Challenging Geriatric Behaviours

EDMONTON, Thurs. October 3, 2019 • CALGARY, Thurs. October 17, 2019

0830 to 1600 hrs

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

*** Brand New Workshop! ***

STEVEN ATKINSON, PA-C, MS

Steven Atkinson, PA-C, MS, is a Board-Certified Physician Assistant specializing in Geriatric Internal Medicine. He practices medicine in the greater Minneapolis area. In addition to his private practice, he has been on the faculty at the University of Utah since 1994 and involved in medicine for over 30 years. Steven is the co-founder and co-owner of Twin Cities Physicians, which serves older adults in nearly all levels of their care. He has presented internationally for over 15 years, primarily speaking about geriatric-related syndromes. Steven is a published author and sits on several boards whose purpose is to elevate the level of care in medicine for the patients they serve. Steven has been described as a “dynamic” educator and one of the most engaging presenters around. Don’t miss him!

Who Should Attend?

- Nurses Who Work With Geriatric Clients in Acute, Long Term, Ambulatory, & Community Settings
- Home Health Care Staff, Geriatric Day Staff
- Physical Therapists, Occupational Therapists, Recreational Therapists
- Social Workers, Dieticians, Pharmacists

Even experienced healthcare professionals can be challenged working with cognitively-impaired geriatric patients. This one-day workshop will give you proven strategies to manage behaviours such as: dementia, aggression, anxiety, depression, refusal of food and fluids, inappropriate sexual advances, and refusal to give up driving when unsafe. If older adults are routinely under your care, this program will help minimize the risks of problems associated with troublesome, often irrational behaviour. Gain valuable insights into the causes of challenging geriatric behaviours and learn innovative and practical intervention strategies to improve the care you provide. Leave this seminar with practical techniques that you can apply the next day!

- $198.00 + $9.45 GST = $207.45 Middle Rate (on or before September 30, 2019)
- $199.00 + $9.95 GST = $208.95 Regular Rate (after September 30, 2019)

Physical Assessment Pearls

RED DEER, October 29, 2019

0830 to 1600 hrs

Holiday Inn Gasoline Alley

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

BARB BANCROFT, RN, MSN, PNP

Barb Bancroft is a widely acclaimed nursing teacher who has taught courses on Advanced Pathophysiology, Pharmacology, and Physical Assessment to both graduate and undergraduate students. Also certified as a Pediatric Nurse Practitioner, she has held faculty positions at the University of Virginia, the University of Arkansas, Loyola University of Chicago, and St. Xavier University of Chicago. Barb is known for her extensive knowledge of pathophysiology and as one of the most dynamic nursing speakers in North America today. Delivering her material with equal parts of evidence based practise, 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.

Who Should Attend?

- Med-Surg & Acute Care Nurses Wishing to Refresh Their Skills
- Nurses New to Acute Care or Med-Surg Areas; Float Nurses
- Home Care, Continuing Care, or Geriatric Nurses
- Tele-Health and Occupational Health Nurses
- Nurses Wishing to Refresh Their Physical Assessment Skills

* This workshop may be too basic for critical care nurses *
* This workshop is not a “hands on” physical assessment course *

Join Barb Bancroft and learn to master Physical Assessment of your patient! In taking the history, learn to characterize the chief complaint by asking the right questions the “PQRST + AAX” way. Barb provides examples of how to use this mnemonic to get the most important information in the least amount of time. Barb will then guide you through assessment basics: where to “listen”, where to “look”, and where to “feel” if you only have a minute. Barb correlates anatomy, physiology, and pathophysiology for each major system discussed. Refresh your knowledge on all the info you can glean from a basic vital signs evaluation. Barb will also discuss various drug classes and the side effects that can confound a physical exam. Join us!

- $198.00 + $9.45 GST = $207.45 Middle Rate (on or before October 15, 2019)
- $199.00 + $9.95 GST = $208.95 Regular Rate (after October 15, 2019)
Over 200 LPNs or about 1% of the CLPNA’s membership experienced a formal complaint of unprofessional conduct in 2018. With so few experiencing these allegations, many may wonder about the disciplinary process. What is a complaint, and who can make one? What standards are LPNs held to? And what’s the responsibility of the CLPNA in the process?

**STANDARDS & DUTY**

Licensed Practical Nurses in Alberta are obligated to provide safe, competent, and ethical professional services. The *Standards of Practice for Licensed Practical Nurses in Canada* is the benchmark by which the minimum standard for LPN performance is measured. The Standards itemize expectations in professional accountability and responsibility; knowledge-based practice; service to the public and self-regulation; and ethical practice.

LPNs are recognized in the *Health Professions Act (HPA)* to be professional nurses who work within their own scope of practice, standards of practice and code of ethics and work ‘autonomously’. This means LPNs take full responsibility for their own
PROTECTING THE PUBLIC

When an LPN’s practice falls below the standards, it may be brought to the attention of the CLPNA. This is a complaint. Common complaints include (but are not limited to) nursing practice and competency concerns such as medication administration errors; lack of documentation; lack of skill, knowledge, or clinical judgment; or sexual misconduct.

It is the CLPNA’s responsibility to manage complaints for public protection and hold an LPN to the expected competencies, standards and ethics expected. The Health Professions Act, Part 4, Professional Conduct, provides the legal authority and defines and outlines the complaint process followed by the CLPNA. The Standards of Practice is used as a reference in reviewing complaints against LPNs.

REPORTING RESPONSIBILITY

Complaints can be made by employers, patients, co-workers, the public, or organizations such as Protection for Persons in Care.

All employers in Alberta have the legal responsibility to report an LPN’s unprofessional conduct to the CLPNA, and these comprise the majority of complaints received. This mandatory reporting is required when an employer believes the conduct is unprofessional, or if the LPN is terminated or suspended, and may occur if an LPN resigns following identification of a concern.

Additionally, all LPNs have the professional obligation to report any unsafe practices, abusive behaviours, incapacity concerns, or any other unprofessional conduct which could be considered below the Standards of Practice, Code of Ethics, the HPA and other relevant legislation.

While stressful for those involved, resolving complaints provides the LPN an opportunity to enhance their practice, correct a wrong, and ensure the error does not occur again. It can also be a guide to develop a better understanding and knowledge of what is actually important while providing professional care.

For more about the Complaints process, see the CLPNA’s website at www.clpna.com.
Professional Development

STUDYwithCLPNA.com

Our Latest Educational Videos

These educational videos may be used as part of a CLPNA member’s annual learning for the Continuing Competence Program. Also available on YouTube. Subscribe today!

Better Basics

Bill 21: An Act to Protect Patients (for Alberta’s Licensed Practical Nurses)
Changes in 2019 to Alberta’s Health Professions Act (HPA) place new responsibilities on health professionals and regulatory colleges around sexual misconduct and professional boundaries with patients.

Savvy Skills

Palliative Care Series
Presenter Kath Murray is a Certified Hospice Palliative Care Nurse, author, and holds a Masters Degree and a Fellow in Thanatology (FT®).

1: Palliative Care – Essential Tools
Uncover the challenges to integrating a palliative approach, gain four essential tools to enhance care and communication, and three resources to support the integration of palliative care in practice.

2: Palliative Care – Communication and Support
Grasp best practice interactions, reflect on “personal best” moments, and identify principles that might help in responding to difficult questions.

3: Palliative Care – Dealing with Dyspnea
Get tools to assess dyspnea (difficult breathing), identify preventive strategies, and pharmacological and non-pharmacological ways to support those experiencing it.

Workplace Wisdom

Advance Care Planning Series
1: Advance Care Planning and Personal Directives for LPNs
Learn about legal and professional obligations that impact your nursing practice, and discover why personal directives are key in providing patient-centred care.

2: Advanced Care Planning – Understanding Goals of Care Designations (GCDs) and Conversations
Improve confidence around interpreting GCDs, and explore conversations, nursing roles and responsibilities.

3: Advanced Care Planning – Green Sleeve Documents and Processes
Hear processes related to Personal Directives and GCD order forms, nursing roles and responsibilities in documenting on the ACP/GCD Tracking Record, and the importance of the Green Sleeve both personally and professionally.

Client Consideration

End PJ Paralysis (Mobilizing Patients)
Paul Wright from Patient and Family Centred Care (AHS) highlights the importance of patient mobility and all the risks associated with hospital inactivity.

Elder Abuse Awareness
Presenter Nicole Downey, MSW, RSW, Elder Abuse Social Worker and Team Lead with Carya, provides engaging strategies.

Integrating Spirituality into Care
Jeanne Weis, MN, BN, RN, CHPCA(c) shares assessment tools to reduce the distress caused by spiritual suffering.
Lead the shift in HEALTH CARE
Health Care Leadership post-diploma program
Start in January | norquest.ca/hcl
By Shawna Dirksen

Magnetic North

Opportunity in Peace Country

Photos by Laughing Dog Photography
Edmonton may be Alberta’s northernmost major city, but the road to opportunity certainly doesn’t end there. As you venture beyond the capital city, making your way into the northern half of our province, you’ll see acre-upon-acre of grassy farmland, grazing cattle, sunny canola fields, sparkling streams, beautiful boreal forest and, if you’re lucky, maybe even a moose or two. Alberta’s north is strikingly scenic and it’s also rich in opportunity. Hundreds of communities, large and small, scattered throughout the area means there’s a major need for healthcare professionals whose skills match the needs of the northern population. When it comes to opportunities for LPNs in northern Alberta, it seems the sky is truly the limit.

Just ask Dayna Walker, licensed practical nurse (LPN). Aside from a two-year stretch in Stony Plain, Walker has spent her entire 12-year career as an LPN in Grande Prairie. For Walker, Grande Prairie is a place that has provided plenty of opportunities for her to explore her career as a nurse, try out different roles and practice areas, and finally find her perfect fit.

Walker has been a nurse in the regional Cancer Centre in Grande Prairie’s Queen Elizabeth II Hospital, practicing in systemic therapy, for just over a year and loves the challenge it provides. Systemic treatment for cancer includes chemotherapy, hormone therapy or targeted therapy.

“It’s a really interesting place to connect with patients. It’s a neat mixture of hands-on nursing skill and an area where you get to develop that patient-nurse relationship because you’re seeing people on a regular basis,” says Walker. “I’m challenged because things are constantly changing. New drugs come out all the time. There are so many things you need to know. You’re keeping up with different therapies and medications, and with the different cancers.”

When Walker first started out as an LPN, she never imagined she’d be working in a unique practice area like systemic therapy because, at the time, she didn’t know this type of opportunity was available to LPNs.

“My LPN position in the Cancer Clinic is the first to be dedicated to systemic therapy [in Grande Prairie]. It’s all a bit new and just getting going, but things are going to keep changing.”

Jennifer Power, LPN, has seen the scope of practice for LPNs change in Grande Prairie during her eight years of practice in the city; in fact, she herself has been a change maker. A nurse for more than 20 years, Power started on the surgical floor at the Queen Elizabeth II Hospital after moving to Alberta from New Brunswick, where she was an operating room (O.R.) nurse.

“When I first got to Grande Prairie, I felt the LPN’s scope of practice was limited. Originally, we were only able to scrub cases in the O.R.; we weren’t given the ability to circulate,” explains Power. “So I challenged that. LPNs provide competent care and we are experts in our field, just like other disciplines are experts in theirs. I made a compelling case [to...
Power is also part of a team that’s working to expand the women’s health program in Grande Prairie. The project aims to create a clinic specifically for women, where patients are seen and treated in the same day.

 “[This clinic] would be a real enhancement to women’s health in Alberta and I’m very excited about this opportunity,” says Power. “We will potentially see positive steps in women’s health … It’s really something exciting that I hope Alberta Health Services (AHS) embraces.”

There is no question that the healthcare landscape in northern Alberta is changing and opportunity for healthcare professionals is growing. According to AHS, a new hospital and state-of-the-art cancer centre that is under construction management]. Now we circulate and scrub. It was a big door blown open, and we’ve gained acceptance and comraderie [within the department].”

Power says, in her experience, people in northern Alberta are willing to listen, open to new ideas and willing to work together to make changes to broaden the scope of practice for LPNs in the area.

“As people start to understand that we [as LPNs] are highly educated professionals, they’ll be more willing to open their areas to us. If you are willing to educate yourself and put in a bit of work to prove to others that LPNs are a great choice for their facilities, then I think you’d have a really strong career here. We’re only limited by being complacent.”

Since advocating for change in the operating room eight years ago, Power has found other opportunities to step up as a leader within the region. As a senior member of the operating team, she does a lot of teaching within the hospital, mentoring students. “I’m always looking for something new in the O.R., that’s why I got into the educational component, to help others.”
There is no question that the healthcare landscape in northern Alberta is changing and opportunity for healthcare professionals is growing.

in Grande Prairie will function as a regional referral centre and will include space for Grande Prairie Regional College’s nursing and medical careers program.

The new hospital will include 172 beds (with space to add 60 more in the future), two radiation vaults, eight operating rooms, space for obstetrics, diagnostic imaging, and respiratory therapy, laboratory and pharmacy services.

“We’ve heard recently that [the hospital] is over half completed,” says Power. “It’s important and exciting that this is coming our way for our patients to access close-to-home healthcare.”

“[The new hospital] will create so many new opportunities,” agrees Dayna Walker. “There will be the addition of radiation therapy [in the new cancer centre], which we don’t have now.”

Although Grande Prairie is the main healthcare hub for patients in northwestern Alberta, there are also excellent opportunities available for highly-trained LPNs in smaller centres within the region. Cherie Hart, LPN, has been a nurse in the Peace River area for about eight years and has practiced in the dialysis unit at the Peace River Community Health Centre for the last six.

“I found the idea of being an LPN with a specialty very appealing,” says Hart. “[In dialysis] you get to know your patients extremely well because you see them so often. We know their families, we know their history, we know their struggles... The most rewarding thing is when people are able to stay as healthy as they can. We’ve had a few patients get transplants and I’ve seen them after, and they look so healthy and so happy. It’s wonderful to see that.”

Hart says, for her, one of the most interesting things about working in a rural hospital is that the four nurses in her unit are the only people in the hospital on the dialysis team.

“We are a satellite unit of the University of Alberta Hospital,” she explains. “Our nephrologists, unit clerk, machine technicians, and access nurses are all in Edmonton, so we do a lot of communication with the city to keep on top of what our patients need. We are an isolated little island, so there is a lot of computer work, a lot of back-and-forth communication.”

To some, working in a satellite unit with less in-house support than a larger centre might sound limiting; however, Hart has the opposite view.

“I like that we are given the responsibility to run the unit. We have lots of support if we need something, lots of policies in place, but I kind of like being our own entity.”

Cherie Hart, LPN
Hart feels that working in a rural centre has led to more opportunities for her to expand her skill set than she would get in a big city hospital. In Hart’s case, her job requires her to do a lot of things that an LPN wouldn’t normally do in a larger centre – things like computer work, scheduling, troubleshooting equipment, taking inventory and ordering supplies. “We wear many hats,” she says. “It’s actually quite a technical job, which appeals to me!”

Power echoes Hart’s sentiment: she loves working in a hospital that serves a large rural community because it means her role is constantly changing. “Here in Grande Prairie, we do a large number of orthopedic surgeries, very complex cases. We service parts of northern Alberta and British Columbia, so our population is bigger than people give it credit for,” she says. “[As an LPN], you don’t get the variety in a larger centre that we do here. I could do orthopedics one day, general surgery the next day. ...I quite like being able to bounce from service to service and being competent wherever I go.”

For many, it comes as no surprise that there is a gap between the number of skilled nurses currently working in rural communities, like those in northern Alberta, and the need for their services. According to a report by the Canadian Institute for Health Information, in 2017, 11.6 per cent of regulated nurses (including LPNs, registered nurses and registered psychiatric nurses) were employed in a rural or remote area of the province. In comparison, in 2016, 18.3 per cent of Alberta’s population was living in a rural or remote area.

With more and more advanced practice opportunities emerging for LPNs in our province’s northern communities, the region’s need for educational opportunities in unique practice areas is an important part of ensuring care is centred on patients’ needs and improving health outcomes.

Training in a unique practice area typically starts with a foundation in post-secondary education and then being hired into a position by a health authority.

Sydney Farkas, provincial educator for the Oncology Practice Readiness Education Program (O-PREP), says nurses who are hired into CancerControl Alberta are offered a robust initial orientation into oncology. “This orientation blends O-PREP e-learning alongside on-site, in-class skills training with clinical educators and clinical skills development,” she explains.

“Oncology nursing is a unique and rewarding area,” Farkas continues, noting that continuing education is very important for LPNs already serving in a unique practice area like oncology. “Caring for cancer patients and their families is complex, and requires specialized knowledge and skills. As such, a career in oncology nursing involves a dedication to...
continuous learning since cancer treatment is constantly evolving.”

Tracy Delorme, patient care manager for the Alberta Kidney Care Program, says there are many reasons an LPN should consider training in a unique practice area, such as kidney care.

“[Training in a unique practice area] gives LPNs the opportunity to 100 per cent function to their complete scope of practice,” she says. “The other thing I think is rewarding [about working in kidney care] is blending highly technical skills with the relationship part that comes with long-term care.”

Tammy Syrnyk, senior advisor for the Provincial Nursing Strategy, encourages LPNs who are considering training in a unique practice area to have a career pathing conversation with their manager. Syrnyk emphasizes that a job shadow experience can assist an LPN in the decision to apply for a specific training opportunity. Her advice: “Go explore, see if it’s a fit!”

If there ever was a place worth exploring, it’s northern Alberta. With its wide open spaces, friendly, small town spirit, and opportunities for advancement that bolster patient outcomes as well as careers, the road north is worth exploring for LPNs looking to take their careers to the next level.

Northern Lakes College (NLC) is a vibrant institution serving northern Alberta. With accessibility as a cornerstone, NLC responds to the challenge of providing access by ensuring programs and services are accessible online. Mobilizing the use of technology, NLC offers flexible learning options, making it ideal for students to obtain a diploma or certificate without moving away from home.

- 50: years of service NLC is celebrating in 2020
- 50: the number of communities served by NLC
- 15: the number of First Nations served by NLC
- 4: the number of Métis Settlements served by NLC
- 35+: number of programs offered
- NLC LIVE Online™: NLC’s unique and interactive online delivery model

The Northern Lakes College Practical Nurse program combines online and face-to-face learning to allow students to study from home. Labs and clinical requirements can be completed in selected communities including: Grande Prairie, Lloydminster, Peace River and Slave Lake (Program locations vary yearly. See website for up-to-date information.) Visit us at www.northernlakescollege.ca or call 1-866-652-3456. New Beginnings. Endless Possibilities.
Connect Care is approaching, and you’ve heard there are specific competencies to allow you to use technologies to enhance patient care. LPNs provide care in a multitude of settings where eHealth technologies, such as electronic medical records, applications and mobile devices are already used. Some may also possess transferrable computer skills. Perhaps you have significant experience using digital health tools at work, or you might think of yourself as a technology beginner, eager to practice hands-on computer skills. Just as likely you’re not sure of your competency level - how do you know which eHealth technology skills you need to develop?

Your first step is to reflect on your current level of experience, comfort and confidence in using eHealth tools. That way you will find out where your skills need to grow and what you should focus on learning.

The Health Informatics Competency Appraisal Tool (HICAT) is a means to help you identify your areas of strength and what you should develop. An instructional video about the tool is available on the eHealth Competence Alberta Health Services (AHS) website.

In addition to completing this self-appraisal, understanding which competencies to develop also involves reflecting on your experience, role and scope of practice at AHS. As discussed in the last issue of CARE, eHealth competencies are expressions of LPN professional competencies, so the LPN scope of practice influences which eHealth skills, knowledge and attitudes are critical for you to develop.

Compare the roles of an LPN working with an at-risk population in community health and an LPN working in post-operative recovery providing care to patients awakening from general anesthesia. The LPN in community health will be more interested in eHealth competencies for patient teaching related to online community resources and advocacy for patient access to online tools. Similarly, if your role involves quality improvement outcomes measurement, you require greater competencies related to data quality and reporting than a nurse whose primary responsibilities involve direct patient care. As outlined in the Competency Profile for Licensed Practical Nurses, “Each LPN has a set of competencies specific to their individual knowledge, experience, practice, and workplace setting” (CLPNA, 2015, p. vii). This includes the skills required to use eHealth technologies in your workplace to find, evaluate and apply information to make decisions.

LPNs working in environments where digital health tools have been adopted may already possess a level of eHealth competencies. Reflecting on your experience involves taking stock of whether you are equipped to use the digital health technologies that will be introduced with Connect Care. For example, computerized provider order entry introduces additional competencies to those required to complete clinical documentation of patient care assessments in an electronic health record. On the other hand, LPNs involved in coaching or mentorship roles may benefit from strengthening their eHealth capabilities in order to effectively support other LPNs.

Accountability for continuing professional development is a standard of LPN practice, in which LPNs are accountable for providing safe, competent, compassionate and ethical care. As healthcare providers, we have a duty to our professions, to our employers and to Albertans to provide the best possible healthcare within our scope of practice. Through competent use of digital health tools introduced by Connect Care, we can maximize the benefits to patients by using the system to its potential.

This is the second in a series of articles about eHealth Competence for licensed practical nurses.
Anxiety in Children and Youth–Practical Intervention Strategies
Edmonton: September 28; Calgary: September 29

Vicarious Trauma–Strategies for Resilience
Edmonton: October 8; Calgary: October 10

Narrative Therapy–Tools for Exploring Stories
Edmonton: October 21; Calgary: October 23

Cognitive Behavioural Therapy–Tools for Thinking Differently
Edmonton: October 22; Calgary: October 24

Play Therapy–Tools for Helping Children and Youth
Edmonton: November 4-5; Calgary: November 6-7

Critical Incident Group Debriefing
Edmonton: November 18; Calgary: November 21

De-escalating Potentially Violent Situations™
Edmonton: November 19; Calgary: November 22

Addictions and Youth–Substances, Technology, Porn
Edmonton: November 30; Calgary: December 1

Mindfulness Counselling Strategies–Activating Compassion and Regulation
Edmonton: December 2; Calgary: December 3

Dialectical Behavioural Therapy–Balancing Acceptance and Change
Edmonton: December 16; Calgary: December 17

Trauma-Informed Care–Building a Culture of Strength
Calgary: January 28; Edmonton: January 29

Brief Focused Counselling Skills–Strategies from Leading Frameworks
Edmonton: February 10; Calgary: February 11

Addictions and Mental Illness–Working with Co-occurring Disorders
Edmonton: February 24; Calgary: February 26

Harm Reduction–A Framework for Change, Choice, Control
Edmonton: February 25; Calgary: February 27

Challenging Behaviours in Youth–Strategies for Intervention
Edmonton: March 7; Calgary: March 14

Autism–Strategies for Self-Regulation, Learning, and Challenging Behaviours
Edmonton: March 9; Calgary: March 11

Anxiety–Practical Intervention Strategies
Calgary: March 10; Edmonton: March 11

Trauma–Strategies for Resolving the Impact of Post-Traumatic Stress
Edmonton: March 30; Calgary: March 31
Falls are the leading cause of injury among older adults. After a fall, many people are unable to live the way they want; they may lose their independence and live in fear of falling again.

A Big Problem that is Getting Bigger

Every day, 92 Alberta seniors are treated in emergency departments for injuries due to a fall and 25 need to be admitted to hospital for treatment. With the population of seniors expected to double by 2040, this problem will get bigger, unless we teach older adults that falls can be prevented.

Nurses are Part of the Solution

Depending on your practice, you will have policies or guidelines to direct you in preventing falls. The Alberta Health Services Falls Risk Management Recommendations for Adults and Older Adults can assist in determining when it is appropriate to use Finding Balance materials.

Using Finding Balance in Your Practice

Finding Balance falls prevention materials are designed to encourage community-dwelling older adults to manage their risk of falling by maintaining or improving their balance and strength. Whether you work with older adults in the community or are preparing them to return home following a stay in acute care, Finding Balance resources can help:

- Start a conversation about the risk of falling
  - Use the Are You at Risk of Falling? quiz with your patients

- Familiarize patients with the impact falls can have on independence and health
  - Discuss the Can a fall change your lifestyle? brochure

- Share this message about how to prevent a fall: Challenge Your Balance, Build Strength, Be Active

- Access Finding Balance materials including
  - Exercises to improve balance and strengthen muscles
  - Tools and challenges to motivate seniors to stay physically active

- Remind your patients that falls are not an inevitable part of aging
  - Balance can be improved with practice
  - Strength can be improved at any age
  - Being active improves balance and strength

- Provide information about reducing risks specific to the individual
  - Share Finding Balance information sheets with patients and their families.

Nurses have a valuable role to play in preventing falls among older adults and Finding Balance can help. Finding Balance is an initiative of the Injury Prevention Centre. Visit findingbalancealberta.ca for more.
Many people in the LGBTQ2S+* community do not always feel safe or included in all environments, including the spaces they encounter in their healthcare journey. Through her role as Program Manager with Diversity and Inclusion for Alberta Health Services (AHS), Marni Panas leads the development and implementation of a provincial diversity and inclusion plan aimed at creating safe, welcoming and inclusive environments for AHS’s staff, patients and families. This work involves educating healthcare providers on the many things they can do in their daily practice to help make spaces safer for everyone.

Why is it important to create safe and inclusive spaces?
Creating safe and inclusive spaces benefits everyone, not just one population. When a marginalized population feels safer and involved in their healthcare, we create an environment where everybody benefits. When one group of people feels safer and more included in their workplace; when one group of people feels more engaged, part of their healthcare experience and safer, then that happens for all communities that we serve.

How can healthcare providers use language to create a safe and inclusive environment?
I don’t expect anybody to be an expert on language. The language is evolving and changing every day. Open your mind to that fact that things are changing every day and really meet the patient where they’re at.

Make sure you’re using the right name. If you don’t know the name, ask what name they want to use and what pronouns they use. When you see other people using language that may not be appropriate – and in most cases they’re not even aware of it – stand up for the community and question that language. It’s really important to hold each other accountable to ensure that everybody is feeling safe and welcome in the work environment.

If I could have one request, it would be for every nurse to walk in and say, “Hi, my name is Marni; I’m your nurse today and I use she/her pronouns.” Setting yourself up that way can provide a very strong message to your patient or your client that you get it. You might be the one person that they know is safe, which could change their whole healthcare experience and ultimately will impact their outcomes.

How can healthcare providers create safe and inclusive physical spaces?
AHS has looked at how we identify single stall, single user washrooms using signage and pictograms that reflect inclusion. Instead of having the male/female traditional stick figures, it’s a picture of a toilet. The sign and the change seems small, but the message is huge to somebody who may not feel safe and included in a washroom that doesn’t look like they belong in it.

We can put rainbow flags on our lanyards or wear pronoun pins on our lanyards or name tags to show what our pronouns are. These can be strong messages that change a space.

Putting a rainbow sticker on a door is tricky because people move offices but the stickers stay. It only means ‘This is a safe space’ if everybody in that place is also safe. If we’re going to identify a safe space, everybody needs to be on board with that and everybody needs to be part of that safe space. It’s the people that make the place safe.
Person-centred care is described as a care philosophy in which a positive relationship is established between a resident and staff member that respects the care recipient’s preferences and life history, honours identity, and enables engagement in meaningful activity (Fazio, Pace, Flinner, & Kallmyer, 2018). The purpose of our project was to improve the provision of person-centred care in residential care homes (RCH) by building the leadership capacity of licensed practical nurses (LPNs) such that collaborative decision-making and supportive teamwork is enabled and encouraged.

Person-centred care encompasses all aspects of care; however, we purposefully selected mealtimes as a focus for this project because mealtimes are concrete, regular, frequent, and discrete events that, when designed in a person-centred way, can have positive outcomes for both care staff members and residents. Research demonstrates that training is needed to support mealtimes with a person-centred, social focus (Murphy, Holmes, & Brooks, 2017; Reimer & Keller, 2009). The CHOICE educational program helps to address these training needs and is based on research evidence to support relationship centred-dining in long-term care (Wu et al., 2018). The principles of CHOICE include Connecting, Honouring Dignity, Offering Support, Identity, Creating Opportunities and Enjoyment (Wu et al., 2018).
For this project, we used the FASCCI (Feasible and Sustainable Culture Change Initiatives) model for change developed by Dr. Sienna Caspar, to support the successful implementation of the CHOICE principles into everyday mealtime care practices. The FASCCI model draws significantly from the Model for Improvement developed by Langley et al., (2009). The FASCCI model adds two key features that are not included in the Model for Improvement. The first is the provision of leadership training (Caspar, Le, & McGilton, 2017) to team leaders—who, in this project, were LPNs working at the selected residential care home. The second feature is the active exploration and application of three key intervention factors that are necessary in ensuring the feasibility and sustainability of the change initiative. These include: predisposing factors (e.g., effective communication and dissemination of information), enabling factors (e.g., conditions and resources required to enable staff members to implement new skills or practices) and reinforcing factors (e.g., mechanisms that reinforce the implementation of new skills) (Caspar, Ratner, Phinney, & MacKinnon, 2016).

After receiving training in both responsive leadership (Caspar et al., 2017) and the CHOICE principles, LPNs learned how to lead a Process Improvement Team (PIT) in the implementation of co-developed, clearly defined aims and practice changes associated with person-centred mealtimes. The PIT, which was led by the LPNs, included key stakeholders (e.g., health care aides [HCA], family members, managers, interdisciplinary team members) and utilized plan-do-study-act (PDSA) cycles to implement the selected practice changes in mealtimes. Each PDSA cycle cultivated collaboration, mutual understanding, and knowledge sharing among the PIT members. By integrating CHOICE education program and the FASCCI model, this project aimed to improve mealtimes experiences of residents while simultaneously building leadership skills and collaborative decision-making amongst LPNs and other care staff members. Ethics approval was received through University of Lethbridge Research Services and the University of Alberta. Institutional approval was also obtained from the site in which the project was conducted.

The Mealtime Scan (MTS) (Keller, Chaudhury, Pfisterer, & Slaughter, 2017) was used to measure outcomes and determine whether or not the project was achieving its goals. Forty mealtime observations using the MTS were completed over the course of six months in two dining rooms, with ten observations at baseline, ten at two months, ten at four months, and ten at six months. Observations were equally divided between the dining rooms in the RCH with ten lunch and ten supper observations completed and residents removed from the dining area throughout the day so that residents were enabled to come and go as they chose. Implementing this strategy had a significant impact on the overall dining experience as it enabled staff and residents to focus on the social aspects of the dining experience rather than ensuring that the tasks associated with dining were completed and residents removed from the dining area within a set amount of time.

**Mealtimes are concrete, regular, frequent, and discrete events that, when designed in a person-centred way, can have positive outcomes for both care staff members and residents.**

**Physical environment.** MTS assessment of the physical environment includes such mealtimes elements as noise levels, seating arrangements, sufficiency of lighting, aroma of food, decorations and ambience, and availability of condiments for residents to choose from. Almost all elements of the environment that scored low at baseline showed significant improvement as a result of the intervention. For example, baseline observations demonstrated that, prior to the intervention, the television was turned on during 100% of the observed meals, food aroma was present during only 10% of the observed meals, and the dining room doors were locked in between every meal. Whereas, at the conclusion of the intervention, the television was off during 100% of the meals and food aroma was present for 60% of the meals. In addition, one of the first changes that the PIT members implemented was to open the doors to the dining room throughout the day so that residents were enabled to come and go as they chose. Implementing this strategy had a significant impact on the overall dining experience as it enabled staff and residents to focus on the social aspects of the dining experience rather than ensuring that the tasks associated with dining were completed and residents removed from the dining area within a set amount of time.

**Social environment.** The social environment is assessed based on the quality/type of five social interactions (e.g., between residents; between residents and staff; staff to staff; etc.) and their frequency. Ratings (0 = never, 4= frequent) are based on the frequency of the interaction as observed and scoring for the social environment scale is
based on the predominance of social interactions that involve residents in contrast with task-focused interactions that exclude residents. Resident-to-resident interactions improved over the course of the intervention, as did other positive interactions, such as staff interacting with affection to residents. Task-focused interactions were reduced, resulting in an overall increase in the social environment score over time.

Person-centred care. Person-centred care practices are primarily evaluated by assessing the degree of choice given to residents regarding mealtime activities (e.g., Did they have the opportunity to assist with mealtime tasks? Were they given a choice of where to sit? Were they offered a choice regarding use of clothing protectors?) and whether or not the residents’ needs were prioritized over the mealtime care tasks (e.g., Was the meal interrupted by the distribution of medications? Were residents’ needs met when they became evident to staff?). Significant improvements were made in all aspects of person-centred care following the intervention.

Process assessments were conducted to understand how the project was being implemented (e.g., What kinds of problems were encountered in implementing the changes to mealtimes? To what extent were the person-centred mealtime strategies implemented as planned?) and to determine whether or not it is sustainable (e.g., Are the mealtime strategies continuing to be delivered? If not, why not?). Process assessments were conducted using data from detailed notes taken during each of the PIT meetings and from one to one interviews during which PIT members were asked to evaluate both the process and the outcomes of the project. Here is a sampling of some of the things they told our project team:

“I see a calmer environment, residents enjoy being able to eat earlier and leave at will, as well as a more social environment; there are so many more meaningful conversations.” – Dietary Aide

“Residents are a lot more happy with more choice, extra portions and second helpings along with the time to enjoy it.” – HCA

“I really enjoyed having the doors open all day and I see the clients visit with each other while they have their coffees. I enjoy being more resident-focused. It’s always a good thing and just reminding us not to forget those little things. They do make a difference to residents.” – LPN

“This team is very engaged. They have been willing to try, implement, and try again. They have taken the initiative to challenge the way we have ‘always done’ things which takes great courage and leadership. It has been an absolute privilege to witness the passion and energy of this group wanting to improve the quality of care. They are an amazing group who have truly taken and ownership for making change and sustaining the change.” – Manager

In summary, our study offers evidence that practice change initiatives that focus on stakeholder engagement can provide a promising method for improving the provision of person-centred mealtime practices in RCHs. Our findings indicate that person-centred change initiatives in RCHs should incorporate individuals at all levels of care and need to take into consideration the socio-structural components of the care environment. Our study also elucidates the importance of cultivating an empowered workforce by implementing practices that enable and encourage collaborative decision-making and increase the autonomy and self-determination of care staff. We found this to be essential to the outcomes that occurred as a result of the change initiative.

Acknowledgements

We would like to acknowledge Alberta Innovates Health Solutions (AIHS) and the College of Licensed Practical Nurses of Alberta (CLPNA) for funding this research. We would also like to extend our gratitude to all of the participants who took part in this study.

References


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2019 Alberta Survey on Physical Activity, Sedentary Behaviour, and Sleep

The Alberta Survey on Physical Activity has reported on adult physical activity status and determinants of physical activity in the province since 1993. In 2019, sleep behaviour was examined. The main findings and recommendations are included in this infographic. See the full report for details.

Active living is a way of life that incorporates a combination of:
- 150 minutes of moderate-to-vigorous physical activity weekly,
- incidental physical activity every hour, and
- low levels of sedentary behaviour during waking hours.

Overall Physical Activity Levels of Albertans 2009-2019

Although highest in 2019, physical activity levels have remained relatively consistent over the last decade.

Overall Walking Levels

26% of Albertans achieve high levels of walking

Sedentary Behaviour

During the week, Albertans sit for:

9.5 hours per weekday

8.8 hours per weekend

Sleep Behaviour

Albertans sleep an average of 7.6 hours per weekday and 8.3 hours per weekend day

70% of Albertans have an electronic device* in the bedroom

75% of Albertans rate their quality of sleep as fairly good to very good

65% of Albertans with electronic devices* in the bedroom use them within 30 minutes of going to bed

71% of sufficiently active Albertans meet the sleep recommendations

Sleep Recommendations

- Adults, 18 to 64 years, of age should achieve 7 to 9 hours of sleep.
- Adults ≥ 65 years should achieve 7 to 8 hours of sleep.

Building Healthy Sleep Habits

- Make time for sleep.
- Maintain a regular sleep schedule.
- Limit distractions including light and sound.
- Avoid electronic devices at least 30 minutes before bed.
- Engage in regular physical activity mid-day or late afternoon to avoid sleep disruptions.
- Keep track of sleep patterns.

Full report available at www.centre4activeliving.ca

*Electronic device includes: television, computer, tablet, smartphone, or video games

A MET is a measure of energy output equal to one’s basal resting metabolic rate which is assumed to be 3.5 mL•kg-1•min-1 (Tremblay, Shephard, & Brawley, 2007). Thus, two METs are equivalent to an intensity twice that of the resting metabolic rate. Physical activity intensity is often expressed in METs.
Six years ago, Christy Watson was looking for a change. She was working in homecare, and had been supporting long-term and palliative care patients in northwestern Alberta for about 16 years. “I was at a point where I needed to be inspired by something else,” says Watson.

It wasn’t long before Watson found the inspiration she needed in what some might consider an unlikely place. A colleague referred her to the Peace River Correctional Centre, which turned out to be the perfect setting for Watson to step out of her comfort zone.

Today, 33 years into her LPN career, Watson isn’t looking back. She is now the longest-employed LPN with the Peace River Correctional Centre and she recently won the Laura Crawford Excellence in Nursing Practice award from the CLPNA.

“Christy is a force of nature,” says Barb Elder, Watson’s supervisor and Correctional Health Services Manager, adding that the day Watson stepped into her office was one of the happiest days of Elder’s career. “She’s highly respected in the corrections environment and is well known across the province amongst the management team. I want to express my gratitude to her for staying here and sticking it out with me!”

Watson shared what it’s like to be an LPN in a correctional facility.

What is a typical day at work like?

At the beginning of each shift, you come in, read the logbook, count your narcotics. We prepare the medications and administer twice a shift (four times per day), in what we call the med line.
[We also] do routine vitals, wound assessments and wound care. The patients here submit healthcare request forms, so we triage and go through those.

We can have some hiccups in there, like emergency situations, or difficulties or delays seeing patients because correctional officers are searching [for contraband] or a unit is locked down because of a fight.

**What makes your workplace different?**

Here, security comes first, which was a hard lesson for me to learn. We have to make sure it’s safe [before we can treat a patient] and we have to go with an officer.

Also, our patients come in with very limited information and can be unpredictable. To me, it’s like an emergency department; you never know what’s going to come through the door.

On each shift, we have two nurses with a patient population upwards of 200. The nurses work in-sync with each other [and they make a] balanced, well-rounded, dynamic team. This working relationship is essential in an emergency because EMS is 16 minutes away from us. This can be life or death for a patient.

**What keeps you motivated?**

I like having the opportunity to help someone during what might be their darkest time. I had an 18-year-old kid once who was picked up [by police] at a house party. He was very frightened. I let him use the phone in the healthcare ward. I went on days off, and when I got back to work, he had been released. Six months later, I saw him out with his dad. His dad came over and thanked me for taking such good care of his son. Because I cared a bit more, I made a difference that day.

**What question are you asked most often about working in a correctional centre?**

Are you scared? For me, there’s nothing to be afraid of. I always have an officer with me, sometimes two. When we give medications, we are always behind a gate. Correctional nursing is the same as any other nursing area; our environment is just a little different.

**What would you say to another LPN considering work in this kind of environment?**

If you need to be inspired, if you want a challenge, if you want freedom while working in your scope of practice, come on down!
Licensed practical nurses are among the many healthcare professionals who work with and care for Alberta’s older population. Part of the CLPNA’s mandate of protecting the public is sharing knowledge on how to communicate effectively and respectfully with older people. This article aims to educate LPNs on ageism, and how to avoid it in communicating with older adults.

Ageism

Geriatrician Robert Butler coined the term ageism in the 1960s. While it was identified as a concern over 50 years ago, it remains a contemporary issue. Ageism refers to the systematic stereotyping of and prejudice against older people. Ageism is shown in our attitudes toward growing old and our stereotype driven interactions with older people. Ageism is common in Canadian society; even young children show ageism toward older people. Holding negative views of aging has been linked with poor health outcomes for older individuals.

Ageism in Communication

Ageism can be shown in communication with, to and about older adults. Research shows that there are stereotypes about aging language and communication abilities (e.g., beliefs that all older people are hard of hearing, ramble on). Interactions guided by stereotypical beliefs can lead to over accommodation in communication (both verbal and nonverbal) with older people that can be patronizing (see Appendix A). Patronizing communication is driven by beliefs associating older age with dependency.
Ageism refers to the systematic stereotyping of and prejudice against older people.

and incompetence. Patronizing communication can also be driven by a desire to be nurturing and benevolent. The tendency to accentuate positivity in communication with, to and about older people can unwittingly reinforce age stereotyping and ageism.

Guidelines for Avoiding Ageism in Communication

Awareness of ageism as it manifests in communication is key to beginning to address ageism.

- Do not let stereotypes dictate interactions with an individual. Focus on the individual and make adjustments in speech and behaviour based on the individual.

- Do not let stereotypes guide communication choices to/about older adults.

As a guideline, before making a communication accommodation/modification, ask yourself:

- Is it appropriate for the individual?

For example, you may be inclined to begin speaking loudly because of a belief that older people are hard of hearing. Be aware of your bias and discern if this accommodation is appropriate for the older person you are communicating with.

- Is it sensitive to individual differences amongst older people?

For example, you may be inclined to use larger font based on a belief associating older age with poor vision. Be aware of this bias and when possible, acknowledge the heterogeneity that exists amongst older people and provide adjustable font size.

As a guideline, avoid positive or negative age stereotype perpetuating language. Ask yourself:

- Is there an implied message I do not intend?

Example: “The Seniors Home Adaptation and Repair program helps seniors update their homes so they can maintain their independence”.

Implies seniors lose independence, reinforcing a dependency stereotype.

Better: “The Seniors Home Adaptation and Repair program provides a low-interest loan to assist seniors renovate or repair a home”.

Example: “When you can no longer live independently, you may need to access Alberta’s continuing care system”.

Implies all older people will eventually require institutionalized care, which is not true.

Better: “If you can no longer live independently, you may need to access Alberta’s continuing care system”.

As a guideline, avoid “us” versus “they/them” and “our” language. It can be isolating and seen as patronizing.

Example: “The senior population is larger than ever before. This is creating opportunities for governments to place value and build on the contributions that our seniors have made, and continue to make to our communities, our workplaces and our families.”

Better: “The senior population is growing. This is creating opportunities for governments to build on the contributions of seniors”.

As a guideline, check yourself by substituting in for the term “senior” any stigmatized group before you write it, say it or implement it. Using the same example, ask yourself:

- How would this go over?

Example: “The senior population is larger than ever before. This is creating opportunities for governments to place value on and build on the contributions that our seniors have made, and continue to make to our communities, our workplaces and our families”.

Substitute: “There are more women than ever before. This is creating opportunities for governments to place value and build on the contributions that our women have made, and continue to make to our communities, our workplaces and our families”.

Appendix B summarizes these guidelines for communicating with, to and about older adults that is sensitive to ageism and its biasing effects on communication choices. These guidelines are suggestions to start the process of addressing ageism by increasing awareness.
### Appendix A

**Features of Patronizing Communication**

When you over accommodate based on stereotyped expectations:

<table>
<thead>
<tr>
<th>Verbal</th>
<th>Nonverbal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Vocabulary</strong></td>
<td><strong>A. Voice</strong></td>
</tr>
<tr>
<td>Simple</td>
<td>High pitch</td>
</tr>
<tr>
<td>Few multisyllabic words</td>
<td>Exaggerated intonation</td>
</tr>
<tr>
<td>Childish terms</td>
<td>Loud</td>
</tr>
<tr>
<td>Minimizing words (e.g., just, little, short)</td>
<td>Slow</td>
</tr>
<tr>
<td>Pronoun modifications (e.g., over inclusive we, exclusive we, avoidance of me/you in favour of name substitutions)</td>
<td>Exaggerated pronunciation</td>
</tr>
<tr>
<td><strong>B. Grammar</strong></td>
<td><strong>B. Gaze</strong></td>
</tr>
<tr>
<td>Simple clauses and sentences</td>
<td>Low eye contact</td>
</tr>
<tr>
<td>Repetitions</td>
<td>Staring</td>
</tr>
<tr>
<td>Tag questions</td>
<td>Roll eyes</td>
</tr>
<tr>
<td>Imperatives</td>
<td>Wink</td>
</tr>
<tr>
<td>Fillers</td>
<td></td>
</tr>
<tr>
<td>Fragments</td>
<td></td>
</tr>
<tr>
<td><strong>C. Forms of address</strong></td>
<td><strong>C. Proxemics</strong></td>
</tr>
<tr>
<td>First names and nicknames</td>
<td>Stand too close</td>
</tr>
<tr>
<td>Terms of endearment (e.g., sweetie, dearie, honey)</td>
<td>Stand over a person seated or in bed</td>
</tr>
<tr>
<td>Childlike terms (e.g., good girl, naughty boy, cute little man)</td>
<td>Stand too far off</td>
</tr>
<tr>
<td>Third-person reference</td>
<td></td>
</tr>
<tr>
<td><strong>D. Topic management</strong></td>
<td><strong>D. Facial Expression</strong></td>
</tr>
<tr>
<td>Limited topic selection and topic reinforcement (e.g., focus on past, shallow, task oriented, or overly personal / intimate)</td>
<td>Frown</td>
</tr>
<tr>
<td>Interruptions</td>
<td>Exaggerated smile</td>
</tr>
<tr>
<td>Dismissive of other-generated topics</td>
<td>Raised eyebrows</td>
</tr>
<tr>
<td>Exaggerated praise for minor accomplishments</td>
<td></td>
</tr>
<tr>
<td><strong>E. Gestures</strong></td>
<td><strong>F. Touch</strong></td>
</tr>
<tr>
<td>Shake head</td>
<td>Pat on head</td>
</tr>
<tr>
<td>Shrug shoulders</td>
<td>Pat on hand, arm, shoulder</td>
</tr>
<tr>
<td>Hands on hips</td>
<td></td>
</tr>
<tr>
<td>Cross arms</td>
<td></td>
</tr>
<tr>
<td>Abrupt movements</td>
<td></td>
</tr>
</tbody>
</table>

**B. Gaze**
- Low eye contact
- Staring
- Roll eyes
- Wink

**C. Proxemics**
- Stand too close
- Stand over a person seated or in bed
- Stand too far off

**D. Facial Expression**
- Frown
- Exaggerated smile
- Raised eyebrows

**E. Gestures**
- Shake head
- Shrug shoulders
- Hands on hips
- Cross arms
- Abrupt movements

**F. Touch**
- Pat on head
- Pat on hand, arm, shoulder

**Verbal**
- Simple
- Few multisyllabic words
- Childish terms
- Minimizing words (e.g., just, little, short)
- Pronoun modifications (e.g., over inclusive we, exclusive we, avoidance of me/you in favour of name substitutions)

**Nonverbal**
- High pitch
- Exaggerated intonation
- Loud
- Slow
- Exaggerated pronunciation
- Low eye contact
- Staring
- Roll eyes
- Wink


References available on request.

For details on the Office of the Seniors Advocate, visit https://seniorsadvocateab.ca/.

### Appendix B

**Improving Communication With/To/About Older Adults**

**Be Aware**
- Do not let stereotypes dictate interactions with an individual. Focus on the individual and make adjustments in speech and behaviour based on the individual.
- Do not let stereotypes guide communication choices to/about older adults.

**Guidelines to consider**
- Before making a communication accommodation/modification, ask yourself
  - is it appropriate for the individual?
  - is it sensitive to individual differences amongst older people?
- Avoid positive or negative age stereotype perpetuating language. Ask yourself
  - is there is an implied message I do not intend?
- Avoid “us” versus “they/them” and “our” language. It can be isolating.
- Check yourself by substituting in any stigmatized group for the term “senior” before you write it, say it or implement it. Ask yourself
  - how would this go over?

**A further resource**
Communicating with adults: An evidence-based review of what really works (free download from the Gerontological Society of America):

This resource covers cognitive and sensory changes that tend to occur in aging and also discusses the role of age stereotypes in communication.
Empowered Patient®
Ten warning signs of a rapidly deteriorating patient

1. **BODY TEMPERATURE** is too high or too low. Report temperatures below 36.0 °C or above 38.0 °C.

2. **HEART RATE** (pulse) or **RESPIRATORY RATE** (breathing changes). A heart rate that stays less than 60 or greater than 100 beats per minute, or a respiratory rate of less than 15 or greater than 20 breaths per minute may need to be evaluated.

3. **BLOOD PRESSURE** numbers are out of the normal range. If the systolic (top number in the blood pressure reading) is less than 90 or greater than 190 mmHg, ask for an assessment.

4. **CHANGE IN MENTAL STATE** including confusion, delirium, or an acute change in personality, memory or alertness.

5. **CHANGES IN URINE OUTPUT OR APPEARANCE**. A decrease in the amount of urine is a concern (less than 50 ml over 4 hours), as is urine that appears darker in colour or looks “concentrated.”

6. **THE PATIENT STATES** that something is wrong with them. Patients often have a sense that they are experiencing a sudden decline in their health.

7. **THE PATIENT DOESN’T LOOK RIGHT** to the family or advocate. Someone who knows the patient personally is often a better judge of a change in normal appearance or behaviour.

8. **SHORTNESS OF BREATH** or having a tight feeling or discomfort in the chest. Shortness of breath can be a sign of a heart attack, pulmonary embolism (blood clot), infection or pneumonia.

9. **ACUTE PAIN**, especially in the abdomen. This could be a sign of an infection (including peritonitis), intestinal obstruction, a perforated ulcer and other potentially life-threatening problems.

10. **VERY PALE** appearance of the skin or breaking out in cold sweats. These symptoms could indicate internal bleeding, shock, infection or heart attack.

Adapted with permission.
Copyright 2011 Julia A. Hallisy. An Empowered Patient® Publication. Please note that the above warning signs are intended to be used as a guideline only and are not intended as a substitute for the medical opinion of your care provider.

SHIFTtoSafety.com
Don't miss this course! For ALL nurses, midwives, paramedics!

The medical record is known as "the one witness that never lies and never dies". Nursing negligence lawsuits are often lost because the documentation fails to show that the standard of care was met. Learn strategies for documentation that will protect and defend you in a lawsuit AND promote safe patient care.

Objectives:
- Effectively improve your documentation AND patient care
- Examine attitudes and beliefs vs. facts and knowledge
- Discuss landmark legal cases affecting the medical record
- Learn what lawyers look for in the medical record
- Examine documentation from real medical legal case studies

Speakers:
Chris Rokosh RN, PNC(C), President of Connect Medical Legal Experts, has reviewed thousands of medical malpractice cases in her successful career as a Legal Nurse Consultant. Her course 'Legal Issues in Nursing' is one of Canada's highest rated and most attended nursing education courses. She brings a wealth of knowledge and experience in medical legal issues and nursing education. Chris is a warm engaging speaker who connects with audiences on a truly personal level.

Also includes a panel of Canada's top medical malpractice lawyers!
- Joe Miller Q.C., Weir Bowen LLP, Edmonton
- Paul McGivern, Pacific Medical Law, Vancouver
- Richard Halpern, Thomson Rogers, Toronto

Also available
"Shift. Change! Empowering Nurses With Medical Legal Knowledge"

This amazing new book offers practical insights to healthcare professionals on how to protect themselves and patients through patient centered care.

Pre-purchase book at registration to get a discounted price!
Council Representatives for Red Deer, Lethbridge, North Central

A new voting system processed the results of the CLPNA Council Elections in June with hundreds of participants.

Congratulations to Ashley Cesar, LPN, on becoming the new Council representative for Lethbridge and area in District 1.

The District 3 incumbent, Kurtis Kooiker, LPN, is headed into his second term representing the Red Deer area. Kurtis was also selected by Council to serve as Vice-President.

Sherry Kanarek, LPN, was appointed by Council to represent District 5: North Central (Jasper, Slave Lake, Cold Lake & area).

They will each serve a three-year term (Sept 1, 2019 – Aug 31, 2022)

The Council thanks all nominees for participating. The next opportunity to serve will be on some of the CLPNA’s Committees. Recruitment begins in October.

Council’s role is to govern the profession and oversee the CLPNA’s management, actions, and policy development within the framework of the Health Professions Act.
Annual LPN Registration Renewal begins October 1 for 2020. The CLPNA encourages all LPNs to renew before December 1 to pay the lowest registration fee of $350. For those who delay, the renewal fee is $550 when submitted between December 2 to 31. Formal notices will be sent by email from the CLPNA’s Registrar.

REMEMBER: Don’t Practice Without a Permit
Anyone found working as an LPN with an expired or invalid Practice Permit may be subject to disciplinary action from the CLPNA, including $500+ fines. Only those individuals with a current CLPNA Practice Permit are authorized to work as an LPN in Alberta or use the title ‘Licensed Practical Nurse’ or ‘LPN’ as stated in Schedule 10 of the Health Professions Act and Section 12 of the LPN Profession Regulation.

HOW TO RENEW
To begin the 2020 Registration Renewal application, login to https://www.myCLPNA.com directly, or go to www.clpna.com and in the upper right corner click on the blue “myCLPNA Login” graphic.

Preparation
Before beginning your Registration Renewal application, have the following ready:
• Your email address and password for www.myCLPNA.com
• Nursing practice hours calculated from Jan. 1, 2019 to the submission date of your Renewal application. Then, add your estimated practice hours from that date to Dec. 31, 2019. If there are significant differences in estimated practice hours compared with actual (more than 20%), contact the CLPNA in January 2020.
• Continuing Competence Program (CCP) Learning Plan for 2019 and 2020
• Current employer’s contact info
• Payment information

Members must successfully complete the annual Registration Renewal process in order to:
• work in Alberta as a Licensed Practical Nurse in 2020 (with an Active registration type)
• OR change your registration type from Active to a non-practicing Associate
• OR cancel a permit and notify the CLPNA you are not renewing for 2020

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

MATERNITY, LEAVES AND RETIREMENTS

For Maternity or Short-Term Leave?
Active Practice Permit
The CLPNA recommends LPNs renew for an Active Practice Permit to return to work without delay for those taking short-term or maternity leave. (The Associate membership type is not recommended.)

For Retiring or Not Renewing?
Associate Membership
A non-practicing Associate membership for $50 provides a CARE magazine subscription and frequent practice updates. It does not allow the individual to work as an LPN in Alberta.

LPNs choosing this option will be listed on the Public Registry as “Associate” with a reason of “Permit Cancelled Non-Practicing”. Associates who apply for an Active Practice Permit must still meet all registration requirements including application approval, fee payment, criminal record check, and evidence of being actively engaged in practice (1000 practice hours in the previous four years).

For Cancellation
To cancel registration completely, LPNs should select the “Cancel” option on their 2020 Registration Renewal application. This will capture final info about the LPN’s practice hours and Continuing Competence Learning Plan.

Until the Registration Renewal form is submitted, LPNs will continue to receive reminders. Suspension and cancellation notices will be sent as required by the Health Professions Act.
During Registration Renewal, CLPNA members will declare their nursing practice hours for the year. This mandatory reporting is part of the Continuing Competence Program Audit process headed into the second year of a three-year transition. By 2021, all LPNs will be required to have worked a minimum of 1000 practice hours within the four-year period immediately preceding Registration Renewal.

### Three-Year Transition Timeline

#### – 2019 –
- The CLPNA advises stakeholders regarding practice hours criteria with increasing specificity every year.
- A practice hours requirement becomes part of the Continuing Competence Program.
- LPNs are asked to declare their practice hours on their Registration Renewal.

#### – 2020 –
- LPNs are audited for practice hours declared on their 2016, 2017, 2018, and 2019 Registration Renewals.
- The Audit reviews practice hours and Learning Plans.
- LPNs with fewer than 1000 practice hours accumulated in the previous four years (2016-2019) will be informed of recommendations for future compliance.

#### – 2021 –
- LPNs are audited for practice hours declared on their 2017, 2018, 2019, and 2020 Registration Renewals.
- The Audit reviews practice hours and Learning Plans.

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

For more info, contact registration@clpna.com, 780-484-8886 or 1-800-661-5877 (toll free in Alberta).
Advance Care Planning: An Important Conversation

By Alexandra Kushliak, BA, BSW, RSW, Education Consultant, Advance Care Planning/Goals of Care, Alberta Heath Services

Advance Care Planning (ACP) is a way to help patients think about, talk about and document wishes for healthcare in the event that they become incapable of consenting to or refusing treatment or other care. Being exposed to these conversations also prepares people for a time when they are still capable but may be faced with important healthcare decisions. LPNs play a key role in this process by encouraging individuals to engage in ACP; help people express their wishes for future care and encourage communication of these wishes to decision makers.

A personal directive should be completed by everyone over the age of 18, and is best done while an individual is in good health. As circumstances change, the personal directive can be updated to appropriately reflect those changes. It is intended to give voice to the wishes of an individual who may, due to a medical emergency, be unable to speak for themselves. The Personal Directive is a gift to the agent who will speak with healthcare providers on an individual's behalf, providing confidence and peace of mind that the individual's wishes are known and will be honoured.

According to the Personal Directive Act, it is our obligation as service providers to ask for the personal directive and follow any directions that may pertain to the situation.

Central to advance care planning is the conversation. The easiest way to start the conversation is by asking your patients if they have a personal directive and to make sure that a copy is on the chart and in their Green Sleeve, if they have one. (A Green Sleeve is a plastic pocket to hold advance care planning forms. Find out more at myhealth.alberta.ca by searching ‘Green Sleeve.’)

LPNs can start a conversation by asking do you have a personal directive? Do you have a legally-appointed decision maker, and do they know what you would want?

Offer your patients resources where they can get more help; for example, hand out the Conversations Matter booklet that goes through the process of advance care planning.

Ensure patients know about the Alberta Health Services website, www.conversationsmatter.ca, where they can access further information, videos and links to more resources. This is also a great resource for yourself where you can obtain copies of all the forms if needed.

If you are having these important conversations, make sure that you are charting on the tracking record, where all disciplines can chart, and placing the original in the Green Sleeve.

Personal directive forms are available free of charge from the Office of the Public Guardian at https://www.alberta.ca/personal-directive.aspx, or Dying with Dignity at https://www.dyingwithdignity.ca/download_your_advance_care_planning_kit, or by creating your own. A personal directive is legal as long as it is written, signed and witnessed. Unlike a will and enduring power of attorney, a personal directive does not have to be completed by a lawyer. If you so choose, a lawyer can do all three documents for you.

Talk with your patients about the process that you have been through making your own personal directive and how important it is for everyone over the age of 18 to have written down their wishes and values in a personal directive.

Our patients, ourselves, and our families all need to be prepared for a medical emergency. Are you ready for the conversation?

References
www.conversationsmatter.ca
In our lives there are different beliefs, experiences, people and actions that bring us meaning and purpose. This is often referred to as "spirituality" which can be broadly defined to mean "whatever brings meaning and purpose to life." Spirituality can look different for everyone and only the individual knows what brings them meaning and purpose. Just as each of us considers what is important and meaningful personally, healthcare providers should also consider this when caring for others.

Spirituality can impact how people deal with illness, make difficult healthcare decisions and cope at the end of life. It can have positive or negative impacts on health and experience. Interestingly, healthcare providers do not always know how to start these conversations or may not feel comfortable in exploring spirituality. As nurses, we are expected to care for the person holistically, and caring for the spiritual self is part of this.

When spiritual conversations occur, they are often profoundly meaningful to patients, and informative and rewarding for healthcare providers.

Assessing spirituality is about learning what is important to the person and integrating this information into the care you provide. For example, a person may indicate that they have strong faith and the faith community was a big part of their lives before illness. Perhaps the patient would enjoy visiting the chapel at their healthcare facility, or engaging in art that allows them to express their faith. Another person may share how important the outdoors has been in their lives, so simply ensuring the curtains are open and supporting the family to take them outside can make a difference. It may not always be this simple; however, if we do not ask, we do not know. Exploring what gives meaning and how the care team can integrate this into daily care can change the care experience.

To support the assessment and integration of spirituality into the care provided, there are several spirituality assessment tools available to support starting the conversation. These tools can also be used to guide documentation and communication with the care team.

Integrating a spirituality assessment and intervention that cares for the holistic self can change how we care and can have positive influence on the health and experience of those cared for.

For more on spirituality assessment and recommended tools, watch the "Integrating Spirituality Into Care" video with Jeanne Weis, MN, BN, RN, CHPCA(c) on the CLPNA's YouTube Channel (www.youtube.com/clpna) or by searching www.clpna.com.

Don't wait for the right OPPORTUNITY; CREATE it.

- George Bernard Shaw -
Liver Logic
Fifty Ways to Love Your Liver

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Signs and Symptoms of Acute and Chronic Liver Failure
- Portal Hypertension - Diagnostics & Management

How to Interpret Lab Tests Related to Liver and Biliary Function
- Hepatocellular Enzymes - ALT, AST, and the AST/ALT ratio
- Hepatobiliary Enzymes—Alkaline Phosphatase, GGT
- Bilirubins - Direct and Indirect

Hepatitis
- Viral Causes: Hepatitis A, B, C, D, E, and G; EBV and CMV
- Alcoholic Hepatitis - An Inflammatory Response to Toxins
- Autoimmune Hepatitis - AIH - Types I & II

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WHO SHOULD ATTEND?
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- Nurse Practitioners, Primary Care Nurses, TeleHealth Nurses
- Nurses in Blood Services, Infection Control, & Public Health
- Home Care & Long Term Care Nurses; Occupational Health Nurses
- Dietitians, Pharmacists, Nurses in Diagnostic Imaging

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

EDMONTON, February 24, 2020 • CALGARY, February 25, 2020
0830 to 1600 hrs.

BARB BANCROFT, RN, MSN, PNP

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WHO SHOULD ATTEND?
- All Regulated Health Personnel in Direct Care Roles
- RN’s, NP’s, RNPs in Acute Care, Critical Care & Special Care Areas
- Professional Staff in Geriatric, Home, Community and Primary Care settings
- Dietitians, Physiotherapists, Pharmacy Staff etc.

The use of dietary supplements, such as vitamins, minerals or herbs, and alternative therapies has become a routine part of the Canadian lifestyle. Nurses and Allied Health Care Professionals are relied on by patients and clients to have accurate information about the uses and effects of these products. But often, these items are marketed as having benefits that are unsubstantiated; do not carry adequate warnings when they interfere with lab tests, and may be misused by the client because they are “natural”. Using evidenced-based research, Barb will present the current clinical findings and safety of the numerous OTC products used for various medical and psychological conditions.

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