Pressure Drop
An LPN’s Role in Pressure Injury Research
Are You a Double-Duty Caregiver?
Cannabis Risk & Work Obligations
Practice Hours Update
**What Every Nurse Needs to Know About...**

**Neurotransmitters**

EDMONTON, October 15, 2018 • CALGARY, October 16, 2018

0830 to 1600 hrs.

**BARB BANCROFT, RN, MSN, PNP**

Neurotransmitters: Too Much, Not Enough, Or Just Right?

- Which Neurotransmitters, Where are They Located and Why Study Them?
- Endocannabinoids: Serotonin & Melatonin
- Catecholamines: Dopamine, Epinephrine, Norepinephrine
- Aminergic: Endogenous Endocannabinoids; Acetylcholine; GABA

Serotonin - 17 Discovered Receptors and Counting!

- What happens when Serotonin is Blocked or Boosted?
- Serotonin in Health: Happiness, Achievement, Self-Confidence
- Serotonin in Disease States: Depression, Eating Disorders, Impulse Control, Migraines, N & G Disorders: Mood, Sleep, Appetite
- Substance Use: Serotonin - Cannabis, Hallucinogens, Opiates, Cocaine
- Depression, Suicidal Ideation & the SSRIs SNRIs, Benzis, & Ketamine

Dopamine - The Pleasure Activator: Its role in Addictive Behaviour

- Addiction in Teenagers - Why's it Different, Early Exposure Matters
- The Penetration Problem and Other illicit Drugs that Block Dopamine
- Dopamine and: Meth, Cocaine, Alcohol, Videogames
- Dopamine and Sexual Function/Dysfunction & Prescription Drugs
- Smoking Cessation Drugs

Low Dopamine & Acetylcholine: Parkinson’s, Huntington’s

- Tardive Dyskinesia: Exemperional Drugs & Drugs that Block or Boost Dopamine
- Restless Leg Syndrome - Link to SSRIs and Other Drugs
- Low Dopamine & Norepinephrine: ADHD
- Norepinephrine & Cortisol: Effect on Mood, Risk Predisposition

Excess Dopamine: Psychosis & Hallucinations

- Organic, Drug, & Infectious Causes; Elderly, Agittal, & Second Generation Drugs to Treat
- Side Effects, Weight Gain, Secondary Dysthesias

GABA: Inhibitory Effect; Panic Disorders & GAD

- Use of Benzodiazepines, Anxiolytics & Hypnotics
- Seizures – Anti-Convulsants and GABA, in Chronic Alcoholism

Acetylcholine & Cognitive Function: Alzheimer's & New Drugs; Boosting Cognition

**Brand New Workshop!**

Does every nurse need to know about neurotransmitters? Absolutely! There is literally no brain or body function that we could survive without them. Inhibitory neurotransmitters like Serotonin and GABA contribute to a stable mood, calm the brain and help create balance; they also help regulate sleep, pain, digestion and cravings. Excitatory neurotransmitters like Norepinephrine and Epinephrine regulate stimulatory processes, heart rate and blood pressure, but also anxiety, decreased focus, stress and insomnia. One neurotransmitter has both effects - Dopamine - and it helps with both depression and focus (this one helps you find your keys!). All neurotransmitters can be affected, blocked, or boosted by imbalances, substances, and drugs and debilitating disease states can result. Join us for this fascinating tour of Neurotransmitters and how they affect your patients & clients.

**WHO SHOULD ATTEND?**

- Nurses who work in Acute & Continuing Care, Community & Primary Settings
- Neuro Nurses; Pediatric Nurses; Street Nurses; Allied Health Professionals
- Addictions and Mental Health Nurses; Mental Health Professionals
- Occupational Health Nurses; Educators & Managers

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 in Infection Control, The Emergency Nurses Association, the American Academy of Nurse Practitioners, and more.

- $179.00 + $8.95 GST = $187.95 Middle Rate (on or before October 1, 2018)
- $189.00 + $9.45 GST = $198.45 Regular Rate (after October 1, 2018)

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**Legal Issues in Nursing**

CALGARY, November 5, 2018 • EDMONTON, November 6, 2018

0830 to 1600 hrs.

**CHRIS ROKOSH, RN, PNC(C)**

Nursing Litigation and Canada's Legal Landscape

- Definitions & Statistics; The History of Litigation
- Clinical Areas Most Likely to be Sued; Trends and Issues in Nursing Litigation

The Stages of a Lawsuit: From Date of Adverse Event to Trial

- How an Adverse Event Becomes a Lawsuit
- If You are Sued, What Happens to You and Your Job?
- What Parts of the Lawsuit Will You be Involved In?

The Four Factors Required to Prove Nursing Negligence

- Establishing the Nurses Duty
- Determining the Breach in the Standard of Care
- Identifying the Injury
- Establishing Causation

The Top Five Nursing Negligence Issues with Case Studies

- Nursing Assessment, Communication
- Medication Errors
- Use of Medical Equipment; Infection Control

Nursing Documentation that will Defend You in the Event of Litigation

- What the Experts Say About Nursing Documentation
- What the Courts Say Your Documentation Must Show
- Examples of Bad, Good, and Better Documentation

**Don't miss one of our highest rated workshops!**

Along with the changes to the ways healthcare is managed and delivered, there has also been a change in the legal issues that are a priority for nurses. This workshop is intended to provide a review of how liability issues may develop in a nurse’s practise. Through understanding the framework of risk to clients and nurses, the goal of this workshop is to assist nurses in making proactive judgements that will guide them to avoid harm for their clients and to safeguard their practise.

**WHO SHOULD ATTEND?**

- Nurses at All Levels of Responsibility
- Nurses in All Settings
- Risk Managers
- Managers, Educators

Chris Rokosh is a Legal Nurse Consultant and Certified Perinatal Nurse with over 34 years of experience. She is President and CEO of Connect Medical Legal Experts Inc., Canada’s first Legal Nurse Consulting firm. Connect Experts provides medical/legal education to health care professionals and nursing expertise to lawyers involved in medical malpractice and class action litigation. Chris is an invited lecturer at universities and conferences across Canada and the US. The Legal Nurse Consulting course she developed has been accepted as credit towards a Bachelor of Science in Nursing at universities across Canada. In 2010 she was named one of Canada’s top 100 entrepreneurs and has been nominated for the Royal Bank Women of Influence award.

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From the College

Finding Joy: Strategies for Meaningful Activity

COVER STORY
Pressure Drop: An LPN’s Role in Pressure Injury Research
An Edmonton LPN’s curiosity makes her a perfect fit for technology-driven research into pressure injury prevention and education.

Parent Advocates Power of Compassion

Connect Care to Improve Case Management, Communication

How Dementia Impacts Canadians

RESEARCH
Cannabis Risk & Work Obligations

Are You a Double-Duty Caregiver?

RESEARCH
News About ‘ACHEWS’
The implementation of an Early Warning Scoring Tool at Alberta Children’s Hospital

TECHNOLOGY
Technology Promotes Health & Active Living for Older Adults

The Operations Room
News for CLPNA members
With social media reaching every aspect of life today, misinformation can spread very quickly and widely. For health professionals, it’s important that health information comes from trusted references.

An example of the widespread effects from misinformation is best demonstrated in the public debate around vaccines. The BBC reports, “Despite science overwhelmingly and indisputably advocating in favour of immunization, a growing number of parents around the world are resisting medical advice by going their own way.” In some circumstances, governments are even implicated: CNN reports that Italy’s governing party elected in March 2018 “ran on an anti-vaccine platform.”

In research supported by America’s National Institute of General Medical Sciences, the American Journal of Public Health (AJPH) published an article on 23 August 2018. This article discusses intentional computer-based disinformation initiatives based in other countries that are negatively influencing the public’s health decisions throughout North America.

According to the AJPH article, an organization called the Internet Research Agency has “weaponized” health communications. “Public health issues, such as vaccination, are included in attempts to spread misinformation and disinformation by foreign powers.” This situation is particularly noted for its efforts to use social media to influence healthcare choices and promote discord in Western countries.

According to the AJPH article, there is a specific process used to target vaccinations: (1) Computer trolls and bots disseminate large numbers of tweets and posts on social media, both favourable and unfavourable to vaccination, to create the impression that vaccinations are very controversial and without scientific consensus. The intent is to create a “false equivalency” between two disparate views. (2) People considering vaccinations for themselves or their children consult social media for more information. On social media they encounter fearful stories and confusing claims about efficacy. (3) People then lack the confidence to proceed with vaccination. (4) Subsequently there are increased cases of diseases that could have been prevented if people were vaccinated.

The article suggests these practices are identifying stresses and fears in Western society and then using high-emotion posts and tweets to create and inflame debate. Health issues can generate fear and are a prime target for trolls. Fortunately most members of the public make their healthcare decisions based on science (such as the need for vaccinations), but it appears some people are susceptible to the influence of misinformation from untrusted sources. The average citizen would not know they had been manipulated in this way, and the impact can be catastrophic.

This debate serves as a reminder for the LPN profession to be prepared for this growing issue. It is a time for heightened awareness of this issue among providers caring for patients who ask for treatments not based on science. It’s important to have discussions with your patients to investigate the source of their understanding. It’s vital to be prepared to link them with credible sources, including their primary physician, to guide care decisions.

As professional nurses, your role in evidence-based practice is vital to guide and inform those in your care. Albertans depend upon it.

Valerie Paice, President and Linda Stanger, CEO

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Meaningful activities in continuing care facilities don’t require significant investments of time, money or energy – just a little creative thinking. In this issue, we look at how LPNs can create meaningful moments in their busy workday while mentoring and encouraging other team members to do the same.

David Sheard is a dementia care expert from the UK who works with care homes around the world to set up the “Butterfly Household” approach to caring for residents with a dementia diagnosis. David’s company, Dementia Care Matters™, is currently working with several continuing care sites in Alberta.

But we’re so BUSY!

Even in a busy day, everyone can be person-centred, touch people’s lives, enjoy the moment and change someone’s day through small things: Butterfly Moments. (David Sheard, Dementia Care Matters™)

**Five Principles of Butterfly Moments**

1. Butterflies know themselves and work from feelings, from their spirit on the inside and not just from a task-focus.
2. Butterflies need environments full of ‘stuff’ and rummage items.
3. Butterflies know how to be good at both flitting and creating 30-second activities, but also good at being still.
4. Butterflies get rid of all negative and controlling care.
5. Butterflies need groups of people at similar points in their journey of dementia to be matched together to enable a clear focus.

**Butterfly Moments are things residents can connect with and smile about:**

- Stop to say ‘hello’ as we pass by, or share a comment that makes them smile
- Sing a song they like to sing, hear or sing along to as you give care
- Go to the garden to check on the flowers
- Offer a slow stroke back rub before bedtime
- Share a few moments over a cup of tea
Stop to share good news: an engagement, wedding, birth of a baby, children’s milestones – first steps, special achievements, graduation

Chat about a family member or pet

Look at a picture they enjoy

Compliment clothes or a new haircut

Help them with make-up or jewelry

Reminisce about the past

Massage hands with special lotions

Bring them a basket of items they enjoy looking at (families may be able to think of and bring in items)

Bring a small, interesting item, and engage residents in conversation about it (shells, buttons, dice, vintage models, bowl of snow or leaves)

Share a photo from your own life (a wedding, vacation, pet) and allow them to make associations and reminisce: “Would you like to see a picture of my dog?”

**Even when we’re busy, we can use what we’re already doing to enrich the moment.**

Something as simple as a request for toast can become an opportunity for meaningful connection.

**Possible responses to a request for toast:**

- Non-meaningful, non-personal: “You just ate breakfast an hour ago.”
- More personal: “What would you like on your toast – jam or honey?”
- Meaningful and personal: Involve the person to the extent of their capabilities – i.e., give them a knife to spread the jam; reminisce about making jam and picking strawberries.

**References:**

David Sheard, Dementia Care Matters™

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.

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During a busy day caring for patients, health research might feel like a distant undertaking for many nurses, a bit disconnected from the many patient needs at hand.

But for Ashley Lloyd, a Licensed Practical Nurse at the Glenrose Rehabilitation Hospital, a recent opportunity to research pressure injury education in spinal cord injury patients offered a glimpse at the rationale behind some existing treatment protocols, while providing an opportunity to inform — and potentially improve — the care her patients receive.

“What got me on board with [the study] is that I do ask so many questions and... always wonder why we do the things we do,” Lloyd says, her eyes widening, as she rests both hands on her abdomen thoughtfully. Lloyd, who is preparing to welcome her second child this fall, was up for the challenges and long, busy days the study brought with it, hammering out a research plan with colleagues who led the study, educating and interviewing patients, and gathering data.

The rehab hospital nurse has been at Glenrose for almost eight years. Back when she did her training in Grande Prairie nearly a decade ago, she notes, there was little or no focus on research training for LPNs. Opportunities are growing, though, suggesting increasing numbers of practical nurses may have the chance to dip a toe into the research realm in the future.

For her own foray into research, Lloyd worked with Simon Palfreyman, registered nurse, PhD, and an assistant professor with the University of Alberta’s Faculty of Nursing, and colleagues from Glenrose and Alberta Health Services (AHS) to investigate the effectiveness of a technology-centric strategy to personalize and present pressure injury prevention programs for spinal cord patients.

Photography by Owen Murray
Occupational therapist Gwen Dziwenko, the Rehabilitation Technology Leader for Glenrose Rehabilitation Hospital’s spinal cord injury and general neurology unit, spearheaded the project. In 2016, it was one of just 12 projects selected from across the province for the AHS Research Challenge — a program that pairs inquisitive would-be investigators on the frontline with research mentors such as Palfreyman.

The Glenrose Hospital Foundation purchased the necessary technology, and the team received financial and educational support from AHS through the Research Challenge program.

When asked why she approached Lloyd to take part in the project, Dziwenko effortlessly lists some of the attributes making Lloyd well suited to the project.

“Ashley’s outgoing, she asks a lot of questions, she’s engaged in things, and she’s got that drive, or that commitment. And she’s curious — she wants to know, ‘Could we do this? Does this affect our patients?’”

Although the team started with a focused research question in mind, Dziwenko adds, Lloyd “took it even further to think about, ‘How is this clinically relevant to my patients? How do I change my practice now?’”

“Ashley’s participation in this project has demonstrated the significant role nursing has in frontline leadership, innovation, research, and technology,” says Michelle Wallace, registered nurse, MN, and patient care manager for adult brain injury, spinal cord injury, and general neurology programs at the Glenrose. She called Lloyd “a very engaged LPN who continuously seeks opportunities to improve and enhance safe quality care of patients living with spinal cord injury or other neurological diseases [or] disorders.”

Under Pressure

Nurses have long recognized the importance of turning and repositioning patients, particularly those with spinal cord injuries or other mobility limitations. More than 150 years ago, the famed nurse Florence Nightingale — who tried her own hand at health statistics research — emphasized the nurse’s role in preventing bedsores, known as pressure injuries or pressure ulcers today.

But despite existing strategies for avoiding pressure ulcers, the vast majority of spinal cord injury patients still develop them at some point in their lives. That’s because these individuals often miss the pings of discomfort that would prompt them to move, and many require assistance to shift into pressure-easing positions.

The impact and severity of these ulcers varies, but they can linger for long periods of time, leading to complex,
Palfreyman brought a body of experience in pressure injury research to the team. Together with AHS senior consultant Doug Hill, he helped Dziwenko, Lloyd, and the other fledgling Glenrose researchers navigate ethics applications, study design, and other logistics of the new pressure injury management project.

“My view of research is that you’re doing what you do as a nurse: asking questions and trying to answer them,” Palfreyman notes. “Research is just putting that in a systematic process.”

Mat Matters

With that support, the Glenrose-led team set out to see just how much XSensor-informed education can influence patients’ understanding and acceptance of pressure injury prevention approaches, following from an earlier pilot program with just a handful of patients on the spinal cord injury and general neurology unit.

“We trialed it with a few patients and realized that it made a really big difference with how patients understood what we were talking about with pressure, positions, and redistributing,” Dziwenko recalls. “From there, that’s where we started with the research project.”

After enrolling four spinal cord injury patients, Lloyd spent about an hour with each individual, using the real-time XSensor pressure readouts to educate them in a personalized way about potential pressure injury dangers and to demonstrate how specific positioning changes might mitigate stresses on different parts of the body.

“It wasn’t just an education about how to turn or why to turn. We’d talk...
about what happens if you do get a pressure ulcer: How do you stop it? How to catch it early? The nutrition behind it. What would change if you did get it,” she explains. “It also brought in another realm of what we could teach, and the cues to do it.”

Lloyd also interviewed each person before his or her release from the rehab hospital and again a month after discharge to explore if, and how, XSensor training influenced the individuals’ understanding of their risks and responsibilities around pressure ulcers, as well as their confidence level in navigating turns and managing that risk with the resources available to them.

**Back On the Unit**

Having nurses and other frontline healthcare workers on the team helped shape the questions asked in the study, Dziwenko notes, bringing practical patient experiences and needs to the forefront of research that might otherwise have become more academic than applicable.

“It’s not just questions that academics might have, it’s questions that Ashley has, or I have,” she says.

Lloyd has presented the group’s findings at two events, including an AHS Research Challenge Forum held in Red Deer in May, which showcased work from the first successful challenge teams. The team plans to submit the research to one or more nursing conferences, and is putting the final touches on a manuscript to send to a peer-reviewed research publication.

The researchers are starting to work on an implementation plan for more broadly applying the research insights they’ve garnered so far, while considering ways to expand the research in the future.

Although the initial study involved only a handful of spinal cord injury patients, its impact is already being felt on the unit at Glenrose. And Lloyd has been “a champion in promoting the use of the XSensor technology to prevent pressure injuries,” Wallace says, explaining that the young nurse has educated not only patients and their family members about the technology, but her healthcare colleagues as well.

Now, some individuals on the spinal injury and general neurology unit are getting the chance to use the pressure sensors for slightly longer periods of time. Lloyd recalls one individual in the midst of developing a pressure injury who “wasn’t quite buying into the teachings from the nurses,” but became more convinced after seeing red pressure spots appear on the XSensor readout.

“That’s the best part,” Dziwenko says. “It started as research and now we’re implementing it. As we use it, we find more and more uses for it.”

Another patient’s experience stands out for Lloyd as an example of the confidence pressure training can give spinal cord patients. He was a man with a medical background who worried about returning home, she recalls. How would he work, he wondered — and how would his wife work? — if he had to wake up every couple hours to turn in the night?

After the XSensor session, he reported feeling more confident in his ability to prevent pressure injuries at home. The insights made his transition home less fraught.

“It kind of took his anxiety away... he came back and said it was so much more relaxed going home than he thought it was going to be,” Lloyd says. In those moments the potential patient benefits become clear, she explains. “When they feel like, ‘I did become a spinal cord injury patient, and I will have the injury for the rest of my life. But I can do this.’ That’s really cool.”

Lloyd says the XSensor study brought a new dimension to her nursing — one that she hopes other nurses will have the opportunity to discover.

“You go into nursing to be beside the patient and take care of them and help them,” she explains. “But it’s exciting to know the deeper why through a research lens, and to see the bigger picture. With that comes more understanding of why we do what we do.”
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Danny Schulz, a trained chef who worked in some of Edmonton’s best restaurants, loved spending time with friends and family, playing music and visiting the family cottage. Four years ago, Petra Schulz lost 25-year-old son Danny to an accidental fentanyl overdose. Her personal tragedy motivated Schulz to become an advocate for drug reform policy and implementation of harm reduction strategies.

Schulz became a founding member of Moms Stop the Harm (MSTH). This is a network of Canadian mothers and families who have lost loved ones to substance use or currently have a loved one living with substance use or in recovery. The primary outcome of MSTH is to advocate a new approach to substance use based on reducing harm and treating people who use with empathy, compassion and support.

Schulz shared her perspective on the panel “Strategies in a Time of Crisis: Opioids and Harm Reduction” at the CLPNA conference in May 2018.

What are the most important goals of Moms Stop the Harm?

To keep people alive and to reduce the horrendous numbers of overdose victims. We have found the stigma surrounding drug use is a huge barrier and is keeping people from seeking help. It also causes people to use substances alone, like our son did.

What we really need is a national strategy. We need a declaration that opioid use is a national emergency. I believe government needs to stop treating substance use as a criminal matter. Really, the safest approach is for government to legally regulate all drugs. What is most dangerous is an unregulated market, regardless if it is legal or illegal. To make a safe supply of drugs available is something I would like to see.

We also want to see more universal access to treatment, and to see treatment expanded to the correctional system.

What more can be done for substance users in the healthcare system?

An abstinence-only approach does not work for most people who use opioids; neither do messages of tough love. What we need are evidence-based approaches to substance use, including access to opioid agonist treatment, ideally combined with psychological counselling. We have to tell families how they can keep their loved one safe.

Nobody, absolutely nobody, told our family about harm reduction, the risk of overdose or the signs and symptoms we should have been looking for to keep our son alive. Naloxone is widely distributed as a safe medication that can reverse an overdose. I didn’t learn about this until a year after Danny died. To this day, I imagine finding Danny in time and being able to save him. It’s so

Petra Schulz

Danny Schulz
Alberta Health Services (AHS) is making a change that will shape the way healthcare is delivered across the province, affecting everyone who provides patient care within AHS and partners like Covenant Health, CapitalCare and Carewest.

The foundation of Connect Care is a common clinical information system (CIS) that will bring together many of the 1,300 independent health information systems now in place across AHS. Connect Care will enable consistent practices across Alberta and will improve the care AHS and its partners provide for patients and their families. It will give clinical staff a platform for electronic medical record documentation, clinical decision support, patient portals and case management. It will also make it easier for health providers to communicate with one another, and introduce new ways for care teams to interact and share information with patients and families.

The first sites to implement Connect Care will be University of Alberta Hospital, Stollery Children’s Hospital, Kaye Edmonton Clinic, and Mazankowski Alberta Heart Institute in late 2019. It will then expand to other areas of the province in a series of phases that will be complete by late 2022. Specific timeline details will be finalized by fall 2018.

Staff will receive role-specific Connect Care training beginning a few months before their sites go live. However, starting in early 2019, new resources will also be available for those interested in becoming more comfortable with information and communication (“eHealth”) technology in general.

The eHealth Competence program provides resources for providers and supporters of clinical care to develop their abilities based on their own starting point of knowledge, experience and attitudes regarding eHealth technology. Available in early 2019, these resources will allow providers and supporters of care to develop their abilities based on their own starting point of knowledge, experience and attitudes regarding eHealth technology. These resources will be available online and can be used at any time by leaders and staff in preparation for Connect Care training in the future.

More information about Connect Care can be found on AHS’ intranet site insite.ahs.ca/connectcare (accessible by staff at AHS and its partners), or on the external AHS site, albertahealthservices.ca/connectcare.
The number of Canadian seniors living with dementia is rising steadily, and so is the demand on their caregivers and healthcare systems across the country. The Canadian Institute of Health Information (CIHI), in collaboration with the Public Health Agency of Canada, estimates that more than 402,000 seniors, or 7.1% of all people 65 or older, were living with dementia in 2013-2014; two-thirds of those were women.

Dementia prevalence increasing, incidence stabilizing (controlling for age)

The age-standardized prevalence of dementia grew steadily from 2002 to 2013: from 5.7% to 7.3% for women and from 4.7% to 6.1% for men. Age-standardized incidence remained steady at about 1.5% for women and about 1.4% for men. Thus factors other than an increase in new diagnoses contributed to this rise in prevalence, including the fact that Canadians with dementia now live longer.

Prevalence is the proportion of people in a population who have a disease at a specified point in time. Incidence is the occurrence of new cases of a disease in an at-risk population over a specified period of time.

More women affected by dementia than men

Dementia is more prevalent among women than men, and the gap increases with age. From age 80, prevalence is about 1.3 times higher for women than for men (20.8% versus 15.6%).

Dementia prevalence by sex in Canada, 2013-2014
Dementia rates low in younger age groups, then increase greatly

Dementia rates are low among those 65 to 69, but they increase with age. Prevalence more than doubles every 5 years among seniors, from less than 1% in seniors 65 to 69, to about 25% among those 85 and older.

Prevalence of dementia varies by jurisdiction

The age-standardized prevalence rate of dementia in Canada is 6.8%. There is provincial and territorial variation in the prevalence of the diagnosed disorder. While the data captures differences in population health status, geographical variations may also reflect differences in data availability and collection methods. Note that due to coding differences in physician-level billing data, Saskatchewan data is excluded from publicly reported CCDSS dementia prevalence for all years.

Relatively rare in younger seniors, dementia as prevalent as heart failure at 80+

Dementia rates increase with age. While the prevalence rate of heart failure (a chronic condition that develops after the heart becomes damaged or weakened) among seniors age 65 to 79 is more than twice the rate of dementia (5.9% versus 2.5%), dementia is as prevalent as heart failure among seniors age 80+.

Cannabis Legalization

Protecting the youth from obtaining cannabis! Preventing illegal cannabis activities! Reducing the burden on the criminal justice system! Improving public awareness of the health risks when using cannabis! These are some key priorities outlined in section 7 of the Cannabis Act. This new piece of legislation launches the legalization of cannabis in Canada and is coming into force on October 17, 2018. The purpose of this widely discussed legislation is to protect public safety and public health by allowing adults access to safe and legal cannabis.

The legalization of cannabis is a difficult task that requires effort and collaboration from all the levels of government and partnership with their key stakeholders. The federal government is largely responsible for establishing the minimum requirements and standards to purchase, sell, and produce cannabis. The provincial and municipal governments can use these minimum requirements as a base to update or develop new regulations that meet the needs of their respective jurisdictions. This includes rules around advertisement, production, possession, and sale of cannabis. Furthermore, workplace safety, public consumption, and zoning will also need to be established.

To prepare for cannabis legalization, the Government of Alberta had passed provincial legislation and regulations and has developed an initiative called the Alberta Cannabis Framework (ACF). The ACF outlines several key priorities that support the goals of public safety and public health with cannabis use. These priorities include protecting safety on roads, in workplaces and in public spaces. The Government of Alberta (GOA) plans to monitor existing legislation and current programs to determine if they are enough to address the current concerns of cannabis impairment. If needed, the GOA will develop new regulations and programs after legalization. In the meantime, employers, workers, and other relevant organizations can prepare for impairment concerns by promoting a common understanding of responsible cannabis use. Rules around cannabis consumption may differ depending on the industry and the employer, but the importance of responsible use is a shared concern and requires understanding the potential risks related to consumption.

Impairment

The CLPNA's review of studies on the risks related to cannabis use shows that impairment is complex. This is because the user's sensitivity and the method of intake can change how quickly someone feels the acute effects of cannabis. For example, it typically takes more time to feel the effects of eating cannabis-infused food, but the effects also last longer. Although the sale of cannabis-infused edibles is not being legalized, Albertans will be able to make and consume edibles at home. If anyone chooses to use cannabis before going to work, including healthcare providers, it is important for them to know that the effects from using cannabis can carry forward into the workplace, and may have consequences based on their workplace's policies on cannabis use and professional accountabilities.

The chemical composition of cannabis is another important factor related to impairment. Tetrahydrocannabinol (THC) and cannabidiol (CBD) are two common chemical compounds found in cannabis. However, only THC induces the psychoactive effects ('the high') associated with cannabis consumption. CBD is not psychoactive and does not have an effect on any neurological or cognitive functions. The concentration of THC and its ratio to CBD affects the presence and amount of risk for cognitive impairment.

The CLPNA's review also found that cognitive impairments that can arise from cannabis use (during ‘the high’) include:

- Impaired attention and concentration
- Impaired learning
- Impaired memory
- Greater impulsivity
- Decreased motivation
- Lowered psychomotor coordination
- Slowed and less accurate decision-making and judgment

Given that recreational cannabis can cause a number of cognitive impairments, it is important to know that these can affect a healthcare provider’s ability to deliver safe and competent care. It is also important to note, however,
that these cognitive impairments can arise from many other substances (e.g., alcohol). Therefore, caution should be taken when using any substance that can impair a healthcare provider’s critical judgment.

**Health-Related Effects**

While cognitive impairment is considered as the main workplace concern, cannabis can also lead to respiratory and cardiovascular health risks based on the CLPNA's review of research studies. Regular cannabis users are at an increased risk for adverse pulmonary effects such as emphysema, pneumonia, and chest tightness. The evidence is less conclusive for the risk of lung cancer. The risk of stroke and other vascular conditions is also higher among regular cannabis users.

**Word of Caution to LPNs**

Licensed practical nurses (LPNs) are one of the many self-regulating health professions in Alberta. As healthcare providers, it is part of a nurse’s professional responsibility and accountability to ensure their own fitness to practice. If LPNs choose to use cannabis recreationally, it is their responsibility to understand how the risk for impairment may interfere with their ability to provide safe care for their patients.

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**Related Resources**


Are You a Double-Duty Caregiver?

Debra Paches, BScN, RN Caregiver Navigator Coordinator and Caregiver Advisor, Caregivers Alberta

Are you working in a healthcare setting as a care provider and also caring for someone (family or friends) at home or in the community? Then you are a double-duty caregiver.

“A ‘double-duty caregiver’ is defined as a paid healthcare professional who simultaneously provides unpaid care to an elderly dependent and/or a dependent adult or child in their time off” (Rutman, 1996). In the past few years, while traveling through Alberta and meeting many healthcare professionals, I have seen a steady increase in those who are balancing work as a professional care provider with caregiving in the home. While being a healthcare professional brings a level of expertise to your role as a family caregiver — knowing the medical jargon, treatment routines and how to navigate the system — you are not immune to the effects it can have on you physically, emotionally, financially and professionally. This article will look at the impact of double-duty caregiving (DDC) and explore some of the strategies to deal with it and the resources available to assist you.

Being “on duty” all the time between work and home can lead to stress. Stress is a natural reaction within the body to meet a challenge; however, the body needs time to decompress and achieve a resting state – which is difficult to do with round-the-clock responsibilities. According to nurse researcher Catherine Ward-Griffin, the constant negotiation between professional and personal care responsibilities leads to compassion fatigue and poor physical and emotional health (Ward-Griffin, 2005). Some of the common signs of stress are fatigue, sleep disturbances, digestive upset, headaches, heart palpitations and hypertension. If you have pre-existing health conditions like diabetes, these can become harder to manage. Prolonged stress can lead to further complications and loss of time at work.
Stress has emotional effects which include feeling overwhelmed, anxious, irritable, angry and guilty. The expectations of family and of ourselves can lead to feelings of guilt when we are unable to meet all our responsibilities. This can affect both personal and professional lives, leaving you feeling exhausted and unable to cope.

Adding to some of the stress is the financial/economic impact of being a DDC. Most caregivers incur direct and/or indirect financial costs owing to out-of-pocket expenses, lost time at work and/or changes in employment: 28% of caregivers caring for a child, 20% of those caring for a spouse and 7% of those caring for a parent reported financial difficulties (Turcotte, 2013). Another 15% of employed caregivers reported decreasing their regular weekly hours of work to meet their family caregiving needs (Sinha, 2013).

The commitment that each licensed practical nurse makes when joining the profession is to ensure their fitness to practice. When stress carries over into the workplace, it can affect the ability to concentrate and perform at a competent level. It is important that healthcare providers learn to recognize these signs in themselves and in their colleagues, and find or offer support to alleviate the stress before they burn out.

STRATEGIES

First and foremost, it is vitally important to care for yourself, to recognize the signs and symptoms of stress and to take action to find ways to reduce the stress in your life.

1. Take care of yourself, see your physician, stay hydrated, eat regularly, and find ways to get restful sleep.
2. Recognize the limits of your own endurance and strength and seek help from others. Explore ways to share responsibilities at home and in your workplace.
3. Work to maintain facets of your own life, social connections and things that you enjoy doing.
4. Take pride in what you are doing but also realize that you cannot do everything.
5. Find supports within your workplace; talk to your supervisor regarding strategies such as flex time or other options.
6. Explore financial supports such as Family Caregiver Benefit for Adults, Compassionate Care Benefits, Special Benefits for Parents of Critically Ill Children, Child Disability Benefit, and Tax Credits for Caregivers. Information is available through Canada Revenue Agency.

Being a care provider (paid) and a caregiver (unpaid) can make it a challenge to do it all and maintain your own health. You may promote self-care to your patients and their families; however, are you taking time to practice self-care? By being aware of the effects of stress and finding supports and resources to avoid burnout and compassion fatigue, you can reach your goal of continuing to provide care for your community of patients and your family care recipients.

RESOURCES:

Caregivers Alberta – Supports for Caregivers:

- COMPASS workshop for caregivers – A nine-week program supporting caregivers and sharing techniques to make their role less difficult.
- Caregiver Advisor is available to talk with caregivers and provide support, advocacy and links to services and resources.
- Information Sessions – education programs offered every two weeks on varied topics of interest to caregivers.

Professional Supports:

Navigator workshop – A one-day program for health professionals to explore the needs of caregivers and learn about resources to support caregivers.

Caregiver Support Team – Aims to link health professionals and service providers to better serve caregivers (and those they care for) in our community. The team is made up of community agencies, healthcare providers and other health professionals providing necessary services to caregivers. Contact: 780-453-5088 / Website: www.caregiversalberta.ca.


Canada Revenue Agency – https://www.canada.ca/en/revenue-agency.html

References available on request.
Alberta Children’s Hospital (ACH) is a 141 bedded tertiary care pediatric hospital situated in Calgary, Alberta. The new ACH building opened in 2006 and was designed and built to provide the best possible care to babies, children, adolescents, and their families who seek care and treatment within its walls.

ACH attracts excellent healthcare providers to its teams and everyone is dedicated to providing a very high standard of care to the patients and families. However, recognizing that we can always improve, and wanting to identify deteriorating patients earlier, a project was launched to develop an early warning score tool that would be appropriate to support and complement the care provided by our teams.

What is an Early Warning Score Tool?

An Early Warning Scoring (EWS) tool is used to assist in identifying patients at risk for a clinical deterioration. EWS tools include care escalation response expectations and a communication framework. EWS tools provide a standard, supportive, validated process for nurses to communicate concerns about their patients to the wider healthcare team using terminology that represents a standard assessment of deterioration for every patient.

How does it work?

- The tool is validated and is based on physiological findings and risk factors.
- Vital signs, including heart rate, systolic blood pressure, respiratory rate, capillary refill, respiratory effort, oxygen saturation and oxygen therapy are entered into the tool and, based on an evidence-based risk factor equation, a score is generated for the patient.
- Each vital sign is rated on a scale of zero to four, and are added together to a maximum score of 26, with higher scores triggering an algorithm of actions.
- Actions include initiating and participating in an “escalation huddle” with physicians and other team members. In the huddle, which can be in person or by phone, team members collaborate on, and communicate, a plan for the patient for the next few hours.
- If the patient’s score is high, or has risen significantly in a short period of time, actions include the “escalation huddle” and activation of the pediatric intensive care outreach team (registered nurse and registered respiratory therapist) to review the patient.

EWS have been implemented in other children’s hospitals across Canada; however, most of these sites use a paper-based EWS tool, which may mean double charting and a manual calculation of the score. At ACH, we had support from our electronic health record (EHR) system team and were able to create and build the ACH Early Warning Score (ACHEWS) tool right into the EHR.

This provides the advantage that nurses enter the vital signs via computer into the EHR in the usual way and an ACHEWS score is automatically generated. If the score has changed significantly (≥ 4) or is high (>9), pop-up messaging prompts the nurse to escalate concerns to the healthcare teams. There is a link to the algorithm, which informs the nurse how to proceed.

Nurses and physicians are aware of the expectation to act on the score; it is not optional to follow the algorithms. This supports the bedside nurse to be confident when escalating her concerns to the healthcare team.

When developing and implementing ACHEWS, planning and development working groups included physicians, surgeons, intensivists, nurses and allied health groups to ensure that the escalation process was helpful and supportive for all members of the teams. The education provided for ACHEWS encompasses all team members and provides a culture of working together for patient safety. Any deviations away from the validated process are reported and followed up to ensure that the ACHEWS process continues to provide a consistent, collaborative, clear and detailed plan of ongoing care for the patients.
Not all acute clinical areas of the hospital use the EHR when caring for patients; however, we wanted to ensure that every admitted patient had the benefit of ACHEWS. For the Pediatric Intensive Care Unit (PICU), Neonatal Intensive Care Unit (NICU) and Post Anaesthetic Care Unit (PACU), it was decided that a baseline ACHEWS for each patient as they were transitioned to the inpatient units would be required. In the Emergency Department, the EHR is not yet available so, for now, a paper version of ACHEWS is being used for every admitted patient and for patients who have been in the department having treatment for less than 4 hours.

Improved communication and understanding between team members was a key aim in implementing ACHEWS. During the first day of using ACHEWS, a nurse had a patient whose score went from zero to six within a very short period of time, indicating a deterioration. The nurse stated that having the score meant she was easily able to demonstrate to the physician how quickly the deterioration had occurred, thus prompting a quick and early intervention.

In another example, a high ACHEWS was obtained on a 14-month-old child with bronchiolitis. The nurse activated the escalation process and, in the subsequent huddle, the team were able to work together to treat and clinically assess the patient. The PICU outreach team were also called to the bedside. The ACHEWS score and process, along with assessments by the clinical team, confirmed the child’s imminent deterioration. The child was moved to the PICU for initiation of non-invasive support. The benefit of the ACHEWS process was that the child was assessed and moved to a higher level of care in less than an hour, potentially preventing further deterioration.

Providing standard approaches to providing timely and safe care to patients is part of our larger safety drive, Safest Together, in which ACH and Stollery Children’s Hospital in Edmonton have joined with over 130 children’s hospitals across North America with the goal of improving safety and preventing harm to our patients, families and staff. The implementation of the ACHEWS tool and process at ACH, while not intending to be a replacement for nursing clinical skill and expertise, provides a standardized, validated approach to early intervention strategies for deteriorating patients and provides an important step towards the goals of continuing to provide the safest care possible for our patients.

References available on request.
When comparing the health of Canada’s older adult population (age 65 - 79) to the rest of the world, a rather bleak picture emerges. Canada ranks third, below the United States and United Kingdom, in number of prescriptions taken daily, with more depression, anxiety and other mental health problems than many other countries. Almost 20% of seniors experience emotional distress and find it hard to cope alone (2018 Canadian Institute for Health Information [CIHI]). Many experience social isolation. This is the first of a two-part interview.

Canadian seniors are slow to accept and adopt many of the technological products or services that can have significant impact on their independent living, well-being and functional ability to engage in their community. Current and emergent technologies like wearable heart and blood pressure monitors, smart insulin patches and remote pacemaker tracking, as well as fitness and health apps that provide guidance, monitoring, and maintenance on diet, nutrition, chronic conditions and medication management can help support health for all, and particularly for seniors. In addition, virtual doctors and other health professionals are available via video link to offer support and guidance for seniors with limited mobility and/or transportation issues.

Aging adults want to be able to meet basic needs, learn, grow, make decisions and continue to contribute to our communities. Independence through mobility and the ability to maintain friendships are important. Assistive technologies aid mobility and increase capacity to do more.

Technology supports well-being and health only to the point that it is accessed and used. While about 56% of older adults have heard of smart devices and technology that support health and well-being, only about 7% use them (2018 CIHI).

Assistive technologies have become big business. Competition drives innovation that produces health products and services that allow more access and independence for today’s senior adult. Today, with exponential advancement of health technologies, healthcare stakeholders including government, non-governmental organizations, and industry are working together to promote physical activity for seniors, while lobbying and advocating for ‘real’ changes in policy, development, and urban planning that support increased mobility for this growing demographic.

CARE magazine recently spoke with Dr. Don Juzwishin, BA, MHSA, Ph.D., FCCHL, Director, Health Technology Assessment and Innovation at Alberta Health Services about the role of technology in the lives of seniors and the arrival of technological advances that will provide improved mobility and access.

**CARE magazine:** How does the older population in Canada compare with the rest of the world?

**Dr. Juzwishin:** If you look at countries like Japan, the Netherlands or Denmark, they have a larger proportion of their population that are elderly; however, they are within a confined (geographic) space that is reasonably...
compact. In comparison, Canada represents 36 million people that are spread over an immense area. That characteristic of rural, remote distribution of population means that if you age in your locality, you may not necessarily have the kinds of healthcare supports that might be necessary. Health care professionals cannot physically be in every vulnerable older adult’s home – so the question arises, how can we use assistive technologies to amplify the presence of our caregivers in Canada?

Are Canadians in this age demographic getting healthier?

If you look at the data, you will find that people are living longer and staying healthier and they want to be making a meaningful contribution in their communities. In the past, if the elderly became incapacitated, we thought of simply accommodating them in institutions and thinking “They are safe and secure.” No, that paradigm of the past is no longer relevant. People wish to be challenged, socially engaged and continue to be active. I think that is what the next opportunity is going to be. How do we adopt and apply new assistive technologies that can help Canadians achieve an improved quality of life as they age?

What do LPNs and other health professionals need to know about our aging population?

If you think all care will be provided in institutions, that really is not preparing for the future. Not everybody wants to be in a hospital or residential care environment. Some seniors have to be, but we need to find ways to facilitate independent living in their own homes and communities, if at all possible. Assistive technologies support independence opportunities for seniors. Health professionals will need to more often consider a client’s local living circumstances when providing care, looking at new ways to address the needs of seniors that will soon be effectively supported by innovative technologies. For example, in the future an unmanned mobile vehicle may pull up to a patient’s home, have them step inside, place their forearm in a sleeve, and provide a blood test - guided through the process and supported by an LPN or physician or other health professional linked through a video screen.

Enhanced roles and new approaches will be required from health professionals working with assistive technologies. Integration of innovation will offer learning opportunities, along with career satisfaction and reward for professionals more effectively meeting the health demands of elderly Canadians.

What innovations will technology offer?

That could be in telehealth, teledmedicine, remote monitoring, social networking, robotics, machine learning and consultation over a distance. There is progress to be made in terms of making this technology more usable and easily accessible to older adults. Beyond health assessment, monitoring and reporting supported by recent innovation, we find that technology can play an important role in connecting people, particularly those dealing with depression and isolation, which is often an issue in the older population. Thinking about usability and ease of use of these technologies with the elderly is essential. With communication and interaction through technology comes a comforting assurance that provides freedom of mind from concerns of physical and social isolation.

If an older individual experiences a loss of capacity (mobility or access), there is a bridge there with technology to keep connected, so to speak?

Yes. We still have some difficulty with inter-professional, inter-healthcare agency communication, coordination and collaboration in the delivery of service. Health and social care needs are falling between the cracks of siloed health and social care delivery. We need to ensure that our dialogue with the patients is such that they clearly understand what resources are available to them and where the gaps are. As assistive technologies continue to support networks of care, older adults will feel reassured knowing that assistance is available seven days a week, 24 hours a day. In Alberta, we have the Help Line that the public can access. The health professions that answer those calls are very knowledgeable and will triage them to the appropriate service or individual.

Today we have insulin patches, pacemakers and irregular heartbeat sensors that monitor and report back to healthcare professionals, keeping patients on track and well. Soon there could be ingestible artery de-clogging micro robots and exoskeletons to help people walk. Does this kind of development just grow exponentially from here?

It’s an interesting question. There is an unmistakable trend toward minimally invasive interventions, self-care and maintenance, coupled with increasing the
autonomy of citizens on the other. Much, not all, open-heart surgery is now being replaced with access through the femoral artery for replacement of valves or even corrective surgery – technology supports that; much less invasive and quicker recovery. They are also now able to use the extremely precise and accurate movement robotics offer to assist surgeons by fine-tuning hand movement with a motor server system. So you may want to cut the margin of a tumour here and physically with a knife you could do it, but with the robotic arm you would be able to do it far more accurately with increased visualization and much more precise manipulative methods. The exoskeleton is moving from military and industrial applications to home use. A paraplegic can purchase a ReWalk that uses powered leg attachments to stand upright, walk and climb stairs.

We know that machine learning and artificial intelligence applications can now identify radiology and pathology anomalies as well or better than a human can. Continual sensor monitoring and reporting can scan for anomalies of behaviour. It’s just a matter of time before this capability spreads to other fields; however, it will still require human supervision. Just like with everything else where human capability has been enhanced with technology, I believe the same will happen with identifying ways to continue improving the quality of life of the elderly. The LPN profession can be a leader bridging between the emergence of these technologies and patients or clients.

Not so much a technology takeover, but a collaboration and new ways of working with technology to support health?

I think so, yes. What farmer would choose to till the soil with a horse and plow rather than with a GPS-guided tractor and cultivator? How could we not provide early stage dementia clients with access to GPS locator devices in the event they get lost and need to be located? There will be usability and ethical issues to address but these will need to be explored and addressed.

How aware of health technology is the older adult population? Can we bridge the gap between a technology-savvy youth generation and older adults?

It is generational, right? You and I feel very comfortable tapping our way through a screen of an iPad. Someone who has lived all of their lives in a tactile and mechanically-driven environment is not likely to be as adept.

Identifying and facilitating ways to bridge the information and knowledge gap between young people and the elderly is important and can serve as a bridge to help seniors who find themselves isolated or abandoned in terms of adoption of technologies.

We can bring these two groups together for positive exchanges. Here is an interesting example: The Netherlands has a program in which children are given a role and responsibility to visit the elderly on a periodic basis and it’s part of their social responsibility. They go to a retirement home to learn about what it was like 50 years ago and they have an assignment to do a short biography of an older person. To thank the seniors for the learning opportunity, the students are expected to teach the elderly how to use an electronic device or how to do a search for information on the internet. Some seniors will be very interested and that will get them started on the path. Or they may say it’s not for me, I’m not interested and that is fine, too. No matter the outcome, you have sharing of narratives that may bring generations together?

There is a positive social outcome from that – empathy and caring for the other person. The other thing that they have really recognized is that the opportunity to tell a narrative story is something that the elderly really appreciate, because they feel that they have not been forgotten and are making some contribution back into the community.

Technology can support story-telling and learning, on any level?

Absolutely. We have to consider the benefit of technology to the simple aspects of social life as well. If understanding how to use a laptop or social media supports sharing and a sense of inclusion – it’s not high tech brain surgery, but there is healing and wellness derived from that interaction. ■
ALBERTA Public Workshops
Fall/Winter 2018-2019

Managing Mental Health in the Workplace—Rights & Responsibilities
Edmonton: October 2; Calgary: October 4

Dealing With Difficult People
Calgary: October 16 & March 12; Edmonton: October 18 & March 14

Management and Supervision—The Crucial Skills
Edmonton: October 24; Calgary: October 25

Assertive Communication
Edmonton: November 6; Calgary: November 7

Time Management
Edmonton: November 21; Calgary: November 22

Leadership—Insights for Thinking Differently
Edmonton: December 5; Calgary: December 6

Conflict Resolution Skills
Edmonton: December 12; Calgary: December 13

Leadership—The Essential Competencies
Edmonton: January 30; Calgary: January 31

Emotional Intelligence
Edmonton: February 12; Calgary: February 14

Mindful Leadership
Calgary: February 27; Edmonton: February 28

The Culture Question—How to Create a Workplace Where People Like to Work
Calgary: March 21; Edmonton: March 22

Anxiety in Children and Youth—Practical Intervention Strategies
Calgary: September 29; Edmonton: September 30

The Ethics of Helping—Boundaries and Relationships
Calgary: October 3; Edmonton: October 4

Narrative Therapy—Tools for Exploring Stories
Edmonton: October 15; Calgary: October 17

Cognitive Behavioural Therapy—Tools for Thinking Differently
Edmonton: October 29-30; Calgary: November 1-2

Self-Injury Behaviour in Youth—Issues and Strategies
Calgary: October 1; Edmonton: November 2

Mindfulness Counselling Strategies—Activating Compassion and Regulation
Edmonton: December 10-11; Calgary: December 11-12

Train-the-Trainer Certificate Program for
De-escalating Potentially Violent Situations™
Edmonton: November 20-22, March 19-21

De-escalating Potentially Violent Situations™
Calgary: November 14 & March 20; Edmonton: November 20 & March 19;
Grande Prairie: November 20

Critical Incident Group Debriefing
Calgary: November 15; Edmonton: November 19

Addictions and Mental Illness—Working with Co-occurring Disorders
Calgary: November 26; Edmonton: November 28

Harm Reduction—A Framework for Change, Choice and Control
Calgary: November 27; Edmonton: November 29

Vicarious Trauma—Strategies For Resilience
Edmonton: December 4; Calgary: December 6

Navigating Difficult Client Relationships
Edmonton: January 28; Calgary: January 30

Motivating Change—Strategies for Approaching Resistance
Calgary: February 12-13; Edmonton: February 13-14

Autism—Strategies for Self-Regulation, Learning and Challenging Behaviours
Edmonton: March 5-6; Calgary: March 7-8

Restorative Justice—Guiding Principles for Schools and Communities
Edmonton: March 18; Calgary: March 19

NEW BOOK!

RELEASE DATE
DECEMBER 2019
Now available for pre-order on our website.

www.achievecentre.com  877.270.9776  info@achievecentre.com
## Resources

### Connections

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

- **Alberta Gerontological Nurses Association**
  - [www.agna.ca](http://www.agna.ca)

- **Alberta Hospice Palliative Care Association**
  - [www.ahpca.ca](http://www.ahpca.ca)

- **Alberta Operating Room Team Association – LPN**
  - [www.clpna.com/members/aorta-affiliate](http://www.clpna.com/members/aorta-affiliate)

- **Canadian Association of Neonatal Nurses**
  - [www.neonatalcann.ca](http://www.neonatalcann.ca)

- **Canadian Association of Schools of Nursing**
  - [www.casn.ca](http://www.casn.ca)

- **Canadian Association of Wound Care**
  - [www.cawc.net](http://www.cawc.net)

- **Canadian Orthopaedic Nurses Association**
  - [wwwcona-nurse.org](http://wwwcona-nurse.org)

- **Canadian Hospice Palliative Care Nurses Group**
  - [www.chpca.net](http://www.chpca.net)

- **Community Health Nurses of Alberta**
  - [www.chnalberta.ca](http://www.chnalberta.ca)

- **Creative Aging Calgary Society**
  - [www.creativeagingcalgary.com](http://www.creativeagingcalgary.com)

- **Emergency Nurses’ Interest Group of Alberta**
  - [www.nena.ca](http://www.nena.ca)

### Learning Links

- **Study with CLPNA**
  - [www.studywithclpna.com](http://www.studywithclpna.com)

- **ACHIEVE Training Centre**
  - [www.achievecentre.com](http://www.achievecentre.com)

- **Advancing Practice**
  - [www.advancingpractice.com](http://www.advancingpractice.com)

- **Canadian Blended Learning Courses for LPNs**
  - [www.jcollinsconsulting.com](http://www.jcollinsconsulting.com)

- **Canadian Diabetes Educator Certification Board**
  - [www.cdecb.ca](http://www.cdecb.ca)

- **Canadian Virtual Hospice**
  - [www.virtualhospice.ca](http://www.virtualhospice.ca)

- **Critical Trauma Resource Institute (CTRI)**
  - [www.ctrinstitute.com](http://www.ctrinstitute.com)

- **de Souza Institute**
  - [www.desouzainstitute.com](http://www.desouzainstitute.com)

- **John Dossetor Health Ethics Centre**
  - [www.ualberta.ca/bioethics](http://www.ualberta.ca/bioethics)

- **Learning LPN**
  - [www.learninglpn.ca](http://www.learninglpn.ca)

- **Learning Nurse**
  - [www.learningnurse.org](http://www.learningnurse.org)

- **Reach Training**
  - [www.reachtraining.ca](http://www.reachtraining.ca)

- **Registered Practical Nurses Association of Ontario**
  - [www.rpnao.org/practice-education/e-learning](http://www.rpnao.org/practice-education/e-learning)
In March, the CLPNA’s Council approved direction to enhance the Continuing Competence Program through the addition of a minimum practice hour requirement.

During Registration Renewal, LPNs will be asked to declare the number of practice hours they accumulated during the current registration year. Reporting will be mandatory and included as a part of the Audit process.

Changes will be fully implemented over a three-year transition period. Effective 2019, practice hours will be a component of the Continuing Competence Program. By 2021, all LPNs will be required to have worked a minimum of 1000 practice hours within the four-year period immediately preceding Registration Renewal.

The new requirement stems from the CLPNA’s regulatory mandate to protect the health and safety of the public by setting standards and ensuring LPNs are competent to practice under the Health Professions Act (HPA) and the Licensed Practical Nurses Profession Regulation. The HPA defines competence as “the combined knowledge, skill, attitudes and judgment required to provide professional services.”

Over the next three years, the CLPNA will provide guidance to members and other stakeholders regarding the requirements for compliance to maintain eligibility for registration.

Three-Year Transition Timeline

**2019**
- The CLPNA will communicate criteria for practice hours to stakeholders.
- A practice hours requirement will be included as part of the Continuing Competence Program.
- LPNs will be asked to declare their practice hours on their Registration Renewal.
- LPNs with fewer than 1000 practice hours accumulated in the previous four years (2015 – 2018) will be informed of recommendations for future compliance.
- The Audit will only include Learning Plans for 2017 and 2018.

**2020**
- LPNs will be audited for practice hours declared on their 2016, 2017, 2018 and 2019 Registration Renewals.
- The Audit will include both a review of practice hours and Learning Plans.

**2021**
- LPNs will be audited for practice hours declared on their 2017, 2018, 2019, and 2020 Registration Renewals.
- The Audit will include both a review of practice hours and Learning Plans.

For more info, contact info@clpna.com, 780-484-8886 or 1-800-661-5877 (toll free in Alberta).
2019 Registration Renewal

Members must complete the annual Registration Renewal Application in order to:

- work in Alberta as a Licensed Practical Nurse in 2019 (with an Active registration type)
- OR change your registration type from Active to a non-practicing Associate
- OR notify CLPNA you are not renewing for 2019

For complete info, see www.CLPNA.com, “Members”, “Registration Renewal”.

Registration Renewal begins October 1 for LPNs wanting an Active Practice Permit for 2019. LPNs are asked to renew before the December 1 deadline to receive the lowest registration fee. Registrants completing renewal for an Active Practice Permit before November 1 will be entered in a draw for $350. Notices will be sent by email from the CLPNA’s Registrar.

Don’t Practice Without a Permit

Working as an LPN with an expired or invalid Practice Permit is considered unprofessional conduct and may subject the individual to disciplinary action, including fines of $500 and up. Only those individuals with a current CLPNA Practice Permit are authorized to work as an LPN in Alberta or use the regulated title ‘Licensed Practical Nurse’ or ‘LPN’ as stated in Schedule 10 of the Health Professions Act and Section 12 of the LPN Profession Regulation.

RENEWING ONLINE

To begin the 2019 Registration Renewal application, login to myCLPNA directly (https://www.myCLPNA.com), or go to www.clpna.com and click on the blue “myCLPNA Login” link located in the upper right corner.

Get Ready

Before beginning your online Registration Renewal process, have the following ready:

- Your email address and password for www.myCLPNA.com
- Nursing practice hours calculated for Jan 1 - Dec 31, 2018
- Continuing Competence Program (CCP) Learning Plan for 2019
- Current employer information
- Payment information

MATERNITY, LEAVES AND RETIREMENTS

Maternity or Short-Term Leave?
Renew your Active Practice Permit

For those planning a maternity or other short-term leave, the CLPNA recommends LPNs renew for an Active Practice Permit to return to work without delay. The Associate membership type is not recommended in these circumstances, as it does not offer an easier, faster or less expensive route to Active registration. Associates applying for an Active Practice Permit must still meet all registration requirements including application approval, fee payment, criminal record check, and evidence of being actively engaged in practice (1000 practice hours in the previous four years).

Retiring or Not Renewing?
Consider Associate Membership

Members who plan to retire or not return to the profession in 2019 may register as an Associate (non-practicing status) for $50. This non-practicing membership type provides a CARE magazine subscription and practice updates, but does not allow the individual to work as an LPN in Alberta.

If an Associate membership is not desired, LPNs should notify CLPNA that they are not renewing by selecting the option of “Inactive” on their 2019 Registration Renewal application. This will ensure the LPN’s practice hours and completion of their Continuing Competency Learning Plan are current. If Registration Renewal is not completed, further reminders and suspension/cancellation notifications will be sent to the member as required by the Health Professions Act.
Fees, Receipts, Deadlines and Proofs

2019 Registration Renewal for Active Practice Permit

<table>
<thead>
<tr>
<th>Fees Paid</th>
<th>Fees Paid</th>
<th>After</th>
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<tbody>
<tr>
<td>October 2 - December 1</td>
<td>December 2 - 31</td>
<td>Reinstatement Required</td>
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<tr>
<td>$350</td>
<td>$400</td>
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Fees may be paid online by credit card (VISA or MasterCard), or by previous enrollment in our Pre-Authorized Payment Plan (PAP). To pay using a different method, contact CLPNA during business hours to make alternate arrangements. All fees will change at 12:00 am (midnight) on the dates listed. CLPNA Payment Policy: Registration fees are in Canadian dollars, and are non-refundable.

Renewing Registration between Oct 1 - Dec 1
Members are urged to renew before the December 1 deadline for the lowest fees. Renew by November 1, 2018 to be automatically entered in our draw to win $350.

Renewing Registration between Dec 2-31
The Registration Renewal fee rises to $400 for those renewing between December 2-31. Reminder that the CLPNA will be closed and registration support will be unavailable on December 24-26, and January 1.

Reinstating Registration after Dec 31
On January 1, the Registration Renewal system will close. Those still wishing to register must complete the Reinstatement Self-Assessment Tool to receive a Reinstatement Application. See www.clpna.com/applicants/previoulsy-licensed-alberta/.

Practice Permits
After their Registration Renewal is approved, most members will receive access to their Practice Permit and Tax Receipt. Exception: Pre-Authorized Payment Plan (PAP) subscribers will receive access to their Practice Permit in late November after their final payment is processed for November 2018.

Proof of Registration on Public Registry
The CLPNA strongly encourages employers who require proof of LPN registration status for 2019 to use CLPNA’s Public Registry at www.clpna.com. The Public Registry shows an LPN’s current and future registration status, specialties and restrictions.

Prepaying 2019 Registration Renewal Fees
The Pre-Authorized Payment Plan (PAP) is a CLPNA payment option that allows members to pay their 2019 Registration Renewal Fee using automatic bank withdrawals of $35/month for 10 months. Go to www.clpna.com, “Members”, “Registration Renewal”, “Pre-Authorized Payment Plan”.

Questions?
Contact CLPNA at registration@clpna.com, 780-484-8886, or toll-free at 1-800-661-5877 (toll free in Alberta only).

CLPNA Holiday Hours

<table>
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<tr>
<th>Date</th>
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<tbody>
<tr>
<td>October 8</td>
<td>CLOSED</td>
</tr>
<tr>
<td>November 12</td>
<td>OPEN</td>
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<tr>
<td>December 24 - 26</td>
<td>CLOSED</td>
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<tr>
<td>January 1, 2019</td>
<td>CLOSED</td>
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Early Renewal Contest

$350 Prize!*  
LPNs, complete your 2019 Registration Renewal by November 1 to be entered in our draw to win $350.

*Prize is equivalent to Active Registration Renewal Fee. To be eligible, members must submit a complete 2019 Registration Renewal for an Active Practice Permit by November 1, 2018. The winner’s name will be publicly announced.
Grande Prairie Area Re-Elects Incumbent to the CLPNA’s Council

The votes are in! Joyce Rossiter, LPN, will continue to represent the Grande Prairie area for the next three years on the College of Licensed Practical Nurses of Alberta’s Council.

In Council Election District 6, there were 137 votes cast on 571 ballots, a 24% participation rate. The CLPNA thanks all LPNs who took the time to learn about the candidates and submit their vote. LPNs voted in Council Elections from June 14 - 30. Ballots were emailed to those residing in Election District 6 and voting took place online.

Unfortunately, there were no nominees for Council Election District 7 (Fort McMurray and area). The Council will continue to search for a candidate. Until one is found and acclaimed, the position will remain vacant.

The College of Licensed Practical Nurses of Alberta is governed by a Council consisting of elected LPNs and three government-appointed public members. The Council regulates the profession and oversees the CLPNA’s management, actions, and policy development within the framework of the Health Professions Act.

Celebrating National Indigenous Peoples Day

A June CLPNA radio campaign on CFWE-FM (owned by the Aboriginal Multi-Media Society) highlighted the competent, committed care Licensed Practical Nurses provide to all Albertans, and the time taken in practice to appreciate the honoured traditions and cultural contributions of the many Indigenous families they provide healthcare for.

Every year on June 21, the CLPNA is proud to join with all Canadians in acknowledging and celebrating National Indigenous Peoples Day.
KOOL FM and WILD 95.3 Visit Calgary Nursing Units During NATIONAL NURSING WEEK

The CLPNA’s 2018 Spring Public Awareness Campaign included Calgary radio stations 101.5 Kool FM and Wild 95.3. During National Nursing Week, May 7 - 13, Wild 95.3 on-air personalities Jess and Bo dropped by local hospital nursing units delivering CLPNA gift bags and words of appreciation for everyone’s hard work and dedication each day. Jess’s experience as a former LPN provided a unique perspective on the special qualities required by health professionals responsible for patient care.

Social media posts and live chatter from both stations helped raise awareness about the week-long celebration.

CLPNA Public Awareness Campaign Resumes this Fall

The CLPNA has a responsibility to inform the public about the roles and responsibilities of Licensed Practical Nurses (LPNs) in healthcare today. Catch the CLPNA television and radio spots on your favourite stations in September featuring passionate, personal perspectives from LPNs providing competent, committed care to Albertans.

VENDOR to Develop Next Generation NATIONAL LPN EXAM

The Canadian Council for Practical Nurse Regulators (CCPNR) selected Yardstick Assessment Strategies Inc. (YAS) to develop a new generation of the entry-to-practice examination for licensed practical nurses (LPNs) in eight jurisdictions in Canada, including Alberta.

YAS is a Canadian company with extensive expertise in examination development and administration. It has worked with Canadian LPN regulators, educators and practitioners for the past 20 years, and is the current provider of the Canadian Practical Nurse Registration Examination. The target date for launching the new exam is 2022.

The CCPNR is the federation of provincial organizations responsible for the safety of the public through the regulation of Licensed/Registered Practical Nurses. The CLPNA is a member.
A lot has changed in nursing practice in the last few years. Even new graduates are finding the workplace isn’t exactly what was learned in class. To provide an update on current practice, the College of Licensed Practical Nurses of Alberta developed a 47-page, comprehensive Practice Guideline on Medication Management, and accompanying self-study course on Medication Administration.

**MEDICATION ADMINISTRATION SELF-STUDY COURSE**

Pharmacology and medication administration is a key role and responsibility in the scope of practice for Licensed Practical Nurses. This role includes assessment and monitoring of the client, safe medication administration, health teaching and coaching about medications, and continuous evaluation and documentation of the client’s response to the medication. Medication administration also includes identifying risks and precautions and being able to respond to adverse events appropriately and in a timely manner.

This self-study course provides Licensed Practical Nurses with a review of pharmacology, the role of medication management and the various components of medication administration in Alberta. This course will be of interest to any nurse – newly graduated or experienced – who wants to benefit from an opportunity to refresh their knowledge.

This course consists of a Medication Administration Study Guide, practice quizzes and other resources.

The CLPNA’s Self-Study Courses are free, online education programs available from www.StudywithCLPNA.com. All courses can be used to fulfill an LPN’s annual Learning Plan goals for the Continuing Competence Program. A printable Certificate of Completion is available after passing a final exam.
Behind the Curtain: Education & Conduct Committees Recruiting LPNs

Nurses have perfected being in front of a crowd. But behind the scenes exists a world of self-regulation where LPNs are making key decisions to lead the profession. These decisions in the areas of nursing education and practice are essential, creating accountability to the public.

LPNs are invited to submit their resumes for one of four CLPNA Committees. It’s an opportunity to share expertise, boost leadership, and discover new skills. Once approved, your appointment is typically for two years, with a possibility of extension.

Pick a committee based on what you value:

SAFE AND ETHICAL NURSING CARE

- Assist the Hearing Tribunal and Complaint Review Committee review evidence and make decisions regarding complaints of unprofessional conduct against LPNs.
- Assist the Jurisprudence Committee in the maintenance and development of our Jurisprudence Examination, a multiple-choice, open-book exam which helps LPNs gain the necessary knowledge to practice nursing safely.

CONTINUING EDUCATION AND LIFE-LONG LEARNING

- Assist the Competence Committee in reviewing and assessing documentation to ensure LPN compliance with the Continuing Competence Program.

Orientation, training, honorarium, and travel expenses are provided. Resumes are accepted online until November 1.

Complete info and online resume submission is available at www.clpna.com/about-clpna/committees/. Or contact info@clpna.com, 780-484-8886 or 1-800-661-5877 (toll free in Alberta).

POLICY UPDATE

In July, the CLPNA released its Practice Guideline on Medication Management. This practical and informative guide outlines the fundamentals of safe, ethical and competent medication management for LPNs in all practice settings.

The Medication Guideline provides LPNs with information related to medication rights and checks, orders and protocols, medication preparation, as well as key considerations in emerging areas of LPN practice such as aesthetic nursing services and the administration of medical cannabis.

LPNs are responsible to ensure they possess the required knowledge, skill and judgment to administer medications safely and competently. The core importance with the administration of any medication is that the LPN is knowledgeable about the medication, safe recommended dosage, appropriate route, indications, contraindications, side effects, interactions, precautions, onset, duration, excretion, related-lab values, appropriate evaluation and documentation.

The release of the medication guideline is accompanied with the Medication Administration Self-Study Course available from www.StudywithCLPNA.com. LPNs are encouraged to use the guideline and take the free, online course to help solidify their knowledge.
Basic foot care is within LPN scope of practice and does not require additional post-basic training to perform. In order to provide care that extends beyond basic foot care and includes the restricted activity of “removing a corn or callus as part of the provision of foot care”, LPN Profession Regulation Section 13(5)(a) states additional authorization is required.

The scope of practice for advanced foot care is defined in the LPN Competency Profile (2015) - Section CC - Advanced Foot Care. The LPN must have the education, knowledge, judgment and competence acquired through completion of an education program recognized by the CLPNA. Upon successful completion of an advanced foot care course, the LPN is required to submit their certificate to the CLPNA in order to obtain authorization to practice in this area.

IPC Standards

The principles of Infection Prevention and Control (IPC) Standards are a necessary element to adhere to when providing advanced foot care. The following resources have been recommended by Alberta Public Health and provide guidance related to IPC standards including sterilization of multiuse instruments.


Additional IPC resources are available at www.albertahealthservices.ca.

Independent Practice

When providing advanced foot care in independent practice (self-employed), there are additional considerations when operating your own business. These are outlined in the LPN Competency Profile (2015), Section BB - Independent Practice which provides guidelines and expectations of LPN practice in this regard.

The CLPNA has also developed a Practice Guideline: Independent Practice for the Licensed Practical Nurse. These guidelines provide important information, to which LPNs are accountable, regarding the additional professional, legal and ethical accountabilities and responsibilities of LPNs providing advanced foot care in independent practice. Both of these resources are available at www.clpna.com under “Governance”.

For more info, contact the Practice Consultants at practice@clpna.com, 780-484-8886 or 1-800-661-5877 (toll free in Alberta).
RESEARCH Update

• This summer, all LPNs were invited to participate in the CLPNA Member Survey 2018. Thank you to all who contributed! The survey will provide valuable information that will help the CLPNA support LPNs to provide the best quality care for their patients. The CLPNA is committed to ensuring that Alberta’s LPNs continue to provide safe, competent, committed care to all Albertans as they continue to grow and develop as professionals.

• In July, the CLPNA, in partnership with Alberta Innovates, launched the third competition of the Advancing Knowledge in Practical Nursing Research Grant. The grant supports projects that build knowledge about the profession and practical nurse practice. This round of applications focused on the following priority areas: Indigenous health, multiculturalism and diversity; gerontology; addictions and mental health; and educational research on the impact of simulation labs. Applications were submitted in September with funding decisions expected by January 2019.

For more info on LPN research, contact the Research Department at research@clpna.com, or 780-484-8886.
Working hard for something we don’t care about is called **STRESS**.

Working hard for something we love is called **PASSION**.

- Simon Sinek -
Mood & Mental Disorders Update
New Thinking, New Directions, & New Medications

**EXECUTIVE LINKS**

**Overview of Pharmacotherapy in Major Depressive Disorder**
- Conventional Treatments and New Medications for Adults with MDD
- Strategies to improve Health Outcomes amongst Adults with Treatment Resistant Depression
- New Investigational Approaches, including Ketamine for Adults with Treatment Resistant Mood Disorders

**Overview of Pharmacotherapy in Bipolar Disorder**
- Conventional Treatments for Adults with Bipolar Disorder and Updates
- Strategies to Improve Health Outcomes amongst Adults with Treatment Resistant Bipolar Disorder, notably Bipolar Depression
- Novel Investigational Treatments including Ketamine, Anti-inflammatory and Antidiabetic medication

**Overview of Treatments for Cognitive Dysfunction in Psychiatry**
- A Review of, and Defining Cognitive Dysfunction across Mental Disorders
- The Mechanisms Leading to Cognitive Dysfunction in Psychiatry
- Brain Capital: New Directions and Treatments for Adults with Cognitive Dysfunction in Psychiatry

**Diabetes and Obesity: Metastasis to the Brain, Implications for Treating Patients**
- Mechanisms linking Diabetes and Obesity to the Brain
- The Role of Obesity and Diabetes in Causing Cognitive Dysfunction and Mental Illness
- How Treatments for Diabetes and Obesity can Benefit Brain Health

**Brand New Workshop**

- $189.95 + $9.45 GST = $198.45 Early Rate (on or before October 15, 2018)
- $199.95 + $9.95 GST = $208.95 Middle Rate (on or before November 13, 2018)
- $209.95 + $10.45 GST = $219.45 Regular Rate (after November 13, 2018)

**Interpretation of Lab Tests**

- **RED DEER, November 27, 2018** • Radisson Hotel

**Windows on an Inner World: the White Blood Cells**
- Functions of Each of the WBCs: Neutrophils, Segs and Bands, Monocytes, Basophils and Eosinophils, Lymphocytes
- Up, Down and All around - Which Changes in WBCs indicate:
  - Acute Inflammation, Infection and Necrosis?
  - Chronic Inflammation, TB?
- Allergies and Viral Infection?

**Interpretation of the Serum Protein Electrophoresis**
- Albumin and its Functions
- Globulins - Alpha One (HDL), Alpha Two, Beta (LDL and VLDL)
- What you Need to Know about the Gamma Globulins
- Drugs and the Lipoproteins
- The Clinical Conditions Associated with Variance of the Serum Proteins

**The Role of the Red Blood Cells and the Correlation to your Patient’s Illness**
- Maturation Process of the RBC; Normoblasts, Reticulocytes, Erythrocytes
- Essential Substances Necessary for RBC Production
- Role of Iron, Amino Acids, Folic Acid, B12, Thyroid, Kidneys & Good Genes

**Determining RBC Function; CBC, MCV, MCH, Retic Count - What Changes in Values Mean**
- Common Clinical Conditions Associated with Variance in RBC Function
- The Anemia - Iron Deficiency, Megaloblastic Anemia, Folic Acid Deficiency, Sickle Cell Anemia, Drug Induced Anemia

**The Body’s Enzymes: What You Must Know About:**
- AST, ALT, CK, Amylase, Lipase, When and Why They Elevate
- What do the Elevations Mean for Liver Function, Cardiac Function, Muscle Integrity and Pancreatic Function?

**EXECUTIVE LINKS**

**Who Should Attend?**
- Psychiatrists, Psychologists, Mental Health Nurses, Social Workers, Therapists, & Allied Staff in Psychiatric Settings
- Primary Care Physicians & Mental Health Staff in Community Settings
- Intake and Frontline Staff, Mental Health Managers & Educators
- Mental Health Nurses & Staff in Correctional and Forensic Settings

**Barb Bancroft**

Barb Bancroft’s approach to interpreting lab tests is a “must-have” for nurses in all areas and nurses at all levels. You will leave the seminar with a number of practical pearls that can be applied to your patients in the hospital, the primary care facility, or in the ICU. The WBC and differential is discussed as it relates to viral infections, bacterial infections, and parasitic infections. Iron deficiency anemia will be differentiated from B12 and folate acid anemias and you’ll get some helpful hints for patients with lead as a cause of anemia. The lipid profile will be discussed, as will liver function tests and clinical correlations. Various drugs will be correlated with their effects on lab tests, including chemotherapy, antibiotics, statins, and other lipid-lowering agents.

**Who Should Attend?**
- RNs, LPNs, NPs, RPNs in All Areas; Acute, Critical Care, Geriatric, Community Care and Primary Care
- Outpost Nurses, Occupational Health Nurses
- Nurse Practitioners, Educators, Managers

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