Butterfly Care Homes Transform Dementia Nursing

New Competency Profile tied to 2016 Registration Renewal
Stroke Update! Different Strokes for Different Folks

EDMONTON, November 3, 2015 • CALGARY, November 9, 2015
0830 to 1600 hrs / ** New Workshop! **

With BARB BANCROFT, RN, MSN, PNP

Only the Stuff you Need to Know About Neuro Anatomy
- Why TIME is BRAIN; Neurogenetics and Plasticity
- A Brief Tour of your Brain and Cranial Nerves
- Blood Supply to the Brain and Spinal Cord

The Clinical Profile of Ischemic Strokes
- Thrombotic Strokes & Embolic Strokes
- Carotid Stenosis; Atrial Fibrillation
- Symptoms & Incidence
- Modifiable and Non-Modifiable Risk Factors

The Clinical Profile of Hemorrhagic Strokes
- Anemia and Anticoagulation Malformations
- Symptoms & Incidence
- Modifiable and Non-Modifiable Risk Factors

Transient Ischemic Attacks!
- Relevance to Strokes; Symptoms & Treatment

Managing the Risk Factors - Control the Hypertension!
- Hypertension: BP Management; Considerations for the Elderly
- Hyperlipidemia; Medication
- Hypoglycemia: Obesity, Inactivity & Alcohol
- Hypertension: The Pill, Obesity and Clotting Risk
- A Word about Brain Boosters

Treatment and Management of Strokes
- Stroke Scales; Recommended Stroke Evaluation Time
- Labs & Imaging Studies
- Current Therapies: Recanalization, Intravenous rt-PA
- Mechanical Thrombectomy: MERCI Retriever & Penumbra Device
- Post Stroke Depression

Strokes in Children & Young Adults

Calgary: November 9, 2015
0830 to 1600 hrs

With BARB BANCROFT, RN, MSN, PNP

Okay... So you only have 5 Minutes!
- The Patient's History, the Chief Complaint, Signs and Symptoms
- Using the PQRST Mnemonic as a Framework
- AAA – Associated Symptoms, Abnormal Symptoms, or ALARM Symptoms
- Revisiting the "Vital Signs" - The Importance of Critical Thinking
- For Example: Using the PQRST to Evaluate Various Types of Pain

Quick Evaluation of Vital Signs
- What's Not Normal? Special Vital Signs Considerations
- Heart Rate, Pulse...and Drugs
- Respirations – Use the KUSMAL Mnemonic
- Blood Pressure Evaluation....and Meds
- Temperature – Special Considerations in the Elderly

Other Important Stuff
- Medications in the Elderly and their Effect on the Physical Assessment
- Evaluating Kids; Vertical Growth, and Iron, Heart Rate
- When is Weight a "Vital Sign"?

The Physical Examination – Quick but Thorough
- Brushing Up Your Inspection, Auscultation, and Palpation Skills
- Sharpening Cardiovascular Exams - From Heart Sounds to JVD
- Improving Respiratory Exams – From Crackles to Hemothorax
- Enhancing GI & GU Exams – From Quadriants to Acute Abdomens
- The Most Important Thing in a Gym Exam
- The Two- Minute Neuro Exam
- Skin! Lesions, Rashers, Hives, & Cancer
- What You Need to Know about Something Called the “Likelihood Ratio”

Barb Bancroft is a widely acclaimed nursing teacher who has taught courses on Advanced Pathophysiology, Pharmcology, 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 practicse, 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?
- Medical, Surgical, ICU, and ER Nurses
- Acute & Long Term Care Nurses in Urban & Rural Settings
- Rehabilitation and Special Care Unit Nurses
- Rehabilitation Therapists with an Interest in Stroke

This one day seminar discusses the latest information on stroke diagnosis and treatment. The lecture will commence with a review of neuroanatomy and the blood supply to the brain and spinal cord. Barb will then discuss a comprehensive overview of modifiable and non-modifiable risk factors for both ischaemic and hemorrhagic strokes as well as the treatment and prevention of the identified risk factors. Barb will differentiate between hemorrhagic and ischemic strokes as well as the differences between thrombotic and embolic phenomenon. Barb will focus on the classic clinical presentations for both hemorrhagic and ischemic strokes based on specific arteries involved. Barb will also discuss the acute neuro exam for the patient presenting to an emergency room with possible stroke symptoms using the NIH Stroke Scale and she will also discuss the neuro exam for the patient with chronic stroke signs and symptoms. Acute emergency treatment for hemorrhagic and ischemic strokes will be discussed as well as chronic treatment protocols.

Conference Fees:
- $179** + $8.95 GST = $187.95 Middle Rate (on or before October 19, 2015)
- $189** + $9.45 GST = $198.45 Regular Rate (after October 19, 2015)
Price includes conference sessions, lunch, coffee breaks, and handouts.

Physical Assessment Pearls

With BARB BANCROFT, RN, MSN, PNP

RED DEER, November 10, 2015 • Radisson Hotel Red Deer
0830 to 1600 hrs

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 "POQRST + AAA" 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 viral signs exam. Barb will also discuss various drug classes and the side effects that can confound a physical exam. Join us!

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

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Price includes conference sessions, lunch, coffee breaks, and handouts.
From Knowledge Users to Knowledge Creators

Every day as nurses interact with patients and families, their decisions are informed by empirical evidence derived from research, supported by the wisdom of their experience and practice-based knowledge. Indeed, the hallmark of most professions is their foundation on a body of empirical knowledge that is unique to each profession. Equally important is the need for professions to be creators of new knowledge through active involvement in research and applying evidence to their practice.

Considering these concepts and the future of healthcare, CLPNA is increasing our focus on research. We have a strong commitment to engaging in research that is focused on the role of the LPN, their place in the healthcare team, and the quality of their professional practice. Over the past decade, we have partnered with colleges, universities, professional associations and employers in an attempt to include an LPN lens in healthcare and nursing research. We have commissioned respected researchers to conduct research on our behalf, we offered professional development opportunities related to research, published relevant research-based articles in our CARE magazine and hosted research sessions at the CLPNA conferences. All these were deliberate steps in the transition from being knowledge users to knowledge creators. And we believe now is the time to embark upon a larger role in this important direction.

In October 2015, we welcome a new role within the College for a Director of Research. The Research Director will lead the development of research capacity within our membership, and develop a research and knowledge integration plan that will inform our practice, our policies, and our place in the healthcare system.

The lack of research within the profession is often a barrier to innovative or creative changes in practice. We know that Licensed Practical Nurses have a wealth of nursing knowledge, some very unique to our profession. We see an opportunity for LPNs to step forward and showcase evidence-based practice by implementing best practices at all levels of care. To do this, we plan to foster a culture of research by guiding the advancement of LPN skill in asking critical questions, proposing and integrating new research evidence, and generally creating an attitude and culture of curiosity within the profession.

This work will empower Alberta LPNs. The CLPNA will work closely with our members as key stakeholders throughout the research process.

This is a big step forward in our development as a profession. We have the potential to transform from knowledge users to knowledge creators – a major accomplishment in the professionalization of Licensed Practical Nurses.

We invite all LPNs to embrace a greater emphasis on research to prepare for a new tomorrow and we look forward to your engagement in the process.

Jo-Anne Macdonald-Watson, President and Linda Stanger, Executive Director
The numbers are in, and the ranks of LPNs are growing. The Canadian Institute for Health Information has published their annual report detailing trends in the nursing workforce for the three groups of regulated nursing professionals in Canada.

Numbers of licensed practical nurses grew steadily in the past ten years while the profession grew younger. The report also tells us that 48.5% of LPNs were employed in a hospital setting, and of those, 46.9% were younger than age 40 in 2014.

**Terminology:**
LPN - Licensed Practical Nurses
RN/NP - Registered Nurses including Nurse Practitioners
RPN - Registered Psychiatric Nurses

Twenty years ago in the U.K., Dr. David Sheard began quietly piloting a radical model of care for people with dementia that he hoped would make a difference in one or two care homes. Today, he is the CEO and founder of Dementia Care Matters and his Butterfly Care prototype has become a global dementia model. This past July, the first of several Canadian pilot projects launched here in Alberta.

In 1995, the belief was that dementia led to behaviours like pacing and picking, and the behaviours led to the need for a safe environment and the use of antipsychotics to calm people down. Sheard believed the complete opposite — that the behaviours of people with dementia were being caused by the culture of care around them and not by the disease.

Sheard believes licensed practical nurses (LPNs) have a crucial role to play in Butterfly Homes. He sees LPNs as being the glue between different staff teams, the person who orchestrates the various players to engage with residents and create well-being.

“I think LPN have seen themselves as singular professionals. I would describe them as not realizing they’re the conductor of an orchestra. What I’m wanting them to do is create a connected team where the core role of the LPN is the lived experience of people,” said Sheard.

The foundation of the Butterfly Care model is that there is a language of dementia. This language is about feelings, not facts. If you learn this language and join a person with dementia in their reality, accepting the things they say as making complete sense, then the behaviours associated with dementia diminish and eventually disappear.

Sheard began his career as a social worker and spent a total of 14 years moving up the administrative chain in the U.K., eventually overseeing dementia care services for the National Health Service. His despair at how dementia care was handled made it “humanly intolerable” for him to remain in that culture.

“Feelings matter most to every one of us each day. That was missing in dementia care. It was so medicalized. So institutionalized. So about them and us,” he said.
A Butterfly Care Home is set up like a household. There are no uniforms. The environment is not clinical or sterile. There’s no watching people eat. Nursing staff and residents all assist with the functioning of the household.

LPNs, in particular, are released from task-based care to a model of care that’s all about connecting to people by creating a meaningful environment, through purposeful occupation and through shared mealtime experience. Staff do not push facts or logic but instead live in the moment, the resident’s moment, connecting with their present, not their past. Transforming the environment into a place of acceptance is where people with dementia come alive, according to Sheard.

“Sheard believes you can change a person with dementia’s life in thirty seconds, even working outside of a Butterfly Home model. He uses the example of someone with dementia asking for a slice of toast: “Do you give them the piece of toast silently? Do you give them the toast, with some choice and say you hope they enjoy it? Or when asked for a slice of toast, do you rub your stomach and say you’re hungry too, that you’d like to share toast with them, offer them white or brown bread, show them real choice — offer them jam or marmalade, smell the marmalade and talk to them about oranges? It takes 30 seconds to transform a task. Any LPN in any care setting can decide to change that moment.”

In October 2014, Dr. Sheard presented the outline of his model and general elements of culture change at CLPNA’s Think Tank. He will be presenting again at the CLPNA conference in April 2016 where he says he will be drawing from eight months of learning from the inaugural Canadian Butterfly Home pilot projects. These first three projects are underway at Copper Sky Lodge in Spruce Grove, Whitemud Lifestyle Options Retirement Community in Edmonton and Villa Marie in Red Deer. Sheard will be sharing learnings from these homes and speaking about how LPNs can take centre stage in this culture change model.

“Leadership is key to this. Real leadership is freedom to think outside the box. It’s about trust, openness, empowering and enabling staff to find the answers. This isn’t rocket science,” said Sheard. “This is giving permission to the staff to be human and to find the humanness in each other.”
“I shall pass this way but once. Any kindness I can do, or goodness show, let me do it now – for I shall not pass this way again.”

Quote on the wall of Terry Duce, LPN, Clinical Care Coordinator, Cardston Medical Clinic
The story of the Cardston Medical Clinic begins with a patient-centric ending:

“All people are beautiful,” says Terry Duce, LPN, and Clinical Care Coordinator at the Cardston Clinic. “There have been really warm moments when a patient and I have shared something that can’t be shared with anyone else. That’s why I’m a nurse. I love my community and its support for me and my family. This is my way of giving back.”

Healthcare is a means. The “end” is a person…a patient…a life…people who struggle or thrive in body and/or spirit.

When you are medically worried or not feeling well, can you get timely access to non-emergency healthcare? The Cardston Clinic has an answer for you: same-day service, amidst a regional Primary Care Network where care within three days is the ambitious objective. “We aren’t a walk-in clinic but we are,” Terry says. “Perhaps your little boy’s fever has you nervous. Access means that when people need help, it’s urgent to them. We’re always going to say bring your child in and we’ll see your child is taken care of.”

When you have a chronic condition and could be helped by that feeling that someone is looking out for you, the Cardston Clinic is there. They have a mission statement, a Lifestyles program, and a Chronic Disease Management program for you. LPN/RN teams of two in each of the programs are focused on education and complex care planning.
The Lifestyles program (Linda Tolman, RN and Shelly Prince, LPN) helps people manage their weight and stay healthy. Its aggressive program enrollment, education, and quantitative tracking have been highly successful and are being emulated in other clinics with mentorship support from the Cardston Clinic.

The Chronic Disease Management program is focused on self-empowerment. It’s a matter of “starting low and going slow” in the words of Cindy Haskins, LPN, who has been with the program for five years.

“If you tell a diabetic truck driver who is 20 kg overweight to munch on a small salad and nuts in their packed lunch, it’s not going to happen,” Cindy says, adding that customization is key to still living the good life with disease as opposed to having it control you. “Everyone has different motivational triggers. You have to look at a whole life, not just a singular condition. We can have an altruistic desire to get all patients to a desired end state, but every journey looks different.”

Core LPN activity in the Chronic Disease Management program revolves around diabetes, COPD, hypertension and asthma education, with remaining time focused on testing. Insulin starts, blood pressure management and education, asthma education, spirometry testing and diabetic foot care form a day-to-day focus. Cindy describes her collaborative partner – Jade Leavitt, RN – as fantastic to work with, with reliance on each other to advance the program. Terry adds the clinic is working to advance the LPN role to the point that there is no gap in flow of patient care if Jade is away.

Cindy’s office is full of creative doodads that help people understand their condition. Perhaps the most compelling is the string of chemical ingredients pulled out of a larger-than-life cigarette, generating a rather visceral “eww” in reaction. “Proactive disease management begins with understanding what the body is doing and not doing, and how our various parts tie together in body health,” Cindy observes.

Among Cindy’s long list of continuing education courses is a reflection of the increased role “mind over matter” plays in chronic disease management:
Our role is to facilitate...to be an enabling connection that provides knowledge, builds a trusting relationship, and lets someone know they are not alone on their journey.

Positive Psychology. Understanding Psychology. Emotional Control and Difficult Personalities.

Asked if patient interaction is akin to addiction counselling where a person has to self-own a condition, Cindy nods her head. “Breakthroughs are largely psychological. Our role is to facilitate...to be an enabling connection that provides knowledge, builds a trusting relationship, and lets someone know they are not alone on their journey.”

Successes include a patient stopping by the clinic to say hi, a wound that resolves or test numbers that improve...the small victories. There are also the bigger differences Cindy describes: seeing happiness, having people see that life can be good and they don’t need to be a victim, people who extend time with their family. “Good days are when we see the change not just in their bloodwork, but in their eyes,” Cindy says.

You appreciate some warmth in a world that can be cold. To be a name and not just a number. The Cardston Clinic has a customer service mantra for you.

“There’s a prescription, see you later” is too common in today’s medical system,” Terry says. “Without explanation or context, the end result is you don’t get the buy-in needed to make a long-term difference in people’s health and well-being.”

“We walk in the patient’s shoes,” Terry notes. “We meet people where they are mentally and physically, and go from there.”

Terry also notes that kindness and compassion go a long way, and that means looking at the details. “We thought about the ‘cattle call’ – how it’s easy to default to the cold-feeling announcement of ‘Mr. Smith’ in the waiting room. How much nicer it is to come out and say ‘Good morning, can I take your coat, and how are you doing this morning?’”

Ron Johnson, Clinic Manager, went so far as to have clinic staff watch a customer service video series he had obtained during his days in car sales, focused on the little, often overlooked things that can make a big difference in quality of experience.

Would one venture to call the clinic customer service-driven? The answer is revealed in activities that focus on:

Patients:
- “Well-woman” and “well-man” letters are sent to those who haven’t recently been in for a check-up, screening, or vaccine.
- A quantitative performance management system focuses on Electronic Medical Records (EMR) and sets screening and test result goals. Ron says the system is one of the best in the province, and includes goal setting, automated reminders, and access to all clinic doctors when a primary care doctor isn’t available.
- Phone consultations with nurses when circumstances warrant.
- An Access Improvement Measures (AIM) program that maximizes efficiency of resources to increase patient access. Clinic successes have included fine-tuning work flow to maximize the use of all staff.
- An aggressive smoking cessation program, including a targeted mail-out offering cessation care.
- A easier-to-use “live voice” phone system.

People:
- An “extended family” clinic culture.
- A “just in time teaching” philosophy that sees clinic staff apply creativity to further connections with patients. “We’re proactive,” Terry says, noting clinic flexibility in flagging additional screening and education opportunities.
- A commitment to conference attendance to learn best practices, including a conference in Alaska focused on Aboriginal culture.
- Twice-a-month staff meetings to talk about issues and ideas, attended by everyone from medical staff to receptionists.
- A “hire for personality; skills can be taught” philosophy that seeks compassion, humility, empathy and team-player qualities in new hires.

Community:
- Community outreach at local events, and operation of a satellite clinic in the community of Stand Off on the Blood Reserve.
- An appreciation of community, since small town living means you see patients at basketball games and church.

Also of note is Terry’s initiative to take an immunization course and offer immunization through the clinic, which now provides flu, pneumococcal, tetanus, diphtheria, and travel vaccinations. Knowing area screening numbers are low, Terry and Shelly are also taking a cervical screening certification course to establish a women’s health program by year-end. Mentored by Dr. David Playfair and Dr. Esther Tailfeathers, an RN-gearred course is being modified by the clinic for LPN-context, with guidance from the CLPNA. Staff also nurture strong relationships with...
the region-based Chinook Primary Care Network, and with public health nurses and pharmacists, which has led to clinic access to ensure public health records are updated, and the pharmacists’ ability to update flu shot information to clinic EMRs.

You can say you are patient-centred, and you can BE patient-centred. The former is talk; the latter is action. Action requires catalysts.

For the Cardston Clinic, those catalysts come in the form of what Terry describes as an “I am the pitcher, you are the back-catcher” calibration of a medical team who understands their mission, and who embrace leadership from anyone with good ideas about how to enhance care.

Dr. Sandy Cunningham, Improvement Lead Physician, says one catalyst is a tight-knit physician team which ensures all staff are full scope, and who believe in team and trust. “When we’re focused on patient care then everyone in the process has an important role to play,” Dr. Cunningham notes.

Ron says a catalyst was the arrival of the Primary Care Network mandate eight years ago, which has enabled the employment of nurses who have considerably expanded the range of health services available in the community.

As Clinical Care Coordinator, Terry plays an important role in the search for new ideas, and as a communications hub between doctors, management, nurses, and medical office assistants to nurture process improvement and service enhancement. Then there’s what Terry would say is her much-beloved jack of all trades role in seeing patients, educating, giving meds and injections, managing ECG, Holter and blood pressure monitors, mid-week work with Dr. Playfair’s patients as part of his nursing team, and booking colonoscopy screenings at the Cardston Hospital for Dr. John Rottger.

Whether it’s a trip to the hospital to address a new diabetes diagnosis, expansion of the immunization program, or the exploration of options for seniors’ living, Terry identifies communication as a bridge that is vital to the patient-centric perspective.

The bridge-building has been enabled by Terry’s migratory pathway: 15 years at the Cardston Hospital as a unit clerk, a start at the Cardston Clinic as an office assistant, mid-career completion of the LPN program at NorQuest College in 2007, and appointment to the Clinical Care Coordinator role two years ago. In short, Terry has deep relationships with, and direct working understanding of, many healthcare system touch points that can make progressive change happen.

Terry is adamant that she’s just a “spoke in the wheel,” and the wheel of clinic success turns because of the work of every staff member.

That said, consider Terry’s story as an aspirational LPN mantra to “aim high” – a guidepost that reflects LPN professional practice advances. Further, Terry is one of a growing number of strong, pioneer-spired LPNs who are successfully assuming Clinical Care Coordinator roles throughout Alberta.

What’s the secret that makes the Cardston Clinic successful?

Here are a few words for thought: Patient-centric. Self-empowerment. Proactive. Connection, kindness and compassion.

YOU come first...the WHOLE you at the Cardston Clinic. You walk your medical path at your speed, with a little help from your clinic friends.

The Cardston Clinic

- Full service medical clinic.
- 7 physicians, 3 LPNs, 2 RNs, support staff.
- Patient base of 11,000 people, including two-thirds of 10,000 Blood Reserve residents, and strong Hutterite and Mormon communities.
- External consults: addictions, mental health counsellors, dietitian, podiatrist.
- A teaching clinic, including LPN and RN preceptorships.
Canadian Patient Safety Week Boosts Safe Care

Every year, thousands of healthcare providers and patients take part in Canadian Patient Safety Week and Canada’s Virtual Forum on Patient Safety and Quality Improvement.

What do they all have in common? A passion for safe care!

Canadian Patient Safety Week is returning October 26 to 30. This year’s theme focusses on improving communication to make care safer. CPSW packages are available to order, and include 15 posters, 15 tent cards, 20 buttons, 200 Hands in Healthcare magazines, and many more materials for healthcare providers to host an effective and fun campaign in their facility.

Canada’s Virtual Forum on Patient Safety and Quality Improvement is back again, broadcasting from Edmonton from October 28 to 30. Learn about the latest and greatest in patient safety in person, or from the comfort of your workspace!

The theme of Canada’s Virtual Forum, “When workplace joy thrives, patient safety comes alive!”, is woven into every session. Last year’s participants indicated a desire to learn more about culture and workplace dynamics, and this year’s forum is going to deliver.

Some of the compelling sessions and speakers lined up for this year:

• **Patient Safety 101** - Dr. Ward Flemons, Health Quality Council of Alberta
• **When Caring Hurts; Helping Helpers Heal** - Dr. Diane Aubin, Canadian Patient Safety Institute; Dr. Cheryl Connors, Canadian Network for Respiratory Care; Dr. Bruce MacLeod, Alberta Health Services; Dr. Katrina Hurley, IWK Health Centre

Canadian Patient Safety Week is a national annual campaign that started in 2005 to inspire extraordinary improvement in patient safety and quality led by the Canadian Patient Safety Institute. Canadian Patient Safety Week is relevant to anyone who engages with our healthcare system: providers, patients, and citizens. Working together, thousands help spread the message to Ask. Listen. Talk.

Established by Health Canada in 2003, the Canadian Patient Safety Institute (CPSI) works with governments, health organizations, leaders, and healthcare providers to inspire extraordinary improvement in patient safety and quality.

Join the conversation at #asklistentalk. For more, go to www.asklistentalk.ca, or contact CPSW@cpsi-icsp.ca, (780) 409-8090, 1-866-421-6933 (toll free).
WORKSHOPS COMING TO ALBERTA IN FALL/WINTER 2015-2016

SELF-INJURY BEHAVIOUR IN YOUTH—Issues and Strategies
Edmonton: October 13-14, 2015; Calgary: October 14-15, 2015
ANXIETY—Practical Intervention Strategies
Edmonton: October 15, 2015; Calgary: October 16, 2015
MINDFULNESS COUNSELLING STRATEGIES—Activating Compassion & Regulation
Calgary: November 9-10, 2015; Edmonton: November 11-12, 2015
CRITICAL INCIDENT GROUP DEBRIEFING
Edmonton: November 23, 2015; Calgary: November 26, 2015
DE-ESCALATING POTENTIALLY VIOLENT SITUATIONS™
Edmonton: November 24, 2015; Calgary: November 25, 2015
TRAIN-THE-TRAINER Certification Program for De-Escalating Potentially Violent Situations™
Edmonton: November 24-26, 2015
ADDICTIONS & MENTAL ILLNESS—Working with Co-occurring Disorders
Calgary: December 8, 2015; Edmonton: December 10, 2015
ADDICTIONS & YOUTH—Creating Opportunities for Change
Calgary: December 9, 2015; Edmonton: December 11, 2015
BRIEF FOCUSED COUNSELLING SKILLS—Strategies from Leading Frameworks
Calgary: February 8-9, 2016; Edmonton: February 11-12, 2016
AUTISM—Strategies for Self-Regulation, Learning & Challenging Behaviours
Edmonton: March 8-9, 2016; Calgary: March 10-11, 2016
CHALLENGING BEHAVIOURS IN YOUTH—Strategies for Intervention
Calgary: March 9, 2016; Edmonton: March 10, 2016

MEMBER PLAN
Both CTRI and ACHIEVE offer separate membership plans that provide the member with unlimited access to our pre-recorded webinars.

MEMBER BENEFITS:
• Unlimited access to all pre-recorded webinars whenever and however often you want. New content added throughout the year.
• Ability to download useful PDF handouts and worksheets, exclusive to members.
• Notification of special discounts and promotions on products and public workshops only available to members.
Please visit our websites for details.

To register or for more information:
info@ctrinstitute.com www.ctrinstitute.com 204.452.9199

LEADERSHIP RETREAT—Building Teams That Last
2015
Bonif: February 18-19, 2016
When you’re finished growing as a leader—you’re finished! The best leaders continuously develop themselves through education, personal reflection and conversation with others.
ACHIEVE’s two-day leadership retreat is an opportunity to engage with other leaders from across North America and explore topics relevant to your role as a leader. Please visit our website for details.

To register or for more information:
204.452.0180 www.achievecentre.com info@achievecentre.com

ALBERTA PUBLIC WORKSHOPS FALL/WINTER 2015-2016

PERSONALITY DIFFERENCES—Myers-Briggs for Individual and Team Development
Calgary: October 13, 2015; Edmonton: October 16, 2015
COACHING STRATEGIES FOR LEADERS—Conflict, Performance, Change
Edmonton: November 5, 2015; Calgary: November 6, 2015
ASSERTIVE COMMUNICATION
Calgary: November 17, 2015 & March 14, 2016; Edmonton: November 18, 2015 & March 15, 2016
EMOTIONAL INTELLIGENCE—Expanding Influence
Calgary: November 18, 2015 & March 15, 2016; Edmonton: November 19, 2015 & March 16, 2016
DEALING WITH DIFFICULT PEOPLE
Edmonton: December 14, 2015; Calgary: December 15, 2015
MANAGEMENT AND SUPERVISION—The Crucial Skills
Calgary: December 14, 2015; Edmonton: December 15, 2015
LEADERSHIP—Creating Opportunities for Change
Calgary: February 9, 2016; Edmonton: February 12, 2016
DIFFICULT CONVERSATIONS
DIVERSITY AND CULTURE—Strategies for Working with Differences
Edmonton: March 30, 2016; Calgary: March 31, 2016
A client’s health record is the main communication tool for the healthcare team. It is also a medical and legal document that tells the story of a client’s background and situation. It enables others to understand treatments and care the client did or did not receive. From a legal standpoint, the client’s chart or record becomes evidence if a lawsuit is initiated. This article will briefly discuss the relationship of accurate documentation with the legal process. It will highlight some protective strategies a care provider may utilize. Please note that this article is not a substitute for legal advice.

The Legal Process

Documented care is just as important as the actual care. The legal system assumes care was not done if it has not been documented. Failure to document care implies failure to provide care (Lippincott, Williams & Willkins, 2009). According to Crawford and Whelan (Osgoode Law School, 2013), regarding the justice system, “good notes will save you and no notes can destroy you”. Therefore, your documentation practices can make the difference between positive and negative legal outcomes. Your documentation may be reviewed for a College complaint or coroner’s inquest. Accurate documentation ensures compliance with legal requirements of provincial laws, employer policies and procedures and College standards and practice guidelines.

Once a lawsuit is commenced, all relevant information regarding a case must be collected. This information is disclosed or shared by both legal teams, the facility or agency, and the care providers who were either directly or indirectly involved with the case. Avenues of investigation and audit can include:
- the client’s full record
- their MAR (Medication Administration Record) or dispensing records
- professional responsibility forms and incident reports
- work schedules and shift trades
- number of clients on a given unit
- the number of staff on vacation, away ill and on time off
- physician appointments or healthcare professional credentials
- human resource or employment files such as performance reviews, family complaints, and interpersonal memos
- the academic grades of a care provider and whether he or she has engaged in professional development activities
- staff mandatory education and training
- policies and procedures of the employer to ensure employer expectations are clear and current
- Internal memos or notes.

Incident reports, though generally confidential, are always reproducible should a legal issue arise. Some agencies or facilities have a client relations department to address family concerns and have notes of interviews or meetings held with family or staff. Although emails may be deleted from...
a computer, they are reproducible and may be used as evidence. Personal notes, sticky notes or a care provider’s diary of an adverse client issue may be demanded by the legal team.

**Plaintiff vs Defendant**

In a potential lawsuit, there are lawyers who act on behalf of the plaintiff (the one who initiates the lawsuit and claims injury, death or damages). There are also lawyers who act on behalf of the defendant(s) or those who are accused of wrongdoing. The defendants could be a physician, facility or agency, or care providers involved in a lawsuit. Lawsuits can become complex when manufacturers of biomedical equipment or pharmaceuticals become involved.

Although you may never be named as a defendant in legal case, you may be called to testify at a discovery or during a trial. You will need to depend on your documentation and not your memory to respond to questions regarding your client care. The client chart or record has the most comprehensive record of care and it is used to reconstruct events. The legal system ultimately wants to prove cause and effect of damages or injuries, and the court accepts the actions and the communications in the client record as proof that these events did or did not occur.

Lawyers for the plaintiff use documentation to prove that the standard of care was breached or not met. The client record is inspected to see that the care was competent, safe and appropriate, as well as completed. The plaintiff’s lawyer is looking for lapses in charting, errors, amendments, deletions, inconsistencies and vague entries. He is trying to draw inferences or conclusions of sub-standard practices.

The lawyer and his team often engage experts to obtain critical opinions. If documentation was done before the care was completed, a plaintiff’s lawyer could argue that the care was never done. Likewise, if the care was completed after the fact and documentation did not indicate a late entry, a plaintiff’s lawyer could argue that the care was altered. Late entries after a serious incident involving death or serious injury may be viewed with suspicion.

The legal team for the defendants are attempting to prove that the standard of care was met and was safe, timely and appropriate for the client. The actions of the care provider are examined to see if they are prudent and reasonable and there is no causal link between the actions of the care provider and the client's injury or death. The team is attempting to show there were no lapses in documentation, errors, inconsistencies or vague entries. An unbiased, healthcare expert may be hired to verify that the defendant's documentation and actions did not breach the standard of care.

**Improve Your Legal Status**

Although very few adverse events go to trial, the following strategies may assist you to improve your legal status:

- Develop a usual or your own practice statement to rely on if your memory fails. For example, (1) it should be your usual practice to shred draft client notes each day, and to (2) communicate to a receiving care provider using SBAR (Situation, Background, Assessments, and Recommendations) or other employer-approved communication tool. Personal practice statements offer added protection in the legal process.
- Incident reports are first used as evidence by the agency or facility in internal investigations. Terms such as “mistake” or “error” convey that something you did or did not do was your fault. Write about facts only, be objective and do not use accusations or blame.
- If you keep personal notes, be prepared to share these with both legal teams. It is generally not in your best interests to keep private files and notes on client care events.
- Record promptly at the time of the event as long delays create a negative impression of the care provider and may be viewed as gaps in client care.
- Record only what you saw, heard or did.
- Record chronologically and be cautious with late entries.
- Record frequently and promptly with client changes, and according to facility or agency policy.
- Record corrections clearly and according to employer policies and procedures.
- Record accurately and completely as the client record should contain assessments, identification of health issues, plan of care, implementation of care and the evaluation of care. Time and details do matter.
- Address facility or agency documentation policies that are not realistic for your healthcare setting.

By considering and applying best practices in documentation, a prudent care provider will ensure a high measure of legal and professional protection. Because your memory often fades with time, your documentation is your evidence for timely, safe and competent care.

References are available on request.
I never thought much about post-traumatic stress disorder (PTSD). Like most people, I thought PTSD was something that only combat soldiers experienced. Then I met my wife. She grew up around PTSD like I grew up around schizophrenia. Her father had been through things in World War II that would have destroyed a lesser man. He fought with flashbacks and nightmares the rest of his life. It is now known that having a parent with PTSD may mean an increased chance of their children developing it as an adult. It’s possible because those who develop PTSD have often suffered from depression previous to the trauma, and depression often runs in families.

For my wife’s family, I suspect it was due to a strong sense of duty. They all served their country or communities. That tends to put you in the line of fire, whether soldier or police officer. My wife went into law, but instead of taking a job in a cushy law firm, she went to work for a non-profit helping family farmers and the homeless. She came up against a group of white supremacists and didn’t back down. She testified against them in court and refused witness protection. They tracked her down, stabbed her several times, and threw her headfirst and backwards down a marble staircase. When that didn’t kill her, her assailant slammed her head into the stone floor and choked her to unconsciousness, thinking she was dead. As she often says, the women in her family are hard to kill.

The attack left her with a brain injury that ended her career, and a back injury that put her in a wheelchair for eight years. It also left her with a serious case of post-traumatic stress disorder. Insurance in the United States is complicated. Because she was in her office building when the attack occurred, her personal insurance said it was work related and wouldn’t pay for her care. Because she was not in her office, and it was after regular office hours, workers’ compensation refused to pay. This meant that she never received treatment for her neurological injuries or the PTSD. She eventually taught herself to walk again. The PTSD wasn’t as easy to fix.

People ask her if it is hard to be married to someone with schizophrenia. She explains that she has the ability to separate me from my illness. When I have breakthrough symptoms and think the TV is talking to me, she doesn’t get mad at me, or afraid of me; she just tells me that if the TV is talking to me, I should turn it off and go to bed. She reserves her anger for the disease. When she has flashbacks or nightmares that keep her up all night, I don’t just get angry at her disease, I get angry at the people who hurt her. I actually get a bit angry at her for being so forgiving of the men who hurt her. When I see her in pain or rubbing one of her old scars, I get really angry.

When a round of flashbacks begins, I try to figure out what might have been responsible for setting them off. I’m a scientist at heart, and I think I should be able to fix things. Watching the woman I love fight with demons in her sleep is really hard. Her illness doesn’t just affect her, it affects the whole family. When she has nightmares, our basset hound wakes her up. If he doesn’t get his solid 18 hours of sleep every day, he can be grouchy. Without proper sleep, she wakes up in more pain than usual. When she is in pain, it scares our son.

There are so many things she can’t do because of the PTSD. Something as easy as answering the phone can be beyond her reach when her symptoms flair up. Sometimes I feel like I am walking on egg shells, afraid that I have done or said something to set off her symptoms. No amount of her reassurance helps. Sometimes I feel like I am developing PTSD from watching her pain. She has always refused to take painkillers stronger than regular Tylenol. She watched a good friend get on the opiate merry-go-round, and didn’t want to go down the same path. It must be hard to be a medical professional who sees people in pain every day.

She and I are both damaged, but we refuse to give up or hide. We were both supposed to be something else by now. I was supposed to be a professor. She probably would have been a judge. She likes to say that life is what happens to you while you are making other plans. At some time in our lives, we will all experience a temporary or permanent disability. It is how we respond and adapt to those challenges that will make the difference in how happy and fulfilled our lives will be.

Dr. Austin Mardon was a respected young scientist when he developed schizophrenia. He has dedicated the rest of his life to advocacy for the mentally ill, and was awarded the Order of Canada in 2007 for his work. The story of his incredible life can be discovered in his book, Tea With the Mad Hatter.
Sixteen years ago, John McCullough made the decision to leave his oilfield career behind and enter the world of nursing – and the profession is the better because of it. John is the 2015 recipient of the Pat Fredrickson Excellence in Leadership Award, for LPNs who demonstrate excellence in leadership, advocacy, communication and a passion for the profession.

John is the Resident Care Manager and Acting Site Lead at Devonshire Care Centre in Edmonton, and is deeply committed to ensuring quality resident-centred care. Known for his positive attitude, the ease with which he interacts with residents, and his focus on professional development, John has earned the respect of his co-workers, residents and families alike. John is involved with a number of internal and external committees including Leadership, Quality Care and the Employee Management Advisory committee, and leads the End of Life/Comfort Care committee. He represents the centre at Park Place Seniors Living Clinical Leaders meetings, and at the Leader’s Forum in Vancouver, B.C., and is a role model for all staff in the way he carries out his leadership responsibilities.

He talked to CARE Magazine about his inspiration behind becoming a nurse, how his parents lead the way, and how he got where he is today. The interview has been edited for clarity and length.

Why did you become a nurse?

My parents were older. My dad was in his mid-50’s when I came along, so I always felt that I grew up with seniors and was very comfortable with them. I spent a lot of time with veterans down at the Legion. My mom was a nurse, and my sister is a respiratory therapist. I was in the oilfield years ago, but lost my job when oil went below $10 per barrel. When I decided to go into nursing, I had two kids under the age of 2. I did my LPN training at NorQuest College from August 2000 to September 2001. I supported my family by working nights and weekends at Extendicare Holyrood as a Health Care Attendant. My first job was at Capital-Care Strathcona in September 2001, where I’m still on casual. It helps me keep my skills up and see both sides of the job. I also worked at the Glenrose Rehabilitation Hospital from September 2001 to September 2003 on the Orthopedic Trauma unit and in the Adult Brain Injury unit. I’ve always had great managers. Karen Fitzgerald, who hired me in my current position, was very encouraging and took the leap to hire an LPN as a Care Manager. It will be 4 years in October in this position.

I’m very fortunate to be a male LPN. It does get you noticed!
What’s your leadership philosophy?

Be open-minded. It all starts there. If you listen and are willing to hear different perspectives, you’ll always get a better response. People buy in when they’re included. I don’t think I’m a typical leader. I’m not type A; I’m more a collaborator and listener. Listening is important. People want to be heard – both staff and families. I always have time to listen and offer encouragement. My dad was an influence on my leadership style. He was very relaxed by the time I came along, though maybe not as much for my older siblings (I’m the youngest of five). He was a listener.

In my first days in my current position, people were respectful but not necessarily supportive and I had to build relationships and show that my door is always open.

Tell us about your family and life outside of work.

I now have five kids aged 17 and younger, four of them girls, including my stepdaughter who I adopted as of today [the day of the interview]. My fiancé is an LPN too and is a home support supervisor for Strathcona County.

My dad emigrated from Ireland when he was two, and my mom when she was 19 years old. She worked as a nurse in Camrose.

I like golf, but finding the time for it is hard. We like to travel and have been to the Dominican Republic, Hawaii and Disneyland in the past 5 years. We’re about to go camping in Saskatchewan.

What advice do you have for new LPNs or those wanting to follow in your footsteps?

My advice is keep going! If you want to be a manager, seek it out. You’re never ‘just’ an LPN. Pursue education, find and take courses. LPNs are achieving so much. It’s an exciting time to be an LPN!

The CLPNA congratulates John on his outstanding achievements and is proud to recognize his work and dedication to the profession!
Peter and his wife Ellen* were both diagnosed with cancer in their late 50s. In 2002 Peter was diagnosed with prostate cancer and in 2004 Ellen was diagnosed with breast cancer.

Peter received extensive treatment, including surgery, radiation, hormone therapy and chemotherapy. To say he had all the treatments available is an understatement. He told me once that his hope was for his current treatment to remain effective long enough for the next treatment to be invented. Similarly, Ellen went through surgery, chemotherapy and radiation.

Canadians have a 41-45% chance of developing cancer within their lifetime, with the most common cancers being lung, breast, colorectal and prostate. The good news is that with new and more effective treatments being discovered each year, more and more people are surviving cancer than ever before.

That should be a good news story, but how good this news is depends on what survival looks like. The fact is that the short and long-term side effects of treatment commonly experienced by cancer survivors (those who are in the midst of treatment and those who have completed treatment) can have a significant impact on their quality of life. Common problems include fatigue, memory problems, pain, muscle wasting and changes to the heart, lungs and bones.
Both physical abilities and quality of life have been shown to improve among cancer survivors who participate in exercise programs.

One study found that 71% of cancer survivors noted one or more of these problems even 10 years after completing their treatment. Research also shows that the distress that cancer survivors experience relates more to their level of disability than to their diagnosis, stage or treatment for cancer.

There is evidence to suggest that exercise can have a significant effect on physical function and quality of life for those who are currently undergoing treatment, or who have completed treatment for cancer, regardless of the type of cancer, stage of cancer or prognosis. Exercise has also been shown to decrease an individual’s risk of developing cancer.

At the time of his semi-retirement, Peter told me his job is to exercise and take care of his health. To that end, he had a regular workout with a personal trainer and used the stationary bike year round, he also continued to downhill ski in the winter and hike and golf in the summer (always insisting on walking the 18 holes).

Afraid of the risk of lymphedema, Ellen started exercising at the local gym and says that if she skips her workouts her shoulder feels tighter. In case that wasn’t enough motivation, she also noted that those regular workouts have helped her to be a better golfer.

Peter and Ellen’s exercise programs were both successful in allowing them to continue to travel extensively. During his time as a cancer survivor Peter celebrated the marriages of both his children and the birth of four grandchildren while enjoying a high quality of life until the final year of his illness. Sadly, Peter died from cancer in 2014, 12 years after his diagnosis.

The last ten years saw Ellen accompany Peter on their many adventures and she continues to enjoy a high quality of life. Regular exercise is a major contributor to that.

Research suggests that Peter and Ellen’s experience with exercise as cancer survivors is not unusual.

Some things that you may not know about cancer and exercise:
1. Participating in exercise during and following treatment helps to decrease cancer related fatigue.4,5,6
2. Some cancer survivors avoid adopting exercise programs due to the inaccurate belief that the effort would be “ludicrous or futile.”4
3. Many cancer survivors report avoiding exercise due to a fear of increasing their symptoms of fatigue, nausea and shortness of breath, but exercise has been shown to decrease these symptoms.4
4. In addition, exercise has been shown to slow or prevent the functional declines often associated with cancer and cancer treatment. 7
5. Participating in regular exercise also helps to improve self-esteem and self-efficacy,7,8 providing an important sense of control to a difficult and often out-of-control time in one’s life.
6. Participation with exercise is “associated with improved survival, prevention of new cancers, and earlier detection of some types of cancer.”2
7. Both physical abilities2,8 and quality of life have been shown to improve among cancer survivors who participate in exercise programs.2,6,7
8. The benefits listed were demonstrated among a mixed patient group that included those who were done cancer treatment, those who were receiving active treatment and those who were in the end stages of cancer.4

Interestingly, most survivors significantly overestimate the amount of exercise they are getting through routine daily activities. Many have also indicated that they believe their physician’s generic recommendations to keep active are an indication that they should continue with their daily activities rather than engaging in more formal exercise.4 Although at Physiotherapy Alberta we often advocate for active lifestyle adoption rather than formal exercise regimes, this is one case where people may benefit from more formalized, supervised exercise programs, both to ensure safety when exercising4,8 and to ensure participation.4

Cancer survivors have unique signs and symptoms and may have other health conditions to factor into their exercise planning, therefore there are no one-size-fits-all recommendations for what exercises to participate in and which ones to avoid. Depending on the type of cancer, the presence of metastatic disease and treatment considerations, specific recommendations are most appropriate to ensure safe exercise.

Consulting a physiotherapist who is experienced in cancer care is a good first step. Check our website for a physiotherapist who works with cancer survivors at http://www.physiotherapyalberta.ca/physiotherapists/physiotherapist_listings. Search for “Cancer care and rehabilitation.”

* Names have been changed

References available upon request.
here are over 40,000 Albertans (725,000 Canadians) living with Alzheimer’s disease or other forms of cognitive impairment. Experts tell us this number may double in the next 15 years. This massive increase in the number of Canadians living with some form of dementia will place a huge load on the healthcare system.

Of these individuals, many have or will experience at some point in time the phenomena of wandering. Individuals leaving assisted living facilities or hospitals without notice, and often without proper clothing, pose a significant safety risk to themselves. There are many, many documented instances of seniors ending up outside in freezing weather without adequate winter clothing and many of these cases end up with tragic results.

Enter the concept of Global Positioning Satellite (GPS) tracking.

Alberta Health Services (AHS) will shortly be introducing a pilot project, similar to programs in place in Europe and in other Canadian jurisdictions, whereby a GPS device worn like a bracelet is provided to dementia sufferers to facilitate prompt tracking in the instances where that individual has gone missing. Locating the patient/resident would be as easy as turning on a computer, and the time taken to locate the wearer will be reduced from hours to minutes. The project will include the involvement of researchers with AHS and the University of Alberta’s Faculty of Rehabilitation Medicine.

Aside from the obvious benefit to the patient/resident, the use of devices such as these provide much-needed comfort to relatives or friends, while freeing police resources which otherwise would be consumed with the search. In Calgary, for example, police statistics revealed over 250 missing persons investigations last year which were somehow linked to AHS facilities (either hospitals or extended care).

But what about the ethical issues? Would the placement of a GPS tracking device on a patient, or a resident of a care facility, breach that individual’s right to privacy? That is the argument advanced by critics of the program. As well, there are concerns with just how far the use of this technology might be extended. For example, could the wearing of such a device become mandatory for all patients, so that bathroom visits or attendance at suggested therapy sessions could be monitored? Or the frequency of stepping off-site for a cigarette? Undoubtedly there is a flavour of “Big Brotherliness” attached to this project.

Advocates of the project would argue, however, that patient safety should trump any suggestion of invasion of privacy, especially if use or access to the tracking program is rigidly controlled, monitored and audited.

One individual interviewed in conjunction with the pending project cares for her 84-year-old mother, who suffers from dementia and short-term memory loss. She says she wouldn’t hesitate to provide her mom with GPS if she ever felt there was a danger of her wandering off and getting lost. “We put them on our phones and I have a GPS unit in my car, so in case it gets stolen they can track it down,” she said in response to questions from a reporter. “If we have GPS for things like that, why wouldn’t we want it to protect the people most precious to us? We could prevent all sorts of tragedies.”

Jill Petrovic, spokeswoman for the Alzheimer Society of Calgary, says keeping such patients safe is paramount – and GPS, if used prudently, appears to be a useful tool. “Although it’s a widely debated issue, it really comes down to making some tough personal choices. Ideally, the family would have these discussions earlier on as part of their future planning.”

That may be the final answer to the critics – consent, or advanced directives. If the patient/resident (assuming he/she is capable of giving an informed consent) is okay with wearing the device, or if the personal representative consents, surely that puts an end to the debate and provides safety and comfort to the individuals and their families.

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LPN Student Research at Cutting Edge of Wound Care

ew advances in wound care and closure were recently researched by LPN students at Edmonton’s NorQuest College. Supervised by NorQuest instructor Harrison Applin, PhD, RN, Valentina Sagdeeva and Shannon McIvor’s paper, titled “Student Inquiry: Cold Plasma and Chitosan Wound Welding”, reports on an Israeli-developed wound closure procedure using cold helium plasma and chitosan film to effectively weld wounds closed. Chitosan is a commercially-produced substance made from chitin, “the structural element in the exoskeleton of crustaceans (e.g., crabs and shrimps) and the cell walls of fungi”, and offers “good biocompatibility and biodegradability and is capable of accelerating the wound healing process” (Hants et al., 2014, p. 4). Their research also reports on the benefits of plasma treatment on patients and healthcare providers, and includes a case study on using this material and technique on a patient recovering from Caesarean section.

The CLPNA is pleased to spotlight this excellent student research. To read their full paper, please email info@clpna.com.
Introduction

Aging of the Canadian population, particularly in rural areas, and increasing migration to urban areas by younger people means the proportion of rural persons with dementia (PWD) will be increasing. Care partners (informal caregivers) of PWD have reported the need for guidance related to the disease process, available support resources, and how to deal with difficult behaviours, as well as the need for a “coach and advocate” to help them navigate the healthcare system. While healthcare practitioners (HCPs) are expected to take an active role in ensuring that PWD and their care partners are equipped with the knowledge they need to provide safe and quality dementia care, HCPs recognize that they often lack this knowledge.

Research Questions

The overall purpose of this research was to enable HCPs, care partners, and PWD to use dementia care information more effectively by examining their information needs, how these change over time, and how they access, assess, and apply the knowledge. Our specific research questions were:

1. What are the stages of the dementia care journey and the types of information needed by rural community-based HCPs, care partners, and PWD at each stage?

2. Where is this information accessed, how is it assessed, and how is it applied by rural HCPs, care partners, and PWD at different stages of the dementia care journey?

Knowledge Exchange in the Rural Dementia Care Journey

Dorothy Forbes, University of Alberta; Sara Finkelstein, University of Calgary; Catherine Blake, Western University; Maggie Gibson, St. Joseph's Healthcare London; Debra Morgan, University of Saskatchewan; Maureen Markle-Reid, PhD, McMaster University; Ivan Culum, Western University; Emily Thiessen, University of Alberta.
What are the stages of the dementia care journey and the types of information needed by rural community-based HCPs, care partners, and PWD at each stage?

The longitudinal data revealed changing information needs during the long gradual deterioration of the PWD as the symptoms of dementia progressed.

The stages of the dementia care journey included: (i) recognizing the symptoms, (ii) receiving a diagnosis, (iii) initiating and using home care and respite services, (iv) long term care (LTC) placement, and (v) decisions related to end-of-life care. Each dementia care journey was an individualized experience, with overlapping stages, and not always linear in process.

Recognizing the Symptoms
Symptoms of dementia were first recognized by care partners. These led them to believe there was an underlying pathological process at work that included marked changes in behaviour and personality, misplacing objects, and forgetting or incorrectly remembering life experiences. At this early stage, PWD and their care partners identified that they needed information about how to recognize early signs and symptoms of dementia, where and when to go for help, and how to manage behavioural changes.

Receiving a Diagnosis
A diagnosis was helpful because it confirmed for PWD and their families that this disease had a name and there was help available. PWD and their care partners needed information that would help them manage the symptoms and slow the progression of the disease. Information was frequently exchanged on healthy lifestyles, keeping physically and mentally active, and available medications. Other types of information requested by care partners during this stage included potential safety issues, home care options, or other forms of help and support. HCPs attempted to tailor the amount and kind of information to what the PWD and care partner(s) could cope with and were interested in knowing at this stage.

Loss of Independence
Care partners and HCPs preferred that the transfer of decision-making authority to another family member was completed while the PWD could still participate in this process. However, when this was not possible, guidance and information were often needed on how to ensure that decisions were made for the PWD in his/her best interests and based on the PWD’s prior attitudes and interests. All of the participating PWD experienced aspects of decreasing independence that were identified as: (i) deferring to the care partner for care decisions; (ii) losing a driver’s licence; and (iii) appointing a trustee or power of attorney (medical and/or financial).

Long-term Care Facility Placement
The longitudinal data clearly revealed the approaches used by the care partners to prolong keeping the PWD at home and how controlled they felt about placing them in LTC. Care partners experienced feelings of guilt but recognized that it was the only way to ensure their family member’s safety and well-being. Care partners typically needed some time to get used to the idea of LTC placement prior to seeking information. The desire to keep the PWD as close to home as possible due to the long travel distances in part governed their choices for LTC facilities.

End-of-Life Care
HCPs spoke about the importance of discussing end-of-life care with care partners to let them know what to expect and their options for treatment and support. However, it was often a conversation that was delayed or avoided. Family members often avoided the conversation as well. However, in a couple of cases, family members were grateful that palliative care had been discussed with them, that they now knew what
to expect and were more prepared for the future.

2) Where is dementia care information accessed, how is it assessed, and how is it applied?

Care partners accessed information from family members, friends, local organizations, and dementia internet sites. PWD tended not to identify the need for dementia care information. HCPs accessed dementia care information from their own organization, other organizations, and internet sites. Care partners and HCPs assessed the trustworthiness of the information based on whether the source was a well-known agency or their own organization.

3) What are the barriers and facilitators to knowledge exchange?

Barriers to knowledge exchange included: lack of rural community-based services for dementia care; care partners reluctance to seek help and limited energy; and lack of integration of dementia-related services and supports. Facilitators of knowledge exchange included: rural care partners with healthcare experience who were actively seeking information; development of trusting relationships between HCPs, care partners, and PWD; and formal mechanisms for exchanging information within and across rural community-based organizations.

Conclusion

This research illustrates the stages of the dementia care journey, and the types of information typically needed, accessed, assessed, and applied at each stage. HCPs can use these findings to support rural care partners in navigating their dementia care journey. Support is needed as care partners often do not have the time, energy, skills, or knowledge to seek out dementia care information independently. In addition, PWD typically do not recognize the need for this knowledge, leaving care partners potentially isolated in this journey. Developing formal linkages within and across rural organizations will facilitate knowledge exchange and the delivery of cost effective, quality dementia care. However, additional rural community-based resources are urgently needed to implement these recommendations. This may require a redistribution of resources from acute care to rural community care.

The full research summary of “Knowledge exchange throughout the dementia care journey by Canadian rural community-based healthcare practitioners, persons with dementia, and their care partners: an interpretive descriptive study” is available from Dorothy Forbes, PhD, RN, Professor, Faculty of Nursing, University of Alberta, 3rd Level ECHA 11405 87th Avenue, Edmonton, Alberta, T6G 1C9. Email: dorothy.forbes@ualberta.ca.
Long ago, when I was twenty and still in university, I worked in a Veteran’s Home as a Nursing Attendant. I’d often work mornings helping the staff get the men up and ready for the day – and then run across campus to my English class, dressed in my nursing uniform and white nylons.

I’m remembering that experience today. Nursing Attendants are true bedside workers. We were the ones who worked directly with the gentlemen on the nursing unit – many of whom required extensive care. We cleaned up things that the housekeeping staff wouldn’t touch. But we also had the luxury of time to spend with the veterans, as we helped them get dressed, or patiently helped feed them meals.

Nobody talked about the War. At the time, there was even a World War I veteran at the Vet’s Home – but there were many veterans from World War II and Korea. While the war was in the distant past, it lived with these men every day. These were just ordinary men who had found themselves in terrible circumstances. The scars from those war-time experiences often were manifested in estranged families, whispers of abusive behaviour and alcoholism. I remember helping men to bed after their return from the Legion, reeking of whiskey, and slurring their words.

But that wasn’t the whole story. The wars had affected a cross-section of the population of men, and there were many dignified, lovely residents at the Veteran’s Home. They enjoyed the company of the young nurses who were there to support them, and many of them reminded me of my own grandpa. It was important for the staff to remember that these ‘residents’ were also fathers, granddads, brothers and sons.

There were many stories of kindness at the Vet’s Home. My clearest memory was one winter, when I was working nights. On night shift, there was a lot of sitting around at the nursing desk, waiting to respond to call bells. Every few hours we would have rounds, where we would quietly walk through the unit, checking on the men, emptying urinals, and turning those who were immobile so they wouldn’t get bedsores.

One night, my patient assignment included an elderly man named Henry. He was in the last stages of life, and his breathing was increasingly noisy and laboured. He had no family or friends to visit him in his final hours. After our first set of rounds, I excused myself from the desk to sit beside his bed. Henry had yelled and sworn at me in the past, but all that didn’t matter now. His hand had paper-thin skin, and I held it softly through the wee hours of the night. It was a long shift. When I left at 7 am, I said a quiet good-bye and gave him a gentle kiss on his forehead. I did not look back when I left the room.

I read Henry’s obituary in the paper a few days later.

I learned many things from working at that Vet’s Home. One was to duck fast if something was being thrown at you. My other realization was that healthcare is really about acts of kindness. And that no man should ever die alone.

Lest we forget.
resources

CONNECTIONS

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

Alberta Gerontological Nurses Association
www.agna.ca

Alberta Hospice Palliative Care Association
http://ahpca.ca

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

Canadian Association of Neonatal Nurses
www.neonatalcann.ca

Canadian Association of Schools of Nursing
www.casn.ca

Canadian Association of Wound Care
www.cawc.net

Canadian Orthopaedic Nurses Association
www.cona-nurse.org

Canadian Hospice Palliative Care Nurses Group
www.chpca.net

Community Health Nurses of Alberta
www.chnalberta.ca

Creative Aging Calgary Society
www.creativeagingcalgary.com

Emergency Nurses’ Interest Group of Alberta
http://nena.ca

LEARNING LINKS

Study with CLPNA
www.studywithclpna.com

ACHIEVE Training Centre
http://www.achievecentre.com/

AHS Education Resource Centre for Continuing Care
http://www.educationresourcecentre.ca/

Advancing Practice
http://www.advancingpractice.com/

Canadian Virtual Hospice
www.virtualhospice.ca

Critical Trauma Resource Institute (CTRI)
http://www.ctrinstitute.com/

Cumming School of Medicine - University of Calgary
http://cumming.ucalgary.ca/physicians/cme/courses

de Souza Institute
http://www.desouzainstitute.com/

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

Learning LPN
http://www.learninglpn.ca/

Learning Nurse
http://learningnurse.org/

Reach Training
www.reachtraining.ca

Registered Practical Nurses Association of Ontario
http://www.rpnao.org/practice-education/e-learning

UBC Interprofessional Continuing Education
www.interprofessional.ubc.ca
LPNs are rushing to view, download and order their copy of the 3rd Edition of the Competency Profile for LPNs (2015). The recently revised 274-page document is necessary to complete Learning Plans for 2016 Registration Renewal.

The Competency Profile defines LPN scope of practice in Alberta. Released in June, the 3rd Edition shows the rising of the profession over the 10 years since its predecessor was released.

The CLPNA advises caution to LPNs completing the Registration Renewal’s Learning Plan, where all reporting is by code. Some Major Competency Areas and many Competency Codes have changed between the 2nd and 3rd Editions. At least 15 basic and 11 additional competencies were updated in the 3rd Edition.

Major Competency Area “S” Clinic Based Nursing Oncology
Competency Code “O4” Assessment for Appropriate Placement Dementia Care

Competency codes from the 2nd Edition will continue to define previous year’s Learning Plans, including 2015.

The Competency Profile:
• identifies base competencies of a typical entry to practice LPN
• serves as a tool for LPNs interested in changing or advancing their area of practice or scope of practice
• provides direction to Practical Nurse Educators regarding essential curriculum components
• guides employers in understanding full scope of practice for role optimization of LPNs across all care settings
• provides a benchmark for performance management and review

The Competency Profile is not intended to:
• be inclusive of all potential competencies required of LPNs. (Some competencies may have been inadvertently omitted.)
• represent the competencies that all LPNs must achieve
• specify obligations and/or requirements of LPNs for third party agencies or any other outside party
• be permanent, but must be updated on a regular basis as requirements and technologies change

Order a print version
In August, print versions became available to order:
• BINDER – Continuing Competency Program for LPNs (in 3-Ring Binder) with Competency Profile for LPNs, 3rd Ed.; Standards of Practice & Code of Ethics (2013) & more. ($50 member or $55 non-member)
• INSERT – Competency Profile for LPNs, 3rd Edition (2015) (shrink-wrapped; 3 hole-punched; insert-only, not in a binder). ($40)
Order Forms are available from www.clpna.com under “I Am a Member” or by contacting info@clpna.com.

Download or print from website
Those requiring immediate access to a 3rd Edition may download or print a copy from CLPNA’s website, www.clpna.com. Look under “I Am A Member” for the Competency Profile for LPNs.

The complete Profile is 274 pages. Individual competency areas are also available.

Upcoming webinars
Watch for more webinars explaining the changes between the 2nd and 3rd Editions of the Competency Profile. Six webinars were presented in June and September.

For more about the Competency Profile for LPNs, contact CLPNA at info@clpna.com, 780-484-8886 or 1-800-661-5877 (toll free in Alberta).
Members must complete the annual Registration Renewal Application in order to:

- work in Alberta as a Licensed Practical Nurse in 2016 (registration type Active)
- OR change registration type to non-practicing (Active to Associate; or Active to Inactive; or Associate to Inactive)
- receive regulatory and practice information
- keep registration in good standing

For complete policies and our step-by-step guide “How To Guide for 2016 Registration Renewal”, go to www.CLPNA.com, “I Am a Member”, “Registration Renewal”. CLPNA staff is also available to assist you with the process.

Beginning October 1, most LPNs will renew their registration for an Active Practice Permit for the 2016 calendar year. The CLPNA encourages all members to renew before the December 1 deadline for the lowest fee and best access to support. Those renewing before November 1 will be entered in a draw for $350 cash! This will be the first Registration Renewal requiring LPNs to complete their Learning Plan using the 3rd Edition of the Competency Profile for LPNs released in June.

Registration Renewal notice emails are sent in late September. Members who do not receive a notice should ensure their email address is correct on their member profile at https://www.myCLPNA.com and check their Spam or Junk folders. Or contact CLPNA at info@clpna.com, 780-484-8886, or 1-800-661-5877.

Practicing Without a Current Practice Permit is Illegal
Only individuals with a current CLPNA Practice Permit are authorized to use the title ‘LPN’ or work as a Licensed Practical Nurse in Alberta, as per Section 43 of the Health Professions Act. Working as an LPN with an expired or invalid Practice Permit is considered unprofessional conduct and violation will subject the individual to disciplinary action, including fines of $500 and up.

Renewing Online
To begin the 2016 Registration Renewal process, go to myCLPNA directly (https://www.myCLPNA.com), or to www.clpna.com and click on the blue “myCLPNA Login” link located in the screen’s upper right corner.

No computer or internet access? Computers are available at the CLPNA office or local library, or ask employers, colleagues, family or friends. For security reasons, ensure you log off after renewing.

Preparation Checklist
Before logging in, please have the following ready:
- User ID (CLPNA Registration Number) and Password for https://www.myCLPNA.com
- Nursing practice hours calculated for Jan 1 - Dec 31, 2015
- Continuing Competency Program (CCP) Learning Plan for 2016
- Current employer information
- Payment information
Registration Renewal Fees & Deadlines

<table>
<thead>
<tr>
<th>Fees Paid</th>
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<tr>
<td>October 1 - Dec 1</td>
<td>December 2 - 31</td>
<td>After Jan 1</td>
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<td>$350</td>
<td>$380</td>
<td>$400</td>
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Fees may be paid online by credit card (VISA or MasterCard), INTERAC® Online (TD Canada Trust or RBC only), or by previous enrollment in Pre-Authorized Payment Plan (PAP). All fees will change at 12:00am (midnight) on the dates listed. CLPNA Payment Policy: Registration Fees are not pro-rated and are non-refundable. All fees are in Canadian dollars.

Not able to use the above payment methods? Contact CLPNA during business hours to make alternate arrangements before starting the online Registration Renewal Application.

Renewing Registration Oct 1 - Dec 1
Members are urged to renew before the December 1 deadline for the lowest fees and most support. Renew by November 1, 2015 to be automatically entered into our Ready, Click, Win contest to win $350!

Renewing Registration from Dec 2-31
Members are reminded that renewal support is only available during CLPNA office hours. The CLPNA will be closed December 22-26, open 8:30am-2:00pm on December 31, and closed January 1.

Reinstating Registration after Dec 31
On January 1, the Registration Renewal system will close. Applicants must contact CLPNA to request a Reinstatement Application Form.

Practice Permits
After completing Registration Renewal, most members will receive immediate access to their Practice Permit & Tax Receipt on the “Permits & Receipts” tab. Exception: Pre-Authorized Payment Plan (PAP) subscribers will receive access to their Practice Permit in late November after their final payment is processed for November 2015.

Associate Membership
Members who, for any reason, do not plan to practice as an LPN in Alberta in 2016 but may return to practice in the future are encouraged to renew as an Associate for $50. Associate status is a non-practicing registration type; therefore, it does not allow you to work as an LPN. Associate members continue to receive CARE magazines, practice updates, and registration renewal notices. If an Associate member decides to return to practice before the next renewal period, the Reinstatement Fee ($50) is waived due to the Associate Fee and only the Active Registration Fee of $350 will be required.

Members Not Renewing
Members who, for any reason, do not plan to practice as an LPN in Alberta in 2016 and do not plan to return to practice in the future, should officially notify CLPNA by changing their registration type to “Inactive” on their 2016 Registration Renewal. This serves as formal notification to CLPNA and ensures the member’s practice hours for 2015 and Continuing Competency Learning Plan completion are on file. If Registration Renewal is not completed, further reminders and suspension/cancellation notifications will be sent to the member as required by the Health Professions Act.

Proof of Registration on Public Registry
The CLPNA strongly encourages employers who require proof of LPN registration status for 2016 to use CLPNA’s Public Registry at www.clpna.com. The Public Registry shows an LPN’s current and future registration status, specialties and restrictions.

Prepaying 2017 Registration Renewal Fees
The Pre-Authorized Payment Plan (PAP) is a CLPNA payment option that allows members to pay their 2017 Registration Renewal Fee using automatic bank withdrawals of $35/month for 10 months. Go to www.CLPNA.com, “I Am a Member”, “Registration Renewal”, “Pre-Authorized Payment Plan”.

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

CLPNA HOLIDAY HOURS

<table>
<thead>
<tr>
<th>Regular Office Hours</th>
<th>Mon – Fri, 8:30am – 4:30pm</th>
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<tbody>
<tr>
<td>December 21-25</td>
<td>CLOSED</td>
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<tr>
<td>December 28-30</td>
<td>OPEN</td>
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<tr>
<td>December 31</td>
<td>closed 2:00pm</td>
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<tr>
<td>January 1</td>
<td>CLOSED</td>
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Ready, click, WIN!
Complete your 2016 Registration Renewal by November 1, 2015 to be automatically entered.

See back cover ad for details!
3 Elected, 1 Re-Elected to CLPNA Council

The results are in from this year’s Council Elections and three new faces will join the team this September as District Representatives. Only Diane Larsen was re-elected to a second term as the Edmonton-area representative. Their two-year terms begin September 1, 2015.

On that same date, Richelle Sutherland will begin her enhanced role as Council Vice-President. The President and Vice-President positions are elected by Council members from within their ranks.

Council Election Results
• District 2 (Calgary & area) – Jean Collins, LPN (1st term)
• District 4 (Edmonton & area) – Diane Larsen, LPN (2nd term)
• District 6 (Grande Prairie & area) – Joyce Rossiter, LPN (1st term)
• District 7 (Fort McMurray & area) – Sara Schmidt, LPN (1st term)

The Council Election ran from June 15-30. Election ballots were emailed to eligible LPNs residing in those Districts and voting took place online.

The Council is the governing body of the College of Licensed Practical Nurses of Alberta (CLPNA) consisting of Licensed Practical Nurses elected from each of the seven CLPNA Districts, plus the President, and government-appointed public members.

Barb Bancroft’s “Geriatrics” Seminars come to Calgary

Canada is aging, and knowledge about healthcare for the elderly is becoming more valuable.

LPNs and all healthcare professionals are invited to attend Barb Bancroft’s key seminars on “Clinical Focus on Geriatrics” in Calgary this November, presented by CLPNA. Barb Bancroft RN, MSN, PNP is a widely-acclaimed national speaker noted for her humorous, entertaining and information-packed seminars. Her latest book is, “Kiss My Asparagus: An Essential Guide to Nutrition’s Role in Health and Disease”.

Alberta LPNs with an Active Practice Permit may apply for full fee reimbursement through the Education Grant Program (http://foundation.clpna.com).

Register to attend one, two, or all three!

<table>
<thead>
<tr>
<th>CALGARY</th>
<th>Nov. 17</th>
<th>Polypharmacy: The Pearls, the Perils, and the Pitfalls</th>
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<tr>
<td>Nov. 18</td>
<td>The Neurology of Aging</td>
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<tr>
<td>Nov. 19</td>
<td>The “OLD TICKER”: The Geriatric Heart</td>
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</tr>
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Registration Fee: CLPNA Members – $125 (incl. GST) per Seminar.
Non-Members – $165 (incl. GST) per Seminar.
These full-day events are from 8:30am - 3:30pm. The fee includes lunch.

For registration or education grant information, contact info@clpna.com, 780-484-8886 or 1-800-661-5877 (toll free in Alberta).
CCP Validation Confirms Lifelong Learning

Congratulations to all CLPNA members who participated in this year’s Continuing Competency Program Validation (CCPV). Since the program’s initial launch in 2003, this was the largest campaign with more than 2100 Licensed Practical Nurses involved. 95.2% of the participants met the submission deadline.

There were many exemplary submissions. One member referred to her professional learning portfolio as “The Art of Reflection”, in which she shared a powerful quote by Albert Einstein, “Wisdom is not a product of schooling but of the lifelong attempt to acquire it”.

CCPV ensures Licensed Practical Nurses are lifelong learners who continually reflect on and improve their nursing practice through education. Meeting the requirements provides an opportunity to continue self-directed learning by reflecting on learning completed over the past two years, and assessing how this learning is integrated into nursing practice.

For more about CCPV, visit www.clpna.com under “I Am a Member”.

CLPNA Committee Recruitment

Volunteering for a CLPNA Committee is a significant step in an LPN’s career to support and influence the profession.

Opportunities are available for the 2016-2017 term in two primary areas of interest. The first, protection of the public, is accomplished through the Hearing Tribunal and the Complaint Review Committee. Second, upholding standards in LPN education, competence and practice is achieved through the Registration and Competence Committee. Orientation, training, honorarium, and travel expenses are provided.

Complete info about Committee positions is available at www.clpna.com/about-clpna/committees. Resumes are accepted until November 1 by Donna Doerr, HR Assistant, at ddoerr@clpna.com, or contact 780-484-8886 or toll free at 1-800-661-5877 for more info.
Nurses are among an ever-growing number of working professionals who feel overwhelmed and frustrated in their attempts to balance work and life in today's constantly changing, high-demand, technology-driven work environment which promotes “24/7 connectedness”. It is widely recognized that significant changes to the work environment over the past few decades have resulted in a culture where the line between our personal and work lives is increasingly blurred and the once-sought “work-life balance” is no longer viewed as an achievable, realistic goal. Many experts like former executive and speaker Teresa Taylor challenge the concept as illogical and simply impossible (Taylor, 2013).

We all know someone who we perceive has achieved balance personally and professionally. How do they do this? They've learned to blend and optimize work commitments, personal time and technology in order to achieve overall productivity in all areas of work and life. The key is successfully adopting the emerging philosophy of “work-life integration”, which research supports is quickly becoming the norm in building better work-life practices. Blending personal and professional commitments through effective use of technology and time management requires self-awareness, self-identity, authenticity, flexibility and one’s own sense of control. (Schachter 2012).

Craig Chappelow of the Centre for Creative Leadership in Greensboro, N.C., in association with Ellen Ernst Kossek, Ph.D., professor at Michigan State University and author of the 2004 book, Work and Life Integration: Organizational, Cultural and Individual Perspectives, have created an online self-assessment tool which helps individuals identify and understand to what degree family and personal time is interrupting work, and vice versa. Recognizing that understanding one’s own behaviours and possible alternatives is critical in moving toward successful integration of personal and professional commitments. Their work identifies the following behavioural patterns, none of which are preferable over the others:

- **Integrators**: those who weave work and personal activities together throughout the day.
- **Separators**: those who seek balance by establishing separate blocks of time for work and life commitments – one does not intrude on the other.
- **Work Firsters**: work takes precedence over all else, protecting work time over family time.
- **Family Firsters**: those who allow family and personal time to interrupt work.
- **Cyclers**: those who switch back and forth between cycles of integration and deliberate separation.
Mr. Chappelow (2012) recommends adjusting personal strategy depending upon job demands and whether your existing approach is ineffective and resulting in increased stress, maintaining “the more we assume actual leadership of our own lives, instead of waiting for someone else to do it for us, the better prepared we are to deal with this unending juggle”.

Literature has shown that having a flexible calendar and purposefully scheduling time for exercise, leisure, and social interactions intertwined with work obligations allows for greater control over one’s time. This can be tricky if you work a shift rotation; however, with a little creativity and determination integrating work and life can be mastered. Another key strategy is to plan ahead — setting annual personal and professional goals and breaking them down to what needs to be achieved daily, weekly, monthly and per quarter. This will increase focused productivity into achievable portions.

Of equal importance to the success of integration is the perceived amount of control you feel in managing the boundaries between your work and personal life. Individuals who demonstrate a high level of boundary control, exercising the ability to decide when to focus on work, family, or blend the two, have a higher success rate overall. Individuals with low boundary control are, not surprisingly, most affected by the stress of trying to manage it all.

As a take-away, experts offer this advice. First, stop attempting to balance work and life. Second, work towards integration instead, which requires keen self-awareness and control to determine what works best for your individual situation. Recognize that there is no “one size fits all” approach, but rather endless possibilities for what successful work-life integration can look like.

References available on request.

NURSING WORD SCRAMBLE

Unscramble the words to find common medical words and phrases.

1. riitazthaoncete
2. tessamhsoio
3. iirolyombogc
4. virtnesnaou
5. cntealr niel
6. adetoicnim
7. tnleam lhteaha
8. oetlgnogyro
9. ceodypons
10. rugesyr
11. cateidsirp
12. adiesse
13. myogahrlopc
14. iutnrtnio
15. lba eulvsa
16. aleersilg
17. eonamiotutdc
18. necofntii

Answers:
1. catheterization
2. homeostasis
3. microbiology
4. intravenous
5. central line
6. medication
7. mental health
8. gerontology
9. endoscopy
10. surgery
11. pediatrics
12. disease
13. pharmacology
14. nutrition
15. lab values
16. allergies
17. documentation
18. infection
Protecting the Public: Hearing Tribunals

The College of Licensed Practical Nurses of Alberta (CLPNA) is committed to ensuring Licensed Practical Nurses (LPNs) in Alberta provide safe, competent and ethical nursing care to the public. The CLPNA’s Hearing Tribunal is one way of accomplishing this.

There are times the competency or conduct of an LPN is in question. When this happens, a complaint may be generated. CLPNA is responsible for managing and resolving any complaints made against LPNs. The Health Professions Act, Part 4, Professional Conduct, defines and outlines the process that must be followed.

A complaint of a serious nature of ‘unprofessional conduct’ is referred to a disciplinary hearing. The Hearing Tribunal functions in a quasi-judicial role which is similar to the court system, whereby evidence is entered and witnesses may be subpoenaed and questioned regarding the allegations against the member. The tribunal collectively acts as a judge in the decision making process.

These disciplinary hearings are legal proceedings and are open to the public. However, the Hearing Tribunal may order that all or part of the hearing be held in private because of the confidential nature of the evidence to be heard.

The Hearing Tribunal is a legislated committee established under the Health Professions Act. LPNs apply for the committee and selected candidates are appointed by Council. The LPNs on this committee are nurses who value safe and ethical nursing practice. In order to be eligible, it is preferred that (but not limited to) LPNs with a minimum of 5 years of nursing practice in any of the following areas: acute care, long-term care, community care, or education.

The Council will appoint no fewer than twelve LPNs who hold an Active Practice Permit and are in good standing with CLPNA. Hearing Tribunal members are appointed for a term of two years and may be re-appointed for two additional two-year terms. In addition to LPNs, twenty-five percent of the Hearing Tribunal is represented by public members. The Government of Alberta has a list of public representatives who may be appointed to Hearing Tribunals under the Health Professions Act.

To assist Hearing Tribunal members, each is provided education which prepares them to understand the professional disciplinary process, the adjudicative role, and their responsibility under the Health Professions Act.
The Hearings Director for CLPNA appoints at least three members to the Hearing Tribunal for each Hearing. The Hearings Director also appoints a chairperson who is responsible for ensuring the hearing process is followed and writing the final decision. There is independent legal counsel available at all hearings to assist the Hearing Tribunal with the process.

Members of the Hearing Tribunal are responsible for:

- Hearing the allegations of the complaint;
- Ensuring fairness by being objective in the consideration of evidence presented by CLPNA Legal Counsel, the Investigated Member and/or their Representative;
- Assessing credibility of information presented by any witnesses;
- Evaluating the evidence;
- Determining if the conduct of the investigated member constitutes unprofessional conduct as defined by the Health Professions Act;
- Determining penalties (or orders); and
- Writing the final decision, within a reasonable time, including reasons for their findings.

If a member is found to be unskilled or has engaged in unprofessional conduct, the Hearing Tribunal determines appropriate measures to ensure the public is protected from unsafe nursing practices. Measures could include remedial activities to enhance the nurse’s skills and/or knowledge deficits and develop strategies to improve their behaviours. The investigated member could be responsible for hearing and investigation costs and/or be fined according to part 10 s. 158 of the Health Professions Act. There is a possibility the Hearing Tribunal may order suspension, condition, or cancellation of a Practice Permit. The Hearing Tribunal may order publication of information from the hearing.

The Hearing Tribunal plays an essential role in ensuring the public is protected from unethical, unsafe or unskilled nursing care.

The CLPNA appoints new members to the Hearing Tribunal every fall. Interested LPNs may submit a resume with cover letter to Donna Doerr, HR Assistant, at ddoerr@clpna.com or contact 780-484-8886 or toll free at 1-800-661-5877.

Resources
- Health Professions Act
- Hearing Tribunal Handbook
- Terms of Reference
The CLPNA has opened its archives to share the most curious and compelling items with CARE readers. We hope you’ll enjoy a look back at everything from high points in LPN history to hairstyles that might be better forgotten...

Do you have pleasing personality traits, good grooming and a willingness to conform to regulations? These were just a few of the suggested requirements for those wishing to start a career as a Nursing Aide in 1965. The newly established Schools for Nursing Aides in Calgary and Edmonton were looking for women between 17 1/2 and 55 years of age for 40 weeks of instruction, tuition-free, including 20 weeks of in-hospital training.

While some aspects of 1965 recruitment do seem dated, applicants were asked to have a ‘genuine interest in people’ – certainly true of today’s successful LPNs as well.
Heart Failure Update

EDMONTON, November 23, 2015 • CALGARY, November 24, 2015

** Brand New Workshop! **

With

CHRISTOPHER COLTMAN, RN, BScN

Topics:

Heart Failure: A Downward Spiral
- A Review of Relevant Cardiovascular Anatomy and Physiology
- A Review of the Continuum of Heart Failure
- Risk Factors for the Development of Heart Failure

You Take My Breath Away
- A Review of Physical Assessment of the Heart Failure Patient
- Life in the Big Apple: New York Heart Association Classification Review
- Methods of Heart Failure Diagnosis

Slowing the Spiral
- Current Therapies and Treatments for Heart Failure Optimization
- Cardiac Re-Synchronisation Therapy (CRT): Explained
- Overview of Home Care Management

Crash & Burn: What do we do Now?
- Profiles of Advanced Heart Failure: INTERMACS Scoring Explained
- A Review of the Treatment of the Patient in Cardiogenic Shock
- Mechanical Circulatory Support Including the Latest Ventricular Assist Devices & More

When All Else Fails...
- Indications and Techniques of Cardiac Transplantation
- Palliative Care and the Heart Failure Patient

Heart failure is a common, disabling and deadly disorder and is thought to be one of the most costly cardiac disorders in terms of annual hospitalization costs and morbidity, despite the tremendous benefit that ACE inhibitors have offered. The dramatic deterioration in quality of life and prognosis when a patient progresses from asymptomatic left ventricular dysfunction to overt heart failure is a major challenge for physicians and nurses. This on day workshop focuses on the recent and more comprehensive nursing and medical interventions that are improving outcomes and quality of life for the heart failure patient.

WHO SHOULD ATTEND?
- Medical, Surgical, Cardiac, ICU, and ER Nurses
- Home Care & Long Term Care Nurses in Rural & Urban Settings
- Primary Care Nurses; Allied Cardiac Staff; Educators
- Dietitians, Rehabilitation Staff with an Interest in Heart Failure

Christopher Coltm a, a graduate of the U of A Bachelor of Science in Nursing program, has been engaged in cardiac and cardiovascular surgical nursing for over 20 years. He has worked in a variety of settings and countries, including Montreal, London (England) and in Riyadh, Saudi Arabia. He has extensive experience in the area of acute coronary syndrome, heart failure and cardiovascular surgery. Chris is well known as an excellent teacher, having over 15 years of teaching experience, and has taught a number of sessions on a variety of topics where his passion for teaching and cardiac care shows. He is currently the Clinical Nurse Educator in the Cardiovascular Intensive Care Unit at the Foothills Medical Centre in Calgary.

Conference Fees
- $169.00 + $8.45 GST = $177.45 Early Rate (on or before October 13, 2015)
- $179.00 + $8.95 GST = $187.95 Mid-Rate (on or before November 9, 2015)
- $189.00 + $9.45 GST = $198.45 Regular Rate (after November 9, 2015)

Price includes conference sessions, lunch, coffee breaks, and handouts.

Risk Assessment of Violence

RED DEER, November 24, 2015

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

With

DR. PHILLIP J. RESNICK, MD

Topics:

Predicting Violence - Can it be Done?
- The Demographics of Violence Prone Individuals
- What is the Risk of Violence in Psychiatric Diagnoses?
- The Impact of Mania, Depression, and Psychosis; The Role of Paranoia
- How Likely is Violence to Occur?
- Assessing Persons with Delusions, Command Hallucinations, Erotomania, Pre-Menstrual Tension, and Homosexual Panic

Clues in the History
- Personality Disorders and Traits: Childhood Factors Correlated with Later Violence
- Affective v. Predatory Violence
- History of Family Violence and Other Important Factors

Current Assessment of Dangerousness
- Behaviour and Risk Factors; Violence Assessment Tools
- The Problem of Countertransference
- Management of Previously Violent Individuals
- Duty to Warn: Third Parties of Potential Violence

Stalkers: The Latest Research and the Risk of Violence
- Stalking Typology, Restraining Orders and Risk Management Prevention; Practical Advice for Stalked Victims

Homicide-Suicide: Who Commits Them and Why
- Spousal/Marital Homicide-Suicide: The Role of Conflict, Non-Conflict and Age
- Facial-Suicide: Profile of the “Family Annihilator”; Role of Altruism
- Mass Murders: Precipitating Events: The Plan and What Factors Predict the Killer’s Decision to Suicidc

One of the most important assessments that mental health practitioners must make today is the client’s potential for violence. Different psychiatric disorders and diagnoses carry different levels of risk and history of personality traits and childhood antecedents will provide additional clues as to whether someone will become violent. During this one-day workshop, techniques and procedures will be discussed as will video case examples and case histories of persons who have committed violent acts.

WHO SHOULD ATTEND?
- Mental Health Nurses, Psychiatrists, Clinical Psychologists, Psychiatric Social Workers and Counsellors, and allied staff who work in mental health, psychiatric, and forensic settings
- Staff in adult or juvenile forensic and/or correctional settings
- Intake and front line staff; Managers & Educators

** Workshop does not address violence in the elderly due to organic causes **

Dr. Phillip J. Resnick is a leading international authority on Forensic Psychiatry, specializing in the clinical prediction of the risk of violence and the assessment of malinger and deception. He has consulted on or provided expert testimony in over a number of well-known criminal cases including those of Jeffrey Dahmer, Timothy McVeigh, Susan Smith, Andrea Yates and the Unabomber. Currently the Director of Forensic Psychiatry at Case Western Reserve University in Cleveland, Ohio, he is also a past president of the American Academy of Psychiatry and the Law. He has written extensively on forensic topics and is well known as one of the most outstanding speakers in the field of forensic psychiatry today.

Conference Fees:
- $179.00 + $8.45 GST = $187.95 Early Rate (on or before October 13, 2015)
- $189.00 + $9.45 GST = $198.45 Mid-Rate (on or before November 9, 2015)
- $199.00 + $9.95 GST = $208.95 Regular Rate (after November 9, 2015)

Price includes conference sessions, lunch, coffee breaks, and handouts.
Ready, click, WIN!

RENEW EARLY & WIN $350*

Complete your 2016 Registration Renewal online by November 1, 2015 to be entered to win back your Active Registration Renewal Fee.

*Prize is equivalent to Active Registration Renewal Fee. To be eligible, members must submit a completed 2016 Registration Renewal for an Active Practice Permit by November 1, 2015. The winner’s name will be publicly announced.