor rather than Nicole Letourneau. Please accept our apologies for this error.
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RN brings FOUR-LEGGED THERAPY to stressed students

WORKPLACE BULLYING, HARASSMENT AND PSYCHOLOGICAL INJURY in Alberta’s health-care system: A CALL FOR LEGISLATION

COVER PHOTO BY:
William Au Photography

THIS PAGE:
WILLIAM AU PHOTOGRAPHY (PG. 24)
VECTORFUSIONART/SHUTTERSTOCK.COM (PG. 30)
The year ahead

Welcome to 2018! And what a year 2017 was. We saw a new disruptor occupy the White House, rising military tensions on the Korean Peninsula and the rise of populist leaders in several countries. As international leadership shifts, we feel the ripples here in Canada. Our peaceable kingdom is attracting desperate people from all parts of the world, including from south of the border. The economic impact of renegotiating NAFTA is yet to be determined. This year promises to be interesting indeed.

There have been significant developments at CARNA over the past year, too. We are influencing health policy in Alberta. For example, CARNA has been asked to join the governing board of the Rural Health Professions Action Plan. This government-funded program was formerly focused strictly on physicians, but is evolving its mandate to look at the broader range of health-care professionals in rural and remote parts of the province. This evolution is one we can support and an invitation to participate in the governance of this activity was most welcome.

Similarly, CARNA has been approached by the Alberta Medical Association and the College of Physicians and Surgeons of Alberta to collaborate on a number of initiatives ranging from strengthening primary care to exploring non-pharmacological approaches to chronic/persistent pain, which could also have a positive impact on the current opioid crisis.

Of course, CARNA staff and Council members, including myself, continue to work very hard to ensure that the proposed amendments to the Registered Nurses Profession Regulation are finally approved and proclaimed at the earliest possible opportunity. We meet with government on a regular basis to continue to push this agenda, because we feel it is essential if we are to see real improvements in the quality and cost-effectiveness of health care delivered to Albertans, and streamline access to that high-quality care.

We also created an advisory committee of Indigenous RNs and community members to help us be a strong advocate in promoting the health of Indigenous people.

Early in December, CARNA welcomed four new public members to Provincial Council, appointed by government on Dec. 5, 2017. I would like to take this opportunity to formally thank our outgoing public members for their tireless dedication to CARNA and to the regulation of the nursing profession in the public interest. These fine individuals – Elaine Andrews of Edmonton; George Epp of Taber; Marlene Pedrick of Sherwood Park; and Doug Romaniuk of St. Albert – made an invaluable contribution to the work that CARNA does during the time that they served on Provincial Council. I would like to also acknowledge the ongoing dedication of our reappointed public member, Frank Work of Spruce Grove, and the calibre of the four new public members who joined us in December: Steven Armstrong of Calgary, Janet Blayone of Peace River, Phyllis Bohachyk of Edmonton and Michael Howden of Priddis.

Let me take this opportunity to wish you and yours all the best for 2018.

Jerry Macdonald, MN, RN, CCN(C)
780.978.1348
president@nurses.ab.ca

STAFFING ANNOUNCEMENT:
Sandra Young began her role as CARNA chief professional practice officer on Jan. 11, 2018. She will lead the Professional Practice Support department. Sandra was previously a Nursing Education Program Approval Board consultant at CARNA.
Professionalism session
2–3 p.m., March 20, 2018
What does being a professional mean? This session will explore various components of professionalism, including increasing awareness of your personal level of professionalism and helping you identify areas that you might like to develop further.

Ethical practice session
2–3 p.m., April 17, 2018
This presentation discusses the values and responsibility statements outlined in the Canadian Nurses Association Code of Ethics for Registered Nurses and ethical principles related to registered nursing practice. The code of ethics illustrates our need to engage in ethical reflection and discussion, as ethical values are at the root of self-regulation and nursing practice.

Infection prevention and control module
Proper infection prevention and control practices can prevent the spread of harmful micro-organisms through contact transmission. This online learning module will increase your understanding of the infection prevention and control standards and guide you through the key principles of hand hygiene, injection safety and more.

To access the online learning module, sign in to MyCarna and click Resources > Learning Modules.

These learning opportunities may help you complete your learning objectives. Update your MyCCP record while the details are fresh and get a head start on renewal.

EDUCATION SESSIONS
JUST FOR new nurses
We’re offering free online education sessions to help nurses in their first year of practice advance their nursing knowledge, learn about CARNA resources, and network with other new nurses.
Topics include documentation, professional boundaries, interprofessional teams and bullying in the workplace.

Learn more and register for these sessions at nurses.ab.ca/events.
Meeting of Dec. 7–9, 2017

Your input needed on palliative care position statement

Have your say on the draft document Palliative and End-of-Life Care: A Position Statement, which has been updated to align with best practices and the palliative and end-of-life care provincial framework. Visit our website to share your feedback by Feb. 19, 2018.

Introducing the Indigenous Advisory Committee

We are striving to be a strong advocate in promoting the health of Indigenous peoples. Council has created an advisory committee of Indigenous RNs and community members to provide guidance and advice to ensure we are an informed and effective partner.

We look forward to working with the following committee members:

- Louise Baptiste
- Chelsea Crowshoe
- Mary Ledger
- Gloria Letendre
- Giovanna St. Onge
- Laura Tomkins

Legacies of outstanding Alberta nurses to be recognized nationally

CARA has nominated Teresita (Tessie) Oliva, Muriel Shewchuk and Margaret Ethier to be recognized in the Canadian Nurses Association (CNA) Memorial Book. The Memorial Book honours deceased nursing leaders who have elevated the nursing profession and health care.

Teresita Oliva was a respected leader who worked tirelessly to mobilize social support in the Filipino community and in the larger multicultural community in Alberta. She founded the Filipino Nurses Association of Alberta, which supported internationally-educated nurses in gaining licensure in Alberta.

Muriel Shewchuk was a major force in moving operating nursing ahead as a specialty. She played a key role in developing national nursing standards, leading her own teams in becoming certified and forming the Operating Room Nurses Association of Canada.

Margaret Ethier was a union activist and tireless advocate for nurses. As president of the United Nurses of Alberta, her strong leadership was instrumental during the tumultuous, strike-filled years of the 1980s.

New specialty practice group: Alberta Primary Care Nurses Association

Congratulations to the Alberta Primary Care Nurses Association (APCNA) which was recognized by Council as a CARNA specialty practice group (SPG). APCNA advocates for mentorship, tools, resources and educational opportunities to foster professional development, leadership and excellence in primary care.

SPGs improve quality of care, standards of practice, knowledge and competency through sharing among peers. See the full list of SPGs on our website, nurses.ab.ca.

NPs one step closer to prescribing methadone

Provincial Council has approved changes to the document Prescribing Standards for Nurse Practitioners (NPs) that provides expectations and support for NPs to prescribe methadone.

The changes will come into effect once Health Canada approves CARNA’s process for authorizing NPs to prescribe methadone. We will inform NPs and all members once we hear back from Health Canada. If you have any questions, please contact us at practice@nurses.ab.ca.

Updated scope of practice for NPs

Council approved changes to the document Scope of Practice for Nurse Practitioners which was updated to more accurately describe the independent nature of NP practice and the NP’s role as an essential member of the health team.

CANA endorses national informatics position statement

Council endorsed the CNA and Canadian Nursing Informatics Association (CNIA) joint position statement Nursing Informatics. This document replaces the CARNA document The Role of the Registered Nurse in Health Informatics and the CNA document Nursing Information and Knowledge Management.
AGM RESOLUTIONS

Do you want your ideas to be discussed by CARNA Provincial Council? A resolution is a way for you to identify a problem and share your ideas for a solution. Your resolution can relate to any area of nursing practice, including direct care, education, administration and research. It can also be about the role of CARNA or RNs and NPs in health care.

How to submit a resolution:
1. Go to nurses.ab.ca and find the AGM event in our calendar. Fill out the resolution form by February 15. We accept resolutions from the floor, but members have more time to consider the issue if we share it in advance.
2. Attend the AGM to move your resolution. Members in attendance will vote on your resolution. Resolutions passed at the AGM are non-binding, but at a later meeting, Council will determine what action, if any, should be taken.

EXAMPLE RESOLUTION

Title of resolution:
Expanded gender identification options for CARNA registration

Be it resolved, that:
CARNA expand gender identification options on the registration forms for all new and renewing members including that providing sex/gender information is optional (not mandatory) and that there be at least three options: male, female and a third option for the completion of any sex/gender question.

Background information and references:
Ethical nursing practice involves endeavouring to address broad aspects of social justice that are associated with health and well-being. These aspects relate to the need for change in systems and societal structures in order to create greater equity for all. This spirit needs to be extended to those people who do not self-identify their gender in the binary of male/female.

CARNA has a legal and ethical obligation to recognize gender identity and expression as protected grounds from discrimination is enshrined in the Alberta Bill of Human Rights. SOURCE: https://www.albertahumanrights.ab.ca/Pages/default.aspx

In January 2017, a landmark settlement of a Canadian human rights complaint has recognized that personally identifiable sex and/or gender data can only be collected if there are legitimate purposes. Pending the completion of a Canadian government review, Employment and Social Development Canada (ESDC) is amending its documents so that:
A. Providing sex/gender information is optional;
B. There are at least three options (male/female/3rd option) for completion of any sex/gender question.

This case provides principles for other government and non-government agencies in their human rights reviews of gender collection practices.

We are pleased to announce the 2018 nominees for the CARNAAWARDS.CA

CARNAAWARDS.CA

We are pleased to announce the 2018 nominees for the CARNA AWARDS OF NURSING EXCELLENCE.

Award recipients will be announced in early March.

ADMINISTRATION
Debra Bardock
Tracy Brown
Deb de Vlaming
Joanne Hunter
Céline O’Brien
and Susan Smith
Twila Orto
Safeworks
Leadership Team
Alberta Health Services
Irma Tamminen
Paul Wright
Paula Zacharias

EDUCATION
Angie Arcuri
Heather Bensler
Lorrie Clizbe
Sandra Davidson
Mohamed El-Hussein
Carla Ferreira
Acute Neurosciences Educator Team
Foothills Medical Centre
Dory Glaser-Watson

RISING STAR
Louise Baptiste
Marnie Colborne
Helen Doan
Stephanie Kellie
Zanecha Maribojoc

CLINICAL PRACTICE
Stem Cell Collection Team
Canadian Blood Services
Jill Congram
Rachael Edwards
Hines Health Services
Guen Kernaleguen
Duncan Stewart
MacLennan
Louise Marles
Sara Marouelli
Marnie Pedersen
Steve Petras
Darcy Ramsdale
Catharine Schamber

PARTNER IN HEALTH
Dr. Keith Aronyk
Hines Health Services
Inclusion and Partner Relations Team
Alberta Parks
Lisa Poole
Trans Equality Society of Alberta

RESEARCH
Kathleen Hunter
Sonya Jakubec
Shahirose Premji

LIFETIME ACHIVEMENT
H. Marian Anderson
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SAVE THE DATE

JUNE 7, 2018 | EDMONTON

FULL DETAILS AT CARNAAWARDS.CA
A Hearing Tribunal made a finding of unprofessional conduct against member #48,794 who, while working as the charge nurse, the member called the doctor to discuss a patient and the family’s wish that patient not be sent to hospital, contrary to the patient’s wishes, the member failed to insist that the physician come in to assess the patient’s capacity, so that the patient’s wife could make health-care decisions. The member also made a section 70 Health Professions Act admission of unprofessional conduct for failing to document an assessment on a resident or provide appropriate followup, and for making three medication errors. The Tribunal issued a reprimand and ordered the member to pass courses in responsible nursing and basic medication administration. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

A Hearing Tribunal made a finding of unprofessional conduct against member #53,901, who on one occasion failed to adequately document or ensure adequate documentation of the initial or ongoing assessments of a resident; and who made an admission under section 70 Health Professions Act that she withheld Aricept from a resident on four evenings without consulting the prescriber, and documented administration of the medication when she had in fact disposed of it. The Tribunal issued a reprimand and ordered the member to pass courses in responsible nursing and basic medication administration. The member is restricted to working in that setting pending two satisfactory performance evaluations. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

A Hearing Tribunal made a finding of unprofessional conduct against member #79,659 who, while working at Alberta Health Services, accessed a patient’s medical records at the request of a litigation lawyer and disclosed confidential clinical information to that party without the proper authority to do so and inappropriately accessed confidential health and personal information on Netcare of family, friends and co-workers, often at the request of that other person who wanted a copy of results of medical tests. The Tribunal issued a reprimand and ordered the member to pass courses in responsible nursing and professional ethics, and complete modules on the code of ethics. 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 member #79,166 who, on about 12 occasions, inappropriately accessed confidential health and personal information on Netcare of family, friends and co-workers, often at the request of that other person who wanted a copy of results of medical tests. The Tribunal issued a reprimand and ordered the member to pass courses in responsible nursing and professional ethics, and complete modules on the code of ethics. 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 member #93,631 who attended at work for two shifts, thereby placing his patients and co-workers at risk of contracting tuberculosis, after he had been told by his physician and a public health nurse that he had tuberculosis and must stay at home on isolation and must not go to work. He also told the public health nurse that he was complying with
isolation and wearing a mask, when he was in fact at work that day. The Tribunal issued a reprimand and ordered the member to pay a $250 fine, write a paper on maintaining his fitness to practise, pass a course on responsible nursing and complete modules on the code of ethics. In addition, the member must submit annual medical reports for five years. He must provide a letter from his next employer prior to commencing employment confirming the employer is aware of the conduct decision and will provide two performance evaluations on the member. 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: 102,525

A Hearing Tribunal made a finding of unprofessional conduct against member #102,525, who failed to close the port on a tube feed resulting in a loss of medication and nutrition delivered to the patient through the feeding tube when stomach contents drained out of the tube, soiling the patient’s clothing and bedding. The member failed to expel air from a preloaded saline syringe prior to flushing the intravenous, twice; gave an intramuscular injection of 3 ml in the deltoid muscle when the maximum volume for injection to the deltoid muscle was 1 ml; had to be stopped from inserting an IV upside down; incorrectly counted numerous narcotic medications, even with reminders; and was unable to properly calculate medication doses. The member failed to close the end of a PICC line, with the result that the patient had his line open for 24 hours, necessitating a trip to the nearest city for removal of that line and reinsertion of a new one; failed to do or ensure adequate care to a patient who had been incontinent of feces and signed for medications not actually administered. At a different work site, the member while being buddied by another RN as part of his orientation, failed to check a resident identification bracelet when administering medication resulting in administration of two medications intended for one resident to the wrong resident. The Tribunal issued a reprimand and ordered the member to pass courses in IV therapy, basic medication administration and documentation, which the member had already completed by the time of the hearing. The Tribunal ordered the member to successfully complete the Advanced Studies in Critical Care Nursing course work only, which the member had already decided to take on his own volition. The member must provide two satisfactory performance evaluations from his next employer. 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: 102,943

A Hearing Tribunal made a finding of unprofessional conduct against member #102,943 who failed to remove nitroglycerin patches on two residents; failed to administer medication to a resident; and failed to administer heparin as ordered to another resident. The Tribunal issued a reprimand and ordered the member to pass courses in basic medication administration and pharmacology and to be restricted to working at her next 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: 103,080

A Hearing Tribunal made a finding of unprofessional conduct against member #103,080 who made an admission of unprofessional conduct in that while working as a graduate nurse for Alberta Health Services, on several occasions diverted narcotics for personal use and remained on shift while significantly impaired by the abuse of narcotics. The member made multiple medication errors including medication calculation, inappropriate or incorrect dosing and, on at least one occasion, administering narcotics to the incorrect patient. The member also failed to accurately (or at all) document and chart narcotic administration and waste and failed to follow several policies and procedures. The Tribunal issued a reprimand and ordered the continuation of an existing suspension of the member’s permit pending their approval to return to work. The Tribunal further required a comprehensive return-to-practice plan including that: the member attend treatment, including being subject to random drug screening; satisfactory medical reports confirming the member is fit to practise be provided; satisfactory performance evaluations be provided; a restricted practice setting be imposed; and annual satisfactory medical reports be provided. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

RN
UNDERSTANDING PATIENT MEDICATION

Management is important for RNs and NPs across a variety of settings. Managing medication involves more than just the task of providing or administering a medication: client assessment and clinical decision-making at the point of care assist nurses in deciding whether or not they will go ahead and administer or provide a particular medication.

CARNAPolicy and Practice Consultants frequently receive questions from members about medications. To help answer your questions, we often refer to our Medication Guidelines (2015), which can be found on the Practice and Learning section of our website at nurses.ab.ca.

Can I use a standing order? How might I use protocols involving medication in my practice?

Standing orders were historically used in some practice settings to prescribe or order treatments or medications. As they were not client-specific, they are no longer recognized as best practice. Pre-printed or electronic order sets with client-specific orders are now often used. Order sets have the potential to reduce medication errors.

Another approach in some practice settings is to use protocols. A protocol is a formal policy that guides decisions and includes interventions for specific health-care problems. Protocols are a set or series of treatment interventions. They’re developed by the interprofessional team in the practice setting and can be implemented by the care provider (e.g., nurse) for a specific group of clients with identified health conditions when specific circumstances and criteria exist.

Before you implement a protocol, you’ll need to determine whether your client has the health condition outlined in the protocol. If the answer is yes, you’ll need to assess whether:

> You have the knowledge, skills and competence to perform the intervention outlined in the protocol.
>
> The policies of your practice setting allow your role to implement the protocol.
>
> Whenever a protocol involves the administration of a medication that requires a prescription or order, there must be a client-specific order from the prescriber to implement the protocol before administering the medication.

NOTE: In emergent situations where it is not possible to obtain an order prior to initiating a protocol, contacting the authorized prescriber can happen at the same time as the implementation of the protocol and interventions.

What if I’m concerned about an order an authorized prescriber has provided?

Nurses question medication orders that are unclear or inconsistent with therapeutic client outcomes or best practice. When you question a medication order, consider all appropriate information and have a clear, evidence-informed rationale to support your concerns.

If there is a discrepancy between the authorized prescriber’s view and what you feel is safe, competent and ethical care, discuss the concern with the prescriber and notify your supervisor or employer about the discrepancy. Document the discussion and decision in the health record.

Can I administer cannabis for medical purposes?

Registered nurses and nurse practitioners often ask us if they can administer cannabis for medical purposes to a client who cannot self-administer the controlled substance.
The federal Access to Cannabis for Medical Purposes Regulation, proclaimed in August 2016, created some uncertainty regarding whether RNs and NPs could administer medical cannabis.

Carna sought a legal opinion, which indicated RNs and NPs could administer medical cannabis in certain settings. In September 2017, Carna Provincial Council approved a policy direction that RNs and NPs can administer and assist with administration of medical cannabis in a “hospital,” as defined in the Narcotic Control Regulations. Learn more about the conditions in our Medication Guidelines.

While at this time “hospital” does not include home care, this is an important step towards improving care for clients who cannot administer the medication themselves. As the laws continue to evolve, we will work to remove barriers when possible.

RNs and NPs working with clients using cannabis for medical purposes should review resources such as Health Canada’s information sheet Information for Health Care Practitioners – Medical Use of Cannabis.

Administering medication
Medication administration can be very complex. Be prepared to administer medication by familiarizing yourself with the following considerations as outlined in our Medication Guidelines:
> infection prevention and control practices
> medication preparation, compounding medication and doses
> administration times
> client consent
> double-checking high alert medication
> client identification
> allergies
> immunizations
> over-the-counter medication

Have your say
We’re reviewing our Medication Guidelines throughout this year. Help us ensure our guidelines are current, clear and applicable by reviewing the document and providing your feedback to practice@nurses.ab.ca.

The antimicrobial resistance risk to clients
Antimicrobial resistance (AMR) is a major health threat as antimicrobials are used to treat our clients’ infections.

Antimicrobials are prescribed in Canada 33 percent more often than in the Netherlands, Sweden and Germany.

Three out of five prescriptions for antibiotics in all Organization for Economic Co-operation and Development (OECD) countries were inappropriate, such as to treat the common cold. This misuse and overuse of antibiotics and other antimicrobials contributes to antimicrobial resistance.

When an infection does not respond to antimicrobial therapy, there can be serious consequences to clients, such as prolonged illness and mortality, as well as the spread of antimicrobial-resistant infections.

Antimicrobial stewardship is your responsibility
All nurses, whether clinicians, educators, researchers, policy influencers or executives, have a role to play in developing and maintaining antimicrobial stewardship programs.

Alberta registered nurses are in an ideal position to reduce AMR. RNs:
• Assess clients for signs and symptoms of infections.
• Administer, monitor and evaluate treatment of infections including side effects.
• Administer vaccines.
• Educate clients, families, communities and populations.
One community program, Do Bugs Need Drugs?™, suggests that antimicrobials only be used when necessary, and when they are used, they should be the right dose, frequency and duration.

Another program identifies several ways to prevent unnecessary tests, treatments and procedures that may cause harm or lack of benefit, such as:

- Don’t insert an indwelling catheter or leave it in place without daily assessment, to prevent urinary-tract infections or sepsis.
- Don’t add extra layers of bedding (sheets, pads) beneath patients on therapeutic surfaces, as this can create wounds or impede the healing of existing wounds.
- Don’t recommend antimicrobials to treat bacteriuria in older adults unless specific urinary tract symptoms are present. Don’t do a urine dip or send urine specimens for culture unless urinary tract symptoms are present.
- Don’t recommend antibiotics for infections that are likely viral in origin, such as an influenza-like illness.
- Don’t overuse gloves, as hand hygiene is the most important way to prevent transmission of infection.
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Antimicrobial stewardship programs vary depending on practice setting, resources, population and local prescribing and resistance patterns.

Registered nurses and nurse practitioners are leaders of and within multidisciplinary teams and you are responsible for using infection prevention and control best practices. By developing, maintaining or being involved in an evidence-based antimicrobial stewardship program, you can help reduce the threat of AMR.

RN-led programs can help reduce risk of AMR resistance

Antimicrobial stewardship programs are “coordinated interventions designed to improve and measure the appropriate use of antimicrobial agents by promoting the selection of the optimal antimicrobial drug regimen including dosing, duration of therapy and route of administration” (Public Health Ontario). The goal of an antimicrobial stewardship program is to use antibiotics prudently and reduce the risk of AMR to achieve the best outcomes for clients.

If you’re interested in starting a program in your workplace, you may want to include components such as staff and client education, guidelines, clinical pathways, route of administration and formulary restrictions. Ensure you’re knowledgeable about AMR, including the microbiology of the infectious agent, the infection process and pharmacology. Start with attainable goals and evaluate the impact of antimicrobial use, costs and infection rates.

Your role:

- Integrate antimicrobial stewardship activities into daily practice and support antimicrobial stewardship programs.
- Educate clients and families about AMR and how to prevent it.
- Ensure, as part of the multidisciplinary team, appropriate use of antimicrobials.
- Support and advocate for stronger infection prevention and control policies and practices.
- Help increase vaccination rates by providing evidence-based, non-judgemental information about vaccines.
- Follow (if authorized) best-practice guidelines for prescribing antimicrobials.

Your program should also encourage health providers to question the use of interventions such as laboratory tests that lead to prescribing antimicrobials, or interventions that increase the risk of infection.

RESOURCES

- http://www.dobugsneeddrugs.org/health-care-professionals/
**CASE STUDY**

**Ethical decision-making**

Mrs. Peterson is a lively 87-year-old woman who broke her hip while walking her dog.

Following hospitalization for the repair of her hip, Mrs. Peterson refused accommodation in any care facilities and asked to be returned to her own home. She was discharged home with home-care services, including daily personal care assistance, which are arranged by case coordinator Rose Parker, RN.

Mrs. Peterson has been home for two weeks and has mobility challenges. She spends much of her time sitting in her chair.

Helen Jones, a health-care aide, visits Mrs. Peterson to assist with personal grooming, to help her into bed and to assist her with her range of motion exercises. Helen, a casual employee with limited experience, has never met this client before and has been told to do only what the client agrees to.

Mrs. Peterson is watching a favourite television show and refuses to go to bed. She says she will do it by herself.

Helen contacts Rose and informs her that after many attempts to convince Mrs. Peterson to accept care, Mrs. Peterson has been left sitting in her chair watching TV as she has refused to go to bed.

Helen also tells Rose that she is no longer at Mrs. Peterson's residence as she has moved on to her other clients to provide care.

Rose recognizes she is faced with an ethical dilemma: Mrs. Peterson has refused assistance to prepare for bed and is now alone and sitting in her chair. Rose knows that Mrs. Peterson has considerable difficulty mobilizing and is concerned with Mrs. Peterson's ability to get herself to bed as well as the potential issues if she remains in her chair all night.

**What should Rose do?**

When faced with an ethical dilemma, registered nurses can approach the situation many different ways. Some RNs may choose to reflect on the ethical values and responsibility statements listed in the Canadian Nurses Association Code of Ethics for Registered Nurses (2017). Others may problem-solve by applying ethical principles to explore the issues, using ethical models to address the problem, or a combination of approaches. RNs may find some models more helpful or meaningful than others, depending on their practice setting.

There is no right or best way to approach ethical issues; rather, each RN must find the approach that works best in their circumstance, accept the struggle of developing a value system and take responsibility for their actions.

**Rose uses the Code of Ethics for Registered Nurses to work through the situation**

Rose reviews the seven values and responsibility statements, which are universal to all domains of nursing and practice settings. She reflects on how they apply to her current dilemma. She finds that some are directly applicable to Mrs. Peterson's situation, while others are somewhat relevant.

**Rose uses the ethical principles to navigate her decision-making**

Ethical principles are another way to express values and can assist in ethical decision-making. The principles central to ethical decision-making are listed in CARNA's Ethical Decision-making for Registered Nurses in Alberta document.

Rose finds that more than one of the principles are applicable to Mrs. Peterson's case and recognizes that the consequences of the recent event may have been as a result of Mrs. Peterson's and Helen's values.

Rose recognizes that, as the registered nurse, she is the appropriate person to initiate dialogue with Mrs. Peterson. Rose works with Helen and Mrs. Peterson to understand all perspectives and plan for safe and effective care going forward.

Case study adapted from Ethical Decision-making for Registered Nurses in Alberta.

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**Case studies help answer common questions from registered nurses.**

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Inadequate pain management costs Albertans billions of dollars each year, and causes distress to nurses and patients alike, but the new Alberta Pain Collaborative seeks to create a province-wide pain strategy.

BY KERI SWEETMAN

When registered nurse Keith King was approached to work on pain management issues in Alberta, he didn’t hesitate for a moment. Pain relief is a professional interest – but it’s more than that.

King is an instructor in the University of Alberta faculty of nursing. In 2017, he met Flo Slomp, who is a doctoral candidate in the faculty of dentistry and medicine and works in Edmonton as a therapist, primarily with people who have spine problems and related pain.

King and Slomp struck up a conversation about the International Association for the Study of Pain (IASP) and the group’s declaration that 2018 will be the Global Year of Excellence in Pain Education. Slomp asked King to help her create and co-lead the Alberta Pain Collaborative to tackle the IASP goals provincially.

“We have the knowledge and ability to take on the challenge of building on the pockets of great work that already exist in the province. We need a comprehensive, collaborative effort to make this happen,” says Slomp.
Passionate about pain management

“One of the reasons that really drove me to get involved is a family member who lives with chronic pain,” says King. “She drives for seven hours to see her rheumatologist to get treatment because she lives in Fairview, Alberta. Due to living in a remote area, she doesn’t have good access to physiotherapy or psychological services to help her deal with these problems.”

“We have pockets of excellence,” says King. “If you are in an urban centre, you’re probably able to access a broad array of services that can help you with your acute or chronic pain. However, outside of those areas where we have expertise in managing pain, the level of service drops dramatically.”

Registered nurses are on the front line when it comes to managing acute and chronic pain. They do many of the day-to-day assessments that lead to physicians prescribing pain medication and consultations with other health professionals.

In her line of work, Slomp has seen many patients with inadequately-managed acute or chronic pain. She is passionate about reducing unnecessary suffering for Albertans.

Ambitious in scope

IASP brings together scientists, health-care providers and policy-makers from 133 countries to study pain relief and translate it to improve care worldwide. For more than a decade, they have focused their activities on one aspect of pain management each year. The 2018 campaign targets inadequate pain education for health-care professionals, which can lead to inappropriate treatments, especially in the developing world and underserved areas in developed nations.

To launch the Alberta Pain Collaborative, King and Slomp pulled together people they knew from across the field – doctors, nurses, other health professionals and educators – as well as patients and families.

Thirty people attended the first meeting, but by the third meeting, 75-80 people had joined the conversation and the group’s ambitions had ballooned. They plan to create an overarching pain strategy for Alberta, one that improves access and equitable care for people across the province. They hope to have recommendations complete by the end of the first quarter of 2018, for presentation to the Ministry of Health, Alberta Health Services and the Pain Society of Alberta.

Educating for excellence

King teaches courses in mental health and addictions in the University of Alberta faculty of nursing. Instructors incorporate pain management early into the medical and surgical lectures, seminars and clinical placements. Pain management is also part of CARNA’s entry-to-practice competencies.

“The challenge is that pain management research is evolving all the time, so it’s difficult for the faculties to keep up. And there’s a large body of nurses who were educated prior to these requirements in the education system. So we are seeing newer generations of nurses who are very skilled in this, and some nurses who need to update their skills.”

King’s group is still working on recommendations but he expects they will push for a requirement that health organizations provide access to mandatory continuing education on pain management. This may be offered as an online learning module, annually or every two to three years.

There would be an organizational cost, but inadequate access to proper pain relief comes with a price tag, too.

“The cost to Albertans on an annual basis is around $6 billion in terms of lost hours of work, lost quality of life, and direct health-care costs,” says King. “A lot of money goes down the drain because of inadequate pain management.”

But it’s about more than dollars for RNs.

“Trying to manage uncontrolled pain on the unit is distressing, for patients and for nurses,” says King. “The vast majority of nurses would jump at the opportunity to learn more about pain management, because it will improve the lives of their patients.”

Carna is 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
The Canadian Diabetes Association estimates 288,000 Albertans live with diabetes, costing $1.3 billion per year (2015). According to Alberta Health Services (AHS), 391 lower-limb amputation procedures were performed in Alberta on patients with a diabetic foot ulcer in 2013 – 2014.

Michele Labbie, a nurse practitioner at the Stony Plain Westview Health Centre, is working to change these amputation stats by focusing on prevention.

Her team provides wound care and diabetic foot complication management and education. They often deal with wounds that people have had for years, are recurrent, or are difficult to manage.

Prevention is the best medicine

Diabetic patients feel pain less than the average person. If they get a rock in their shoe, glass in their foot or a sunburn on their feet, they likely won’t notice. And like most people, they don’t look at their feet on a regular basis.

But Labbie says this needs to become a part of their daily routine.

“One patient didn’t notice a golf ball in his shoe. This can lead to a serious wound in a short time,” says Labbie.

“Diabetic patients don’t have the luxury of taking their shoes off without inspecting their feet.”

She teaches patients to recognize the early signs of what may lead to a wound, such as footwear that rubs.

Though these personal assessments seem minor, they can have tremendous outcomes for the patients and significantly reduce health-care costs.

A small wound can lead to the amputation of toes, feet and limbs. Research shows that as many as 85 percent of lower limb amputations can be prevented through early screening for, and treatment of, diabetic foot ulcers.
“Our team is very passionate about preventing diabetic foot complications,” says Labbie. “Unfortunately, patients have to pay out of pocket for treatments such as offloading devices.”

The Canadian Diabetes Association reports 57 percent of Canadians cannot adhere to prescribed treatment because of the out-of-pocket cost of medication, devices and supplies.

One of the preventative tools Labbie uses to manage diabetic foot ulcers is total contact casting. Unfortunately, the cost of the cast – about $120 – is enough to deter many patients from trying it. “One patient had an ulcer on her foot for eight months, and made regular emergency room trips for antibiotics,” Labbie says. “We put her in the cast and the wound healed in nine days.”

Proactive treatments could prevent patients from multiple trips to the ER or amputation.

The Registered Nurses’ Association of Ontario recently raised this issue with their government, and their health minister announced in May 2017 that the cost of offloading devices for diabetic feet will be covered by provincial health care.

Labbie says the savings and the quality of life improvements for patients and families would be invaluable if we did the same in Alberta.

“I think my team gives our patients the best chance to avoid lower limb complication or amputation because of the education, support and early intervention we offer,” says Labbie.

The “Westview Way”

“We strive to maintain ongoing, therapeutic relationships with high-risk patients so that there isn’t a delay if they need repeat care. We try to have a circle of care where we follow through from beginning to end with patients and engage their family physicians,” says Labbie.

Her team inspires patients to achieve the best outcomes by:

- Creating individualized care plans.
- Finding out what they’re willing to do for themselves.
- Teaching them to advocate for their own health and care for themselves.
- Having them sign informal self-care agreements.
- Being flexible to meet their needs. Labbie says her team is close-knit.

“I have a really supportive management team who listens to and supports good ideas. If you put together a strong business case for my manager, she doesn’t dismiss it,” Labbie says. “She’s allowed me to do things I’ve really felt are important and that make a difference. If you have a management team who sees what you do as important, you can affect change.”

Labbie sees her nurse practitioner role as the hub of a wheel, as she connects patients with the right care provider to meet their needs. She might diagnose and investigate, but she also connects each patient with who they need to see next in a timely manner, such as an occupational therapist, a physician specialist or a mental health therapist.

Labbie makes sure the health-care professionals involved in care create a plan together, rather than in silos.

A provincial strategy

Labbie says shared knowledge, improved knowledge translation and provincially-accepted guidelines would strongly benefit client outcomes. She sees value in a strategic clinical network dedicated to wound management.

“What’s really needed is a provincial team committed to incorporating proactive prevention measures and education for patients. That kind of work takes funding and focused people,” Labbie says.

Teaching wound care to other RNs

Labbie believes she has a responsibility to share her knowledge. Better education will lead to better wound management.

“That’s why I’m excited to be teaching in MacEwan University’s wound management certificate course this year,” Labbie says. “I want to improve what health professionals know about wound management so they can manage complex wounds better. Educating other health professionals will sustain the benefits to the people we serve.”

“When I leave nursing, I want to leave a legacy: something that makes peoples’ lives better,” says Labbie.

REFERENCES

AFTER WATCHING A DOCUMENTARY ABOUT INTEGRATING THERAPY ANIMALS INTO EDUCATIONAL FACILITIES, REGISTERED NURSE LINDA SHAW GOT AN IDEA SHE COULDN’T SHAKE. AS THE NORTHERN ALBERTA INSTITUTE OF TECHNOLOGY (NAIT)’S STUDENT WELL-BEING FACILITATOR IN THE STUDENT COUNSELLING DEPARTMENT, SHE REALIZED THE THERAPEUTIC VALUE A DOG MIGHT BRING TO POST-SECONDARY STUDENTS ON CAMPUS. “I THOUGHT, WOULDN’T IT BE NICE TO HAVE AN EXTRA SUPPORT SYSTEM FOR STUDENTS WHO FEEL PHYSICALLY OR MENTALLY UNWELL?” SAYS SHAW.
“Fetching” attention from international students

SHAW says many NAIT students come from countries where dogs aren’t considered safe animals to be around. But Flynn helps introduce these students to the Canadian lifestyle, where dogs are a valued part of families.

“I have many great stories about people who’ve never touched a dog because they’re afraid,” says Shaw. “So I coach them about what do: ‘his tail is wagging, that means he’s happy to see you. If you touch him, he’ll turn his head toward you, but don’t be scared; he’s just looking to see what’s touching him.’ It’s a great way to build their confidence around animals.”

Shaw says they pet Flynn, then take pictures and send them to their families back home.

“It helps normalize dogs, which is helpful in a culture where we spend more money on dogs than ourselves!” says Shaw.

Supporting students through a ruff time

IN the counselling department, Shaw informs students about health and community resources.

“I don’t flood them with resources, but I assess their needs and guide them to support services that will help them stay in school and complete their chosen career path,” Shaw says.

The proof is in the puppy

SO Shaw put her registered nurse skills to work and began her research. One of her first steps was to take an online animal-assisted therapy certificate through Oakland University school of nursing. The course included a capstone project in which Shaw shared why she would like to integrate an animal program, what it would cost, what it would look like and how she would measure the outcomes. Then she pitched the idea to NAIT.

“When Flynn was a puppy, I was allowed to bring him in for training. Word of mouth led to people showing up at my office seeking puppy therapy,” recalls Shaw.

That was three years ago, and Flynn’s been a permanent NAIT wellness dog ever since.

Last year, Shaw received a grant from Alberta Blue Cross to conduct research about Flynn’s impact on students. She proposed the “PAWS For a Break” program: Shaw and Flynn would visit campus locations and students could relax and talk to Shaw, who opened the lines of communication about resources such as student counselling, learning services and the health office.

Shaw worked with NAIT researchers and the ethics board to survey students using rating scales, after spending time with Flynn. The final report indicated that the shift in mood and well-being was overwhelmingly positive.

“I might have initiated the program, but Flynn’s the one who does the work. If he didn’t make such positive connections with the students and staff, this program wouldn’t be so successful.” —LINDA SHAW
Shaw helps with everything from housing to bursaries. But Flynn works his own magic. “I might have initiated the program, but Flynn’s the one who does the work. If he didn’t make such positive connections with the students and staff, this program wouldn’t be so successful,” says Shaw.

She explains that students describe Flynn’s gaze as though a person is looking back at them—in a way that isn’t threatening. Shaw says in the counselling office, he will go to a person who is having a difficult time and either lay at their feet or put his head in their lap, as though he’s trying to ground them.

“Because of Flynn, students with health issues feel the office is a safe place to come when they start to feel overwhelmed,” says Shaw. “A distraught or emotional student calms down when they pet Flynn, and gets to a point where they can make a plan and move forward. He helps them get ready to figure out what to do next.”

Shaw feels proud when she hears students describe Flynn as “our dog,” as she senses a feeling of ownership and value in their words.

“A few years ago, I was walking with Flynn down a hallway and an instructor saw us. ‘What does a dog really do? Why do we need a dog here?’ he said,” describes Shaw. “It was perfect timing. At that moment, a group of health students came down the hallway and went right to Flynn, saying ‘This is just what we needed! We just had an exam!’ They were all laughing and smiling and saying how much better they felt.”

The instructor said ‘Never mind! I get it,’” laughs Shaw. Now, instructors invite Shaw and Flynn to classrooms. “I talk about stress and anxiety related to presentations and group work. We discuss what stress is and how your brain functions under stress. Then I teach the students simple techniques to recognize signs of their body under stress, so they can address it,” says Shaw.

Before presentation time, Shaw visits classrooms and students pet Flynn at the front of the room, which makes them more relaxed for their presentations.

Shaw shared a story about a student who recently told her that a few years ago, he decided to quit school. He packed up his stuff and was walking out when he ran into Shaw and Flynn in the hall. “He said, ‘You stopped and talked to me. I was petting Flynn and you told me where I could go to get support. Instead of leaving NAIT, I went to that resource. Not only did I graduate, but I’m back for a second program.’”

As a registered nurse, Shaw says she has learned to ask the right questions to open the door to what’s happening with a person, and that the resulting discussion may impact their life.

Linda and Flynn also volunteer at numerous NAIT events and with St. John’s Ambulance’s animal therapy program. They’re a common sight at the Stollery Children’s Hospital.

Shaw’s diligent therapy research extended to her search for an appropriate dog. “I knew I wanted a dog suitable for this work, a dog of a decent size because of the trades at NAIT, and a low-allergy breed,” says Shaw. “But in the end, he chose me.”

Shaw made relationships with people who dedicated their time to animal therapy and who had a lot of experience. “They guided me to a very ethical labradoodle (Labrador retriever mixed with a poodle) breeder who I felt comfortable working with. They let me bring an animal behaviourist to test puppies. Two puppies met the requirements,” describes Shaw. “The behaviourist told me the pup would have to pick me, so I sat in the pen and Flynn picked me.”

I chose his name because Flynn means ‘of red-headed descent,’” says Shaw.

At one year old, she took him to a trainer who could test for the requirements of a therapy dog. He went through two tests: obedience and connection with the handler, and a temperament test. The latter ensured Flynn had the right temperament to socialize with many people at once. Shaw’s animal-assisted therapy certificate also helps her recognize when Flynn is stressed.

Fortunately, Flynn is the type of dog who enjoys the company of people and can maintain his compassionate behaviour as a therapeutic professional.
Pat Jeffery’s life and nursing career have been nothing short of awesome, from STARS flight nurse to remote arctic nurse to screenwriter to luge champion to astronomical enthusiast. This registered nurse’s philosophy is that it’s not work if you love it.

Rural roots
Jeffery describes herself as a farm girl from Okotoks. She jokes there were only three careers available to women when she was in high school: teacher, nurse and X-ray technician – and she’s grateful she chose a career in nursing.

She graduated from Holy Cross Hospital school of nursing and started her first job at High River Hospital. Jeffery feels she got experience with a little bit of everything in the small rural hospital, where she moved between departments depending on patient volumes and needs. “I really enjoyed working there. But I worried if I stayed I would never leave, so I moved on,” she laughs. >
“If you really want to talk about RNs working to their full scope of practice, STARS is a forerunner. I CAN DO EVERYTHING.”

PAT JEFFERY

Rockyview game-changer

Jeffery started at Rockyview General Hospital in the ICU in 1981. She claims she retired three years ago, but still works there at least two shifts each month.

She works as part of an ICU outreach code 66 team: an RN and respiratory therapist pair who hurries to any part of the hospital where a patient is deteriorating and at risk of cardiac arrest.

In the past, the hospital had limitations on what RNs could do when a patient was deteriorating. The only options were to call in a physician or follow physician instructions over the phone if they couldn’t attend the patient in person. If the patient failed to improve, the RNs had to wait until the patient was in cardiac arrest before they could call a code blue.

She helped implement a process to prevent patients from coding rather than just treating patients who were already experiencing cardiac arrest. Jeffery says when the team took this proactive approach, cardiac arrests dropped by almost 40 percent.

“We were so proud to trial and then permanently implement this approach. Now, when we hear code 66 called, it means a patient meets certain criteria, such as low blood pressure, low heart rate and unconsciousness – but hasn’t gone into cardiac arrest yet. We have a chance to stabilize the patient,” Jeffery says.

Before she “retired”, Jeffery had one more obstacle to tackle.

In emergencies, vascular access systems are used for quick intraosseous (“IOs”; into bone) access when an IV is difficult to start. Unfortunately, the outreach code 66 and code blue teams were not allowed to insert IOs per the hospital policy. But Jeffery and her colleague gathered testimonials about the procedure and its importance for patient stabilization to share with their executive leadership team. As a result, both teams were approved to insert IOs and a company came to host labs to teach RNs proper insertion on cadavers.

Jeffery became so involved that she began to teach these free labs to healthcare providers across Canada as part of her “retirement.” She also teaches pediatric life support and advanced life support.

Sky superhero

When Jeffery started working as a flight nurse in 1989, it was a volunteer role that she did in addition to her work at Rockyview. She still works eight shifts each month.

“If you really want to talk about RNs working to their full scope of practice, STARS is a forerunner. I can do everything,” says Jeffery. “It’s very rewarding to do all the things within my scope, make a difference and save a life.”
Jeffery says a typical day involves flight training, aircraft checks, restocking equipment, giving tours or practising procedures on a mannequin.

The radio tones sound when there is an emergency. The team receives basic information before they get into the helicopter. Once, on the way to a call, as she received more information, she was shocked to learn that the patient in critical condition was her brother.

“That’s never happened before. I wouldn’t wish it on anyone, but I’m glad I was there,” says Jeffery. Thankfully, her brother survived.

Recently, a trip with STARS was to a serious motorcycle crash. The patient had severe facial damage and her airway was full of blood; she needed an IV, but her veins had collapsed. She needed saline to prevent brain swelling and she needed blood. She had bilateral rib fractures.

“We rarely have a physician, but that day we did. The ground medic inserted an IO while I drew up meds and hung blood. The paramedic captured her airway and the physician inserted chest tubes. It was a wonderful example of everyone working together,” says Jeffery.

The patient was critical, but a few weeks later, she’s doing well.

“It was a true save,” says Jeffery. “Not all the skills RNs have are technical; we use assessment and critical thinking skills. I consider: what does the patient need right now? What about in 10 minutes? I make a plan and follow it.”

Remote realities
Because working at both Rockyview and STARS wasn’t enough jobs for Jeffery, she worked simultaneously at remote nursing stations in places like Fox Lake in northern Alberta and Aklavik and Deline in the Northwest Territories, providing care for patients within several hundred kilometres.

“The northern lights are south of you!” says Jeffery of Cambridge Bay, a high arctic community in Nunavut, where she worked for four years as a critical care transport nurse. “We went to patients in small airplanes and sometimes even on snowmobiles.”

One of her most memorable experiences was flying out to a six-week-old baby in 40 below. Upon arrival, she learned the baby was six weeks premature and was a twin.

“I was the only person within hundreds of miles who could save his life,” says Jeffery, who gave the baby a breathing tube. “A few months later, he was thriving, and it was so rewarding. I really made a difference. That will always stay with me.”

Leaving a legacy
“My goal is to leave the world a better place,” says Jeffery.

And in following her passion, she’s done just that. Her advice to nurses who feel stressed or burned out is to try a different area of practice, find a challenge and discover something they love.

“Try to find a nursing job that incorporates something you’re interested in. It makes a huge difference,” says Jeffery. “It’s been a wonderful career.”

Just 24 per cent of STARS’ funding is from the government and the group must fundraise for the other 76 per cent. Learn more at stars.ca/ab.

More about PAT
Her personal interests are almost as cool as her nursing career—literally. When Jeffery learned Calgary was going to host the Winter Olympics in 1988, she wanted to be involved.

“I picked a sport I was familiar with—every kid slides on a toboggan; how hard can the luge be?” says Jeffery. “It’s harder than it looks.”

Snow luge goes about 30–40 miles per hour. In the Canadian championship, Jeffery took home a gold medal.

Aside from sports, Jeffery took up screenwriting on a dare. To date, she’s written three screenplays and is working on another. One was shortlisted for the Writers Guild of Canada Screenwriting Awards.

She also wrote a novel about a woman working as a flight nurse who ends up marrying a pilot.

“Life imitates art!” says Jeffery, quoting Oscar Wilde. “I ended up marrying a STARS pilot myself!”

On top of all that, she rescued a cat, rides a motorcycle and is part of the Royal Astronomical Society of Canada.
Examining the effects of

WORKPLACE BULLYING, HARASSMENT AND PSYCHOLOGICAL INJURY in Alberta’s health-care system:

A CALL FOR LEGISLATION

BY CHERIE C. SEVERSON, MN, RN, BMTCN AND SANDRA A. CLOVECHOK, BN, RN
Being that it’s a new year, it is a good time to reflect on issues that impact our ability to safely care for the public and each other, and maintain healthy workplace environments.

Bullying is a form of aggressive behaviour in which someone intentionally and repeatedly causes another person injury or discomfort. It can take the form of physical contact, words or more subtle actions and is considered a form of trauma. This trauma forms the basis for psychological, spiritual or brain/bodily injury. Bullying is repeated malicious, health-endangering mistreatment of one employee (the target) by one or more employees (the bully or bullies) to prevent the target from performing well, affecting the provision of quality care.

### HOW THE BRAIN IS NEGATIVELY AFFECTED

If you can remember your medical science course in nursing school, the human brain is an intricate structure providing millions of simultaneous synaptic transmissions when sensory and motor stimuli are present. During synaptic transmission, expected levels of neurotransmitters allow the brain to process and function normally. However, when bullying, harassment and psychological trauma occur, neurotransmitter levels and areas of the brain such as the prefrontal cortex and the limbic system are affected, reducing the brain’s ability to bring the body back into balance (see FIGURE 1). The alteration in neural activity causes:

- Changes in:
  - blood pressure and heart rate
  - relational response, empathy and connecting
  - emotional reactivity
  - fight-flight-freeze stress response
- Inability to:
  - monitor for perceived threats
  - maintain impulse control

Chemicals or hormones such as catecholamines, corticosteroids, opioids, and oxytocin are powerful substances which control fight or flight response, energy and immune functioning, pain...
control and memory function and the promotion of good feelings respectively. When trauma is too severe and prolonged, increased catecholamines cause damage to rational thought, hypervigilance and an inability to distinguish danger signals; low corticosteroids lead to reduced immune function and chronic diseases; increased opioid levels are thought to be equivalent to having 8 mg of morphine in the body causing the person to exhibit a flat affect; and increased oxytocin levels cause memory impairment.

Neurotransmitters such as serotonin, dopamine, and gamma aminobutyric acid (GABA) are also inhibited in cases where psychological trauma occurs, leading to alteration in the balance of emotion and mood including depression, obsessive compulsive disorder and suicide; decreased arousal, alertness, attention and motivation; and increased anxiety respectively.

Bullying is thought to be more prevalent amongst nurses than any other health-care profession. While there is no definite theory, scholars contend that nurses are prone to be submissive to physicians and administrators, resulting in their actions being taken out on each other.

In her book, The nurses: a year of secrets, drama and miracles with the heroes of the hospital, Alexandra Robbins examines hazing, bullying and sabotage in nursing that is so destructive that patients can suffer, and in some cases, have died. In her study, Robbins outlines numerous behavioural patterns including colleagues withholding crucial information or help, spreading rumours, name-calling, playing favourites, and intimidating or berating nurses until they quit. The behaviour can also include direct sabotage of a nurse’s career by outright lying about that person’s performance. In some studies, nurses report patients have suffered lengthy and uncomfortable moments due to nurses who bully through their refusal to assist with providing care, and increased patient morbidity and mortality due to bullying tactics between health-care professionals, particularly nurses.

A UMass Lowell nursing professor found in a 2010 study that nurses reported extreme forms of bullying. In this study, Simons quotes a nurse saying: “During my pregnancy, because the charge nurse didn’t like me, I was assigned the most infectious patients – HIV, tuberculosis and hepatitis.”

Bullying, harassment and trauma pose a significant risk to the nurses, patients and families. The effects of prolonged bullying cause extremely detrimental psychological effects including memory loss, inability to focus, difficulty with speech, reactivity, lack of emotional control, impulsivity, the inability to feel safe, alteration in neurotransmitters needed for normal brain function and post-traumatic stress disorder (PTSD). This list is not exhaustive. Dr. Tim Field reports PTSD can include:

- hypervigilance
- exaggerated startle response
- irritability
- sudden angry or violent outbursts
- flashbacks
- nightmares
- intrusive recollections
- replays
- violent visualizations
- triggers
- sleep disturbance
- exhaustion and chronic fatigue
- reactive depression
- guilt
- feelings of detachment
- avoidance behaviours
- nervousness
- anxiety
- phobias about specific daily routines, events or objects
- irrational or impulsive behaviour
- loss of interest
- loss of ambition
- anhedonia (inability to feel joy and pleasure)
- poor concentration
- impaired memory
- joint pains, muscle pains
- emotional numbness
- physical numbness
- low self-esteem
- an overwhelming sense of injustice and a strong desire to do something about it

“Bullying upregulates the fear response, triggers the stress systems and shifts neurochemical releases - this results in a significant decrease in well-being.”

P.J. ROSSOUW
As RNs, we follow a code of ethics which includes professionalism while ensuring the safety of the public in our province. If a nurse chooses to partake in workplace bullying and harassment knowing the effect it can have on the victim, they are in contravention of the code—a reportable offence. It is not enough to say that bullying is just part of the nursing culture, especially when detrimental effects occur in the victim and negative patient outcomes are reported.

**Bullying, harassment, and trauma pose a significant risk to nurses, patients, and families.**

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It’s difficult to assess the cost of workplace bullying, harassment and psychological injury to the health-care system, though a significant portion of mental health spending could be attributed to bullying.

Reflecting on the issues surrounding workplace bullying, harassment and psychological injury should spark incentive to address the need for legislation. Bullying may seem harmless, however over time it becomes detrimental. From the affected neurobiological/psychological trauma to unhealthy workplace environments, a reduction in quality health care and escalating cost, the extent of damage is overreaching. Legislation is needed to ensure safety of individuals in a healthy, bully-free workplace, as well as the safety of patients and families.

**HOW WORKPLACE BULLYING AND TRAUMA IMPACTS ALBERTA**

**SIXTY** percent of Albertans have experienced workplace harassment while half of the victims of workplace bullying or harassment would not report it. In 62 per cent of the cases where it was reported in Alberta, the employer took no action. Although 70 per cent of Alberta employers have a harassment policy, it may not be enforced because there is no legislation in place.

Legislation governing workplace bullying, harassment and trauma is significant to Albertans and our health-care system. Legislation would require workplace harassment policies, and hold employers accountable to safe and healthy work environments. Legislation would benefit health-care employees and ensure patients and families receive quality health care.
BACKGROUND

Access to and use of best available dementia care evidence is challenging in northern rural Alberta.

RESEARCH QUESTIONS

1. What is the nature of the development and implementation of integrated knowledge translation strategies (e.g., practice guidelines, decision aids, care pathways) in two northern Alberta home-care centres?

2. How does a knowledge broker influence the development and implementation of these strategies?

ABSTRACT

The role of a knowledge broker in promoting the use of dementia care evidence in rural home-care centres

AUTHORS:
FORBES, D.A., BAYLY, M., COATSWORTH-PUSPOKY, R., MARSEAU, R., RAJAN, R., HAWRANIK, P., BLAKE, C., PEACOCK, S., STRAIN, L., MORGAN, D., INNES, A.
OUR APPROACH

A knowledge broker was hired for one year at two home-care centres in northern Alberta to facilitate the development of integrated knowledge translation strategies and projects.

Sixty-three people living with dementia, family caregivers, home-care providers and managers participated in 98 interviews at baseline, six months and three to four months following the termination of the knowledge broker role. Transcribed interviews were analyzed using thematic analysis. Themes related to the challenges, facilitators, and outcomes affecting the knowledge broker role and the development and implementation of knowledge strategies were identified.

Staff at each site identified improvement projects that were feasible with current resources. A standardized dementia education package including site-specific dementia service information and links to relevant online information were developed by the team at site one. In addition, the team made a presentation to zone leaders about the current dementia crisis, highlighting gaps and opportunities for change within their local setting.

At the second site, home-care providers completed the U-First/P.I.E.C.E.S. online educational modules designed to enhance their understanding of the people living with dementia. This information, combined with the U-first wheels, was applied with people living with dementia and their family caregivers during respite and daily care.

THEMES RELATED TO CHALLENGES

The knowledge broker was described as “steering the boat” rather than the home-care providers taking on some responsibilities:

“I take everybody’s ideas into account. I work with the group, I try and be the facilitator... but basically so far I have been steering the boat or the chairperson.

They want me to do the background work and the secretarial kind of work because they don’t have time. I’m the one that’s keeping it going.”

(Knowledge broker)

Dementia was described as a “shameful process” by the participants:

“A lot of people hide dementia for a long, long time. They don’t want to admit that their loved one has dementia, like it’s a shameful thing because it’s mental health, right? To normalize it more and bring it out more and give people the information early so that they know that some of the behaviours – that they think they’re the only ones that are experiencing – are normal...”

(Knowledge broker)

THEMES RELATED TO FACILITATORS

A supportive manager encouraged the staff to participate:

“Where the staff are taking these online modules and spending work time or extra time doing them, is very much facilitated by the manager being on board with that and saying yes, we’re doing this and yes, I’m gonna be at these meetings and we’re gonna have these discussions.”

(Knowledge broker)

THEMES RELATED TO OUTCOMES

Use of the U-First wheel enhanced therapeutic relationships:

“When I did go on to the wheel to find the information I needed, I took a step backwards from my regular routine, which was hurry, hurry... Finding the gentleman very agitated, very lonely... I don’t have time for this. Then I started paying more attention, started listening to him, taking an extra five minutes to pay attention to what he had to say, an extra few minutes to answer his questions... the more I used the wheel and tried to figure him out, the easier it became. My approach, my attitude made a difference in how he approached me and how he felt. Then he started to open up and tell me a lot of stuff about his life and about himself, he became more confident and confident in me and trusted me more.”

(Home-care provider)

Enhanced resources for staff and clients:

“The feedback that we’ve got has said how helpful (the package) has been to people. [For example, one woman] thought somebody had gone into her bedroom when she wasn’t quite dressed, one of our aides... [Someone responded], ‘Well I keep telling her it doesn’t happen.’ Then I said, ‘Don’t do that, just say, “I’ll look into this, that shouldn’t happen.” That might make your life a little easier. Don’t try and argue, nobody was there.’ Simple tips like that help people tremendously.”

(Manager)

CONCLUSIONS

The U-First/P.I.E.C.E.S. modules were found to be helpful and practical for staff at all levels, and considered to be useful as part of the orientation for all new staff. Two long-term care lodges requested the U-First modules be introduced to their staff. Participants described the knowledge broker as integral to the successful development and implementation of their integrated knowledge translation strategies, and overwhelmingly recommended the integration of a knowledge broker as a staff member.

For more information about this study, contact Dorothy Forbes, PhD, RN, professor, faculty of nursing, University of Alberta, 780.492.4709, dorothy.forbes@ualberta.ca. Funded by the Covenant Health Network of Excellence in Seniors’ Health and Wellness and Alberta Health Services.
Almost 90 percent of the Canadians living in long-term care facilities have some type of reduced mobility, with approximately 40 percent of long-term care residents with dementia losing their ability to walk annually. Loss of mobility leads to a significant decline in basic function, quality of life and overall health among long-term care residents, so registered nurses should develop strategies to maintain and improve the mobility of older adults.

The MOVE study evaluated the effect of a simple mobility intervention, the sit-to-stand activity, on the mobility and function in activities of daily living of residents with dementia in long-term care. The sit-to-stand activity is simply standing up and sitting down, as many times as is safely possible in a one-to-two-minute session.

**ABSTRACT**

**MOVE (Mobility of Vulnerable Elders): Implementation of a mobility intervention in long-term care facilities.**

**AUTHORS:**
SUSAN SLAUGHTER, PhD, RN, GNC(C); NAVTEJ K SANDHU, BPT, MA;
CARLA ICKERT, MA
STUDY METHODOLOGY
The researchers chose the sit-to-stand activity because of its various benefits, including: not requiring extensive health-care aide training; ease of completion during daily care routines; overall simplicity; requiring minimal equipment (e.g., a chair) and ease of trialing and adjusting according to individual residents’ needs.

The researchers taught the sit-to-stand activity to four health-care aides in long-term care facilities in Edmonton. Each education session lasted for 20 minutes and focused on:
1. Introducing the sit-to-stand activity within the health-care aide scope of practice.
2. Reviewing safe transfer and body mechanics techniques.
3. Using case scenarios to address the potential challenges encountered when completing the activity with residents who have dementia.
4. Introducing daily documentation flow sheets for record-keeping.

The researchers asked the health-care aides to prompt residents to repeat the sit-to-stand activity four times daily: twice on day shift and twice on evening shift. Repetitions varied according to the ability and fatigue level of the residents. The sit-to-stand activity was integrated into usual care routines such as entering the dining room at mealtimes, toileting and on other occasions of regular activity. The timing and location was at the discretion of the health-care aide. The researchers reminded health-care aides that, as with their usual care activities, when a resident’s condition deteriorates they should consult an RN about continuing the sit-to-stand activities. The health-care aides documented their completion of the activity with daily documentation flow sheets.

The researchers compared residents in the intervention group with residents who agreed to participate in the study from three different long-term care facilities in Edmonton. Residents in these comparison facilities received care as usual.

To measure resident health outcomes, the research team gathered data on resident mobility using a timed sit-to-stand test. They tested how long it took for the resident to complete one full sit-to-stand-to-sit transition, as well as how many sit-to-stand-to-sit transitions a resident could complete in 30 seconds. To measure function, the research team completed interviews with health-care aides to gather data for the Functional Independence Measure.

All measures were gathered at baseline and six months for each participating resident.

INCREASED MOBILITY
We found the average time taken by residents in the intervention facilities to complete one sit-to-stand decreased from 6.96 seconds to 6.09 seconds. In other words, they were taking less time to complete their first sit-to-stand transition after six months of completing the sit-to-stand activity and hence improving their mobility. On the other hand, residents in the comparison facilities worsened: the time to complete the first sit-to-stand for those residents increased from 4.37 seconds to 5.40 seconds after six months.

INCREASED FUNCTION
Using the Functional Independence Measure to quantify activities of daily living, we found a decline in physical function in both the intervention and comparison groups, as would be expected for those with dementia. But for residents not receiving the sit-to-stand activity the decline was significantly greater. For the residents receiving the sit-to-stand activity, their slower decline suggests that they could benefit from this small amount of physical activity each day.

IMPLICATIONS FOR PRACTICE
The sit-to-stand activity is a promising way to improve mobility and slow the functional decline of residents with dementia in long-term care facilities. However, given the workload and time constraints of health-care aides, attending education sessions for the sit-to-stand activity and implementing the activity into daily care routines was challenging. The involvement and support of the facility leaders during education sessions and throughout the study was instrumental in motivating health-care aides to complete the sit-to-stand activity with residents.

CONTACT
For more information regarding this study or the sit-to-stand activity, contact Susan Slaughter at: susan.slaughter@ualberta.ca.

REFERENCES
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### CALGARY/WEST

**Western and North-western Region Canadian Association of Schools of Nursing Conference**  
Feb. 21-23, 2018 | Calgary  
nursing.ucalgary.ca/wnrcasn

**Choosing Wisely Alberta Symposium**  
March 7, 2018 | Calgary  
cumming.ucalgary.ca

**Stroke Symposium**  
March 23, 2018 | Calgary  
cumming.ucalgary.ca

**Cannabis Update – A Framework for Conversations with Patients**  
April 18, 2018 | Calgary  
cumming.ucalgary.ca

**Calgary Therapeutics Course**  
April 19-20, 2018 | Calgary  
cumming.ucalgary.ca

**Women’s Mental Health Day Conference**  
April 27, 2018 | Calgary  
cumming.ucalgary.ca

**Calgary Pain Conference**  
May 7-8, 2018 | Calgary  
cumming.ucalgary.ca

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### CENTRAL

**MSK Clinical Pearls Conference**  
April 9, 2018 | Red Deer  
cumming.ucalgary.ca

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### EDMONTON/WEST

**NPAA Conference: Together. Stronger and Smarter.**  
April 14-15, 2018 | Edmonton  
albertanps.com

**Royal Alexandra Hospital Class of 1978 Reunion**  
May 4-6, 2018 | Edmonton  
ddroth@shaw.ca or debbiehq@telus.net

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### OUTSIDE ALBERTA

**Healthy Mothers and Healthy Babies Conference**  
March 1-2, 2018 | Vancouver, BC  
interprofessional.ubc.ca

**International Seating Symposium**  
March 6-9, 2018 | Vancouver, BC  
seatingsymposium.com

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## CANADIAN DOMESTIC VIOLENCE CONFERENCE

March 20-23, 2018 | Truro, Nova Scotia  
canadiandomesticviolenceconference.org

**Western Canadian Addiction Forum**  
May 4-5, 2018 | Kelowna, BC  
wcaforum.ca

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### Educational Opportunities

**The Opiate Crisis: Heroin, Fentanyl & Its Analogues**  
Understanding and Treating the Emerging Epidemic  
Edmonton | May 9, 2018  
Calgary | May 10, 2018

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**Somatic Interventions for Treating Complex Trauma**  
Banff | July 16 & 17, 2018

**Healing the Fragmented Selves of Trauma Survivors**  
Overcoming Self-Alienation  
Banff | July 18, 2018

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**CogNitive BEhavioural Therapy & T.E.A.M. Techniques**  
4-Day Summer Intensive  
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**IN MEMORIAM**

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

**Copple, Jacqueline A. (née Clark),** a 1969 graduate of the Montreal General school of nursing, who passed away on July 14, 2017 in Calgary.

**Mulherin, Cynthia Mary (née Jay),** a 1979 graduate of the University of New Brunswick, who passed away on Sept. 20, 2017 in Penticton, British Columbia.

**Omogbenigun, Olufemi,** a 2013 graduate of the University of Alberta, who passed away on Jan. 18, 2017.
This ongoing and advanced nursing education saves and improves the lives of Albertans each and every day. ARNET is committed to be there supporting Alberta’s RNs and NPs, but we cannot do this without your support.

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- Friday, May 11: Lethbridge Nursing Gala
- Friday, September 28: Red Deer Nurses on the RuN night walk

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Leadership science is often perceived as a softer side of the health sciences, yet research suggests it contributes significantly to our understanding of the factors that influence patient outcomes in the health system.

Effective, supportive and positive nursing leadership contributes to developing future nurse leaders, mentoring new researchers, supporting staff and providing exemplary care. Knowing that we have the potential to influence the health-care system in a positive way transformed my practice, and I suggest this knowledge can influence yours as well.

We know that a lack of positive, effective leadership can result in a workplace ripe with incivility, often when a dissonant leadership style (command and control) is used. Dissonance is a style of authoritarian leadership that causes distress, crisis, internal disquiet and unrest. Uncivil behaviours in a workplace can negatively influence job satisfaction and commitment to stay, and can contribute to burnout and negative patient outcomes.

So what kind of leadership style is right? Current research points to a resonant leadership style. Resonant leadership is distinguished from other styles in that it is rooted in the emotional intelligence framework: emotional self-awareness, self-management, socio-political awareness and effective management of relationships with others.

Leaders who practise a resonance leadership style, based on the emotional intelligence framework, have the ability to consciously renew themselves through mind, body, heart and spirit in a holistic process. Thus, resonant leaders show concern, work to resolve conflicts, are easily accessible, and enable staff growth and development, and these behaviours contribute to positive nurse work and patient outcomes.

The effects of dissonant leadership on work environments are well-known, but how do nursing leadership behaviours influence patient outcomes? Researchers in Alberta examined the contribution of nursing leadership styles in hospitals to 30-day mortality of medical patients. They categorized hospitals based on the leadership styles of nursing leaders. After controlling for the majority of factors that influence patient mortality, the relative contribution of nursing leadership styles to 30-day mortality was 5.15 percent. High-resonant leadership styles were significantly associated with 26 percent lower odds of mortality when compared with the mixed leadership group as reference.

I have listed a few suggestions to integrate a resonant leadership model, at the health-care organization level, unit of care/group level and within your own nursing practice. Of course these depend on your area of practice and your span of influence.

At the organizational leadership level:
- Support and foster participatory leadership across organizations.
- Engage and communicate often.
- Provide access to leadership education and time for reflection.
- Ensure position descriptions include expectations of leadership behaviours.

At the unit/group leadership level:
- Support shared governance and decision-making models.
- Expect and welcome questioning of long-held practices.
- Cultivate an environment that actively encourages new ideas and innovation.
- Acknowledge the depth of knowledge within the team and support inter-professional communication and sharing of experiences.

At the individual nurse leader level:
- In leadership roles, develop a shared vision and share it broadly.
- Demonstrate trust and expect accountability.
- Emphasize teamwork; show appreciation and openness.
- Be humble and helpful.
- Offer praise in public for work well done.
- Be open to and ask for feedback as you continually refine your leadership style.
- Engage in mentorship opportunities.
- Speak truthfully and openly about changes.
- Admit you don’t know everything and ask questions.
- Think “we,” not “I”.
- Rest and reflect. Resonant leadership can be challenging; acknowledge your need to recharge.

These suggestions come from my own personal experience but there are several books and articles to assist you in your own leadership journey. It is time to make a change that can positively impact our work environments and outcomes for our patients, families and communities—certainly, a worthy New Year’s resolution for 2018.

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