Compassion & Collaboration: Boyle McCauley Health Centre

LPNs & Cancer Care

Organizational Changes at CLPNA
Oncology Update

What Every Nurse Needs to Know About Cancer

EDMONTON, April 16, 2018 • CALGARY, April 17, 2018

BART BANCROFT, RN, MSN, PNP

The Big C - From the Beginning

- The Definition of Cancer
- Embryology – Differentiation and Maturation of Cell Lines
- The Role of Oncogenes in the Loss of Control of Maturation and Differentiation
- The Role of Angieplasty in the Development of a Malignant Tumour
- The Role of Growth Factors and Hormones in Oncogenesis
- The Role of Chronic Inflammation

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- Understanding the Grading and Staging of Tumours
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Notes on Specific Cancers - What's New, What’s Old, What's in the Future

- Breast Cancers, Colorectal Cancers, Lung Cancers, Prostate Cancer
- Malignant Melanoma

Geriatric Gems: Beyond the Basics

RED DEER, May 1, 2018 • Radisson Hotel

BARB BANCROFT, RN, MSN, PNP

The Essence of Senescence: Aging and the 1% Rule

- Functional Reserve Capacity of Tissues vs. Baseline Function
- The Kidneys and Nephroprotective drugs
- Anti-Cholinergic Drugs and the Cognitive Function
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- Prostatitis and Urinary Tract Infections

Endocrine System

- The Geriatric Patient with Diabetes
- Thyroid Disorders in the Elderly

** Register Early to Avoid Disappointment **

This workshop provides an update and overview on the pathophysiology of cancer, how it starts, how it spreads, the role of oncogenes, the role of the environment (viruses, hormones, chemicals, etc.) as well as many other facts and tidbits about the growth and differentiation of cells. Nomenclature, grading and staging of tumors will be explained. Specific cancers to be discussed include breast cancer, prostate cancer, lung cancer, skin cancer, hematologic malignancies, brain tumors and GI cancers.

WHO SHOULD ATTEND?

- Acute Care Nurses in All Areas
- New Oncology Nurses; Palliative Care Nurses; Geriatric Nurses
- Primary Care, Home & Community Health Nurses; Tele-Health Nurses
- Nurse Practitioners, Transition, Outpost & Occupational Health Nurses

Barb Bancroft is a widely acclaimed nursing teacher who has taught courses on Advanced Pathophysiology, Pharmacology, and Physical Assessment to both graduate and undergraduate students. Also certified as a Pediatric Nurse Practitioner, she has held faculty positions at the University of Virginia, the University of Arkansas, Loyola University of Chicago, and St. Xavier University of Chicago. Barb is known for her extensive knowledge of pathophysiology and as one of the most dynamic nursing speakers in North America today. Delivering her material with equal parts of evidence based practice, practical application, and humour, she has taught numerous seminars on clinical and health maintenance topics to healthcare professionals, including the Association for Practitioners for Infection Control, The Emergency Nurses’ Association, the American Academy of Nurse Practitioners, and more.

** Back by Popular Demand **

This one-day workshop is designed for nurses who provide care to older adults in acute care settings, long-term care, and the home. Barb will assist nurses in developing skills in assessment and care of urgent problems that commonly occur in older patients/clients.

WHO SHOULD ATTEND?

- Med-Surg Nurses
- ER/Critical Care Nurses
- Geriatric RN’s and LPN’s
- OT’s and PT’s
- Social Workers
- Home Care Nurses
- Rural Acute Care Nurses
- Discharge Planners
- Ambulatory Care Nurses
- Nurse Practitioners

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To register: Call toll-free 1.866.738.4823 or visit NursingLinks.ca
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News for CLPNA members

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The College of Licensed Practical Nurses of Alberta (CLPNA) is responsible to ensure that LPNs provide safe and effective care for Albertans. LPNs, as members of this self-regulating profession, are individually responsible and accountable to provide competent, committed care.

Beginning on the first day of nursing school, LPNs are taught the basics of care, including nursing fundamentals, holistic approaches to health, critical thinking and decision making, in anticipation that LPNs will deliver the best care possible to clients. This education continues as we gain experience and exposure to various healthcare settings and improve and advance our abilities. LPNs are continuously building their competence.

Another fundamental aspect of our education comes from professional standards and our code of ethics. Our code of ethics describes the responsibility that LPNs have to the public, to clients, to the profession, to our colleagues, and to ourselves. These principles guide us daily as we take responsibility for the care we provide and demonstrate accountability for the decisions we make, and the actions we take in the public interest. Through adherence to these principles, LPNs are providing committed care to our patients.

This goes beyond our technical competence and our compassion for those in our care. Being a committed professional nurse includes integrating and modelling patient-centred principles and inter-professional competencies into our daily work. As autonomous nurses, we work as part of a team. Recognizing our responsibility and accountability within a team, and particularly within teams we lead, is critical to delivery of excellent care.

Ultimately, competent, committed care is the result of blending technical competence with compassionate caring and a demonstrated commitment to the accountabilities we hold as professional nurses. The perfect blend results in achieving the best possible outcome for the client.

LPNs are encouraged to continue developing competence, and this includes revisiting the CLPNA guiding documents that support us in providing competent, committed care in our professional practice every day.

The outcome we all want is excellence in practical nursing. Albertans are counting on us.

Valerie Paice, President and Linda Stanger, CEO
Caregivers. Educators. Nurses.

Being a nurse isn’t just something you do – it’s something you feel. It’s what drives you to provide uncompromising care in a challenging and ever-changing environment.

The Centre for Professional Nursing Education at MacEwan University helps nurses and health-care professionals across Canada keep pace with the evolution of their profession.

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YOUR WORKING PEOPLE

 Delivering quality health care that Albertans depend on every day. It’s all in a day’s work for AUPE - your working people.
CLPNA 2017 YEAR IN NUMBERS

1390
Alberta Graduate registrations
2016 - 1215

444
Out of Province registrations
2016 - 517

409
IEN registrations
2016 - 261

15,860
total registrations

5%
growth in registration

38
average age of LPNs

161
new complaints received

92%
8%
93% of candidates passed CPNRE Exam on 1st write

Top Places of Employment

- Hospital: 4860 (38.7%)
- Nursing Home: 3473 (27.6%)
- Community Care*: 3418 (27.2%)

Continuing Competency Validation

- 2559 members selected
- 98% member compliance

Professional Development

- 11 webinars
  - 1258 attendees
- 3 workshops
  - 234 attendees
- 9 workshops: ‘Building Successful Mentoring Relationships’ Workshop’s

9 practical nurse programs

11 research projects

*Community Care includes: Community Health / Health Centre, Home Care Agency, Physician’s Office / Family Practice Unit
COMPASSION & COLLABORATION:

Photography by Leroy Schulz
Kim uses the time with Preston to go over how to care for the wound as it heals. She also reminds him to eat more often. He says he’s been drinking lots of strong beer lately and doesn’t really feel like eating. “I know what I should do, but sometimes I just don’t care,” he says. After tending to his finger, Kim gently asks him if he’d like an apple or a fruit cup to take with him when he leaves.

Preston is a regular client of the Boyle McCauley Health Centre (BMHC). Located in Edmonton’s inner city, the clinic provides primary medical services to those facing multiple systemic barriers to accessing healthcare. People experiencing homelessness, addiction, mental health issues and other socio-economic obstacles such as illiteracy or isolation receive professional and compassionate care here.

“Our clients are dealing with complex social and acute medical issues,” says the centre’s executive director, Cecilia Blasetti. “All reasons why they don’t do very well going to a traditional walk-in clinic.”

The BMHC is based on an alternative model of healthcare. It’s a community owned and operated health centre in which a client is matched to a comprehensive team of medical professionals. “We have a culture of providing healthcare in a different way,” says Cecilia. “We only take on people who are really complex and need an interdisciplinary team, including social work and outreach.”

The BMHC was the first of its kind in Edmonton—it’s now 39 years old. In terms of operations and the work...
the centre functions autonomously.

“I think that has had a huge impact on us being able to forge our own way and do things differently,” says Cecilia. “Things that seem avant-garde in healthcare now, we incorporated long ago. We’ve had interdisciplinary teams since day one.”

The health centre’s staff consists of licensed practical nurses, doctors, nurse practitioners, social workers, medical office assistants, psychologists and outreach workers. Together they form four similar interdisciplinary teams. The staff provide a range of medical services in the clinic and in the community, including emergency treatment and wound care. Of the 85 staff members, 25 are LPNs.

BMHC’s healthcare model offers its numerous LPNs the opportunity to work to their full scope in many areas. LPNs are front line staff and deal with triage and emergent situations both in the clinic and outside the health centre. They run the foot care program and wound care clinic; educate clients about chronic illnesses such as diabetes and hepatitis C; administer immunization and flu shots; conduct smoking cessation and nutrition counselling; and provide mental health support. LPNs also oversee the centre’s autoclaving, and train staff and clients on the use of naloxone.

Every LPN works on one of the centre’s four teams. Each team has a LPN as its team lead—Kim is one of them. She’s worked at the clinic on and off since 2009 and has been full time since 2015. Today she’s overseeing patients in the wound care clinic as part of her team’s turn in the three-month rotation of duties at BMHC.

Kim works here because mental health and homelessness are issues close to her heart. Her uncle, who had schizophrenia, lived on the streets for 30 years. “This feels like where I’m supposed to be,” she says.

This feeling of belonging and answering a call resonates with one of BMHC’s newer nurses, Jessica Fedun, LPN. She started with BMHC in 2016, shortly after graduating.

“I’ve always had an interest in mental health,” she says. “It’s something that’s been a passion of mine.”

Originally from a small town in Alberta where she didn’t encounter many people with mental illness or addictions, Jessica admits that working at BMHC has been an eye-opener. “When I first started, I jumped in and saw mental illness all day long. It made me take a step back—I realized it was a big issue,” she says.

About 50 percent of BMHC’s clients are homeless upon their first visit to the clinic and 75 percent have been diagnosed with a mental health issue.

“There are a lot of people out here who live in shelters, they haven’t eaten that day, they have wet socks and
for their nursing care needs,” she says. “You feel good about doing what you do because the doctors have that trust in you.”

Jeff agrees. “Doctors will ask you what you think,” he says. “It boosts your confidence when you get to execute your idea of a care plan.”

The atmosphere at BMHC is casual; staff refer to clients and to each other by their first names. There is an apparent culture of collaboration amongst everyone in the health centre’s close quarters. “Our model has people working together instead of an entrenched hierarchy,” says Cecilia. “Everyone is part of the team and it requires all the imagination, compassion and goodwill of everybody on the team to get people what they need.”

In order to provide the multi-faceted care that clients need, staff at BMHC spend more time with them than at a typical medical office. Once a client goes through the intake process and is...
assigned to one of the four teams, their first visit is 60 minutes long; subsequent visits are 20 minutes. “They’re attached to their team. They understand that there’s a whole group of people taking care of them as opposed to just one practitioner,” says Cecilia.

It’s no wonder the staff form long-lasting relationships with their clients and vice-versa. Karin says that for her, this is an important part of her work here.

“Clients will get to know front line staff really well and build a rapport with them. It’s always the same team who sees the client and that provides continuity and relationship development,” she says. “There’s a satisfaction in the long-term relationship you build with clients and the progress that you see in their lives.”

The nurses acknowledge that working with a vulnerable population in an inner-city neighbourhood might not be for everyone. “People have an idea that it’s dangerous here because it’s inner city,” says Kim. “But I feel safer here than I would working at a hospital. I feel safer with my patients out there. They have my back.”

The LPNs are very protective of their clients and advocate tirelessly for them. “We take people who can’t go anywhere else. They’re battling addiction, they’re homeless, they’re involved in the sex trade, they just got released from prison—that’s our clientele,” says Kim. “Lots of our patients don’t have a voice, or they’ve been told ‘no’ so many times from so many places. This is often the first place that will listen to them. This is why we advocate so forcefully for our clients.”

“A lot of us go above and beyond what’s expected for our patients,” says Jeff. “That’s what keeps them coming back.” In fact, many clients continue to visit BMHC after they’ve stabilized because they’ve developed relationships with the staff.

The BMHC is a funded community agency, and as a result of this financial reality, the staff are paid less than colleagues in other organizations. “But we don’t have trouble hiring and retaining because it’s a practice setting where LPNs can absolutely practice to their full scope,” says Cecilia. “We have flexibility and the freedom to allow us to be responsive.”

This flexibility helps in a place where no two days are alike. “You really don’t know what’s going to happen here each day,” says Jeff. “There’s a certain type of unexpectedness, but at the end of the day you feel it was productive.”

The care and compassion that clients receive from the LPNs and other staff at BMHC is the one thing that is constant, though. As Preston leaves the wound care room and heads down the hall to pick up his snack, he says, “I love them. And they love me.”
According to the Mayo Clinic, stretching helps improve flexibility and range of motion in the joints. Improved flexibility decreases the risk of injuries and enables muscles to work more effectively. Stretching also increases blood flow to muscle, flushing out oxygen-depleted cells and increasing energy levels. Jeff Miller, a certified personal trainer and owner of Function Fitness, recommends the four best stretches for nurses to stay relaxed and loose during a shift.

1. Neck stretch
Stand up straight with your head level. Place one hand behind your back as if standing “at ease,” only with the back of your hand on your lower back. Put the other hand on top of your head, and gently pull your head to the side until you feel a stretch. You should feel the stretch in your neck, shoulder, and a little bit in your core. Hold for 20 seconds, then do the other side. Do this once an hour to help keep your neck muscles loose and balanced.

2. Chest and shoulder stretch
Stand up straight with good posture. Put your hands out to your side, and rotate your hands so your thumb is pointing backward until they’re pointing at the wall behind you. Arch your back, pressing your shoulder blades together, and hold for five seconds. If you do this once an hour, it will help prevent back, shoulder, and neck pain caused by constantly leaning over your patients and looking down at their charts.

3. Hula-hoopers
Put your hands on your hips and slowly swivel them around like a hula-hooper. Do this five times per side every hour. It will help keep your hip and back muscles stable and balanced, preventing low-back pain.

4. Standing row with tubing
Attach some exercise tubing (just medical tubing with some grips on it) to a coat hook or something else relatively close to eye level on the wall. Holding your hands thumb-side up and your arms straight out in front of you, pull your elbows straight back toward the wall behind you. Do three sets of three reps, 12-15 times, at least three times per week.

This article originally appears on DailyNurse.com and is reprinted with permission from Springer Publishing Company.
Why did you become an LPN? Perhaps you always wanted to work in healthcare, or you find the human body fascinating, or perhaps you loved the idea of being able to wear scrubs every day. Whatever the reasons, I imagine one of them was that you have a genuine desire to care for and help others.

That’s where patient and family centred care comes in. Let’s talk about what patient and family centred care is, why it matters, and how you can incorporate it in your daily work in order to create positive patient and family experiences.

Patient and family centred care (PFCC) can mean different things to different people. At its core, PFCC means working in partnership with patients and family members in the planning, delivery, and evaluation of health services. It means building a culture of healthcare that arranges care around the patient and their family, not around the health system.

There are four principles of PFCC to guide us as we work with patients and families:

1. **Respect & Dignity** - Treating patients and families with respect and dignity; listening to and honouring their perspectives, choices, beliefs, and values.

2. **Participation** - Inviting patients and families to participate in their care and in decision-making at the level they choose.
3. **Information Sharing** - Sharing complete and unbiased information with patients and families in ways they can easily understand.

4. **Collaboration** - Collaborating with patients and families in all levels of healthcare service planning.

Providing PFCC benefits your patients, their families, yourself, and the health system. According to the Institute for Patient- and Family-Centered Care, providing PFCC “leads to better health outcomes, improved patient and family experience of care, better clinician and staff satisfaction, and wiser allocation of resources.”

Here are some ways you can live out PFCC in your day-to-day work as an LPN:

- Use “N.O.D.”: Whenever you meet a patient, introduce yourself with your name, occupation, and duty. For instance, “Hi Andrew, my name is Carl. I’m one of the nurses here and I’m here to check your blood pressure. Is now a good time?”
- Make eye contact
- Ask patients how they would like to be addressed (i.e., Mr/Mrs/Ms, first name, nickname).
- Include patients in conversations and ask them how they would like to be involved in decision-making regarding their care.
- Use everyday language when talking with patients and families (avoid medical jargon).
- Welcome questions from patients and families and check for understanding (i.e., “I want to be sure I explained things clearly. Tell me how you would share this information with a friend.”).
- Consider how you can involve family members/support persons in the patient’s care.
- Find out what matters to your patients:
  - “What do I need to know about you in order to provide the best possible care for you today?”
  - “What is important to you during today’s appointment?”

The strategies above are not labour or time-intensive, yet they can make a world of a difference to your patients. The following excerpts from some of Alberta Health Services’ digital patient stories show the positive difference it makes to be cared for by healthcare providers with a patient and family centred approach:

- “He wanted to know me. Not just to learn about my medical history, but also what my hobbies were, what I enjoyed doing… For the first time in my healthcare journey, a [healthcare provider] saw me and talked to me like I was a regular person. And for the first time I felt like I was not my condition.” – Maya’s story

- “I don’t think patients want to go on such a personal healthcare journey with healthcare providers they don’t know. How can they ask the right person the right question if they don’t know their job?… How can we thank you if we don’t know your name?” – Michelle’s story

- “During these times, it’s the small moments of connection and understanding that can really make the biggest difference.” – Laurie’s story

(For all AHS digital patient stories, search ‘AHS digital stories’ on www.youtube.com.)

Every shift you have the honour of caring for others in some of their most vulnerable times. You have a hand in their recovery, their ongoing care, or helping improve their quality of life. And every interaction is an opportunity to provide patient and family centred care and create exceptional experiences for your patients and their families.

For more information about PFCC, visit the Institute for Patient and Family Centered Care’s website at www.ipfcc.org.

CLPNA thanks AHS for this article and Paul Wright, Calgary Zone Manager for Patient and Family Centred Care for the related previously-recorded video webinars, which can be found at clpna.com.

1 http://www.ipfcc.org/about/pfcc.html
Nearly 50% of Canadians will develop cancer in their lifetime and as a result of this disease, 25% of these individuals are expected to die. In 2017, it was estimated that 206,200 individuals were diagnosed with cancer, and the trend shows yearly increases in diagnoses. With the escalating incidence of cancer combined with advances made in cancer detection and treatment, the demand for nurses with specialized cancer knowledge is growing. Nurses — whether it is in a cancer centre, general hospital or community setting — need continuous knowledge updates and skills training to keep up with best practices across the cancer care continuum. This article will briefly review some of the cancer care topic areas that are relevant to licensed practical nurses.
Let’s begin with how cancer develops. It starts from gene mutations in a person’s deoxyribonucleic acid (DNA), and for this reason, all cancer is considered to be genetic. Gene mutations happen either by chance, or they can be inherited. The “by chance”, or spontaneous mutations, cause change at various points over a person’s lifespan. These spontaneous mutations are called sporadic (or acquired). Most cancers are the result of a sporadic mutation of the genes which control cell growth; multiple gene mutations are necessary to result in the unregulated cell that becomes a tumour.

Have you ever had a patient ask you “Why didn’t you find the cancer earlier through my blood work?” or “Could cancer be detected during a regular check-up”? The response is that routine blood work does not detect cancer, and not all cancers have early detection and screening tools available. A tumour is clinically undetectable until it reaches an approximate size of one centimetre and weighs about one gram. This means that it is not seen on medical imaging or clinically noticeable during a physical exam. Patients usually present to their primary care provider with complaints of weight loss, unfamiliar pain, unexplained fever, fatigue or one of the warning signals of cancer: changes in bowel or bladder habits; a sore that does not heal; unusual bleeding or discharge; thickening or lump in the breast, testicles or elsewhere; indigestion or difficulty swallowing; obvious change in the size, colour, shape, or thickness of a wart, mole, or mouth sore; and nagging cough or hoarseness. Nurses must be knowledgeable and aware of such signs and symptoms so that they can notify the patient’s attending practitioner for timely assessments, tests, diagnosis and if warranted, treatment. Lumps that are suspected to be cancer, regardless of whether they were found by imaging tests or felt during a physical exam, need to be biopsied before they are to be diagnosed as cancer. The reason for this is that not all lumps felt or seen on imaging are cancer; in fact, most growths or lumps are not cancerous.

Most patients diagnosed with cancer will undergo at least one of these treatments. For some patients, surgery alone may be considered curative, while others may require additional treatments such as chemotherapy/biotherapy and/or radiation, depending on the stage of the tumour.

Patients receiving cancer treatment often experience side effects such as nausea and vomiting, hair loss, or diarrhea. It is important to know that not all patients will experience these side effects. The severity of side effects depends on the type of treatment, as well as the type and dose of the prescribed drugs being used. Nurses are not only responsible for assessment but also education. The delivery of effective patient education should incorporate not only the needs of the patient, but also, and just as important, the needs of the family. Patient and family education should occur prior to starting the treatment, this ensures that patients and families are fully informed and can participate in the treatment planning and delivery as active partners. Their involvement in either preventing, reporting or managing side effects is vital. Common assessment tools used to assess and grade the severity of cancer side effects include: Edmonton Symptoms Assessment System-revised (ESAS-r) and National Cancer Institute Common Toxicity Criteria for Adverse Events (NCI CTCAE). Nurses should familiarize themselves with these tools as they are broadly used across clinics in North America.

Nurses are a critical resource for patients and families. Standardized continuing education programs, including de Souza Institute’s Cancer Care Basics course, are available to support nurses in obtaining cancer care knowledge and maintaining competencies. The knowledge and skills obtained through these courses are portable from one organization to another, allowing nurses to provide safe and high quality care in all settings.

Finding JOY: Strategies for Meaningful Activity

When continuing care facilities reduce antipsychotics and sedatives, residents often wake up and look for activity. How can busy nursing professionals create opportunities for meaningful activities despite limited time and resources?

In part two of this series, we look at self-care, and rest and restoration, two of the four categories of activity identified by dementia care expert Teepa Snow. These activities can fill the day and help human beings feel valued, productive and purposeful.

Self-Care: Though occasionally it’s nice to sleep in and relax in pajamas, it’s satisfying to look your best, clean the kitchen, tidy the yard, organize the garage, sort through junk mail, and figure out a crossword or sudoku puzzle. Self-care attends to our bodies, minds and environments.

The more residents do for themselves, the better they feel! Provide choices and visual cues to maximize independence with eating, washing, dressing, brushing teeth and hair, or shaving with an electric razor.

Other self-care ideas:

- Take out the garbage, dust furniture or carpet sweep
- Help make the bed, or hold the pillow or bedding while someone else makes it
- Explore a bag of their own clothing
- Explore a rummage drawer of men’s ties, handkerchiefs, jewelry
- Match and sort activities: egg cartons with different sizes and shapes of buttons, bolts and screws, locks, pictures or parts of pictures, simple foam puzzles, and tea cups with saucers
- Armchair exercises: stand or sit in front of the resident and ask them to mimic your movements. Raise and lower your arms, touch your shoulders with your fingertips, rotate your ankles, etc.

Rest and Restoration: This includes sleep, but also time taken alone or with others to recharge and restore. Introverts and extroverts recharge in different ways.

Restoration may include quiet time in a room with music or a photo album, time in nature (a quiet park, gardening), or night routines such as reading the Bible and prayers. One care centre had a resident who had once been a gardener. Dirt and indoor plants mysteriously moved and appeared in unexpected places – a source of restoration and meaningful work for him.
Other ideas for rest and restoration:

- A courtyard or indoor garden with flowers, potted plants and natural sunlight
- An afternoon rest period when the lights are turned down, staff whisper and avoid moving noisy carts and equipment around
- 30-60 minute rest in bed
- Use of a chair massage mat with soft soothing instrumental music, sounds of nature, a lava lamp
- Herbal or decaffeinated tea, or non-alcoholic cocktails and snacks in the evenings
- Outdoor spaces to sit in the sun, watch children play

REFERENCES:
Teepa Snow, Positive Approach to Brain Change™
Reprinted with permission from the Seniors Health Strategic Clinical Network (SH SCN™).
For more resources, check out the Appropriate Use of Antipsychotics (AUA) Toolkit at http://www.albertahealthservices.ca/scns/auatoolkit.aspx.
SH SCN™ also recommends the book ‘Creating Moments of Joy’ by Jolene Brackey.
In this decade, the world of healthcare is changing at an amazing pace, faster than ever before. New legislation and emerging technologies challenge Licensed Practical Nurses and other health professionals, regulators, and employers on a regular basis. Integrating these variables and the impact on health system policy into daily practice requires professionals who are flexible, multi-skilled and resilient.

This two-day event provides opportunity for learning and networking as we scan the multifaceted current and future reality of nursing and healthcare, examining key trends, exploring the authentic reality in each of us, and looking closer at emerging and future realities as we prepare for tomorrow.

May 9-11
Edmonton Marriott at River Cree Resort
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Alison McMahon – CEO, Cannabis at Work

After 10 years of providing HR solutions to customers across Canada, Alison founded Cannabis at Work in 2015. Cannabis at Work is the leading source in Canada for cannabis jobs, recruitment services, online industry training, and workplace impairment training. Alison holds a Bachelor of Human Resources and Labour Relations (B.HRLR) and a Certified Professional in Human Resources (CPHR) designation. Alison served on the board for the Human Resources Institute of Alberta (HRIA) for three years. In addition, Alison is a former Term Instructor at the MacEwan University School of Business.

Marni Panas – Senior Advisor Diversity and Inclusion, Alberta Health Services

Marni co-leads the development and implementation of a provincial diversity and inclusion plan aimed at creating safe, welcoming and inclusive environments for AHS’s staff, patients and families. Marni has been invited to share her experiences and expertise in inclusive health and cultural safety for LGBTQ+ people locally, nationally and internationally. Marni is also a transgender woman, who has been very transparent throughout her journey in the hopes of fostering acceptance through education and respectful dialogue.

Exhibitors’ Reception • Silent Auction
Awards Reception & Dinner
Lunch and Learn: Nurturing Relationships

www.clpnaconference.com
As a family doctor with a typical general practice of young families, I see ordinary people who are too often facing extraordinary challenges, especially when it comes to domestic violence. Every week I see at least one woman who is facing the effects of domestic violence in her past or present situation. Here is the story of one of my patients.

She is a woman in her mid-50s, suffering from acute anxiety. As her new primary care physician, part of my role was to examine the underlying causes of her anxiety. At first she was reluctant to reveal these to me. However, over time, we built a trusting relationship which allowed her to tell me about the many years of domestic violence and abuse she had endured in her first marriage. The details of his abuse towards her and her children were horrific, including emotional, sexual, physical and financial abuse.

At first I felt powerless and helpless in my ability to help her. Her anxiety, far from being irrational, such as a fear of flying or of spiders, was rooted in a real life experience in which the man she loved had turned against her, manipulated her and violently attacked her. She had been betrayed to the very core when she was expecting love and acceptance.

When she had asked for help, few people believed her. They often sent her back home to her attacker. She had very little trust left in the medical or judicial system. She was often hostile and frustrated towards me, and as I listened to her story, I understood the hostility was towards the medical institution I represented, that failed so many times to help her.

Instead of simply providing medication to help her with her panic attacks, we implemented a program of treatment which included counselling, chronic pain treatment, and mental health supports. After four years of supportive care by me and my colleagues, she recently told me that for the first time in her life, she sees light and feels hope. She has dreams for her future and is learning to love and accept herself. She now views herself as a courageous survivor, instead of feeling the guilt and shame of being a helpless victim. Women suffering from violent attacks from their partners often blame themselves; unfortunately, so does society.

Over time I began to feel like I could help her make a difference in her life even though I feel relatively unsupported by a system which does not recognize the extent or nature of this problem. This type of care takes time, teamwork, energy, and compassion.

The first step must be prevention. As a family physician, I am trained in primary prevention— I don’t treat acute heart attacks, but I work with my patients to help prevent them by quitting smoking, lowering cholesterol and blood pressure. Prevention is always more cost effective and humane.

I want our society to develop similar approaches to domestic violence:

- how do we prevent it?
- how do we give the best care possible to minimize the suffering?
- how do we help people heal so that it doesn’t repeat itself?
The World Health Organization estimates that one in four women in Canada will experience intimate partner violence or sexual violence in her lifetime.

I believe the answers to these questions start with the willingness of our society to completely change our understanding of family violence.

We must shift our attitudes to understand:

> That family violence is a common problem;
> That family violence is a root cause of difficulties which can span generations; and
> That family violence has an enormous cost to our society in respect to addictions, mental health issues and chronic diseases.

The stories of women I encounter are also supported by the medical and scientific evidence. In 1995, Dr. Robert Anda, a prominent American public health physician with the Centre for Disease control, published the results of a study on what are known in the medical world as ‘Adverse Childhood Experiences’. His study demonstrated the impact of child abuse on women, children and men throughout American society. Anda has described his research as:

“stumbling on the gravest and most costly public health issue in the United States... Eradicating abuse of women and children in society would reduce the overall rate of depression by half, alcoholism by two-thirds, and suicide, drug use and domestic violence by three-quarters. It would also dramatically improve workplace performance and vastly decrease the need for incarceration.”

In Alberta, almost 10,000 women and children were accommodated by shelters in 2016-2017. More than 22,000 were turned away in the same period. The World Health Organization estimates that one in four women in Canada will experience intimate partner violence or sexual violence in her lifetime. As a basis for comparison, consider that one in eight Canadian women will be affected by breast cancer in her lifetime.

So women are twice as likely to experience domestic violence as they are to experience breast cancer.

Take a moment to reflect on that - and then reflect on how well-resourced our public health campaigns are to screen for and diagnose breast cancer. Every doctor’s office provides information about breast checks and mammograms, we have high-profile campaigns and plenty of fundraising for research to treat cancer. The work to prevent and cure cancer is hugely important. I want it to continue. But I also want us to understand how we are neglecting the public health implications of domestic violence.

One simple - and unscientific – comparison is to outline the budget for the federal organizations which work to end breast cancer and to end domestic violence.

The annual budget for Women’s Shelters Canada, the network which supports shelters and organizations like the Alberta Council of Women’s Shelters, is $248,137.5

The budget for the Canadian Cancer Society, which incorporates Breast Cancer Canada, is $137,146,000.

I think the funding gap between these two charities demonstrates the comprehension gap in our society about the social and health impacts of domestic violence on the lives of women, children and men.

I believe every healthcare professional can help recognize and prevent the domestic violence that occurs every day. When women ask for help, the system we are part of must respond with a courage that matches hers. Too often, victims are ignored, told they need to ‘prove it’ or responded to with a lack of urgency. Domestic violence is life threatening and life-altering.

As a society we must re-imagine domestic violence as a problem which we can solve and which we aim to eliminate. This is not easy work. But we can no longer afford to be shocked and horrified by stories of appalling domestic violence, because people aren’t helped by our shock and horror. Let’s work together to be the first generation of healthcare professionals who are part of the solution.

This article began as a speech delivered by Dr. Squires at the Alberta Council of Women’s Shelters annual Breakfast with the Guys event, and has been revised and reprinted with her permission.

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1 From The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma, by Bessel van der Kolk, MD
2 Alberta Council of Women’s Shelters, Annual Provincial Shelter Data, 2016-17, https://acws.ca/collaborate-document/3065/view
Create a Department-wide Guide for Nursing Clerical Tasks

By Johanna Vien, LPN

This idea is intended to impact the standardization and quality of hands-on patient care, the ability of front line staff to perform their jobs and the ability of the department to function smoothly in times of staffing shortages.

Current Practice

Nursing staff are trained in the patient care aspects of their job. They practice them regularly and plan for emergency situations or consider them alone and determine how they will approach the situation. Similarly, patient care tasks are often discussed between staff as to how to approach them, in order to come up with an organized, collaborative approach.

However, the administrative tasks related to working in the department are picked up on the job, often informally, while watching or questioning coworkers. Tasks that are infrequently performed can be missed in this process, leading to staff having to learn to do the tasks at the time they are required.

Complications of Current Practice

From department to department, specifics of job-related tasks differ, even within the same hospital (i.e., where supplies are kept, or the typical way to perform a task that can be done many ways). It takes the staff time to get up to speed with the specific ways of doing tasks. This time is spent looking up answers, questioning coworkers, and searching for solutions to problems.

Disorganization in this area leads to less time on patient care, which contributes to care left undone. This in turn leads to a dollar cost to provide extra time or staff to provide the patient care (2016, Cho, Lee, Kim, et al).

The time and mental energy spent figuring out how to do a task is time and mental energy not spent on patient care. Nurses often have multiple cognitive and physical demands on them simultaneously. A resource that simplifies the look-up process for tasks means they can use those cognitive resources for something else.

The Manual

The solution could be the creation, implementation and maintenance of an on-site instruction manual, available for staff reference with topics that cover a multitude of administrative and location-based information. Sample topics include “How to print worksheets” to “Where to find X item”. It is written in plain English with step-by-step, click-by-click directions, and includes pictures and maps as appropriate.

This resource is important for quality purposes because patient care time spent on non-patient care tasks (i.e., searching for supplies, deciphering how to enter an unusual order into the computer system) directly takes staff away from patient care and leads to decreased patient satisfaction (2016, Ratanawongsa, Barton, Lyles, et al). This resource streamlines the problem solving and searching processes for routine, but irregular, tasks. This means that the staff can use the time and cognitive energy on another task such as connecting with a family, or providing care for a patient.

Desired Result

This is a valuable and needed resource because it simplifies and standardizes the administrative aspects of nursing in the environment. This idea is easily translated to another department or area with different job requirements and skill needs. This is an in-progress idea, which is currently being created and implemented, so results are not yet in. It will be interesting to track how having such an reference guide impacts the ground level staff, especially the casual and float nurses that move from department to department regularly.

References


Johanna Vien is a 15 year LPN, with dual registration in the provinces of BC and Alberta. She is currently completing the Athabasca University’s LPN to BN program. She is employed with Interior Health in BC in the Okanagan Region.
EXCEPTIONAL TRAINING AND RESOURCES - Mental Health, Counselling and Violence Prevention

TRAUMA – Strategies for Resolving the Impact of Post-Traumatic Stress
Calgary: March 20-21; Edmonton: March 19-20

BORDERLINE PERSONALITY DISORDER – Understanding and Supporting
Edmonton: April 10; Calgary: April 11

ANXIETY – Practical Intervention Strategies
Edmonton: April 23; Calgary: April 24; Grande Prairie: April 30

DEPRESSION – Practical Intervention Strategies
Edmonton: April 24; Calgary: April 25

CRISIS RESPONSE PLANNING
Calgary: May 7; Edmonton: May 9

BRIEF FOCUSED COUNSELLING SKILLS – Strategies from Leading Frameworks
Edmonton: May 28-29; Calgary: May 30-31

DE-ESCALATING POTENTIALLY VIOLENT SITUATIONS™
Calgary: June 6; Edmonton: June 7

WALKING THROUGH GRIEF – Helping Others Deal with Loss
Edmonton: June 18-19; Calgary: June 20-21

ATTACHMENT AND FAMILIES – Strategies for Engaging and Helping
Edmonton: July 16-17

MOTIVATING CHANGE – Strategies for Approaching Resistance
Calgary: July 18-19

LIVE STREAM WORKSHOPS
Participate in full-day, live workshops from any location.
For a list of workshops being streamed in 2018, visit our website at www.ctrinstitute.com.

MINDFULNESS RETREAT
Banff: July 11-13
The ability to regulate one’s body and find balance in emotion, thought and physical health is at the core of healing and well-being. It is extremely important for caregivers to cultivate their own well-being and deepen their own practice of developing regulation skills. This ‘working retreat’ will assist participants in developing their own mindful practice and provide the opportunity to experience the effect of a deeper embodied presence and attunement with others. Please visit our website for details.

An introductory course in Cancer Care for Health Care Professionals

For more information visit: www.CancerCareBasics.com
We’ve received a number of complaints alleging physicians are providing substandard care when assessing patients with sudden onset hearing loss. In some cases, physicians did not diagnose or even consider Sudden Sensorineural Hearing Loss (SSNHL), and the patient’s loss became permanent.

**About Sudden Sensorineural Hearing Loss**

SSNHL affects the patient quickly, usually over 72 hours or less. The cause is largely idiopathic; however, viral infection is sometimes associated. Other symptoms may include tinnitus, vertigo and a sense of aural fullness, and it can affect all or a portion of hearing frequency. In all the cases brought to our attention, the hearing loss was severe.

**Complaint Commonalities**

We found similar issues in the complaints surrounding SSNHL. We hope sharing these will help enhance patient care. In all cases, we found the physician:

1) Did not take an appropriate patient history, including a full exploration of symptoms, past medical history (including possible barotrauma, ototoxic medications and focal neurological symptoms).
2) Did not exam the patient thoroughly (or did not examine at all). Usually there was no Rinne and Weber testing, no cranial nerve/ocular testing and no cerebellar review, all which a physician should use to delineate if the hearing loss is conductive or sensorineural.
3) Did not arrange urgent audiometry for the patient.
4) Did not consider appropriate differential diagnoses.
5) Did not recognize the urgent nature of the loss, and did not initiate contact with/provide for urgent otolaryngology consultation.

**Treatment and Prognosis**

While many patients have spontaneous recovery of hearing, some do not. The evidence for acute intervention is weak – however, most authorities suggest immediate initiation of steroid therapy (certainly no later than 7-14 days after the onset of symptoms) such as prednisone 1 mg/kg for 7-14 days, with a taper of equal duration following (maximal dose 60 mg/day). Authorities also recommend follow-up with an otolaryngologist and a non-urgent MRI.

Although treatment may not be successful and spontaneous resolution is possible, physicians are still responsible for recognizing the differential diagnosis of SSNHL. Sudden and permanent hearing loss is devastating for anyone. It’s important that a thorough history and physical exam is completed to consider SSNHL and advise the patient on treatment and the prognosis.

**Quick Facts**

Experts estimate SSNHL strikes one in 5,000 people every year, typically adults in their 40s and 50s. The actual number of new cases could be higher because the condition often goes undiagnosed. Many people recover quickly and never seek medical help.

Only 10 to 15 percent of those diagnosed with SSNHL have an identifiable cause.

**References:**

1. Canadian Family Physician, October 2014, 60 (10) 907-909: Can you hear me? Sudden sensorineural hearing loss in the emergency department
2. CMAJ March 20, 2017: Sudden sensorineural hearing loss
How to Read a Bedside Monitor

RED DEER, May 14, 2018 • LETHBRIDGE, May 15, 2018
0830 to 1600 hrs.

CHRISTOPHER COLTMAN, RN, BScN

Why Does Your Rhythm Interpretation Ability Need to Get in Shape?
- Why Increasingly More Patients are Being Monitored

Let's Get to the Core
- Basic Electrophysiology - Only the Things You Need to Know

Interval Training... and More
- Identifying Waveforms and Measuring their Intervals
- P Wave
- QRS
- ST Segment
- T Wave
- U Wave
- PR Interval
- Intervals
- QT Interval

Maximum Heart Rate Achieved
- Calculating Heart Rate Using Various Methods Made Simple

Rhythm is Not Just Important for Zumba
- Sinus Rhythm
- Atrial Rhythms
- Ventricular Rhythms
- AV Blocks
- paced Rhythms

Time to Sweat it Out
- Practice Rhythm Strips
- Case Studies to put your Knowledge to the Test

What every nurse needs to know about...

Anxiety & Depression

CALGARY, May 28, 2018 • EDMONTON, May 29, 2018
0830 to 1600 hrs.

SANDRA REICH, M.Ed.

What are Anxiety & Depression?
- North America's #1 Psychological Health Challenge
- Anxiety: Facts and Figures
- Hypothesis of Why Anxiety is Increasing
- Impact on Your Patients’ Lives and Yours
- Depression: Treatment Options
- Male/Female Manifestations
- Medication/Psychotherapy

Strategies & Help You Can Give Your Patients Right Away
- These Strategies Will Change your Patients Lives - And Yours Too
- Autonomic Nervous System Relaxation Response / Paced Breathing
- The Magic of Cognitive Restructuring
- Challenging Distorted Thoughts
- Stress Inoculation

Traps Caretakers Fall Into
- Compassion Fatigue
- Secondary Trauma Dangers
- Caretaking: A Very Slippery Slope
- Challenging the Victim Role
- How to Get Out of the Martyrdom Complex
- The Liberation of Empowerment

Question & Answer Session
- $179.95 + $9.45 GST = $189.45 Early Rate (on or before April 14, 2018)
- $199.95 + $9.45 GST = $209.45 Regular Rate (after April 14, 2018)

To register: Call toll-free 1.866.738.4823 or visit NursingLinks.ca
resources

CONNECTIONS
Connecting LPNs to other health professionals with your interests in mind.

Alberta Gerontological Nurses Association
www.agna.ca

Alberta Hospice Palliative Care Association
www.ahpca.ca

Alberta Operating Room Team Association – LPN
www.clpna.com/members/aorta-affiliate

Canadian Association of Neonatal Nurses
www.neonatalcann.ca

Canadian Association of Schools of Nursing
www.casn.ca

Canadian Association of Wound Care
www.cawc.net

Canadian Orthopaedic Nurses Association
www.cona-nurse.org

Canadian Hospice Palliative Care Nurses Group
www.chpca.net

Community Health Nurses of Alberta
www.chnalberta.ca

Creative Aging Calgary Society
www.creativeagingcalgary.com

Emergency Nurses’ Interest Group of Alberta
www.nena.ca

LEARNING LINKS

Study with CLPNA
www.studywithclpna.com

ACHIEVE Training Centre
www.achievecentre.com

Advancing Practice
www.advancingpractice.com

Canadian Blended Learning Courses for LPNs
www.jcollinsconsulting.com

Canadian Diabetes Educator Certification Board
www.cdecb.ca

Canadian Virtual Hospice
www.virtualhospice.ca

Critical Trauma Resource Institute (CTRI)
www.ctrinstitute.com

de Souza Institute
www.desouzainstitute.com

John Dossetor Health Ethics Centre
www.ualberta.ca/bioethics

Learning LPN
www.learninglpn.ca

Learning Nurse
learningnurse.org

Reach Training
www.reachtraining.ca

Registered Practical Nurses Association of Ontario
www.rpnao.org/practice-education/e-learning
Organization Changes Prepare CLPNA for the Future

The College of Licensed Practical Nurses of Alberta has completed a significant organizational change effective January 15, 2018.

Two new Executive Officers will provide leadership over day-to-day operations of all programs and services. The Practice and Communication portfolio has been split, giving increased focus to each critical area. A Senior Director of Communications has been added and is responsible for strategic and innovative communication. These three positions, with the CEO, comprise the Executive Team. Changes at the Director level include dedicating a Director to the area of Professional Practice and consolidating the portfolios of Policy and Research.

CEO Linda Stanger states, “These changes support an increased focus on key areas, creating synergies and opportunity both internally and with our stakeholders. I look forward to what we can create within this new structure.”

Tamara Richter, MBA, PMP, Executive Officer, is responsible for registration, conduct, finance and human resource planning and management. Tamara holds a Master of Business Administration and is a Project Management Professional with over 18 years’ experience in healthcare administration and leadership for the LPN profession. Previously, as Director of Operations, she has specialized in the areas of human resources, information technology and privacy, project management and finance, and also has experience in conduct and registration. Tamara has directed and led multiple projects and initiatives which have contributed to the advancement of the CLPNA.

Jeanne Weis, MN, BN, RN, CHPCN (c), Executive Officer, is responsible for professional practice, professional development, policy and research. Jeanne holds her Master of Nursing and has worked in healthcare for over 20 years as an HCA, LPN and RN. Jeanne has practiced clinically in the areas of vascular surgery, gerontology, oncology, palliative and community care, in clinical and academic research, and in leadership capacities. Jeanne also has extensive experience in practical nurse education, including instruction, leadership and national examination. Her most recent work with CLPNA includes provincial, national and international initiatives in education, practice, policy and research.

Teresa Bateman, MA, LPN, Senior Director Communications, is responsible for core communication messaging with integration of organizational brand, regulatory image and historical integrity. Teresa has almost 30 years of nursing experience, with the last 17 years in regulation. Teresa’s experience includes leadership, practice consultation, competency development, continuing competence and education approval. She has represented the LPN profession on provincial, national and international initiatives and holds a Master of Arts in Professional Communication and a Certificate in Adult and Continuing Education.
Northern LPNs to run for CLPNA Council

A career-expanding opportunity is opening up for the 1400 licensed practical nurses in northern Alberta to guide the practical nurse profession in the province. CLPNA Council elections will be held in June for representatives to the Grande Prairie and Fort McMurray areas.

This is the first year where all Election Districts will be on a regular staggered schedule of three-year terms. In 2017, both northern districts ran elections for a one-year term.

Council meets quarterly to plan and evaluate CLPNA’s annual Strategic Plan, policies and finances to achieve regulatory excellence. Successful Council members are team-oriented, servant-leaders focused on the future of the LPN profession.

To run, eligible LPNs must have an Active Practice Permit from CLPNA and reside in the Election District. Nomination Forms must be submitted by May 31. District Elections are held in June by email ballot. To discover your District, use the “Find My Election District” document to look up your town or city of residence.

ABOUT COUNCIL

The CLPNA’s primary responsibility is regulating the LPN profession, setting and maintaining standards to ensure the public receives safe, competent, and ethical healthcare services.

The CLPNA is governed by a Council, which consists of members of the profession (elected by peers) and three government-appointed public members. Council’s role is to regulate the profession and oversee the CLPNA’s management, actions, and policy development within the framework of the Health Professions Act. This system of governance is called self-regulation. While government establishes the healthcare ‘rules’ through legislation and regulation, the CLPNA implements and enforces the ‘rules’ for the profession of licensed practical nursing. Self-regulation is a privilege, not a right, granted by government on behalf of the public.

2018 ELECTION DISTRICTS

Three-Year Term

DISTRICT 6: NORTH WEST
(Grande Prairie & area)

DISTRICT 7: NORTH
(Fort McMurray & area)

Nomination Forms and complete information available from www.clpna.com under “About” and “Council”, or by contacting info@clpna.com, 780-484-8886 or 1-800-661-5877 (toll free in Alberta).
NEW CULTURE NURSING
- An Approach to Person-Centred Care

with Dr. David Sheard

The College of Licensed Practical Nurses of Alberta is pleased to partner with Dr. David Sheard, Founder/CEO of Dementia Care Matters, to offer a workshop focusing on person-centred care coming this April to Edmonton and Calgary.

In his passionate, challenging and emotional presentation style, Dr. Sheard will call on LPNs to be the leaders of a new culture of care where people, not just policies and procedures, really matter. This workshop can be the starting point for LPNs who want to improve organizational culture so that person-centred care is priority.

Benefits/Learning Objectives:
• Understand the definition and importance of “new culture” nursing
• Recognize the value of emotional intelligence in person-centred care
• Learn about attachment theory and its relationship to leadership and professionalism
• Learn how to lead, model, influence and implement person-centred care using practical approaches and tools

WORKSHOPS

EDMONTON
April 11, 2018
8:30 am - 4:00 pm

CALGARY
April 13, 2018
8:30 am - 4:00 pm

REGISTRATION

To register, contact profdev@clpna.com, or register by phone at 780-484-8886 or 1-800-661-5877 (toll free in Alberta) using your VISA or MasterCard.

Your registration confirmation will be sent by email. Please allow three business days for processing. Notice of cancellation must be made in writing to cturkington@clpna.com on or before April 4, 2018. After April 4, no refunds will be given.

The College of Licensed Practical Nurses of Alberta hosts these events as part of the Strategic Plan to empower Licensed Practical Nurses for the future.

Payment is due upon registration. Eligible LPNs (those with an Active Practice Permit and living in Alberta) may qualify for fee reimbursement through the Education Grant Program (http://foundation.clpna.com).

BUY NOW!
$50 Registration Fee (incl. GST) includes continental breakfast, lunch, coffee breaks and parking.
Infusion Therapy & Relational Practice: New Areas of Self-Study

CLPNA's growing library of self-study courses are meeting the needs of more LPNs each month. Over 2000 people completed courses on the 'Study with CLPNA' webpage so far in 2018 to engage with the free, online self-study courses designed specifically for Alberta's LPNs.

**INFUSION THERAPY SELF-STUDY COURSE**

Infusion therapy is an efficient way to deliver all aspects of fluid and medication by 'intravenous' application. Besides the many benefits, there are inherent risks that must be considered. Licensed practical nurses have a responsibility to keep current in their knowledge and competent in all areas of their professional practice through continuing education. Safe practice is paramount.

The new Infusion Therapy Self-Study Course is designed to prepare LPNs by building on previous nursing knowledge in infusion therapy, care of central lines, blood transfusions and much more. This course includes learning activities, quizzes and study guide.

**RELATIONAL PRACTICE SELF-STUDY COURSE**

Self-awareness, partnership, relationship building, communication – what do these words mean to you?

Relational practice is the current term for what nursing usually refers to as interpersonal communication skills, but it encompasses so much more! It’s a means of building and sustaining health-promoting relationships with clients, families, colleagues and others. It is very client-focused and concerned with healthcare needs based in the complexities of a client’s lived experiences. Partnership is the heart of relational practice.

The Relational Practice Self-Study Course is designed to assist LPNs to practice and explore how to use communication skills in real-life practical nursing situations. The course consists of seven modules and includes learning activities, quizzes and study guide.

All CLPNA Self-Study courses are suitable to help LPNs meet the Learning Plan goals of the Continuing Competency program. A printable Certificate of Completion is available after passing the final exam for each course.

There is no cost to take these courses (it's FREE!) and they are available to anyone who wishes to increase their knowledge.
Professionalism in nursing practice ensures the consistent provision of safe, ethical and competent care by licensed practical nurses to their clients.

The updated Practice Policy: Professional Responsibility and Accountability discusses key professional responsibilities of LPNs to clarify expectations of the College of Licensed Practical Nurses of Alberta related to:

- abandonment of care,
- fitness to practice,
- professional boundaries,
- professional development,
- and the duty to report.

Being a member of a self-regulated profession is a privilege and this privilege comes with professional obligations. The duty to provide quality care is fundamental to professional nursing practice. As professionals, LPNs are expected to:

- provide safe, competent and ethical care to their clients;
- maintain the standards, guidelines and continuing competence required by their regulatory college (CLPNA); and
- work within the role, expectations, policies and procedures of their employer.

The Practice Policy was approved by CLPNA’s Council in December 2017. It replaces an outdated document, Practice Statement #1 Professional Responsibility and Accountability.

A related document, Practice Statement #4 Actively Engaged, was also removed from CLPNA’s roster of active practice policies.

Questions? Contact our Practice Consultants at practice@clpna.com, 780-484-8886, 1-800-661-5877 (toll free in Alberta).
If you work in the area of healthcare, chances are you are familiar with evidence-based practice. In Canada, licensed practical nurses (LPNs) and registered nurses (RNs) are required to engage in evidence-informed practice as an entry to practice competency. Using evidence to inform practice is essential to ensure safe, quality care in all areas of nursing.

According to research findings, nurses generally have a positive attitude toward evidence-based practice (EBP). Viewing EBP positively and being aware of the professional expectations to engage in EBP, however, do not always lead to the consistent application of evidence-based practice on the job. The College of Licensed Practical Nurses of Alberta, in collaboration with an investigator from the Faculty of Nursing at MacEwan University, decided to look further into this gap.

First, we asked LPNs in Alberta, what kinds of knowledge do you use in your practice? Three top sources of practice knowledge emerged. LPNs looked to individual clients, personal experience, and nursing school to inform their practice. Using personal experience was more likely with age and more years of practice, while using nursing school as a knowledge source was more likely among LPNs with fewer years of practice. Second, we asked, what barriers prevent nurses from engaging in EBP? From a review of the literature, the most common barriers identified by nurses were a lack of time and a lack of skill.

With these barriers in mind, we created an accessible education program targeting essential EBP skills. The program consists of a series of three interactive webinars designed to increase nurses' skills in EBP and their self-efficacy for carrying out those skills in practice. The program has a strong focus on the clinical application of EBP skills, highlighting the relevance of research for practice and enhancing the real-world application of EBP for practicing nurses. Evaluations by webinar participants have shown improvements in the targeted learning areas.

Despite the success of the webinar series, it is important to recognize that individual skill building is only one part of the equation. To create a culture of evidence-based practice, educational and system changes must also occur.

With this in mind, in the spring of 2017, practical nurse (PN) educators from Alberta institutions were invited to participate in an online survey conducted by the CLPNA. The survey was designed to assess the needs around EBP education capacity in the province’s Practical Nurse programs.

Thirty-five PN educators from seven educational institutions participated. Their demographic information is provided in Table 1.
The PRECEDE/PROCEED Model

The PRECEDE/PROCEED model has largely been used in the area of health promotion. The model provides a structure for developing, implementing, and evaluating behavioural interventions.

Framed within this model, the PN educator survey examined factors that can influence the successful development and implementation of an educational intervention to increase the capacity of practical nurses to implement EBP. According to the model, there are three categories of factors that can affect behaviour: predisposing, reinforcing, and enabling. These factors may influence the provision of evidence-based practice education to student nurses, and may point to barriers that prevent EBP.

Predisposing Factors

Predisposing factors include individual knowledge and attitudes that affect the likelihood that a person will behave in a particular way. The predisposing factors examined in the survey showed agreement across participating PN educators on the importance of using evidence to inform patient-centred care and including EBP skills in PN training. Furthermore, participating educators largely shared the belief that PN students understand patient-centred care. These values and beliefs lay the foundation for the success of curriculum-based interventions to increase the capacity of practical nurses to implement EBP.

Reinforcing Factors

Reinforcing factors relate to the consequences of behaviour that affect the likelihood that the behaviour will be repeated over time. Reinforcing factors examined in the survey showed that approximately two thirds of participating educators felt that PN students have the abilities to describe what is considered evidence, differentiate types and sources of evidence, identify where evidence is needed in practice, and access evidence from multiple sources. Around 70% of respondents felt that PN students are able to use evidence to support patient-centred care, while 60% felt PN students are able to integrate evidence with clinical expertise. Reinforcing factors examined in the survey can serve to improve students’ motivation, sustain their interest, and focus their behaviour on learning and implementing EBP.

Enabling Factors

Enabling factors are environmental or system characteristics that help to support the successful implementation of an intervention. Three key enabling factors were examined. Participating educators were split in their opinions as to whether adequate time is currently devoted in the curriculum to teaching EBP. While two thirds of participants agreed that adequate resources are available to support teaching EBP, about half felt there were teaching tools available to enhance EBP education.

In summary, it is encouraging to see agreement across educators on important factors that lay the foundation for the success of curriculum-based intervention efforts to improve the use of EBP by practical nurses. The survey revealed some areas for further skill development (e.g., the ability to integrate evidence with clinical expertise), as well as areas for further consideration including the amount of time spent on teaching EBP and the availability of useful educational resources. Educators identified videos and webinars as helpful in teaching EBP, and asserted the value of case studies in demonstrating the application of classroom learning.

As for next steps, the CLPNA plans to develop a webinar series that incorporates case studies, and looks forward to collaborating with PN educators to pilot these efforts.

Table 1. Demographics

<table>
<thead>
<tr>
<th>Demographic Category</th>
<th>N</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Role</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrator</td>
<td>8</td>
<td>(22.9)</td>
</tr>
<tr>
<td>Classroom/Lab Instructor</td>
<td>15</td>
<td>(42.9)</td>
</tr>
<tr>
<td>Clinical Instructor</td>
<td>12</td>
<td>(34.3)</td>
</tr>
<tr>
<td>Primary Teaching Subject</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical</td>
<td>11</td>
<td>(31.4)</td>
</tr>
<tr>
<td>Lab Skills</td>
<td>6</td>
<td>(17.1)</td>
</tr>
<tr>
<td>Nursing Theory</td>
<td>10</td>
<td>(28.6)</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>8</td>
<td>(22.9)</td>
</tr>
<tr>
<td>Employment Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Casual</td>
<td>6</td>
<td>(17.1)</td>
</tr>
<tr>
<td>Full-time</td>
<td>25</td>
<td>(71.4)</td>
</tr>
<tr>
<td>Part-time</td>
<td>4</td>
<td>(11.4)</td>
</tr>
</tbody>
</table>
The CLPNA is pleased to announce the recipients of the Fall 2017 Advancing Knowledge in Practical Nursing Research grant competition. Congratulations to Dr. Sienna Caspar and Dr. Jude Spiers for their successful proposals!

Dr. Caspar, from the University of Lethbridge, will conduct the study LPNs as Change Agents: Building LPN Leadership Capacity to Enable Practice Change in Residential Care Homes.

Dr. Spiers, from the University of Alberta, will conduct the study Enhancing LPNs’ Family Communication Skills to Reduce Potentially Avoidable Transfers of Continuing Care Residents to the Emergency Department: A Mixed Methods Pilot Study.

For more info on LPN research, contact the Research Department at research@clpna.com, or 780-484-8886.

Silent Auction Donations
Further LPN Education

The Frederickson-McGregor Education Foundation holds a vital role in supporting ongoing post-basic education of LPNs in Alberta. The foundation honours excellence in practice by encouraging LPNs to strive to enhance their competencies.

Since its establishment in 2006, over $2 million in funding has been approved. By assisting LPNs with their continuing educational goals, the foundation is able to enrich recipient’s nursing knowledge, skills and abilities.

The Silent Auction held during the CLPNA Annual General Meeting and Conference is the single largest contributor to the foundation. The success of the fundraiser relies on the generosity of donors.

The Frederickson-McGregor Education Foundation is seeking donations of all shapes and sizes for this year’s conference held May 9-11, 2018. Auction items typically include, but are not limited to:

• Handicrafts
• Garden and yard accessories
• Gift certificates
• Jewelry
• Electronics
• Household goods
• Sports and theatre tickets

All contributors will be provided with the opportunity to display their business card and/or brochure alongside their donation.

For further information including Donation Forms, please visit the Frederickson-McGregor Education Foundation website at www.foundation.clpna.com or contact Donna Doerr, Foundation Assistant, at 780.669.1852 or foundation@clpna.com.
Bringing the ‘swag’-ger to National Nursing Week, May 7-13

Party!! National Nursing Week is not only about parties. It’s a sober acknowledgement of the importance of professional nurses and their valuable work which benefits all Canadians. And doesn’t that deserve a party?

Supporting parties and teas and luncheons and wine, Special Event Kits filled with LPN-branded swag are once again being made available by the College of Licensed Practical Nurses of Alberta for events held the week of May 7 - 13, 2018. The product includes lip balms, pens, and much more. Your ‘What should we get for door prizes’ dilemma is solved!

Last year, over 700 kits were distributed, so event organizers are encouraged to place their requests early. Supplies are limited. Kits may be requested by April 6 using the form at www.clpna.com. Kits are not guaranteed to contain one item per attendee.

In 1971, the International Council of Nurses designated May 12 (Florence Nightingale’s birthday) as International Nurses Day.

In 1985, in recognition of the dedication and achievements of the nursing profession, Canada's Minister of Health proclaimed the second week of May as National Nursing Week.
Don’t JUDGE each day by the HARVEST you REAP but by the SEEDS that you PLANT.

- Robert Louis Stevenson -
Pediatric Potpourri

EDMONTON, June 5, 2018 • CALGARY, June 12, 2018
0830 to 1600 hrs.

Barb Bancroft, RN, MSN, PNP

Understanding Growth and Developmental Milestones as an Approach to Pediatric Assessment
- The infant, toddler, pre-schooler, school-aged child, pre-teen and adolescent
- The teenage brain - an osseomere

Specifics of Assessment - Tips and Tricks
- Observation of parent/child interactions, child-child interactions, and the child alone
- Weights, head circumferences, and vital sign measurements - age-dependent assessment and interpretation
- ALARM signs in toddlers vs. alarm signs in teenagers
- The assessment of the hydration status in children

Treatment Do’s and Don’ts
- Use of acetaminophen and ibuprofen in children with fever
- Anti-depressants in children
- The overuse and abuse of antibiotics in children - otitis media and bronchitis
- The treatment of febrile seizures - simple vs. complex febrile seizures
- The treatment of asthma - acute and chronic
- Notes on vaccination schedules and specific vaccines

Key things to Know about Selected Conditions in Kids
- Asthma, allergic rhinitis
- Bronchiolitis, bronchitis, pneumonia
- Diabetes
- Tonsillitis and adenoids
- Meningitis
- Autism and autistic spectrum disorders
- Child abuse
- Head trauma; Concussions
- Gastroenteritis
- Acute appendicitis
- Celiac disease
- Abdominal pain
- Heart murmurs - functional, pathologic

To register:
Call toll-free 1.866.738.4823 or visit NursingLinks.ca

Executive Links

Who Should Attend?
- Nurses who care for adults, but occasionally care for children
- Nurses from mixed medical-surgical/pediatric units
- Operating room and post-anesthesia care unit nurses
- Nurses who float to pediatric areas
- Ambulatory Care Nurses (clinic, doctor’s office, primary care, etc.)
- New Pediatric Nurses
- Tele-health Nurses, Community Health Nurses, Outpost Nurses
- Not recommended for experienced pediatric or critical care nurses

Infectious Diseases Update

Shampoos, Tattoos, and Barbeques: What’s New in the World of Infectious Disease?

EDMONTON, September 24, 2018 • CALGARY, September 25, 2018
0830 to 1600 hrs.

Barb Bancroft, RN, MSN, PNP

Immunizations & Vaccines: The “Need To Know” Info
- Pediatric/Adult: Immunization, Herd Immunity, Pertussis
- Tdap; Zostavax; HPV Vaccines
- Meningooccal Vaccine

Global Warming, Global Travel, & The Patient With Travel History
- The Implications of Migration of Mosquitoes Away From The Equator
- Infectious Diseases and Airplanes - What’s The Risk?
- Transportation of Food Across Borders - Is There a Problem?

Major Food-borne Illnesses & Their Sources; Treatment
- The Dreaded E. Coli O157:H7; Salmonella
- Campylobacter jejuni; Listeria monocytogenes
- The Perils Of Antibiotic Misuse, Overuse, & Abuse
- Increasingly Dangerous Drug Resistant Bacteria, MRSA, CRE, VRE
- Mutilations Of Bacteria - the Difficult C. Difficile; Antimicrobial Stewardship

Infectious Disease Trends Throughout the World that Show Up in Your Patient Population
- The Role of Sexual Transmission in Infections
- HIV Infections; HPV Infections
- Hepatitis Infections; Syphilis & Others

Will I Know It When I See It? The Presentation, Pathophysiology And Rx of Specific Infectious Diseases
- Zika: Worse Than We Thought & What You Need to Know
- Avian Flu, MERS, SARS
- Fido, Boots, & Rex: The Risk Of Infectious Illness From Pets
- Exotic Puts; Dogs from Puppy Mills; Pocket Pets; Reptiles; Bats

To register:
Call toll-free 1.866.738.4823 or visit NursingLinks.ca

Executive Links

** Updated With New Content! **

Few areas in healthcare are changing as rapidly as infectious diseases. This one day seminar provides an up-to-the minute update on current issues in infectious diseases. Major infectious disease trends will be reviewed, including: global warming and travel, bioterrorism, food-borne illnesses, infectious agents and their relationship to acute and chronic disease. New vaccines, new diseases, and new drugs will also be reviewed. A seminar you don’t want to miss for both your patients’ and your own benefit!

Who Should Attend?
- RNs, RPNs, LPNs; All Front Line Nursing Staff
- Infection Control, Public & Occupational Health Nurses
- Educators, Managers, NPs, & Telehealth Nurses

Barb Bancroft is a widely acclaimed nursing teacher who has taught courses on Advanced Pathophysiology, Pharmacology, and Physical Assessment to both graduate and undergraduate students. Also certified as a Pediatric Nurse Practitioner, she has held faculty positions at the University of Virginia, the University of Arkansas, Loyola University of Chicago, and St. Xavier University of Chicago. Barb is known for her extensive knowledge of pathophysiology and as one of the most dynamic nursing speakers in North America today. Delivering her material with equal parts of evidence based practice, practical application, and humour, she has taught numerous seminars on clinical and health maintenance topics to healthcare professionals, including the Association for Practitioners for Infection Control, The Emergency Nurses’ Association, the American Academy of Nurse Practitioners, and more.

- $159.95 + $7.95 GST = $167.90 Super Early Rate (on or before May 28, 2018)
- $169.95 + $8.45 GST = $178.40 Early Rate (on or before August 13, 2018)
- $179.95 + $8.95 GST = $188.90 Middle Rate (on or before September 10, 2018)
- $189.95 + $9.45 GST = $199.40 Regular Rate (after September 10, 2018)