Lessons from Assosa: Practical Nursing in Ethiopia

Bill 21 - Protecting the Public
LPN Practice Decision-Making Tool
Leg Ulcers

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 ABI
- Studies of Venous Insufficiency

Management of Arterial & Venous Leg Ulcers
- Medical Therapies & 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; Proliferative 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.

WHO SHOULD ATTEND?
- Nurses in Acute Care, Critical Care, and Long Term Care Settings
- Nurses in Home Care and Rehabilitation Settings
- Wound Care and Infection Control Nurses
- Adult Nurse Practitioners and Diabetes Educators
- Physiotherapists and Occupational Therapists

Dr. Kevin Woo is an internationally-recognized expert in wound care and has served on a number of panels and advisory boards to develop best practice recommendations in Canada and internationally. A recipient of the Early Researcher Award from the Ministry of Research and Innovation (2014-19) and the International Association for the Study of Venous Disease (ISVVD) 2015 Early Career Research Award (2012-13). He has authored or co-authored over 100 peer-reviewed publications and is the web editor for the Advances in Skin and Wound Care website, co-editor of the book Wound Care, A Clinical Source Book for Healthcare Professionals, 5th edition and a member of several editorial boards including Canadian Journal of Nursing Research, World Council of Enterothelial Therapy Journal, International Wound Journal, and International Journal of Lower Extremity Wounds. Dr. Woo maintains his clinical expertise and functions as an Advanced Wound Consultant at the West Park Health Center, a specialized chronic care and rehabilitation hospital.

$189.99 + $9.45 GST = $198.45 Regular Rate

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 “statin”, the “pros” the “triptans” and the “varens”
- The “prazoles” and the “ofils”
- The “closils”, the “lotsils” and the “dipins”
- The “czzhils” the “maphs”, and the “glizones”
- The “comalsils”, the “cyclorils” 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 “Highway System” and the “pros”
- The Neuralex Lister and the “statins”
- The Proton Pump and the “prazoles”

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

There are staggering number of drugs that nurses are expected to keep current with. Without some systematic way of categorizing the information, it’s easy to become overwhelmed by such a vast amount of information. This course is aimed at simplifying the volume of drug information into easier recall and to crystallise the key things you need to know about the major categories of drugs. And as always, a day with Barb Bancroft will include humour along with important clinical applications that will help you remember and apply the material on a daily basis in your clinical setting.

WHO SHOULD ATTEND?
- RNs, NPs, RPNs, & LPNs in All Areas
- Acute & Critical Care, Special Care Areas
- Geriatric, Home, Community, and Primary Care
- Outpatient Nurses, Occupational Health Nurses; Transition Coordinators
- Nurse Practitioners, Tele-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 pharmacology and as one of the most dynamic nursing speakers in North America today. Delivering her material with equal parts of evidence based practice, practical application, and humour, she has taught numerous seminars on clinical and health maintenance topics to healthcare professionals, including the Association for Practitioners for Infection Control, The Emergency Nurses’ Association, the American Academy of Nurse Practitioners, and more.

$169.99 + $8.45 GST = $177.44 Early Rate (on or before April 1, 2019)
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$189.99 + $9.45 GST = $198.45 Regular Rate (after April 29, 2019)
Contents | Spring 2019

4 | Regulatory Spotlight
Building Awareness, Protecting Patients: Bill 21

6 | Policies
Orders and Protocols, Pseudo Prescribing and OTC Medications

7 | MyHealth Records

8 | Cover Story
Lessons from Assosa: Practical Nursing in Ethiopia
An LPN writes eloquently about her time in Ethiopia: the challenges, the learning and all that she gained from her experience.

14 | Nursing with Heart:
Talking to a Leader in Harm Reduction

17 | Series
Marni Panas - How to be a Better Nurse to the LGBTQ2S+ Community

18 | 2019 CLPNA AGM & Conference

20 | CLPNA 2018 Year in Numbers

22 | Research
Nurse Work Life: A Preliminary Look at Alberta’s LPNs

24 | Professional Development
9 Things Every Nurse Needs to Know About Palliative Care

26 | Series
Finding Joy: Strategies for Meaningful Activity

29 | Alberta LPN News
Protecting the Public Interest

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In November 2018, the Alberta government passed Bill 21: *An Act to Protect Patients* which amends the *Health Professions Act (HPA)* and introduces a number of new requirements that apply to all regulated health professionals in Alberta.

**Concerning Sexual Misconduct**

The purpose of Bill 21 is to better protect patients from sexual abuse and sexual misconduct by regulated health professionals. Each regulatory college, including the College of Licensed Practical Nurses of Alberta (CLPNA), will define who constitutes a ‘patient’ in their Standards of Practice, but generally speaking, a patient can be anyone being provided professional services.

The amendments to the HPA define ‘sexual abuse’ and ‘sexual misconduct’ and establish obligations on health professionals and regulatory colleges. The new rules aim to ensure consistent penalties are applied to all regulated health professionals for findings of sexual abuse or sexual misconduct. If complaints involve conduct that falls under these definitions, then specific obligations are triggered, including:

- restrictions on the use of informal resolution procedures,
• requirements for the composition of Hearing Tribunals and training, and
• mandatory sanctions.

| Legislation in Effect |
Although most changes go into effect on April 1, 2019, some of the changes are already in effect, such as the additional information required from applicants at registration and the ability of the Complaints Director to appeal a Council decision to the Court of Appeal.

| Increased Transparency |
The amendments also give regulatory colleges new tools to increase public access to members’ disciplinary history and help maintain public confidence in the profession. Information available on the CLPNA’s website will be changing to provide more transparency around disciplinary decisions.

| Mandatory Sanctions |
There are mandatory sanctions for health professionals found to have committed sexual abuse or sexual misconduct towards a patient that go into effect on April 1:

• upon a finding of sexual abuse, the health professional’s practice permit must be permanently cancelled;
• upon a finding of sexual misconduct, the health professional’s practice permit must be suspended, although the length of the suspension or the imposition of more severe sanctions (including cancellation) are within the discretion of the hearing tribunal; and
• any health professional whose practice permit is cancelled for sexual misconduct towards a patient has a five-year prohibition on applying for reinstatement.

Due to the position of power and trust that health providers have over their patients, a consensual sexual relationship with a patient is not possible. The Standards of Practice specific to Boundary Violations (coming into effect on April 1) define when someone is considered a patient for the purposes of these sanctions.

| Patient Relations Program |
Under the new amendments, each regulatory college is required to establish a patient relations program. This program will include measures for preventing and addressing sexual abuse and sexual misconduct towards patients by regulated members by:

• establishing educational requirements for regulated members,
• establishing educational guidelines for the conduct of health professionals towards patients,
• providing training for the CLPNA’s staff, Council and Hearing Tribunals on trauma-informed practices, and
• providing information to assist the public in understanding the CLPNA’s complaints process.

| LPN Professionalism |
At the CLPNA, we know that the vast majority of LPNs maintain professional boundaries and treat their patients with respect and professionalism. These new amendments to the Health Professions Act serve as an important reminder for all LPNs to have a heightened awareness and professional respect for the power imbalance between health professionals and patients.

Learn more at www.clpna.com
Orders and Protocols, Pseudo Prescribing and OTC Medications

This past July, CLPNA released the Practice Guideline on Medication Management. The guide provides LPNs in all practice settings with the information required to ensure the safe, ethical and proficient management of medication. It’s intended to help LPNs make informed decisions using the best available evidence. This is the second in a three-part series designed to increase LPNs’ familiarity with topics addressed in the guideline.

Orders and Protocols

The administration of medication is a major component of practice for many LPNs. It’s up to every LPN to ensure they have the required knowledge, skill, and judgement to administer medications safely and competently.

Before any medication is administered to a client, LPNs must ensure they have a clear, complete, up-to-date, legible and clinically relevant order from an authorized prescriber. Any uncertainty about an order must be clarified with the prescriber prior to administration.

The administration of a medication is sometimes part of an ‘order set’ or a ‘protocol’. An order set is a predetermined, evidence-based tool used to manage a common state of disease (e.g., community acquired pneumonia) or to address a clinical need (e.g., standard admissions orders).

Well-designed order sets can positively impact staff communication, client safety, and overall care. Note that if order sets are used in an organization, the authorized prescriber should indicate the particular order (or orders) that applies to a specific client; standing orders are no longer considered to be best practice. LPNs can use
a client-specific order set in an electronic or pre-printed format received from an authorized prescriber.

A protocol is an approved, organization-specific guideline used to manage client health requirements (e.g., the Basal Bolus Insulin Therapy (BBIT) protocol developed to regulate diabetes management in hospital). Different practice environments may have varying protocols, but they should always be evidence-based and formulated using standardized criteria.

LPNs are responsible to ensure their employer policy supports them in implementing any protocol. In addition, LPNs must properly assess a client to ensure they meet the protocol’s criteria before administering any medication. Refer to the Practice Guideline for information regarding emergency situations and protocols for Schedule 1 drugs.

Pseudo-Prescribing Over-the-Counter (OTC) Medications

As healthcare professionals, LPNs may be asked for advice about over-the-counter medications and/or natural health products by clients or their family members. LPNs are not authorized to prescribe any medication, so it’s important to understand that any recommendations made (or advice given) to clients about over-the-counter products may be viewed as ‘pseudo-prescribing’.

LPNs should direct clients to discuss any over-the-counter medications with a healthcare provider authorized to provide such information. Once an authorized prescriber places a covering order for an over-the-counter medication, the LPN is then able to discuss it with the client and their family members.

Please refer to the Practice Guideline on Medication Management for more in-depth information on these topics. We also encourage LPNs to take the accompanying free online Medication Administration Self-Study Course at www.StudywithCLPNA.com.

Coming soon:
MyHealth Records

This year, the province will be launching MyHealth Records, an online tool that will give adult Albertans access to some of their personal health records from any computer, tablet or smartphone. Using MyHealth Records, Albertans will be able to view:

- medications dispensed from a community pharmacy,
- the majority of immunizations administered in Alberta, and
- common lab test results.

MyHealth Records will also allow users to upload and track information from health devices, including blood pressure monitors, blood glucose meters, and fitness trackers.

Evidence points to a number of benefits when patients have electronic access to health information. Studies report improvements in the quality of patient-physician interactions, with patients indicating they are better informed about their own health, such as being better prepared for provider visits and better able to appreciate the impact of treatments and preventive care. Many health systems also report benefits from providing patients access to laboratory test results by helping to reduce patient anxiety and in some cases, reducing the frequency of follow-up phone-ins and visits.

For more information on MyHealth Records and its features, visit https://myhealth.alberta.ca/mhr-provider
Lessons from Assosa: Practical Nursing in Ethiopia
Well, I have been here for pretty much a month now. I am located very close to the Sudan border in the westernmost part of Ethiopia in a town called Assosa. It is so very different from home, and very much what you think of when you think of Africa. Red dirt roads, lush green vegetation, most of the traffic on the road is donkey carts and ‘bajaj’ (three-wheeled covered scooters that will, uncomfortably, seat five).

The people here are amazing; I have never been to a place that is so welcoming and friendly. Everyone is always keen to talk and share; I don’t believe they get many Westerners here, so I can never blend in.

Ashley Holloway, licensed practical nurse (LPN), graduated from the Calgary campus of Bow Valley College (BVC) in 2006. Her nursing career has taken her from acute care, back to BVC as an instructor in their Nursing Simulation Centre, and now to her latest position in the post-diploma Health and Human Services Management program in BVC’s School of Community Studies.

August 2018 saw Ashley embark on a new adventure. She travelled to western Ethiopia for 16 weeks as a volunteer with Cuso International, a Canadian not-for-profit organization that works to eradicate poverty. One of Cuso’s focus areas is maternal, newborn and child health, which aligned well with Ashley’s interests and experience.

Writing about what she saw there allowed Ashley to stay connected to home and family, and helped her process the differences in medicine, culture, food and daily life that she encountered. Ashley’s emails are filled with detail and compassion. These excerpts tell the story of her time in Ethiopia.

The majority of the medical issues here result from infectious diseases, malnutrition, or poor hygiene. Typhus is very common, as is malaria and tuberculosis. The incidence of HIV is rising again. The focus of a large portion of healthcare funding is related to prevention and education; however, life here is often about choices. Bed nets are distributed in the communities, especially in rural areas; however, balancing the needs of today versus what may happen tomorrow often underlies how that bed net...
is used. The new baby that requires a hammock to sleep in tonight, or the need to strain the beans used for dinner, versus the risk that malaria may be contracted will define this. This isn’t simply about education, or lack thereof, it is about needs. Choices are made based upon necessity.

Cuso supports volunteers with a broad base of training, and then offers a great deal of independence. Ashley was advised to settle in for a month at the general hospital and then write a needs assessment and work plan.

I am starting to put together a plan from my needs assessment and am planning to implement some training for the nurses and hospital staff. For the nurses, vital signs and intramuscular injection training, and for the staff, some infection prevention and control training, along with empathy/compassion training. [I’ll work on] some protocol development for the physicians and the development of pamphlets for contraception, antenatal and postnatal care. If I can make any headway at standardization of the different wards, I certainly will; however, I feel that that task might be too much to take on in the time that I am here.

“Nursing gives you amazing skills you can use anywhere,” Ashley says. “It was always my intention to travel.” When she finished a Master’s in Public Health in 2017, it gave her the confidence to look for international opportunity. She chose to volunteer in Guatemala, a country where she had taught English back in the 1990s.

The project in Guatemala focused on bridging gaps between government healthcare and traditional midwifery. Ashley saw that both sides were passionate about caring for mothers. This was her first experience with medicine and maternal care outside the West, and it left her determined to repeat the experience.

She calls her discovery of Cuso’s health advisor position in Ethiopia “serendipitous”; the timing was right and so she set off for Assosa in August 2018. There, she discovered new challenges and new opportunity for learning.

I was recently assisting with a woman whose labour was induced due to eclampsia. She was on her second round of induction via intravenous oxytocin after the first attempt failed. As such, she had had several litres of fluid via intravenous. After [the physician] decided she was ready for labour, we helped her into the delivery room… [but] she was failing to progress. Because she had not had
the chance to void prior to being brought to the delivery room, I suggested that perhaps we could try to insert a urinary catheter to... create more space for the passage of the baby; the physician agreed, requesting something in Amharic [the local language] from the midwife in the room. She quickly brought over a set of IV tubing, which the physician broke/tore in half. ...It suddenly dawned on me what he was planning to do. I watched in a combination of horror and awe as he attempted to catheterize the woman with the broken tubing, the rough, jagged edges of the plastic being forced, unsuccessfully, into her urethra. I was struck by both the brutality of his attempt, as well as his creativity in working within the narrow limitations of the scarce resources available here. In the end, the woman was sent for a caesarean section and delivered a healthy baby boy.

Cultural expectations must be set aside when faced with the realities of medical care in a developing country. “There are reasons for their choices,” Ashley realized after her initial shock at some of the local medical protocols. “I needed to step back and re-evaluate my perception of how a health system should be run.”

This past week has been a mixture of ups and downs - I worked on the maternity ward, and assisted with a brutal abortion. Abortion is very common here, and it is legal in certain circumstances (most notably in cases of rape, socioeconomic status [such as extreme poverty], and if congenital abnormalities are detected). This particular woman was far enough along that she required a vacuum extraction and yet there was zero regard for her. There were no medications or sedation given, and the procedure was done in quite a vicious manner. I was appalled.

However, this was overshadowed by helping to deliver three beautiful babies yesterday. I applaud the women here, as the birthing process is highly de-medicalized, and seen as the natural process it is. The women were all fantastic, each delivery lasted no longer than a half hour, then they were up and walking to their rooms to greet a roomful of family and smiles. It was truly lovely, and I feel so honoured to have been a part of it.

When I first arrived, I thought the seemingly flagrant use of abortion was akin to culling out the population, removing those that would be seen as a burden on society. However, as I have spent more time here and have a greater appreciation for how hard and unforgiving life can be in Ethiopia, I realize that this practice is less about elimination and more about preservation. Balancing the needs and demands of a family with the addition of a child with high care needs is a balance very difficult to reconcile, often resulting in the neglect of the child and death. Rather than risk upsetting the already-difficult-to-achieve balance, one could argue that pre-emptive abortion is the more humane option for all.
Whether you or I agree with this is irrelevant; I will go home in two months to my life in Canada, where there are social supports aplenty to assist with mental illness and psychosocial support, physical and mental disabilities, access to proper abortion care and adequate healthcare, subsidized housing and daycare, and social assistance for those that need it, none of which are options here.

During her time in Ethiopia, Ashley tried to understand the daily challenges faced by local nurses, doctors and patients, while working towards her larger goal of achieving sustainable change.

I approach working at the hospital with a strange combination of both dread and awe; there are things that make me simply cringe, and others that fill me with wonder at the sheer ingenuity of the nurses and physicians, and I marvel at the approach to medicine here. They place high value on prevention, as the majority of health issues are related to infectious diseases or malnutrition. It does seem that their efforts are all for naught in some ways, but there are so many passionate people here trying to do right, we could certainly take some lessons from here.

I am currently working on implementing a protocol for standardizing the administration of analgesics and anxiolytics prior to an abortion. After having witnessed several such procedures where the women have suffered greatly, I feel an ethical and professional obligation to see these women receive proper and adequate medication.

As I spend more time in the various wards at the hospital, I am troubled by how Western medicine considers itself the pinnacle of modern medicine. As I observe the nurses, midwives and physicians practice their art, I have realized that the act of the true physical assessment is being lost in North America. The practice of medicine is much purer here, with doctors relying on their instincts, their knowledge, clinical presentations of their patients, epidemiological patterns and their physical assessment skills to make their decisions on treatment. In other words, they touch their patients. ... The medical ward does not have a functioning blood pressure cuff. The pediatric ward does not have a pediatric oxygen saturation monitor. Each ward has only one set of nasal prongs with which to administer oxygen; he with the greatest need receives it. Working amongst these conditions, one must rely on their knowledge of clinical manifestations of disease and strong physical assessment skills in order to triage who needs to be seen promptly and what can be done. They touch their patients to achieve this.
We relinquish our assessments over to technology in the West, assuming that it will uncover hidden truths within the body, that it will do the touching for us. I will not deny that technological advances have benefited medicine as a whole; miracles have been performed, patients have been healed that otherwise would not have been. However, my fear is that in our reliance on technology, on machines, on monitors, we will eventually lose the human element of medicine, the part that machines, monitors and technology cannot possibly provide: the power of human touch. We risk forgetting that there is indeed a human behind the patient. There is much healing in a simple hand on a shoulder, or the offer of a hug when the news is grim... It isn’t perfect, as no system is; however, despite the lack of resources, patients are still healed, patients recover, and patients are discharged home.

Ashley’s message to nurses considering volunteering abroad is simple: “Do it! As nurses, we enter the profession to help people. This is a way to help and get a great learning experience at the same time. It lets you really put your education to use.”

A few other things I have learned thus far are that a smile has the capacity to reach through any language barrier, that jalapenos can add flavour to almost any dish, that I didn’t realize how much water I actually drink until I now must pay for it every day, and that I place great value upon public restrooms (there are none here). And also that a hot shower really is lovely.

My time here in Assosa is almost complete, and I am feeling the stress of trying to finish up the projects I have been working on, including a proposal to the Federal Ministry of Health to include males in their HPV vaccine program, as well as (hopefully) developing a cervical cancer screening program for women, and training the hospital staff on infection, prevention and control measures.

Though there are times when working at the hospital filled me with a sense of dread and frustration, I feel I have gained more in my time here than I will be leaving behind.

Photos courtesy of Ashley Holloway and Cuso International

Cuso International is a not-for-profit development organization that works to eradicate poverty and inequality through the efforts of highly skilled volunteers, collaborative partnerships and compassionate donors. They have programs in North America, Latin America and the Caribbean, Africa and Southeast Asia.

Promoting access to quality basic healthcare is one of their three focus areas. Their volunteers work with local partners—including hospitals, health centres, universities and communities—to create long-lasting and sustainable change in areas such as quality healthcare and reproductive, maternal, newborn and child health services.

In collaboration with local partners, they develop and deliver trainings; work with health organizations to strengthen their capacity to provide quality care; and help promote community outreach programs designed to achieve greater use of health services.

They are currently recruiting for several health positions, including nurse and midwife advisors, health policy specialists, health education advisors and many others. For more information and to see available volunteer job posts, please visit www.cusointernational.org/placements or email cuso.recruitment@cusointernational.org.
Compassionate and completely committed to her profession, Marliss Taylor has been a registered nurse for well over three decades. She has made countless contributions to the health and medical field all while following a career path that is anything but conventional.

Marliss is a program manager with Streetworks, an inner city program that applies harm reduction principles to help street-involved people who use substances live safer, healthier lives. In her role at Streetworks, she makes a difference each day, helping people who use substances access important medical care and resources.

Marliss has contributed to harm reduction initiatives not only provincially and nationally, but also internationally in Guyana and Siberia. She has been recognized with both a Clinical Innovation Award and a Leadership Award from the Nursing Honour Society, and has received a YMCA Woman of Distinction Award in Health and Medicine.

Marliss talked to CARE Magazine about her nursing career, opioids and harm reduction, and the stigma surrounding substance users.

You’ve been a program manager with Streetworks for more than 20 years. Why have you dedicated your career to harm reduction?

For me, this is the way nursing makes the most sense. Abstinence or disease-based nursing is not the right solution for many. With people who use substances, there is often more to the story. Using a harm reduction approach means we do not demand things of people that they can’t do. We ensure people who use substances, and who are often involved in other risky activities like sex work, get the care they need. We help them be as healthy as possible by not putting them in a riskier environment than they are already in. This field lets me be the best nurse I can be.

You are clearly very passionate about what you do. What keeps that passion going?

I really love transcultural nursing. I get to come from a place where I look not at what people can’t do, but at what people can do. Some of the stories I hear would break your heart or make you angry, so it’s important to come at things in a positive way. This kind of nursing is relationship based. You really need to let yourself care about people and let them get to know you as a human being.

What impact is the opioid crisis having on nurses?

I think it has opened a door that many people don’t want open. It’s an area that many nurses don’t have confidence in; there is often a lack of understanding or even fear. I think most healthcare professionals knew opioids were a problem, but many had no idea of the magnitude. I think the overdose crisis has led to uncertainty for many nurses. They aren’t sure how to approach people who use substances or they react from fear.

What would you say to nurses about the stigma surrounding substance users?

I think many people stigmatize without realizing it. A lot of it comes from media messaging and pop culture - news stories and television shows showing people who use substances at their absolute worst. This kind of stigma prevents people from seeking help when they need it. They are afraid of judgement or afraid that their substance use will be put on record. Most nurses want to do their best, but when some don’t, the message gets out on the street. As a result, many people don’t receive care.

What advice do you have for nurses to help them care for patients who use substances?

Nurses are in an incredibly unique position to provide care and support to people who use substances, but the judgement piece is a killer. We must appreciate that people use substances for a reason. We need to treat people like people and move away from that notion of “good” or “bad”. Often people who use substances or who work in the sex trade are seen as one-issue people, but they are folks who also get appendicitis, or have babies, or catch a cold. Everything in their health picture is not about the at-risk behaviour. These are just people.
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The Personal refers to The Personal Insurance Company. Certain conditions, limitations and exclusions may apply. Auto insurance is not available in MB, SK and BC due to government-run plans.
**Why is recovery oriented language important?**
- Intentionally or not, language communicates collective meaning, attitudes, expectations, and actions of a society in both positive and negative ways.
- We should be striving to be:
  - Respectful and non-judgemental,
  - Hopeful and committed to the potential of every individual and their recovery journey.

**Recovery oriented language:**
- Is reflective of what other messages we may be sending,
- Is reflective of how others might understand what we are saying/writing/thinking,
- Conveys a sense of hope and potential for the individual,
- Conveys an expectation for recovery and progress,
- Is person centred, respectful, and empowering.

For more information about Recovery Oriented Language or to request a presentation about mental health, stigma, recovery oriented language, or suicide awareness, contact:

CMHA-Edmonton  
t: 780.414.6300  
education@cmha-edmonton.ab.ca  
Visit www.edmonton.cmha.ca

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**Recovery oriented language**:  

**Is person centred**
- “People with mental illness” vs “The mentally ill”.

**Is not discriminatory or insulting**
- “He is not himself” vs “He is acting crazy”.
- “She is experiencing hallucinations” vs “She’s lost her mind”.

**Doesn’t equate diagnosis with identity**
- “She has schizophrenia” vs “She is schizophrenic”.
- “His name is Jack” (no mention of his mental illness) vs “He’s bipolar”.

**Emphasizes abilities over limitations**
- “They are committed to psychotherapy” vs “They refuse to take medication”.
- “She feels she can use her coping skills to manage the illness” vs “She is resisting additional treatment”.

**Doesn’t imply that people who recover are an anomaly**
- “They are moving along in their recovery journey” vs “They actually recovered from schizophrenia”.

**Doesn’t sensationalize**
- “She is living with anorexia” vs “She is a victim to her anorexia”.

**Doesn’t equate suicide as a crime or as a success**
- “He died by suicide” vs “He committed suicide”.
- “She attempted to take her own life” vs “She had a failed attempt at suicide”.
- “He suicided” vs “He was successful at suicide”.

**Doesn’t minimize, stigmatize or promote difference**
- “I like order” vs “I’m really OCD about that”.
- “That frustrated me” vs “That made me crazy”.
- “It changes often” vs “It is really schizoid”.
As the Program Manager, Diversity and Inclusion for Alberta Health Services (AHS), Marni Panas co-leads the development and implementation of a provincial diversity and inclusion plan aimed at creating safe, welcoming and inclusive environments for AHS staff, patients and families. Part of her work involves providing education and supports to LPNs so that they can better serve the LGBTQ2S+* community. As the healthcare providers who are often the first line of contact for their communities, it’s important for LPNs to be committed to making everyone feel safe and included in their healthcare experience.

How can LPNs be better nurses to the LGBTQ2S+ community?

The most powerful tool is knowledge. Get to learn about people who may be different than yourself, know some of the barriers that this community faces, and get to know the language that we use. Get to know the patient so that you can treat them the way they wish to be treated. This will change from patient to patient.

Ensure that when transitioning care to someone else, you involve the client in the conversation and ask if they want to share any of this information – involve them in those decisions.

What are some of the barriers that LGBTQ2S+ people experience in the health community?

A lot of it has to do with a lack of knowledge and confidence in one’s competence to provide care to trans and non-binary people. Many people don’t have experience working with trans people, so they [the patient] are told to go somewhere else but quite often there’s no place else to go. But most of the time when I’m going to see a healthcare provider it has nothing to do with being trans; that just happens to be one adjective of many which describes me.

Discrimination is definitely a big barrier. That often comes from lack of experience working with or knowing people who are trans, or not knowing anybody in the sexual and gender minority community.

Some of the other barriers are the systemic issues, like how we track information in patient records and whether the records are able to support all identities of people, and how we get around that if they’re not.

What would you like LPNs to keep in mind during their daily work?

Like any other patient, they are people first. Remember that there is a human on the other side of that diagnosis or on the other side of that bed.

Where should LPNs go for guidance and to learn more?

Go to the AHS website (www.albertahealthservices.ca/info/Page15590.aspx), which has information for and about LGBTQ2S+ people. Throughout the province, there are many community-based resources like Pride centres and other community groups who are working very closely with members in the LGBTQ2S+ community, so there are great opportunities for education. It’s also important to understand that it’s not always the job of that trans person or that marginalized person to educate you.

What if I make a mistake?

If somebody was to misgender me or use my incorrect pronoun, I will correct them, every single time, and your response would be “I’m so sorry. I will try harder next time.” And then try harder next time. That’s really important. Sometimes we’re not going to get it right. But we need to recognize it, take ownership and then try harder and continue moving forward.

*Lesbian, gay, bisexual, transgender, queer, questioning, and 2-Spirit. The + indicates other sexual and gender minority people who may not be included in the identified terms. This acronym has changed over time and is an example of how language is constantly evolving as cultural and societal understanding grows.
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.

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**NEW FRESH FORMAT**

**KEYNOTES**

**Falling through the Cracks: Greg’s Story**
Teri Price and Dave Price, Greg’s Wings Projects

Falling Through the Cracks: Greg’s Story is a short film on Greg Price’s journey through the healthcare system. The film gives a glimpse of who Greg was and focuses on the events of his healthcare journey that ended in his unexpected and tragic death. In spite of the sadness of Greg’s story, the film is intended to inspire positive change and improvement in the healthcare system.

**10 Top Causes of Unprofessional Conduct**
Jim Casey, QC Partner, Field Law

Renowned regulatory lawyer Jim Casey, Q.C. shares an illuminating presentation from his experiences with hundreds of unprofessional conduct cases in a broad range of professions.

**NEW FRESH FORMAT**

**ANNUAL GENERAL MEETING**

**LPNs ENCOURAGED TO ATTEND**

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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2019 CLPNA AGM & CONFERENCE

www.clpnaconference.com
CLPNA 2018 YEAR IN NUMBERS

1047
Alberta Graduate registrations
2017 - 1390

434
Out of Province registrations
2017 - 444

259
IEN registrations
2017 - 411

16,657
total LPN registrations

92%  8%

212
complaints received

23
hearing tribunals

38
average age of LPNs
90% of Canadian-trained candidates passed CPNRE Exam on 1st write

Employment Status

10,360 FT/PT
78%

2979 Casual
22%

5% growth in registration

Practice Consultations

2401 inquiry responses

Continuing Competency Validation

3165 members selected

10 research projects

9 practical nurse programs
Nurse Work Life: A Preliminary Look at Alberta’s LPNs

By CLPNA Staff Writer

With Alberta’s aging population, the overall demand for nurses to provide continuing care to seniors is projected to steadily increase over the next 20 years. Demands on the nursing workforce will also intensify as care needs around complex, chronic diseases continue to grow. In addition to these shifts in our health system, a considerable portion of the nursing workforce is heading towards retirement. To meet the demands of ongoing shifts in our health system, it is critical to support a resilient and stable workforce and their fitness to practice into the future.

It is well documented that nurses face many physical and emotional challenges in their work. This can lead to burnout, anxiety, turnover, and increased intent to leave nursing practice. To support a strong, resilient nursing workforce, it is important to understand the work life of nurses. In the literature, there has been considerable interest in the work life of nurses. Much attention has been paid to nurse burnout and resilience. Attention has also been given to nurse health-related quality of life, particularly its association with workforce retention and intention to leave the profession. Increased understanding in these areas has valuable implications for creating healthy, supportive work environments which have been linked to nurse retention and reduced nurse turnover rates. So far, there has been limited research in these areas specific to licensed practical nurses (LPNs).

In August 2018, the College of Licensed Practical Nurses of Alberta (CLPNA) surveyed its entire membership to closely examine the work life of Alberta’s LPNs. Informed by the literature, the CLPNA Member Survey 2018 included questions on work environment, burnout, resilience, intention to stay, health status, and quality of life.
Several standardized questionnaires were included in the survey including the following. The Maslach Burnout Inventory (MBI) looks at Emotional Exhaustion, Depersonalization, and Personal Accomplishment. These three areas represent feelings individuals have about their work and the people with whom they work closely. In general, someone who’s feeling more positive towards their work will be lower on emotional exhaustion (feeling emotionally overextended and exhausted by one’s work) and depersonalization (an unfeeling and impersonal response towards others), and higher on personal accomplishment (feelings of competence and achievement in one’s work). The Connor-Davidson Resilience Scale (CD-RISC 10) looks at resilience, which is seen as a combination of personal attributes that enable an individual to cope with demanding life circumstances. The Practice Environment Scale of the Nursing Work Index (PES-NWI) examines nurses’ perceptions of their practice environment, including the nature of their relationships with their leadership and other healthcare professionals, the adequacy of staffing and resources to provide quality care, and the availability of opportunities to participate in workplace activities. The Intent to Stay Scale is a measure of a nurse’s intentions to stay with their current unit/facility, employer, and their profession. The higher the score, the more likely the nurse intends to stay with their current unit/facility, employer, and the profession.

Overall, 4,425 LPNs completed some or all of the survey items. This constituted 28% of the registered LPNs in the province. As a group, the LPNs who participated in the survey are almost identical to the reported population demographics in the CLPNA’s 2017 Annual Report. As shown in Graph 1, participating LPNs have similar burnout scores to other human services professions. Their burnout scores indicate they generally have moderate Emotional Exhaustion, low Depersonalization, and a high sense of Personal Accomplishment (Graph 2). As shown in Graph 3, in Community Care and ‘Other’ work settings, participating LPNs indicate favourable work environments. In Acute Care and Continuing Care, they indicate mixed feelings with regard to the measured aspects of their work environment. When asked to indicate if they intend to leave their current work environment and the profession, participating LPNs indicate they are highly unlikely to leave (Graph 4). In addition to these findings, participating LPNs reported a resiliency score indicating a high capacity to cope with demanding work and life stressors. Further analysis will confirm these preliminary findings.

The CLPNA Member Survey 2018 offers a rich dataset unlike any previously collected in the province on LPNs. The information is highly relevant to the current Canadian healthcare context and can inform activities (e.g., professional development) that enhance the professional well-being and fitness to practice of LPNs. Understanding the context in which LPNs work is an essential step in creating better work practices and environments, benefiting both the profession and ultimately the quality of care for patients.

References available on request.
Professional Development

9 Things Every Nurse Needs to Know About Palliative Care
By Katherine Murray

As our population ages, nurses will care for more people who are dying. As a nurse, you may think of dying as a steady decline in the last six months of life. Interestingly, this is not what dying looks like for most people.

1. Seventy to 90% of Canadians living with chronic life-limiting illnesses experience a stuttering decline (see figure). This decline is common for respiratory, cardiac, and kidney diseases, organ failure and some cancers.

Many times, death appears imminent but then the crisis passes, and the person improves. The person and family may not recognize the decline, may not realize that death is near, and thus, when death occurs, it may feel sudden and unexpected.

What You Can Do: Help the person and family to identify the decline – ask about changes over the past years, months, weeks. Consider asking, “If this pattern continues, what do you think might happen in the coming months?”

2. Cross-country research suggests that Canadians do not know what palliative care is. The World Health Organization offers this definition:

“Palliative care is an approach that improves the quality of life of persons and their families facing the problems associated with life-limiting illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.”

What You Can Do: Educate yourself about palliative care and develop skills for explaining palliative care to people in your community. Teach them that palliative care is beneficial for any dying person, regardless of the decline. Advocate for excellent palliative care.

3. Predictions are difficult, especially for a person experiencing a stuttering decline. Dr Joanne Lynn states that 50% of people dying with chronic life-limiting illness will not know the week before they die that this is their last week.

What You Can Do: Monitor a person for decline in functional abilities. Collaborate with the team and ask, “Could they be dying?” (See Tools: SPICT)

Provide early, frequent opportunities for the person and the family to establish and update goals of care and participate in serious illness conversations. These conversations may improve quality of living and dying as well as help prepare for loss, grief and time of death.

4. The Framework on Palliative Care in Canada states that 90% of people with chronic illnesses can benefit from early integration of palliative care.

What You Can Do: Develop skills, knowledge and attitudes for integrating a palliative approach into the care for people with any life-limiting illness, early in the disease process, across all care settings.
Care of the dying person is the responsibility of every nurse. Maintaining quality of life requires early, effective symptom management.

According to Palliative Care Australia, 65% of the dying can be well cared for by their primary care teams and do not require specialist supports. In Canada, 70% of dying individuals do not access specialty palliative care teams.

**What You Can Do:** Use standardized tools to identify symptoms early and complete impeccable assessments (See Tools). Use the SBAR to communicate assessments and increase the nurse’s ability to advocate for appropriate care. Refer to symptom management guidelines in your location and at the web resources Pallium and Virtual Hospice.

Palliative care is best when provided by a team.

Whether you work in a large urban centre, rural or remote settings, providing palliative care with a team will best support the person and family.

**What You Can Do:** Wherever you work, create and cultivate a team. Get to know colleagues, the interprofessional team, volunteers and family. They are vital members of the team.

The Canadian Hospice Palliative Care Association Process of Providing Care includes two additional steps (in bold): assessment, information-sharing, decision-making, care planning, implementation and evaluation.

**What You Can Do:** Share information before asking people to make decisions. Assess how information is best shared and how decisions are made. Support people to make decisions in a way that works for them personally and culturally.

There are instances when symptoms do not settle, or when the psychosocial needs of the person and family exceed the capacity of the team providing care.

**What You Can Do:** Identify the palliative care team, specialists or consultants and learn how to access them. If these resources are not currently available, advocate for connections.

Virtual Hospice provides excellent support for professionals, and people living with illness and their loved ones.

Caring for people is special and sacred. It is also hard.

**What You Can Do:** Cuidate (qwee-da-te): Spanish for “take care.” Take care of yourself so you can better provide care for others. This is difficult work. To quote Rachel Remen, 8

“The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet.”

Tools

- **SPICT™ (Supportive and Palliative Care Indicators Tool)** Screening tool for identifying people at risk of decline and dying.
- **ESAS (Edmonton Symptom Assessment System)** Quick self-assessment tool that identifies presence of symptoms.
- **PPS (Palliative Performance Scale)** Provides a snapshot of the person’s level of ambulation, evidence of disease, self-care, intake, and level of consciousness, and allows for tracking of overall trajectory.
- **OPQRSTUVW Symptom Assessment Tool** A framework for a thorough assessment of symptoms.
- **SBAR Situation – Background – Assessment – Request/Recommendation** A tool for ensuring precise and concise communication.

Tools are available in Essentials in Hospice and Palliative Care: A Practical Resource for Every Nurse, Katherine Murray, 2016.

Final Thoughts

Regardless of where you work, I hope that these ideas can inspire and help you to integrate a palliative approach in caring for any person living with chronic life-limiting illness.

For more information, visit https://lifeanddeathmatters.ca

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2Family as defined by the person. Ibid
4Explore colleges, online programs, Pallium [https://pallium.ca/], Virtual Hospice [http://www.virtualhospice.ca/] and Life and Death Matters [https://lifeanddeathmatters.ca/].
6Ariadne Labs: Resources, Downloads and Tools: https://www.ariadnelabs.org/
In the first three parts of this series, we discussed how to create opportunities for meaningful activity in the areas of work, self-care, leisure and rest/restoration. In this final installment, the focus is on simple ideas to enrich the continuing care environment.

Environments that Support Meaningful Occupation

Dementia care expert David Sheard (Dementia Care Matters™), makes the distinction between being occupied and engaging in organized activities: being occupied is about filling the day with things that are meaningful to us. These can be spontaneous, singular, need little skill, take seconds, minutes or hours.

Organized activities, on the other hand, take up only a small percentage of our time (a cooking or exercise class, a day skiing with friends). They usually involve more than one person, occur at a set time and need someone to coordinate and run them. Examples of organized activities for residents include a trip to the country to watch the combines at work, a music class, a baking or craft session, a musical crossword puzzle, making s’mores over a propane campfire, a Zumba or polka class.

Scheduled group activities can’t possibly meet the needs of every person throughout each day – but caregivers can create a rich environment where residents can occupy themselves in spontaneous, meaningful ways:

<table>
<thead>
<tr>
<th>Category</th>
<th>Items / Activities To Support Spontaneous, Meaningful Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensory</td>
<td>Busy aprons and waistcoats, pictures on the walls, fresh flowers, soft blankets, music playing, pleasant food aromas: cookies, bread baking, an onion roasting, baskets of colourful textured balls and bean bags, hand massage, hand-holding, soft fabric.</td>
</tr>
<tr>
<td>Domestic</td>
<td>Dusters, carpet sweepers, washing tables, putting away their clean laundry, baskets of children’s socks to sort, baby clothes to fold.</td>
</tr>
</tbody>
</table>

In 2016, over 25% of licensed practical nurses worked in continuing care facilities. LPNs are key team members in the care of Alberta’s aging and elderly. This 4-part series from the Seniors Health Strategic Clinical Network aims to help nurses find realistic, thoughtful ways to engage their residents/clients.
### Category | Items / Activities To Support Spontaneous, Meaningful Occupation

**Comfort**
- Items appropriate to the person such as pictures of family, memory books, video/audio messages from family, soft blanket, stuffed animal, other items they enjoy.

**Rummage**
- Boxes of handbags, trays of jewellery, drawers of clothing and bags to pack the clothing in, sewing supplies (thread, buttons, lace, elastic, fabric and leather scraps), nuts and bolts, bits of wood.
- Toolkit, tackle box, purses with items in them. Some items could be attached to a fabric placemat or to belt loops.

**Cognitive**
- Catalogues and magazines, poems, puzzles, word association games, reading or listening to someone read the newspaper, watch a movie and talk, bingo, ability-appropriate activities with playing cards (sorting by suit, turning all face-up).

**Movement**
- Scarves for dancing, blowing bubbles, balloon toss, bowling pins and ball, music that promotes dancing/movement.

**Musical**
- Instruments, music posters, sing-alongs.

**Spiritual**
- Pictures of waves or religious scenes, birdsong, Bibles, hymns, pussy willows (sign of hope), audio of family praying in the resident’s first language.

**Normal life**
- Sort socks in pairs, sort shoe laces and buttons, polish shoes, provide newspapers to browse.

**Work life**
- Fill envelopes, jobs from the past.

**Fun**
- Puppets, feather boas, DVDs (e.g., I Love Lucy), rain sticks, accessible art items.

**Art**
- Photos, paintings, silk flowers to arrange or sort, paint supplies, colouring supplies.

### 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.

### Update the Care Plan

Share things that help residents smile with the family and care team, and become part of the care plan. Remember to consider residents as participants in planned recreational activities now that they are more awake!

Monitor and document the effects of these activity interventions on responsive behaviours and ask families for their input.

### Summary

Meaningful activities address underlying boredom, loneliness, frustration and lack of purpose or enjoyment. Responsive behaviours may be reduced when the person experiences pleasure, joy, relationships, a sense of purpose and enhanced well-being. A reduction in intensity or frequency of responsive behaviours may be more realistic than elimination, but never underestimate the power of the little things. Good feelings linger, whether it’s a belly laugh, a warm hug, a sing-along, doing something helpful, or an interesting discovery in a rummage drawer.
**Don’t miss one of our highest rated workshops! **
Three Seats on CLPNA’s Council up for Election

**2019 ELECTION DISTRICTS**

DISTRICT 1: SOUTH (Lethbridge, Medicine Hat & area)
DISTRICT 3: SOUTH CENTRAL (Red Deer & area)
DISTRICT 5: NORTH CENTRAL (Jasper, Slave Lake, Cold Lake and area)

Nominations accepted until May 31.

Leaders of all types, planners, strategists, evaluators and budgeters, are eyeing the call for nominations to CLPNA’s Council. Three large areas are up for election surrounding the major centres of Lethbridge, Medicine Hat, Red Deer, Jasper, Slave Lake, and Cold Lake. LPNs considering throwing their hat into the ring must live in the election district.

Successful Council members are team-oriented servant-leaders focused on the future of the LPN profession. Council’s role is to regulate the profession and oversee the CLPNA’s management, actions, and policy development within the framework of the Health Professions Act. They meet quarterly with occasional additional meetings or teleconferences. The three-year terms begin September.

In the south, a tremendous thank you is extended to Richelle Cash, LPN, the representative for District 1 for completing two terms of service. This District will not have an incumbent running. District 3 and 5 may have their current single-term representatives run again. A June election will decide.

Nomination Forms must be submitted by May 31. Eligible LPNs must hold an Active CLPNA Practice Permit and live in the election district. To discover your District, use the “Find My Election District” document to look up your town or city of residence.

The CLPNA’s primary responsibility is regulating the LPN profession, setting and maintaining standards to ensure the public receives safe, competent, and ethical healthcare services. The CLPNA is governed by a Council, which consists of members of the profession (elected by peers) and three government-appointed public members.

Find Nomination Forms and more at www.clpna.com by searching “2019 Council Nominations”, or contact info@clpna.com, 780-484-8886 or 1-800-661-5877 (toll free in Alberta).
‘Can This LPN Do That?’: Answers from the LPN Practice Decision-Making Tool

In the minds of healthcare managers and licensed practical nurses (LPNs), maybe the question is more accurately:

“Can this particular LPN perform this nursing activity, intervention, or role, taking into consideration their education, experience, role, regulatory authority, and accountability?”

For example, “Can my employee Jane, LPN, give immunizations to children under five years old?”

The frequency of these types of questions encouraged the College of Licensed Practical Nurses of Alberta (CLPNA) to create a tool to help employers and LPNs determine the parameters of safe and authorized practice for an LPN in Alberta.

The **Licensed Practical Nurse Practice Decision-Making Tool** leads the user through increasingly more specific considerations to determine whether a role or activity is appropriate. Applicable to all practice settings, it considers the individual nurse’s education, experience, role and accountability within the LPN scope of practice.

Find the LPN Practice Decision-Making Tool at www.CLPNA.com under the Governance tab.

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Our Apologies

Sharp-eyed readers noticed we didn't show any representatives of our male LPN members on the cover of CARE’s Winter issue.

We sincerely apologize for the unintentional oversight and for any hurt this may have caused.

The CLPNA is committed to accurately representing our diverse membership and aims to more precisely hit that target in future.
Ending PJ Paralysis

“PJ Paralysis” is a term describing the negative physical and psychological effects experienced by patients who spend lengthy periods of time inactive and in a hospital gown or pyjamas while in hospital. People on lengthy stays can lose muscle strength, which leads to longer hospital stays. Wearing a hospital gown or pyjamas can also make a person feel less human, more vulnerable and constantly remind them they’re ill.

The End PJ Paralysis movement was started by Professor Brian Dolan of the United Kingdom’s National Health Service.

If patients stay in their pyjamas for longer than they need to, they have a higher risk of infection, loss of mobility, fitness and strength, and will ultimately stay in hospital longer. If we can help patients get back to their normal routine as quickly as possible, including getting up and out of bed, this will mean a quicker recovery.

- Bedbound patients lose 1 – 5% of their muscle strength every day they are in bed.
- For an older person, a loss of muscle strength can make the difference between dependence and independence.
- Many patients lose the ability to carry out routine daily functions like bathing, dressing, getting out of bed and walking, due to unnecessary bed rest.
- Every 10 days of bed rest in hospital is the equivalent of 10 years muscle aging for those over 80.

The #EndPJParalysis movement is a joint effort between healthcare providers, patients and their families. This approach encourages family members to contribute to the care of their loved ones by bringing in items such as day clothes, well-fitting shoes and toiletries.

Discover more ideas on how to End PJ Paralysis by watching the video presentation on www.StudywithCLPNA.com.
LPN Specializations and Authorized Restricted Activities

Two new Practice Policies help clarify that high-risk nursing practices require additional education and some areas may also have supervision requirements. High-risk areas of practice are considered restricted activities under provincial legislation and may be associated with one of the five specialty areas: Immunization, Advanced Foot Care, Perioperative, Dialysis, and Advanced Orthopedic. Details about the authorization and the requirements to practice in a specialty area or to perform a specific restricted activity are described in the CLPNA’s Practice Policies on “Specialized Practice Areas” and “Authorized Restricted Activities for Licensed Practical Nurses”.

Privacy, Confidentiality, Duty to Report

Three documents help Licensed Practical Nurses navigate between different obligations related to privacy, confidentiality, and reporting of information. It is a professional and ethical responsibility to practice within relevant laws governing privacy and confidentiality. However, this duty must also be balanced against the need to disclose information in certain situations. Specific information about key considerations that help LPNs maintain confidentiality, the relevant privacy law for an LPN, and situations that require reporting are described in the CLPNA’s Practice Guideline on “Confidentiality” and Interpretive Documents on “Privacy Legislation in Alberta” and the “Duty to Report”.

Immunization Regulation Duties

The Alberta Government introduced a new regulation on immunizations in late 2018. The CLPNA’s Fact Sheet on “Immunization Regulation Duties” outlines the obligations and/or requirements that are relevant for all LPNs and LPNs practicing in the Immunization Specialty. Topics mentioned in the Fact Sheet include the reporting of adverse immunization events; the storing, handling, and transporting of vaccines; and other reporting requirements.
As a person with dementia, I have the same human rights as every Canadian as outlined in the Canadian Charter of Rights and Freedoms. The following charter:

- Makes sure people with dementia know their rights,
- Empowers people with dementia to ensure their rights are protected and respected, and
- Makes sure that people and organizations that support people with dementia know these rights.

As a person with dementia, the following rights are especially important to me. I have the right:

1. To be free from discrimination of any kind.
2. To benefit from all of Canada’s civic and legal rights.
3. To participate in developing and implementing policies that affect my life.
4. To access support so that I can live as independently as possible and be as engaged as possible in my community. This helps me:
   - Meet my physical, cognitive, social, and spiritual needs,
   - Get involved in community and civic opportunities, and
   - Access opportunities for lifelong learning.
5. To get the information and support I need to participate as fully as possible in decisions that affect me, including care decisions from the point of diagnosis to palliative and end-of-life care.
6. To expect that professionals involved in my care are:
   - Trained in both dementia and human rights.
   - Held accountable for protecting my human rights including my right to get the support and information I need to make decisions that are right for me.
   - Treating me with respect and dignity.
   - Offering me equal access to appropriate treatment options as I develop health conditions other than my dementia.
7. To access effective complaint and appeal procedures when my rights are not protected or respected.

It will take the effort of every Canadian to protect and respect the rights of people with dementia so that we are seen as valuable and vital community members.
You are never too old to set a new goal or to dream a new dream.

- C.S. Lewis -
How to... 
Deal With Difficult People
...without becoming one yourself!

EDMONTON, June 3, 2019 • CALGARY, June 10, 2019
0830 to 1600 hrs.

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

Why Are People Difficult... 
Or What They Didn’t Teach Us In Nursing School
• ‘Difficult’ or just ‘Different’?
• ‘Insensitive’ or ‘Intentional’?
• Demonstrated Behaviours versus Personal Traits
• Pay-offs for Dysfunctional Behaviours
• ‘Upset’ versus ‘Difficult’

Understanding Difficult Behaviours
• Difficult People Defined
• Who is Difficult for you to Deal With?
• Specific Challenging Behaviour Patterns
• Do’s and Don’ts for Managing ‘Difficult’ Interactions

Self-Management
• The Triple ‘F’ Response
• How to Turn Emotion into Empathy
• A Four-part Process for Dealing With Difficult People
• A Distanced View of Close Things
• A Helpful Self-Management Strategy - Coping Self-Talk
• Tips for Overcoming Negative Aspects in Yourself

Name The Game
• Know Your Hot Buttons; Make the Conver Oathers

Turn Conflicts Into Cooperation
• Helpful Tips for Managing Conflict and Anger
• Acknowledge, Don’t Argue; Side-stopping Debates
• Helpful Communication Techniques for Responding to Difficult People
• The Five ‘F’ Formula

When Difficult People Don’t Change
• Organization Strategies
• Continuum of Intervention in Conflict; When to Call in Help

STACEY HOLLOWAY, BScN
Stacey Holloway is a skilled interventionist in the fields of Human Relations and Organizational Development. Stacey focuses her talents and energy on organizational development - particularly, change educators, change strategy consulting, and change leadership development. A graduate of UBC and Senior Trainer at the BC Justice Institute in the Centre for Conflict Resolution, she is an in-demand speaker. Stacey has conducted seminars for thousands across Canada and the United States. Her active, participatory seminars are charged with energy, humour, and creativity.

Interpretation of Lab Tests
To register: Call toll-free 1.866.738.4823 or visit NursingLinks.ca

LETHBRIDGE, June 4, 2019 • Lethbridge Lodge
0830 to 1600 hrs.

BARB BANCROFT, RN, MSN, PNP
Windows on an Inner World: the White Blood Cells
• Importance of WBC’s: Mature and Immature Cells
• Functions of Each of the WBCs: Neutrophils - Segs and Bands; Monocytes; Basophils and Eosinophils; Lymphocytes
• Up, Down and All around - Which Changes in WBC’s indicate:
• Acute inflammation, Infection and Neutrosis?
• 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 Variances 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 Variances in RBC Function
• The Anemias - Iron Deficiency, Megaloblastic Anemia, Folic Acid Deficiency, Sickled Cell Anemia, Drug Induced Anemias

The Body’s Enzymes: What You Most Need to Know About:
• AST, ALT, CK, Ampholas, Lipase; When and why they Eulate
• What do the Elevations Mean for Liver Function, Cardiac Function, Muscle Integrity and Pancreatic Function?

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, in the primary care facility, or in the ICU. The BWC and differential is discussed as it relates to viral infections, bacterial infections, and parasitic infections. Iron deficiency anemias will be differentiated from B12 and folic 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.

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 is 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 continuing education topics to healthcare professionals, including the Association for Practitioners for Infection Control, The Emergency Nurses Association, the American Academy of Nurse Practitioners, and more.

CARE | SPRING 2019 35