The Face of LPN Professionalism

Supervised Consumption Sites
2018 Think Tank
Bar 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.

**Physical Assessment Pearls**

EDMONTON, February 25, 2019  •  CALGARY, February 26, 2019

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**Barb Bancroft, RN, MSN, PNP**

Okay...So you only have 5 Minutes!
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**Leg Ulcers**

CALGARY, April 1, 2019  •  EDMONTON, April 2, 2019

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**Leg Ulcers**

**With**
- Dr. KEVIN WOO, Ph.D, RN, NSWOC, FAPWCA

**Overview of Wound Healing Physiology**
- Phases of Wound Healing
- Review of Arterial System; Venous System; Lymphatic System
- What Makes Chronic Wounds Chronic?

**Wound Healing**
- Wound Bed Preparation; Debridement
- Infection Management; Importance of Moisture Balance

**Vascular Evaluation**
- Differential Diagnosis; Medical History & Risk Factors; Physical Examination
- Invasive and Non-Invasive Arterial Studies: Think ABPI
- Studies of Venous Insufficiency

**Management of Arterial & Venous Leg Ulcers**
- Medical Therapies Or Surgical Interventions
- Approach to Non-Healable Arterial Leg Wounds
- For Venous Leg Ulcers: Compression Therapies: Elastic or Inelastic?
- How to Apply Compression to Venous Leg Ulcers; Dos, Don’ts, and Secrets

**Management of Mixed Venous Arterial Disease**
- The Evidence and the Controversy

**Management of Lymphedema**
- Medical & Surgical Therapies
- What Can Be Done to Promote Lymphatic Drainage?

**Atypical leg ulcers**
- Inflammatory Diseases; Prolifeartive Diseases
- Lipidema

**Leg ulceration is a chronic health issue posing significant burden on individual patients and the health care system. This workshop will describe the clinical approach to diagnose and differentiate various types of ulcers in the lower extremity due to venous insufficiency, lymphedema, arterial compromise, malignancy, inflammatory diseases, infection, and other systemic conditions. Participants will develop an understanding of the mechanisms and rationale behind the appropriate use of compression therapy for the treatment of chronic edema and lower extremity ulcers. Discussion will also focus on holistic care including the needs to optimize medical treatment and lifestyle modifications. Participant will develop a pragmatic local wound care approach that is based on best practice evidence.**

**Assessment & Management**

**With**
- Barb Bancroft, RN, MSN, PNP
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Embracing Innovation

Taking the time to reflect on big ideas like the role of genetics in medicine, replacing orthopedic surgery with regenerative medicine or the impact of artificial intelligence on healthcare is what CLPNA’s annual Think Tanks are about. This year’s theme of Inspiring Innovation & Creativity gave licensed practical nurses and stakeholders a chance to explore what’s new and what’s coming in healthcare delivery.

We heard of advances in genetic testing helping to determine whether a person is at risk for medical conditions like inherited cancers. In the near future, pharmacogenetics – the study of how genes affect a person’s response to drugs – could help match the right treatment to a person’s genome, reducing the chances of offering a treatment that won’t be effective. Regenerative medicine is providing significant impact, replacing invasive orthopedic surgery and lengthy recovery periods.

So while genetics and regenerative medicine may seem removed from our daily routines, these concepts already play a role in the healthcare of Albertans – which means they’re important to licensed practical nurses.

Of course, innovation comes with the risk of failure. While patient care and safety can never be compromised, healthcare only improves when someone takes a chance, tries something new, and finds a better way to do things.

Through leading edge experts at Think Tank, our annual Conference, and in every issue of CARE magazine, we are challenged to read, learn and stretch. By remaining open to new technologies and innovations in treatment, we prepare ourselves to adapt and keep pace with the breathless rate of change in today’s healthcare world.

Core to nursing is the therapeutic nurse-client relationship and a focus on compassionate care. New technology and innovations in care delivery are changing how we achieve this and are impacting the very definition of competent, committed, care.

Looking for opportunity to innovate and collaborate for improved person-centred care demonstrates the leadership our system will benefit from and be grateful for. Embracing and modeling a keenness for innovation is critical to positively impacting the health journey of Albertans. It is also critical to our role as leaders in the system. Albertans deserve the best and depend on us to deliver!

Valerie Paice, President and Linda Stanger, CEO

Looking for opportunity to innovate and collaborate for improved person-centred care demonstrates the leadership our system will benefit from and be grateful for.
Recognize an exceptional LPN or supportive non-LPN by nominating them for an Award of Excellence.

Winners will receive a $1000 cash prize and will be honoured at the Awards Dinner at the CLPNA's 2019 AGM & Conference in Edmonton, Alberta on May 6, 2019.

Nominations open until February 15, 2019

NOMINATION FORMS
from www.clpna.com, foundation@clpna.com, 780-484-8886

Winners are chosen by the selections committee of the Fredrickson-McGregor Education Foundation for LPNs. Only complete nomination applications will be considered.
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Fractures from osteoporosis are more common than heart attack, stroke and breast cancer combined. At least one in three women and one in five men will suffer an osteoporotic fracture during their lifetime.

The cost to the Canadian healthcare system of treating osteoporosis and the fractures it causes was more than $2.3 billion in 2010. The amount rises to $3.9 billion if a proportion of Canadians were assumed to be living in long-term care facilities because of osteoporosis.

Sadly, it is not unusual for a person to experience many fractures before they are actually diagnosed with osteoporosis. Osteoporosis Canada believes that a national network of locally-based fracture prevention volunteers can successfully deliver fracture prevention education to positively impact their communities.

We are seeking to intervene between that first and second fracture so we don’t see patients with several fractures before they are diagnosed and treated. To deliver locally-based fracture prevention education, Osteoporosis Canada has developed online training courses to train people who want to do prevention education.

Online Learning

LPNs and other healthcare professionals are uniquely placed to act as fracture prevention volunteers and deliver a prevention message in their workplace or community. There are four levels of training with Osteoporosis Canada’s Volunteer Education Training Program. Each level is made up of modules filled with easy to understand visuals, audio and graphics. With their

nursing knowledge, LPNs should be able to complete the testing for levels one and two with minimal time commitment.

Level four will give the LPN advanced knowledge in bone health and recognition as a certified osteoporosis health professional. On completion of level four, LPNs will be able to coordinate the work of fracture prevention volunteers -- an excellent leadership opportunity!

Good for You

The benefits of being a volunteer fracture prevention educator include:
• Receiving top-notch training developed by osteoporosis experts
• Having an opportunity to develop your skills
• Adding your certification to your CV
• Being a part of reducing secondary fracture.

For more information or to get started, contact Chloe Kilkenny, your Osteoporosis Canada Community Engagement representative at ckilkenny@osteoporosis.ca or toll-free 1-800-463-6842, ext. 2460. For more tools in the fight to get our patients ‘Too Fit to Fracture’, visit www.osteoporosis.ca/health-care-professionals/tools/.

Too Fit to FRACTURE:

Fractures from osteoporosis are more common than heart attack, stroke and breast cancer combined. At least one in three women and one in five men will suffer an osteoporotic fracture during their lifetime.

The LPN Role in Preventing Osteoporosis-Related Fractures

By Chloe Kilkenny, LPN, Educator, Osteoporosis Canada
Imagine being asked to capture a portrait of today’s licensed practical nurse.

From one perspective, this is impossible. Today’s LPN is:

- Fresh out of nursing school and full of energy; or entering their third, fourth or fifth decade of practice, strengthened by years of experience and wisdom.
- Practicing in the same small town or familiar city they’ve always called home, or new to the province or country where they’ve chosen to put down roots.
- Happily working in home care, community nursing, or a hospital. Or really looking forward to making a change to practice with seniors, children, or find a focus on research.

While today’s practical nurses are perhaps more diverse than ever before, any portrait of an LPN must contain certain brushstrokes.

- A commitment to care for and protect the public; and an understanding that the public means every patient, every day.
- An inner compass that guides each LPN to uphold professional standards of practice and conduct.
- A pride in representing their chosen profession, and an internal voice that reminds each LPN that the person is the centre of the care they provide.

There are many faces of LPNs across our province. The individuals shown here symbolize the commitment and excellence of the profession.

Each one is the face of LPN professionalism, dedicated to providing safe, compassionate and ethical care to Albertans.
“Every day I get to provide spiritual and emotional support. At the end of the day, I’ve made a difference, giving them choices, allowing them to direct where they want their care to go.”

Bonnie, LPN

“I want people to know how caring LPNs are, how dedicated we are to our careers, how much we all love our jobs.”

Amanda, LPN

“I love nursing because I can make an impact on someone’s life.”

Eliza, LPN

“LPNs are a very skilled group of nurses.”

Brett, LPN
As four—sometimes five—generations of nurses seek to collaborate in the workplace, awareness and understanding are imperative.
Generation Z nurses are now entering the workforce, and this generation for whom social media is lifeblood, may well embody the largest generational shift in the nursing profession. For a short period, at least until the last of the Traditionalists (the pre-Boomer generation) retire, five generations of nurses will share work spaces. With as much as half a century separating the oldest from the youngest, these diverse cohorts will need to find common ground and collaborate in a constantly evolving workplace.

Generational theory proposes that individuals within a generation develop values, beliefs and attitudes largely in response to the major events, developments and social issues that dominate the period between when they’re born and adulthood. Though this theory is often criticized as pigeonholing generations too narrowly, it nonetheless bears out in the realm of nursing.

Differences in values and experiences are bound to create some tension and misunderstanding, especially in an intense work environment where communication and teamwork are critical. However, when an intergenerational nursing team views their differences as an opportunity rather than a challenge, the result can be exceptional patient care and a mutually respectful environment, particularly when each generation deploys its unique strengths and insights.

Traditionalists and Baby Boomers: Laying the groundwork

Born between 1922 and 1942, and thus between 73 and 93 years of age, Traditionalists are largely retired from the workplace. This generation includes the first individuals to become “licensed” or “registered” nurses. These nurses laid the foundation and set the initial tone for nursing as a profession.

Growing up during the war years and the Great Depression, Traditionalists were young at a time when “children should be seen and not heard” was the mantra of parents struggling to survive in a difficult world. This generation, also called the Silent Generation, carried that mantra with them into adulthood, working hard, saying little, respecting seniority and never questioning authority. So, for Traditionalists, the doctor was “the guy in the sky,” says Charles Keim, associate professor in the Department of Organizational Behaviour, Human Resources and Management at MacEwan University.

As Keim explains, organizations have “founder effects.” The personality and style of an organization’s founders remain even when those individuals have left. Work ethic, integrity, loyalty, respect... the values of Traditionalists have remained the foundational elements of the nursing workplace for years.

The predominant generation in the workforce since the late ’60s, Baby Boomers were born between 1946 and 1964. Ranging from 54 to 72 years of age, they’re retiring in droves, but the youngest members of this generation currently hold the bulk of upper management roles in all organizations, including nursing, so they’ll continue to be leaders in the workplace for a decade or more.

Growing up in a post-war period of economic prosperity, Boomers had their pick of educational and employment opportunities and are often referred to by sociologists and the media as “The Lucky Ones.” But, having learned from their parents to take nothing for granted, they worked hard and pushed the work ethic of their Traditionalist predecessors to the extreme.

However, Boomers are often the first to admit that sometimes their intense drive has had its pitfalls. “Balance is important, and sometimes our generation didn’t quite get that,” says Shirley Galenza, director of the Centre for Professional Nursing Education (CPNE) at MacEwan University and a Baby Boomer herself. “You saw a lot of burnout with Boomers. As nurses, we know as well as anyone that isn’t healthy, physically, mentally or in terms of work-life balance.”

According to Nicole Simpson, a Gen Xer and academic coordinator at the CPNE, subsequent generations have often found themselves unable to relate to the Boomers’ tendency to work themselves to exhaustion. However, she says, it’s important to give credit where credit is due. “We have a tendency to say that the younger generations work smarter, not harder, but we need to be mindful of the fact that that’s not really fair to Boomers,” she says. “We’re only able to create efficiencies because of the groundwork laid by them and the generation before them. I think one of the biggest things we miss as Boomers retire is just that understanding of the history of our profession. When we know and understand our history, it helps us set a better and more informed course for the future.”

Generation X and Millennials: Valuing balance

Though every generation that enters the workplace brings with it some changes and, as a result, some friction, Galenza and Simpson both describe a particularly pronounced divide between Boomers and the generations that followed: Generation X and Generation Y (more commonly known as Millennials). Major shifts in the economy, family structure and social values meant that the existing career model wasn’t sustainable, and the values and practices of young nurses effectively upended the status quo.

Sandwiched between—and overshadowed by—the Baby Boomers and the Millennials (two very large cohorts), Generation X is sometimes called the “Forgotten Generation.” Born between 1965 and 1980, members are now 38 to 53 years old. Dubbed “latchkey” kids, because many were raised by two working parents or a single (divorced or separated) working parent, Gen Xers grew up fending for themselves.
As a result, they developed independence, self-reliance and creativity. Many are also tech-savvy, having embraced the World Wide Web (invented in 1989) and having grown up during its rapid evolution.

That well-developed independence shaped the way Gen Xers view their careers and in many ways has been a necessary survival tool. According to Keim, this generation has seen a shift in the nature of the employment contract, from relational to contractual, driven by economic unpredictability. “It used to be that you would stay with a company for life; you were loyal to them, and they were loyal to you,” he says. “But, we’ve become more cynical because we see a bank, for example, have record profits and, five days later, they lay off 1,200 people. So, it becomes a case of, ‘Well, I’m going to look out for myself.’”

The boundaries that Gen Xers drew between work and life were amplified by Millennials as they began entering the workforce. And as a result, the criticism leveled against them was also amplified, perhaps more so by the media than by employers or older colleagues. Criticism of Millennials—from their work habits to their delayed home ownership and the amount they spend on avocados—has essentially become a subgenre of contemporary journalism that has left employers and colleagues. Criticism of Millennials—from their work habits to their delayed home ownership and the amount they spend on avocados—has essentially become a subgenre of contemporary journalism that has left employers and colleagues.

Galenza suggests that this isn’t necessarily a bad thing. “When Gen Xers entered the workplace, they brought a strong work ethic, but also stronger boundaries and a better sense of work-life balance,” she explains. “Some nurses of my generation had a hard time understanding that, and maybe viewed it as them being less dedicated or loyal. But really, it’s about being good at what you do in all parts of your life, professionally and personally. I think we can actually learn from that because having a ‘work work work’ mentality doesn’t always produce an environment that’s conducive to good health. We would never recommend a patient push themselves that way, and we shouldn’t expect it of ourselves or our colleagues.”

The boundaries that Gen Xers drew between work and life were amplified by Millennials as they began entering the workforce. And as a result, the criticism leveled against them was also amplified, perhaps more so by the media than by employers or older colleagues. Criticism of Millennials—from their work habits to their delayed home ownership and the amount they spend on avocados—has essentially become a subgenre of contemporary journalism that has left employers with the task of sussing out the genuine concerns from the hyperbole.

Narcissistic and unrealistic with an attitude of entitlement? Or tech-savvy agents of change with a desire for leadership? According to Galenza, the truth, unsurprisingly, lies somewhere in the middle.

“In every generation, you have nurses who work hard and make their teams better, and you have nurses who are not as invested in their practice,” she says. “Millennials are no different.” Born between 1981 and the mid- to late ’90s, Millennials are roughly 23 to 37 years old today. The most populous of the generations, it’s estimated that by 2020, they’ll make up more than 50% of the nursing workforce.

Jayne Young, clinical nurse educator in surgery at the Grey Nuns Hospital, and a Millennial herself, sees some of these “laid-back work habits” in her generation and feels they can impact patient care, but she also feels that Baby Boomers have an “older way of thinking” about patient care, based on the way they were educated. They expect to be the caregivers for their patients, catering to them, knowing everything about them.

“So, there’s this expectation that we [younger nurses] are also going to be doting caregivers,” she says, “but what we’re being taught in school is shifting us away from that, toward patients [playing] a bigger part in their own care. I don’t think the younger generation isn’t as compassionate; it’s just a different way of caring.”

Young believes most individuals who go into nursing do so because they genuinely care for and want to help people, but she says she’s also aware that some members of her generation enter the field because they perceive nursing as a job with good pay and job security. And because it’s just a job to them, if they have to work an extra minute, they expect to get paid for that extra minute, she adds. If a shift starts at 7 a.m., they’ll walk in the door at 7 a.m., not a minute earlier. And, if they give nursing a try and find it’s not for them, they move on.

Shifts in education

It isn’t just factors external to nursing, such as the economy or societal values, that create generational disunity among nurses. Many of the changes in priorities and approaches stem from changes in nursing education.

Whereas Traditionalists and many Boomers became nurses through certificate and diploma programs, Gen Xers and Millennials trained for the same role through diploma (LPN) and baccalaureate degree (RN) programs.

The result is that nurses enter the workforce with differing ideas about how to approach their job. But according to Jessica Wyllie, academic coordinator in MacEwan’s CPNE, it isn’t the changes in education that are triggering changes in nursing; in fact, it’s the other way around.
“There has been a shift in the structure of healthcare as a whole,” she says. “Education has to prepare nurses for the reality of their workplaces. We have to be more efficient. Instead of doing all of the tasks ourselves, we’re working with teams of healthcare providers, and our education reflects that.”

Galenza agrees. “The scope of healthcare is changing, and the roles that are being assumed have required nursing education for RNs, LPNs and other healthcare professionals be elevated,” she says. “Education has had to change to respond to the needs of our environment.”

Galenza also points out that as the role of nurses has expanded, the profession has flourished, creating a need to prepare nurses for roles that fall outside of acute care. “Entry to practice is still our priority, but we’re also preparing students to someday take on leadership roles or to enter graduate studies if that’s what they choose,” she says.

**Generation Z: The unknown future**

Its members are 22 years old or younger, so it’s too soon to tell how Gen Z will fare in the nursing workplace. This generation, which was raised on social media (hence the moniker “iGeneration”), will either widen or narrow the generational divide. Some experts speculate that Gen Z individuals, raised by Gen X parents who grew up in tough times, will have a work ethic reminiscent of the Baby Boomers. Some say Gen Z will have poor people skills, however, because they’ve been immersed in technology since birth. Yet others say Gen Z will be multitaskers, capable of processing a variety of information from a wealth of sources.

How will this translate into patient care, professionalism, commitment, teamwork and leadership? We’ll have to wait and see.

**Building bridges**

Because there will never be a time when the nursing workplace consists of only one generation, generational conflict is inevitable. Keim says bridging the gap begins with recognizing and understanding the different perspectives. “You have to put the points of conflict on the table and have the awkward conversation,” he says, acknowledging that everyone is pushed for time, and making time for that discussion might not be a priority.

With respect to continuing education, Young believes it’s imperative that educators appeal to the different learning styles of the generations on the nursing floors and acknowledge that each generation has something to offer. This will build better teams, and, Young adds, “I really do think how your team functions makes all the difference.” She recalls a unit she worked on shortly after she graduated. She wasn’t embraced by the team—consisting mainly of Baby Boomers—but was, instead, expected to demonstrate her worthiness. “The feeling that I had to prove myself to them made it toxic.”

Another way of building unified multi-generational teams is to ensure that new nurses are prepared for the realities of the nursing workplace. This could mean linking nursing students to specific sites and strengthening preceptorship and mentorship programs, or placing greater focus on clinical performance than on classroom marks.

The ultimate goal of nursing is to provide patient-centred care. Ideally, through education, discussion and awareness, nurses may be better prepared to embrace the generational divide from a multi-generational “we” perspective and achieve harmony in their working relationships.

A version of this article originally appeared in MacEwan University’s Nursing PRN magazine.
An a-ha! moment came for Dr. Francesco Mosaico while listening to a presentation on the Adverse Childhood Events (ACE) study, research from the United States that connected developmental trauma to illness and social disorders in adulthood, including substance use. He sat in the audience, wondering why he hadn’t learned about this in medical school. It’s because results from the ACE study, conducted through the 1990’s, were not widely shared through the medical community until about 2008.

A family physician, Dr. Mosaico has been practicing at the Boyle McCauley Health Centre for 11 years, currently serving as medical director. Boyle McCauley provides primary care to marginalized urban clients, and is one of four locations in Edmonton that will serve as safe injection sites.

Many Boyle McCauley clients are opioid users, and insights from the ACE study inform the centre’s holistic approach to harm reduction and treatment.

The ACE study explored types of trauma experiences in childhood, including abuse, and linked these to adverse adult health outcomes. The study produced a questionnaire for use in healthcare settings, assigning points for each type of trauma experienced. The higher a person’s points score, the higher their burden of illness and health risks.

Dr. Mosaico spoke to CARE Magazine about the implications of the ACE study for informing holistic clinical practice.

**Why is the ACE study important in addressing substance use disorders?**

Before the ACE study, healthcare workers were limited in finding ways to link developmental trauma to adult health outcomes. The clients I was seeing at Boyle McCauley -- many were homeless, had complex substance use disorders, complex psychiatric disorders, profound social instability, were in and out of correctional facilities. I suspected that most of them would have a high ACE score.

So, we piloted the questionnaire at Boyle McCauley, and saw a rate of 89% percent of clients with a high ACE score [compared to about 12% among Alberta’s general population]. It shows there is a disproportionate burden of developmental trauma and resulting illness among clients of Boyle McCauley.

**Where does harm reduction fit in as part of a holistic approach?**

It stems from an understanding of what we call the social determinants of health. There are a lot of considerations that are holistic that you have to focus on in order to achieve good health outcomes for a client. If not, then healthcare becomes a very symptoms-focused way of managing illness.
I don’t view harm reduction in isolation. I think it’s an integrated part of primary care, part of a continuum. An individual might be in a stage of action for addressing one health issue. But they might still be at the contemplation stage for addressing another health issue, and here you might use harm reduction.

Don’t stop at the addiction – see it in the context of the whole person. To achieve better outcomes you have to explore the different aspects of a person, all the domains of their life together in context, and treat holistically. This usually requires a very collaborative, team-based approach.

When you understand the roles of the people on a healthcare team, and, more importantly, when the patient understands, they’re encouraged to connect with different parts of the healthcare team, to address different facets of their wellbeing.

A great benefit of integrating a service like safe injection sites into more traditional primary care is that it creates additional opportunities for these connections between clients and healthcare workers.

How can LPNs and other clinicians develop a holistic approach?

We had a nurse at Boyle McCauley who was very effective at connecting with clients; she was non-judgmental and never seemed to take anything personally. She told me it was because her mother used to be at Boyle McCauley. I said to her, ‘I didn’t know your mother was a nurse here’. But she told me her mother was not a nurse, she was a client.

Front-line care workers often see anger or fear from clients. The ACE study provides a way to understand what’s behind these responses, which makes it easier to take a non-judgmental approach that encourages clients to trust.

It’s such an honour to work with the LPNs and all our team members at the Boyle McCauley Health Centre, but irrespective of which field of health we work in, we can all seek out and create collaborative, holistic environments. It’s good to remember you don’t always have the privilege of seeing the impact of your work. You just do the best you can, and trust that it will be meaningful to someone.
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Marni Panas, Interim Lead of Diversity and Inclusion for Alberta Health Services (AHS), works to create safe and inclusive environments, especially for sexual and gender minority people. She shares her story and her perspective with LPNs in this four-part series.

**Marni Panas - Her Own Journey**

By Mel Priestley

Having grown up Catholic in a small Alberta town, Marni Panas didn’t even learn the word “transgender” until well into her 30s. She began her healthcare career working at the Stollery Children’s Hospital and chose to transition while working there. Now, she’s the Interim Lead of Diversity and Inclusion for Alberta Health Services. Panas has shared her journey openly in the hopes that others can learn from her experience and feel empowered in their own lives.

**Why have you decided to be so open about your life’s journey?**

As I came out as a trans person, I felt it was important for me to share my story on my terms. By not doing that, people could fill in the narrative for me and make assumptions. I needed to own my story.

I learned that when you’re real with people, you get real in return. And when you’re vulnerable and honest with people, you get that in return. It is in those moments where you build intimacy and you build connection. Relationships turn into friendships. At first I think it’s something I did to survive, but since then I’ve never really stopped.

**What are some of the impacts of being so open?**

It comes at a cost; there’s no question. There’s an emotional cost. There is a lack of privacy and the safety that comes with privacy. But I know that by being so visible, others who see me in their journey will think, “OK, that could be me too.” That can be life changing for somebody and I’ve heard this a few times, which gives me resilience.

**Why did you decide to transition when working at the Stollery Children’s Hospital?**

I didn’t choose that time – that time chose me. That environment was truly about being safe and inclusive of all people. It was quite exceptional to feel that and I started to believe in myself, thinking that maybe I could truly be me in all things in my life. As I started to disclose with certain very close peers, I knew that if I couldn’t transition here at AHS, I couldn’t do it anywhere.

**What did becoming a Canadian Certified Inclusion Professional mean to you?**

Where I grew up, I always felt that going to university was what other people did. I didn’t get my degree until just after my transition, and then my professional designation after that. It wouldn’t have happened without me being able to truly live and be my whole self.

**What’s life like outside work?**

My passion is my son. We go camping every second weekend in the summer. We like to go for bike rides and we love to travel together. Last year we went to Australia and New Zealand for a few weeks and we love to explore and have new adventures.

There are also always people who call me for help and don’t know where else to go. Saying “no” is never an option when somebody’s reaching out. So I spend a lot of time with people who need the supports that I might not have had back in the day, but I’m now in a position of privilege and experience to provide.
Nurses Need to Know: Supervised Consumption Services

What are supervised consumption services?
Supervised consumption services are part of a range of evidence-based services that support prevention, harm reduction and treatment for Albertans living with substance use challenges. Supervised consumption services provide a place where people can use drugs in a monitored, hygienic environment to reduce harm from substance use while offering additional services such as counselling, social work, and opioid-dependency treatment.

Why provide supervised consumption services?
Supervised consumption services provide a safe environment for people who use drugs, and reduce:
- overdose deaths
- transmission of diseases and infections
- public substance use and discarded needles.

Supervised consumption services are a compassionate, comprehensive, and collaborative form of evidence-based care and provide options when clients are ready for change.

Do supervised consumption services encourage people to experiment with, and use, drugs?
Supervised consumption services are designed for people already dealing with substance use issues.

Will introducing the services attract more people to use?
Supervised consumption services are typically used by long-time drug users, who often are forced to use in public or in unsupervised spaces. Consumption services help keep drug users safe, particularly vulnerable and marginalized chronic substance users in inner cities. It is unlikely that novice drug users will use these services; however, even for this population, using in a monitored environment is safer than using alone.

Will supervised consumption services attract people who sell drugs?
Studies of supervised consumption services have shown that they actually improve public order and have no effect on criminal activity in the vicinity of the services. Supervised consumption services are generally integrated with other programs used by people with and without substance use issues and it is not obvious which service community members are seeking when they enter the facilities. Enforcement related to illicit drugs remains a component of a comprehensive strategy to address substance use issues.

Why aren’t we putting more resources into prevention and treatment?
Supervised consumption services are part of a continuum of services that includes awareness, prevention, harm reduction, treatment, and addressing organized crime. No single approach is going to solve the whole problem. Supervised consumption services are one important factor in saving lives and keeping communities safe.

Reprinted courtesy of Alberta Health Services. For more information, visit www.albertahealthservices.ca/info/Page15434.aspx
Physical Activity for Decision-Makers

Reasons to Support Physical Activity

Reduces the risk of developing:
- Heart disease
- Type 2 diabetes
- High blood pressure
- Premature death
- Dementia
- Osteoporosis
- Cancers
- Type 2 diabetes
- Depression
- Anxiety
- Stroke
- Cancers

Contributes to:
- Socially connected communities
- Boost to the economy
- Increased productivity
- Improved quality of life
- Optimal health
- Reduced absenteeism
- Reduced health care demands
- Reduced risk of falling
- Environmental sustainability
- Life-long health and well-being
- Reduced criminal activity and vandalism
- Improved memory and task performance

Policy Decisions to Support Physical Activity

Education and Awareness Campaigns
- Changing social norms can increase the acceptance of engaging in physical activity
- Support campaigns that develop clear and consistent messages across various media outlets and methods.
- Develop messages that support and inspire the population to be physically active in their everyday life.
- Provide resources and create awareness of the many ways and places the population can be physically active in their homes, schools, workplaces, and communities.

Health Care and Health Education
- Most people trust health care providers and listen to their advice
- Make assessment and advice about physical activity a routine part of health care services.
- Increase knowledge of the preventative and treatment benefits of physical activity by including it as a core component of training for all health professionals.
- Support integration of physical activity into the practices of long-term care facilities.
- Support regular surveillance and monitoring of levels of physical activity and chronic disease, and evaluation of training programs and practice.

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150 MINUTES of MVPA weekly for adults

&

60 MINUTES of daily MVPA for children and youth

MVPA = Moderate-to-Vigorous Physical Activity

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Adapted for:
COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA
WWW.CLIPNA.COM
The Alchemy of Professionalism refines the perfect combination of knowledge, skills and attitude to inform nursing practice. In the journey from student to professional nurse, competence and wisdom are gained along the way. Ethical decision-making combined with the ability to creatively manage complex nursing practice are required skills for today’s nurse.

Alchemy is about mixing the right elements to create optimal patient outcomes and safe care.

The 2019 CLPNA AGM and Conference - The Alchemy of Professionalism examines the elements of nursing professionalism, with experts from a regulatory, legal, clinical, research and patient safety perspective.

May 6 - 7 | Edmonton
The Alchemy of Professionalism refines the perfect combination of knowledge, skills and attitude to inform nursing practice. In the journey from student to professional nurse, competence and wisdom are gained along the way. Ethical decision-making combined with the ability to creatively manage complex nursing practice are required skills for today’s nurse. Alchemy is about mixing the right elements to create optimal patient outcomes and safe care.

The 2019 CLPNA AGM and Conference - The Alchemy of Professionalism examines the elements of nursing professionalism, with experts from a regulatory, legal, clinical, research and patient safety perspective.

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**Monday, May 6, 2019**

Lunch Meeting

DoubleTree by Hilton Hotel West Edmonton

**PROGRAM:**

- Presidential Address
  Valerie Paice, CLPNA President
- College Activities
  Linda Stanger, CLPNA CEO

Resolutions may be filed until May 3, 2019
Resolution Forms available by request at info@clpna.com or 780-484-8886

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www.clpnaconference.com
Putting the Pieces in Place: Healthy Work Environments

By CLPNA Staff Writer

What do we know about the work life of nurses? This question has drawn much interest over the years with nurses making up a large part of the Canadian healthcare workforce. Demands on the nursing workforce have intensified with growing needs in seniors’ care and in the management of complex, chronic diseases. And while these shifts in the system are happening, many in the nursing workforce are heading towards retirement. To meet the demands of these ongoing shifts and ensure patients continue to receive the best quality care, it is critical to support a resilient and stable workforce into the future.

Getting a better understanding of what nurse work life is like is an important first step. To do this, a lot of focus has been placed on the work environment. In simple terms, ‘work environment’ refers to the conditions in which an employee does her or his work. Work environments, however, are far from simple. There are many facets to consider, from physical conditions to social and cultural aspects.

When looking at the nursing work environment, investigators have been particularly interested in what makes a healthy work environment. This is a very rich area to explore and not easily defined. At a broad level, a healthy work environment is one that is safe, empowering, and satisfying - a place of physical, mental, and social well-being, supporting optimal health and safety. If we drill down further, there are a few key components to a healthy work environment that are consistently noted.
One is effective leadership. Under effective leadership practices, nurses feel genuinely supported. Mistakes are framed as learning opportunities. And all nurses are recognized as having the capacity to take on leadership roles. Their potential for leadership growth is fostered and lifelong learning is encouraged. Equal opportunities exist for professional development and career advancement.

Effective leaders also recognize the efforts and achievements of everyone on the team. In a healthy work environment, nurses are recognized and recognize others for the value each brings to patient care and organizational goals. Engaging in this meaningful recognition is found to be effective for improving work motivation and employee engagement.

A healthy work environment is also seen as one in which the thoughts and opinions of nursing staff are sought and encouraged. This includes opportunities for nursing staff to participate in making decisions on patient care as well as at the organizational level. A healthy work environment ensures those in positions from the bedside to the boardroom have a chance to contribute to decision making.

Another key component to a healthy work environment is collaboration. To meet the goals for the patient and the organization most efficiently, the healthcare team must work together. The team includes nurses, physicians, allied health professionals, management, patients, and families. It is not simply enough to have people on the team in the same location. It is about embracing a culture of collaboration.

With collaboration and leadership identified as key components, it makes sense that healthy working relationships are considered essential to setting the foundation of a healthy work environment. Trust, respect, support, and communication are elements of healthy working relationships. Trustworthy individuals are often described as dependable, knowledgeable, capable, and for the most part, predictable in their behaviour. Respect is the unconditional regard we have for each other. It is recognizing that everyone has a contribution to make. Support in a healthy working relationship is when one person can depend on the support of another. The support is two-way and is offered regardless of whether the circumstances are positive or negative.

Another cornerstone to effective working relationships is communication. Some argue that nurses should be as proficient in communication as they are in their clinical skills. Skilled communicators listen to all relevant perspectives, work towards mutual consensus, are solution-focused, and hold themselves accountable.

A final key component to a healthy work environment is adequate staffing. This supports fair and manageable workloads and job demands. Human resource planning in a healthy work environment strives for adequate staffing to ensure safe, high-quality patient care.

These are a few of the main components found in healthy work environments. There is a lot more complexity involved, but this is a good snapshot of some of the key pieces.

What happens when a workplace lacks these pieces? Serious challenges can arise. There are increased risks for high stress levels, low morale, and burnout. Absenteeism and sick time may rise, with higher turnover rates and increased intention to leave nursing practice. This can affect the efficiency of care delivery as well as the well-being of nurses and others on the healthcare team.

When the pieces fall into place, the benefits of a healthy work environment are significant. Healthy work environments enable nurses to meet the needs of their patients and their families, as well as the goals of the organization. In turn, nurses are more likely to gain personal satisfaction from their work, leading to higher quality of nursing work life. In a healthy work environment, the healthcare team works together to deliver high-quality patient care. This creates an atmosphere helpful to healing for patients - leading to improved patient outcomes. A healthy work environment can also promote successful staff recruitment and retention.

Given these benefits, it is no wonder that attention remains on learning more about healthy work environments. It is important to appreciate that creating a healthy work environment is an ongoing process. It can be a challenge to maintain such an environment. A healthy work environment does not just happen. Effective leadership is essential, as well as an active commitment from all of the healthcare team. It takes deliberate and positive intention by everyone. Creating and maintaining healthy work environments is not always easy, but is of great value for the well-being of patients and care providers, as well as the sustainability of healthcare services into the future.

References available on request.
Seniors & Technology: Helpful, Healthful Innovation

What can technology do for seniors? It can address quality of life concerns and offer support -- for basic needs; the ability to learn, grow, and make decisions; mobility; building and maintaining relationships; and contributing to their communities.

This is part two of CARE’s conversation with Dr. Don Juzwishin, BA, Ph.D., MHSA, 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: You have a complexity of issues in the senior population: chronic conditions, multiple prescriptions management, mental health, numerous treatment options, and under-utilized technology that could offer support. When it comes to health technology, where do you start?

Dr. Juzwishin: Nothing is simple. I think it’s a mutually supportive enterprise. Governments have a responsibility to put in place a policy framework. They don’t necessarily want to get deep into providing direction on how that’s to be developed, but providing a broad framework of saying we need to be certain that the elderly are able to exercise their autonomy for as long as possible, living securely and confidently in the settings of their choice. Those are the broader policy frameworks that would be governing our approach to societal wellness. The actual delivery and accommodation of those higher principles really then becomes the responsibility of families, institutions, organizations, and healthcare professionals like LPNs.

Industry has a role as well. They have a market niche that they want to serve with their products. The challenge for industry is getting their product to market so that consumers can utilize them. Succeeding in reaching and serving an audience means companies earn revenue, and with profit have the opportunity to reinvest in research and development, and then innovate again, developing better and better products as they go.

The problem with chronicity is that it is complicated and has multi-faceted solutions. So then you need to create an environment in which you’ve got a multi-faceted approach. Agendas need to be aligned, because if you have conflicting incentives and conflicting efforts that are taking place then you end up with a sort of zero sum bit of progress, but I think if you get enough of the vision being advanced within the community, you find ways to accomplish great things in healthcare with technology.
Families can help older adults access available technology. This now becomes an ongoing dialogue between the elderly and health providers, in terms of knowing about the latest technologies that can support good health and mobility.

I think so. The primary care setting really becomes the nexus point that an individual identifies as the place where their care needs are being coordinated or facilitated.

Is it costly to accommodate new technology?

I think during periods of health reform, when things are being dismantled because the way that services have been delivered in the past are no longer appropriate for the values or the expectations of patients, what happens is the static part of the system... isn’t quite ready to adapt quickly enough to meet with these needs, so guess what happens – things fall between the cracks. For example, hemodialysis – more and more people want hemodialysis in their home settings rather than within the institutional setting or driving to a local area. Before jumping in to what seems to be a good idea, we need to think...you have somebody who is 80 years old and you are going to drop off a 15 gallon container of solution for them to use in their renal dialysis machine – how? They can’t pick it up or carry it into their house and hook it up to a machine. Technology and innovation come with costs - for the provider and for the patient. Where we want to save cost for everyone is by doing the proper investigation of benefit when considering a particular technology before introducing it.

Health technology is big business. You have corporate entities, NGOs and all levels of government working together on policy and integration. Is this an accurate assessment of current momentum and collaboration?

Yes, it is. You have research platforms like the Canadian Longitudinal Study on Aging, and shared spaces for idea generation and innovation like Developing Regional Health Innovation Ecosystems (DRIVE) and organizations like ECOTECH (Engaging Older Adults in Health Technology Innovation Ecosystems) partnering with older adults and caregivers in communities innovative in health and aging to get technology into the hands of those who will benefit the most and ensure that older adults can remain vibrant community members for as long as possible.

How are governments contributing?

The Federal Government has made a commitment through their Networks of Centres of Excellence investment into a program called AGE-WELL, a cross-country network of universities, researchers, and providers working to articulate where gaps in policy exist and offer remedial responses to support innovation and the advancement of technology.

Exciting things have been happening at the provincial level as well. The Seniors Health Strategic Clinical Network (SCN) from Alberta Health Services (AHS), brings together a diverse group of stakeholders – clinicians, researchers, patients, families, decision makers – to reshape and improve healthcare services and practices that enable seniors to optimize their health, well-being and independence. AHS Connect Care provides a bridge between information, healthcare teams, patients – and the future. Through a common provincial clinical information system, Connect Care will enable consistent practice across the province. The Institute of Health Economics is a not-for-profit organization with key competencies in health economics & decision analytic modeling, health technology assessment, and knowledge transfer/exchange.

Municipally, the Health City Initiative first announced in the Mayor’s 2016 State of the City address is a new strategy to propel Edmonton as a leader in healthcare innovation. This plan aims to increase access to capital for local health sector companies and accelerate the commercialization of new technologies and products created right here in Edmonton.

It’s really about bringing the community together on a grand scale, as well as to develop solutions to support healthy aging. The result is real-world products, services, and policies/practices that enhance the lives of older adults and caregivers.

Is it clear what works when it comes to technology? Is it obvious to see if it is helping people be more healthy and engaged?

Well, it is obvious to some extent, but take, for example, an area like accommodation/adaptation. When we tried out locator devices for early stage dementia patients, we worked with the vendor and the people that...
manufactured it to learn about the barriers and challenges of using that technology in the setting in which it was going to be trialed. The manufacturer and the vendor were very interested in getting feedback from the patients (and from caregivers), so that they could adapt the technology to more appropriately meet any deficiencies that were there.

If a vendor puts a product out there, and they are saying, here it is, this is what is going to be available and they stop there, they probably will not survive. I mean, how many versions of Apple iPhone have there been? Apple is an example of a company that understands that the solution is not the end point, the solution is one step in the adaptation towards further refinement.

So many of these technologies need to be put into place, trialed, refined, adapted, and then that process is repeated. And because companies are not going to want to take on the cost of adaptation on their own, it has to be a shared responsibility between the providers, the consumer, the manufacturer and the researchers to figure out how best to make it all work.

So, at the end of the day, a cost savings to the healthcare system validates the effort?

I don’t buy that. I think we should be doing things for the right reasons and the costs will look after themselves. When you try and achieve cost savings by saying we will do this and it will save this amount of money in this particular area – guess what, the area that is supposed to be saving the money isn’t that enthusiastic about giving it up. So, you must use a more strategic approach, making some upfront investment and then allowing the passage of time to demonstrate the value of the investment.

And you have quality of life, independence, access, contribution for an entire demographic of older adults. This is hard to place a monetary value on.

Yes. Where technology investment has an impact and supports people as productive members of a community – that has value; it is not an intangible.

Where technology investment has an impact and supports people as productive members of a community — that has value; it is not an intangible.

and how it can support decision-making, funding and policy.

Data provides a rationale for funding and access to planning. But what I think is missing now, is that you need to bring the individuals, including older adults with medical conditions, to the table for these conversations when you are doing the design work. So you want to have the patient that’s going to be living at home utilizing these technologies involved with the manufacturer, the researcher and the caregiver and have them engage in a conversation — "Here’s what we are thinking of doing, is this going to work?"

Are end-point users an important audience?

We fall into a trap when we hoist health professionals onto a mantel saying they are responsible for healthcare and delivery to the community. So as a doctor, I know best or as a nurse, I know best, but I never asked you what you thought would be best for you.

So maybe we should do a little bit more of that. Bring those people into the conversation.

What about tomorrow? Do we keep the dialogue going?

We want to be able to encourage the dialogue in specific directions, so those of us with family members who are elderly, and with the older adult community themselves, get them vocalizing their needs to the policy makers and to the healthcare providers so that they are aware of where the policy and service delivery weaknesses are. Nothing is more important in a democratic setting than citizen participation. This drives policy agenda.

Conclusion

Current and future technology will reduce the burdens and consequences of care, enhancing the quality of life of patients and caregivers. Awareness and integration of helpful technology that supports independence and mobility becomes part of the ongoing dialogue between patients, healthcare providers, and community leaders in all sectors.

The CLPNA wishes to extend gracious thanks to Dr. Juzwishin and wish him well as he retires from his position with AHS.
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

De-escalating Potentially Violent Situations™  
Edmonton: March 19; Calgary: March 20

Train-the-Trainer Certification Workshop for  
De-escalating Potentially Violent Situations™  
Edmonton: March 19-21

Trauma  
–Strategies for Resolving the Impact of Post-Traumatic Stress  
Calgary: April 9-10; Edmonton: April 11-12

Attachment and Families  
–Strategies for Engaging and Helping  
Edmonton: April 24-25; Calgary: April 25-26

Borderline Personality Disorders  
–Understanding and Supporting  
Edmonton: May 7; Calgary: May 8

Trauma-Informed Care  
–Building a Culture of Strength  
Calgary: May 28; Edmonton: May 30

Walking Through Grief  
–Helping Others Deal with Loss  
Edmonton: June 4-5; Calgary: June 5-6

Clinical Supervision  
–Skills for Developing Counsellors  
Edmonton: June 18; Calgary: June 20

Brief Focused Counselling Skills  
–Strategies from Leading Frameworks  
Edmonton: July 16-17

One-day workshops: Early rate: $209; Regular rate: $235  
Two-day workshops: Early rate: $399; Regular rate: $445
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
www.learningnurse.org

Reach Training
www.reachtraining.ca

Registered Practical Nurses Association of Ontario
www.rpnao.org/practice-education/e-learning
“CLPNA believes there is no neutral ground in addressing change; you either go forward or you go back.”

Valerie Paice, President of the Council of the College of Licensed Practical Nurses of Alberta, welcomed over 300 healthcare professionals to the 6th Annual Think Tank with these words on October 11th. The Sutton Place Hotel in Edmonton was home to this Council-hosted event that showcased leading-edge health thought and practices. Practical nurses, educators and stakeholders heard from innovative voices like these.

Dementia costs more than cancer, heart disease and stroke together; delaying onset by five years would save a huge amount.

Corinne Schalm, Executive Director of Continuing Care, Alberta Health

With a 15% national dementia rate, Japan’s problem of today is your problem of tomorrow.

Dr. Kentaro Horibe, Neurologist at National Center for Geriatrics and Gerontology, Japan

You’re the ones who drive innovation. The role of government in fostering innovation and creativity is to set the stage and then get out of the way.

Milton Sussman, Deputy Minister of Alberta Health

Will artificial intelligence replace human diagnosticians? Yes & no. It’s good at pattern recognition, but not good at common sense, so it will never replace caregivers.

Dr. Richard Sutton, Research Scientist, DeepMind, University of Alberta

We will be taking care of baby boomers for the next 30 years. We still need caring individuals at the bedside using all the new technology.

Gary Goldsand, Think Tank Facilitator, Clinical Ethicist, University of Alberta

Have you ever tried anything new that failed?

Dr. John Mackey, Director of Clinical Trials Unit, Cross Cancer Institute, on encouraging innovation and risk-taking to fight cancer.
2019 Registration Renewal

Practice Permits expire Dec 31

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

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

It’s the final days of registration renewal for the CLPNA’s members before the December 31 deadline.

Don’t get Fined; Renew on Time
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. 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.

Fees

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<th>2019 REGISTRATION RENEWAL FOR ACTIVE PRACTICE PERMIT</th>
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<tr>
<td>Fees Paid</td>
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<td>October 2 - December 1</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: Fees are in Canadian dollars and non-refundable.

Maternity or Short-Term Leave?
CLPNA recommends LPNs renew for an Active Practice Permit to return to work without delay. The Associate membership type is not recommended.

Retiring or Not Renewing?
Associate (non-practicing) memberships are $50/year including a CARE magazine subscription and practice updates. It does not allow the individual to work as an LPN in Alberta. Those LPNs not renewing are advised to notify CLPNA on their 2019 Registration Renewal application.

Reinstating Registration after Dec 31
Those still wishing to register after Dec. 31 must complete the Reinstatement process online. As the database is evolving, there will be more information on the reinstatement process available closer to January 1.

Proof of Registration on Public Registry
The CLPNA’s Public Registry of LPNs at www.clpna.com shows current and future registration status, specialties and restrictions.

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

Congratulations to Jasbir Gill, LPN, on winning $350 in our Early Renewal Contest.

Thanks to the thousands who completed their 2019 Registration Renewal by November 1 and were automatically entered in our draw.

NEW Immunization Regulation in the Public Health Act — What LPNs Need to Know!

Alberta’s immunization services are evolving to better serve the public and meet national immunization targets. This means new requirements for health professionals, including licensed practical nurses, regardless of whether they have Immunization Specialization.

As of December 17, 2018:

• LPNs will need to report adverse events following immunization to Alberta Health Services within three days of becoming aware.

• LPNs will need to follow specific requirements for the storage, handling and transportation of vaccines.

Effective January 1, 2021:

• LPNs will be required to report immunizations and assessments electronically to Alberta Health within a week. This start date ensures health practitioners and other stakeholders are positioned to comply with electronic reporting requirements.

The regulation will improve the effectiveness and responsiveness of Alberta’s immunization program.

Alberta Health’s Immunization Policy is available at http://www.health.alberta.ca/professionals/immunization-policy.html and provides information on these new changes and other regular updates to provincial immunization policies.

CLPNA guidance related to LPN accountabilities is available at www.clpna.com.
How popular are the CLPNA’s educational offerings? A phenomenal 20,000 Certificates of Completion will be earned by LPNs successfully completing the 12 available Self-Study Courses this year. Thousands more are watching educational videos on topics ranging from recreational cannabis to patient-centred practice.

Courses are suitable to help LPNs meet their annual Learning Plan goals for the Continuing Competence Program. Course content comes in all varieties, including printable documents, downloadable podcasts, case studies, quizzes and more. All courses also work on mobile devices and course components can be downloaded for offline use.

Better Basics

- Medication Administration Self-Study Course
  A companion to the CLPNA’s recent Practice Guideline: Medication Management, this valuable course provides comprehensive education on authorization, pharmacology, medication management, and safety considerations. It’s a big subject so we’ve made it fun. Speed up your medication memorization through flashcards, wordguess, and drag and drop games. Six practice quizzes will help you review drug classifications, categories and indicators, and more.
- Nursing Documentation 101
- Health Assessment Self-Study Course
- Infection Prevention and Control Self-Study Course
- Medical Language and Terminology Self-Study Course
- Medication Drug Calculations Self-Study Course

Client Consideration

- Relational Practice Self-Study Course
- Relational Practice: Beyond Introductions and Interviewing (for Licensed Practical Nurses)
  Relational Practice allows LPNs to reach beyond a superficial nurse/client relationship while maintaining professional behaviours, knowledge, skills and boundaries. Our self-study course is accompanied by a 35 minute video presentation helping you understand how to practically apply this philosophy to your practice.
- Elder Abuse Self-Study Course
- Elder Abuse Awareness for Licensed Practical Nurses
- Improving the Experience for Sexual & Gender Diverse (LGBTQ) People
- Licensed Practical Nurses Supporting Caregivers with Debra Paches
- Patient and Family Centred Care – An Introduction with Paul Wright
- Patient and Family Centred Care – The Patient’s Voice with Paul Wright
- Trauma-Informed Care for Licensed Practical Nurses (with ECDSS)
A Word about Aesthetic Nursing

From dermal fillers to collagen stimulators, the trendy glamour offered by cosmetic treatments is increasingly popular. CLPNA’s Practice Consultants explain the key elements of aesthetic nursing practice:

There are specific aesthetic and dermatological treatments and procedures authorized for LPNs with advanced competency in this area. The information related to LPN scope of practice in aesthetic nursing can be found in Section DD: Dermatology of the CLPNA’s Competency Profile for LPNs (3rd ed., 2015).

LPNs that have completed education and are competent with intramuscular, intradermal, and subcutaneous injections may administer injectable aesthetic and dermatologic treatments including neuromodulators such as Botox and fillers.

IMPORTANT NOTE: The College of Licensed Practical Nurses of Alberta requires that LPNs providing aesthetic nursing procedures within their defined scope of practice must have direct or indirect supervision by a physician. The physician must be trained in dermatology, on site, and available to assist as necessary. If this condition is not met, it would be considered that the LPN is working outside of their defined scope of practice and is in breach of professional conduct.

At this time, the CLPNA does not endorse any specific training course related to the field of aesthetic nursing. Aesthetic nursing treatments and procedures are often supported with onsite employer education or by pharmaceutical supplier certification. It is the responsibility of the LPN to ensure that any education and training they undertake provides core competencies to perform aesthetic procedures. The CLPNA would expect that LPNs undertake additional theoretical knowledge and supervised clinical practice pertaining to the procedures and treatments in at least the following areas:

- Anatomy and physiology related to the treatment area
- Specific assessment of the aesthetic/dermatology patient
- Medications, pharmacology, and technique for treatments and procedures
- Complications of treatments and procedures, and the appropriate interventions

For more information, please read Aesthetic Nursing in Alberta Frequently Asked Questions on www.clpna.com, or Ask a Practice Consultant at practice@clpna.com, 780-484-8886 or 1-800-661-5877 (toll free in Alberta).
How Many LPN Practice Hours Do You Need?

Beginning in 2019, practice hours will be included as part of the CLPNA’s Continuing Competence Program, as outlined in the Registration Policy: Practice Hours and in the Continuing Competence Program Guide for 2019. LPNs will be required to meet a minimum of 1000 practice hours in the previous four registration years.

**Transition Period**

This requirement will be implemented over a three-year transition period. When fully implemented in 2021, LPNs who do not meet this practice hour requirement at the time of registration renewal may not be eligible for a practice permit in the following registration year of 2022. Until renewal for 2022, the CLPNA will be working with members to ensure complete understanding of the new requirements.

**Practice Hours**

Practice hours are defined as the provision of practical nursing services to non-family members, whether paid or voluntary. LPNs are expected to be actively engaged in practical nursing services including both direct nursing practice and/or roles that are linked to administration, management, education and research. As long as LPNs are providing these services, they can include the hours as part of their initial application or registration renewal. Eligible hours do not include being “on call”, on a “leave of absence” (sick, vacation, maternity/paternity) or attending training, college or university. Hours are calculated using the calendar year from January 1 through December 31.

**Other Roles**

Alternative roles and responsibilities may be considered practical nursing services and included in the annual number of practice hours on the renewal application. Volunteer positions or non-traditional roles are some examples of different roles, depending on the requirements of services provided. These roles must meet the requirements of the Health Professions Act (HPA), the Licensed Practical Nurses Profession Regulation and considered part of the LPN scope of practice.

Members are encouraged to contact the CLPNA to ensure their non-traditional role and responsibilities meet regulatory requirements and can be included as part of annual practice hours.

For more info, contact ccp@clpna.com or registration@clpna.com, 780-484-8886 or 1-800-661-5877 (toll free in Alberta).
Bladder Scanning

A Fact Sheet was updated to clarify the authorization of LPNs in using a bladder scanner for nursing assessments. It has been clarified that bladder scanning uses non-ionizing radiation (ultrasound technology) to obtain an image for an assessment of bladder volume. Applying non-ionizing radiation is a restricted activity under the Government Organization Act, which LPNs are not authorized to perform independently. The CLPNA is working with Alberta Health to amend the Licensed Practical Nurses Profession Regulation to add authorization for LPNs to perform this restricted activity. Meanwhile, the CLPNA supports LPNs to perform bladder scanning under supervision of a physician or group of physicians. Please refer to the CLPNA's Fact Sheet: Bladder Scanning for additional information.

Recreational Cannabis

Maintaining fitness to practice is a key professional responsibility in the LPN profession. The CLPNA's Fact Sheet: Recreational Cannabis emphasizes this responsibility in light of recently changed cannabis legalization. The consumption of cannabis may lead to various health risks. It also has the potential to compromise an LPN's ability to provide safe, competent and ethical nursing care. If LPNs wish to use recreational cannabis, they must ensure that their fitness to practice is not impaired.

The CLPNA's current nursing policies, including the above documents, are available on www.clpna.com under Governance, Practice & Policy, or by searching the policy name.
The CLPNA recently released the Practice Guideline on Medication Management. The guideline provides LPNs in all practice settings with the information required to ensure the safe, ethical, proficient and evidence-based management of medication. This is the first in a three-part series designed to increase LPNs’ familiarity with topics addressed in the guideline.

**Medication Administration**

LPNs are required to administer medication as part of their practice in many care settings. It’s important that LPNs have the necessary education, skills, judgment and information to enable them to perform this aspect of their practice in a safe and competent manner.

Medication must be carefully administered in accordance with current legislation, regulation standards, LPN profession-specific policy documents and employer policy. LPNs may administer medication under the conditions noted on page five of the practice guideline. They are also expected to adhere to the Standards of Practice, Code of Ethics and the most up-to-date Competency Profile for LPNs.

**Medication Rights and Checks**

It is critical that LPNs check three times that the following information is correct: the client, the medication, the dose, the route, and the time and frequency before, during, and after preparing any medication for administration. As well, LPNs must perform the following eight core medication rights every time a medication is to be administered to a client (as well as any additional requirements outlined by employer policy).

**Right Reason**

LPNs should know why they are administering a certain medication to a client and must be able to correctly assess the medication’s suitability for the client’s needs.

**Right Client**

LPNs must make sure the correct client receives the correct medication. To eliminate medication delivery errors, follow the client identification policy as set out by your employer. Practice settings and employer policies may vary, but best practice encourages the use of two client-specific identifiers.

**Right Medication**

LPNs must personally prepare the appropriate medication for a client. If there is any doubt about a medication, do not administer it until the order has been confirmed with the authorized prescriber.

**Right Dose**

LPNs are responsible for accurate and applicable dosage calculations. If a prescribed dose requires calculation or conversion, an independent double check is required, where a second regulated healthcare professional must independently verify the core medication rights and checks before administration. Medication administered to certain populations, such as children or geriatric clients, or clients with chronic disease or substance abuse and addiction issues also require additional considerations.

**Right Route**

The way a medication is administered is ordered by the authorized prescriber and determined through collaboration with the care team. LPNs can administer fluids and medications by injection or infusion, with some delivery methods requiring additional and specialized training. Refer
to your employer policies as well as the Competency Profile for LPNs for more information.

Right Time and Frequency
Some medication is time-critical; LPNs must be aware of this and administer on schedule. Should a dose be missed or delayed, the actual time it was administered must be noted on the client's record.

Right to Refuse (and Right to Know)
Clients have a right to be informed and can decide whether or not to accept recommended nursing care. Should there be a concern about the client's ability to consent, or if a client refuses a medication, consult with the care team and authorized prescriber and document accordingly.

Right Documentation (and Right Evaluation)
LPNs must correctly record the administration of a medication as soon as possible. As well, they must assess the client for any adverse reactions or side effects and monitor for effectiveness, and document accordingly.

Please refer to the Practice Guideline on Medication Management for more in-depth information on these topics. CLPNA also encourages LPNs to take the accompanying free online Medication Administration Self-Study Course.

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Up to $2500 available
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Closes February 15, 2019
Questions? Contact foundation@clpna.com, 780-484-8886 or 1-800-661-5877 (toll free in Alberta) http://foundation.clpna.com

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One KIND word can WARM three winter months.

- Japanese proverb -
CHRISTOPHER COLTMAN, RN, BScN

What is Shock?
- Defining Shock
- What Are the Different Classifications of Shock?

The Pathophysiology of Shock
- The Stages of Shock
- What Happens in Initial, Compensatory, Progressive or Refractory Stages?
- What Are the Clinical Signs of Each Stage?
- Why is Early Recognition so Important?

Hypovolemic Shock
- Causes and Treatment
- When To Use Vasopressors; Which Fluid is Better: Crystalloid or Colloid?

Cardiogenic Shock
- Who’s at Risk: The STEMI or NSTEMI Patient?
- When Does It Occur? Why is the Incidence Decreasing?
- Assessment: Physical Assessment, Hemodynamics
- Treatment: Which Vasopressive Drugs Are Best
- What About Obstructive Causes: Aortic Dissection, Pericardial Tamponade

Distributive Shock
- What Is Distributive Shock?

Septic Shock
- Who Gets Sepsis? Are There Gender Differences?
- Identifying Those at Risk: Why is the Incidence Increasing?
- The Continuum: SIRS, Sepsis, Severe Sepsis, Septic Shock, MODS
- Update To Surviving Sepsis Campaign “International Guidelines
- What Is Early Goal Directed Therapy and Why is it Important
- Assessment, Treatment, Which Vasopressors Are Indicated

TRAIL - Transfusion Related Acute Lung Injury

Case Studies

Simplify, Don’t Mystify...
Pharmacology Update for Nurses

BARB BANCROFT, RN, MSN, PNP

9000 Drugs, Where to Start? Differentiate Quickly Among the Classes of Drugs with the “Suffix” of Each Class
- The “naxan”, the “pril”, the “capron” and the “sartan”
- The “prazosin” and the “ilika”
- The “idol”, the “alido”, the “load” and the “dipenex”
- The “coxib”, the “mabbi”, and the “platiemor”
- The “comaza”, the “cicilvex” and more

Clinical Uses and Mechanism of Action: The Key Things You Need to Know
- Analgesics, Drugs for Diabetes, Targeted Therapies
- Cholesterol-Lowering Agents, Anti-Hypertensives
- Anti-Fungal and Anti-Viral Agents

Understanding the Common Treatment Regimens for Selected Clinical Conditions
- Hypertension, Chronic Heart Failure
- Diabetes Mellitus Type 2
- Depression

You’re Taking WHAT??? Clinical Interactions Between Drugs, Alternative Therapies and Food
- The Effect of Grapefruit Juice on the Metabolism of Certain Drugs
- Foods with Potassium; Foods with Vitamin K
- St John’s Wort

Specific Mechanisms of Actions of Drugs in Popular Use
- The “Higinese System” and the “pril”
- The Nocturnal Laser and the “sartan”
- The Proton Pump and the “prazolase”

The Buzz on Medical Cannabis - What the Evidence Says
- Indications; Communications
- Methods & Issues with Use

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