CONNECTIONS
RNANT/NU NEWSLETTER

SPRING 2016

Photo taken in Yellowknife, Northwest Territories | Photo Courtesy of the Snowking Festival

The Diversity of Nursing

Inside Highlights

The Registered Nurses Association of the Northwest Territories and Nunavut (RNANT/NU) is the professional registering body and professional association. Its purpose is to register nurses for practice for the benefit and protection of the public; and to promote standards of nursing practice and education.

Mission
To promote and ensure competent nursing practice for the people of the NT and Nunavut

The RNANT/NU newsletter is published three times a year by the Registered Nurses Association of the Northwest Territories and Nunavut. The publication dates are March 15th, July 15th and November 15th. Deadlines for submission of articles are January 30th for March 15th; May 30th for July 15th; September 30th for November 15th.

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Executive Director's Message

DONNA STANLEY-YOUNG

The theme of the spring newsletter is "The Diversity of Nursing". There are many opportunities to practice nursing in multiple roles and domains in the NT and NU. The articles contributed by our members in this edition demonstrate nursing involvement in and influences on research, community development and education. I encourage you to read these well written items.

Also in this edition, is an explanation of jurisprudence and jurisprudence competence. Ten of the twelve nursing associations and colleges in Canada currently have or are in the process of developing a format for nurses to demonstrate jurisprudence competence. RNANT/NU is one of these associations. The RNANT/NU Registration Committee is currently developing a jurisprudence learning module.

The RNANT/NU Board of Directors recently approved three new bylaws and changes to Bylaws 2 and 5. Changes to Bylaw 2 include a new registration renewal period. The 2017 registration renewal period will be from September 1st, 2016 to October 31st, 2016 pending ratification of the Bylaws at the 2016 AGM. Please take the time to read Bylaws 2, 5, 22, 23 and 24 available on the RNANT/NU website.

Last, RNANT/NU plans to launch a new website with the same address in early April. The new website will include an online verification system listing all actively practicing members.

I hope you enjoy reading this edition of our newsletter. Thank you to our newsletter editor, Pat Nymark, for gathering and editing the contents for this edition and Nikki Johansen for formatting.

Donna Stanley-Young
Executive Director

Meet your Board

Joanne Dignard

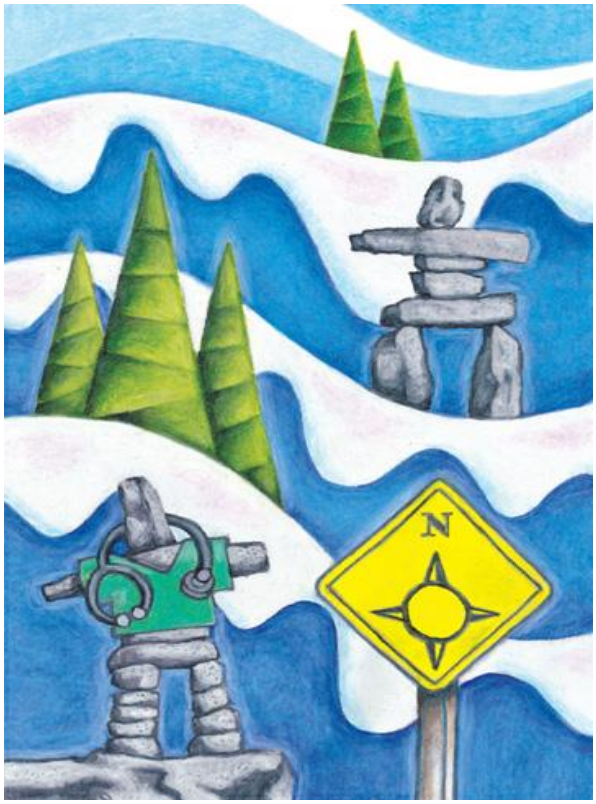
NU East Regional Member
Grise Fiord, Nunavut

I'm originally from a small town in New Brunswick, called Tracadie. I graduated from the Providence School of Nursing in 1988 and worked in NB for 1 1\2 years coming up North. I worked in Hay River for 2 years then headed to Baffin in 1992 for my first job in Cape Dorset. Nunavut has been my home since that date having lived in 5 different communities. I have been in Grise Fiord for the last 3 years but a part of my heart remains in all the communities I have worked.

In each community, I have not just worked but also enjoyed the outdoor life and experiences that beauty of the north. I am still in awe of the beauty of the Arctic and its culture, the northern nursing experience and the broad scope of practice for nurses. When on vacation back home, I volunteer at the local schools to do presentations about the Arctic life. I fee it's important to promote and educate kids about the North because that how I believe I was attracted to the Arctic.

I have joined the Canadian Rangers since moving to Grise Fiord and take time off for Ranger Patrols. I have gone on ski trips in the Arctic and love cross country skiing. I am involved with teaching kids and adults to ski and enjoy taking them out when I have time. In each community, I have tried to be involved with community events. I do programs to keep kids educated by offering babysitter courses and programs to play the violin, ski and exercise at different times.

I am also currently a member of several committees for the GN involved in the review and prenatal and well child records. I want to contribute to our nursing association and learn more about how I can help. As well, I want to be involved with the decisions made by the association and provide input from my colleagues from the NU East region. I joined in January 2016 as the Acting NU East Representative and hope to continue if I am re-elected.



2016 Annual General Meeting

The 2016 AGM will be held on Saturday, May 14th, 2016
1:00 pm – 4:00pm
In the Baffin Room of the Frobisher Inn - Iqaluit, NU

Followed by:

2016 Members Dinner

6:30 pm Cocktails
7:00 pm Dinner

Cash Bar, Entertainment, Door Prizes

To Reserve tickets to the Members Dinner please contact the RNANT/NU Office no later than April 29th

Tickets: Early Bird Special - $50.00 per person
**Reserve before April 15th*

RNANT/NU Dinner Reservation Form

CANADIAN NURSES ASSOCIATION

The Canadian Nurses Association's Annual Meeting of Members

When: Monday, June 20, 08:30 am - 5:00 pm
Where: Saint John Convention Centre, NB

Follow the link for more information:

https://www.cna-aiic.ca/en/about-cna/meeting-of-members-2016

Call for Resolutions for 2016 AGM

Deadline for resolutions to be submitted is:

1:00 pm, Friday May 13th, 2016

Resolutions can be sent to Robert Nevin, Chair Person of the Resolutions Committee at

resolutions@rnantnu.ca

Community Response to Partner Violence in the Northwest Territories: Frontline Workers Perspectives and Recommendation

Dr. Pertice Moffitt is the Manager, Health Research Programs, Aurora Research Institute in Yellowknife, NT. She has lived and practiced nursing in Canada's north for 30 years. She received a PhD in Nursing, University of Calgary; MN, University of New Brunswick; BSN, University of British Columbia; and, a diploma in nursing from Victoria Public Hospital, Fredericton, New Brunswick. She also completed an internship for health science researchers in Potchefestrom, South Africa July-August, 2011. She is a Past President, Northwest Territories Registered Nurses Association (1994-96); Past-President of the Canadian Association for Rural and Remote Nursing (CAARN); past Board Member of the Canadian Rural Health Research Society (CRHRS). She is an activist against family violence and is a member of the Coalition against Family Violence in the NT. Her research and teaching interests include nursing philosophy, theory, and science; nursing ethics; women's health; culture and health; scholarship of teaching; evaluation; and health promotion. Her research methods are qualitative including fourth generation evaluation, ethnography, photovoice, and community participatory action research. She is currently a co-investigator in research on community response to intimate partner violence (SSHRC funded), a rural and remote diabetes intervention project (PHAC funded), and, a national study of rural and remote nursing (CIHR funded).

Intimate partner violence[1] (IPV) is a serious public health problem in the Northwest Territories (NT). Health and Social Services (2011) noted that the rate for spousal violence was second highest in Canada. It is difficult to ascertain intimate partner violence for the NT since there is no specific category listed with Statistics Canada. The above statement from the Government of the Northwest Territories was determined on related offences of sexual assault, common assault and assault with a weapon, and stalking. Within our study, statistics were provided directly from the RCMP at a point in time (2009 to 2010). Because we live and practice in the NT, we do know that since 2011 when this study began there have been homicides each year of the study related to intimate partner violence.

This five year SSHRC/CURA study (2011-2016) conducted in the NT is part of a larger project that includes researchers and community partners from the three Prairie Provinces. The purpose of this brief research update is to alert registered nurses and nurse practitioners about the study's findings, implications and recommendations. For a more detailed account, we are in the process of producing a plain language report about the entire study and publications in peer-reviewed journals.

Methodology

The study was conducted over five years with three short term objectives and two outcomes.

[1] Intimate partner violence is defined as a range of physically, sexually and psychologically coercive and controlling acts used against an adult woman by a current or former male or female intimate partner (Ellsberg & Heise, 2005)

The three objectives were: to discover the unique needs of victims of IPV living in the NT; document gaps that exist in meeting these needs; and, create narratives and a theoretical model that describes ways to create non-violent communities.

The two outcomes we hope to achieve are a model and action plan for sustaining non-violent communities and implementation of policy change recommendations provided to NT policy makers with subsequent community action from our research findings. The research team included Pertice Moffitt (Academic Lead) Lyda Fuller (Community Lead), Heather Fikowski (Co-Investigator) and many student research assistants over the five years (Marshi Mauricio, Ann Mackenzie, Cheryl Cleary, Valisa Aho, Alexis Reuttneuer, Christina Volstad, Beth Thompson, Michelle Bourke). Greg Towler (RCMP) and the Coalition against Family Violence were collaborators.

Participant Sample & Recruitment

Participants were recruited into the study purposively and through snowball sampling from 12 NT communities using Geographical Information System (GIS) maps as guideposts. Frontline workers in this study are defined as justice, health and social workers who respond to incidents of violence against women in their everyday practice. They were comprised of RCMP, nurses, shelter workers, victim service workers, counselors and others (community justice workers, wellness workers, counselors) who responded to women seeking help from IPV Appendix A).

Data Collection & Analysis

Grounded theory informed this study (Wuest, 2012) through interviews, focus groups and observations in the communities where data was gathered. In year one, we conducted an environmental scan that identified police services, legal services, crisis intervention, women's shelters and second-stage housing, counselling and children's IPV services, and informal or volunteer services in the NT. At the same time, we collected aggregated data on incidents of IPV in the NT (Jan 2009 to Dec 2010) from the RCMP. This data from the environmental scan and the IPV incidents was portrayed in GIS maps. The maps provided direction for data collection, dialogue and interpretation and visual clarity for a more holistic picture of IPV during this period of time in the NT.

In the second year and following informed consent, frontline workers (n=31) were interviewed face-to-face or over the telephone using a semi-structured interview guide. The interviews were audio-taped, stored in a password protected computer and completed by the academic researchers and the student research assistants. The interview guide was developed in collaboration with the multidisciplinary research team from all four jurisdictions. The interview guide included questions directed at identifying the needs of women seeking help from IPV, gaps in services that women experience, and ways to create nonviolent communities. Broad open ended questions were used such as asking about descriptions of a typical journey for a woman experiencing IPV in NT communities and seeking clarification about a known expression of normalization of violence as a community response (Mbilinyi, Logan-Greene, Neighbors, Walker, Roffman, & Zegree, 2012).

In the third year, we identified two communities to conduct focus group meetings. The communities were chosen based on the following selection criteria: incidents of violence; one regional and the other a remote community; one northern and the other in a southern location in the territory.

The GIS maps were a tool in this exercise along with advice from our research team. Individual interviews were continued with participants from the two communities (n=13) and a focus group was held in each community with six participants in each focus group (n=12). The data collected utilized an amended interview guide based on findings from year two findings and questions about the emerging theory to validate the theory and enhance variations. Narratives were constructed from the focus group data, documentary analysis and a media watch analysis.

In the fourth year, we conducted documentary reviews and began the creation of an action plan. Throughout the research process, we held annual meetings with the larger team from all jurisdictions, presented locally, nationally and internationally and disseminated through publications and the media (Moffitt, 2012; Moffitt, Fikowski, Maurico & Mackenzie, 2013; Moffitt, 2014; Fikowski & Moffitt, 2015).

Open line by line coding, axial coding and theoretical coding were completed with the year two and three dataset. Coding was collapsed into categories of common themes related to the three research aims and explication of the community response[2] to intimate partner violence sought. This community response was identified as the central problem or phenomenon. Constant comparative method is a way of examining the data throughout the research process in an iterative and continuous process so that data collection and analysis occurred together until the theory emerged.

Research Ethics

Multi-year (five years) ethical approval was received from the University of Regina and a research license from the Aurora Research Institute.

Findings

There were a total of 56 front-line workers who participated in this study. All of the participants (from a justice, health or social system) worked with women who experienced IPV. Findings in this brief report are presented on the social processes (responses) at work to create the central problem for frontline workers of "our hands are tied[3]". The three processes are putting up with violence, shutting up about violence, and getting on with life. This will be followed by actions recommended by the frontline workers to sustain non-violent communities.

Shutting up about Violence

Shutting up about violence goes hand in hand with putting up with the abuse. It has been a learned response that may be a form of resistance and resilience for women against the trauma occurring in their lives. Kimiksana (2003) describes it as follows: "trauma led parents to teach their children not to talk about their pain, their fear, or their abusive experiences, including those that occurred in

[2] Community response is defined in this study as reactions or behaviours of members of the community to encounters of IPV. In the broadest of terms, responses can be seen as both helping and hindering when incidents of IPV occur. In this study, the community is the local frontline workers and their descriptions of responses and reactions to intimate partner violence within their geographical communities. In the project funding submission, Hampton et al. (2010) defined community within our logic model as "a group or groups of citizens who have something in common; for purposes of our research, the focus of our research will be on geographical communities located in rural and northern regions of SK, AB, MB, and NT".

[3] Hands are tied is an expression of the binding circumstances, causes and context of intimate partner violence in the NT.

residential schools. As a result, even years later, the pain, fear and hurt can become unbearable, leading sometimes to alcohol and drug abuse, and sometimes to violence toward oneself or others" (p.87). This pressure, to refrain from disclosing violence and abuse from an intimate partner, continues to be enacted by family and community members. There is community retribution (gossip, treatment of blame and shame, loss of support, and defamation) towards the intimate partner speaking out and reporting, as was witnessed in the recent case of a prominent elected official and responses of community members in the media. The normalization of violence has led to an acceptance within our society of its occurrence that keeps women quiet. This process of "shutting up" leads in an inability for frontline workers to adequately address the needs of women requiring safety and support from a violent partner.

Getting on with Life

Despite the everyday violence in the lives of many women in the NT, strength and resilience is present. Our shelters are full and there are wait lists for placement in secondary housing. Women are sharing their stories and encounters with violence in attempts to provide hope and action for other women in similar circumstances. However, there is another picture to share that culminates from the processes of putting up and shutting up about violence. This is the use of drugs and alcohol to deal with problems. Substance use is directly linked to the violence and is a contributing factor to both the frequency and lethality of violence. Desensitization to violence is an added response that accompanies normalization and in a sense enables getting on with life but also hinders our steps to nonviolent communities.

Actions to Nonviolence

We are currently in the process of developing an action plan that will be shared with government decision makers and community advocacy groups, but I will highlight some key areas of action including assessment and screening, education and awareness, coordinated community response to violence, and programs for children.

Assessment & Screening

Currently police, shelter workers, victim service workers, and New Day[4] Counsellors in the NT have adopted and are using the Ontario Domestic Assault Risk Assessment (ODARA) screening tool to identify patterns of intimate partner violence and with an estimated risk score to determine the likelihood that it will occur again. There are tools used by nurses in specific areas such as the community prenatal forms but this assessment is used inconsistently across the territory. Participants in the study suggest that we need to ask the question- are you in a violent relationship? If so, as health care providers we need to be prepared with tools (such as, a clinical pathway) that effectively assist women who disclose about violence in their lives. For example, nurses need to determine risk for women and help women develop safety plans for themselves and their children. As well, we need to heighten the comfort level for health care providers to ask the question.

Education & Awareness

By far the most frequent suggested intervention highlighted by the participants in answer to the question, "how can we create and sustain nonviolent communities?" was education and awareness at the local level. Dialogue about the normalization of intimate partner violence and the sustained hurt that is a result of normalization needs to be prompted in every community. Education about the effects on

[4] New Day is a program offered in Yellowknife for men who are violent with intimate partners.

children's development when they witness violence must be shared. Teaching about the violence content produced within media and listened and watched by children must be monitored.

There needs to be an emphasis on breaking the cycle of violence along with responses that normalize it. Focusing on healthy relationships and parenting will give women some skills to help but having a safety plan in place when they are involved in a violent and abusive relationship is required.

Coordinated Community Response

The NT continues to have a transient nursing workforce (Kulig, Kirkpatrick, Moffitt & Zimmer, 2015): RCMP turnover is ongoing, most are posted for two years in communities; many communities do not have either shelter workers or victim service workers (Moffitt, Fikowski, Mauricio & Mackenzie, 2012). This recruitment and retention issue means that as one participant suggested "there is no institutional memory". Frontline workers require orientation to the nature of violence and women need to tell their stories many times. On top of that, participants expressed concern with an interpretation of the Access to Information Policy in their community that leaves them unable to share vital information with each other. All of these factors, leaves frontline service for women facing violence fragmented. Interagency meetings have been implemented in some regional communities which are needed as part of a coordinated response that occurs consistently, accountably and responsibly.

Programs for Children

The normalization of violence for children increases perpetration of violence in adulthood (Mbilinyi, Logan-Greene, Neighbors, Walker, Roffman, & Zegree, 2012). The NT experiences high rates of both suicide in young people and family violence. There are few opportunities for children exposed to violence to receive treatment. Few families have the kind of in-depth assessment required to meet the diversity of family relationships, custody arrangements and mediating correct response for the types of IPV (Hughes & Chau, 2012). These types of initiatives will require a great deal of coordination between Child Protection and Family Law systems (ibid). Several recommendations from the Auditor General of Canada (2014) about child and family services in the NT are important considerations for children. Two recommendations that coincide with findings from this study are: a need to improve monitoring and reporting (accountability) and tools to support the child and family services programs.

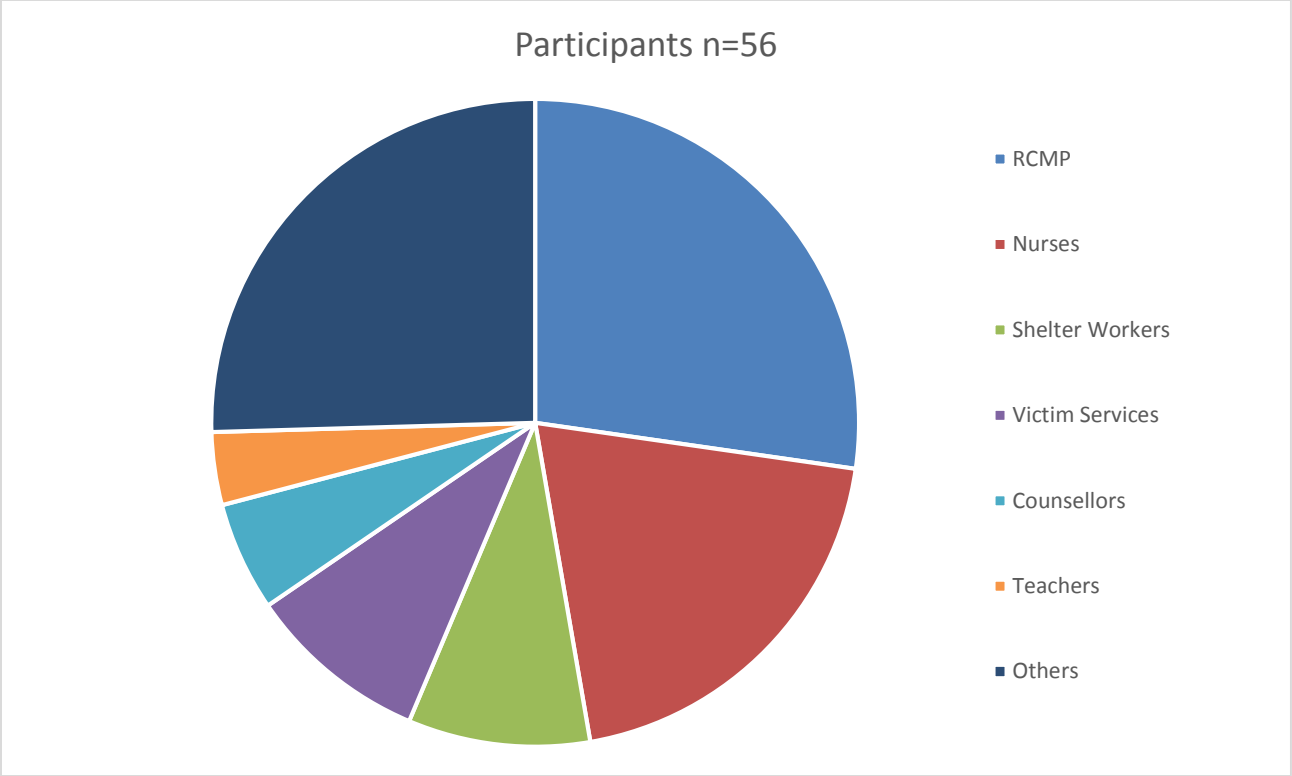
Conclusion

This project has provided an understanding of the complexities, context and nature of community response to IPV against NT women. We have learned the needs of women experiencing IPV and the gaps in services required to meet those needs.

The emerging theory of *Our Hands are Tied* highlights social processes (responses) that require transformation if we are to disrupt the normalization of violence that is the current reality and create nonviolent communities. An action plan with detailed recommendations will provide direction to decision makers at the local, territorial and national level.

If you have any comments about this research brief, please contact pmoffitt@auroracollege.nt.ca.

Appendix A: Research Participants



Acknowledgements

We appreciate funding for the "Rural and Northern Community Response to Intimate Partner Violence" project from the Social Sciences and Humanities Research Council, Community/University Research Alliance (SSHRC/CURA) and the direction provided by Dr. Mary Hampton, Luther College/University of Regina and Diane Delaney, Community Partner.

References

Auditor General of Canada. (2014). Child and family service- Department of Health and Social Services and Health and Social Services Authorities. Retrieved from Http:// www.oag-bvg.gc.ca/internet/English/nwt_201403_e_39100.html.

Ellsberg, M., & Heise, L. (2005). *Violence against women: a practical guide for researchers and activists.* Geneva, Switzerland: World Health Organization.

Fikowski, H., & Moffitt, P. (2015). *Community response to intimate partner violence north of 60.* Safety School Poster Presentation. Family violence Awareness Week. Yellowknife, NT.

Health & Social Services, GNWT. (2011). *Northwest Territories health status report.* Yellowknife, NT: Author.

Hughes, J., & Chau, S. (2012). Children's best interests and intimate partner violence in the Canadian family law and child protection systems. *Critical Social Policy, 32*(4), 677-695. doi: 10.1177/0261018311435025

Kimiksana, A. (2003). Community responses to violence in Holman, Northwest Territories, *Arctic Anthropology, 40*(2), 87-89.

Mbilinyi, L.F., Logan-Greene, P.B., Neighbors, C., Walker, D.D., Roffman, R.A., & Zegree, J. (2012). Exposure to domestic violence and childhood emotional abuse. Childhood domestic violence exposure among a community sample of adult perpetrators: what mediates the connection? *Journal of Aggression, Maltreatment & Trauma, 21*, 171-187. doi: 10.1080/10926771.2012.639203

Moffitt, P. (2004). Colonialization: A health determinant for pregnant Dogrib women, *Journal of Transcultural Nursing*, (15), 323-330.

Moffitt, P., Fikowski, H., Mauricio, M., & Mackenzie, T. (2012). *Summary of the Northwest Territories Environmental scan (Rural and Northern Community Response to Intimate Partner Violence).* Yellowknife, NT: Aurora College

Moffitt, P. (Spring, 2012). Research notes: Rural and Northern response to intimate partner violence. *Northern Public Affairs Magazine, 1*,62.

Moffitt, P**.,** Fikowski, H., Mauricio, M., & Mackenzie, A. (2013). Intimate partner violence in the Canadian territorialnorth: perspectives from a literature review and a media watch. *International Journal of Circumpolar Health, S72*: 21209. Retrieved from http://doi.org/10.3402/ijch.v72i0.21209.

Moffitt, P. (2014, February). Investigating community response to intimate partner violence in the Northwest Territories. *Research and Education for Solutions to Violence and Abuse (RESOLVE)*, 16, 1-8

Truth and Reconciliation Commission of Canada. (2015). Honouring the truth, reconciling for the future: summary of the final report of the Truth and Reconciliation Commission of Canada. Retrieved from www.trc.ca/websites/trcinstitution/File/2015/HonouringtheTruthReconcilingfortheFuture

Wuest, J. (2012). Grounded theory: the method. In P.L. Munhall Nursing research; a qualitative perspective (5th ed.) [229-284], Mississauga, ON: Jones & Bartlett

CANADIAN NURSES ASSOCIATION

The call for resolutions is now open!

Resolutions are a great way for you to voice your opinion about which issues CNA should focus on. Submit a resolution on any nursing or health-care topic you feel passionate about, as long as it fits with CNA's mission and goals.

Who: CNA members

Why: To voice your opinion, raise matters and highlight important nursing and health-care issues.

How: Read the **resolution guidelines** and then complete the **submission form**

When: By April 14

Where: Resolutions received by the deadline will be presented at CNA's 2016 annual meeting of members.

Resolutions received after the deadline will not be presented at the meeting of members. Instead, they will be deferred for board consideration at its November meeting.

If you have any questions, please do not hesitate to contact Debbie Ross, manager of governance and events at **dross@cna-aiic.ca** or 1-800-361-8404, ext. 214

www.cna-aicc.ca

Exciting year for CNA Certification Program

In 2016, our certification program is moving to fully digital applications and test writing. For the first time, new and renewing candidates will apply exclusively online and take their exams at computer-based testing centres.

Planning to apply or renew in 2016? For key dates and information follow the link:

getcertified.cna-aiic.ca

Jurisprudence: What You Need to Know

Demonstrating jurisprudence competence will soon be a mandatory part of the RNANT/NU Continuing Competence Program for all registered nurses and nurse practitioners licensed to practice in the Northwest Territories and Nunavut.

1. *What is Jurisprudence?*

By definition, jurisprudence refers to the study of the law. In relation to nursing, and the RNANT/NU, jurisprudence is used to refer to the laws, regulations, and standards that govern our nursing practice as registered nurses or nurse practitioners in the Northwest Territories and Nunavut.

2. *Why is it important for my nursing practice?*

Jurisprudence competence is important for your nursing practice in the Northwest Territories and Nunavut. By developing a better understanding of the laws, regulations, and standards that govern your nursing practice, you will be better able to practice within the boundaries of those laws, regulations, and standards. Furthermore, you will acquire knowledge of self-regulation and its importance to the nursing profession.

3. *What can I do now?*

You can begin working on your jurisprudence competence by reviewing documents that address the laws, regulations, and standards that govern our nursing practice as registered nurses and nurse practitioners in the Northwest Territories and Nunavut, such as the (a) Nursing Profession Act (2003), (b) Nunavut Nurses Act (1998), and (c) RNANT/NU Standards of Practice For RNs and NPs (2014).

Professional Conduct Decisions

RNANT/NU Member # 5499

On January 20, 2014 the Chair of the Professional Conduct Committee approved a Settlement Agreement between RNANT/NU and Member # 5499. The Member voluntarily entered into Alternate Dispute Resolution and was fully involved and co-operative with the process. The member was found to have inadequately assessed home care clients resulting in a lack of adequate treatment on more than one occasion. The member was found to have failed to thoroughly document client care in a timely manner on more than one occasion. The member used a government vehicle for personal reasons on more than one occasion violating government policy. As part of the Settlement Agreement, the Member has completed an ethics course, an advanced nursing assessment course, a documentation course and 300 hours of supervised home care practicum.

RNANT/NU Member # 5477

On February 12, 2016 the Chairpersons of the Professional Conduct Committee accepted a complaint of professional misconduct against the member who refused to comply with the 2015 Continuing Competence Plan audit process. The Member accepted full responsibility for failing to submit the 2014 Continuing Competence Plan as requested and as indicated as being completed on the 2015 registration renewal form. As a result of this noncompliance the Chairpersons ordered the member receive a letter of reprimand to be placed on the registration file. The Chairpersons also ordered a Continuing Competence Plan be submitted prior to the member being eligible to renew certificate to practice nursing.

RNANT/NU Member # 444

On February 12, 2016 the Chairpersons of the Professional Conduct Committee accepted a complaint of professional misconduct against the member who refused to comply with the 2015 Continuing Competence Plan audit process. The Member accepted full responsibility for failing to submit the 2014 Continuing Competence Plan as requested and as indicated as being completed on the 2015 renewal form. As a result of this noncompliance the Chairpersons ordered the member receive a letter of reprimand to be placed on the registration file. The Chairpersons also ordered a Continuing Competence Plan be submitted prior to being able to renew certificate to practice nursing.

CNA Certified? Post-Grad Educated?

If you have completed a CNA Certification Program or post-graduate studies, let us know – we would like to acknowledge you in the next edition of the newsletter.

Community Development Competencies in Canada's North

Submitted by: Kerry Lynn Durnford MN, RN & Pertice Moffitt PhD, RN

Public and community health in Canada's north is complex and mitigated through a generalist function, yet how many health care workers are prepared for this expectation? One of the main roles of community health workers is to collaborate with communities to identify issues and empower community members to establish a plan and solve problems together. The purpose of this article is to share with Registered Nurses a new and unique professional development resource in the area of community development. This resource, a community development workbook developed in the north using northern materials and research, allows participants to gain the foundational knowledge required to develop the competencies necessary to work in community health. A brief description of the survey assessment conducted to identify competency strengths and learning needs among health and social service care providers in the north is provided and offers background and rationale for the development of this innovative community development workbook. A competency approach to curriculum development, used in this project, is both appropriate and relevant to the health and social service environment in the north.

Community Development Defined

In public and community health nursing, the community is the client. Community development is a "process whereby community members come together to take collective action and generate solutions to common problems" (Frank & Smith, 1999, p.3). Community development, according to the Ottawa Charter (World Health Organization, 1986), involves exploring the strengths, skills and resources currently available in a community to strengthen collaborative action and improve health at the community level. Registered Nurses in regional centres and remote communities of the north, and across Canada, engage in a plethora of services and programs from acute and chronic care, emergency services to public health planning and service delivery. Success of public health programs depends on a level of community capacity and engagement along with the community development competency level of community leaders and professionals.

The Community Development Training for the Public Health Workforce Project – A Brief Overview

A pan-territorial project team comprised of faculty from Yukon College in Whitehorse, Aurora College in Yellowknife, and Arctic College in Nunavut, as well as members of each of the three territorial governments and the Northwest Territories and Nunavut Public Health Association, collaborated to create a professional development workbook titled "Community Development in Northern Canada: A Competency Approach for Strong Communities". This three year, pan-territorial project, was made possible through funding from the Public Health Workforce Development Products and Tools Program from the Public Health Agency of Canada. The team knew that gaps existed in the type and extent of professional development opportunities in the area of community development (Frank, 2009). Based on this knowledge, the project team assessed the learning needs and strengths of health and social service employees of the Government of the Yukon

and Northwest Territories. Nunavut was unable to participate in the needs assessment due to competing priorities in the health and social service sector and human resource constraints at the time. Using findings from the needs assessment of existing competency strengths and needs, the team developed a workbook and piloted the workbook with professionals in all three territories. The workbook will be available to health and social service providers in the north and across Canada in early 2016.

Competency to Curriculum

A competency based approach to learning provides participants with relevant professional development opportunities. The Canadian Nurses Association (2015) defines competency as "the knowledge, skills, judgment and attributes required of an RN to practice safely and ethically in a designated role and setting" (p. 27). A competency based approach to curriculum has been recommended in community health nursing (Levin, Swider, Breakwell, Cowell, & Reising, 2013; Swider et al., 2006). Many competencies exist for the practice of nursing and the Public Health Agency of British Columbia developed specific community capacity building competencies that were adapted for the needs assessment conducted in the Yukon and Northwest Territories. Knowledge of the context of health and social service systems in each of the three territories allowed the project team to use the BC competencies as the framework for the development of northern community development competencies (see Table 1).

Table 1: Northern Community Development Competencies (right)

1. Understand the concepts of working effectively in the community and able to build community capacity in my work.
2. Able to establish effective working relationships with all kinds of individuals, organizations and groups.
3. Able to influence others, foster leadership, mobilize a community to action and help others to successfully work through change.
4. Able to use a population and social determinants approach to explore factors that affect health (i.e. income, food, housing, etc.) in order to improve health and wellbeing of groups and communities.
5. Able to apply at least two of the following to develop capabilities of others: Group facilitation, Coaching, Consultation techniques, Community engagement processes.
6. Able to engage communities to advocate for services and policies that influence the health and wellbeing of many people at the same time.
7. Able to ensure information (both written and oral) is passed on and understood by others in a timely and effective way.
8. Able to help communities work through issues using problem-solving and conflict resolution skills.
9. Able to understand and apply at least one of the following to gather information: Participatory action research, Community asset mapping, Participatory evaluation.
10. Able to take into account diverse values, beliefs and cultural practices when working with communities.
11. Able to advise on and influence opportunities to help communities keep their efforts going.
12. Able to develop two or more of the following: Strategic plans, Grant proposals, Project proposals, Briefs, Options papers, Requests for proposals.
13. Able to encourage innovation and support new approaches.

Public and community health care in the north offers unique challenges. A transient workforce, professional development opportunities complicated by cost of travel and information technology difficulties are some of the issues faced by practitioners in obtaining and maintaining competency. The health care team can also be quite diverse, comprised of lay dispensers, community health representatives, Licensed Practical Nurses, Registered Nurses, and Nurse Practitioners, among other professionals. The responsibilities of community health workers often include community development, whether or not they are actually hired into public health roles. The importance of competencies, developed in the north that reflect the nature of northern community work was a critical first step in this project. Continuing competence is required of all Canadian Registered Nurses and registered nurses working with communities need to reflect upon and assess their level of competence against these established competencies.

Northern Community Strengths & Gaps

A needs assessment of the employees in health and social service sectors in both Yukon and Northwest Territories in 2013 (n=242) revealed that employees have a variety of strengths in the areas of community development. In fact, respondents in the survey tended to indicate areas of strength rather than learning need. Most participants in the assessment survey indicated they engaged in community development work; 81% of respondents in the NT indicated they used community development skills at least sometimes. Many participants stated they were using community development concepts however, they lacked the formal education to actually name the work they were doing. Survey participants were interested in a learning resource that provides recognition of their accomplishment, meets the needs of a variety of care providers, and provides tangible and relevant resources to assist them in their work with communities.

Participants in the needs assessment identified strengths in the areas of: understanding and building community capacity (competency 1); establishing effective working relationships (competency 2); applying skills in the areas of group facilitation; coaching, consultation techniques and community engagement (competency 5); written and oral communication (competency 10), and encouraging innovation and supporting new approaches (competency 13). These strengths were reassuring to the project team and evident in the relationships that many northern nurses develop with their community members.

Despite the contextual differences in the territories there were similarities in the competencies identified as learning needs. The top five competencies for which participants wanted further professional development included: engaging communities in advocacy (competency 6); using problem solving and conflict resolution skills (competency 8); understanding and applying community assessment and evaluation methods (competency 9); helping communities to sustain efforts (competency 11); and, developing documents essential in community development work (competency 13).

The workbook has five chapters, each devoted to one of the competencies identified as a learning need. The workbook, available completely online from the Northern Institute for Social Justice, Yukon College, uses northern resources, links, case studies and questions to guide learners to gain foundational knowledge necessary for competence in these areas of community development.

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Conclusion

A competency to curriculum approach can offer health care providers an invaluable opportunity to develop the knowledge, skills and abilities needed to engage in safe, effective and ethical care. Registered Nurses in the Northwest Territories and Nunavut, whether working in front line roles in practice, education, research, administration or policy, can benefit from the community development workbook. It is hoped that Registered Nurses will avail of this free, professional development opportunity to allow them to work effectively and collaboratively with communities to empower them to reach optimal levels of health and wellness.

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References

Canadian Nurses Association (2015). *Framework for the practice of registered nurses in Canada*. Ottawa, ON: Author.

Frank, F. (2009). *Community development for health professionals: Scan of online training resources*. Meacham, SK: Common Ground Consulting.

Frank, F., & Smith, A. (1999). *The community development handbook: A tool to build community capacity*. Retrieved from http://publications.gc.ca/collections/Collection/MP33-13-1999E.pdf

Levin, P.F., Swider, S.M., Breakwell, S., Cowell, J.M., & Reising, V. (2013). Embracing a competency-based specialty curriculum for community-based nursing roles. *Public Health Nursing, 30*, 557-565. doi:10.1111/phn.12042

Swider, S., Levin, P., Ailey, S., Breakwell, S., Cowell, J., McNaughton, D., O'rourke, M. (2006). Matching a graduate curriculum in public/community health nursing to practice competencies: the Rush University experience. *Public Health Nursing, 26*, 190-195.

World Health Organization (1986). *The Ottawa charter for health promotion*. Retrieved from http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

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Cancer Survivorship: A Care Plan to Last a Life Time

Submitted by: Betty Ann Marriott, BSN, RN

The topic of cancer survivorship is just beginning to gain momentum in the field of health care. Nurses need to become familiar with this concept and its implications for patient care. According to the NWT Breast Health/Breast Cancer Action group (Action group) (2016), cancer survivorship is a term used that refers to those who have been diagnosed with cancer and are still alive. "Cancer survivorship starts from the time the diagnosis is received and beyond…" (p.24). The words "*and beyond*" are key. Most think that cancer care finishes when treatments like surgery, radiation and chemo are completed. However, many survivors would agree that they have more health care needs as a result of these treatments or from on-going treatments such as hormone therapies, additional surgeries (such as reconstruction, plastics, or further excisions), as well as mental and/or emotional support requirements.

A common misperception among health care professionals and the public, is that once a person undergoes treatment, they are cured and it is 'done'. They are expected to continue with their lives where they left off. In reality, many survivors require ongoing care to address treatment side effects. They may also need further surveillance and monitoring. This includes things such as: X-rays, bone scans, blood tests, injections, etc. Recovering, healing, and in some instances continuing to live with cancer, can be a lifelong challenge.

In the NT and Canada, survivorship has not been a priority. In my experience, the acute phase of survivorship (active cancer treatment) has been easier to accept and endure than the extended phase of survivorship. Recognizing that cancer survivors require continued support, care and follow-up from their healthcare professionals, survivor care plans are being implemented throughout Canada and the United States. The Action Group believes that "survivor care planning starts when a person is first diagnosed with cancer and continues through the rest of his or her life. This will help ease the transition between each stage in the cancer journey" (p. 24). It is known that due to earlier cancer screening, focused health promotion and improved cancer treatments, survivorship numbers are increasing. According to the Canadian Partnership Against Cancer (2011), it is predicted that the number of survivors in Canada will reach 2.2 million by 2031 (p.21). The development and utilization of survivorship care plans will become increasingly important for health care providers and survivors.

The NWT Action group, in partnership with the Department of Health and Social Services, the Sahtu and Fort Smith Health and Social Services Authorities, cancer survivors and others, established the project, "Living the Journey: Cancer Survivor Care Plan Demonstration Project". To date the Action Group has developed three survivor care plans (breast, colorectal and general cancer) which will be implemented in the NT. They are in draft form and are currently being piloted in the communities of Fort Good Hope and Fort Smith.

As a member of the Action Group, I travelled to Fort Good Hope to provide 'pre-pilot' training about the survivor care plan. This care plan is a 'living' document that contains pertinent information for the survivor. The document has two parts; part one

contains health information about their specific cancer, for example, tumor characteristics, prescribed medications, radiation fractions, and chemotherapy. Depending upon the type of cancer, there may also be information about potential side effects and/or complications and strategies to deal with them. On point, the breast cancer survivor care plan contains information about lymphedema (signs and symptoms, exercises and when to notify their healthcare provider). There is also space to document any reactions related to medications and/or treatments. Part two is an interactive booklet that allows the survivor to rate their wellbeing on a scale from one to five. Areas being rated include: physical, emotional, psychosocial, financial, and sexual wellbeing. Sleep, nutrition, returning to work and family dynamics are also addressed. The survivor and a healthcare provider collaboratively determine what aspects require attention and goals are then developed to meet the identified needs. The survivor care plan is a portable document that can be carried to all appointments. There is ongoing discussion that the care plan will eventually be accessible on the NT EMRs. This would facilitate continuity of care, especially when multiple caregivers are involved.

Being a nurse and a breast cancer survivor, I can say, overall, I experienced amazing care. However, I also felt and still feel the impact related to gaps in our healthcare system. I felt prepared for the initial cancer treatment (surgery, radiation and eventual hormonal therapy). I knew I had help and the healthcare team was at my side. However, I was not prepared for what came next. Other than a bit of weight loss, there were almost no external visible changes. On the inside, it felt like I was no longer in control; there were battles with fatigue, disorganized thoughts, and an overall sense of disconnect. It felt surreal as I tried to pick up where I left off as if nothing happened. Taking on my pre-cancer responsibilities at home and performing my everyday ADLs like getting groceries, meal planning, cleaning, being taxi mom and resuming work were all a challenge. I wanted to do things just like I always had but found myself not even able to plan a meal. Why was I so slow? Why couldn't I multi task? This added to my frustration. No one had shared with me the road I was about to head down. I experienced changes in my thinking, in my physical appearance as well as other changes in my body. I believe most of these were/are related to the psychological and emotional impact of having been diagnosed with cancer as well as the effects of the medications (artificially induced menopause and all of its 'ramifications', for example). Despite being a nurse and researching everything related to my diagnosis, I was not prepared for the ongoing struggles. I did not want to talk about how I was struggling because I thought I was just "over thinking it." In a recent meeting of a cancer survivor support group, I learned that the questions I asked myself, and the feelings that I had, are common among many cancer survivors. My journey and the journey of other survivors has validated the importance of having a survivor care plan. These plans can include things as simple as keeping future tests organized and on schedule to providing information about potential after-effects of treatment and how being a cancer survivor can affect your life in ways you never considered. As nurses, by understanding the lives of survivors, building egalitarian relationships and promoting a holistic approach to care, we can support our patients through their journey of survivorship.

For more information about the Breast Health/Breast Cancer Action Group visit: *www.breasthealthnwt.ca* Or like us on Facebook at NWT Breast Health/Breast Cancer Action Group

Canadian Partnership Against Cancer (2011). Retrieved from www.partnershipagainstcancer.ca

NWT Breast Health/Breast Cancer Action Group (2016). *Survivor care plan training workshop facilitator's manual.* Yellowknife, Canada: Author.

Canadian Nurses Protective Society

infoLAW®

Legal Risks of Email - Part 2
Practical Considerations

Vol. 22, No. 3,
December 2014

Practical Considerations

Email, in some cases, may be the preferred option to communicate with patients or others efficiently and expeditiously. Before using email, it is important for nurses to be aware of the risks and alternative ways to transmit information. In addition to the privacy and confidentiality considerations set out in the *infoLAW*, Legal Risks of Email – Part I, nurses may wish to consider the following practical issues relating to email use with patients and others in their practice.

Managing Expectations

Some nurses are using email to communicate directly with patients, both during and after hours. In addition to managing the privacy and security concerns associated with these communications, nurses should consider how to best manage patient expectations about the appropriate uses of these communications, how quickly they will respond to enquiries and what steps should be taken if a timely response is not forthcoming. Reasonable limits and response times may then be clearly communicated to patients.

Further, even when a patient has consented to email communication, a nurse may insist on an alternate mode of communication in certain circumstances. For example, if there is uncertainty as to the identity of the recipient, where the patient should be given an opportunity to ask questions, if it is necessary to ascertain whether the patient properly understood the information or if the information is simply too sensitive to be communicated by email, the nurse may consider a more traditional method of information exchange.

Documentation

Nurses are cautioned to maintain copies of all email messages to and from patients. These copies should be kept in the patient's electronic or paper chart. This acknowledges that such communications are professional and that they have potential clinical and legal implications.

Personal Use of Email at Work

Nurses using email at work for personal purposes should be aware of potential disciplinary consequences. In some cases, using an employer's email system for personal communication or including inappropriate language and jokes has resulted in disciplinary action by employers and even termination of employment. One example involved an employee whose employment was terminated after 26 years of service for accessing inappropriate material that had been emailed to him at work by others. He forwarded such emails to some of the company's employees, suppliers and contractors. The court concluded that the company's code of conduct allowed employees to use its computers for "limited" personal use but expressly prohibited sending pornographic, obscene, inappropriate, or other objectionable communications. The employee was found to have read, understood and accepted the terms of the code of conduct.[1]

Communicating by email:

Are your patients aware of the potential risks?

More than liability protection

Use in Legal Proceedings

Generally speaking, most documents (including electronic documents like emails) are producible in legal proceedings if their content is relevant to matters in the proceeding. As such, emails with patients or other health care practitioners that contain clinical information or other information about a patient may need to be disclosed in the event of a patient request for access to personal health information, civil action or complaint to a regulatory body or investigation by another statutory body.

It is important to recognize that email has traditionally been seen, and used, as a manner of sending *informal* communications and less care may be taken drafting an email than would be taken if sending a letter or writing in a patient chart. Language used in emails tends to be less factual, less precise and less professional. For these reasons, caution should be exercised when communicating via email and nurses are reminded to use a professional tone and clear content for all email communications.

Nurses should also be aware that any email communications should be considered permanent. Although email programs have a delete function, IT professionals can retrieve deleted emails with relative ease, even years later. Multiple copies may continue to reside in back-up files, the recipients' email, or in the email of third parties to whom the email was forwarded.

Risk Management Considerations

To limit the potential legal risks related to email communications, consider implementing the following risk management strategies:

- Let patients and other health care providers know when the use of email is appropriate, the turnaround time for received messages and what to do in the event that symptoms worsen or there is a delay in responding;
- Place emails of a clinical nature in the patient's chart;
- Be aware that when using an employer's email system, the employer has the ability to access the email communications;
- Use a professional tone, and generally take as much care as when using any other formal mode of communication or documentation; and
- Follow employer guidelines and policies regarding email communications.

Please contact CNPS at **1-844-4MY-CNPS** if you have any questions regarding legal risks in email and visit our website at **www.cnps.ca.**

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1. *Poliquin v Devon Canada Corporation*, 2009 ABCA 216 (CanLII).

Related infoLAWs of interest: Mobile Devices in the Workplace and Legal Risks of Email – Part 1.
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ISMP Canada Safety Bulletin

Volume 15 · Issue 12 · December 30, 2015

Medication Incidents that Increase the Risk of Falls: A Multi-Incident Analysis

An aggregate analysis of medication incidents showed the following key themes associated with falls and risky fall-related situations:

- *Failure to anticipate the inherent risks of medications*
- *Inadequate proactive clinical assessment*
- *Communication gaps*
- *Failure of medication-use processes*

Falls remain the leading cause of injury-related hospital admissions among Canadian seniors, with 20% to 30% of this age group (age 65 years and older) falling each year.[1] Psychotropic medications and polypharmacy are widely recognized as factors contributing to an increased risk of falls, because of the inherent clinical effects of the medications, their adverse effects, additive toxic effects, and drug interactions.[1,2] Lack of adherence with medication therapy and less-than-optimal treatment of the underlying disease state may also trigger falls. ISMP Canada has received reports of medication-related falls from various sectors of healthcare, including hospitals, long-term care, and the home environment.

A multi-incident analysis of reported incidents was conducted to identify system processes that had clearly resulted in a fall or that could increase the risk of falls (i.e., by causing a symptom that could contribute to a fall).

Methodology and Quantitative Findings

Reports of medication incidents were extracted from voluntary reports submitted to ISMP Canada's medication incident reporting databases from August 1, 2000, to December 31, 2014.* Key words such as "fall", "fell", "stumbled", and "tripped", as well as terms relating to symptoms that increase the risk of falls (e.g., "drowsiness", "dizziness", "blurred vision", "balance", and "muscle weakness") were used for searching. From this database search, reports of 938 medication incidents were identified and reviewed. Those with descriptive text identifying the occurrence of a fall or the presence of a symptom that was likely to lead to a fall were retained. A total of 243 incidents were included in the final analysis, which was conducted according to the methodology outlined in the Canadian Incident Analysis Framework.[3] Patient harm was reported to have occurred in 133 (54.7%) of these incidents. Table 1 outlines the most common classes of medications associated with falls or an increased risk of falls.

* It is recognized that it is not possible to infer or project the probability of incidents on the basis of a voluntary reporting system.

Table 1. Top Medication Classes/Groups Associated with Falls or Increased Risk of Falls

Medication Class	Number of Reports (n=243)
Opioids	61 (25.1%)
Psychotropics (including antipsychotics, sedative hypnotics, antidepressants)	52 (21.4%)
Cardiac medications (including diuretics)	42 (17.3%)
Hypoglycemic agents (including insulin)	33 (13.6%)

Findings of the Qualitative Analysis

Analysis of the incidents revealed 4 main themes, each with one or more associated subthemes (see Figure 1). This bulletin describes each of the main themes, along with illustrative examples.

Theme: Failure to Anticipate Inherent Risks of Medications

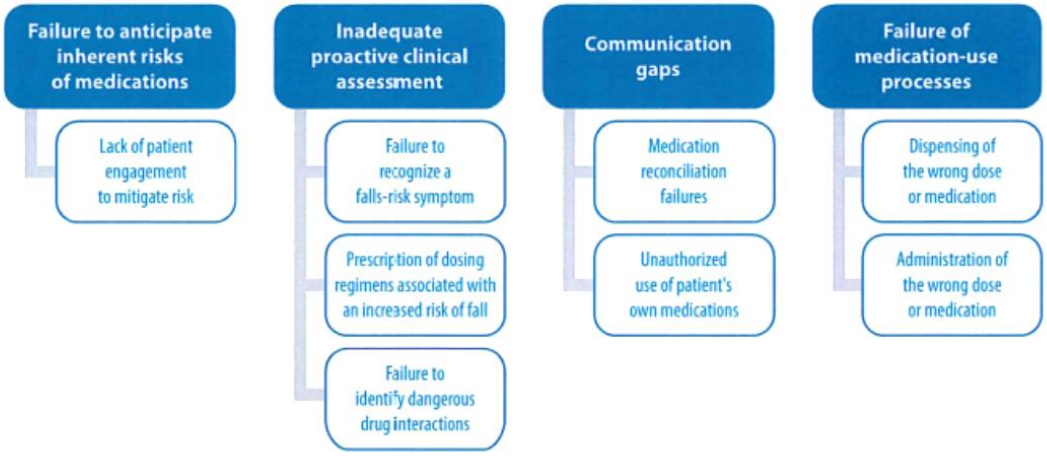
Some medications have well-known adverse effects, unrelated to dose, that can increase the risk of falls. These adverse effects include dizziness, drowsiness, syncope, bradycardia, muscle weakness, and Parkinson-like symptoms.[1] In 19 (7.8%) of the reported incidents in this analysis, the medication carried an inherent risk related to the potential for falls.

Incident Example

A patient was given codeine 30 mg and dimenhydrinate 50 mg in the evening. The next morning, the patient reported that she had fallen in the night and had returned to bed herself. There was no apparent injury, but the onset of slurred speech prompted computed tomography scanning of her head.

Patient and caregiver education and engagement are critical to preventing harm from known clinical and adverse effects of medications. Patients should be advised to be alert to the occurrence of these effects and to inform caregivers and the healthcare team if they occur. Patients should also be given strategies to reduce the risk and action plans for what to do if adverse effects do occur. The patient's voice was evident in many of the reported incidents: they reported their concerns to the healthcare team, which often allowed an intervention to be undertaken to avert harm.

Figure 1. Main themes from the qualitative analysis



Theme: Inadequate Proactive Clinical Assessment

Clinical assessment is an essential skill in prescribing, dispensing, and administering a medication safely and effectively. Integrating patient-specific factors (e.g., renal function, weight, cognition), medical status, physical limitations, and preferences into the clinical assessment can allow interventions to be initiated to lower the risk of falls. The current analysis identified several incidents that demonstrated the value of proactive clinical assessment. The analysis also identified 25 (10.3%) medication incidents in which clinical assessment appeared to be absent or overlooked, including cases in which an inappropriate medication was prescribed, a symptom that could predispose the patient to falls went unrecognized, or opportunities to identify a dangerous drug–drug interaction were missed.

Incident Example

A patient taking warfarin, verapamil, rosuvastatin, and citalopram was started on clarithromycin. After starting the new medication, the patient experienced severe bradycardia and was admitted to hospital. It was determined that a known drug interaction between clarithromycin and verapamil had caused her bradycardia, which could have led to a fall.

Contributing factors that may have led to the absence of clinical assessment and resultant interventions included knowledge deficits, drug interaction warning fatigue, neglect of voiced patient concerns, and lack of consideration of patient-specific factors. Conversely, in descriptions of cases in which potential adverse drug events (and, by extension, potential falls) were averted, the involvement of a pharmacist or a nurse was typically noted.

Theme: Communication Gaps

Medication reconciliation is a vital process at points of transition in the healthcare system. Cases were identified in which deficits in communicating necessary information during hospital medication reconciliation processes (at admission or discharge) led to incorrect orders on admission or conflicting or absent information at discharge. Communication gaps were also evident in cases of patients self-administering their own medications during the hospital stay without notifying staff and cases in which healthcare professionals failed to engage patients in dialogue about their medications.

Incident Example

A pharmacist saw a patient at home 5 days after discharge from hospital. During the visit, it was discovered that the dosage information about gliclazide (an oral hypoglycemic) provided to the patient on the hospital's medication discharge plan (40 mg twice daily) conflicted with the prescription instructions received at discharge (gliclazide MR 30 mg each morning). As a result, the patient was taking gliclazide MR 30 mg twice daily and was experiencing symptoms of hypoglycemia. Although the patient did not fall, the medication error created a risky condition that could have resulted in a fall. Fortunately, the error was identified and corrected before harm occurred.

Failure to engage patients in dialogue when completing admission or discharge medication reconciliation in acute care facilities was identified as a factor contributing to fall incidents.

Theme: Failure of Medication-Use Processes

Three-quarters of the medication incidents (n=183) were determined to have resulted from poor execution of dispensing and administration processes. The majority of these incidents involved dispensing or administration of incorrect medications or dosages, which resulted in the appearance of a symptom that either caused or was likely to cause a fall.

Incident Example

Following surgery, a patient inadvertently received double his methadone dose on 2 consecutive days. After receiving one of these double doses, the patient became quite drowsy and fell while trying to get into bed. Fortunately, no injuries resulted from the fall.

In the hospital setting, factors contributing to administration errors that may have been associated with falls or increased risk of falls included missing documentation for medications administered, lack of

documentation processes to indicate removal of a patch before application of a new patch, illegibility of orders, use of dangerous abbreviations, lack of an independent double check for high-alert medications, and use of preprinted order sets not tailored to a patient's specific needs.

In the community pharmacy setting, factors contributing to dispensing errors included look-alike products or packaging, errors in transcription from the prescription to the computer system, simultaneous processing of multiple patients' prescriptions, and issues related to accepting verbal orders. Notably, patients and caregivers identified many of the incidents themselves and contacted the pharmacy directly for resolution.

Discussion

Research has led to the creation of a list of "fall risk-increasing drugs"[4] and several risk assessment tools are readily available for assessing the risk of falls.[5-7] Hospitals and long-term care facilities are encouraged to have a regular medication review process in place for patients who have been identified as being at risk of falling. All healthcare providers, patients, and caregivers should be part of the assessment and intervention process, with the goal of reducing the overall number of medications and evaluating each medication's potential for contributing to falls.[1] In addition, safeguards to reduce the likelihood of medication administration errors should be considered.

The Public Health Agency of Canada recently reported that 50% of fall-related hospital admissions in Canada originated from a fall at home.[1] Many health care regions have implemented screening and falls-prevention programs for patients who are receiving home care; however, many of these programs do not include a comprehensive medication review. In addition, for many patients living independently in the community, there has been no formal consideration of fall risk. Home care providers and community-based pharmacists can support and assist other primary and community healthcare providers in utilizing structured assessments to reduce medication-related falls.

Conclusion

Reducing the occurrence and risk of falls requires commitment, effective teamwork and excellent communication from the entire spectrum of the healthcare system, including patients and their caregivers, community and home care providers, and all care facilities. Organizations can create protocols and establish processes for structured assessment of known risk situations. Such protocols and processes can also be used to engage patients in their own care and to empower care teams to intervene in situations that require clinical judgement.

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References

1. Seniors' falls in Canada. Second report. Ottawa (ON): Public Health Agency of Canada; 2014 [cited 2015 Mar 28]. Available from: http://www.phac-aspc.gc.ca/seniors-aines/publications/public/injury-blessure/seniors_falls-chutes_aines/assets/pdf/seniors_falls-chutes_aines-eng.pdf
2. de Jong MR, Van der Elst M, Hartholt KA. Drug-related falls in older patients: implicated drugs, consequences, and possible prevention strategies. Ther Adv Drug Saf. 2013;4(4):147-154.
3. Incident Analysis Collaborating Parties. Canadian incident analysis framework. Edmonton (AB): Canadian Patient Safety Institute; 2012. Incident Analysis Collaborating Parties are Canadian Patient Safety Institute (CPSI), Institute for Safe Medication Practices Canada, Saskatchewan Health, Patients for Patient Safety Canada (a patient-led program of CPSI), Paula Beard, Carolyn E. Hoffman, and Micheline Ste-Marie.
4. Milos V, Bondesson Å, Magnusson M, Jakobsson U, Westerlund T, Midlöv P. Fall risk-increasing drugs and falls: a cross-sectional study among elderly patients in primary care. BMC Geriatr. 2014;14:40.
5. Falls risk assessment, prevention and management. Self learning package. Whitby (ON): Ontario Shores Centre for Mental Health Sciences; 2010 Apr [cited 2015 Apr 13]. Available from: http://www.patientadvocatetraining.com/resource/collection/AC3FB86F-BE67-47A7-BBDB-87325AC473D7/Falls_Risk_Assessment_Prevention_and_Management.pdf
6. Safer Healthcare Now! Reducing falls and injuries from falls (falls): getting started kit. Edmonton (AB): Canadian Patient Safety Institute; 2013 Apr [cited 2015 Apr 12]. Available from: http://www.saferhealthcarenow.ca/en/interventions/falls/pages/default.aspx
7. Kisswani R. Integrated provincial falls prevention framework and toolkit. LHIN Collaborative; 2011 Jul [cited 2015 Apr 14]. Available from: http://rgps.on.ca/files/IntegratedProvincialFallsPreventionFrameworkToolkit_July2011.pdf

CMIRPS SCDPIM
Canadian Medication Incident Reporting and Prevention System — Système canadien de déclaration et de prévention des incidents médicamenteux

The Canadian Medication Incident Reporting and Prevention System (CMIRPS) is a collaborative pan-Canadian program of Health Canada, the Canadian Institute for Health Information (CIHI), the Institute for Safe Medication Practices Canada (ISMP Canada) and the Canadian Patient Safety Institute (CPSI). The goal of CMIRPS is to reduce and prevent harmful medication incidents in Canada.

HIROC

The Healthcare Insurance Reciprocal of Canada (HIROC) provides support for the bulletin and is a member owned expert provider of professional and general liability coverage and risk management support.

ISMP CANADA

The Institute for Safe Medication Practices Canada (ISMP Canada) is an independent national not-for-profit organization committed to the advancement of medication safety in all healthcare settings. ISMP Canada's mandate includes analyzing medication incidents, making recommendations for the prevention of harmful medication incidents, and facilitating quality improvement initiatives.

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Contact Us

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Upcoming Webinars, Seminars and Conferences

CNPS: Protecting your Patient's Privacy - Webinar

When: Wednesday, April 6th, 2016

Research on Adolescents and Adults: If Not Now, When?

7th National Biennial Conference on Adolescents and Adults with Fetal Alcohol Spectrum Disorder

When: April 6 – 9, 2016, The Hyatt Regency Vancouver, Vancouver, BC
Event Details: http://www.interprofessional.ubc.ca/

Managing Urgent/Emergent Clinic Problems in Children: A Course for Nurse Practitioners – Webinar and in-person

When: April 15 – 17, 2016
Event Details: http://rnantnu.lamp.yk.com/wp-uploads/2013/09/BloombergNursing_ManagingUrgentEmergentChildApril20162.pdf

Managing Urgent/Emergent Clinic Problems in Adults: A Course for Nurse Practitioners – Webinar and in-person

When: April 15 – 17, 2016
Event Details: http://rnantnu.lamp.yk.com/wp-uploads/2013/09/BloombergNursing_ManagingUrgentEmergentAdultApril20163.pdf

CNPS: Social Media and Technology - Webinar

When: Thursday, May 12th, 2016

Advanced Health Assessment and Clinical Reasoning in Primary Health Care: A Review for Nurse Practitioners – 6 Week Online Course

When: May 16 – June 24, 2016
Event details: https://bloomberg.nursing.utoronto.ca/pd/professional-development/advanced-health-assessment

Coming your way…

In the RNANT/NU 2016 Summer Edition of Connections Look for:

Nurse to Know

RNANT/NU has many members who have made a significant contribution to the nursing profession and to the lives and health of the people of the Northwest Territories and Nunavut. RNANT/NU would like to acknowledge these contributions by featuring a "Nurse to Know" in **each** edition of the newsletter.

The "Nurse to Know" must be nominated by a peer and must meet the following criteria for the domain of nursing they practice.

All nominees must:

- be an active practicing member in good standing;
- promote the nursing profession by acting as a positive role model; **and**
- have made a contribution to nursing in the north through
  - a) Clinical Practice
    - ❖ Provides holistic care grounded in evidence-based practice and/or best practices.
  - b) Education
    - ❖ Demonstrates a dedication to improving the quality of healthcare through nursing education.
    - ❖ Demonstrates a commitment to motivate learners and address the needs of individual learners.
  - c) Research
    - ❖ Conducts research relevant to practice in a northern setting and population.
  - d) Leadership
    - ❖ Promotes a culture and environment where nurses are positive, prepared, involved and empowered.
    - ❖ Advocates for registered nurses and/or nurse practitioners in the healthcare setting.
  - e) Policy
    - ❖ Demonstrates a strong understanding of the significance of policy to the safe, competent, and ethical practice of nursing in the healthcare setting.

Nurse to Know Nomination Form

Items in the Newsletter do not imply endorsement or approval by RNANT/NU.