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SLEEP, SENIORS AND SEDATIVES

nurses.ab.ca | WINTER 2017 VOLUME 72 NO 4 ALBERTA RN 3
What’s your story?

I was talking with a client in my clinical practice just a few weeks ago. She is in her mid- to late-40s with chronic heart failure resulting from ischemic heart disease. But her disease process is only a small part of who she is and what she is living with. She described numerous socio-economic, interpersonal and health-related challenges that add to her stress.

She told me that she had a follow-up appointment with a specialist to assess her condition and update her treatment plan. I told her, yes that’s fine, but I still want to see her in followup myself. I said, and this is key, that while that physician will prescribe a course of treatment, my role as a nurse is to take a step back and identify (with her) any potential barriers to following that treatment plan, assist her in developing strategies to overcome those barriers, and work with her to begin making positive health behaviour changes that are consistent with her values and priorities.

This is just one example of how one nurse can articulate the role with one client. I’m sure each and every one of you reading this could come up with your own as it applies to your practice setting.

My predecessor, Dr. Shannon Spenceley, often talked about the “elevator conversation,” and I have always found this formulation quite apt. If you find yourself in an elevator, and are asked exactly what a registered nurse does, how will you reply before the elevator door reopens and the conversation is ended?

As I write this, I am preparing to head to Ottawa to attend my first meeting as your Alberta representative on the board of the Canadian Nurses Association. One of the questions to be discussed arises out of a number of resolutions passed in June 2016 at the annual general meeting in Saint John, NB. Those resolutions call upon CNA to work to provide Canada’s registered nurses with the tools to more effectively articulate their critical role in, and essential contribution to, our health-care system.

These resolutions were proposed in a climate when more and more RNs were feeling insecure about their career prospects, as other health-care professionals, such as pharmacists and licensed practical nurses began providing services once provided only by RNs.

And yet, the role of the RN has also evolved a great deal in the 100 years since the birth of regulated professional nursing in Alberta. We’ve gained a great deal of autonomy, independence and authority in the care setting; demand more entry-level and ongoing education from every practitioner; and continue to expand our scope of practice and so many other factors.

For example, the amendments we’ve proposed to the Registered Nurses Profession Regulation will add RN prescribing and ordering of diagnostic tests to the list of restricted activities we are already authorized to perform.

At CNA, just as here at CARNA, resolutions carried at the AGM are not binding, but are advice to the board which it may choose to follow or not. But, regardless of what the CNA board decides to do, we don’t necessarily have to wait for CNA to take action on our own, right here in Alberta. There are ways to articulate our roles right now. I challenge you to think of one of your recent patients or clients and write down how you would describe your role to them and how you can contribute to their care. Write it down and submit it to albertaRN@nurses.ab.ca. I’d love to read your story and share with others.

Jerry Macdonald, BScN, RN, CCN(C)
780.978.1348
president@nurses.ab.ca
RUN FOR PROVINCIAL COUNCIL

Being on council is a great opportunity to represent the profession and make a difference!

As a provincial councillor, you will...
> set CARNA’s strategic direction
> make regulatory decisions in the interest of the public
> advocate to increase awareness of the RN role
> bring the voice of the profession to health policy discussion

You will also make regulatory decisions regarding standards and guidelines for nursing practice, and standards for approval for nursing education programs.

We are seeking candidates for three-year term positions in the following CARNA regions:
> Calgary/West
> Central
> Edmonton/West
> South


For details about the role and nomination process, visit: nurses.ab.ca/elections

DEADLINE TO APPLY: April 1, 2017
LETTERS TO THE EDITOR

At what point does the “art of nursing” become mundane?

A recent experience at work left me pondering this point. I have worked in the area of neuroscience nursing for 29 years in various capacities. My work began as an RN on the neurosurgical ward and neurosurgical ICU, followed by neurosurgical nurse practitioner, and most recently as a stroke nurse practitioner.

Over the years, I have been with many patients and families during what is often one of the most devastating moments in their lives, as I am sure is a situation shared by many of my colleagues.

Today, a patient’s family member commented to me, “you must be used to this as you see it all of the time.” The comment resonated deeply within me. As nurses we are privileged to be part of the intimate journey of our patients and families. The “art” of nursing provides us with the knowledge and skill to support, listen to, and care for people when they are most vulnerable.

I do not think that I will ever get “used to” watching families and patients face loss. God forbid that it ever becomes “mundane.” If it does, then I believe I will have lost my way as a nurse. I hope that all of us will continue to support our patients and families with grace, love, and compassion, for this is truly the “art” of what we do as nurses.

Judy S.
Edmonton, AB

The role of the RN in palliative care

Thank you for the interesting article on palliative care (fall 2016 Volume 72 No 3; ‘The Palliative Approach’) and the role we as registered nurses play in end-of-life care.

Having been on both sides of the issue, as a provider (a pediatric oncology nurse for over 20 years), and sadly, as a receiver (having been the caregiver to a loved one who has recently passed away from cancer) I was saddened by the realities of today’s palliative care in our health system.

In our family’s experience, the registered nurse, both in home care and in hospice care, has become the coordinator of care and their contact with patients and families is now limited to ‘case management’; managing the aides, LPNs, and other interdisciplinary partners responsible for front-line care. While my family appreciated the role of each and every one of these staff, the amount of time spent in palliative care discussions with an RN during my husband’s palliative phase was minimal.

So while we talk of the importance of our role as RNs in the palliative process, we need to continue to advocate strongly for relational practice to allow for more time for therapeutic nurse-client dialogue.

Gwen E.
Edmonton, AB

We want to hear from you!

Letters to the editor should be a maximum of 300 words and include your name and city.

Articles should be a maximum of 800 words about new developments in nursing practice, findings from research studies, or opinions on nursing or health-care issues.

Email your articles and letters to the editor at AlbertaRN@nurses.ab.ca.

PLEASE NOTE: the editor reserves the right to edit all articles and makes the final decision on publication suitability. CARNA also reserves copyright for all articles published in Alberta RN magazine so reproduction without the written permission of the publisher is not allowed.
What is a resolution?
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.

What happens with my resolution?
Attend the CARNA AGM on March 8, 2017 in Edmonton to move your resolution. CARNA members in attendance will vote on whether council should consider 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.

Resolutions submitted before Feb. 1, 2017 will be posted on the CARNA website.
Resolutions are accepted from the floor at the meeting, but advance posting gives members more time to consider the issue.

I want to share my resolution with council. What do I do next?
Go to nurses.ab.ca for full instructions and a template for writing your resolution.

Do you want your ideas to be discussed by CARNA Provincial Council?
Submit a resolution to our annual general meeting on March 8, 2017.

What is a resolution?
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.

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I want to share my resolution with council. What do I do next?
Go to nurses.ab.ca for full instructions and a template for writing your resolution.
Registered nurses and nurse practitioners integrate infection prevention and control (IP&C) principles, standards and guidelines in the care they provide including the safe preparation and administration of injectable medications and vaccines. Nurses, pharmacists and physicians, along with other health-care professionals have overlapping roles in the preparation of medications and vaccines. For consistency of practice and the safety of our clients, CARNA collaborated with the Alberta College of Pharmacists, Alberta Health Services – Public Health and the College of Physicians and Surgeons to develop the Guidelines for Medication and Vaccine Injection Safety. These guidelines were approved by CARNA Provincial Council in December 2016. Find the full document at nurses.ab.ca/documents.

Each of the six guidelines contain further direction for practice. The guidelines are:

- Medications are stored, handled and used safely.
- Vaccines are stored, handled, and used according to provincial policy and national guidelines.
- Injections and other sterile preparations are prepared safely.
- Injections and sterile preparations are administered safely.
- Medical sharps are stored, handled, used and disposed safely.
- If hazardous drugs are administered in the practice setting they are stored, handled and used safely.

Registered nurses and nurse practitioners prepare and administer parenteral medications and vaccines, e.g., by injection. While this is common in many practice settings, this intervention does carry risk including the transmission of bloodborne viruses and other microorganisms. When providing care, bloodborne viruses and other microbial pathogens can be transmitted to clients during health-care procedures due to improper injection and infusion techniques or handling of medication vials. Interventions, such as providing injections, need to be carried out aseptically. Transmissions of bloodborne viruses and other microorganisms can be prevented by following the principles of aseptic technique for the preparation and administration of parenteral medications and vaccines. These include the use of single use devices such as a sterile, single-use, disposable needle and syringe for each injection given, and prevention of contamination of injection equipment and medication. Potter & Perry (2014) state aseptic technique is the practice “that keeps a patient as free from pathogens as possible.” This can be either medical asepsis, which is a clean technique, or surgical asepsis, which is a sterile technique.

Proper storage is equally important as preparation and administration, not just for the integrity of the medication or vaccine but for the prevention of growth of viruses or other microorganisms. This includes the storage of multidose vials that have been opened. As with any hazardous material, sharps and unused medications or vaccines must be disposed of safely.

It is recognized that not all health-care professionals have sufficient IP&C resources available to them. In November 2013, we met with the College of Physicians and Surgeons of Alberta and the Alberta College of Pharmacists to determine where we could work collaboratively regarding the issue of IP&C. In June 2014, a working group of representatives from the three colleges was formed to develop guidelines on medication and vaccine injection safety. In September 2015, we asked our members to submit feedback on the draft document through a survey. The survey was also sent to stakeholders such as Alberta Health Services, Covenant Health, educational institutions, United Nurses of Alberta and CARNA specialty practice groups. 

Want to learn more about IP&C? CARNA is developing a new online module on infection prevention and control using gamification techniques, scheduled to be released this year. Visit nurses.ab.ca/IPC for more resources.
Self-employed or volunteering? Make sure you’re covered.

BY CARNA POLICY AND PRACTICE CONSULTANTS

Nursing can be risky. Risky in the sense that registered nurses and nurse practitioners in Alberta perform a variety of high-risk activities that may have serious consequences for the people in their care. When nurses are providing nursing services outside of the standard practice setting, they may question whether they require extra liability protection.

CARNA assures the public, through requirements for registration and other regulatory processes, that RNs and NPs are authorized to practise nursing and are a regulated professional.

CNPS can provide additional protection and advice
CARNA is a member organization of the Canadian Nurses Protective Society (CNPS). CARNA members may consult with CNPS to receive legal advice, assistance with legal proceedings, risk management and education services, and supplementary protection. CNPS also provides basic liability protection for all practising CARNA members.

However, there may be times when this liability protection is not enough. If you call CNPS, they can help determine whether or not you need additional liability protection based on the activities you perform in your practice setting.

Other considerations for self-employed practice
In addition to thinking about liability protection for self-employed practice, nurses should consider other aspects of self-employed nursing.

If you were to call CARNA about self-employed practice, we would first...
ask you questions about your practice to assess the situation. We would then direct you to the CARN A standards and guidelines documents to provide further direction. For example, when wondering about launching your self-employed practice, consider whether the practice falls within the definition of registered nursing practice, whether the practice can be carried out independently and autonomously, or if the practice requires collaboration with other health-care providers. The CARN A document Self Employment for Nurses: Position Statement and Guidelines can help provide answers to these questions and more.

Are you wondering if your practice is considered self-employed? Refer to the CNPS brochure available online titled Collaborative Practice: Are Nurses Employees or Self-Employed? for direction. Members planning to engage in any type of self-employed nursing practice need to apply to CARN A for recognition of their self-employed practice to be able to use these practice hours to renew their RN or NP practice permit. You may also need to consider the use of your professional nursing title when advertising your practice.

We also discuss with members other pertinent factors related to self-employment they should consider, such as management of health information, standards for documentation, performance of restricted activities, as well as business considerations.

Detailed information and the application form are available in the section on recognition of a self-employed practice on CARN A’s website. Whether the focus of self-employed practice is providing foot care, aesthetic nursing, or other nursing services, it is important for members to understand the implications of self-employment to ensure that all components of providing safe, competent and ethical care, and having proper liability protection, are addressed.

Can I provide nursing services as a volunteer?

Every year, members have questions about providing nursing services as a volunteer, for example as a camp nurse. We help assist by identifying potential liability aspects of the camp nurse role and providing support and guidance in understanding this role and the nurse’s accountabilities.

We refer to the Camp Nursing: Guidelines for Registered Nurses document to facilitate the discussion and help members consider many important elements. For example, questions the nurse may need to ask the camp leader to determine if this role is the right fit for them are:

> Is there a job description available that provides explicit information about the role and responsibilities of the camp nurse?
>
> Will the camp nurse be the only health-care provider on site and be on call 24/7?
>
> What are the characteristics and health needs of the camp population?
>
> Are the expectations for this role a good fit with the RN’s knowledge and experience?
>
> Does the camp insurance cover the camp nurse? Are there any exclusions?

As registered nurse practice continues to evolve and change, RNs and NPs need to be confident that they have the requisite knowledge, skills, education and competence to carry out activities safely.

We help guide your decisions

Wherever the setting, the practice of all CARN A members is grounded in the Practice Standards for Regulated Members (2013) and the CNA Code of Ethics for Registered Nurses (2008).

As registered nurse practice continues to evolve and change, RNs and NPs need to be confident that they have the requisite knowledge, skills, education and competence to carry out activities safely.

Ultimately, nurses are accountable for the decisions they make about their professional role. CARN A’s policy and practice consultants and documents are available to help provide nurses with the context and direction to make informed decisions.

Contact CARNA or CNPS

Contact a CARN A policy and practice consultant by calling 1.800.252.9392 or email practice@nurses.ab.ca.

Visit the CARN A website at nurses.ab.ca to view all supporting documents mentioned here.

Contact CNPS by visiting their website at cnps.ca or calling 1.800.267.3390.
Do I have professional liability protection if I do volunteer nursing work?

CNPS recognizes that registered nurses and nurse practitioners have valuable skills, knowledge and expertise that are an asset to their employer and to the public in general. Accordingly, some nurses may wish to volunteer to provide professional nursing services outside of the workplace setting on an unpaid basis.

CNPS professional liability protection is not contingent upon getting paid for your work; rather, it focuses on the type of work that you are doing.

To be eligible for CNPS professional liability protection, the following conditions must be met:

- You must be licensed to practise by your provincial or territorial professional nursing association or college, i.e., CARNA; and
- You must be providing professional nursing services.

Some nurses choose to volunteer in a variety of capacities where their nursing services are not being relied upon (such as a sports team coach, administrative support for an organization, etc.). In those circumstances, you would not normally be eligible for CNPS protection.

Additionally, a retired nurse who chooses to work as a volunteer may or may not be eligible for assistance. As noted above, it is a condition of CNPS assistance that a registered nurse or nurse practitioner must hold a valid licence to practise in one or more Canadian provinces or territories. Retired nurses must thus maintain full licensure to remain eligible for CNPS assistance. Retired nurses who chose to maintain a non-practising licence will likely not be eligible to access CNPS services.

The organization you volunteer for may also carry professional liability insurance for nurses and other staff. You may wish to consult with the organization to determine the scope and eligibility for such protection. Some organizations request that volunteer contracts be entered into prior to commencing volunteer services.

CNPS offers pre-contractual reviews relating to the provision of volunteer professional nursing services to help you identify whether other professional liability insurance exists, as well as identify provisions or requirements that may compromise your professional or legal obligations.

TO DISCUSS your volunteer arrangement with a legal advisor on a confidential basis, please contact the CNPS at 1.800.267.3390.

CNPS. More than liability protection.

1.844.4MY.CNPS
www.CNPS.ca

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

FOR MORE INFORMATION about CNPS services or if you have any questions regarding legal risks, contact CNPS to speak with a legal advisor at 1.844.4MY.CNPS (1.844.469.2677) or visit www.cnps.ca.
NOMINEES & RECIPIENTS
This year, the CARNA Awards Selection Committee selected eight award recipients out of 59 exceptional nominees.

**CLINICAL PRACTICE**
- Brenda Ferros, RN
- Derek Luk, RN
- Gail Payne, RN
- Heather Burton, RN
- James Veenstra, NP (recipient)
- Janice Lind, RN
- Jocelyne Duerksen, RN
- Linda Sinal, RN
- Marlene Varga, RN
- Mary Ellen Plumite, RN
- Michele Suitor, NP
- Nancy Newcommon, NP (Committee’s Choice)
- Pam Hirschkorn, RN
- Shelley Sluser, RN
- Steven Harbourne, RN
- Vicky St. Germaine, RN

**EDUCATION**
- Cydnee Seneviratne, RN (recipient)
- Erin Jong, RN
- Mohamed El-Hussein, RN
- Solina Richter, RN

**RESEARCH**
- Catherine Laing, RN (recipient)
- Sonya L Jakubec, RN
- Vera Caine, RN

**LIFETIME ACHIEVEMENT**
- Joanne Leavitt, RN
- Joanne Profetto-McGrath, RN (recipient)
- Judith Hanson, RN
- Kim Cholewa, RN
- Linda Gail Cameron, RN
- Noreen Blachly
Join us in celebrating nursing excellence

THE CARNA AWARDS GALA

Thursday, May 18, 2017
5:30 p.m. Champagne reception
6:30 p.m. Dinner and awards
Hotel Arts, Calgary
carnaawards.ca

ADMINISTRATION
Alison Connors, RN
Claudette Boisvert, RN
Deb de Vlaming, RN
Diane Fraser, RN
Gayle Urquhart, RN
Janice Blair, RN
Julianna Kudryk, RN
Karen Maier, RN

Lori Apostal, RN (recipient)
Mollie Cole, RN
Sharon Crockett, RN
Stacey Brewster, RN
Tosha Draper, RN
Tracey Schneider (Gelinas), RN

RISING STAR
Cathy Le, RN
Helen Doan, RN
Jaricho Monk, RN
Kaitlyn Tate, RN (recipient)
Kassandra Tiessen, RN
Kate Newcombe, RN

Kayla Maksymiw, RN
Kennedy Cox, RN
Nicholas Howe, RN
Stephen Page, RN
Thy Thy Nguyen, RN

PARTNER IN HEALTH
Ali Cada, LPN, Alzheimer Society Calgary Program Manager
Candice Keddie and the Stollery Respiratory Therapy Group

David Bilan, Alberta Health Services VP of Collaborative Practice, Nursing and Health Professions (Interim)

Jill Norris, University of Calgary Scientific Writer
The Medical Team of the Calgary Stroke Program (recipient)
Celebrating 100 years

RNss from across the province mingled and danced the night away at the centennial galas in Calgary and Edmonton in October 2016.

PHOTOS BY WILLIAM AU PHOTOGRAPHY
Storytelling is one of the oldest methods of communication. It’s valuable in health care because it helps us learn, creating a link from what we learn in the classroom or what is written in books to the reality of our practice setting.

We learn from stories but we also remember them, perhaps because stories engage us at an emotional level. We remember when the same story is told or a similar story is told. When we think about pride in our profession, telling these stories helps us remember why we became a nurse and the value that we bring to the profession and to health care.

Stories also help us connect with each other. Fostering this collaboration bolsters and inspires pride in the RN profession.

Nurses speak two distinct languages, “...one of empirics and scientific evidence, and one of aesthetics; the language of people, personal wisdom, insight and creativity,” (Hunter, 2008). When we talk about pride in the profession we speak the language of aesthetics; it is our language, insight, wisdom and creativity.

The role and value of RNs is not widely understood by health-care providers, leaders, government, patients and the public. The Uniquely RN initiative at CARNa is focused on articulating the primary distinguishing qualities of RNs: the knowledge base and unique skills and abilities.

A working group of CARNa members is currently developing a strategy to help ourselves and others articulate an understanding of the uniqueness and value of the RN role. These members have begun telling their stories.

What is an RN? Shining a light on RN contributions

How do we communicate our unique value to leaders, government, patients and other health-care providers? Members identified the following recommendations to help us start to answer this question: focus on value, be deliberate, provide visible leadership and educate decision-makers.

Uniquely RN working group member Maggie Danko suggests that one way to address all the recommendations is to encourage members to submit nominations to the CARNa Awards program. Maggie’s roles as a registered nurse in the cardiovascular intensive care unit at the Mazankowski Alberta Heart Institute, a volunteer member of the Uniquely RN working group and also of the Awards Selections Committee gives her a unique perspective on the challenge of increasing RN visibility.

READ MORE AT... nurses.ab.ca/UniquelyRN

Voicing my identity as an RN

Over the past two years, since starting in the profession, I have risen to the challenge of discovering my role as a registered nurse. I find the topic of working to full scope of practice as a registered nurse exciting and am always looking to further define myself and my profession.

Who am I? I graduated with a bachelor of science in nursing degree in 2014 from MacEwan University. I was one of the first candidates to write the new national entry-to-practice exam, the NCLEX-RN. I began my career working in the emergency department at the University of Alberta Hospital. I attribute my foundation in nursing to the education I received and my career experiences thus far. I think it is important for patients to know how I got to where I am now so they trust my knowledge and skills.

READ MORE AT... nurses.ab.ca/UniquelyRN
Is avoidance a boundary issue?
Right from the beginning, Nico feels a little put off by his new dialysis client, Mr. Stedman. Nico’s clients have always responded to his cheerful and upbeat manner, but Mr. Stedman does not. He’s non-communicative and unsmiling, responding to Nico’s questions with monotone one-word answers...

Witnessing vs. obtaining consent
As Susan walks into the room, Mr. Yan turns and smiles. Recently diagnosed with an aggressive form of cancer, Mr. Yan is being admitted for same-day surgery. While performing her admission assessments, Susan notices the surgical consent form, typically completed in advance at the surgeon’s office or the pre-admission clinic, is not signed...

Caring for yourself
Her shift hasn’t even started and already Doris has snapped at a colleague. She knows she’s become increasingly short-tempered as winter sets in. She thought getting through the holiday season would improve her irritability but it hasn’t...

Find out what happens next in these stories at nurses.ab.ca/casestudies.
EVERY YEAR, MORE THAN 3,000 ALBERTANS DIE AS A RESULT OF TOBACCO USE, WHILE MANY MORE SUFFER FROM TOBACCO-RELATED ILLNESSES. THE GOOD NEWS IS THAT THIS CAN BE PREVENTED, AND RNS EVERYWHERE CAN HELP.

Whether in a hospital, at a private clinic, through a primary care network, home visit or other health-care setting, registered nurses have many opportunities to identify those patients that use tobacco, and encourage them to quit and lead healthier lives.

“RNs in primary care are uniquely positioned to support our patients in their journey to become tobacco free,” says RN and clinical lead Ruth Weins, from the Peaks to Prairie Primary Care Network. “We can discuss it at each visit as part of their overall health goals, show them the benefits of quitting to reduce their cardiovascular risk as we review their labs and provide intensive tobacco intervention if that is their goal.

“The trusting relationship developed between the RN and the patient is extremely valuable in providing a safe, non-judgmental environment in which to address tobacco use.”

Michael C. Fiore at the University of Wisconsin school of medicine and public health and other researchers have shown substantial evidence that nurse-supported tobacco reduction and cessation are equally important in the acute care and public health settings. These practice settings provide ‘teachable moments’ for those who may be having first- or second-hand tobacco-related health problems.

Further, research shows that receiving support and advice from a nurse specially trained in tobacco cessation can double a tobacco user’s chances of successfully quitting. Current evidence supports the 5 As (ask, advise, assess, assist and arrange) tobacco intervention approach for health professionals to identify and support tobacco users in any setting.

Registered nurses and other health professionals looking to increase their awareness, knowledge and skillset needed to provide effective tobacco interventions can do so by taking courses in the AlbertaQuits Learning Series, offered by Alberta Health Services’ Tobacco Reduction Program.

The Learning Series includes e-learning and classroom units that will enable health professionals to offer tobacco intervention effectively in nearly every health-care setting. The AlbertaQuits Learning Series also prepares interested health-care professionals to write the national Certified Tobacco Educator exam through the Canadian Network for Respiratory Care (CNRC).

Learning units include:

> Tobacco basics
> Brief tobacco intervention
> Tobacco cessation pharmacology
> Intensive tobacco intervention
> Applied tobacco intervention

“AlbertaQuits provides excellent and easily accessible resources to build the capacity and confidence of health professionals in addressing tobacco reduction and cessation,” says Margot Underwood, assistant professor of nursing at Mount Royal University.

“Over the past 10 years we have used all of these evidence-based materials as part of the tobacco reduction training of multidisciplinary teams in the acute, primary care, and community settings, as well as with undergraduate nursing, respiratory therapy and medical students. RN

FOR A COMPLETE LIST of AlbertaQuits Learning Series units, descriptions and registration information, please visit www.albertaquits.ca/learning.
A Hearing Tribunal made a finding of unprofessional conduct against member #47,997 who, while working as a registered nurse at a long-term care facility in Edmonton, Alberta, failed to adequately care for a resident by not conducting an immediate and full post-fall assessment as well as not fully documenting actions post fall; and, on two occasions, maintaining professional and therapeutic relationships with residents and staff of the facility. For this finding of unprofessional conduct, the Hearing Tribunal issued a reprimand, as well as an Order for completion of coursework, completion of a reflective paper, and submission of a satisfactory performance evaluation. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

A Hearing Tribunal made a finding of unprofessional conduct against member #49,125 who, while working at an acute care hospital in Edmonton, Alberta, breached employer’s policies by inappropriately accessing health information within Netcare on four occasions for personal use, or otherwise not within or for their job responsibilities. For this finding of unprofessional conduct, the Hearing Tribunal issued a reprimand, course completion, completion of a written paper, and a fine. 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 #53,461 who engaged in disrespectful and inappropriate communication with coworkers on several occasions; failed to provide adequate mentorship to LPN students by communicating with them in a disrespectful and demeaning manner; failed to contact a physician regarding a patient’s condition; failed to adequately (or at all) communicate, document and assess a patient in accordance with their goals of care; and documented care of a patient when such care was not provided. The member also, between the months of October and December 2014, made inappropriate remarks to a patient’s family member, which were found to be disrespectful or otherwise uncaring. For this finding of unprofessional conduct, the Hearing Tribunal issued a reprimand and ordered coursework, two satisfactory performance evaluations, and a restricted work setting. 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 #65,082 who on numerous occasions prepared reports on patients that contained inaccurate information. The Tribunal issued a reprimand and ordered the member to complete courses in documentation and assessment, and to provide a satisfactory performance evaluation from her current employer. The member had fully complied with all requirements at the hearing.

A Hearing Tribunal made a finding of unprofessional conduct against member #70,209 who, while working as a community health nurse, breached her employer’s policies by inappropriately accessing health information about five individuals for personal use, or otherwise not within or for her job responsibilities. For this finding of unprofessional conduct, the Hearing Tribunal issued a reprimand, and an Order to complete course work and submit a satisfactory practice report letter from her employer. 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 #73,515 who, while working as a registered nurse at the University of Alberta Hospital in Edmonton, Alberta, failed to accurately document full nursing assessments on patients; intervene appropriately when following physician orders in the treatment of a patient; accurately administer and document medications and blood product which constituted a breach in safe patient care; and accurately label and identify IV lines according to policy. On a separate incident, the member failed to complete documentation in a timely and accurate manner including validation of vital signs, insertion of tubes, and communication with staff; holding administration of a narcotic; and failed to provide sufficient background information for provision of care for staff on
the following shift. The member also crossed professional boundaries by providing the member’s personal cellphone to a patient’s family. For this finding of unprofessional conduct, the Hearing Tribunal issued a reprimand and ordered comprehensive coursework to be completed. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

CARN A MEMBE R:
REGISTRATION NUMBER: 77,991
A Hearing Tribunal made a finding of unprofessional conduct against member #77,991 who made an admission under section 70 of the Health Professions Act. The member admitted she inappropriately accessed Netcare on a few occasions for personal purposes, not related to her duties as an RN, and shared the information inappropriately. The Tribunal issued a reprimand and ordered the member to pass courses in responsible nursing and professional ethics, complete modules on the Code of Ethics and modules on privacy and write a paper on nursing ethics and privacy. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

CARN A MEMBE R
REGISTRATION NUMBER: 79,797
A Hearing Tribunal made a finding of unprofessional conduct against member #79,797 who, while working as an RN in Calgary, Alberta, failed on at least three occasions to document adequately; on one occasion to fully process lab work orders; and on another occasion to clarify confusion of a prescription. For this finding of unprofessional conduct, the Hearing Tribunal issued a reprimand and an Order that coursework be completed. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

CARN A MEMBE R
REGISTRATION NUMBER: 92,562
A Hearing Tribunal made a finding of unprofessional conduct against member #92,562 who, while responding to an emergency situation where a patient experienced a tracheostomy de-cannulation and respiratory distress, failed to conduct an adequate assessment and manage the situation adequately. For this finding of unprofessional conduct, the Hearing Tribunal issued a reprimand and ordered that coursework be completed. The member was deemed compliant at the Hearing and as such, no condition shall be placed on the member’s permit.

CARN A MEMBE R
REGISTRATION NUMBER: 98,180
A Hearing Tribunal made a finding of unprofessional conduct against member #98,180, who, on a few occasions, administered 12 units of Lantus insulin to a patient in error, rather than the six units ordered, as the member had not checked the physician’s order, as prompted to do so on the MAR. Subsequently, on three consecutive dates, although the member had not actually administered the medication, she documented that she had administered Olanzapine to a patient when that medication was on hold. The Tribunal issued a reprimand and restricted the member to working at one approved employment site pending a letter from her manager. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

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A registered nurse accesses the Netcare clinical record of a friend who isn’t in their care. The member has no authority to do so and this is a breach of the patient’s privacy. Under the Health Professions Act, the RN’s manager is required to submit a complaint to CARNA when a member has been suspended or terminated for what the employer believes is unprofessional conduct. Breach of privacy falls within that definition. What is the appropriate course of action for CARNA to address this breach of professional conduct?

In 2015, CARNA began using “right-touch regulation” in all regulatory practices. We want to only do what is necessary and appropriate in any given situation to protect the public and to regulate the profession. Keeping this approach in mind, let’s take a look at our options for the situation above.

When someone submits a complaint, the complaints director determines if the complaint should be investigated or not. If yes, an investigations officer conducts an investigation into the complaint and submits their findings to the complaints director. The complaints director then reviews the evidence to determine whether or not there is sufficient evidence of unprofessional conduct to refer the matter to a hearing.

When determining if this complaint should go to a hearing, or if a complaint resolution agreement is appropriate, the complaints director considers factors which include the potential risk to the public, the administrative fairness of the approach, the accountability of the member, any prior discipline history and the potential for remediation.

TRADITIONAL APPROACH: Hearing

The CARNA complaints director has the authority under the Health Professions Act to resolve complaints where there is evidence of unprofessional conduct in a number of different ways. The traditional approach was to refer the allegations of unprofessional conduct to a hearing. Over the past few years we’ve had approximately 100 complaints referred to a hearing per year.

Is this the right amount of regulation?

Scheduling a hearing can take several months – or sometimes a year or more – and cost thousands of dollars to conduct. If the hearing tribunal finds the member is found to have practised unprofessionally, they will impose remediation or sanctions.

Most hearings proceed by way of consent. This means that going into the hearing, the facts are agreed upon and the member acknowledges responsibility and admits unprofessional conduct. The member also usually agrees to the remediation or supervision required. So in this case, a hearing is scheduled simply for everyone involved (a hearing tribunal, the member, the member’s lawyer or counsel, CARNA’s legal counsel, a court reporter, CARNA staff) to agree to the facts and outcomes.
FRESH APPROACH:
Complaint Resolution Agreement

Another option for resolution is through a “complaint resolution agreement” between the member and the complaints director. The legislation requires that the complainant, the member and the complaints director consent to any resolution process other than the referral to a hearing.

The process for negotiating and signing the agreement usually takes 30-60 days and does not incur any additional costs. The complaints director and the member enter into a formal agreement which identifies the issues of unprofessional conduct, acknowledges the member’s accountability, the required remediation and the consequences for non-compliance with the agreement. The existence of the complaint resolution agreement does not become “discipline.” When appropriate requirements may be placed on the member’s practice permit, employers and jurisdictions are notified.

Is a complaint resolution agreement always the right amount of regulation?

Not all complaints are suited for the complaint resolution agreement process. If the member under investigation has a history of professional discipline, or the allegations have to do with abuse or harm to a patient or member of the public, or in the absence of complainant consent, or a number of more serious situations, the complaint will be referred to a hearing.

Our example of the RN and the Netcare breach may be a good opportunity for a complaint resolution agreement if a number of criteria are met, including but not limited to: the member admits to the unprofessional conduct, there is no history of discipline, the complainant consents to the use of the process and the member agrees to remediation that is similar to that which a hearing tribunal would impose.

When it comes to regulating the registered nurse profession, public safety is our number one priority. We will always use appropriate regulatory practices to ensure all of our members practise nursing safely, competently and ethically. But we also realize that not all allegations of unprofessional conduct require a hearing, which is where the application of right-touch regulation principles are most appropriate. This is a process where matters can be more expediently dealt with, the potential for risk to the public is minimized and the registered nurse can maintain a safe practice.

Carna will continue to apply the practices of right-touch regulation in all of our work, and we will regularly update our members on the status of new projects and initiatives in this area. RN

RIGHT-TOUCH REGULATION

Right-touch regulation is all about changing the way the registered nurses profession is regulated, so that only the appropriate amount of regulation necessary is used. Regulation should aim to be:

* **Proportionate**: Regulators should only intervene when necessary. Remedies should be appropriate to the risk posed, and costs identified and minimized.

* **Consistent**: Rules and standards must be joined up and implemented fairly.

* **Targeted**: Regulation should be focused on the problem, and minimize side effects.

* **Transperent**: Regulators should be open, and keep regulations simple and user friendly.

* **Accountable**: Regulators must be able to justify decisions, and be subject to public scrutiny.

* **Agile**: Regulation must look forward and be able to adapt to anticipate change.

8 elements of right-touch regulation

1. Identify the problem first.
2. Quantify the risks.
3. Get close to the problem.
4. Focus on the outcome.
5. Use regulation only when necessary.
6. Keep it simple.
7. Check for unintended consequences.
8. Review and respond to change.

FOR MORE INFORMATION about right-touch regulation, visit www.professionalstandards.org.uk.
The use of game elements in a registration requirement would likely be considered unusual, but CARNA set out to embrace this approach.

Tasked with creating a requirement that educates and assesses competence, CARNA teamed up with Yardstick and Trajectory IQ to design a learning module for nurses and nurse applicants using the principles of gamification.

**What is gamification?**

The use of gaming principles in non-game contexts is referred to as gamification. Gamification is intended to harness the engagement and focus of game playing, for other purposes like educating students, advertising products and services, motivating employee productivity and more.

**CARNa and gamification**

In 2010, CARNA Provincial Council agreed that RN applicants need to demonstrate competence in the principles of law as they relate to their nursing practice—known as nursing jurisprudence.

The conventional approach used by other regulators to determine jurisprudence competency is a
In 2015, 75 nurses from various practice settings tested the jurisprudence module. Participants were asked to complete the module and then a survey. > 94 percent learned new information. > 97 percent thought what they learned would influence their practice. > Overall, they felt engaged and liked the interactivity of the module.

A second round of testing took place to evaluate question performance and overall experience.

What this means for applicants and members

This jurisprudence module will be mandatory for new and returning-to-practice applicants when the revised Registered Nurses Profession Regulation is proclaimed by Alberta government, which is anticipated to happen in 2017. Eventually, all renewing registrants will also need to complete the module as part of their continuing competence requirement.

The module takes shape

In May 2014, the jurisprudence requirement took form as an online module. Participants start out by choosing a character and progress through scenes and challenges. As you go through the module, you learn about legislation, regulations, standards and policies that affect your practice, while earning points and badges for completing various challenges.

At the same time, participants can access a resource library with information pertinent to each scene, similar to an open-book exam.

Each stage of the module represents a nursing competency topic to learn about. At the end of each scene, you answer practice questions before completing the scene’s exam. Once you pass each scene, you are rewarded with a badge, confetti and applause, elements we associate with games as motivational tools.

“The module takes shape”

Members test the module

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The potential for future applications seems vast, particularly for similar assessment requirements. CARNA has embraced the use of gamification for professional development models, and development of these educational modules is underway.
Do you tend to raise the volume of your voice when speaking to an older adult? Have you ever used the phrases “I’m having a senior’s moment” or “you can’t teach an old dog new tricks?”

In 2011, members responded to a survey to let us know they believe quality care for older adults should be one of our highest priorities for public policy advocacy. We have since committed to optimizing and promoting the health and well-being of Alberta’s older adults. We developed the Older Adults Policy Pillar in 2013 to set a vision, guiding principles, strategies and actions to fulfill our commitment. The full document is available at nurses.ab.ca/older-adult-pillar.

The pillar identifies the guiding principles, including respect, and acknowledges the societal contributions of older adults. We are proud to have had the opportunity to fund a recent study putting this principle into action, Discourse Analysis of Western Canadian Print News Media: Aging and Health Care.

This study from Dr. Wendy Duggleby, Mehri Karimi-Dehkordi and Jennifer Swindle took an in-depth look into how Alberta’s news media portrays older adults and their needs within the health-care system. The study included articles about health provision and older adults from a sample of Alberta media outlets over five years. Of the more than 600 articles collected, not one portrayed older adults positively. Instead, older adults were depicted as helpless, a burden and to blame for problems in the health system.

In reality, aging occurs on a continuum. Many people over 65 years old are independent and require very little support and health services. However, the study found the Alberta media study focused only on examples of older adults on the other end of the continuum: frail, vulnerable and with complex needs.

The authors stress the importance of being aware of the implications of these biased representations. These stereotypes reinforce existing stigmas and unfairly generalize a whole group of people. These portrayals negatively impact Albertans on all levels. Individual older adults may be left...
Of the more than 600 articles collected, not one portrayed older adults positively.

Instead, older adults were depicted as helpless, a burden and to blame for problems in the health system.

feeling they are a burden and doubt their worth in society. People tend to copy behaviours they see in the media, and treat older adults accordingly. As developing policies are also exposed to ageist media, there may be implications in Alberta’s health-care system.

TURNING THE PROBLEM INTO THE SOLUTION

Ageist depictions stretch beyond the news media. Television, movies and advertising are awash with stereotypes of the elderly. A grumpy older man tells an uninterested audience how things were better back in the day. A scatterbrained elderly woman constantly loses her train of thought. An infomercial features a helpless older adult unable to complete an everyday task. It’s no wonder we struggle to shake preconceived notions about what an older adult looks like.

Perhaps more importantly than condemning poor representations is to uphold and learn from the good. For example, the 1980’s sitcom The Golden Girls defied notions of how “women of a certain age” should look, speak and act. For seven years the vivacious Dorothy, Sophia, Blanche and Rose demonstrated how ridiculous it is to assume age would restrict them from working, living independent and fulfilling lives, and yes, even having sex.

More recently, in an episode of the Netflix comedy series Master of None, the main character played by Aziz Ansari experiences an epiphany about his aging father. What makes the episode particularly impactful is that Ansari recruited his actual non-actor father to play opposite him. The episode opens with another common trope – the younger generation reluctantly acting as “tech support” for the older generation. As the episode progresses, an old family friend sparks Ansari’s interest with a story about his father’s work ethic. He becomes enthralled with stories about the struggles his father faced in childhood and the hard work and sacrifice he endured to provide for his family. By the end of the episode the two have formed a stronger relationship built on respect and understanding. >
Did you know that as of 2014 The Golden Girls employed more actresses over age 60 than any other show on television?

MAKING A DIFFERENCE GOING FORWARD

Ansari’s enlightenment serves as an important reminder to look past the stereotypes and biases we have internalized. A bias cannot be corrected unless we first recognize it.

The study submitted by Dr. Duggleby indicates that many nurses are already attuned to and fighting ageism. Attendees of CARNA’s centennial conference shared examples of ageism they have experienced in practice. They also recommended that nurses should do some self-searching, pointing out stereotypes being perpetuated by others and advocating respect and empathy for older adults.

Changing the way media depicts older adults is a near impossible task. But adjusting your perceptions isn’t. Challenge your own assumptions and the assumptions others have about older adults. Question the source of your biases and encourage others to the same.

Foster the trickle of change and maybe one day the media will follow. RN

REFERENCES:

College and Association of Registered Nurses of Alberta. (November 2013). Older Adults Policy Pillar: Environmental Scan and Identification of Issues.


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BACKGROUND
The purpose of this study was to explore the ways in which print news media published in Alberta constructed aging in relation to the provision of provincial health-care services. To provide geographical diversity, four areas across the province were selected (Slave Lake, Edmonton, Calgary and Brooks) and a newspaper from each respective area chosen.

OUR APPROACH
The Canadian Newsstand Complete database was used to access articles that: a) contained a positive and/or negative reference to health-care provision to older persons (65 years

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Discourse analysis of Western Canadian print news media: AGING AND HEALTH CARE

and over) in Alberta; b) were published in the Lakeside Leader, Edmonton Journal, Calgary Herald or Brooks Bulletin; and c) were published between Jan. 1, 2010 and March 31, 2015. This included articles primarily about older persons in reference to health-care provision and ones primarily about other subjects that incorporated this criterion for some purpose. Articles were excluded if they: a) mentioned the health-care system but did not explicitly relate to health-care provision to older persons; b) were exclusively about health-care provision to older persons outside of Alberta; or c) were specific to people less than 65 years of age.

A total of 654 articles were collected (Edmonton Journal: 339; Calgary Herald: 257; Brooks Bulletin: 32; Lakeside Leader: 26). Findings were that older persons were negatively portrayed as to blame for health-care system problems, as a burden, and helpless. The portrayal of aging as positive in the context of health-care was absent in print media. Analysis of the articles yielded three discourses centred around blame, being deserving/undeserving, and being helpless.

> **Blame:** Throughout the media articles, older persons were described as the reason for pressures related to health-care provision in five main realms: growing senior population, creating challenges for the health-care professional, being a burden, using scarce health-care resources, and for the nature of their needs. In all of these areas, older persons were stereotyped as the reason for these problems.

> **Intertwined deserving/undeserving discourses:** Discursive constructions of deserving and undeserving were reflected in the contradiction in the media when reporting the need to support older persons in rhetoric and the failure to advance health-care services in actions. Indeed, older persons were constructed as deserving of better health-care services in talks and debates; however, they were constructed as undeserving in action.

> **Being helpless:** Texts extensively positioned older persons as helpless, as they were described as powerless to influence, unable to act, and unable to defend themselves.

**IMPLICATIONS FOR PRACTICE**

It is important to be aware of this negative portrayal as it has implications for individuals (i.e., older adults feeling like they are a burden), for communities (behaviours toward older adults) and for the development of future health-care policies (ageism affecting policies).

At the CARNA Centennial Conference in March 2016, we engaged 38 nurses in discussions about the study findings. Nurses described many incidents of ageism. They also recommended that nurses should:

a) engage in self-searching and advocacy to make sure they are not stereotype older persons in their practice
b) let others know when they are being ageist
c) increase awareness of the issues
d) start a dialogue between peers
e) focus on respect for older persons
f) advocate for better staffing

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Sleep is crucial for cognitive, mental and physical health. Poor sleep makes us grumpy, foggy, depressed and irritable, and can cause high blood pressure, falls, pain, decreased immunity, delayed wound healing and medical instability. But sedatives are not the answer, and here’s why.

- **Confusion.** Have you ever taken Gravol for nausea or Benadryl for allergies (or either for sleep)? Think about how groggy you felt. Now you have a small glimpse of what it’s like to be a frail senior on a sedative.

- **No evidence of long-term benefit.** Few medications have been trialed in the frail elderly or in those on multiple medications. Most sedatives stop working after a couple of weeks; some cause rebound insomnia when discontinued. Some sedatives slightly increase light sleep, but decrease REM and deep sleep.

- **Sedatives actually interfere with sleep by making people groggy during the day.** Older adults only sleep an average of eight hours—it’s no surprise they’re awake all night if most of that sleep occurs in morning and afternoon naps and early bed times.

- **Insomnia can be caused by medications.** Hundreds of common medications block acetylcholine and other crucial brain neurotransmitters required for regulating sleep and REM cycles. This results in insomnia, urinary retention, restlessness, confusion, falls, blurred vision and many other side effects. Shrinking the medication list will usually be more effective for sleep than adding another medication.

Bethany Airdrie long-term care staff used to wake 60 per cent of residents for scheduled care. Now only 16 per cent

**Staff recognized most of the night noise was talking - now they whisper.** The unit is noticeably calmer, especially at night, and falls dropped by 50 per cent!
10 WAYS TO SUPPORT SLEEP IN SENIORS

1 Shhhhh. The average facility-dwelling senior hears 32 noises per night louder than 60 decibels (dB). Thirty dB is a whisper. Adjust unit routines to avoid nighttime interruptions caused by cleaning and stocking. Close the door on shift reports, telephones and label machines. Avoid overhead paging and minimize use of bed and equipment alarms.

2 Work with the brain’s response to light and darkness.
Light increases serotonin (to keep us awake, alert and calm) and darkness increases melatonin (we feel sleepy and relaxed). Expose residents to daytime light by positioning them towards an outside window, or expose to bright full-spectrum overhead lighting. Dim the lights in the evening, and block out/turn off lights at night. Motion-activated nightlights can show the way to the bathroom without disrupting sleep. Have a bright place for staff to work— but keep the unit dark for patients.

3 Don’t wake for assessments.
Seniors sleep more lightly and wake more frequently than younger adults. Avoid waking stable patients for vital signs, pain assessment or repositioning—request changes to orders to prevent unnecessary sleep interruptions.

4 If sleeping in means missing breakfast, keep some cold trays available.

5 Avoid scheduled continence care if patients seem to be sleeping comfortably. Apply correctly sized extra-absorbent incontinence products as late as possible in the evening. Yes, people may wake up wet, but a change in staffing routines makes more sense than interrupting an older adult’s sleep “so they can wake up dry for day shift.”

6 Keep patients active during the day with walking, recreational activities, volunteers and visitors. Assist patients to rest for 30-60 minutes in the afternoon—long enough to be refreshed for the evening, short enough to avoid interfering with nighttime sleep.

7 Request medication reviews and reductions especially in patients with insomnia, those on five or more medications, or those experiencing evening confusion (sundowning) and responsive behaviours.

8 Look for reasons for insomnia such as untreated pain, restless legs, itchy skin, too hot or cold, hunger, thirst, noise, flashing lights and nightmares.

9 Conduct nighttime safety rounds in the least disruptive way—avoid bright lights and be as quiet as possible. Some care centres use red filtered flashlights, and others use video monitors to observe resident safety at night.

10 Be person-centred. A resident was up all night, wandering into others’ rooms. She fell asleep in a recliner one evening and staff discovered she’d slept in a recliner for the past 35 years!

receive scheduled care; the rest are assisted as they wake. On the last evening round, staff wedge a pillow behind residents needing repositioning, and gently remove it on the first night round to offload pressure points.

Staff recognized most of the night noise was talking—now they whisper. Night staff are now able to provide 1:1 attention to residents who are awake, and assist them back to bed when they’re ready. The unit is noticeably calmer, especially at night, and falls dropped by 50 percent!

At Chateau Vitaline Supportive Living in Beaumont, residents are left to sleep through the night as much as possible, even though day staff now come on shift to find some residents are wet and need immediate changing. The change has been dramatic! With a more restful night’s sleep and no six a.m. rounds and changing, we see more cooperation and less aggression in residents during the day.

Sleep is essential for health and well-being. Isn’t it time we made sleep a priority for our patients?

REFERENCES
Cuellar, Rogers, Hisghman and Volpe. Assessment and Treatment of Sleep Disorders in the Older Adult. Geriatric Nursing Vol 28, No 4.
Addis 2007 Sleep-promoting medications should be used with caution in elderly nursing home residents. Drugs Ther Perspect 2007 pVol 23, No 4 Cuellar 2007
Gordon AL and Gladman JRF, Sleep in care homes, Reviews in Clinical Gerontology 2010 20:309-316
for

over two decades, capacity issues within Edmonton hospitals have existed. Crowded emergency departments with numerous patients waiting for admission into inpatient beds has made patient flow a topic at all administrative levels for all services. From a systems perspective, most strategies have simply displaced the problem from one part of the system to another. If we are going to make a true difference, a “big picture” systems approach is required and traditional ways of doing business need to be challenged.

Like any discussion around flow, inputs and outputs must have a level of equilibrium and equality, or bottlenecks will occur. Although patient flow has been a huge focus across the continuum of care, discharge planning traditionally has remained with the provider where the patient currently is, as opposed to where the team feels the patient’s end destination will be.

Background

The Glenrose Rehabilitation Hospital (GRH) in Edmonton is the largest free-standing tertiary rehabilitation centre in Canada. The facility has 244 inpatient beds and offers over 120 different outpatient programs, clinics and services. The GRH accepts referrals from across Alberta as well as neighbouring provinces and territories. With limited beds providing specialized service, wait times for admission can be lengthy. With the majority of patients waiting in acute care for transfer to the GRH, these wait times can have a significant impact on patient flow from emergency departments into inpatient care.

Many patients with spinal cord injury (SCI) enter the system after a traumatic or acute event and require treatment and support from the neurosciences department until they are transferred to the GRH. The GRH spinal cord injury/general neurology (SCI/GN) program is limited in the capacity of services it can provide. There are only 15 SCI/GN rehabilitation beds, and in 2014-15 an average length of stay was 46.9 days.

In addition, multiple challenges to timely access of community placements and resources exist, leaving some patients experiencing lengthy delays in being discharged from the GRH once their rehabilitation is complete. In 2014-15, 134 days were identified as patients waiting for alternate level of care and 293 days were identified as patients waiting for transfer services. As patients in acute care must wait to access rehabilitation services, timely discharge of just one patient from the GRH impacts patient flow across the continuum.

Identifying an opportunity

A working group was established with representation from across the continuum, including the GRH, IQM, the University of Alberta Neurosciences divisions and continuing care (community). The goal was to bring leadership and front-line teams together to collaborate, identify challenges and seek opportunities to become actively involved in improving patient flow. Collaboration across the continuum of care was enhanced, and partnerships formed throughout the system with staff working together to support and facilitate seamless, timely transitions for patients and families. Front-line staff were engaged and empowered by leadership to identify the issues and challenges that they would like to work on with teams from across the continuum of care in order to enhance the care provided to patients and their families.

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Spinal cord injury acute to community pathway

Understanding the process
Although the initial work began with improving the flow of patients with SCI, it was quickly identified that much of the work could be applied to all three GRH neuro-rehabilitation cohorts: SCI/GN, brain injury and stroke.

Acute care and community partners identified early on that more information was needed not only about the programs, but also on the referral criteria and processes for referral and admission. A consultation with a physiatrist is required for all of these services and the referral, inclusion and exclusion criteria was authored and shared. In addition, a GRH consultation/transfer checklist was developed and implemented bringing more awareness of the information required to support safe patient transitions. This information sharing was the beginning of an enhanced dialogue. There was now a better understanding of each other’s core business and an enhanced desire to make things better for all – most of all, for the patients.

Streamlining pre-admission
This work laid the foundation for an even more coordinated effort. A pre-admission census template was created and shared for all patients referred and waiting for admission to one of the neuro-rehabilitation programs. The census includes all patients waiting from Edmonton and outlying zones, including those who have been moved to other hospitals, or are at home waiting for services. The pre-admission census also includes patients that the physiatrist has seen in consult, but acceptance has yet to be confirmed. Transparent and clear information to all referring sites gives a complete summary of the patients waiting for services with an anticipated date of admission to the GRH, readiness for rehabilitation, and an area to identify and discuss proactive transition planning.

Getting a head start on discharge planning
For many patients with SCI, discharge planning is multifaceted. It involves home modifications or alternate living arrangements; facility or supportive living; specialized equipment; home care or self-managed care; patient and family education and support; ongoing community support and resources; as well as many other considerations. Many patients lose their ability to work and may need to apply for disability benefits or other sources of funding to initiate the discharge preparations and sustain their future.

Traditionally, all of these discharge considerations would wait until the patient was transferred to the GRH. It is now recognized that some of these activities, such as initiating and securing financial resources, can start in acute care while the patient is waiting for transfer. The sooner these activities are initiated, the more prepared patients and families are to engage in discharge planning once they arrive at the GRH. The opportunity for interdisciplinary team collaboration before the transfer became quickly evident. Social workers and transitions coordinators from all sectors now have the opportunity to discuss barriers to discharge and to work collaboratively to address the challenges these patients and their family experience.

Every Wednesday morning, hospitals in the Edmonton zone with patients waiting for one of the neuro-rehabilitation programs, or those consulted but not yet accepted, take part in a 30-minutes-or-less call to share information among the teams to improve patient transitions. These weekly rounds were developed to discuss patient progress from a rehabilitation or readiness perspective as well as the initiation of discharge planning considerations such as finances or home living options.

Conclusion
Monthly meetings continue with the hope that other patient populations and strategies can be explored. Patient flow is complex and dynamic. Even the smallest of things that can add efficiency will make a difference. Collaboration and removing barriers has paved the way to look beyond neurosciences at the Glenrose, and to all points along the continuum of the patient’s journey. Discharge planning from a patient flow perspective and the activities within need to be collectively owned and worked on together.

The Glenrose Rehabilitation Hospital would like to acknowledge all the managers and staff within the Edmonton Zone that have contributed and continue to advance this important work.
PROVIDING LEADERSHIP AND SUSTAINABILITY for future generations

Two Alberta registered nurses were thrilled to be selected as the only two Canadians to attend the International Council of Nurses (ICN) Global Nursing Leadership Institute (GNLI) in beautiful Geneva, Switzerland this past September.

Ginger Sullivan, director of global health at the University of Alberta, and Mona Haimour, assistant professor of nursing at MacEwan University, are ready to teach the next generation of nurses about global leadership and sustainability.

Mona and Ginger answer CARNA’s questions about global leadership and help us break down the theme of this year’s institute: “Nursing opportunities in a world focused on sustainable development.”

What is sustainable development, and how does it relate to nursing?

**MONA:** At its most basic level, sustainable development is about growing our economy without depleting our natural resources. Within the context of health and health care, we consider non-health goals including water, poverty, food security and gender equality as part of growing health-care services globally, as well as ensuring proper human health resources such as staffing, and proper equipment and locations for health care. Nurses are ideally suited to helping their governments reach their sustainable development goals within the context of health care at the policy development level; by using evidence-based research and their own front-line experience, nurses can make the case for policy decisions that achieve our health-care goals in a resource-sustainable way.

What was it like being in Switzerland for a week with nurses from different countries?

**GINGER:** It was a really great opportunity. The most valuable piece of the institute was that we had this amazing eclectic group of nursing leaders from all around the world – 26 nurses from over 22 countries, coming together to talk about what were the most pressing issues facing nurses in their regions. What was surprising for me was that a lot of the issues that were raised, or some of the things that we were grappling with, were similar to each other – like human resources for health, ensuring the RNs of tomorrow had these leadership competencies, and how do we achieve these goals?
What activities did you participate in?

**MONA:** Building professional networking and international alliances and becoming more aware of our leadership strengths and areas for improvement. We had the opportunity to discuss global health challenges, improve our policy-related skills, and most importantly learn that taking on higher leadership actions will advance nursing at provincial, national and international levels—starting at our workplaces and beyond.

**GINGER:** It was a really well-thought out program focused on leadership in a global context for practising nurses, educators. Nurses talk about influencing policy, but how do we actually do so? We participated in a simulation where we developed a three-minute public announcement to policymakers on a global health issue of importance to us. We learned to keep it brief, keep it simple, and keep it to the point. We would talk about how the issues affect the public, because ultimately policymakers answer to the public.

What did you learn about your leadership style?

**GINGER:** I’m quite flexible in terms of my leadership style, and while that’s usually a good thing, there are also situations where flexibility is not helpful, like when you need clear direction. So ICN gave me some strategies to help me work on that. And they talked about different leadership styles for different purposes, and we learned that within the core group of people that you work with, there are different personalities and ways of leading, and to focus on your coworkers’ strengths. They focused largely on effective leadership styles, and a big piece of that was really knowing yourself, who you are as a leader, and knowing your strengths and how to pick up on your weaknesses. I thought that was really worthwhile.

How will your experience affect your nursing practice here in Alberta?

**MONA:** As an educator, I wanted to contribute to achieving sustainable development goals through advancing nursing education. For the senior elective course I teach, “High Priority Populations,” I will give my students a new assignment that aims to provide them the opportunity to contribute to sustainable development through the use of social media and a communications strategy. Students will work collaboratively to develop innovative and evidence-informed messages that target multidisciplinary stakeholders; aiming to promote health equity, universal access to health care and social justice. They will present their final work at the MacEwan Global Awareness Week, which takes place Jan. 30 to Feb. 3, 2017. Furthermore, I’m currently collaborating with other professors at MacEwan University to establish a new initiative that will build on the existing sustainable activities within the university; aiming to expand our focus to target all the global goals.

What was your biggest take-away lesson?

**MONA:** For the first time on a global scale, the nursing leadership role in the context of sustainability was addressed. The important niche and differentiating feature of the GNLI 2016 was the emphasis on the impact nursing leadership can do to advance global health agenda and priorities; targeting developing innovative interventions that generate high-impact and sustainable outcomes. Moreover, and more importantly, nurses and the nursing organizations have a moral and ethical obligations to ensure that these goals are met by 2030.

**GINGER:** I learned that leadership, like most things, can be learned and practiced. It’s not like either you have it or you don’t. Nurses are really well-positioned to be leaders in health care and leaders in policy, and it is well worth spending the time to participate in professional development that is focused on leadership.
An older adult was admitted to hospital with a diagnosis of new-onset seizures. Admission orders included initiation of the anticonvulsant phenytoin (hand-written using the brand name Dilantin), 300 mg orally every evening. Before the pharmacy closed, a pharmacy staff member who was new to the clinical area entered the Dilantin order into the pharmacy computer system, so that the medication could be obtained from an automated dispensing cabinet (ADC) in the patient care unit overnight.

In the pharmacy’s computer system, medication selection for order entry was performed by typing the first three letters of the medication name (“dil” in this case) and then choosing the desired medication name from a drop-down list. The computer list contained both generic and brand names. The staff member was interrupted while performing the order entry. When this task was resumed, diltiazem 300 mg was selected instead of Dilantin 300 mg.

On the patient care unit, the order for Dilantin was correctly transcribed by hand onto the medication administration record (MAR). The MAR entry was verified against the prescriber’s order sheet and was co-signed by a nurse. The nurse who obtained the evening medications from the unit’s ADC noticed the discrepancy between the MAR and the ADC display, but accepted the information displayed in the ADC as correct. The patient received one dose of long-acting diltiazem 300 mg orally instead of the Dilantin 300 mg ordered. The next morning, the patient exhibited significant hypotension and bradycardia, which was attributed to the administration of the unordered diltiazem.
BACKGROUND
The implementation of clinical information technology in medication-use systems is widely accepted as a means of reducing the incidence of adverse drug events by decreasing the potential for human error.1 Examples of such technologies include computerized order entry systems (e.g., for pharmacy and prescriber order entry), clinical decision support (e.g., for use during medication dispensing and administration).

Designing safe systems and making subsequent improvements involves the integration of multiple interventions, including high-, medium-, and low-leverage strategies.2 Because automation and computerization are considered high-leverage, they are expected to be more effective than lower-leverage strategies in combatting the shortcomings of existing manual medication systems.

DISCUSSION
Automation bias and automation complacency
Although consensus has not been reached for definitions of these two concepts, the tendency to favour or give greater credence to information derived from an automated decision-making system (e.g., an ADC display) and to ignore a manual (non-automated) source of information that provides contradictory information (e.g., a handwritten MAR) illustrates the human cognitive phenomenon of automation bias.3

Automation complacency is a related, overlapping term that refers to the monitoring of an automated process less frequently or with less vigilance than optimal because of a low degree of suspicion of error and a strong belief in the accuracy of the technology.4 End-users of an automated technology (e.g., the ADC display listing medications to be administered) tend to forget or ignore that information output from the device may depend on data entry by a human being.

In other words, processes that may appear to be wholly automated are often dependent upon human input at critical points and thus require the same degree of monitoring and attention as manual processes. Automation bias and automation complacency are thought to result from three factors:4

- In human decision-making, people have a tendency to select the pathway requiring the least cognitive effort, which often results in letting technology dictate the path. This factor is likely to play a greater role as humans are placed under heavier workloads or face increasing time pressures – common phenomena in health care where resource constraints are in place.
- People often perceive that the analytic capability of automated aids is superior to that of humans, which may lead them to overestimate the performance of these technologies.
- People may reduce their effort or shed responsibility in carrying out a task when an automated system is also performing the same function. It has been suggested that the use of technology convinces the human mind to hand over tasks and associated responsibilities to the automated system.5 This mental handover can reduce the vigilance that the person would demonstrate if carrying out the particular task independently.

There is conflicting evidence as to the effect of training and experience on automation bias and automation complacency. One study indicated that these types of errors may occur more frequently with inexperienced staff and that as experience and confidence in one’s own knowledge increases, there may be reduced reliance on technology.3 Conversely, it has also been shown that increased familiarity with a technology can lead to desensitization and habituation effects, which may cause clinicians to contradict their own instincts by accepting inaccurate technology-derived information.3 In the incident described above, there were two occurrences of automation bias/complacency: first, when the pharmacy staff member accepted diltiazem as the correct drug in the computerized pharmacy order entry system, and second when the nurse identified the discrepancy between the ADC display and the MAR but trusted the information on the ADC display over that on the handwritten MAR.

As trust in automation increases, people tend to use it “as a heuristic replacement of vigilant information seeking and processing.”5,6 In other words, when automation is perceived as reliable, people are less likely to question the accuracy of its outputs and are therefore particularly prone to missing failures of automation.7 Automation bias can be considered a rational strategy to optimizing decision making – but only if the users’ trust in the automation closely matches the reliability of the automation itself.

Therefore, strategies to address errors related to automation bias should focus on:
- improving the reliability of the automation itself; and
- supporting clinicians to more accurately assess the reliability of the automation, so that appropriate monitoring and verification strategies can be employed.

Clinical context
Automation and computerized order entry systems should be considered additional tools in the safe delivery of care. Although their use can make many aspects of the medication-use system safer, health-care professionals must continue to rely on and apply their clinical knowledge and critical thinking to provide optimal patient care. Thoughtful consideration of the nature of the therapy in the context of the patient’s clinical presentation can play a significant role in preventing errors.

An opportunity exists to modify and improve order entry systems so that they compare and match a patient’s diagnoses and conditions with the medications being prescribed.8 However, the introduction of such technologies needs to be studied thoroughly to identify the benefits and risks with such an approach. >
RECOMMENDATIONS

Health-care organizations

- Provide training about the automated components of the medication-use system to all involved staff, both at orientation and on an on-going basis.
- Include information about the limitations of such technology, as well as previously identified gaps and opportunities for error.
- Allow trainees to experience automation failures during training. Understanding the technology and the human-technology interfaces within the system can help to reduce automation bias and encourage critical thinking in using automated systems.
- Conduct a proactive risk analysis (e.g., failure mode effects analysis [FMEA]) and/or staged implementation for new technologies to identify unanticipated vulnerabilities. Address any system shortcomings that are identified before undertaking facility-wide implementation. In particular, seek feedback directly from end-users to identify limitations and encourage reporting of technology-associated risks, issues, and errors.
- Allow automated systems to communicate seamlessly, thereby limiting human-computer interfaces. Consider an integrated system comprised of physician order entry, pharmacy, ADC and pharmacy-generated MAR components that allow for independent double checks throughout the process.
- Incorporate recommendations for pharmacy and nursing (see below) into organizational medication administration policies.

Pharmacy and nursing

- Ensure those involved in the double check process can do so uninterrupted and are not simultaneously responsible for other tasks. Automation failures are less likely to be identified if the human monitoring the automated outputs is required to multi-task.
- Establish a standardized process to address identified medication discrepancies, including verification of the original prescriber’s order before medication administration. This manual verification counteracts automation complacency that can occur with technological outputs from the medication use process. Part of the verification process should include assessing the appropriateness of the medication based on the patient’s medical history and treatment plan.
- When selecting a medication from the ADC, compare the ADC display with the MAR to confirm the accuracy of order entry and transcription. Locating ADCs in areas where nurses have easy access to patients’ MARs will support this process.

CONCLUSION

Over-reliance on automated processes, as well as the inevitable increase in human/technology interfaces, can result in unanticipated errors. Automation and its associated technologies play an important role in the design and improvement of medication systems; the technology must be viewed, however, as supplementary to clinical judgement.

Acknowledgements

ISMP Canada gratefully acknowledges the reporting facility for sharing the incident and the following individuals for their expert review of this bulletin (in alphabetical order):

Maria Anwar, BScPharm, ACPR, Pharmacy Clinical Practice Leader – South Health Campus, Alberta Health Services, Calgary, AB
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Munira Jessa, MAsc, PEng, Senior Project Manager, Alberta Health Services, Calgary, AB. RN

REFERENCES

EDUCATIONAL OPPORTUNITIES

NOTICEBOARD

CALGARY/WEST

EMERGENCY MEDICINE FOR RURAL HOSPITALS
Jan. 20 - 22, 2017 | Banff
cumming.ucalgary.ca

PREVENTION AND LONGEVITY: EVIDENCE BASED MEDICINE FOR YOU AND YOUR PATIENTS
Jan. 27, 2017 | Calgary
preventionandlongevity.ca

ERASALBERTA SYMPOSIUM
Jan. 27–28, 2017 | Calgary
cvent.com/d/zvqw0d

RURAL AND REMOTE MEDICINE COURSE
April 6 - 8, 2017 | Calgary
srpc.ca/rr2017

CALGARY GENERAL HOSPITAL SCHOOL OF NURSING ALUMNAE HOMECOMING BANQUET
May 5, 2017 | Calgary
louisems@shaw.ca

EDMONTON/WEST

NP FORUM FOR NURSES AND ALLIED HEALTH
April 7, 2017 | Edmonton
npforum.ca

ROYAL ALEXANDRA HOSPITAL SCHOOL OF NURSING BANQUET
May 5, 2017 | Edmonton
rahreunion2017@gmail.com

The submission deadline for events and reunions in the Spring 2017 issue of Alberta RN is Feb. 3, 2017. Go to nurses.ab.ca for a complete and up-to-date listing of events and reunions or to submit an event for publication.

CARNA modules

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Access at nurses.ab.ca/privacy

> Leadership
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To be introduced in 2017.

IN MEMORIAM

Boren, Beverly, a 1970 graduate of the University of Alberta hospital school of nursing, who passed away on Oct. 12, 2016 in Edmonton.

Button, Kerry (née Lastiwka), a 1992 graduate of the University of Alberta hospital school of nursing, who passed away on March 11, 2016 in Show Low, Arizona.

DeHaan, Tara, a 2005 graduate of the University of Alberta, who passed away on June 26, 2016 in British Columbia.

House, Gloria (née Fedorenko), a 1953 graduate of Providence hospital school of nursing, who passed away on Oct. 27, 2016 in Edmonton.

Johnston, Beatrice (née Kennedy), a 1961 graduate of South Waterloo hospital school of nursing, who passed away on April 22, 2016 in Edmonton.

Meikle, Sheena (née Ferguson), a 1974 graduate of the Royal Alexandra hospital school of nursing, who passed away on Feb. 19, 2016 in Calgary.

Reich, Laura, a 1958 graduate of Edmonton General Hospital, who passed away on May 6, 2016 in Edmonton.

Wolfe, Lydia (née Shroeder), a 1937 graduate of the Royal Alexandra hospital school of nursing, who passed away on Feb. 15, 2016 in Edmonton.

SUBMIT TO:
In Memoriam

To submit the name of an Alberta registered nurse, current or former, who has passed away, please forward the relevant information including an obituary to registration@nurses.ab.ca.

PLEASE NOTE: under the Personal Information Protection Act, in order to publish certain information included in In Memoriam, we need written consent from the person who has authority to act on the deceased’s behalf: the executor/administrator of the estate or the funeral arranger.
Established through the generosity of our donors, excellence in academic achievement and professional contributions are recognized through the annual scholarships which are awarded to CARNA members studying at masters or doctoral degree levels. Scholarships are awarded based on academic achievement and strengths in nursing leadership, research, professional contributions, administration, education and/or nursing practice.

Alberta RNs and NPs are also fortunate benefactors of numerous named scholarship funds established by donors in specialized areas of nursing study. ARNET uses a single application format for all ARNET scholarships and the review process is highly competitive.

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FRIDAY, MAY 5, 2017

REGISTRATION BEGINS JANUARY 2017

nursesontherun.ca
Welcome to the next century of registered nursing

This past July, Provincial Council appointed me as acting CEO to steer CARNA operations until the selection committee found the right candidate to fill the position. Provincial Council has begun final interviews with the short-listed candidates, and hope to make an announcement of a new CARNA CEO soon.

With the support of my colleagues on the CARNA leadership team, we have continued the work on several major initiatives including the ongoing collaboration with Alberta Health and other stakeholders on the revisions to the Registered Nurses Profession Regulation. At the same time, we are developing the necessary plans, policies and processes to implement the regulation once the Alberta Government proclaims it. We’re also reassessing our continuing competence program, creating a new module for the jurisprudence requirement (see page 22) and creating new standards and guidelines for registered nurse prescribing and ordering of diagnostic tests. We have asked for, and received, member input throughout this ongoing journey and appreciate the time you’ve given to participate in this next iteration of our continuously evolving profession.

The organizational transformation we introduced in the winter 2016 issue of Alberta RN (available to read online at nurses.ab.ca) also continues. We hired new staff and reorganized the roles of many others with the goal of improving efficiency and meeting our members’ expectations of CARNA. I’d like to thank my colleagues pictured here for their hard work and unwavering support throughout this transition.

For example, members told us they want access to relevant education and professional development supports. The Professional Practice Support department is currently developing new online learning modules for nursing leadership and infection prevention and control, and we’re making other learning opportunities such as case studies available to members.

Another way that members wanted CARNA to improve was through our participating in, and advocacy for, provincial health-care initiatives. Staff are participating in the “Just Culture” project initiated by the Health Quality Council of Alberta. The project aims to develop principles, communications tools, an accountability review process, and support a research project. We are also members of the strategic clinical network supporting the AHS Indigenous Health Program to provide high quality, culturally-appropriate health services to indigenous populations in Alberta.

In the last six months, we implemented the celebratory activities for the second half of our centennial year in keeping with Provincial Council’s vision. This included a tour of our centennial exhibit to local hospitals, centennial galas in Edmonton and Calgary and finally the distribution of the souvenir postcard book included with this issue of Alberta RN. Highlights’ of all the celebratory activities and a historical retrospective of the profession are available at the centennial website carna100.ca.

So as we say goodbye to 2016 and move forward into the next century of registered nursing in Alberta, we want to thank all of our CARNA members who have set the extraordinary example of what registered nursing in Alberta is – compassionate, caring, skilled, educated and ethical.

Jeanette Machtemes, MBA, CPA, CMA
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