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**COVER PHOTO: YANG HU**

COOPER AND O’HARA PHOTOGRAPHY (PG. 20)
ALDECA STOCK/SHUTTERSTOCK.COM (PG. 27)
The future is in your hands

In November, we celebrated approval of amendments to the Registered Nurses Profession Regulation under the Health Professions Act. Coming into force on May 1, the amended regulations have potential to improve health service delivery and care for the public through RN authorization for prescribing and ordering of diagnostic tests. Provincial council will be approving revised practice standards at its March meeting which will enable these legislative changes.

Significant changes in practice take time to implement. Alberta Health Services will be piloting RN prescribing in three areas: occupational health and safety, travel clinics and sexual health clinics. There is also significant interest from Indigenous Services Canada. It is important to point out that RN prescribing will be limited to specific clinical practice areas where the employer has policies to support RN prescribing and a clinical support tool to clearly guide prescribing decisions. This is quite different from the broad authorization of NP prescribing. However, we can envision a time when RN prescribing is making a difference in management of chronic health conditions; improving access to care, particularly for seniors and in rural and remote communities; and contributing to a more efficient and cost-effective health system.

Self-regulation is based on trust: government and society trust the profession to act in the interests of protecting the public.

We live in a time when trust in the ability of professions to put the public interest first has been eroded. Today, there are only a few countries, including Canada, where health professions are still self-regulating. There are increased expectations that regulators will regulate their members openly and transparently and governments have the power to enact legislation to make sure they do. Alberta’s Bill 21, An Act to Protect Patients, which amends the Health Professions Act, is a good example of this. Passed in November, Bill 21 introduces:

- mandatory sanctions for health professionals who commit sexual abuse and sexual misconduct
- specific requirements about information to be posted on the college website
- creation of a fund to support complainants

CARN A and the other health colleges must also develop a standard of practice that reflects the changes under Bill 21 for approval by the minister of health.

This particular government decision directly affects us as health professionals, but government decisions impact our lives as citizens in a variety of ways. That is why it is so important to participate in provincial and federal elections, to elect the politicians who will reflect our values and ideals as they govern on our behalf.

In our provincial election this spring, I hope that you will take the time to consider the different party platforms with respect to health care and ask questions when speaking with candidates in your riding. That way, you can elect representatives who will make decisions that support our publicly-funded health-care system. Above all, vote! RN

Dennie Hycha, MN, BScN, RN
President
403.783.1504
president@nurses.ab.ca
November 2018, the Lieutenant Governor in Council proclaimed amendments to the *Registered Nurses Profession Regulation* under the *Health Professions Act* that will further support nursing practice in Alberta. The changes will authorize registered nurses to prescribe common medications and order diagnostic tests such as X-rays. While nurse practitioners already have broad prescribing ability for all medications appropriate to their stream of practice and competency, the regulation changes will establish authority for NPs to set bone fractures.

RN prescribing will be limited to specific clinical practice areas where employers have identified a need. The employer must also develop policies to support RN prescribing and a clinical support tool to clearly guide prescribing decisions. An RN will only be able to prescribe the specific medication and dose identified in the clinical support tool. If the client’s symptoms do not meet the inclusion criteria, the RN will need to refer the client to a physician or a nurse practitioner for assessment.

RNs interested in becoming authorized to prescribe and order diagnostic tests will first need to complete a minimum of 3,000 clinical hours with 750 of them in the clinical practice area where they wish to prescribe. They will also need to complete an approved nursing education program to be offered by Athabasca University.

The RN’s practice permit will identify the clinical practice area where they are authorized to prescribe and order tests. The RN will have a “prescribing ID” so that CARNA can inform the Alberta College of Pharmacy and Alberta Blue Cross that the RN is authorized to prescribe.

Other changes to the regulations

Other amendments in the regulation provide more flexibility for CARNA as a regulator in areas such as continuing competence and licensure requirements. Indirect supervision will now be required for all those on the provisional register. Applicants will no longer be limited to three attempts at the entry-to-practice exam but must pass it within 24 months. Another important change is that CARNA can now require RNs and NPs to take mandatory courses as part of their continuing competence requirements.

The new regulations come into force on May 1, 2019.

In December, Council voted that draft revisions to CARNA’s Bylaws and the *Practice Standards for Regulated Members* were ready to be posted for member and stakeholder feedback. The practice standards are currently being reviewed by the government. Council is scheduled to vote on the final version of these documents at their March meeting.

Requirements for prescribing

This new authority for RNs represents a significant opportunity and change for the health system, but it will take time for widespread implementation. Registered nurse prescribing and ordering tests will be introduced gradually, starting with three pilot sites within Alberta Health Services. Indigenous Services Canada is also interested in implementing registered nurse prescribing in rural and remote regions of the province to improve access to care.
Carna supports the Alberta Government’s new law to ensure Albertans are safe when accessing health-care services. Bill 21, *An Act to Protect Patients*, establishes mandatory penalties for sexual abuse and misconduct by all health professionals regulated under the *Health Professions Act* (HPA), including registered nurses, nurse practitioners and those on the temporary and courtesy registrar.

New applicants are now required to submit a criminal reference check and disclose any completed or ongoing conduct investigation under HPA, or equivalent in another jurisdiction. In the future, we may also require a vulnerable sector check.

After April 1, 2019, if a hearing tribunal finds a CARNA member’s action to constitute sexual abuse, that member’s practice permit will be permanently cancelled. When a hearing tribunal finds actions constitute sexual misconduct, the member’s practice permit will be suspended.

The bill requires disciplinary actions for sexual abuse and misconduct to be clearly and consistently posted online. The bill also requires that survivors are provided with access to treatment and counselling.

We will continue to communicate how Bill 21 impacts patients, members, employers and others as we finalize details.
Join Alberta registered nurses for the CARNA annual general meeting to learn about issues affecting nursing practice.

**MAY 6, 2019**

Oasis Centre
10930-177 St. NW, Edmonton

To view the agenda and register to attend, go to nurses.ab.ca and look for the meeting in our event calendar.

**FEATURING GUEST SPEAKERS:**

**Kathleen Bartholomew, MN, RN**
National public speaker and consultant
Kathleen Bartholomew has been a national speaker for the nursing profession for the past 11 years. As the manager of a 57-bed surgical unit in Seattle, Kathleen quickly recognized that creating a culture where staff felt a sense of belonging was critical to retention.

**Greta G. Cummings, PhD, RN, FCAHS**
Dean of the faculty of nursing, University of Alberta
Dr. Cummings is passionate about relational nursing leadership that empowers individuals, teams and organizations to achieve shared goals.
We are pleased to announce the 2019 CARNA AWARDS NOMINEES

Thank you to those who took the time to nominate their outstanding colleagues for their demonstration of excellence.

RISING STAR
- Caitlin Fenton
- Sobhy Hajji
- Rachel Ollivier
- Crystale Paquette

RESEARCH
- Cathy Carter-Snell
- Bukola Oladunni Salami
- Gwen Rempel

EDUCATION
- Kerri Alderson
- Dustin Chan
- Seanna Chesney-Chauvet
- Foothills Medical Centre
- Department of Clinical Neurosciences
- Julia Imanoff
- Penny Nickle
- South Health Campus,
  Family Maternity Place
- Yvonne Verklan

CLINICAL PRACTICE
- Joni Bjorge
- Elizabeth A. Cowan
- Robert Hornbeck
- Kristina Lauridsen
- Debra Lundberg
- Pat Miller
- Theresa Pasquotti
- Milton Perla
- Renee Pippin
- Stephanie Scott

ADMINISTRATION
- Dianne Benner
- Joanne Cabrera
- Dustin Chan
- Juanita House
- Treena Klassen
- Alison Nelson
- Diane Pyne
- Jacqueline Sperling
- Navjot Virk
- Amanda Weiss

PARTNER IN HEALTH
- Saad Al Khafaji
- Pregnancy Pathways

CARNAAWARDS.ca
NURSING EXCELLENCE GALA

The celebration only lasts an evening,
but the memories will last a lifetime!

Friday, May 10, 2019
Hotel Arts, Calgary

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

TICKETS: carnagala.eventbrite.ca
A Hearing Tribunal made a finding of unprofessional conduct against member #56,439, who communicated unprofessionally or negatively with co-workers. The Tribunal issued a reprimand.

A Hearing Tribunal made a finding of unprofessional conduct against member #67,048, who, while working at Alberta Health Services (Central), engaged in inappropriate and unwanted interactions with a co-worker on multiple occasions. On one occasion, the member made an error in IV medication administration when administering the incorrect antibiotic and subsequently failed to document and communicate accurately in the administration error or assessment. Additionally, the member failed to complete a reporting and learning system and complete the ordered dressing change. For this finding of unprofessional conduct, the Hearing Tribunal issued a reprimand, ordered coursework to be completed and restricted the member to working at his current settings pending one satisfactory performance evaluation. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

A Hearing Tribunal made a finding of unprofessional conduct against member #85,150 who failed to account for narcotics on a number of occasions when she made errors by entering the wrong patient names into the automated dispensing cabinet when obtaining narcotics, thereby making it very difficult to determine what had happened to those narcotics. On a number of other occasions, the member failed to document verbal orders she received for medication administration, failed to follow the protocols on that unit regarding narcotic administration and on five occasions inaccurately calculated and documented narcotic wastage. The Hearing Tribunal issued a reprimand and ordered the member to pass three courses: documentation, nursing informatics and basic medication administration. The member is restricted to working at an approved setting pending one satisfactory performance evaluation. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

A Hearing Tribunal made a finding of unprofessional conduct against member #89,485, whose behaviour toward a health-care aide was described as “bullying.” The member administered methadone rather than morphine to a patient in error. On another occasion, the member failed to adequately or accurately chart her assessments, the patient’s condition or care provided for a patient who was in respiratory distress. She also failed to notify the patient’s emergency contact and administered O₂ at a rate higher than appropriate until she called the doctor who asked her to turn it down. The member engaged in inappropriate communication with the mother of a palliative infant, despite the member having received prior direction and coaching regarding her communication skills. The Hearing Tribunal issued a reprimand and directed the member to pass courses in interpersonal aspects of nursing and in documentation. The member must also complete e-modules on the Code of Ethics. The member is restricted to working in her current practice setting pending one satisfactory performance evaluation. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.
A Hearing Tribunal made a finding of unprofessional conduct against member #92,394, who failed to document adequately on two occasions regarding administration of medications. The member on one occasion administered morphine 2.5 mg instead of the ordered 1 mg. On one occasion, the member failed to fully close the Pyxis medication drawer while retrieving medication for a patient who was coding. The member was issued a reprimand and was ordered to pass a course in basic medication administration, and to prepare and submit a professional development plan. 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 #100,247 who failed to ensure her own fitness to practise when she failed on several occasions to complete the monitoring required by her physician as part of her treatment. The member failed to report a relapse to the Complaints Director and failed to complete the follow-up procedure for positive test results as directed by her physician. The Tribunal issued a reprimand and directed the member to notify them as soon as she had complied with the requirements of the Complaints Director under section 118, Health Professions Act. At that point, the member shall complete 480 hours of supervised practice. The member shall undergo screening and submit medical reports for two years after successful completion of the supervised practice. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

Join us for a 45-minute online huddle to discuss CARNA’s harm reduction resources.

Professional Practice Huddles are a new innovative mechanism to support you in understanding policy and practice direction on a variety of topics. During a huddle, you will have the opportunity to engage in discussion with CARNA’s practice advisors so that you will have a better understanding of CARNA nursing policy documents and/or emerging policy and practice topics.

Register at nurses.ab.ca/events.
NEW RULES FOR MEDICAL ASSISTANCE IN DYING REPORTING NOW IN EFFECT

ON Nov. 1, 2018, the Government of Canada’s new *Monitoring of Medical Assistance in Dying Regulations* came into effect. Requests in progress before Nov. 1, 2018 are not subject to the new rules.

Physicians and nurse practitioners are now required to file reports at each step in the process, including when they receive a request. Pharmacists who dispense any substance for medical assistance in dying will also be required to report basic information.

To streamline reporting:

- All practitioners will report through the AHS Care Coordination Service.
- Forms already in use are being updated to incorporate the federal requirements.

The AHS Care Coordination Service will collect data on behalf of the Medical Assistance in Dying Regulatory Review Committee for reporting to the Alberta minister of health and Health Canada. As well as making it easier for practitioners, this process will provide a safeguard against non-compliance with the regulations, enacted under the *Criminal Code*.

Practitioners are also required to submit specific information to the Office of the Chief Medical Examiner within 24 hours of the patient’s death.

WHERE TO FIND THE FORMS

You can find forms in MyCarna or on the AHS website under the forms tab. A summary detailing what to report and when, FAQs and other resources are also posted there. A secure RightFax has been set up to submit completed forms to the AHS Care Coordination Service. RN

QUESTIONS?

Please contact maidreporting@ahs.ca.
MEETING OF DEC. 7, 2018

No more fees for education program re-approval

CARN A will no longer charge fees for nursing education re-approval but will still charge honoraria, travel and accommodation fees for new program approval. Internal efficiencies mean that we no longer need cost recovery measures.

Supporting harm reduction in nursing care

We support integrating harm reduction into the care RNs and NPs provide. Council endorsed Harm Reduction and Substance Use (2018), a joint position statement from the Canadian Nurses Association, Canadian Association of Nurses in HIV/AIDS Care, and Harm Reduction Nurses Association. They also approved the CARN A document Harm Reduction Practice Advice (2018).

Preparing to update Bylaws

Council approved draft revisions to CARN A’s Bylaws related to the amendments to the Health Professions Act and the Registered Nurses Profession Regulation. The revised Bylaws were then posted for member and stakeholder feedback. At the March meeting, council will vote on whether or not to approval the final draft.

Three documents updated

- On Nov. 1, 2018 new regulations came into effect for monitoring medical assistance in dying. Physicians and nurse practitioners are now required to file reports at certain stages, including when they receive a written request for medical assistance in dying. Council approved revisions to Medical Assistance in Dying: Guidelines for NPs (2018) to align with the new regulations.
- Council approved changes to Medication and Vaccine Injection Safety Guidelines (2018) to reference the 2017 Alberta Health Alberta Vaccine Cold Chain (AVCC) Policy, as well as changes to the wording of Guideline 1(d) in the document. This change allows for the use of a multi-dose vial beyond 28 days if specified by the manufacturer.
- Council approved revisions to Complementary and Alternative Health Care and Natural Health Products Standards (2018). The revisions provide clarity for members in understanding their responsibilities and accountability related to complementary and alternative health care and natural health products, which will help ensure patient safety. RN

UPCOMING PROVINCIAL COUNCIL MEETING:
March 7–8, 2019
Nursing is changing.

**AR NET is changing with it.**

For details, visit arnet.ca

Changing to a single application form

Changed application dates

New phone number and toll-free number

And more changes planned for 2020

Your charity. Our health.

*Dedicated to quality health care by supporting lifelong learning for Alberta RNs.*

Please Give. arnet.ca
Albertans gain online access to their health records

MyHealth Records is an online application where adult Albertans can:

- View medications dispensed from a community pharmacy. Medication history includes any medication dispensed up to 18 months prior to signing up to MyHealth Records.
- View immunizations administered in Alberta. Users will also be able to enter immunizations received outside of the province.
- View the results of 59 kinds of common lab tests completed within 18 months of the sign-up date.
- Record blood pressure and blood glucose.
- Keep journals to track mood, sleep, weight and fitness goals.
- Upload and track information from health devices, including blood pressure monitors, blood glucose meters and fitness trackers like FitBit.
- Print out reports and health data to share with care providers.

MyHealth Records empowers patients to manage their care by providing a secure and convenient place to view their health records and record their health information to later share with their care providers. Users will need to obtain a MyAlberta digital ID, which involves a comprehensive verification process. Information will be protected using both server authentication and data encryption. A privacy impact assessment has been completed to ensure MyHealth Records maintains personal privacy and third-party security firms will test the site’s security on a regular basis.

Immediate access to lab test results

With MyHealth Records, Albertans can access common lab test results as soon as a result is made available. For specialized or otherwise sensitive tests, patients will receive the results directly from their care provider. All lab tests found on MyHealth Records will include clinical abstracts to explain test results and individuals can call the help line to connect with a public health nurse if they have further questions.

Integration with Connect Care

MyHealth Records and Connect Care (the provincial clinical information system) will be fully integrated systems designed to work together to provide a seamless experience.

When Alberta Health Services (AHS) launches the public-facing portal of Connect Care later in 2019, it will be integrated within MyHealth Records, providing Albertans with detailed health records from AHS hospitals, programs and facilities.

More features coming soon

More enhancements will be added to MyHealth Records in the coming months and years including:

- The ability to share online health records with other adults, such as family members and caregivers.
- Access to comprehensive health records from hospital visits.
- Schedule, track or cancel appointments, tests and treatments arranged with an AHS care provider.
- And much more! RN

For more information, visit alberta.ca/myhealthrecords.
To restrain or not to restrain?

Tyler is in the first year of his career as a registered nurse and was recently hired into a casual position at a long-term care facility. While completing his morning rounds, he sees Tracey, a licensed practical nurse, at the medication cart.

Tracey tells Tyler that one of her clients, Mr. Brown, who has dementia, is very unsteady on his feet and frequently tries to get out of bed by himself. “He requires assistance getting in and out of bed, and neither I nor the health-care aides have had time to help him yet. He had a fall last week,” says Tracey. “I’ve tried persuading him to stay in bed until someone can assist him, but the last time I checked on him, his right leg was practically touching the ground and he was pulling on the bedrail to try and get up.”

Tyler wonders if obtaining an order for a restraint would help ensure Mr. Brown’s safety while staff are busy caring for other clients.

WHAT SHOULD TYLER CONSIDER FIRST?

There are many clinical, ethical and legal considerations to think about before using restraints. First and foremost, it is Tyler’s responsibility to conduct his own assessment to determine Mr. Brown’s level of understanding about the use of a call bell and his risk of another fall. Based on Tyler’s assessment, there could be other interventions that can be integrated into Mr. Brown’s care plan such as more frequent checks, use of volunteers, health-care aides, or the presence of a family member.

He should also think about the legal considerations that come into play, including informed consent of clients, families and/or legal guardians, client safety and the use of least restrictive options.

Tyler reviews CARNa’s Practice Standards for Regulated Members and is reminded that he is accountable at all times for his own actions and is required to follow legislation, standards and policies relevant to his practice setting. He also remembers his employer has a “restraint as a last resort” policy and procedure. CARNa’s Practice Standards for Regulated Members outline that he is expected to:

- Use appropriate information and resources that enhance client care and the achievement of desired client outcomes.
- Protect and promote a client’s right to autonomy, respect, privacy, dignity and access to information.
- Collaborate with the client, significant others and other members of the health-care team regarding activities of care planning, implementation and evaluation.

He also finds an ‘ethical model for reflection’ tool in the Canadian Nurses Association’s Code of Ethics for Registered Nurses and uses the reflection questions to help guide his decision-making.

WHAT DOES TYLER DO?

Tyler decides to conduct his own assessment of Mr. Brown. He asks Mr. Brown why he wants to get out of bed by himself. Mr. Brown responds, “It’s time for me to go to work. I’m going to be late.” Knowing that Mr. Brown has been diagnosed with dementia, Tyler takes some time to talk with Mr. Brown and replies “well, let’s get you up and out of bed for breakfast so you aren’t late for work.” He tries redirecting the conversation and is successful with encouraging Mr. Brown to eat his breakfast in the dining room. As he continues talking with Mr. Brown, a health-care aide enters the room to help Mr. Brown with his morning care.

After ensuring Mr. Brown’s safety, Tyler returns to the nursing station and calls Mr. Brown’s daughter. He shares his concerns with her and learns more about his daily routine while living at home, in order to better support his care. Tyler also explores ways in which Mr. Brown’s family can work collaboratively with the staff to ensure his safety without the use of restraints. In the meantime, Tyler asks one of the usual volunteers to keep Mr. Brown company, while Mr. Brown’s daughter makes plans to visit later that day.

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.
Tucked into the bustling centre of the Stollery Children’s Hospital lies a group of passionate women who are working to support Indigenous families and help bridge barriers in our health-care system.

Awasisak (A-WAH-SI-SICK) is the Cree word for “children” and is the only program of its kind in Canada. Originating in 2016, this team has rapidly grown from just one to six people. The team includes a registered nurse, a pediatric social worker and a hospital host. The program aims to build supports around discharge for patients and their families and was developed out of feedback from talking circles, a traditional Indigenous practice where individuals take turns speaking freely and uninterrupted.
“More than anything, this program is designed to facilitate and comfort Indigenous families at the Stollery who are uncomfortable in our health system,” explains Hailea Purcell, registered nurse and member of the Awasisak team.

How do RNs support Indigenous patients?

Purcell landed her dream job just a few years after graduating from nursing school at the University of Alberta. After her initial preceptorship at the Royal Alexandra Hospital emergency department, her goal was to venture to northern Indigenous communities. In the remote community of Fort Smith, Northwest Territories, patients experience difficulties accessing appropriate health-care services. Many northern nursing stations also face challenges such as staffing shortages. For many individuals in northern Indigenous communities, coming to Edmonton for services is the best option. Often families drive for hours and when they arrive they may face prejudices in the health-care system and don’t necessarily feel at ease or comfortable in health facilities. Her previous experience working in a remote Indigenous community and personal experiences as an Indigenous woman help Purcell understand the barriers that many Indigenous families face in accessing health care.

The Awasisak Indigenous Health Program combines her love of nursing and her connection to the Indigenous community. As the Indigenous RN case manager, Purcell provides discharge summaries to patients’ home communities. This support system aids community leaders to make sure the transition from hospital to community is smooth. In collaboration with the Stollery staff, she can ensure the family is being heard and understood.

What medical services are available?

Through her medical background, Purcell can assist and facilitate if families have difficulty understanding procedures. With facilitation and support from the Awasisak program, Indigenous families at the Stollery can feel more comfortable and confident returning to their communities to continue care. Purcell communicates with nurses in remote Indigenous communities to establish the appropriate supports for the children. If communities are lacking in supports, she can facilitate teaching, provide educational packages to nurses or arrange to use telehealth for appointments.

If followups aren’t appropriately made, children may end up returning to the Stollery and in some cases this compromises their recovery. Purcell explains that she can arrange communication for these families and in some cases even schedule their appointments. The most fulfilling aspect of Purcell’s experience with Awasisak is knowing that Indigenous families feel supported and their children are receiving the care that they need.

Even the process to get a medevac for scans into some of these northern Indigenous communities can be very extensive, where some of the services are far less accessible than in urban areas.

“More than anything, this program is designed to facilitate and comfort Indigenous families at the Stollery who are uncomfortable in our health system,” explains Hailea Purcell, registered nurse and member of the Awasisak team.

What else does the Awasisak program offer?

Along with providing medical supports, Purcell and the Awasisak team educate hospital staff on Indigenous cultures and traditions and the importance of remote and rural community knowledge. Working closely with their social workers, Purcell aims to help families and patients feel comfortable by supporting culturally-responsive care in their discharge. In addition, the Awasisak program works tirelessly to provide a space for Indigenous families through sharing circles (which are traditionally used to find resolution for conflict), drumming circles (a way of bringing healing to Indigenous peoples in a colonial institution), and much more. The connection the Awasisak team makes with Indigenous families is the most rewarding part for Purcell. “It’s all about learning everyone’s story,” Purcell emphasizes the physical, mental, emotional and spiritual support for families and the dedication of her team.

In addition to barriers such as access to services, some Indigenous families face adversity when communicating with medical staff. The Awasisak program has some language services in place to assist Indigenous families, such as Cree translation, to increase communication between patients, families and medical staff. Awasisak advocates for these
families and assists in breaking language barriers. Culturally, medical staff and Indigenous families may have alternate interpretations of health. This difference in beliefs can often cause unclear communication and lack of understanding between patients and medical staff.

What is CARNA doing?
Currently, with the aid of Indigenous Cultural Advisor Amanda Gould, CARNA is developing a project regarding a grant for human rights with surrounding initiatives to address discrimination of Indigenous people in Alberta’s health system. With the help of Indigenous people, subject matter experts and nurses, CARNA will be working to revise policy and develop content for staff and members. Beginning internally, staff within CARNA are learning about Indigenous issues through lunch and learns, ceremonies such as blanket exercises and sharing circles, and a variety of materials across multiple media.

By learning together as an office, CARNA staff will gain confidence in Indigenous issues so that they can better develop resources on Indigenous health. Through changing the perspectives in the office, it will create a ripple effect to the outlying issues in Indigenous health in our province. Awasisak and CARNA both aim to face the issues in Indigenous health and work to improve Alberta’s health system. Gould praises Indigenous advocacy, stating “it’s key to have that support, so there is a feeling of safety, ensuring patients are heard and all can receive quality care.”

What does the future hold?
As an Indigenous woman herself, Purcell and the other staff at Awasisak can understand what life is like for Indigenous people and the inequalities they face. Having developed relationships in Indigenous communities creates a deeper connection for the team. Patients and families can feel safe from prejudice and can relate to the women at Awasisak, which gives them a sense of security and comfort. The team creates close relationships with the parents and the children at the Stollery and they maintain these connections even after the patients return home.

“I hope to go to each community eventually and see them firsthand,” says Purcell. In addition to her experience at Awasisak, she would like to travel to multiple remote and rural Indigenous communities and establish an even deeper connection with patients and families as well as the health-care teams in those areas.

In such a short amount of time, Purcell has found an inspiring position to improve the supports for Indigenous families. “I feel I was meant to be in this position, I’m truly thankful I can help individuals while being passionate about my career.” This experience with Awasisak has inspired her to improve the lives of Indigenous people in health care.

Programs like Awasisak advocate for Indigenous patients and their health, and furthermore, they help patients feel that someone is on their side during their treatment.

References
We’ve moved!

You can find our new office at:
11120 178 street NW
Edmonton, AB  T5S 1P2

We’ve relocated to a new building just a stone’s throw away from our old building. The move will help us address problems including a growing list of costly upgrades and increasingly crowded quarters. We’re excited to move into a new home where we’re better equipped to provide the best service to our members and the public.

COMING SOON:
The next big thing in professional development

We are excited to announce a new online learning platform! Further your professional development and support your continuing competence with learning modules, case studies, webinars and much more. You can take and track CARNA education in a confidential and secure environment anytime, anywhere.

Keep your eye out for the new system launching in late February! More information coming soon.
We have a new look!

Just as the nursing profession has grown immensely, we too have grown as an organization. To represent and celebrate this growth, we have adopted a new logo, new colours and a new tag line: protecting the public, evolving the profession.

THE ICON
Our new icon embodies our ongoing evolution as a collaborative, dual-mandate organization. The organic, flowing appearance of the icon—an abstract “C”—speaks to our dedication to advancing the nursing profession while protecting the public.

THE COLOURS
Our new muted, gender-neutral colours are timeless and approachable. Reflecting the relational aspects of CARNA as an organization while touching on the diversity of nursing as a profession.

THE TAG LINE
Protecting the public, evolving the profession.
Our new brand is focused on articulating how we deliver on our dual mandate and our new tag line will remind CARNA and everyone we encounter of the important role we play.

Protecting the public, evolving the profession.
Covenant Health is one of Canada’s largest Catholic health care organizations serving 12 vibrant urban and rural communities across Alberta including: Banff, Bonnyville, Camrose, Castor, Edmonton, Killam, Lethbridge, Medicine Hat, Mundare, St. Albert, Trochu and Vegreville. Join our team and experience one of Canada’s Most Admired Corporate Cultures.

CovenantHealth.ca/careers
The opioid crisis has propelled harm reduction into the collective consciousness. But what does harm reduction actually entail and what does it mean for nursing care across the province and nationwide?

Harm reduction, in the context of substance use, encompasses programs, policies and a philosophy of care centred on helping people lead healthier lives without necessarily reducing substance use.
Harm reduction centres on minimizing the harmful consequences of substance use and can include:

> Providing sterile needles to reduce possible transmission of blood borne illnesses.
> Distributing Naloxone which can reverse the effects of an overdose.
> Providing access to safe consumption sites (SCS) where substance use is supervised and medical assistance is available.
> Advocating for ethical social policy such as the decriminalization of illegal substance use.

Harm reduction began at a community level in the 1980s when access to sterile syringes and condoms were increasingly important due to growing concerns about HIV. Nurses worked alongside communities from the beginning and many programs focused on relational care and innovative public health strategies. There is substantial evidence supporting harm reduction with many programs reducing both health-care costs and improving access to care for many marginalized communities.2

In Canada, many health and political leaders have endorsed moving away from prohibitionist policy, as seen with the legalization of cannabis. However, harm reduction is not a new development.3 Many community agencies and nurses have been providing evidence-based harm reduction-centred care for decades. Alberta has been a leader in advancing harm reduction as seen with initiatives such as Edmonton’s Streetworks founded in 1989, Calgary’s Safeworks founded in 1997, Lethbridge’s ARCHES founded in 1986 and the innovative province-wide Naloxone distribution program and Canada’s first SCS in an acute care hospital.4

While harm reduction began as a grassroots movement within the community, there has been a shift to integrating harm reduction into acute care and as a tenet of nursing practice. On a national scale, the Canadian Nurses Association has released supportive position statements and papers on the public health approach.5 Yet, increased support for harm reduction remains challenging in environments where many policies and mandates do not explicitly guide practice.6

This changing landscape was partially what led to the formation of the Alberta Nurses Coalition for Harm Reduction (ANCHR). Founded in 2016, ANCHR is a volunteer-led specialty practice group recognized by CARN. Its aim is to support nurses across the province in integrating a harm reduction approach to care and advancing harm reduction as an integral aspect of nursing care. ANCHR came together after a decision by the founding members that there needed to be more collaboration and communication amongst nurses working in the harm reduction field. The founding members had heard from many nurses across the province that they felt isolated at times in their work, struggled to access resources or up-to-date research and were unclear in their roles as care providers.

ANCHR is committed to supporting and educating nurses province wide through sharing current news and research on social media and its website to help connect nurses to policy, research and education events. The website also features the “Ask ANCHR” section, where nurses can submit concerns or questions and receive an evidence-based response from the ANCHR team.

Beyond direct practice, ANCHR aims to advance nurses’ political engagement. ANCHR supports advocating for an increased consideration of front-line care provider perspectives in policy and program development, as well as collaboration with national advocacy groups such as the Harm Reduction Nurses Association. It also recognizes the importance of working with community members and individuals who use substances by seeking their expertise on policies, programs and care that directly affect their lives.

While harm reduction has advanced substantially in the past few years, there are still challenges on the road ahead. Harm reduction, while both ethical and evidence-based, is still intensely polarizing. Many of the decisions to fund and support harm reduction programs are not grounded in evidence or ethics, but in moralistic judgments on substance use. There are also issues in scalability, with many nurses struggling with burnout, as well as a lack of education and support when working with marginalized communities.

Although it faces these challenges, ANCHR is primed to work alongside community members, nurses and decision makers in advancing harm reduction across Alberta. The group seeks to ensure that nurses are supported and that all individuals, regardless of their substance use, receive ethical and compassionate nursing care. RN

References:
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WEB-BASED TOOL strives to reduce DEMENTIA CAREGIVER BURNOUT

BY WENDY DUGGLEBY, PhD, RN; KATHYA JOVEL RUIZ, BScN, RN; JENNIFER SWINDLE, PhD

DEMENTIA IS THE MOST COMMON CAUSE OF DISABILITY AMONG CANADIANS OVER THE AGE OF 65 YEARS. PEOPLE WITH DEMENTIA OFTEN LIVE AT HOME AND RECEIVE CARE FROM FAMILY OR FRIENDS. AS A RESULT, CAREGIVERS OFTEN EXPERIENCE NEGATIVE PHYSICAL AND PSYCHOLOGICAL HEALTH ALONG WITH SOCIAL AND FINANCIAL DIFFICULTIES, ALL OF WHICH CAN NEGATIVELY IMPACT THEIR QUALITY OF LIFE.
Due to their flexibility and ease of access, web-based interventions have become increasingly popular as a means to support caregivers. Following years of research, a Pan Canadian team developed My Tools 4 Care (MT4C), an interactive, self-administered, portable toolkit to support caregivers of community-living persons with Alzheimer’s disease and related dementias (ADRD) and multiple chronic conditions (MCC). MT4C contains five main sections:

- **About me**: An interactive section allowing users to upload pictures and PDFs, and write their thoughts.
- **Common changes to expect**: Information on the transitions caregivers can expect, along with quotes from other caregivers.
- **Frequently asked questions**: Questions suggested by caregivers from a previous research study with corresponding answers provided by experts and practitioners.
- **Resources**: Links to reliable websites, relevant books, resources and brochures. Contains a section to add additional resources.
- **Important health information**: An interactive section allowing users to enter health information about the person with ADRD, create a contact list and upload relevant files and PDFs.

One hundred and ninety-nine caregivers of community-living older persons with ADRD and MCC from Ontario and Alberta participated in a study. It evaluated MT4C for its effectiveness in increasing hope, self-efficacy and health-related quality of life.

**APPRAOACH**

A pragmatic randomized control trial was conducted between June 2015 and April 2017. Participants were recruited from local Alzheimer’s Societies in Alberta and Ontario and through newspaper ads in Alberta. Following screening, eligible participants were randomly assigned into a treatment (MT4C; n=101) or educational control (n=98) group. Caregivers in the treatment group used MT4C for three months and were instructed to use the site at their convenience. All information entered by participants was kept confidential, including from the study team. Research assistants phoned participants in both groups at baseline, one, three and six months to collect data on hope (Herth Hope Index), self-efficacy (general self-efficacy scale), and quality of life (short form – 12 item [version 2] health survey).

**HIGHLIGHTS OF FINDINGS**

On average, caregivers were 64 years of age (SD 12), most were female (81 percent), Caucasian (93 percent), and either the spouse (49 percent) or adult child (46 percent) of the person with ADRD.

Persons with ADRD had a mean age of 80 years (SD 8) and on average 10 chronic conditions (SD 4). In the treatment group, 73 percent of caregivers used MT4C at least once over the three-month period. At one month, participants spent most of their time on Section 1: About me. By three months, this had changed to Section 2: Common changes to expect.

There was a significant difference in hope at two months between the treatment and control groups. The treatment group reported higher hope, specifically in the confidence of their ability to have a positive future, compared to the educational control group. No statistically significant differences between treatment and control groups were found in quality of life or self-efficacy. Loss of participants throughout the study, and the fact that not all caregivers in the treatment group used MT4C, may explain these results.

**IMPLICATIONS FOR PRACTICE**

Caring for a person with ADRD can have negative consequences for caregivers. The majority of persons with ADRD live with additional MCC which can add to the stress and complexity of the caregiving experience. Given the 24/7 nature of caring for a person with ADRD and MCC, accessing resources can be challenging. A web-based intervention like MT4C is portable and flexible, allowing caregivers to focus on what they need without time constraints. An intervention like MT4C has the potential to increase hope, which has been found to improve quality of life in studies of caregivers of persons with ADRD. This, in turn, can improve the caregiving experience allowing the person with ADRD to remain at home for longer.

**FUNDING ACKNOWLEDGEMENT**

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**RESOURCES**

MT4C is available at mytools4care.ca. For more information regarding this study, please contact Wendy Duggleby, professor, faculty of nursing, University of Alberta, at wendy.duggleby@ualberta.ca.

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ARN Careers is a job board created in partnership with the College and Association of Registered Nurses of Alberta and Madgex.
2018 marked the 100th anniversary of one of the most catastrophic public health crises in modern history, the 1918 influenza pandemic, also known as the Spanish flu. The pandemic infected one-third of the Earth’s population, about 500 million people. By the time it subsided two years later, an estimated 50 million people had died.

Everyone has a part to play in infection control. The spread of infection is not just a local concern, but provincial, national and international in our current global environment.
Global
Of the top 10 global causes of death in 2016, three were related to infectious diseases, including lower respiratory infections, diarrhoeal diseases and tuberculosis.

In September 2018, 100 passengers on a flight from Dubai to New York fell ill with respiratory symptoms. Health officials were concerned passengers might be carrying a serious respiratory illness called MERS-CoV (Middle East respiratory syndrome coronavirus) and quarantined the plane until further health checks could be completed. Testing showed that several were positive for the influenza virus, which can be easily spread when people are in close contact or in contained spaces such as airports and planes for several hours.

Climate change will have enormous implications for human health especially related to vector-borne and water-borne infectious diseases. Rising temperatures and changes in rainfall patterns will increase the infectious diseases transmitted through insect vectors, as well as contaminated water. Infections such as West Nile virus and malaria emphasize the importance of thorough assessment and carefully taking a complete client history.

Health care-associated infections in hospital
It is not likely that all infections can be eliminated, but there is evidence a high proportion could be prevented. When reviewing harmful events that clients experienced during a hospital stay, the percentage of health care-acquired infections (HAI) was equally as high as that of health care medication-associated conditions at 37 per cent.

Inadequate infection control can result in increased infection rates, antibiotic-resistant organisms and the closure of nursing units and health-care facilities. Infections acquired in hospital are a major source of client harm, occurring in one out of every 41 hospitalizations (2.4 per cent). Of the $685 million that harmful events cost health-care systems, $281 million, or 41 percent of the total cost, was associated with HAIs. The most common types of HAIs are urinary tract infections, pneumonia, post-procedural infections, aspiration pneumonia and sepsis. Transmission of infections, such as methicillin-resistant staphylococcus aureus and clostridium difficile diarrhea, continues to impact client care in health-care agencies and in the community.

Infection prevention and control in the community
Although the current focus on adverse events and infection prevention and control (IP&C) is primarily within the hospital, nursing care provided in the broader community also provides opportunities to implement best practices. As the health system has changed and evolved, clients are going home earlier and the health care they need is being provided in the community. Institution infection control practices have to be adapted to the home environment. Family members, friends or informal caregivers must be taught the principles that will keep both the client and caregivers safe from infection. Basic infection control to reduce the risk of infection of both the client and caregivers will be particularly important in a pandemic as it is anticipated that most of the care and prevention measures will take place in the home.

Be involved, be informed, be an advocate
Your solid knowledge base as a nurse equips you to play a critical role in client safety. Listed here are a number of ideas and resources on infection prevention and control to help you assess your practice and your practice setting and to contribute to ensuring the safety of your clients.

Safer Healthcare Now!
Safer Healthcare Now! (SHN), a Canadian Patient Safety Institute program, provides evidence-based interventions to reduce preventable harm and improve patient safety and care in hospitals and health-care facilities. Since it was launched in 2005, over 700 organizations have enrolled in Safer Healthcare Now! The interventions combine clinical and patient safety improvement expertise and are designed to engage and empower by providing front-line staff and managers with resources to implement, measure and evaluate patient safety initiatives. Interventions related to IP&C are central line-associated bloodstream infection, surgical site infection and ventilator-associated pneumonia. Getting started kits and worksheets are available free at patientsafetyinstitute.ca.

Choosing Wisely Canada
Since Choosing Wisely Canada launched in April 2014, they have published over
250 recommendations across a large number of clinical specialties. The recommendations identify commonly used tests and treatments that are not supported by evidence and could expose patients to harm. The list of questions that nurses should ask related to unsupported IP&C practices have been developed in collaboration with Infection Prevention and Control Canada (IPAC).

While each Choosing Wisely Canada recommendation is a simple declarative statement about a test or treatment clinicians and patients should question, there are many ways to implement it. The Canadian Nurses Association partnered with Choosing Wisely Canada in 2016 to bring the nursing perspective.

Local context, culture and capabilities matter. Choosing Wisely Canada encourages and supports local ingenuity in the implementation of the recommendations.

**Antibiotic overuse**

Every year, over 25 million antibiotic prescriptions are written for human consumption in Canada. Antibiotic overuse is a major contributor to antibiotic resistance and is threatening our ability to treat common infectious diseases. New resistance mechanisms are emerging and spreading globally, which have been expedited by the overuse of antibiotics. A growing list of infections—such as tuberculosis, gonorrhea, and bacteria that cause pneumonia and urinary tract infections—are becoming harder, and sometimes impossible, to treat as antibiotics become less effective.

One of the ways that we can help fight antibiotic resistance is to use antibiotics more wisely.

Using antibiotics wisely improves patient outcomes, reduces side effects and antimicrobial resistance and optimizes resource utilization. There are over 20 Choosing Wisely Canada recommendations that encourage judicious antibiotic use, created by over 15 national specialty societies.

In Alberta, there are six provincial IP&C surveillance protocols in place across Alberta Health Services and Covenant Health to measure antibiotic-resistant organisms.

**CHEEP/CHEER**

Covenant Health’s IP&C program and stakeholders determined that despite application of routine practice and other interventions, they had continued hospital-acquired transmission of antibiotic-resistant organisms and clostridium difficile infections. Hospital staff were cleaning their hands, shared equipment, client care environments and clients. However, the actual approaches, practices and processes were performed by a variety of staff members, in a variety of different ways and with varying levels of account-

ability. There was no mechanism in place to measure patient outcomes related to hospital-acquired antibiotic-resistant organisms and clostridium difficile infections. The CHEEP/CHEER (clean hands, environment, equipment, patient/resident) program began. These are care bundles to improve the standard of care and client outcomes by promoting consistent implementation of a group of effective interventions. They found that during the project period, the majority of the units/facilities had a decrease in HAIs with antibiotic-resistant organisms and clostridium difficile infection transmission compared to the previous six months or during the same six months in the previous year.

**STOP! Clean Your Hands campaign**

Stop! Clean Your Hands is a national hand hygiene campaign aimed at promoting the importance of hand hygiene in reducing the occurrence of HAIs in Canada. The Canadian Patient Safety Institute website offers a number of tools and resources related to hand hygiene best practices from national and international levels.

Simple hand washing is the first line of defence and consistently identified by infection control experts as the most important thing we can do to prevent and control infection. Since the time of Florence Nightingale, nurses have always understood the importance of maintaining their vigilance with respect to hand washing and infection control practice.

**Consult your infection control practitioner**

Infection control is a rapidly evolving science. Nurses can access some of the best informed individuals on current best practice through their employer. Infection prevention and control practitioners (ICPs) employed by health-care facilities and health regions are responsible for developing, implementing and evaluating policies, procedures and practices that impact the prevention of infections.
The importance of a healthy organizational culture that promotes and has a strong commitment to safety in infection control was shown in a study by Yassi et al. (2007). Their study found that compliance with infection control procedures was significantly affected by the organization and environment. They found that while education is important in building knowledge and skills, the more important result is demonstrating organizational commitment to keeping workers informed and confident that the organization can manage present and emerging infections.

Nurses have always been leaders in infection control practices and knowledge of infection control practices is continually growing and changing. Nurses in all roles and settings can demonstrate leadership in IP&C by using their knowledge, skill and judgment to advocate for the implementation of current best practices in their workplace.

Since the time of Florence Nightingale, nurses have always understood the importance of maintaining their vigilance with respect to hand washing and infection control practice.

References

- WHO spotlight. Influenza: are we ready? Accessed October 2018
- IPAC. Definition of an ICP. Accessed October 2018 from ipac-canada.org

Integral competencies to the role include:

- knowledge of infectious disease processes
- microbiology
- routine practices and additional precautions
- surveillance (counting infections)
- reporting infection rates to appropriate caregivers
- answering questions regarding infection control practices
- assisting staff and clients with implementation of appropriate interventions
- provision of education

ICPs are dedicated to the discipline of IP&C and many of them are certified in infection control as they have passed an examination set by the Certification Board of Infection Control. Currently, 156 RNs in Alberta are members of IPAC and are practising in the area of IP&C.

**Access publications on best practice**

The *Prevention & Control of Emerging and Persistent Infectious Diseases Report*, posted on the Public Health Agency of Canada website, contains infection control guidelines for acute care, long-term care, ambulatory and home care practice settings. Additional information can be found at the Infection Prevention and Control Canada website, the Public Health Ontario website, Alberta Health Services and in CARNA’s documents.

**Apply best practice to products and technology**

While IP&C principles do not change, specific clinical practices may evolve as a result of new evidence and technology. New products are constantly emerging that can be used to increase safety and decrease the incidence of infection. These products may be helpful in assisting with safer provision of care, but it is still up to the nurse to use them according to the manufacturer’s instructions and to ensure that other caregivers follow safe care practices. In response to the spotlight on patient safety and on IP&C in particular, new programs and strategies to address identified issues are often developed. The critical issue is how hospitals and other health-care practice settings, which are already stressed in terms of capacity and resources, can implement these changes. Nurses can, and should, be advocates and implement changes. Today, more than ever, nurses are provided with an excellent opportunity to review current best practices and/or advocate for increased infection control resources.

**Advocate for a culture of safety**

Infection control is a crucial building block for a culture of safety and prevention.
What is my responsibility following a privacy breach?

BY TAMMY KOHUT, MN, RN, CARNA POLICY AND PRACTICE CONSULTANT

You discovered that your client’s health information has been accessed inappropriately by a staff member on your unit. What should you do next?

Health information is sensitive and patients trust you to take necessary steps to protect it. Your responsibility as a regulated member is to ensure you understand and comply with the legislation and policies in your area of work with regards to the Health Information Act (HIA).

The Alberta Health Information Act and Health Information Act Regulations were recently amended to include mandatory reporting of privacy breaches. Further amendments include fines of up to $50,000 for failing to comply with the new legislation.

WHAT IS A PRIVACY BREACH?
Privacy breaches can happen in any setting in a variety of ways. A privacy breach is “a loss of, unauthorized access to, or unauthorized disclosure of personal information or individually identifying health information.” Examples include:

- accessing an individual’s health information in error
- hacking of computers or servers containing health information
- malware, phishing or other computer attacks
- stolen paper files from a home, office or vehicle
- improper disposal of records
- emails/faxes/texts of health information to an unintended recipient

- lost or stolen laptops, USB sticks, phones, tablets or other mobile devices containing personal health information
- accessing patient files by someone who should not have access to that file for medical reasons
WHAT IS MY RESPONSIBILITY FOLLOWING A PRIVACY BREACH?

Your responsibility will depend on your role as a custodian or affiliate within the organization.

Custodians are designated by the *HIA Regulations* and include:

- Alberta Health Services
- Covenant Health
- Nursing home operators
- Occupational health nurses employed by non-health related companies (e.g., oil companies) to provide health services to the company’s employees
- Self-employed nurses

If you are a custodian, your role is to ensure there are proper safeguards to avoid potential privacy breaches. In the event of a breach, your role is to assess the risk of harm and notify the Office of the Information and Privacy Commissioner (OIPC), the minister of health and individuals affected by the breach “as soon as practicable.”

Most CARNA members are affiliates of a custodian. An affiliate is:

- Employed by a custodian
- Performs a service for a custodian as an appointee, volunteer or student, or under a contract or agency relationship with the custodian
- A health services provider who is admitting and treating patients at a hospital as defined in the *Hospitals Act*

As an affiliate, your role is to understand and comply with the legislation and your employer’s policies regarding collection, use, disclosure and security of personal health information.

HOW DO I REPORT A BREACH?

OIPC and the minister of health have reporting forms which can be found on the OIPC website (How to report a privacy breach) and the Alberta Health website (Health Information Act – Notification to minister of health report form). When completing these forms, remember to use non-identifying information to avoid further compromising the individual’s privacy. These websites have separate information documents that can assist in the notification process.

When notifying the individual, custodians are required to provide:

- Details regarding the breach
- Date or time period when the breach occurred
- Name of the custodian in control of the health information at the time of the breach
- Non-identifying description of the type of information involved in the breach
- Description of risk of harm to the individual
- Steps the custodian is taking/intending on taking to reduce the risk of harm to the individual and to reduce the risk of a future breach
- Steps the individual can take to reduce the risk of harm
- A statement that the individual may request an investigation be performed by the commissioner, including the contact information for OIPC
- Name and contact information of a person who can answer questions on behalf of the custodian
- Other information deemed relevant by the custodian

Further information about the reporting of breaches can be found in section 8.2 (4) of the *Health Information Act Regulations*, accessible through the Alberta Queen’s Printer.

ARE THERE TIMES I SHOULDN’T NOTIFY THE INDIVIDUAL?

There are times when a custodian may determine it is not appropriate to give notice to the individual regarding the breach, including circumstances where it could be reasonably expected to result in a risk of harm to the individual’s mental or physical health. In this instance, the custodian must immediately give notice to OIPC of the decision not to notify regarding the breach and the reasons for the decision.

REFERENCE:

Mental Health or Hospital Acts contain specific procedures to address the issue of consent to treatment for those with a psychiatric disorder. This infoLAW will not touch on persons subject to those Acts but will focus on other adults who do not have the capacity to give or refuse consent to treatment on their own behalf. Examples include: a young adult living with a permanent developmental handicap; an adult temporarily unconscious due to injury or intoxication; and an older adult whose mental abilities have deteriorated.

Provincial/territorial statutes differ in their content. They may set out how consent to treatment is to be obtained when the patient does not have the capacity to consent. They may also stipulate how an advance directive for health care may be made. Nurses must comply with the applicable legislation in their jurisdiction.

What is meant by having the capacity to consent to treatment?

Having the capacity to consent to treatment means understanding the nature of the decision to be made and understanding the consequences of the decision, including the decision to decline treatment.

The legal presumption is that all adults have the capacity to consent to treatment. A nurse need not explore an adult’s capacity to make treatment decisions unless there is reason to believe he does not understand the nature of the decisions to be made or their consequences.

A person’s capacity may vary with time or with the nature of the decision to be made. An assessment of a person’s capacity may lead to different results at different times. Obtaining consent to treatment should therefore be considered a process rather than a single event.

Who decides on an adult’s capacity or incapacity?

The health care professional proposing the treatment is responsible for obtaining the patient’s consent. For example, if a nurse runs her own foot care business, she must obtain consent before providing care or not proceed. If a patient is clearly incapable of consenting, the nurse must adhere to the law on substitute decision-making in her jurisdiction. If the nurse is unsure of the patient’s capacity to consent, an assessment and determination is needed, with thorough documentation of the process and its outcome. Consultation with other professionals is recommended.

It is more common for the patient to be under the care of a physician who is proposing an overall treatment plan. This physician should make a determination of capacity if the circumstances warrant it, unless additional expertise is required. Because nurses have such close contact with patients, the information they gather may be of critical importance to the physician making the determination. Sharing relevant patient information between health team members is proper practice and is not a breach of confidentiality.
When an adult is deemed incapable, who makes decisions about their care and treatment?

Statutes tend to provide a hierarchy of substitute decision-makers. First priority is given to a court-appointed substitute decision-maker or person with a power of attorney for personal care or proxy. If these do not exist, authority falls to a spouse, or then to various family members in accordance with the statutory list. Careful documentation is essential when consent is obtained from a substitute decision-maker.

When devising a plan of care to meet the incapable adult’s current health needs, substitute decision-makers and health care professionals must consider and respect the patient’s previously known wishes or advance directives that were expressed when he was capable and apply to the situation, and the patient’s best interests.

What if emergency treatment is required?

When immediate medical treatment is necessary to save the life or preserve the health of a person who, by reason of unconsciousness or extreme illness, is incapable of either giving or withholding consent, the law considers this an emergency that justifies an exception to the usual rules of consent. Giving emergency treatment without consent is lawful if the delay that would result from obtaining a consent or refusal would put the patient at greater risk.

The fact that a person is in serious physical jeopardy does not nullify previously expressed directives regarding health care treatment if these directives become known to health care professionals and apply to the emergency situation. An Ontario court made this clear when it found a physician had committed battery when he personally gave blood transfusions to an unconscious MVA victim whose wallet card identified her as Jehovah’s Witness. The wallet card contained an explicit refusal of any blood or blood products but consented to non-blood intravenous fluids. The court found that she had clearly communicated a health care directive in the only way possible in preparation for just this kind of emergency.

Summary

Failure to obtain consent means the treatment cannot be legally given unless it is an emergency. Given the variations in the laws between provinces and territories governing consent procedures for incapable adults, it is important to follow your agency’s policies and procedures for obtaining consent in these situations. If you have questions or concerns, call CNPS at 1-800-267-3390.


2. infoLAW, Independent Practice (Vol. 4, No. 1, November 2004; Revision of September 1985).

N.B. In this document, the feminine pronoun includes the masculine and vice versa except where referring to a participant in a legal proceeding.

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Aesthetic nursing is the provision of specialized procedures for the purpose of cosmetic treatment including dermal fillers, volume enhancers, collagen stimulators, lipolysis and neuromodulators.

We developed this FAQ with the College of Registered Psychiatric Nurses of Alberta and the College of Licensed Practical Nurses of Alberta to inform all nurses in Alberta about their professional responsibilities and accountabilities related to aesthetic nursing practice. If you are looking for further guidance, please contact your respective organization. You can also find more resources at nurses.ab.ca.

Do aesthetic procedures fall within my scope of nursing practice?

Administering neuromodulators and dermal fillers are post entry-level competencies and are not taught in the entry-to-practice nursing programs. Neuromodulators, such as Botox®, require a client-specific order following an initial assessment by an authorized prescriber such as a physician, dentist or nurse practitioner. As aesthetic nursing procedures pose potential risk to the client, appropriate emergency support should be readily available.

The nurse providing an aesthetic procedure uses a skill set comprised of the following competencies:
- a sensitive and respectful manner of communication, a positive non-judgmental attitude and caring behaviours
- thorough knowledge of anatomy and physiology of the skin and underlying tissue
- thorough understanding of the medications and substances to be used
- strong analytical skills and clinical competence in this practice area
- provision of honest and factual counselling and advertising

In Alberta, RPNs, RNs and LPNs are authorized under regulation and have the education to administer medications and substances by injection. An order by an authorized prescriber is required before any nurse can administer schedule 1 medications and/or substances. The nurse is responsible and accountable to have the required education and experience to carry out the order.

In addition, LPNs are required to have direct or indirect supervision by a physician when providing aesthetic nursing procedures within their scope of practice. The physician must be trained in dermatology, on-site and available to assist as necessary.
Is there a difference between esthetic procedures and aesthetic procedures?
Yes. Many esthetic procedures do not need to be performed by a regulated health professional (e.g., facials, waxing, piercings, tattooing including semi-permanent makeup, etc.). These would not fall within the definition of nursing or health services but are included in the Personal Services Regulation under the Public Health Act. The individual performing these personal services could not use the protected title “nurse” and these hours would not qualify as practice hours.

Do I need further education to provide aesthetic procedures?
Yes. Nurses must have the additional education to practise competently and ensure public safety. At entry-to-practice, nurses do not have the competencies or education to administer dermal fillers, volume enhancers, collagen stimulators and neuromodulators. Nurses must be sure the education and training they take provides core competencies, including infection prevention and control best practices. On-the-job training may not provide the necessary competencies to practise aesthetic nursing safely as this requires specific education in anatomy and physiology of the skin and underlying tissue, assessment, and knowledge of neuromodulators and dermal fillers. Each nurse is responsible and accountable to ensure they have the knowledge to practise safely, competently and ethically.

Documentation and record keeping–Is it required?
Yes. Nurses are required to document the care they provide accurately and in a timely, factual, complete and confidential manner. All documentation and record keeping must adhere to the documentation and privacy requirements as defined by their regulatory body, employer policy and provincial legislation. These documentation expectations are the same across all practice settings.

Documentation is not separate from care and is not optional. It is an integral part of nursing practice and an important tool to ensure high-quality client care.

Do I need to obtain informed consent?
Yes. It is very important that the client understand risks, benefits and expected outcomes of treatment. Before providing any aesthetic nursing procedures, the nurse must obtain informed consent from the client for the specific procedure. Consent must be valid and current, and not have been retracted or withdrawn at the time of the procedure or treatment. Performing a procedure on a client without informed consent is considered unlawful and can result in professional conduct investigations and/or criminal charges regardless of whether the client is harmed or not.

For consent to be ‘informed,’ the nurse must explain the intervention, including alternative options, as well as the disclosure of risks and complications. Consent must be voluntary and cannot be coerced from the client through undue influence or intentional misrepresentation. It is the responsibility of the nurse providing the service to:

- Assess the client’s ability to understand the nature of the proposed procedure, any risks and complications, and the right of refusal. Consent is only considered valid if the client fully understands what they are consenting to.
- Ensure that the proposed procedure is only provided to a minor (under 18) when parent/legal guardian consent is also obtained prior and treatment is mutually agreed upon between parent/legal guardian and minor.
- Obtain consent in an ethical manner and document accordingly. Re-establish consent if there are changes to the client’s initial care plan or the client has changed their mind.
- Consent to the proposed procedure needs to be obtained each time the intervention is provided.

What are my infection prevention and control responsibilities?
Nurses must always ensure client safety. This includes preventing health care-acquired infections. If you are practising in a clinic or have a self-employed practice, it is important to use infection prevention and control (IP&C) best practices and follow IP&C policies.

The following routine practices are an important component of IP&C and should be used at all times:
- There should be dedicated hand-washing sinks and hand sanitizer stations.
- Follow the four moments of hand hygiene.
- Ensure the appropriate personal protective equipment is used for the procedure performed.
- Surfaces and equipment must be cleaned, disinfected and/or sterilized appropriately.
- Single-use devices must only be used once.
- Any waste, whether general or biomedical, must be disposed of safely and appropriately.

What do I need to know about liability and self-employed practice?
The Canadian Nurses Protective Society (CNPS) provides professional liability protection, as well as offering legal advice, risk management services and legal assistance. CNPS will only provide liability protection if you are providing professional nursing services. When working in collaboration with other health-care professionals, you should confirm each health-care professional has adequate liability protection.

RNs or NPs who engage in independent nursing practice by themselves, in partnership with other practitioners or by employing others, are considered to be self-employed. If you plan to start a self-employed nursing practice, you need to apply for recognition of your self-employed practice in order to have liability protection.
to report your practice hours and renew your practice permit. If you have questions, feel free to contact us at self-employed@nurses.ab.ca.

Who can prescribe neuromodulators and dermal fillers?
Medication listed on Health Canada’s prescription drug list can only be prescribed by authorized regulated health professionals. In Alberta, these health professionals include physicians, nurse practitioners, dentists and pharmacists who have been granted prescribing authority by the Alberta College of Pharmacy.

Neuromodulators, such as botulinum toxin, are schedule 1 medications and can only be prescribed by an authorized prescriber as outlined in the Government Organization Act and respective regulation for each health profession. Some dermal fillers are classified as schedule 2 medications and do not need a client-specific order unless required by employer policy.

Nurses must be satisfied that the practitioner prescribing the neuromodulator or dermal filler is authorized by their college to engage in this practice.

What are the rules governing prescribers?
Authorized prescribers must abide by the standards of practice developed by their regulatory college. The standards of practice governing physicians and nurse practitioners require them to personally assess a client prior to providing a prescription. Physicians and nurse practitioners can only prescribe neuromodulators and other medications on Health Canada’s prescription drug list when an in-person client assessment has been performed. Physicians can only provide a prescription for “office use” when they personally will be attending the patients for whom they will provide an order for injection. An office-use medication (e.g., a multi-dose vial) can be used for more than one patient attending a clinic.

What are the considerations for procurement and storage of medications and substances?
Medications and substances for administration by injection (prescription or otherwise) must be procured through legitimate means (e.g., through a pharmacy or the pharmaceutical company). Medications and substances procured by other means may not be the correct substance, may be beyond expiration date or may have been stored inappropriately, thereby altering composition, safety and efficacy. Pharmaceutical companies may have restrictions on who may procure medications and substances. A nurse should not use another health-care professional purely for the purposes of procurement. Nurses need to follow the manufacturer recommendations for storage and handling as outlined in standards, best practice guidelines and manufacturer recommendations. RN
EDUCATIONAL OPPORTUNITIES

NOTICEBOARD

EDMONTON/WEST

Annual general meeting
March 6, 2019 | Edmonton
nurses.ab.ca

Provincial council meeting
March 7–8, 2019 | Edmonton
nurses.ab.ca

Royal Alexandra Hospital
School of Nursing Banquet
May 3, 2019 | Edmonton

CENTRAL

Positive approach in dementia care workshop
July 29–30, 2019 | Olds
gnp-tee pasnow.eventbrite.ca

OUTSIDE OF ALBERTA

Nursing and health care 2019
Feb. 25 – 26, 2019 | Durban, South Africa
scientificfederation.com/nursing-2019

The submission deadline for events and reunions in the Spring 2019 issue of Alberta RN is March 1, 2019. Go to nurses.ab.ca for a complete and up-to-date listing of events and reunions or to submit an event for publication.

EDMONTON/WEST

NPAA Conference
April 6 – 7, 2019 | Calgary
albertanps.com

CARN A Awards Gala
May 10, 2019 | Calgary
nurses.ab.ca

CALGARY/WEST

FIRST YEAR RN EDUCATION SESSIONS

Register for these sessions just for new nurses at nurses.ab.ca/events.

Documentation: Principles and pitfalls
> Feb. 27, 2019

Are you a team player?
> March 20, 2019

Bullying in nursing: Recognition and recommendations
> March 27, 2019

Where is the line? Professional boundaries and why we need them
> March 13, 2019

It is our deepest regret to announce the passing of Yvonne Chapman.

Yvonne influenced many developments in the nursing profession during her 13-year career as executive director for the Alberta Association of Registered Nurses (now CARN A), including the development of the Nursing Profession Act in 1983, the establishment of graduate nursing education and the move to baccalaureate preparation for nurses.

Yvonne gained a reputation as a skilled negotiator and consulted on many national initiatives. She chaired the committee that established the Canadian Nurses Protective Society, a national professional liability foundation for registered nurses.

IN MEMORIAM

Ellis, Rachelle, a 1994 graduate of Mount Royal College, who passed away on Dec. 1, 2018 in Calgary.

Community Health Nurses & Nurse Practitioners Needed

CHNs and NPs will provide a primary health care approach to address overall health in Northern Alberta First Nations communities, this includes Primary Care and Public Health Services.

Assessment and Diagnostics are fundamentals for CHN professionals. NPs will diagnose health conditions, order treatments and prescribe medications. A hands-on, as well as comprehensive orientation program, gives instruction in expectation of clinical assessment and illness management. Public Health, Acute and Emergency Services are provided.

Relief in remote and/or isolated First Nations communities, offers a rewarding career choice, accompanied with a flexible schedule and this could be the career you have been looking for!

Apply today at www.travelnursing.ca or hr@travelnursing.ca.
Impetus for change

President John F. Kennedy famously said: “Change is the law of life. And those who look only to the past or present are certain to miss the future.” Change, whether something we initiate ourselves or have thrust upon us, forces a shift in perspective and can be a catalyst for growth.

This is certainly a period of change at CARNA. In January, staff completed the move into our new office building. All staff are reunited in one location; there is sufficient meeting space to accommodate both internal and external meeting needs and technology upgrades will allow us to work more effectively and efficiently. We have also rebranded CARNA with a new logo, colours and tag line, “Protecting the public, evolving the profession.”

There have also been significant changes in the regulatory environment. This issue of Alberta RN brings you up-to-date on the work being done to implement changes to the Registered Nurses Profession Regulation, including RN prescribing and ordering of diagnostic tests. The regulation comes into force on May 1.

What was less expected was the speed with which government passed Bill 21: An Act to Protect Patients. This bill amends the Health Professions Act and substantially changes the approach health professions must take to professional misconduct complaints related to sexual abuse and misconduct. The purpose of Bill 21 is to increase transparency regarding the disciplinary process and increase sanctions for these complaints, including mandatory cancellation of a health professional’s practice permit for sexual abuse and suspension for up to five years for sexual misconduct.

The Act recognizes that the nature of a therapeutic interaction can be quite different for different health professions and allows each health regulator to determine the criteria for establishing who a “patient” is by creating practice standards. Each profession can determine which consensual sexual relationships will constitute sexual abuse if a patient is involved and or if a patient is not involved. CARNA is currently developing this essential practice standard for registered nurses and it will come to provincial council in March for approval. It must then be approved by the minister of health. Some sections of the Act came into force on Nov. 19, 2018, but the practice standards will not come into force until March 31, 2019.

There are also a number of changes related to the process for handling complaints related to sexual abuse and sexual misconduct, including what information must be posted on a college’s website. This includes a requirement to make information on the website easily accessible to the public. CARNA was already making some technical changes to our website as well as rebranding it, so we are taking this opportunity to make information on the public look-up more accessible.

One change that is new to Alberta is a requirement for colleges to develop a patient relations program and make funding available to complainants for counselling if they lodge a complaint related to sexual abuse or sexual misconduct. CARNA is fortunate because similar programs already exist in other nursing jurisdictions which can serve as helpful models. For instance, the College of Nurses of Ontario has had such a program for several years. We are also working with other members of the Alberta Federation of Regulated Health Professions since there may be an opportunity for shared services related to the patient relations program.

Looking ahead, the provincial election in the spring and the federal election in the fall will introduce changes in policy and direction. At CARNA, we look forward to capitalizing on opportunities to enhance our ability to protect the public and evolve the profession.

Joy Peacock, BSN, MSC, RN
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upcoming ARNET events

Lethbridge Nursing Gala
05.03.19

ARNET’s 2019 Lantern Walk
09.20.19
The walk-and-talk in support of Alberta RNs
TICKETS ON SALE SUMMER OF 2019

CENTRAL ALBERTA Nursing Dinner
A Night in Black and White
An evening of laughter, reminiscing & wine
05.30.19

visit ARNET.CA for details
Cosmetic Injectors and Aesthetic Practitioner opportunities are on the rise. It's even more important now for practitioners to focus on patient safety, product efficacy and results.

Where does a nurse find out more about the advanced aesthetic industry?

May 3-5, 2019
Mount Royal University
Calgary, AB Canada

www.theaestheticsummit.ca

It's even more important now for practitioners to focus on patient safety, product efficacy and results.

Jason Olandesca BN, RN CCPE has been in the industry of Aesthetic Nursing since 2006. As a clinical trainer, practice advisor and advanced aesthetic consultant he has worked with advanced aesthetic clinics and cosmetic medicine practices across North America focusing on Practice Management, Medical Devices and Technology.

He is the CEO and Founder of GLOW MD INC, GMI PRACTICE SOLUTIONS, and GLOW MD CLINICS and is proud to once again bring together practitioners, business owners, and advanced aesthetic experts to The 2019 WESTERN CANADIAN AESTHETIC SUMMIT for a weekend of education and networking where the focus is on SAFETY, EFFICACY, and RESULTS.

#WCAS2019 is hosted by www.gmipracticesolutions.com Follow on Instagram @advancedaestheticscanada