Coming of age

Attitudes toward older adult population present barriers and opportunities to improve care

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President’s Update
What’s the plan for continuing care?

“Can you please articulate the essential role of the RN/NP in _______?” It is a question I am asked frequently, across settings. Like most nurses, I am a seeker of solutions, and like most educators, I am quick to jump to the education solution; if I could just articulate it better, say it differently, maybe do a video, then people will get it, and they’ll be able to do it. Here’s the thing though: there’s a whole lot more going on and a lack of understanding or envisioning our roles is only part of it. The truth is, there are also entrenched cultural and institutional barriers and expectations that are getting in the way of RNs and NPs – constraining the roles we are educated to fulfill.

This struck me about the time I was working on the script for my third video blog on the role of RNs and NPs in continuing care (I have done two other videos about roles in primary care and in acute care). Here I was, saying many of the same things I said in those other two scripts: the role of RNs/NPs in continuing care is to lead the enactment of the principles of primary health care and use every encounter with a resident as an opportunity to improve health and well-being. Fair warning: I can’t silence my inner educator for long, so I invite you to consider that in continuing care settings, enacting the principles of primary health care means:

- knowing the population well (both as a group with specific levels of risk for certain adverse events or outcomes, and as individuals who are part of families and a community)
- knowing the evidence well around best practices to support care in this environment
- actively incorporating health promotion into the plan of care, such that life in a continuing care setting is about living well, and putting the right supports in place to help that happen within a web of supportive relationships
- actively incorporating preventative health care by making plans to prevent problems that might compromise health (falls, loss of continence, loss of mobility, etc.)
- building capacity in the care team and leading integrated, family-centred care planning that looks well ahead of today, actively engages residents and families, and puts their goals/preferences and needs first
- ensuring a solid foundation of continuous primary care, and problem-solving with team members and families when complex or urgent health issues arise
- speaking up for policies and resources that focus on building the right supports around residents where they live, in their homes, whether that home is in the community or in a facility

If this doesn’t look like the way RNs/NPs are able to practise in continuing care settings that you know, it isn’t only because we can’t envision it – it’s because of systematic barriers that we must work collaboratively to address at all levels, such as:

- short-term budgetary thinking (cut staff and dilute skill mix to save money)
- a culture of health care that sees continuing care as “less than” other sectors
- a system preoccupied with disease and decline in continuing care instead of maximizing health and restoring function
- a system preoccupied with eligibility criteria for service instead of tailoring service to meet need

There is a lot underway in the policy environment around continuing care: Alberta Health Services and Alberta Health are working on a vision for a provincial dementia strategy; Alberta Health has a vision for a new continuing care strategy; CARNA is moving forward on its policy advocacy around the health and well-being of older Albertans; the Minister of Health has made announcements about new ‘continuing care spaces;’ and the rural health review that I am part of is certainly highlighting gaps in continuing care (including home care) in rural/remote communities.

There’s a lot of ‘vision’ going around, but it’s been said that a vision without a plan is a daydream. I urge policy and decision makers to ensure that the plan for continuing care is founded on a system-wide culture shift towards primary health care. And by the way, Alberta’s RNs and NPs can help you with that!

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Connect with Shannon: @SSpenceley expertcaringmatters.ca
In September 2014, CARNA Provincial Council decided to:

- withdraw the *Evidence-Informed Staffing for the Delivery of Nursing Care: Guidelines for Registered Nurses* (2008) document, and

- endorse the Canadian Nurses Association (CNA) document *Staff Mix Decision-making Framework for Quality Nursing Care* (2012).

Feedback from a survey of members and stakeholders suggested that the document was outdated and not sufficient to meet your needs when making staff decisions at the unit level. The key questions in the framework section for making staffing decisions were found to be useful. There are similar questions, and many more, in the CNA *Staff Mix Decision-making Framework for Quality Nursing Care* (2012). These questions can assist staff mix decision-making in each of the following phases: assessing, planning, implementing, and evaluating. The CNA document is now available on the CARNA website at nurses.ab.ca.

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### CORRECTION TO FALL 2014 ALBERTA RN

In the previous issue of the magazine, we printed an incorrect website address for the Skin & Wound Alberta Group. The correct website address is: www.skinwoundalbertagroup.com

We apologize for any inconvenience this may have caused.
Professional development opportunities and information about CARNA provided by Regional Coordinators highly valued by nurses

If you have ever attended a CARNA education session or a CARNA regional event, you have probably met your regional coordinator(s).

We conducted an evaluation of the regional coordinator program to learn more about how relationships are established and how regional coordinators reach CARNA members across Alberta. We wanted to explore the regional coordinator connections with members and what value it brought to members’ practice. The feedback was used to strengthen the goals and objectives of the program. The goals of the program are to:

1. increase members’ awareness and understanding of the role of CARNA and their responsibilities in a self-regulated profession;
2. support and encourage registered nurse leadership at the regional and provincial level; and
3. support and encourage pride in the registered nurse profession.

Participants of the evaluation spoke highly of the relationship between regional coordinators and members at the regional level. They see value and worth in the engagement of members and the networks established. Survey respondents rated the importance of the relationship to be “very important” (31%) or “extremely important” (9%).

The three main reasons members and stakeholders identified connecting with a regional coordinator were:

- needing information (31%)
- professional development sessions (23%)
- providing feedback to CARNA (20%)

Findings in the evaluation indicated that the regional coordinator is more than just the CARNA connection in the region. They are also a part of the local fabric which facilitates connection and provides a sense of a trusted navigator.

If you haven’t yet met your regional coordinator, send them an email, a quick phone call or attend the next education session in your region to introduce yourself. You can find the contact information of all regional coordinators on the CARNA website at nurses.ab.ca.

Thank you to all who participated in the interviews and completed the survey as part of the evaluation of the regional coordinator program.

Share your nursing practice articles with us!

Are you proud of your contribution to the program or services your team provides? Would you like to share your clinical practice, education, research or administrative expertise with other RNs? We would like to help you spread the word! We are looking for fresh nursing content for Alberta RN magazine. With an audience of more than 35,000 registered nurses and nurse practitioners, your message can really make an impact in the Alberta nursing community.

Send your articles and photos to albertarn@nurses.ab.ca.

The editorial deadline for the Spring 2015 issue is Feb. 6, 2015.
Due to a resignation, this position will be for a three-year term instead of the usual four-year term: one year as president-elect and two years as president.

**Four Provincial Councillor positions open!**

Being part of Provincial Council, you will work alongside colleagues who share your passion for championing the contributions of registered nurses and nurse practitioners, promoting the role of CARNA and making policy decisions in the best interest of the public.

**Do you have what it takes?**

- You understand nursing and health-related issues.
- You have a willingness to embrace a leadership and decision-making role.
- You have the ability to examine, debate and decide on issues that form the basis for policy.
- You are a resident in the CARNA region in which you run.

**For more information** about the role of president-elect or provincial councillor, contact Chris Davies, Chair, Nominations Committee, at 403.650.0864 or cdavies@nurses.ab.ca. You can also watch *Your Professional Voice in Alberta and Nursing: A Self-Regulated Profession* at nurses.ab.ca/webinars.

**NOMINATION FORMS ARE AVAILABLE AT:**

nurses.ab.ca

Or contact Aura Juarez at ajuarez@nurses.ab.ca or 780.733.9392, toll-free 1.800.252.9392 ext. 435
Carna Election Teller/Alternate Teller
Two members needed

Duties
• be present during the electronic ballot count at the CARN A office
  in Edmonton on May 18, 2015 (approximately two hours)
• determine the admissibility of all questionable ballots in accordance
  with election rules
• prepare teller reports for the CARN A president and chair of the Nominations
  Committee

The alternate teller will serve as teller if the teller is unable to fulfill their duties.

CARN A will reimburse travel expenses of the teller and offer a salary replacement/
per diem to compensate for time away from work.

Qualifications
• RN or NP member of CARN A
• not a candidate seeking election to Provincial Council

Questions?
If you have questions about the role of the teller, please contact:
  Diane Wozniak
  780.453.0525/1.800.252.9392 ext. 525
dwozniak@nurses.ab.ca

How to apply
Download an application form at nurses.ab.ca.

Apply by: Friday, Feb. 27, 2015
COMMITTED TO COMPETENCE

Did you submit enough information for your continuing competence this year? The answer may surprise you.

When it comes to your yearly learning plan, there is no set amount of information you must submit for your plan to be accepted. All that is required is that you document that you participated in activities that meet your specific learning objective, and have thoughtfully considered the impact of the activities on your practice. That’s it!

Continuing competence, although a requirement of registration, is based on the nurse’s self-learning and self-evaluation of that learning on their practice. It’s up to you to determine if you have continued to improve your competency in nursing by engaging in learning activities throughout the year.

Some people may engage in 10 or more activities and relate them all back to their learning objective; some may engage in the same number of activities but only two relate to their objective; and others may only participate in a few activities overall. The important part isn’t the number of activities or length of your evaluation, but the quality and relevance of each to your learning objective.

The vast majority of members randomly selected for review of their continuing competence information have shown their strong commitment to achieving practice excellence through professional development.

A small sample of some of these exceptional learning plans are included here, with the consent of their authors, to help you in the development of your own plans. Their plans showcase the efforts of nurses from a broad range of practice settings, with varying years of experience and with very different objectives and activities.

Thank you to those who agreed to share their learning plans, and to all the nurses who participated in this year’s review.

M.R. / PACU, ACH, 26 years experience

LEARNING OBJECTIVE:
I would like to increase my knowledge regarding the many different types of blocks seen in my practice. Specifically how long each block is expected to last, possible complications and patient care regarding same.

RELEVANCE:
Many anesthetists are now using blocks regularly. Pain control is a huge issue in the recovery room. Proper assessment and patient care/education is essential.

ACTIVITIES:
Self-Study Modules: Completed Module on Regional Anesthetic Nerve Blocks; Completed Post-test; Attended PACU Skills Day. 10/16/2013

EVALUATION:
I am able to confidently manage complex pain patients who have received regional blocks and anticipate the need for further analgesia. I have had the opportunity to share this knowledge with students and junior staff.

H.B. / NICU, 35 years experience

LEARNING OBJECTIVE:
I will become familiar with current standards, policies and protocols regarding MRSA so that I will be able to:
• know the admission criteria for someone who is admitted with MRSA
• identify the usual sites to be swabbed
• understand how MRSA may be contracted
• identify methods to reduce the spread of infection

RELEVANCE:
MRSA is becoming more prevalent and presents a significant health hazard. It is important that I become familiar with current research and best practice concerning prevention and control of infection so that I may maintain a high standard of practice.

ACTIVITIES:
Group/Team Project: As a group we wanted to know the policy for MRSA in our hospital, and so we read and discussed amongst the group how to do this. We went over the sites to be swabbed, discussed how MRSA is contracted, and we identified methods to reduce the spread of infection. We also looked into the history of MRSA. 08/01/2014

EVALUATION:
I am now aware of the MRSA policy and am confident about what to do when a patient with MRSA comes into hospital. Also I feel comfortable with explaining to a patient what our policy is and why we need to reduce the spread of infection.
### Learning Objective

- **L.T. / Intermediate Care Nursery, 35 years experience**
  - To learn methods that will help encourage and assist mothers to breastfeed their babies successfully.

- **J.S. / Acute Care & Diabetes Education, 15 years experience**
  - Learn to integrate Health Care Approach style communication into client-based conversations and interviews.

### Relevance

- **L.T. / Intermediate Care Nursery, 35 years experience**
  - It is important that all nurses give consistent information about breastfeeding both verbally and through demonstration... (as it) can influence how long a mother may decide to breastfeed... to promote health and well-being.

- **J.S. / Acute Care & Diabetes Education, 15 years experience**
  - Clients/caregivers/spouses who feel comfortable with the provider will feel secure to ask relevant questions, which enhances safety when dealing with new or changes in insulin.
  - By using techniques learned, I will be better able to assist clients to self-manage chronic diseases, determine readiness, importance, commitment and knowledge of subject.

### Activities

- **L.T. / Intermediate Care Nursery, 35 years experience**
  - **Journal Article:** The Baby-Friendly Initiative, *Alberta RN* Spring 2014 vol. 70 no. 1. 5/15/2014
  - **Online Modules:** Complete the practical component of the Breastfeeding Essentials course. 3/16/2014
  - **Demonstrated Learning:** Complete the practical component of the Breastfeeding Essentials course. 3/30/2014
  - **Presentation:** ‘A Good Feed” A Speech Language Pathologist’s Perspective. 5/28/2014
  - **Presentation:** Review literature from presentation Breast Files – Galactogogues and Milk Supplies. 4/3/2014

- **J.S. / Acute Care & Diabetes Education, 15 years experience**
  - **Conference/Seminar/Workshop Presentation:** Best Practices for Diverse Populations: Communications with Low-German speaking Mennonites. 4/23/2014
  - **Group/Team Projects:** ‘Health Change Approach Monthly Practice Technique – January 2014-’First Ask, then offer’ and ‘Menu of options.’ 01/31/2014
  - **Case Studies/Simulated or Demonstrated Learning:** Health Change Approach Case study: P.S. 01/22/2014
  - **Case Studies/Simulated or Demonstrated Learning:** Health Change Approach Case Study: F.T. 05/14/2014
  - **Conference/Seminar/Workshop Presentation:** Beyond the Scale—Exploring weight and health. 05/23/2014
  - **Conference/Seminar/Workshop Presentation:** Palliser Primary Care Network—Diabetes workshop. 11/21/2013

### Evaluation

- **L.T. / Intermediate Care Nursery, 35 years experience**
  - The learning activities for this indicator have given me a broader knowledge base which I can use to teach and assist moms breastfeeding with more confidence. (This) allows me to strive for higher consistency... and to communicate mom’s wishes in the breastfeeding process to other members of the nursing team.
  - I also learned that this teaching can be done with patience and a hands-off approach which often leaves everyone more calm and positive.
  - Overall, I feel this new knowledge helps me assess and teach reliably and work cohesively with my co-workers to help the mom and baby learn how to breastfeed successfully in a positive partnership.

- **J.S. / Acute Care & Diabetes Education, 15 years experience**
  - ... by learning and implementing the communication tools and techniques used in Health Change Approach my communication with clients and significant others has become more effective and respectful. Continuous awareness and exercises... helped me to gain confidence. I have implemented a wide variety of techniques with surprising success... over the course of the year it has become more routine. Clients are absolutely more engaged in health maintenance and self-management. By improving health, this improves safety outcomes as well as quality of life. Seeing these changes improves my own job satisfaction and pride in my profession.
### C.E. / Informatics, Hospital, 12 years experience

**Learning Objective:**
How eDocumentation will impact nursing services. Understand the flow of information between disciplines for continuity of care. Learn more about clinical informatics and how it is being used to complement nursing care.

**Relevance:**
In my role as lead for [redacted] I want to ensure that what is implemented in the eDocumentation system will enhance patient care and improve nursing practice.

**Activities:**
- **Consultation with Experts/Peers:** Implemented an electronic documentation system at the hospital. Met regularly with staff, managers and leadership to identify progress, adoption, gaps and areas of improvement. Worked with team to improve the system and communicate changes to staff. 8/15/2014
- **Workflow Impact Sessions:** 7/02/2014
- **Clinical Working Group/Electronic Documentation:** 8/11/2014
- **Journal Article:** on peer support and generation gap using electronic documentation. 6/02/2014
- **Books/Manuals:** Hiatt, J. (2012). Change Management: The people side of change. Loveland, Co: Prosci Research

**Evaluation:**
These activities prepared me for the human side of change. I was very much focused on the electronic documentation system itself when I first selected this indicator. I realized through this practice year how it is the users of the system that will make the system successful. While we can create a tool, the development of the tool requires an understanding of the user’s needs, feedback from their experiences and knowledge of how they will react to a change of practice to make the change happen and stick. While you can communicate the need for quality improvement and give them the opportunities to change, the change starts with the individual recognizing the need for the change. It is the “What’s In It For Me” attitude that must be acknowledged by the change makers.

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### D.T. / ICU, 10 years experience

**Learning Objective:**
My objective is to enhance my knowledge, understanding and interpretation (within the RN scope) of ECG 12 leads. I will do this by self-discovery, utilizing our ICU CNEs and possibly residents and/or physicians.

**Relevance:**
In critical care, we often do ECGs on our patients... recently I realized that I am at a very basic level of knowledge and understanding of ECGs.

**Activities:**
- **Education Courses:** Counter shock-defibrillation and synchronized cardioversion, transcutaneous pacemakers, and emergency cardiac management. 04/10/2014
- **Books/Manuals:** ECGs MADE EASY, by B. Aehlert. I have worked through the test rhythm strips and the review questions at the end of each chapter. 06/29/2014
- **Education Courses:** Mandatory packages which included temporary trans venous pacemakers. 03/18/2014
- **Consultation with Experts/Peers:** Met with CNE in regards to follow up from mandatory Education days. 05/08/2014
- **Distance Education/Online Modules:** Signed up and completed ECG basics and interpretation, arrhythmia practice drills, 12 lead training. I found this site at practicalclinicalskills.com. 11/04/2013
- **Consultations with Experts/Peers:** CNE was doing informal teaching about heart blocks... (including) physiology and anatomy of the heart, and recognition and potential risks if left undetected and untreated. 04/22/2014

**Evaluation:**
Improving my ECG interpretation skills has ensured that I have the knowledge to make the best care decisions for my patients. Increasing my understanding about the relationship between ECG analysis findings and disease process and medications has helped me communicate with my colleagues and physicians and recognize changes in my patients that I may not have recognized without this knowledge. Throughout this year, I have gained a true sense of accomplishment. I have increased my knowledge and confidence when it comes to my nursing practice. I can freely say that I am competent in the areas of interpreting ECGs/cardiac strips, within an RN scope. I believe that being comfortable with interpreting cardiac tracings makes me a better nurse, mentor, teacher and co-worker.
### C.C. / Rehabilitation (Management), 35 years experience

**Learning Objective:**
To improve my leadership skills, techniques and strategies by May 30, 2014.

**Relevance:**
As a manager, it is important to provide mentorship to other staff in order to provide quality of care to our patients.

**Activities:**
- Leadership Development Program: received certificate from Conestoga College and the Research Institute for Aging. Comprised of six courses and many modules per course. Aspects of the course included in-class days; webinars; readings; individual assignments and group work 04/24/2014
- Books/Manuals: Strength Based Leadership, Great Leaders, Teams and why people follow by Rath & Conchie. 04/24/14
- Internet Research: Watched many YouTube presentations on leadership. 04/24/14

**Evaluation:**
Completing the Leadership course has given me knowledge and confidence to lead my team into the unknown future of healthcare. I can bring new ideas forward to my team with the openness, understanding, and confidence that we can make changes as a team for the better.

I also have team members that have also completed this course that I can bounce ideas off of when things become more difficult and I need support and suggestions. I have learned much in the area of leadership and each day I need to put into practice at least one thing in order to continue growth.

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### P.K. / PACU, 40 years experience

**Learning Objective:**
Current methods of pain control for post-op patients.

**Relevance:**
In my practice, I deal with pain control issues on a regular basis.

**Activities:**
- **Workplace Presentation:** ‘Methadone use in Acute pain’ presented by acute pain service RGH. 02/21/2014
- **Workplace Presentation:** ‘Everything About Epidurals’ presented by Acute Pain Service RGH. 03/14/2014
- **Workplace Presentation:** ‘Ketamine Infusions’ presented by Acute Pain Service RGH. 04/25/2014
- **Journal Article:** “Perioperative Pain Management in Opioid Tolerant Patient with Chronic Pain—An Evidence Based Practice Project” Journal of Perianesthesia Nursing Vol 27 No 6 2012. 06/24/2014
- **Journal Article:** “Physiology and Treatment of Pain” Jennifer Helms RN PhD, C. Barone RN EDD LNC CPC CCNS-BC APN Critical Care Nurse Vol28 No 6 Dec 2006/24/2014
- **Journal Article:** “Learning the Essentials of Epidural” by A. J. Schwarts RN CRNA DDS Nursing 2006 Vol 36 No 1. 03/14/2014

**Evaluation:**
I found that if I started post-operative pain control immediately upon waking, I was able to collaborate with the patient regarding their pain needs before pain escalated.

Through my learning activities, I learned that a combination of analgesia methods (opioid, NSAIDS, hot/cold therapy, guided imagery etc.) helped especially in the chronic pain patient. Working in combination with the patient, I was able to allow the patient to have control in their post-operative stay; I found that in doing so, they were much more comfortable upon discharge from PACU. RN
Entry-to-practice exam writers now have access to faster test results with the NCLEX-RN, the registered nurse exam for those seeking to practice as an RN in Canada. It uses Computerized Adaptive Testing (CAT), a method that combines computer technology with modern measurement theory to create a more efficient, fair and psychometrically-sound exam.

Key benefits of the NCLEX-RN

- **More flexibility:** the exam can be taken year-round at any registered centre.
- **Quicker testing time:** the exam is tailored to your competence level resulting in a shorter exam.
- **Sample questions:** a tutorial provides practice questions to help you “settle in” to the testing situation.

CAT tailors the exam by identifying each writer’s competency based on the difficulty of questions answered correctly, rather than the number of questions answered correctly.

For example, if you are asked a relatively easy question, and you answer it correctly, you will be asked a somewhat harder question because you’ve shown that you can probably answer easier questions correctly. For that reason, the next question will be slightly more difficult. Increasingly more difficult questions will be asked, until you’ve incorrectly answered a question. At that point, the next question asked will be slightly less difficult.

This means that as you progress through the exam and the calculations become more precise, you will be asked fewer questions as you keep answering questions that are above or below the passing standard. This leads to a shorter exam and a quicker pass or fail. Others, however, who are near the standard, either a little above or a little below, will be asked more questions in order to determine their pass or fail results.

After a writer has answered the minimum number of questions, the computer compares their competence level to the passing standard and makes one of three decisions:

- **If the candidate is clearly above the passing standard, they pass and the examination ends.**

- **If the candidate is clearly below the passing standard, then they fail and the examination ends.**

- **If the candidate’s competence level is close enough to the passing standard that it’s still not clear whether they should pass or not, then the computer continues to ask questions.**

While most candidates finish the exam in about two hours, they will be given up to six hours to complete the exam. Therefore, the final competence level is not determined by the number of questions answered correctly, but by the difficulty level of questions answered correctly.

We are pleased to be moving forward with the NCLEX-RN as the entry-to-practice registered nursing exam in Canada.

**What’s different about the NCLEX-RN?**
Change is in the Air: Monitoring our Progress

Jurisprudence
In September 2010, CARNA Provincial Council established a requirement for new applicants and current CARNA members to demonstrate competence in jurisprudence. Development of a product to fulfill this requirement is now complete with final testing scheduled for this fall.

The product integrates education about profession-led regulation with assessment of this knowledge. The principles of online gaming are applied to test items developed using traditional test development techniques. The intent is to create an engaging and educational experience, while also being a meaningful and sound assessment of competence in jurisprudence.

RN Regulations
An environmental scan of national and international RN prescribing educational programs was completed. The scan also looked at prescribing education required by other professions within Alberta who had initiated prescribing for their members. The environmental scan provided information that will be considered in the development of an educational program for RNs who will be authorized to prescribe in a specific clinical area of practice.

At the time of printing, we continue to wait for the next draft of the revisions to the Registered Nurses Profession Regulation from Alberta Health.

Vascular Risk Reduction (VRR)
The VRR working group, led by the Cardiovascular Heart and Stroke strategic clinical network (SCN), is seeking to optimize the prevention, detection and management of people at increased vascular risk in Alberta. CARNA is a member of the working group and is participating on three sub-groups that will address tobacco use, healthy eating and physical activity, and vascular risk assessment. Initiatives developed so far are pilot testing of a healthy living prescription and a letter to AHS supporting a program that assesses and follows up on smoking behaviour of patients admitted to a hospital.

Infection Prevention & Control (IPC)
Over the last several years, government has been increasingly concerned about breakdowns in infection prevention and control practices. In 2013, the Auditor General of Alberta reviewed the implementation of the Alberta Health IPC strategy and made recommendations to Alberta Health and Alberta Health Services. In response to the auditor general recommendations, Alberta Health initiated a review of the IPC and hand hygiene strategies.

Within the IPC strategy are five strategic directions:
• Accountability and Monitoring;
• Province-Wide Surveillance;
• Human Resource Capacity;
• Physical Environment and Infrastructure; and
• Public Awareness and Education.

Within each of these strategic directions are recommended actions for the three partner groups: Alberta Health, Alberta Health Services and regulatory colleges.

When the revised IPC strategy is approved, there is an expectation that the regulatory colleges will provide Alberta Health with an implementation plan. Alberta Health intends to establish a monitoring committee to track progress.

Issues related to IPC that are appropriate for CARNA’s involvement are being identified and an action plan will be developed to address issues and concerns. This action plan will inform CARNA reporting in response to the IPC strategy from Alberta Health.

Learning from Experience Project
The implementation phase of this project continues. CARNA registration department staff members are using new criteria for Internationally Educated Nurses (IEN) application assessment, based on policy changes that were informed by analysis of applicant data and outcomes. Further analysis will be completed at the end of the implementation period in 2015. The goal of this project is to improve the efficiency and quality of the assessment decision-making process regarding IEN applications for registration with CARNA.
A Hearing Tribunal made a finding of unprofessional conduct against a member who administered IV fluids and Maxeran on an RN coworker without ensuring there was a written physician’s order or proper documentation done of an assessment or the interventions provided. The Tribunal issued a caution.

A Hearing Tribunal made a finding of unprofessional conduct against a member who requested that a coworker initiate an IV and administer Maxeran without a physician’s order and without being a patient. The Tribunal issued a caution.

A Hearing Tribunal made a finding of unprofessional conduct against a member who, while working as a Resident Care Manager, failed to communicate effectively with the lead LPN, other staff, and a new staff member, whom the member had just hired, regarding the specific duties the new staff member could and could not perform, when the member erroneously assumed they would know the new staff member should not be allowed to administer medications and was only to perform the duties of a student HCA, such as assisting with bathing and portering. The Tribunal issued a caution.

A Hearing Tribunal made a finding of unprofessional conduct against a member who, while working as a Manager, she misrepresented her qualifications to the Acting Complaints Director of CARNA on two occasions by telling her that the member has a Bachelor of Science in Nursing, when, in fact, she does not; and who misrepresented her qualifications to the Acting Complaints Director of CARNA on two occasions by telling her that the member has a Bachelor of Science in Nursing, when, in fact, she does not. The Tribunal issued a reprimand and ordered the member to pay a $2,000 fine and complete the e-modules on the Code of Ethics. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

A Hearing Tribunal made a finding of unprofessional conduct against member #64,212 who, for three consecutive years, failed to ensure his practice permit was renewed by October 1, when he knew he would be working after October 1 each of those years, and did, in fact, work in an RN role for approximately two to three months in each of those three years without a practice permit. The Tribunal issued a reprimand, and ordered the member to pass a course in responsible nursing and pay a fine of $2,400. 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 by member #65,289. The member assisted a physician with a procedure on a patient that was not authorized by the employer; took an extended, unauthorized break from the unit as a result of falling asleep; failed to account for/document 4mg of Dilaudid and 10mg of Morphine; and failed to properly document the administration of 10mg of Morphine at the correct times. The Hearing Tribunal issued a reprimand to the member and ordered the member to take three courses: one in medication administration, one in responsible nursing and one in documentation in nursing. In addition, the member is required to provide CARNA with a satisfactory performance appraisal.
after the completion of 465 hours from an RN manager, should the member return to a work setting where medication administration is part of the RN role. Conditions to this effect were placed on the member’s practice permit and will be removed once satisfied/completed by the member.

C ARNA Member
Registration number: 66,630

A Hearing Tribunal made a finding of unprofessional conduct against member #66,630 who misappropriated funds from her employer’s social fund for personal use. For this finding of unprofessional conduct, the Hearing Tribunal issued a reprimand and an Order that the member pay restitution for the full amount misappropriated; undergo financial counseling; be under the supervision of a Trustee in bankruptcy for the purpose of filing a Consumer Proposal; and complete a nursing ethics course. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

C ARNA Member
Registration number: 86,531

A Hearing Tribunal made a finding of unprofessional conduct against member #86,531 who made an admission of unprofessional conduct under section 70 of the Health Professions Act. The member had on numerous occasions pilfered Hydromorphone from the Pyxis machine, had wrongfully used the names of patients in narcotic records to cover the pilfering of Hydromorphone and had self-administered Hydromorphone while on duty. The Tribunal gave the member a reprimand and accepted an undertaking to not practise as a registered nurse pending proof from a physician and counselor that the member is safe to return to practice at which time, the member has a choice to return to either a practice setting where there is no access to narcotics or controlled substances, or do a supervised practice in a setting where the member is expected to administer medications, including narcotics and controlled substances. In either setting, the member’s employer will report back to a Hearing Tribunal. The member is required to continue drug screening and provide further medical reports to a Hearing Tribunal. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

C ARNA Member
Registration number: 91,706

A Hearing Tribunal made a finding of unprofessional conduct against member #91,706 who pilfered narcotics, including injectable Morphine, Fentanyl and Hydromorphone from his employer on approximately 54 occasions. To cover the pilfering of narcotics the member repeatedly falsified the narcotic records to falsely show narcotics as being signed out to patients when the member did not give or intend to give those medications to the patient; and wastage of narcotics, which were not properly wasted, but pilfered by the member. In addition, to cover the pilfering of narcotics, the member repeatedly forged signatures of colleagues on the narcotic record. The member also pilfered wastage and self-administered the pilfered narcotics while at work. The Hearing Tribunal issued a reprimand and upon receipt of medical proof of fitness to practice, restricted the member to working under supervised practice, with ongoing drug screening, and ongoing medical reports during the supervised practice and for two years beyond completion of the supervised practice. Conditions shall appear on the member’s practice permit. Failure to comply with the Order may result in suspension of CARNA practice permit.

D ID YOU KNOW?

A Hearing Tribunal is composed of two or three RNs and a public representative. Each RN must have at least 10 years nursing experience.
not following CARNAP on social media yet?
Here’s what you’ve been missing:

Be the FIRST to hear about:
- updates to documents, bylaws and other information that affects your practice
- current events, news and interesting stories and articles
- new CARNAP blog entries
- meetings, conferences, webinars and other events

Touching stories from real Alberta RNs
We asked Alberta RNs, “What’s your favourite memory of working during the holidays?” Over the holiday season we shared some of the moving memories and traditions Alberta RNs submitted. View our Facebook photo album “RN holiday memories” to read the stories.

CONTESTS!
In the past year, we’ve given away:
- Merchandise from the CARNAP online store, expertcarewear.ca
- Several gift cards including: Starbucks, Tim Hortons, iTunes and Cineplex Odeon
- An iPad mini
- Books from our online bookstore

CONNECT WITH US TODAY:
Facebook.com/AlbertaRNs  Twitter.com/AlbertaRNs  Youtube.com/CARNAvideo  Expertcaringmatters.ca
Submit a resolution to our annual general meeting on March 18, 2015.

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 the role of RNs and NPs in health care.

What happens with my resolution?
Attend the CARNAGM on March 18, 2015 in Edmonton and read your resolution aloud at the microphone. CARNAMembers will vote on whether Provincial Council should consider your resolution. Resolutions passed at the AGM are non-binding, but Council is required to discuss your idea at a later meeting and determine what action should be taken.

Resolutions submitted before Feb. 27, 2015 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 CARNAProvincial Council. What do I do next?
Go to nurses.ab.ca for full instructions and a template for writing your resolution.

FICTIONAL SAMPLE RESOLUTION:

Be it resolved, that ice-cream trucks will continue to run in the months of September and October.

Background information and references
There are hot, sunny days in September and October equal to that in the summer.
SOURCE: www.weather.com
The season of summer lasts until mid-September.
SOURCE: www.almanac.com
Children and adults eat ice-cream year round.
The ice-cream truck delivery system is efficient and convenient.
We often hear stories from patients or members of their families regarding the exceptional care they received from RNs all across Alberta. However, on occasion we receive less than stellar stories. Sometimes, these stories are from RNs themselves. While concerning, these stories are equally as important as they provide the opportunity to learn from them.

The places and identifying details in these stories have been altered to protect the identity of those involved, but the accounts are accurate and the individuals involved have asked that their stories be shared.

The waiting game

My mother is nearly 80 years old, lives alone and is mostly independent. Early this year, her speech started to slur, and it became progressively worse. Shortly after, she was diagnosed with ALS. Her speech slowly deteriorated and finally became completely garbled. At the same time, her ability to chew and swallow became more and more impaired.

Mom required a feeding tube. We were told by the physician that after the feeding tube was inserted, she would need to stay in hospital for one night to learn how to manage her new tube. This made a lot of sense to me and my mom.

On the day of the procedure, the nursing staff said my mom would be discharged right after the procedure. I had to tell the staff what the physician had explained to us. They did not seem to know about this and seemed agitated. My mom and I overheard the nurses make several negative comments about having to arrange an overnight stay. My mom asked me why she was such an inconvenience for them. This broke my heart. I tried to reassure her that this was not the case, but I felt it too. She was being treated as a problem, not a person.

After the tube insertion, mom was taken to a unit in the hospital. She walked, without problem, from the stretcher to the bed. A nurse entered the room, introduced herself and asked a list of questions that were unrelated to my mom or what she was admitted for. I assumed they were a standard set of questions that all patients were asked. Patient assessments are done to formulate a care plan, tailored to the individual client. This clearly did not happen for my mom.

A dietitian visited us that day and gave us some paperwork and information about the tube-feeding program. She said a nurse would be by soon to teach us how to use the tube and set up the feeds.

Mom and I waited, and waited, and waited. No nurse showed up that afternoon. In the evening, two nurses showed up and said that they had come to reposition mom. I informed them that mom has been up and moving all day. They said “Oh” and disappeared. I was really dismayed. Didn’t anyone communicate what mom’s needs were?

The tube feeding was rescheduled for the next day and the nurse on duty requested that a family member be present. The nurse didn’t show up until an hour after the appointed time. At this point in time, mom did not have anything to eat or drink for over 14 hours.

We understand that more urgent tasks take precedence, but wish we could have received an explanation or apology.

The nurse then promised my mom that she would be back to give her a shower and show her how to clean around the feeding tube. Again, we waited, and waited, and waited. Mom finally asked a nurse to show her how to clean the area around the tube. She never did get a shower.

The 4 p.m. feeding was to be observed by the nursing staff and then mom was supposed to be discharged. By the time the feeding was completed, there was still no discharge order. We were told that the physician was being paged to get the discharge order. There was no response by late evening. I left for the night.

The following day, the whole family was waiting for mom to be discharged. At 2 p.m. we still had heard nothing. I spoke with the nurse at the desk to find out what was going on. We received...
What can we learn from these stories?

These stories are certainly an eye-opener and we hope they will encourage you to reflect on your own practice and the events that lead to the frustration and helplessness these clients felt.

How we practise is influenced by the atmosphere of our work environment. It would be easy to say that pressures in the practice setting such as scheduling errors, being short-staffed or very busy that day resulted in these patients’ experiences. Regardless, as RNs we have a responsibility to ensure that clients get safe, competent and ethical care while maintaining a high level of professionalism. Often, a seemingly small change in our practice can make a significant positive impact on a client’s care.

RNs are uniquely prepared with in-depth knowledge in their entry nursing programs to collect information, perform holistic assessments, work with clients and families and to collaborate with the health-care team to identify and understand health-care needs, strengths and goals.

This information is used to plan and coordinate continuity of care for the client.

RNs are also client advocates. We support clients in obtaining the necessary information, care and resources to meet their needs. Although various professionals from the interdisciplinary team might have been involved in caring for these clients, the RN is accountable for their own role and actions. The scope of knowledge of RNs along with their clinical skills and judgement enables them to provide quality care and to provide leadership in coordination of care and health services. RN

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The night I will never forget

I was an RN for almost 20 years, half of which were on an emergency unit. During a vacation, I was intubated and put on a propofol drip for symptoms I was experiencing.

I remember throughout our training, we are told that a person’s hearing is the last thing to go. That night, I discovered first-hand how true that is.

I heard the emergency physician say I had overdosed. I hadn’t.

After many tests (all of which I remember), they discovered a bithalamic stroke. I heard the radiologist say, “She has suffered a catastrophic event and won’t live through this.”

When I was brought back to the ER, I remember the emergency physician telling my friends that people don’t recover from this type of stroke and a family member needed to be contacted to decide how long to keep me on life support.

I heard staff say I would never walk or talk again.

Within the hour I woke up and was extubated. Three days later, I was sent back home where I followed up with my general physician. I had left-sided deficits, but mild. I could talk, but certainly not clearly, and I could walk. I was discharged after two months of rehabilitation and followed with six months of speech therapy.

Five years later, the most difficult thing to recover from is the fact I could hear everyone talking over me and I couldn’t do anything about it. I want to remind RNs and other health-care professionals that intubated patients can hear you. Be very careful what you say. I think back to my time as an emergency nurse and I know I was guilty of not being aware of my conversations.

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The same response, that they will look into it.

The discharge order was finally received at 3:30 p.m. and we were told that the nurse would be along to do the discharge paperwork. Mom finished getting dressed and getting her few belongings together. Finally, the nurse came flying in, read the discharge summary to us, asked mom to sign, and left.

We waited for that?

My mother spent an extra 24 hours as an inpatient because no one coordinated her care and there was little or no communication between and among care providers.

No patient or family member should ever feel that they are an inconvenience. No one should be expected to wait without apology or explanation. The reason for the admission must be addressed as a priority, not as an incidental, and individual health needs must be acknowledged and be part of the care plan.

As a daughter, I’m annoyed and upset. As an RN, I’m horrified.

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Learning from our mistakes to provide the best quality care for our clients.

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nurses.ab.ca Winter 2015 Volume 70 No 4 Alberta RN 19
Inappropriate use of dressing supplies and the amount of unused, unopened dressings, often stockpiled in patient rooms and discarded upon patient discharge begs the question about the environmental impact of this common practice. Thousands of dollars could be saved each year if nurses placed more emphasis on prevention and education, and addressed wound care in a standardized way that blends cost-effectiveness with evidence-based practice.

Nurses witness daily the incredible amount of waste generated using standard procedures when it comes to wound care. “It is pretty depressing to imagine over time, supplies piling up in a landfill somewhere,” said Chelsea Yeates, a registered nurse at Calgary’s Peter Lougheed Hospital.

“At a large scale, the problem of excessive hospital waste is probably beyond reversal. Even a few policies, which could take an incredible effort to initiate, would barely make an impact on reducing waste,” she added.

“Given our current practices with sterility and isolation in hospitals, there are very few solutions.”

In hospital rooms across the province, especially when patients have chronic wounds, dressing supplies are routinely stockpiled in rooms, ready for the next dressing change. When patients are discharged, many of these unopened dressing supplies are thrown away. This is because traditionally, dressing packages have been made of porous material, which allow for potential contamination if left in a patient’s room.

“I would argue that we’re wasting without even perhaps knowing what we’re wasting,” says wound care nurse Marlene Varga, RN, MSc.

She believes that advanced wound care therapies such as electrical stimulation, when used appropriately, can be an effective cost-saving measure and result in better outcomes for patients, especially those with chronic wounds.

“We’re in this culture where we just kind of stockpile things up, we don’t even look ahead to see if there are supplies in the room,” Varga said. “Sometimes we bring in stuff that doesn’t even match the current plan.”

At the Queen Elizabeth Hospital in South Australia, spiraling costs, the stockpiling of dressing supplies in clinical areas, and the often inappropriate use of advanced wound dressings led to the creation of a unique program called The Dressing Bank™.

Housed in a centralized location within the hospital and modeled after the banking system, it allowed clinicians 24-hour access to a formulary of advanced wound-care products.

While each unit maintained a supply of standard dressings, those wishing to access The Dressing Bank™ would chart the patient’s name, clinical area, product(s) used, information on the type of wound and rationale for why each product was appropriate. Then each clinician signed for the material they were using from The Dressing Bank™.

The program was not initiated in the Emergency Department or Outpatient Services as each of those areas maintained their own stock of dressing supplies. Clinicians could “withdraw” up to a box of dressings with the ability to return them all, or a “refund” while abiding to infection control guidelines.

The establishment of The Dressing Bank™ coincided with a legally-approved wound assessment and documentation chart, and the development of evidence-based tools. A resource folder located inside The Dressing Bank™ allowed clinicians to make evidence-based, informed decisions about which dressings were appropriate. A Wound Advisory Group at the hospital decided which products were stocked and was responsible for the ongoing development of practices.
and protocols that relate to wound-care management. Not only has The Dressing Bank™ allowed for greater equity of access to advanced dressings at Queen Elizabeth, it significantly reduced waste and made it easier for patients who no longer need to wait for specialized dressings to arrive or need to be located within the hospital.

The hospital has also seen significant cost savings since implementing The Dressing Bank™. Previously, a one-year supply of one type of four-layered compression cost the hospital $22,872. One year later, the cost was reduced to $17,208 and in year two to $11,797.

Despite the challenges, there are some things nurses can do to help reduce the amount of dressing waste in their workplace.

What can you do to prevent wasting supplies?

1) Standardized assessment tools

The use of a structured, standardized wound assessment tool can help reduce the amount of materials wasted and lead to better wound care management for patients.

One example is the TIME paradigm, which stands for Tissue, Infection/Inflammation, Moisture and wound Edge and can be used by nurses every time they assess a wound.

First, nurses need to note if the tissue is healthy or not, as unhealthy tissue can be a physical barrier to wound healing and can harbour bacteria. Second, if there is any inflammation or infection present, wound healing is not going to progress. Next is moisture, which Varga called the most important thing in wound care. “I think the number one myth in wound care is that wounds need to be dry to heal,” she said, adding that moist wounds heal three times faster than dry wounds. The use of dry dressings, Varga said, is no longer evidence-based. Lastly, nurses should assess the wound edge. “If you’ve got a wound edge, that’s not going to heal, if the wound edge is too wet then you’ve got another problem,” said Varga.

Wounds should be assessed weekly for changes in the size and condition of the wound bed. In addition, nurses should determine if the wound is actually healing. If not, something in the care plan needs to be revisited.

Varga said doing the same thing over and over again without seeing an improvement in the wound goes against cost-effective wound management.

2) Advanced wound care therapies

Another challenge facing many health-care settings is a lack of access to wound-care specialists who can advise on the use of advanced wound-care therapies which can help stimulate wounds that have stalled out and become chronic. One example, electrical stimulation, introduces an electrical current to the wound to kick-start the wound-healing process. Despite a number of different advanced wound healing therapies in existence, Varga said most patients don’t have access to them or to the specialists who know how to manage them.

Often the use of advanced wound therapies earlier on in the course of wound healing can result in significant savings in dollars and dressing supplies, over time.

“Let’s say you had a wound that was stalled out, you could be living with this wound for the rest of your life. So count up the costs of treating and managing that versus using something like electrical stimulation which may cost anywhere from $500 to $1000 to treat and possibly heal you in a short period of time, and that would actually be cost-effective,” Varga explained. She also believes it’s important to label a wound “unhealable” if it is, rather than do the same thing over and over again expecting the wound to improve.

Advanced therapies also reduce the need for daily dressing changes, something Varga calls a “ritual” that is no longer evidence-based.

3) Advocate for evidence-based wound care practices

Nurses can also advocate for a reduction in daily dressing changes, where appropriate, and discourage the common practice of physicians who routinely peel back dressings to look at the wound. Instead, nurses can inform physicians ahead of time of a scheduled dressing change and encourage a team to assess the wound together, therefore reducing the need for an unnecessary dressing change later on. Making sure you know your dressings and procedures and assessing the patient and knowing what materials are needed before you enter a patient’s room, are steps you can incorporate into your routine to prevent wastage.

4) Prevention

The most important step in reducing the amount of wasted dressing supplies involves educating nurses, physicians and the public about how wounds can be prevented in the first place.

“The three main challenges we face are number one: diabetes, number two: chronic disease and number three: everyone is living longer,” said Varga.

According to her, 20 to 30 per cent of patients develop pressure ulcers, a particularly challenging wound to heal in hospitalized elderly patients, but one that is also largely preventable.

Worldwide, the prevalence of diabetes is rising and the Public Health Agency of Canada (2011) estimates that by 2019, as many as 3.7 million Canadians will be diagnosed with the disease. For nurses, diabetes presents unique challenges and increasingly complex care plans. Up to one-fifth of patients will develop a diabetic foot ulcer, often the most challenging wounds to deal with due to compromised immune systems and poor circulation.

“Number one is prevention. If you want to save money, our emphasis should be preventing wounds from happening in the first place,” said Varga.

“If we invest more in prevention, we wouldn’t be spending money on one aspect which is dressings.”

With files from the Public Health Agency of Canada, Canadian Nurses Association and the Australian Wound Management Association
Continuing Care Resource Manual

Alberta Health Services (AHS) Infection Prevention & Control (IPC) has developed a new, online and interactive resource to help support staff caring for residents living in Continuing Care settings. The Continuing Care Resource Manual guides staff in managing the care of those residents who have a known or suspected infectious disease or condition.

The manual is organized in alphabetical order based on either the common or scientific spelling of the disease, condition or microorganism.

There are links throughout the manual to information sheets outlining Routine Practices or Additional (Isolation) Precautions as well as signs which explain the procedures required.

Choosing the correct Personal Protective Equipment (PPE) for resident interactions is critical to a healthy environment. Using the flow chart embedded in the manual, staff can determine what is appropriate for themselves, their residents, visitors and families.

For more information on the continuing care manual and other IPC resources visit www.albertahealthservices.ca/9237.asp

A new online Chronic Kidney Disease (CKD) Clinical Pathway has been developed to aid in the identification, management and referral of adults with CKD, in line with best practices and local, national and international guidelines.

In Canada, chronic kidney disease affects approximately nine per cent of the adult population or roughly three million Canadians. All primary health-care providers play an important role in the identification and management of patients with CKD. The CKD Clinical Pathway is a tool to support nurses in their practice.

The Interdisciplinary Chronic Disease Collaboration, Northern and Southern Alberta Renal Programs, Alberta Health Services and key CKD stakeholders (primary care physicians, nurses, allied health professionals and nephrologists) collaborated to develop an interactive, online CKD Clinical Pathway for health care providers. It provides information and recommendations that assist in the screening, diagnosis, management and referral of adults with CKD.

CKD is present if patients have a GFR less than 60 mL/min/1.73m² or markers of kidney damage (such as albuminuria) for at least three months. The CKD Clinical Pathway provides direction on vascular disease risk management, blood pressure and hemoglobin A1C targets, use of medication, and recommendations for lifestyle management (links to patient handouts). The CKD Clinical Pathway also provides criteria to determine which patients require referral to a nephrologist.
The pathway can be accessed in the following ways:

1. **URL link in your patients’ eGFR and urine lab test results.**
   This prompt will direct you to the online pathway where you will be provided with information to guide diagnosis, management and referral of adult patients with CKD.

2. **Webpage:** [www.ckdpathway.ca](http://www.ckdpathway.ca)

**CHEMISTRY**

**Routine Chemistry**

<table>
<thead>
<tr>
<th>UNITS</th>
<th>REFERENCE RANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creatinine</td>
<td>206 umol/L</td>
</tr>
<tr>
<td>Estimated GFR</td>
<td>52* mL/min/1.73m²</td>
</tr>
</tbody>
</table>

2014-07-09 09:10 MDT Estimated GFR:
This patient may have chronic kidney disease (CKD). Please refer to [www.diagnoseckd.ca](http://www.diagnoseckd.ca) for management and referral.

For more information or to provide feedback, please contact ckdpathway@ucalgary.ca.
When was the last time you remember seeing someone aged 65 or older as a main character in television or in a movie? How about in a magazine ad or a television commercial? Chances are if you have seen someone of retirement age featured in the mass media, the portrayal was less than flattering. Whether it was a senior who can’t figure out their iPhone or an elderly relative whose hearing impairment results in a comical misunderstanding, older adults are often there as the butt of jokes. Dr. Mario Trono, an expert in the field of popular media, explains that those negative portrayals can have serious consequences.

Dr. Trono notes that the mass media’s tendency to serve up mean-spirited clichés for the sake of cheap laughs has contributed to what is becoming a “perfect storm” to encourage and exacerbate ageism. That although “ageism isn’t new, it’s definitely on the rise.” Instead of learning their social roles from friends or family, people now take their cues for how to treat and interact with seniors from what they see on television and in advertising – the same television and advertising that often depicts older adults as incapable and incompetent.

Dr. Trono, who was one the guest speakers at the CARRA’s recent RN Solutions in Older Adults Care Conference, explains that although “ageism isn’t new, it’s definitely on the rise.” Instead of learning their social roles from friends or family, people now take their cues for how to treat and interact with seniors from what they see on television and in advertising – the same television and advertising that often depicts older adults as incapable and incompetent.

Dr. Trono notes that the current rise in ageism is also tied in part to the huge number of baby boomers that are now reaching retirement age. Baby boomers – that influential demographic born between 1946 and 1964 – first began to reach retirement age in 2011. In 2031, when all of the boomers...
reach 65, older adults could represent between 23 per cent and 25 per cent of the total population.

“As more and more boomers move into their senior years, there seems to be an increasing hostility around the idea that seniors are monopolizing the time and resources that could be devoted to younger, healthier people.” It’s an idea that breeds resentment from people who feel the health-care system is already overwhelmed.

“When you get phrases like ‘bed blockers’ being used, it sneaks into our thinking and makes us see older adults in a negative light.” This kind of negative language can influence how the rest of society views older adults. “No one is immune to this kind of unconscious prejudice, including health-care workers,” says Dr. Trono.

Unfortunately, those unconscious prejudices can have a negative impact on the care older adults receive, even from the most compassionate, professional practitioners.

The impact on care

How does ageism impact the care older adults receive? It’s a complex question that has been the subject of several research studies and reviews. What emerges from many of the reports is that negative attitudes toward older adults in the health-care setting can result in patients receiving less effective care.

Research studies indicate that many older adults feel health-care providers make assumptions about their physical frailty or mental capacity based on their age rather than their symptoms. This means health-care providers may assume patients are physically impaired or mentally incompetent simply because of their age. This can mean that even the best-intentioned health-care professionals might skip over explaining details because they assume patients won’t understand what is being said or not asking for more detailed descriptions of issues or symptoms because they assume the patient can’t articulate it more clearly.

In addition to leaving patients and their families feeling frustrated and dismissed, these types of interactions can also result in older adults not receiving the care they need to maintain their health, dignity and independence. Less effort may be made to investigate illnesses or injury that could be treated, because health-care providers dismiss symptoms as being an inevitable byproduct of aging. At the same time, preventative care may be overlooked as older adult patients are seen as already being generally “unhealthy” and unlikely to benefit from further effort.

So why do so many health-care providers, including registered nurses, struggle with caring for older adults? In many instances, it may simply be inexperience. A 2009 study entitled Attitudes Toward Aging: Implications for a Caring Profession published in the Canadian Journal of Nursing Education, noted that at that time less than 10 percent of North American nursing students’ clinical hours occurred in a gerontological setting and only half of the nursing programs offered certified gerontological courses. The study’s authors emphasized the need to better prepare current and future nurses to care for older adults and noted that the more nurses know about older adults the more positive their attitudes tend to be.

That’s good news for Dan Levitt, the executive director of Tabor House in Abbotsford, BC and an adjunct professor in gerontology at Simon Fraser University. Levitt, who believes that nurses hold tremendous power to influence the patient experience for older adults and to encourage other health-care providers to do the same.

“RNs can do so much, simply by treating patients like they are a person instead of a problem,” explains Levitt. “If we are able to see an older adult, especially those in long-term care, as an individual with a family, a history and a life, who still has more to offer, we can create a meaningful interaction with that senior.” He stresses that nurses who take the time to connect with patients, ask questions and really listen to what seniors have to say are leading by example and can “make the organizations they work in more age-friendly.”

Meeting the needs of older adults

The importance of preparing now to meet people’s needs as they age was the driving force behind the creation of CARNA’s Older Adults Policy Pillar. Published in November 2013, the document spells out CARNA’s vision and guiding principles for the care of Alberta’s older adults. It also describes strategies and actions for addressing the needs of older adults that are intended to help the nursing profession use its skills, experience and expertise to guide how our province cares for older adults.

Understanding the diverse needs of older adults can still be a challenge, explains Dr. Helen Vallianatos, an associate professor of anthropology at the University of Alberta who also presented at the recent CARNA conference. “Aging means different things to different people, both within and across cultures,” says Dr. Vallianatos. She notes that even how we
perceive or describe pain can vary widely, which can make it hard for health-care providers to get an accurate understanding of what a patient is experiencing.

Dr. Vallianatos points to menopause as one example of how something that should be a universal biological experience for women is experienced differently. “Here in North America we often talk about the stereotypical symptoms of hot flashes and night sweats, but how women experience menopause varies widely around the world.” She notes that in Japan, hot flashes are far less prevalent – with only 12 per cent of women experiencing them compared to 33 per cent of women in Canada.

In order to understand cultural differences, Dr. Vallianatos recommends that practitioners take the time to ask questions rather than make assumptions. “Being aware of the differences is the first step because that allows people to ask questions. It doesn’t have to be specific, but asking a question in a way that indicates an openness to hearing about different understandings of what it means to be old can create a dialogue.”

She notes that creating that dialogue and building trust with patients and their families is critically important, but takes time. “Obviously that’s hard in acute care settings, but when providers can get to know the patients and their families they can build a relationship with them.”

The importance of building relationships is reflected in the strategies outlined in CARNa’s Older Adults Policy Pillar, which includes a recommendation to optimize the health and well-being of older adults by strengthening health promotion and preventing disease and injury. Health promotion and prevention are two of the main drivers behind Alberta’s move towards strengthening its primary health-care system, a move CARNa has strongly supported. Other strategies included in CARNa’s Older Adults Policy Pillar speak to optimizing community-based care and supports, strengthening the provision of continuing care services and building older adult-friendly communities.

Not surprisingly, these are the same kinds of strategies that Dan Levitt advocates as being important to improving the patient experience for older adults. “We’re working to create spaces, supports and environments that keep older adults engaged and interested in life. We know a healthy, enjoyable, productive old age is possible and we want more people to experience that.”

**The future of aging**

Although there are still many negative stereotypes and assumptions made about older adults, there is reason to be optimistic that things are beginning to improve.

Media portrayals of older adults are slowly beginning to show more honest, realistic depictions of what aging looks like through movies such as Quartet, Ladies in Lavender and Away from Her. Even the enduring popularity of actors like Helen Mirren and Maggie Smith speak to society’s willingness to embrace older actors. “While there are certainly still problems, there’s a lot of supportive mass media too,” notes Dr. Trono.

Much of the reason for optimism about what the future holds for seniors may come from the most influential group of older adults the world has ever seen – the baby boomers.

“Boomers have the power and that means they have the ability to change how we view aging,” explains Dr. Vallianatos. “That’s why we hear about things like 50 being the new 30 – because boomers don’t see themselves as traditionally old.”

Dan Levitt agrees, noting “people are experiencing a different kind of aging now. Baby boomers were the ones who were at the front of all the change in society. The civil rights movement, the women’s movement, the sexual revolution – baby boomers were the ones who were driving it. And ultimately, I think they’ll be the ones to make us think about old age as a phase of life, not the end of life.”

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**WILL 100 BE THE NEW 65?**

Statistics Canada reports that in 2011 an estimated five million Canadians were 65 years of age or older. By 2036 that number is expected to double and by 2051, about one in four Canadians is expected to be 65 or over. By 2031, when the last of the baby boomers reach age 65, experts predict that older adults could account for between 23 per cent and 25 per cent of the total population. (link: http://www.statcan.gc.ca/pub/11-402-x/2011000/chap/seniors-aînes/seniors-aînes-eng.htm).

“We’re already seeing a dramatic shift in our country’s demographic makeup, and from 2015 to 2021, the number of seniors is projected to exceed the number of children aged 14 and younger for the first time ever. By 2036, the number of people aged 80 and older is expected to be more than double to 3.3 million and the population aged 100 and older could triple to more than 20,000.

As expected, health problems become more complex as people age. Statistics Canada reports that individuals aged 65 and older were more likely to have one or more chronic health conditions such as hypertension (53%), arthritis (43%) and back problems (29%) than those aged 45 to 64 (24%, 20% and 25%, respectively). Seniors are also more likely to report chronic conditions and to consider themselves to be in poor health. In 2009, one quarter of seniors reported having at least four chronic conditions—this compares to just 6 per cent of adults aged 45 to 64 who reported having the same number of chronic conditions.
Ask people to name common health concerns for older adults and it's doubtful that many would immediately think of sexually transmitted infections (STIs). But for a growing number of older adults, STIs are a growing and serious problem.

The Center for Disease Control (CDC) advises that close to 2,550 cases of syphilis were reported among adults in the United States between the ages of 45 and 65 in 2010—compared to approximately 900 cases that were reported in 2000. In that same time period, the number of reported cases of Chlamydia in that age group almost tripled, from around 6,700 in 2000 to 19,600. HIV rates are currently rising faster in those over 50 than those under 40, a fact that prompted the CDC to develop a fact sheet targeted specifically at older Americans.

Researchers have also found that older adults are more sexually active than ever before, with some studies indicating that more than 60 percent of those over age 60 have sex at least once a month. This increased activity is attributed to many factors, including more common use of erectile dysfunction medications for men, hormone replacement therapies for women and older adults living longer, healthier lives that allow for sexual activity.

So why aren’t seniors using protection? Experts speculate that because older adults aren’t worried about pregnancy, they simply don’t bother with birth control. Often health-care providers overlook discussing sexual health with older adult patients, either because they assume it’s not a concern or they are focused on other health issues. And older adults may not be comfortable asking about sexual health with their health-care providers, many of whom may be younger than their patients.

How much of an issue are STIs for seniors? A January 2014 article in the *New York Times* noted that a report released by the U.S. Department of Health and Human Resources on Medicare indicated that in 2011 and 2012, 2.2 million beneficiaries received free STI screenings—roughly the same number who received colonoscopies to screen for colon cancer.

As health professionals and educators look for ways to prevent STIs among older adults, some experts warn that the problem will get worse before it gets better. And that means health-care providers and older adults need to start talking about safe sex as openly as they discuss other important health-care concerns.
In September 2014, we sent a survey to a sample of CARNA members to gauge your satisfaction with our communication methods. The responses gave us insight into where our strengths are, and where we have room to improve. Thank you to the 1,069 members who responded to the survey. Your feedback will help shape our communications strategies going forward.

How are you connecting with us now?

<table>
<thead>
<tr>
<th>Connection Method</th>
<th>Read率 (%)</th>
<th>Viewed率 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alberta RN magazine</td>
<td>read by 94%</td>
<td></td>
</tr>
<tr>
<td>CARN website</td>
<td>viewed by 94%</td>
<td></td>
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<tr>
<td>Take Note newsletter</td>
<td>read by 54%</td>
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<tr>
<td>ABRN Online newsletter</td>
<td>read by 50%</td>
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</tr>
<tr>
<td>Social media*</td>
<td>viewed by 38%</td>
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* Includes: Facebook, Twitter, expertcaringmatters.ca blog

Could you be missing the message?

If you’re not one of the 6,000 people following us on Facebook, or the nearly 1,500 following us on Twitter, here are a few of the things you’ve been missing:

- Educational and professional development opportunities
- Current events, news and trends in nursing
- Being the first to hear about documents, bylaws and other information that affects your practice
- Job postings
- Contests

How do you want to receive CARNA updates?

<table>
<thead>
<tr>
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<tr>
<td>Email</td>
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<tr>
<td>Enewsletters</td>
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<tr>
<td>Online surveys</td>
<td>31%</td>
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<tr>
<td>Virtual meetings/webinars</td>
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<tr>
<td>Physical mail</td>
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<tr>
<td>Social media</td>
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<td>Mobile app</td>
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<tr>
<td>In-person conferences</td>
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<tr>
<td>Text messages</td>
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<tr>
<td>Private online forum</td>
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<tr>
<td>Telephone</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
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Do you prefer to get updates by email?

Due to new anti-spam legislation, we are no longer able to send you emails about member benefits, conferences, special events and other CARNA activities without your consent. You can provide consent and start getting our emails through the sign up form on nurses.ab.ca.
Measure up?

How do you prefer to contact us?

<table>
<thead>
<tr>
<th>Method</th>
<th>Preference</th>
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<td>CARN website</td>
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<tr>
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<tr>
<td>Telephone</td>
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<tr>
<td>Physical mail</td>
<td>14%</td>
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</table>

What section of *Alberta RN* do you turn to first?

<table>
<thead>
<tr>
<th>Section</th>
<th>Preference</th>
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<tbody>
<tr>
<td>Disciplinary decisions</td>
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<tr>
<td>Articles about clinical practice</td>
<td>52%</td>
</tr>
<tr>
<td>Articles about CARN regulatory policies, programs and processes</td>
<td>43%</td>
</tr>
<tr>
<td>Articles about Alberta RNs</td>
<td>34%</td>
</tr>
<tr>
<td>Event notices</td>
<td>31%</td>
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We recently did a complete overhaul of nurses.ab.ca.

Our new and improved website includes additional features like comment sections. We’ve also reviewed all the content to make it easier to understand so you can find the information you need.

What are we doing right?

Responses included our wide variety of communication methods and that we send relevant and interesting information. Members also identified specific communications channels such as emails, *Alberta RN* magazines and our website as strengths.

Where we have room to improve

When asked to describe the weaknesses of our current communications, the most commonly mentioned concern was that not all members have access to more technologically-based communications channels like social media. Members also indicated that we need to put a stronger focus on communicating the importance of being an RN.

Did you miss our advertising campaign promoting the RN role that was featured on radio, billboards, bus advertisements, indoor media and various online and social media sites? Visit expertcaring.ca to view the campaign materials and learn how your expertise is irreplaceable at the bedside. RN
THURSDAY, MAY 21, 2015
5 p.m. RECEPTION  6 p.m. DINNER AND AWARDS
SHERATON SUITES CALGARY EAU CLAIRE
255 Barclay Parade SW, Calgary
Registered nurse Stefany Hunter, a recent grad working at Alberta Children’s Hospital, was having a perfectly normal day. She was busy checking on patients, when she overheard an RN on the phone leaving a voicemail. It stopped her dead in her tracks.

Stefany recognized the RN’s name and realized that this nurse took care of her, in this same hospital, 20 years earlier. When she was five years old, Stefany was playing at a neighbour’s house, taking turns jumping off furniture onto the bed. She jumped off the dresser but lost her confidence halfway through the jump. Instead of landing softly on the mattress, she landed stomach-first on the bedpost. She immediately started feeling unwell and looked pale, so she was rushed to Alberta Children’s Hospital.

A CAT scan revealed she had badly damaged her pancreas. She would require surgery and a long, intensive stay in the hospital. Eight weeks, to be exact.

At the time, Lori Fairservice was a recent grad herself, having finished nursing school only a couple years before.

“I remember this bubbly little girl with pigtails,” says Lori. “She was there for a long time and became one of our favourites.”

Stefany recalls loving being in the hospital, despite two surgeries and being on TPN. She remembers the fun nurses who would paper her room with tissue when she wouldn’t listen, and leave her little notes of encouragement.

“I turned six years old while in the hospital, and the nurses threw me a birthday party,” recalls Stefany. “I wasn’t able to eat any cake, but they promised to bring me one when I was allowed to eat again. They followed through on their promise when I was discharged.”

Stefany’s hospital stay wasn’t all fun and games. Her mom was unable to stay with her all the time and Stefany would often wake up scared. She said the nurses would come into her room and play with her hair until she went back to sleep.

And it wasn’t just Stefany that the nurses cared for, but her family as well. “My older sister was so upset when they had to put a tube in my nose,” says Stefany. “The nurses comforted her and made her feel better. They were very supportive of my parents and sister and got to know all of us really well.”

When she was discharged, Stefany’s mom helped her make a scrapbook of pictures with her and the nurses who cared for her. It was then that Stefany decided she wanted to become a nurse in pediatrics and care for others the way those nurses cared for her.

Stefany never wavered from her dream. She went straight into nursing school after graduating high school. She graduated from Athabasca University in 2010 and started working at the Alberta Children’s Hospital.

“I had seen Lori around, but it’s a big hospital and I just wasn’t sure it was her,” says Stefany. “She looked so familiar to me, but I couldn’t place it.”

“I was up on the inpatient unit and just hung up the phone when Stefany came over to me,” recalls Lori. “She asked me if I used to work on the K-cluster at the old site and said she was my patient! We had a chuckle and talked a bit about what I’ve done with my career and what she has done with hers.”

“It was like a moment out of a movie,” says Stefany.

After confirming her suspicions to be true, Stefany brought her scrapbook to the hospital to show Lori the pictures of her time in the hospital as a young girl. “It was beautiful because I was able to thank her for the influence she had on my life and tell her she is why I became a nurse. We both started crying,” she says.

Lori says it brought back many memories of putting in Stefany’s IV and the two of them just talking or reading.

Lori was also able to identify other nurses from the scrapbook who still work at Alberta Children’s Hospital.

“To meet someone I cared for who is now a nurse was touching and special. Plus it’s really neat that we work in the same hospital,” says Lori, a Cystic Fibrosis nurse. “I’m 24 years nursing and I still love being a nurse and love what I do.”

“I have an advantage as a nurse because I remember what it’s like to be in that position, so I remember that it can be as simple as calling a patient ‘sweetheart’ or ‘honey’ and that can reassure them,” explains Stefany. “You don’t always know what happens to your patients and you always hope for the best for them. To be able to come full circle is a unique, and special, experience.”
BY KELLY ARRAF, RN

While attending nursing school, the thought of nursing abroad in a third world country was always very alluring. The opportunities in the late 90s mostly consisted of organizations like the Red Cross and Doctors Without Borders that typically required commitment times of six to 12 months.

After I finished my nursing degree, my medical mission aspirations seemed further dashed as I began grad school, and then again when I started a large family. Like many nurses, real life had become too busy and complicated to realistically sign on to a half-year or year-long mission in another country.

In recent years however, many smaller organizations have begun to adopt shorter mission commitment times, often between seven days to one month. Perhaps with the goal in mind of generating more interest from registered nurses and other health-care professionals, short mission trips often appeal to those who desire to volunteer overseas. Team Broken Earth is one such Canadian organization.

Team Broken Earth is a Canadian organization that was founded in Newfoundland by Dr. Andrew Furey. The goal was to organize medical teams of physicians, nurses and physiotherapists from across Canada who were committed to delivering and improving health care in Haiti. Individual nurses or doctors can sign up, or in the case of Team Broken Earth, whole medical teams for the operating, emergency and ICU departments are organized to provide patient care, one week at a time.

At the start of October 2014, I completed my second mission as an OR nurse with Team Broken Earth, Calgary. Round trip, each of the missions took nine days, and this time frame was short enough that I could arrange childcare for my four children and take time away from work.

In the two mission trips I have participated in, our team completed over 80 successful surgeries and provided care for hundreds of patients in the emergency room, ICU and pediatric units, as well as provided triage and physiotherapy to many more.

Although it was a short seven days at the hospital, the impact that our group had will surely change the lives of those Haitians who would otherwise not have had access to medical care.

Of course, I initially went to Haiti hoping that some small piece of my nursing would change the lives of a few Haitians. Perhaps what I neglected to anticipate was that the lives of the Haitians would instead change the way I nurse. Even in one short week, perhaps that was the point.
BY LEANNE FOFF, RN

My outlook on life is that I always want to make a difference. If I have the means to give and there are people who need it, I can make a difference. So I started out here at home, volunteering where I could. At first, I would help provide meals at the Mustard Seed downtown every few months for about 10 years, until I had my children.

For a few years, I took part in Soles4Souls, a charity that collects shoes and distributes them worldwide to people in need. I would email or connect with my friends, colleagues, just about anyone in my network to ask for shoe donations. Most years, we would collect around 500 pairs of shoes. Most of them went to Haiti or other hurricane zones, and shoes that were more appropriate for our colder climate were donated to the Bissell Centre.

My first charity mission abroad happened in 2008, when I went to Cambodia with a couple of nursing friends. We went to a very remote town in northern Cambodia for a couple of weeks and set up a mobile medical clinic.

During this trip, I realized there was a huge need for affordable and accessible medical care for those in rural Cambodia. After I returned home, I went back to school to learn more about international nursing and public health.

My husband and I established a charity called Kindred Hearts Cambodia Foundation. We have founded a clinic in the small village in Cambodia I visited previously, which is in the city of Stung Treng. We partnered with Stung Treng Women’s Development Centre, a self-weaving training centre that houses approximately 250 people, 98 per cent of which are women and children.

We direct clinic operations from here in Canada and employ a Cambodian physician and midwife to run the clinic. The clinic provides free medical care to men, women and children who live in the centre’s compound. We have recently extended care to all family members of anyone who is part of the training centre.

With so many women, as well as an orphanage, daycare and kindergarten all operating in the compound, our efforts focus mainly on women’s and infant/adolescent health. In addition to providing free medical care, we also provide monthly health education sessions to the women and children. Education topics have included hand washing, nutrition for mother and child, women’s health and hygiene and acute diarrhea.

Kindred Heart’s Cambodia Foundation was established in 2011 and the clinic has been open since 2013. To raise funds to build and operate this clinic, we first solicited money from the community and last year we held a successful silent auction.

I feel like it’s not hard for us to make a difference in countries that need assistance. This is just something I live by, which is rooted in my Christian faith; I want to make a difference both here and abroad.
The South Health Campus (SHC), located in Calgary, Alberta, was recently honoured by the U.S.-based Institute for Patient- and Family-Centered Care in recognition of the progressive steps that have been taken to actualize working and collaborating with patients and their families as active partners in care. This honour was shared by 12 hospitals across North America, with South Health Campus being the only Canadian site selected as an exemplar health facility in the Institute’s new campaign, Better Together: Partnering with Families.

Collaborating with patients and their families, and involving them in the care planning and delivery process in their health-care journey, are key aspects of the registered nurse profession. The South Health Campus in Calgary has been demonstrating the importance of working in partnership with patients, family members and citizens in the planning, delivery and evaluation of health services.

The concept of Patient and Family Centred Care (PFCC) at South Health Campus has been helping health-care professionals provide patient care in a collaborative approach, working together with patients and families to contribute their knowledge and skills to care through a process of continuous communication and shared decision making.

PFCC means:

* patients and families are full partners in care;
* all decisions contribute to creating a supportive and respectful environment for patients, families and providers to promote wellness and teamwork;
* a community of mutual respect; and
* building supportive relationships with businesses, organizations and associations who enhance the well-being of patients, families, staff, physicians and the community.

PFCC has been implemented at the South Health Campus in a number of ways, a few of which are listed here:

**Name, Occupation & Duty (NOD):** The hospital can be overwhelming and scary, as each patient interacts with multiple staff during a single visit. Staff introduce themselves by their name, occupation and duty (role) when caring for patients and families.

**Family presence:** Involvement of family and friends are central to the patient’s healing process. Family is welcomed as essential members of the health-care team, and is actively involved in the collaborative care process. At SHC, the term ‘family’ is defined by the patient to recognize that it includes more than traditional definitions; family is who the patient views as their family.

**Patient’s visitors:** There are positive effects of visitors’ presence (visitors do not include family) to the patient’s overall well-being. Visiting is encouraged and supported during visiting hours (in most inpatient areas family members have no visiting hour restrictions).

**Patient and citizen engagement:** A patient and family council has been involved since the early planning stages of the facility. The Citizen Advisory Team (CAT) is composed of former patients, family members and community members. The CAT brings the perspective and voice of patients, families and communities into the planning, operations and evaluation of programs, services and facilities.

There are many challenges in delivering PFCC in the acute inpatient mental health setting. For example, the severity of a patient’s symptoms may lead to them not wanting to or being able to receive visitors. Some patients may have tenuous relationships with family members from past experiences related to their mental health issues. Staff at SHC recognize that patients define who their family support is and that being patient- and family-centred involves more than simply allowing or facilitating family visits. Family is encouraged to be involved at all stages of a patient’s stay to build a collaborative relationship that promotes, supports, educates and builds skills for care of their loved one.

Barriers to fully embodying a PFCC approach are sometimes constructed by health-care professionals. For example, traditional acute inpatient approaches have been paternalistic and hierarchical, with doctors and other health-care professionals making decisions for patients. At SHC, deliberate efforts are made to provide training in nursing-driven, family-centred interventions for all staff, embedded in the Family Systems Nursing approach. At the centre of the Family System Nursing model is the basic understanding that we are all parts of families, meaning care and care planning is developed in collaboration with patients and their families reflective of their needs, wants, choices and preferences.

RN
Canadian Association of Rehabilitation Nurses
NATIONAL 2015 CONFERENCE

MAIN CONFERENCE: June 3-5, 2015. Edmonton.
carn.ca/news

Join us at our conference, hosted by the Alberta Rehabilitation Nurses Interest Group, to learn more about advancements in rehabilitation nursing in Canada.

Rehabilitation nursing is a rapidly growing specialty in nursing. Due to advances in research, technology and treatment, people are living longer and surviving severe traumatic accidents. Nurses are ideally positioned to assist patients in the recovery and adaption to life altering events. Promoting and facilitating optimal functioning and recovery is the goal of rehabilitation nursing.

Rehabilitation nursing uses a holistic approach with patient- and family-centred care at the core. Rehabilitation nurses are integral members of the interdisciplinary team and work with patients and families to attain the best possible outcomes. The role of the rehabilitation nurse can be complex; specialized care, coordination and collaboration are some of the skills required in order to assist patients and families in attaining optimal function, adapting to their injury/disease, and reintegrating into the community. Rehabilitation nursing is a rewarding experience through assisting the patient and family through rehabilitation and the recovery process and playing large part in successful outcomes.
In December, CARNa told an all-party committee that the recommendations of the Auditor General’s report on chronic disease management (CDM) were a strong “call to action” for the Alberta government and the health delivery system. We said that the blueprint for a comprehensive strategy for CDM already existed; we need look no further than the existing primary health-care strategy published by Alberta Health in January 2014.

The focus on chronic disease management and growing interest in primary health care are also a call to action for registered nurses. Why? Registered nurses have a unique perspective on the patient as a whole rather than only relating to the diagnosis or treatment.

The Auditor General’s report and other evidence indicate that a small percentage of patients with chronic disease have a care plan and a very low percentage of these are monitored. You have the necessary skills and knowledge to develop and manage a patient care plan that incorporates physician, pharmacist and other provider input while fully engaging the patients. You tend to spend significantly more time with patients than other health-care professionals which allows you to get to know a patient’s unique environmental, social and financial concerns that may affect how patient’s wellness or recovery.

It’s increasingly clear that the shift to primary health care and effective CDM needs to leverage and optimize the expertise of the largest group of health-care providers - registered nurses.

This “nursing solution” would enhance not only CDM, but can have an impact on the health care needs of other populations. Maternal/child, mental health and addiction and rehabilitation patients also need coordination of care and case management; they also need to access a variety of community resources. In short, they also need the expert caring of registered nurses.

In her President’s message on page 3, Shannon describes what it would look like if all of us embraced the principles of primary health care to influence improvements to continuing care. I encourage all of you to imagine what your practice would look like if all team members enacted the principles of primary health care.

As emphasis on health and health delivery systems shifts more and more quickly from hospital to home, from institutions to communities, from curative to preventative, I urge you to develop skills such as communication, collaboration and teaching/coaching which complement your clinical expertise. Interestingly, many of you have already identified this need. In the past year, the CARNa education session on professional communication was one of the top three sessions requested by members. These skills are equally important both in and outside the hospital setting.

I’m encouraged that registered nurses were invited to address the Public Accounts Committee to bring our perspective on the AG’s report on CDM. CARNa has consistently advocated for more meaningful consultation by Alberta Health with registered nurses in health policy development. Persistence, a collaborative approach and a focus on demonstrating the value of nursing input on government decision are paying off.

Health promotion and prevention are two of the main drivers behind Alberta’s move towards strengthening its primary health-care system. I am very proud that RNs, including our president and myself, were invited to participate in the development of the primary health-care strategy.

CARNa strongly supports the three strategic directions set out in this strategy: enhancing the delivery of care, changing the culture of health care, and creating the building blocks for change. Unfortunately, the primary health-care strategy sits on a shelf and has yet to be implemented.

As Shannon succinctly put it in her message, “Alberta’s RNs and NPs can help you with that!” RN

MARY-ANNE ROBINSON, MSA, BN, RN
Chief Executive Officer
780.453.0509 or 1.800.252.9392, ext. 509
mrobinson@nurses.ab.ca
Ready, set... run, walk, pledge!

Join ARNET in an illuminating event to celebrate nursing.

May 7, 2015  6pm  Bower Ponds, Red Deer

Be the overall fundraiser and win a Luxury Weekend Under the Stars at Fairmont Jasper Park Lodge. Be the top fundraising team and win the Ultimate Team Party Package. Be the top RN fundraiser and win an Education Gift Pack.

All funds raised support nursing education and improved health care for Albertans.

REGISTRATION BEGINS JANUARY 19, 2015  nursesontherun.ca
One of Alberta’s top employers is looking for you!

Covenant Health is Canada’s largest Catholic health care organization, serving 12 communities across Alberta. With over 150 years of history, we are a valued part of Alberta’s integrated health system.

CovenantHealth.ca/careers