Trust Comes First in Pediatric Home Care

Need-to-know Dementia Facts

LPN Regulation Changes Proposed
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 one 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.

Christopher Coltman, a graduate of the UofA 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 13 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:
- $169.50 + $8.45 GST = $177.95 Early Rate (on or before October 3, 2016)
- $179.50 + $8.95 GST = $188.45 Middle Rate (on or before October 31, 2016)
- $189.50 + $9.45 GST = $198.95 Regular Rate (after October 31, 2016)

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

As a final common pathway or numerous disease states, the early clinical signs of shock can be somewhat non-specific, and as such, can be a contributing factor to the high mortality rates for certain kinds of shock. The nurse can play a key role in identifying shock by the pairing the clinical history with early recognition of symptoms. With high mortality rates for septic shock, which is on the increase, and even higher mortality rates for cardiogenic shock, every nurse needs to know the differences between the several kinds of shock that may present in patients, regardless of the setting. This workshop will review pathophysiology, signs, symptoms, the objective of early, acute and intensive treatment, and various nursing interventions.

Christopher Coltman, a graduate of the UofA 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 13 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:
- $169.50 + $8.45 GST = $177.95 Early Rate (on or before October 11, 2016)
- $179.50 + $8.95 GST = $188.45 Middle Rate (on or before November 7, 2016)
- $189.50 + $9.45 GST = $198.95 Regular Rate (after November 7, 2016)
## contents | FALL 2016

<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>From the College</td>
</tr>
<tr>
<td>6</td>
<td>Ten Nutrition Tips for Shift Workers</td>
</tr>
</tbody>
</table>
| 8    | COVER STORY  
**Trust Comes First in Pediatric Home Care**  
CareGivers Home Health Care offers excellent pediatric home care in Edmonton, with LPNs providing both complex bedside care, and strong management skills behind the scenes. |
| 14   | Life Expectancy for First Nations in Alberta |
| 15   | New IPAC General Standards |
| 16   | Speaking Out For Change:  
A Personal Story about Life in Long Term Care in Alberta |
| 20   | Delirium Management and Prevention |
| 23   | 10 Facts We All Need to Know about Dementia  
Check your knowledge of dementia diagnosis and treatment with these 10 facts. |
| 24   | TECHNOLOGY  
Apps for Today’s Nurses |
| 27   | The Operations Room  
News for CLPNA members |
Regulation Consultation - It’s Time for Change

To regulate and lead the profession in a manner that protects and serves the public: this is the mandate of the College of Licensed Practical Nurses of Alberta, and it’s not new to a self-governing profession like ours. In 2001 the Health Professions Act (HPA) brought about a new way of regulating health professions. The HPA introduced overlapping, non-exclusive scopes of practice and a system for managing high risk interventions (restricted activities) through authorizations for those professions appropriately educated and regulated. Additionally, a new way of thinking was introduced, focusing on the concept of competence (knowledge, skills, attitudes and judgment) and autonomy, rather than the previous focus on delegation of tasks.

Adopting the HPA quickly, with the LPN Profession Regulation coming into force in 2003, was a strategic move for CLPNA. LPNs had just completed a mandatory education upgrade (1996-1999), our Competency Profile (1st Edition, 1998/2000) was adopted and for the first time, it clearly defined LPN competencies. Employers were eager for the new scope of practice that included intramuscular injections and administration of vaccines. But there was more. Our profession was ready for a Regulation that allowed LPNs to work more independently, with autonomy rather than ‘under the direction’ of registered nurses, psychiatric nurses or physicians (LPN Regulation, 1997).

Being an early adopter of change comes with opportunities and challenges. Our opportunities in the last 13 years have been vast and this is showcased in our newest version of the Competency Profile (3rd Edition, 2015), along with the varied roles for LPNs throughout the health system, particularly in high acuity and leadership areas. The challenges have been ongoing related to the facilitation of a clear, concise and aligned understanding of restricted activities, specifically what they are and what interventions are included within each one. This challenge remains today, with heightened impact in the last few years through issues with bladder scanning and dispensing, motivating a strong need for changes to the 2003 LPN Profession Regulation.

CLPNA initiated the process of updating the 2003 Regulation several years ago, starting with a consultation with employers related to the gaps in the Regulation. This process continued with ongoing policy work within the CLPNA and resulted in many proposed changes to LPN Regulation and specifically to the Restricted Activity authorizations for LPNs. Additionally, Council approved a draft ‘Standards of Practice for LPNs on the Performance of Restricted Activities (2016)’ to further clarify restricted activities authorized for the profession and outline specific parameters.

For several months CLPNA has been collaborating with Alberta Health to prepare our proposed Regulation amendments for the Alberta Health consultation process, which occurred over the summer. At the same time, CLPNA performed a member survey with rich feedback from LPNs related to the proposed changes. We have had great response from all parts of the system and have great support for many of our proposals, along with questions related to others, and through the fall, we will be reviewing and managing all consultation feedback in preparation for moving forward.

Our goal remains to ensure LPNs have the education, competence and authorizations necessary to continue to perform safe care for the public and to advance in the various roles and activities demanded in an evolving health system.

Our goal remains to ensure LPNs have the education, competence and authorizations necessary to continue to perform safe care for the public and to advance in the various roles and activities demanded in an evolving health system. This truly is the essence of the Health Professions Act and is what self-regulation is all about.

Although Regulation change is a lengthy and arduous process, we see great value in consulting broadly with all our stakeholders. Consultation with our members is a fundamental principle under the HPA, and because practical nursing is a self-regulating profession, the profession needs to have a say and play an important role in changes to the Regulation. Thank you to all LPNs and stakeholders who participated so far. We appreciate your thoughtful consideration.

Valerie Paice, President and Linda Stanger, CEO

Read more detail about the proposed changes to the LPN Restricted Activities on page 30.
Want your degree? We have it down to a science.

If you have already have a Bow Valley College diploma in Practical Nursing, Social Work, Pharmacy Technician, or Disabilities Studies, you can get your Bachelor of Health Sciences from the University of Lethbridge. Located on the 6th floor of our downtown campus, this new pathway makes it even easier to go further. Learn more at bowvalleycollege.ca

Provide essential support to renal patients in Northern Alberta.

The Northern Alberta Renal Program provides local and mobile care to patients that need a variety of treatment and support. From hemodialysis and nephrology clinics to blood pressure assessment and consultation in managing kidney disorders, no two days are alike.

Join a team that truly cares, treating patients, clients, families, and one another with compassion, accountability, respect, excellence and safety. Discover excellent wages and benefits, incentives in some areas, and opportunities for personal and professional growth. Join our team today!

www.ahs.ca/careers
Shift work means working outside the usual 7 am to 6 pm time period. Three out of every ten Canadians work shifts. You may work straight nights, straight afternoons, or rotate these different shifts.

Working shifts can upset your body’s “internal clock.” Your “internal clock” tells your body to be awake during the day and to sleep at night.

When you work shifts, you may find it hard to know when and what to eat. It may also be hard to find enough time to exercise regularly. Maybe you have already experienced some of these common problems:

- a change in your appetite;
- trouble falling asleep or getting a good night’s sleep;
- weight loss or weight gain;
- constipation, diarrhea, gas;
- indigestion, heartburn or stomach ulcers; and
- high blood pressure.

The good news is that by eating well and keeping active you can avoid some of these problems. Follow these nutrition tips to stay healthy, alert and feel your best at work and when you are at home.

Here are 10 tips for shift workers.

1. Eat your “main meal” before going to work. If you are on the afternoon shift have your main meal at mid-day around noon. If you are on the evening shift, eat your main meal at about 6 pm before you go to work. Have a small meal and healthy snacks during your shift. Eating large meals during the night can cause heartburn, gas, or constipation. It can also make you feel sleepy and sluggish. Be careful not to overeat on the job.

2. Pack your own healthy snacks. It can be difficult to find healthy snacks during the afternoon and night shifts. The cafeteria may be closed. Vending machines may only carry salty or high fat snacks, and high calorie sugary drinks.

Plan ahead and pick a variety of snacks from the four food groups in Eating Well with Canada’s Food Guide (www.healthcanada.gc.ca/foodguide). Examples of good snacks are an apple with a small piece of low fat cheese or a handful of nuts with low fat yogurt. See more snack ideas in the...
Healthy Snacks for Adults factsheet in the Additional Resources section below.

3 Avoid fatty, fried or spicy foods. Foods such as hamburgers, fried chicken and spicy chili may lead to heartburn and indigestion. Eating too much fat can also increase your risk of heart disease and type 2 diabetes.

4 Avoid sugary foods and drinks. You may feel a quick boost of energy after having a chocolate bar or sugary soft drink. This feeling doesn’t last long and you may experience low energy levels later on. Enjoy nutritious snacks and beverages instead to stay alert and keep your energy up.

5 Take your time eating. Don’t rush when you eat. You deserve your break, so enjoy every single bite of your meals and snack! If possible, eat with your co-workers for some company.

6 Stay well hydrated. Drink plenty of water to prevent dehydration. It may help you to stay alert and not feel so tired during your shift. Keep a water bottle nearby and take sips even before you feel thirsty. Low fat milk, tea, unsweetened herbal tea, and lower sodium 100% vegetable juices are other nutritious beverages that you can drink. Watch the amount of 100% fruit juice you drink because the calories can add up quickly.

7 Watch the caffeine. Drinking coffee, tea and other caffeinated beverages can help you stay alert. But don’t consume more than 400 mg of caffeine a day. That is about the amount of caffeine found in 4 small cups of regular coffee. Caffeine can stay in your system for up to eight hours. This can affect your sleep. Switch to decaffeinated drinks, unsweetened herbal tea or water about four hours before bedtime.

8 Avoid alcohol. Avoid drinking alcohol after work and when you get home. A drink may make you feel more relaxed, but alcohol can disturb your sleep.

9 Have a light snack before bedtime. It’s hard to fall asleep when you’re too hungry or too full. If you’re still hungry after work eat a small healthy snack before bedtime. Try a bowl of whole grain cereal with milk or a piece of whole grain toast with jam. If you’re too full at bedtime, try cutting out a snack during your shift.

10 Stay at a healthy body weight. Healthy eating and active living play a big role in helping you reach and maintain a healthy weight. When you have a healthy body weight, you’ll lower your chances of getting heart disease, diabetes and some types of cancer.

Special Considerations

Stick to your routine. On your days off, try to eat and sleep around the same times that you would if you were working your shift. That way your “internal clock” stays on schedule. Talk to the company’s occupational health nurse about the best sleeping schedule for you.

Eat together. Whenever possible, try to eat at least one meal a day with your family. Families who eat together actually eat healthier and more well-balanced meals. Mealtimes are a great time to connect with each other too!

Keep active. Good nutrition and fitness go hand in hand. Keep active to:
• improve your mood;
• stay fit;
• manage stress;
• sleep better; and
• re-energize yourself while at work.


Stay in touch. Working shifts can be stressful on your social and family lives. Keep in touch with your spouse and kids every day. Plan your vacation days in advance to attend family activities and events.

Additional Resources

- EatRight Ontario, Nutrition Tips for Shift Workers
  www.eatrightontario.ca/en/Articles/Workplace-wellness/Nutrition-Tips-for-Shift-Workers

- EatRight Ontario, Healthy Snacks for Adults
  www.eatrightontario.ca/en/Articles/Weight-Management/Healthy-snack-ideas-for-adults

- Canadian Centre for Occupational Health and Safety
  - for good information and advice about shift work.
  www.ccohs.ca/oshanswers/ergonomics/shiftwrk.html

©Dietitians of Canada. 2016. All rights reserved. Permission to reprint in its entirety. For non-commercial use only. http://www.dietitians.ca
By Tara Hogue Harris

TRUST COMES FIRST in Pediatric Home Care

Photos by Owen Murray
Knock on wood, every parent hopes that their child's life will never depend on emergency medical intervention. But if by some twist of fate it does happen, every parent hopes that the care their child receives is skilled, timely and compassionate.

Now imagine that the life of your child does depend on expert healthcare – not just once, not twice, but many times each day.

This is the life of the Lohin-Duchaine family. Their bright, sociable daughter Enna was diagnosed within months of her birth with the genetic disorder Spinal Muscular Atrophy (SMA). SMA affects the nerves that control muscle movement. Children like Enna who are born with SMA-1, the most severe type of the condition, are unable to sit unsupported, and though the course of the disease is different for each child, all experience generalized muscle weakness, difficulty in swallowing and digestion, and a weakened respiratory system. SMA is the number one genetic cause of infant mortality.

The majority of children with SMA-1 have a life expectancy of less than two years, so each of Enna’s eight birthdays has been a cause for special celebration. Every one of her years has been fiercely fought for by her mother, Lisa Lohin, and dad, Hugo Duchaine, and that fight has included finding the right home care. Enna requires 8 hours each day and 10 hours each night of licensed practical nurse (LPN) care.

Before beginning to work with CareGivers Home Health Care, Lohin had ups and downs in trying to find care that she could trust with Enna’s complex needs, and which would work with their busy family. In addition to mom Lisa, and dad Hugo (whose work often takes him away to northern Alberta), Enna lives with her older brother, Dawson, aged 14; four-year-old sister Hope; and grandma Irene Salberg, who is an invaluable family caregiver. The family lost their second son, Caleb, to viral pneumonia at three months of age in 2010.
“It’s important to have good LPNs,” says Lohin with the understatement of a parent accustomed to caring for a child with a disability. She admits that she was frustrated and lacked trust when she first contacted CareGivers on the recommendation of their AHS home care team, but that changed when she began to work with them.

“They promised they’d do their best to find the right people. [Operations manager and LPN] Danielle Nault-Canning works hard to understand where we’re coming from, and goes out of her way to give us some say in who we work with,” something not every home care company is open to, Lohin says. All home care requires a balance of hard healthcare skills and soft people skills, and a busy home like Lohin’s, plus Enna’s multifaceted care, means Lohin has high standards when it comes to caregivers. Since May, Enna’s primary daytime care has been provided by Elaine Urgel, LPN.

“I like knowing that Enna is having a good day,” says Urgel as she brings her face close to Enna’s and gently strokes the girl’s cheek while she talks. “I like the connections that you build in home care.”

Urgel has been employed by CareGivers Home Health Care for almost three years, since moving here from the Philippines in 2014. There, she worked as a pediatric nurse in the intensive care unit (ICU) of one of Manila’s largest hospitals. With little or no home care available in the Philippines, she was amazed at the freedom and interaction that home care in Canada allowed.

“It’s like working in a home ICU,” Urgel says of the time she spends with Enna. Her young patient’s medical interventions include a feeding tube, tracheostomy tube, ventilator, humidifier, BiPAP and cough assist machines, as well as regular suctioning. But in addition to the complex nursing skills she uses five days a week with Enna, Urgel finds fulfilment in building a connection and finding ways to enrich their time together. Today, she is guiding Enna’s hand to decorate tiny pots in which they’ll plant flower seeds. Other activities they’ve shared have included small science experiments and crafts.
Danielle Nault-Canning, LPN, joined the company that year. First hired as a nursing supervisor, Nault-Canning soon moved up to her current role as operations manager, and began to advocate to add pediatric care to the company’s offerings.

“The pediatric program was my focus and my first love,” says Nault-Canning. Her younger sister was a client of Alberta Health Service’s Pediatric Home Care, so even before becoming an LPN, Nault-Canning knew the difference that good home care could make to a child. She soon convinced the company’s owner to expand into offering pediatric care, but next had to convince AHS’s Pediatric Home Care program in Edmonton. “We had to prove ourselves. I promised them that we would never miss a shift,” she remembers, and they didn’t—even when that meant that she had to personally cover night shifts for one of their first pediatric patients after the unexpected departure of a caregiver. “It was very difficult,” she remembers of that trying stretch of days, “but I kept my promise.”

Lohin and grandmother Irene Salberg both share the story of Urgel’s first outing with Enna. Any trip is a complicated undertaking that involves battery packs, backup medical equipment and a lot of organization. As Enna waited for her grandma to arrive home so they could all go out, her heart rate, normally about 85 to 100, jumped to between 140 and 170 as soon as Salberg came through the door.

“She was so excited to go out,” says Lohin. “Enna can’t smile too well, but her pulse oximeter, her heart rate and her eyes all tell the story. She can’t hide her emotions.” This experience allowed Urgel to experience not just the complexity of going out with Enna, but the opportunity to see how each new experience—browsing a book shop, visiting the cats in a pet store—makes Enna light up.

Urgel keeps up a constant stream of conversation and gentle touches with Enna, who replies ‘yes’ with a definite movement of her lips, and ‘no’ with an emphatic gaze that is clear even to first-time visitors. She and Urgel have gradually developed a friendship since Urgel joined the family in May, making it through the stage in which Enna tested her caregiver with expressive eye rolls or crying. It’s apparent that Urgel is attuned to Enna’s cues and needs, and that her focus on Enna’s care and comfort is earning the family’s trust.

“It’s life and death,” Lohin emphasizes when talking about caring for her daughter. If Enna is lifted the wrong way, she can break a bone. Nurses must be able to change a trach tube in seconds. A change in weather affects Enna’s respiration and secretions. New caregivers have to learn to monitor Enna’s chest for mucus plugs, potentially life-threatening thick secretions that can block her airway and must be treated immediately and prevented with regular chest physio. Urgel earned Lohin’s respect when the busy mom saw that the LPN was quick to take in the many aspects of Enna’s care. “She put on her cape and flew with it,” says Lohin.

Before 2009, CareGivers did not offer pediatric home care. Established in 1998, the company first focused on seniors’ home care. That changed when the company’s owner to expand into offering pediatric care, but next had to convince AHS’s Pediatric Home Care program in Edmonton. “We had to prove ourselves. I promised them that we would never miss a shift,” she remembers, and they didn’t—even when that meant that she had to personally cover night shifts for one of their first pediatric patients after the unexpected departure of a caregiver. “It was very difficult,” she remembers of that trying stretch of days, “but I kept my promise.”
Nault-Canning, who earned her LPN credentials 17 years ago in Nova Scotia and licensed in Alberta in 2005, has been the driving force that has built and nurtured their pediatric program from those early days. Today, CareGivers serves about 70 percent seniors clients, and 30 percent pediatric. They have a contract with AHS to serve 80 percent of AHS’s pediatric home care patients. CareGivers Home Health Care has over 200 employees, with a mix of health care aides, LPNs and a few registered nurses.

How does CareGivers achieve the delicate balance of matching caregiver to home care patients? Angela Corbett, LPN and supervisor of CareGivers’ pediatric program, says that it’s crucial that healthcare staff, patients and families work as a team. Her role is to make sure every client has the staff and care they need. This includes going into the field to offer on-the-job skills training when caregivers begin with a new family. It means meeting as a group – parents, child, and caregivers - to go through a child’s care plan and routine.

“How every client is different,” Corbett says. Her supervisory role means respecting the parents’ expert knowledge of their child, while making sure new caregivers have the right skills to be safe and confident on the job.

“The right care, the right person, the right amount of hours,” is how Anne-Kay Gorden Brown, LPN, Quality Assurance manager and Lead Nursing Supervisor describes her role in the process of delivering exceptional care. Gorden Brown is in the office early each day to audit client and caregiver files, troubleshoot client concerns, and, as her title says, assure quality care.

If it’s not clear already, licensed practical nurses are the oil that makes CareGivers run as smoothly as it does. Besides being at bedsides and in family rooms providing the competent, hands-on care they’re synonymous with, LPNs set the course and lead the home care organization, too. Owner Terrance Graden has put his trust in the experience and skills of LPN Nault-Canning as she has built a solid organization of healthcare professionals with licensed practical nurses as the foundation.

“Terry had faith in the LPN role from the start. He trusts the education and the process,” says Nault-Canning. It’s clear he also trusts Nault-Canning’s vision and leadership, since as operations manager, she runs the show. Nault-Canning says she’s been fortunate to have the autonomy and flexibility to hire and build the strong team they have today, and to have strong people working alongside her from the beginning. She also values that CareGivers’ family-friendly policies have meant her son has practically grown up in the CareGivers office with her.

“Some LPNs work 10 or 15 years without experiencing all I’ve done here,” says Gorden Brown, who earned her LPN credential while working at CareGivers. In her six years with the company, the born & raised Edmontonian moved from weekend receptionist, to scheduling, to her current supervisory position.
“I’ve experienced all sides of the LPN role here – administrative, educational, clinical and management. Working here instills confidence in the skills I already have,” Gorden Brown says.

“I can do a catheter change, start an IV, and I know all the regulations so I can come up with the policies that guide us.”

“There are a million hats, and we wear them all here,” interjects Nault-Canning.

This diversity is exactly what led Corbett, pediatric program supervisor, to transplant herself from Newfoundland less than a year ago. “I wanted to better myself and my career,” she explains. “I would never get this role back home. There’s so much opportunity to grow as an LPN in Alberta. I’m learning every day.”

Elaine Urgel, Enna’s caregiver, echoes that every home care client teaches her something new, like the positioning skills she’s learned to ensure Enna’s comfort. When she began to work with Enna, Urgel underwent a week of training, buddy shifts, and the very important bedside training from Enna’s family. Enna’s mother is a health care aide herself who used to work in long-term care, and while she never imagined she’d be on the receiving end of home care, Lohin says that it’s important for any caregiver to remember that the person they’re caring for is a person and a member of a family.

“She’s so smart,” notes Urgel of Enna, who is starting grade 3 in September. Enna is one of the first children to attend an Edmonton Public School via Skype – another achievement fought for and achieved by Enna’s mom. Lohin was impressed when Urgel began to include a weekly plan for activities and interaction with Enna as part of her care.

“She needs that interaction and stimulation,” says Lohin of her daughter, whose condition does not affect her cognitive abilities.

“The CareGivers nurses are amazing. They don’t question my instincts. I can sleep again,” she says, instead of listening for emergency alarms from Enna’s equipment in the night.

“I’m a firm believer in parents knowing what’s best for their children,” Nault-Canning acknowledges. “There has to be a level of comfort and intimacy. We’re looking after their prized possession, their child.” She talks about finding room for common sense while still ensuring the best in patient care and caregiver safety, and how important it is to find the right personality to match each patient or family.

When talking about Urgel, Nault-Canning calls her ‘the best of the best’. Urgel is simply focused on making sure that each day is a good one for Enna. “With CareGivers, we have an understanding,” says Lohin, and it’s clear that this is a source of some comfort and relief in a complicated life. The LPNs in the CareGivers office and those working in Lohin’s home are united in their firm desire to smooth the path for families like Enna’s, who have found themselves on an unexpected journey. ■
Life expectancy at birth is the average number of years a newborn baby is expected to live if current death trends apply. In this first edition of First Nations – Health Trends Alberta, life expectancy at birth is presented for 187 countries (not all labeled in figure) and for non-First Nations and First Nations in Alberta separately.

Country-specific life expectancies were reported by the United Nations Development Programme. In 2013, life expectancies ranged from 83.6 in Japan to 45.6 in Sierra Leone. For almost all countries, life expectancies were higher for females than males (average 5 year difference).

Amongst the 187 countries, Canada was ranked 9th in 2013 with a life expectancy of 81.5 years (79.3 for males and 83.6 for females). This is a substantial improvement from life expectancies reported by Statistics Canada a century ago: in 1920-1922, Canadian males were expected to live to 59 year of age (61 years for females).

Life expectancy for First Nations in Alberta is 10 years shorter than non-First Nations

In Alberta, life expectancy at birth for non-First Nations in 2013 was 82.1 years (80.0 in males and 84.1 in females). This life expectancy was comparable to countries such as Australia, Singapore, and Sweden which all had life expectancies around 80 years of age. For First Nations in the province, however, life expectancy was 10 years shorter: 72.5 years. This was true for both males and females with life expectancies of 70.5 and 74.8 years, respectively. Countries with life expectancies similar to First Nations in Alberta included Guatemala, Paraguay, and Cambodia.

1 This is the first in a series of First Nations-specific Health Trends compiled in collaboration by Alberta Health and the Alberta First Nations Information Governance Centre (AFNIGC). To suggest future topics, please contact the AFNIGC (communications@afnigc.ca; 403-539-5776).
New IPAC General Standards for Private Medical Facilities

Following extensive consultation and piloting, the College of Physicians & Surgeons of Alberta’s Infection Prevention and Control (IPAC) Program has released standards for general infection prevention and control in private, non-governmental medical facilities not accredited by the CPSA. The standards replace the Checklist for Physician’s General Office Environment and will serve to clarify the expectations of clinics in topics for which there were previously no minimum requirements. Meeting the IPAC general standards will help ensure the clinic environment in Alberta is safe for patients and staff alike.

Some standards that may affect the day-to-day responsibilities of a licensed practical nurse in community medical practice include: hand hygiene, personal protective equipment and precautions, management and disposal of medical sharps, environmental cleaning and disinfection, cold chain management of vaccines, and others.

These standards apply only to private, unaccredited community medical clinics. These do not apply to government facilities (Alberta Health Services, Covenant Health, etc.), CPSA accredited facilities (Non-Hospital Surgical Facilities, Diagnostic Imaging, Medical Laboratories), or healthcare facilities operated by a regulated health professional other than a CPSA registered physician/surgeon (e.g., dentists, podiatrists, physiotherapists, etc.).

IPAC assessors will start using the new standards immediately to address IPAC-related complaints; however, clinics will be given a grace period to comply with a few specific standards (clearly highlighted in the standards document).

If you have questions, please contact the IPAC Program at ipac@cpsa.ab.ca or 780-969-5004.

Knowledge. Stat!
Programs to help nurses grow

Nurses are the heart and soul of our health care system, so we develop programs to keep them at the top of their game. Because when nurses rise, so does the quality of life for Albertans. Check out these programs:

- Health and Human Services Management Graduate Certificate at bowvalleycollege.ca/leadership-certificate
- Phlebotomy at bowvalleycollege.ca/phlebotomy
- Immunization at bowvalleycollege.ca/immunization
- CPNRE test prep at bowvalleycollege.ca/exam-prep
- Leadership for Licensed Practical Nurses at bowvalleycollege.ca/lpn-leadership

The World Rises Here
Speaking Out for Change:
A Personal Story about Life in Long Term Care in Alberta
by Linda McFarlane, Master of Social Work (retired)

The nurse at the long term care facility welcomed me. She led me along a smelly corridor past people waiting in wheelchairs to a tiny room which I was to share. Music blasted from a radio and a television blared nearby. I was depressed and had akathisia, a side effect of a medication which my physician had prescribed for treatment-resistant depression. I had lost my hope, relationship, home, and my role in my family and as a student. I felt alone, abandoned and that I had been tossed into a warehouse to wait until death. I was only 57.

I would like to share my story with you. It is a unique story but also a universal story as all of us share the need for dignity, meaning and purpose, respect, quality of life and caring relationships. I hope that sharing my experience will help you understand how vulnerable people in our care system may feel and that it will encourage everyone to speak out for change.

Out of Options

My long term care journey began in May 2005 in Calgary. Akathisia caused me to pace endlessly so that I felt trapped in a body that refused to rest. Hospital physicians decided they could do no more, my family could not help, and no group homes were available. Long term care seemed the only option.

My roommate coughed all night. When a private room became available, I was lucky to have extra money for it. The room was 10 by 11 feet. It still smelled like death.

Food was pre-cooked and then warmed. Fresh fruit was rarely offered. The only outside sitting space was a deck overlooking the parking lot and was designated as a smoking area.

I learned that my facility was privately owned, for profit and received funding from the government to provide care. Residents ranged from 30 to 90 years old. Some were old and frail, others suffered from a mental illness or dementia, and two had developmental disabilities. One woman had severe cerebral palsy. Many had dual diagnoses.

There were caring staff, but the facility, programs and care were not appropriate for me. At times I felt that I was treated as less than human. I dreaded waking up to face each new meaningless day.

I paced the halls and acted out my anger. I do not remember anyone expressing understanding or saying something like, “This must be really difficult for you.” I was not invited to my first case conference until my family insisted. At the conference, staff discussed my behaviour and their goals for me. The main goal was that I participate in bingo and socialize.

Months later I could sit for short periods. Desperate for companionship, I begged staff to play cards with...
me. Some did. These caring people, along with family and friends who visited, made life more tolerable but it was never enough.

Activities were bingo, chair exercises, crafts suitable for children, occasional outings, and sing-a-longs with songs from the 1940’s. The physician and others often barged into my room without knocking. Staff had little time to spend with residents beyond doing basic care. A social worker occasionally arrived to help with financial issues.

Getting My Life Back

I began to visit and stay with my family for many days at a time. When needed, I babysat and helped out. Family urged me to leave the facility but I dreaded living alone. When I asked the nurse about supportive housing, she said I was not ready.

After feeling useful, life at the care centre was unbearable. I volunteered to set tables and help take people in wheelchairs for walks. I ventured on a hike with a paid companion and was so delighted to be back in the mountains that I started exercising to get in shape for more hikes.

When my daughter-in-law was placed on bed rest because of a high risk pregnancy, my family lent me their car so that I could assist. Care workers were shocked when they saw me driving! A physician friend introduced me to a psychiatrist. When I met with her, she said I did not belong in long term care and that I needed to move out and get my life back.

All of us share the need for dignity, meaning and purpose, respect, quality of life and caring relationships.
With leadership and a guiding vision for quality of both care and life, we can make a ‘good life’ a reality for those in care.

My family and I repeatedly requested a case conference and one was finally organized. I learned the date and time from my family. The transition care nurse treated me like a human being, spoke to me directly and discussed options. She said I did not qualify for long term care but there were no transition homes. The facility director gave me two months to leave. Using a computer borrowed from a care aid, I found a place of my own and on a freezing night in February 2008, moved out with the help of a volunteer.

One year later I climbed Kilimanjaro, then returned to university and completed my Masters in Social Work. I became politically active and helped initiate Calgary Social Workers for Social Justice. Currently I am working with the Gerontology Social Workers Action Group on a research/action project on continuing care.

A Good Life for Those in Care

If I had not had money, friends and a family that needed me, I might have suffered forever in a long term care facility with care that did not meet my needs. Overall, the personal cost and the cost to the health care system were enormous.

Many other Albertans in our care system suffer as well. Despite caring staff and some good initiatives, advocacy groups, people in care and family members still report inconsistent and at times inadequate care and poor quality of life in long term care. Alberta’s Auditor General’s 2014 report found that “Alberta Health Services has insufficient assurance that long term care facilities are appropriately and consistently allocating publicly funded staff hours to each shift, to deliver daily care that fulfills individual residents’ care plans.”

With leadership and a guiding vision for quality of both care and life, we can make a ‘good life’ a reality for those in care. We must listen to patients, their families and our own frontline workers. There are great models and research to learn from. No one should live in an institutional type facility or in a shared room no matter their care needs. All facilities can be homelike and organized in smaller family size groupings. Everyone should have choice and help to be as independent as possible.

Increased funding for home care and day programs will allow us to bring care to people in their homes as long as possible instead of making them move to get care. Better training and pay for staff, higher staffing levels, and an ombudsperson program will make a difference. More accountability and transparency are essential. We must phase out government contracts and subsidies to for-profit providers and stop making care for vulnerable people a business opportunity.

With our new government, change is possible in Alberta but we need political will to put this on the provincial agenda. Whether you work in the care system or are concerned about family or friends, please speak out about your concerns and encourage others to do so.

LINDA MCFARLANE is a retired social worker, a grandmother of four and loves travel, adventure and social justice.
Delirium Management and Prevention

Background

- Delirium is an under-recognized, but surprisingly common problem in hospitalized intensive care unit (ICU) patients.

- Up to 80 percent of critically ill patients from various ICU populations can be identified as having delirium or sub-syndromal delirium according to validated screening criteria.\(^1\),\(^2\)

- Delirium is associated with worse outcomes such as increased length of stay and ventilator-days, long-term cognitive dysfunction, self-removal of important devices (endotracheal tubes, central venous catheters) and mortality.

- The pharmacologic treatments (e.g., antipsychotics, sedation) used to manage delirium are associated with risks as well.

- The identification and management of delirium is complex. Improved outcomes are noted when ICU teams utilize a structured approach for the administration and titration of sedative, analgesic and antipsychotic medications.

Intervention

Managing and preventing delirium for a critically ill patient can be addressed through implementing the elements of the Safer Healthcare Now! Delirium change package (found at www.patientsafetyinstitute.ca) that include:

1. Recognize/manage/mitigate risk factors for every patient (“universal precautions”).
2. Assess for delirium every shift and as required.
3. Develop standardized protocol for management of delirium. Initial strategies to support the implementation and documentation of the protocol include:
   a. Identifying and treating underlying causes of delirium,
   b. Use of non-pharmacological strategies (early mobility, optimize sleep routines, daily reassessment of sedation needs, paired with readiness to wean, provide need for communication adjuncts and reassess restraints daily),
   c. Use of environmental strategies (i.e., visible daylight, allow visitors, display calendar and clocks in the room, avoid restraints, etc.),
   d. Use of pharmacological strategies appropriately and only after underlying causes addressed,
   e. A plan for withdrawal of anti-psychotics (before transfer to ward and/or other location).
4. Support patients and families of patients with delirium and integrate them in the management of delirium.
5. Include a multidisciplinary team in planning and managing care (i.e., physician, nurse, psychiatry, pharmacy, RT/OT and social worker).
6. Create a unit culture that is sensitive to delirium by raising awareness and improving knowledge and skill to identify and manage delirium.
7. Manage hand-offs (communication, documentation, information within ICU, pre and post ICU stay).

Intervention Measures

Delirium 1: Percentage of Patients Screened for Delirium

The percentage of patients screened for delirium for a specific patient population in order to allow for early identification, targeted prevention and the effective utilization of management strategies. Using a validated screening tool (e.g., ICDSC, Cam-ICU), all patients will be screened daily or as deemed clinically appropriate.
Delirium 2: Percentage of Patients Identified with Delirium

The incidence of delirium within the ICU. The measure will be used as a baseline assessment and as an ongoing outcome to assess the impact of improvement efforts in reducing the rate of delirium. Using a validated screening tool (e.g., ICDSC, CAM-ICU), all patients will be screened daily or as deemed clinically appropriate.

Delirium 3: Percent Compliance with Non-Pharmacological Strategies

The percentage of delirium-positive patients where all elements of the bundle have been considered.

Delirium 4: Number of Unplanned Extubations per 1000 Mechanical Ventilation Days

An unplanned extubation is the unscheduled removal of an artificial airway (endotracheal or tracheostomy tube) due to accidental dislodgement or patient self-extubation. The patient need not be ventilated at the time of the event (e.g. tracheal collar). The occurrence of unplanned extubations may be associated with patient harm, poorer outcomes and prolonged length of stay, due to loss of the airway and the risks associated with re-intubation. Putative factors may include inadequate/inappropriate: (1) patient vigilance, nurse-patient ratios, and use of physical restraints; (2) practices for: analgesia, sedation/comfort, delirium assessment/management, patient mobilization and transport; (3) ETT position, length and fastening.

Success Stories

Covenant Health has implemented a data collection tool and processes to ensure 100 percent of intensive care unit patients are screened for delirium. Delirium is very difficult to recognize in a critical care setting and very often goes undiagnosed. The most important step in delirium management is early recognition. When Alberta Health Services asked its Edmonton zone to standardize and implement delirium screening, the team at Covenant Health’s Misericordia Hospital site, along with other teams in Edmonton, looked for help from the Safer Healthcare Now! Delirium and Medication Reconciliation Collaborative to improve care for critically ill patients.

To increase delirium awareness for staff on the unit, Covenant Health created and put into practice a comprehensive education program. From this program came strategies to arm families of delirium patients with support and information. The team has also developed noise reduction strategies to minimize sleep disturbance for patients in the ICU and a mobilization protocol to ensure that patients are out of bed when appropriate. A new pain assessment tool is under development for intubated patients who cannot express their pain level.

The Covenant Health team included the nurse practitioner, educator, supervisor, manager, pharmacist, respiratory therapist and two physiotherapists – all instrumental in the development of delirium reduction strategies and making the mobilization protocol a reality. A physician group provided support in the ongoing management of appropriate medications.

“The Covenant Health team has made huge strides in implementing a significant change in practice and improved care,” says Kim Scherr, Nurse Practitioner. “Our efforts to manage and prevent delirium have had a positive impact on the health and quality of life for countless ICU patients.”

Other Resources

- IHI Improvement Map - “Acute Delirium Prevention and Treatment”. www.ihi.org/offerings/Initiatives/Improvemaphospitals/Pages/default.aspx

1. **Dementia is much more than poor memory.** To diagnose dementia, evidence of aphasia, apraxia, agnosia or executive dysfunction, and personality or behavioral changes must be present, and the changes are sufficient to interfere with daily activities.

2. **Very few people who attend a clinic alone complaining of memory problems have dementia.** Some have age-associated memory impairment (AAMI), depression, drug or alcohol-related memory changes or mild cognitive impairment (MCI). When brought to an appointment unwillingly by a family member, the probability of underlying dementia is higher.

3. **Mild cognitive impairment is defined as subjective and objective memory deficits without significant aphasia, apraxia, agnosia or executive dysfunction.** MCI may progress to dementia and sometimes reverts to ‘normal’.

4. **Patients with dementia and MCI, as well as people with other neurodegenerative conditions, are at high risk of developing delirium when they are sick, injured, post-operatively, or when using multiple medications.**

5. **Alzheimer’s disease (AD), mixed dementia, and vascular dementia (VaD) are the most common causes, accounting for 50 to 70% of dementia.** Next in frequency are dementia with Lewy bodies (DLB), Parkinson’s dementia (PD) and frontotemporal lobar dementia (FTD or FTLD), previously known as Pick’s disease. Normal pressure hydrocephalus and Huntington’s disease are infrequent. An estimated 4 to 5 percent of dementias are early onset (starting before age 65).

6. **Most AD is sporadic.** Between 5 to 10 percent of AD is familial. Having a close family member with dementia increases the risk of developing AD.

7. **There is currently no evidence that early treatment of patients with MCI with anti-dementia drugs will delay progression to dementia.** Investigations to rule out potentially correctable and contributory causes of memory loss are indicated, and treatment of vascular risk factors may delay or prevent progression in both AD and VaD.

8. **Other risk factors for dementia include age, low level of formal education, vascular risk factors and head injury. Healthy diet, physical activity and social engagement may be protective.**

9. **While not part of “normal aging”, dementia prevalence increases with age, doubling every five years after age 65.** (<65: < 1%; 65 and over, 8%; over 85, 25 to 35%).

10. **Currently there is no drug to prevent or reverse dementia. Current treatments may help some patients, with some symptoms, for some time and are worthy of trial if there are no contraindications and their limitations are understood. There are many treatments under investigation that target beta amyloid and tau protein metabolism, nerve growth factors and central nervous system inflammation. ■**
Apps for Today’s Nurses

There’s an app for almost everything, including making your job easier. Here are more healthcare resources you can find on your mobile device.

Medscape (by WebMD) – Clinical reference database / Free / iOS and Android

This clinical reference database includes 8,000 drugs, 4,000 diseases and conditions, clinical images, procedure videos, a drug interaction checker tool, medical calculators and more. It can be accessed offline, and is meant to be a resource for nurses, students and physicians in 34 specialty areas. Medscape CME’s are also available for Canadian physicians.

Bugs and Drugs – Antimicrobial/Infectious Disease Reference / $29.99 / iOS and Android

A comprehensive, evidence-based reference from Alberta Health Services that provides healthcare practitioners with the latest recommendations for the appropriate use of antimicrobials and the optimal treatment and prevention of infectious diseases. With the goal of optimizing patient outcomes and minimizing the unintended consequences of antimicrobial use, such as toxicity, superinfections and resistance, this app doesn’t need internet access.

Nursing Reference Center – Point-of-Care Reference tool / Free / iOS and Android

This app is a universal, comprehensive reference tool offering clinical resources to nurses directly at point-of-care. It has evidence-based care sheets, skill competency checklists and up-to-date clinical information. While it’s free, it does require an institutional subscription to Nursing Reference Centre to access.

The CLPNA and CARE magazine do not endorse the apps shown above. Please exercise your own judgement and the rules of your employer when choosing to use healthcare apps or mobile technology in your workplace.
Helping Albertans get better - it’s all in a day’s work for members of the Alberta Union of Provincial Employees.

www.aupe.org • facebook.com/yourAUPE • @_AUPE_
resources

CONNECTIONS

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

Alberta Gerontological Nurses Association
www.agna.ca

Alberta Hospice Palliative Care Association
www.ahpca.ca

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

Canadian Association of Neonatal Nurses
www.neonatalcann.ca

Canadian Association of Schools of Nursing
www.casn.ca

Canadian Association of Wound Care
www.cawc.net

Canadian Orthopaedic Nurses Association
www.cona-nurse.org

Canadian Hospice Palliative Care Nurses Group
www.chpca.net

Community Health Nurses of Alberta
www.chnalberta.ca

Creative Aging Calgary Society
www.creativeagingcalgary.com

Emergency Nurses’ Interest Group of Alberta
www.nena.ca

LEARNING LINKS

Study with CLPNA
www.studywithclpna.com

ACHIEVE Training Centre
www.achievecentre.com

Advancing Practice
www.advancingpractice.com

Canadian Blended Learning Courses for LPNs
www.jcollinsconsulting.com

Canadian Diabetes Educator Certification Board
www.cdecb.ca

Canadian Virtual Hospice
www.virtualhospice.ca

Critical Trauma Resource Institute (CTRI)
www.ctrinstitute.com

des Souza Institute
www.desouzainstitute.com

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

Learning LPN
www.learninglpn.ca

Learning Nurse
learningnurse.org

Reach Training
www.reachtraining.ca

Registered Practical Nurses Association of Ontario
www.rpnao.org/practice-education/e-learning
New President & District Reps Announced

Elected District Representatives for South, South Central and North Central Districts to CLPNA’s Council will begin their term on September 1 under the leadership of a new President.

Valerie Paice, LPN, was elected by Council members to take over Presidential duties from Jo-Anne Macdonald-Watson, LPN, who served as president for two terms. Valerie Paice previously served back-to-back terms as a Council Representative for District 3. Val has been an LPN for 26 years and is excited about the future of the profession and her role as President.

The Council and CEO Linda Stanger express sincere thanks to Jo-Anne Macdonald-Watson for her time and many talents during her eight years on Council, and wish her all the best as she moves on from this major commitment.

CLPNA 2016 COUNCIL ELECTION RESULTS

- **DISTRICT 1: SOUTH** (Lethbridge, Medicine Hat & area)
  - Richelle Sutherland, LPN (2nd term)
- **DISTRICT 3: SOUTH CENTRAL** (Red Deer & area)
  - Kurtis Kooiker, LPN (1st term)
- **DISTRICT 5: NORTH CENTRAL** (Jasper, Slave Lake, Cold Lake & area)
  - Roop Rani, LPN (1st term)

LPNs voted in Council Elections from June 10-30 by electronic ballot. There was a single nominee for District 5, and as per CLPNA Bylaws, the nominee was approved to become the District Representative by acclamation.

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

SAVE THE DATE
YOU WON’T WANT TO MISS THIS EVENT!

2017 CLPNA AGM & Conference

APRIL 26-28
Grey Eagle Resort & Casino
CALGARY, ALBERTA

Come join us as we celebrate the 70th Anniversary of the LPN Profession at this great venue with some new surprises in our program, and of course, the ‘Academy Awards’ of the LPN profession!

www.clpnaconference.com
Registration Renewal starts on October 1 for most LPNs seeking an Active Practice Permit for the 2017 calendar year. Members are asked to renew before the December 1 deadline to receive the lowest registration fee, $350 for an Active Practice Permit.

Due to a significant increase in late renewals, CLPNA Council has increased the renewal fee to $400 if paid between December 2 and December 31 to encourage members to renew before the deadline as per the Bylaws. Adding to the motivation, those who complete their online application before November 1 will be entered in a contest for $350.

Member notifications are sent by email beginning in late September. Members who do not receive a notice should notify CLPNA at info@clpna.com, 780-484-8886, or 1-800-661-5877 (toll free in Alberta).

Don’t let your Practice Permit expire
Only individuals with a current CLPNA Practice Permit are authorized to use the title ‘Licensed Practical Nurse’ or ‘LPN’, or work as an LPN 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 2017 Registration Renewal application, log in to myCLPNA directly (https://www.myCLPNA.com), or go to www.clpna.com and click on the blue “myCLPNA Login” link located in the upper right corner.

Preparation Checklist
Before logging in, please have your:
- User ID (CLPNA Registration Number) and password for https://www.myCLPNA.com
- Nursing practice hours calculated for Jan 1 - Dec 31, 2016
- Continuing Competency Program (CCP) Learning Plan for 2017
- Current employer information
- Payment information

Members must complete the annual Registration Renewal Application in order to:
- work in Alberta as a Licensed Practical Nurse in 2017 (registration type Active)
- OR change your registration from Active to a non-practicing Associate
- OR notify CLPNA you are not renewing for 2017
- receive regulatory and practice information
- keep registration in good standing

For complete policies and our step-by-step guide "How To Guide for 2017 Registration Renewal", go to www.CLPNA.com, “I Am a Member”, “Registration Renewal”.

2017 REGISTRATION RENEWAL
Deadline December 1
Registration Renewal Fees & Deadlines

<table>
<thead>
<tr>
<th>2017 REGISTRATION FEES FOR ACTIVE PRACTICE PERMIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fees Paid</td>
</tr>
<tr>
<td>October 1 - December 1</td>
</tr>
<tr>
<td>$350</td>
</tr>
</tbody>
</table>

Fees may be paid online by credit card (VISA or MasterCard), or by previous enrollment in our 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. To pay using a different method, contact CLPNA during business hours to make alternate arrangements before starting the online Registration Renewal Application.

Renewing Registration between 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, 2016 to be automatically entered into our Ready, Click, Win contest to win $350!

Renewing Registration between Dec 2-31
The Registration Renewal fee rises to $400 for those renewing between December 2-31. Please renew before December 1. Renewal support is only available during CLPNA office hours. The CLPNA will be closed December 26-27, and closed January 2.

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 2016.

Associate Membership
Members who, for any reason, do not plan to practice as an LPN in Alberta in 2017 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 2017 and do not plan to return to practice in the future, should officially notify CLPNA by changing their registration type to “Inactive” on their 2017 Registration Renewal. This serves as formal notification to CLPNA and ensures the member’s practice hours for 2016 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 2017 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>
</tr>
</thead>
<tbody>
<tr>
<td>October 10</td>
<td>CLOSED</td>
</tr>
<tr>
<td>November 11</td>
<td>CLOSED</td>
</tr>
<tr>
<td>December 26-27</td>
<td>CLOSED</td>
</tr>
<tr>
<td>January 2, 2017</td>
<td>CLOSED</td>
</tr>
</tbody>
</table>

Complete your 2017 Registration Renewal by November 1 to be entered to win back your Active Registration Renewal Fee.

See back cover ad for details!
In July, LPNs received a first look at the College of Licensed Practical Nurses of Alberta's (CLPNA) proposed changes to the Licensed Practical Nurses Profession Regulation (LPN Regulation) and Standards of Practice for LPNs on the Performance of Restricted Activities (Standards of Practice). The CLPNA appreciates all feedback received from LPNs and CLPNA stakeholders on this topic during the consultation; all comments become part of the formal review process.

Why propose change?

In the thirteen years since the LPN Regulation was proclaimed in 2003, LPN education, practice and roles in Alberta's health system have evolved considerably. Due to the restrictive wording in the current LPN Regulation, there have been interpretation issues within the existing restricted activities for LPNs. From the CLPNA’s experience, multiple interpretations of the same restricted activity across the province and within different sites results in confusion for staff, disruption for the patients, an inability to do effective workforce planning, and ultimately potential patient safety issues.

The CLPNA believes the proposed amendments are necessary. They will allow LPNs to utilize their education and competence, to maximize their contribution in healthcare, to support a sustainable health system, and to minimize the risk of error that currently exists in care transitions when the LPN must hand off care in which they are fully competent, but not currently authorized to perform. LPNs would still have to meet the parameters (education, competence, etc.) outlined in the Standards of Practice for LPNs on the Performance of Restricted Activities.

What are Restricted Activities?

Restricted Activities are regulated health services that by law can only be performed by individuals who are authorized to perform them and are listed in Schedule 7.1 of the Government Organization Act. These include procedures such as, but not limited to, surgery, assisting in childbirth, performing injections, prescribing medication, entering into one or more body cavities, and setting fractures. (Health Professions Act Employer's Handbook, p7).

When will the Regulations change?

After consulting with LPNs and stakeholders, the CLPNA’s next steps include working with Alberta Health towards drafting new wording in the LPN Regulation; CLPNA Council approving the final draft; and Alberta Health submitting the revised Regulation to the lieutenant governor for government approval. Making amendments to any Regulation is a lengthy and complex process; CLPNA is not able to provide a timeline for completion at this time.
Summary of Key Proposed Changes

Proposed addition of four restricted activities that LPNs would be able to perform:

- dispense, compound, provide for selling or sell a Schedule 1 drug or Schedule 2 drug (preparing ‘to go’ and ‘bridge medications’);
- apply non-ionizing radiation in the form of ultrasound imaging, including any application of ultrasound to a fetus (bladder scanning, fetal heart monitoring);
- administer parenteral nutrition; and
- administer blood or blood products.

Proposed changes to current practice limitations:

- Supervision requirements to be removed from inserting liquid into the ear canal, administering imaging contrast agents, administering nitrous oxide, administering influenza vaccines to clients of all ages.

Proposed changes to specializations:

- Two LPN specialties would be maintained: Perioperative and Orthopedic practical nursing. These two specialties will continue to require completion of a Council-approved education program and approval by the Registrar will be noted on the practice permit.
- Renal Dialysis, Immunization and Advanced Foot Care would be self-managed by the LPN by completing advanced education.

Proposed new Standards of Practice for LPN Performance of Restricted Activities

- New standards for 13 restricted activities that set practice requirements.

VOLUNTEER for a CLPNA Committee

Get a unique insight on the nursing profession. Opportunities are available for the January 2016 to December 2017 term for LPNs to participate on a CLPNA Committee.

Make significant contributions to protection of the public by volunteering for the Hearing Tribunal or Complaint Review Committee. These committees review evidence and make decisions regarding complaints of unprofessional conduct against LPNs.

Those interested in the impact of continuing education on nursing practice might be drawn to the Competence Committee. These valuable members review Continuing Competency Program Validation submissions for compliance.

A background in practical nurse education or as an educator/preceptor is useful for those wishing to participate on the Education Standards Advisory Committee (ESAC). ESAC reviews current and proposed Practical Nurse programs in Alberta, as well as specialty programs outlined in the Health Professions Act, and reports to the Council with its recommendations.

Orientation, training, honorarium, and travel expenses are provided. Complete info is available at www.clpna.com/about-clpna/committees. Resumes are accepted until November 15 by Donna Doerr, HR Assistant, at ddoerr@clpna.com, or contact her at 780-484-8886 or 1-800-661-5877 (toll free in Alberta).
Make Your Learning Count!

Between May and July, 2400 Licensed Practical Nurses demonstrated completion of their reported learning objectives through CLPNA’s Continuing Competency Program Validation (CCPV).

Evaluation of competence and documentation of learning are expectations of the Continuing Competency Program. With continual changes in today’s health care system there is an essential need for ongoing learning. LPNs who continually enhance their practice by expanding their knowledge report they are able to maintain a higher level of competence and confidence in their area of practice. In their CCPV review, the Competence Committee observed that LPNs engaged in diverse learning opportunities and looked for occasions to share new knowledge: “I learned that end of life involves not only looking after the patients but also the family by offering and providing emotional comfort” and “This new information will help me to help my colleagues [with] medical terminology” both illustrate why gaining and sharing knowledge is beneficial.

It has been identified that LPNs who have maintained excellent records of their learning have a better experience when completing the CCPV process. To make record-keeping easy, LPNs can access CLPNA’s online Record of Learning through their member login at https://www.myCLPNA.com. This tool enables members to enter information regarding completion of their learning objectives in an organized and efficient fashion.

Questions? Visit www.clpna.com under “I am a Member”, or contact prof.dev@clpna.com, 780-484-8886 or 1-800-661-5877 (toll free in Alberta).

$25K in Research Grant funding available to LPNs

Alberta Innovates – Health Solutions (AIHS) in collaboration with the College of Licensed Practical Nurses of Alberta (CLPNA) are now taking applications for the very first Advancing Knowledge in Practical Nursing Research Grant.

The one-year grant is intended to encourage licensed practical nurses, in partnership with researchers or clinicians, to make fresh discoveries to positively influence practical nursing. Up to $25,000 is available to conduct the research. Applications will be accepted until October 14, 2016.

Research topics may include, but are not limited to:
- illness and injury prevention and management;
- wellness and health promotion;
- workplace safety (psychological and physical);
- impact assessment of LPN processes in relation to Occupational Health and Safety;
- measures of occupational impact of LPNs in the health system.

For the Program Guide and Application Instructions, search “Research Grant” on www.clpna.com or contact Tara McCarthy at AIHS, Tara.Mccarthy@albertainnovates.ca or (780) 429-9337.

Participation in research and innovation by Alberta’s licensed practical nurses is a primary goal on CLPNA’s 2016-2019 Strategic Plan. Last year, CLPNA created a Research Department to inform LPN practice and policies, and our place in the healthcare system.
Career Directions© & Mentoring Workshops in Calgary

Looking for career guidance and peer support? Full-day professional development workshops are coming to Calgary this fall and spring. The workshops, created specifically for nurses, are part of CLPNA’s Strategic Plan to empower LPNs for the future.

The Career Directions© Workshop (Sept. 21 & Mar. 7) guides LPNs through a hands-on process to review your career to date, learn strategies to assist in making future career decisions, and begin developing a career plan, and is led by Mary M. Wheeler RN, MEd, PCC from donnerwheeler.

The Building Successful Mentoring Relationships Workshop (Sept. 22 & Mar. 8) teaches about the CLPNA Mentorship Program, basic concepts about mentoring, the phases of the mentoring relationship, and will build a network for ongoing learning and support. The workshop is coached by Michelle Cooper RN, MScN, ACC from donnerwheeler.

The cost is only $25 per workshop including a workbook and lunch. To register, search “Career Directions Workshops” at www.clpna.com or contact Colleen at cturkington@clpna.com, 780-638-6714 or 1-800-661-5877 (toll free in Alberta).

More free courses at “Study with CLPNA”

To boost your nursing skills, even more courses are coming to “Study with CLPNA”. Approved by CLPNA for all LPNs, many of the professionally-designed self-study courses include guides, exams and videos. Courses may be used as part of annual Learning Plans for the Continuing Competency Program.

Discover them all at www.studywithclpna.com.

- Infection Prevention and Control Self-Study Course (COMING SOON)
- Medical Terminology Self-Study Course (COMING SOON)
- Medication Administration Self-Study Course (COMING SOON)
- Medication Drug Calculations Self-Study Course
- Pressure Ulcers eCourse
- Nursing Documentation 101
- Jurisprudence Exam Study Guide
- Adverse Transfusion Reactions: A Reference for Nurses
- Intradermal Medication Module
- Intradermal and Intramuscular Injection Performance Checklist
- Anaphylaxis Module
- VIDEO: Professional Practice for Licensed Practical Nurses in Leadership Roles
- VIDEO: LPN Practice: History, Education & Authority in Alberta, Canada
- VIDEO: Code of Ethics & Standards of Practice: Licensed Practical Nurses in Alberta, Canada
- LPN Code of Ethics Learning Module
Caring for patients at end of life has always been a role of the licensed practical nurse in Alberta. With the introduction of medical assistance in dying (MAID) legislation in Canada, the LPN may also assist the physician or nurse practitioner (NP).

Each nurse has their own value system and it is essential to respect the decisions colleagues make about their participation in MAID. No nurse will be forced to assist in MAID. If an LPN is asked to participate and it conflicts with their beliefs or values, the LPN must notify their employer so alternate care arrangements can be made.

Understanding the LPN Role

If the LPN chooses to assist the physician or nurse practitioner in MAID, they must fully understand their role and what is required. Specifically:

The LPN cannot administer the substance that elicits death, only the physician or NP may administer this.

The LPN cannot determine if the eligibility criteria have been met; this is done by the physician or NP. LPNs should, however, be aware of these eligibility parameters and have a reasonable basis to believe that the physician or NP providing MAID has assessed the client's eligibility and it complies with legislation and its safeguards. If the nurse has any questions about the eligibility criteria or safeguards, they should inquire directly with the physician or NP.

The LPN should be aware of and follow all federal and provincial legislation, directives, regulatory body (CLPNA) guidance and employer protocols, policies and procedures on MAID. In Alberta, there is an Alberta Health directive that outlines that Alberta Health Services shall co-ordinate and facilitate access to services related to medical assistance in dying. Both Alberta Health Services and CLPNA have information and links on their websites to this specific information.

The LPN can support the access to accurate and objective information about MAID to clients so that they
may make informed decisions about their care. It is important that the LPN does not initiate a discussion on MAID with their client as this can be interpreted as counseling a person to die or can put pressure on the client. Provision of any information is strictly at the request of the client.

If the LPN is asked to assist, it is paramount that they have the knowledge, skill and ability to provide the care required competently. For example, the LPN may be asked to start the IV. It is important to understand what is involved so competent care can be provided.

All nursing care provided, from the initial inquiry to the care during and after MAID, must be documented in accordance with the LPN standards of practice and employer policies.

If Asked to Participate

MAID as an option in end of life care is new to nursing in Canada and brings forth questions, to which the CLPNA is working diligently to provide answers. As an LPN, if you are asked to participate in the provision of MAID, we recommend that you review the guidelines provided on our website (search “MAID guidelines”), contact CLPNA directly for additional advice at practice@clpna.com, 780-484-8886 or 1-800-661-5877 (toll free in Alberta), and contact the Alberta Health Services Medical Assistance in Dying Care Coordination Team via email at MAID.CareTeam@ahs.ca.

NURSING WORD SCRAMBLE

Unscramble the words to find common medical words and phrases.

1. fierortlibadl
2. seimcihc
3. neohytinsop
4. mdideasilpyi
5. aoetiiddnsr
6. heoicmsydmna
7. ncnteoalg
8. mteyleert
9. aeirhorsesclost
10. shdmrhyaisty
11. preipaelrh
12. icioyosmdtar
13. ridacvulsoaac
14. svenuo
15. sommtbmblorehio
16. pseruers
17. onpnaceiemstdo
18. icorpodhgyhaecra

Answers:
1. defibrillator
2. ischemic
3. hypotension
4. dyslipidemia
5. endocarditis
6. hemodynamics
7. congenital
8. telemetry
9. atherosclerosis
10. dysrhythmias
11. peripheral
12. myocarditis
13. cardiovascular
14. venous
15. thromboembolism
16. pressure
17. decompensation
18. echocardiography
HEARING TRIBUNAL DECISION

LPN’s refusal to participate in Hearing results in penalty

A Hearing Tribunal recently reviewed the conduct of a regulated member of the College of Licensed Practical Nurses of Alberta, and as part of their decision, ordered the publishing of an anonymous synopsis in CARE magazine to act as a deterrent to the membership. Following is that synopsis:

CLPNA is the legislated body responsible for administering the Health Professions Act (HPA) and Licensed Practical Nurses Regulation. The foremost obligation of CLPNA is to protect the health and safety of the public through the regulation and discipline of practical nursing. It is CLPNA’s responsibility to review complaints regarding LPNs’ practice and conduct to protect the public and ensure LPNs meet the competencies, standards and ethics expected.

Given the seriousness of the allegations made against the member, CLPNA proceeded with a disciplinary hearing. As per the HPA, the investigated member must appear at the hearing and may be compelled to testify. In this situation, the LPN refused to participate or send representation to the Hearing. Unwillingness to cooperate with disciplinary proceedings is considered unprofessional conduct.

At a disciplinary hearing, the investigated member is given the opportunity to present their argument. The onus is on CLPNA to establish a balance of probabilities that the facts as alleged in the Statement of Allegations occurred and that it rises to the level of unprofessional conduct. The arguments presented by both parties at a disciplinary hearing are the fairest way a decision can be reached by the Hearing Tribunal.

The second task of the Hearing Tribunal is to determine the penalties required to resolve the complaint, if the LPN is found to be unprofessional. The Hearing Tribunal recognizes its orders with respect to penalty must be fair, reasonable, and proportionate. There are several factors the Hearing Tribunal will take into consideration when determining penalty, including the unprofessional conduct of an LPN who refuses to participate in the proceedings.

There are several factors the Hearing Tribunal will take into consideration when determining penalty, including the unprofessional conduct of an LPN who refuses to participate in the proceedings.

CLPNA received two complaint letters regarding a member, who was employed in the capacity of an LPN at the time of the complaints, outlining serious concerns with respect to the member’s practice and the member’s fitness to practice.

A full investigation was conducted to determine if there was sufficient evidence of “unprofessional conduct” as it is defined in the HPA. Specifically, whether there is sufficient evidence the member displayed a lack of knowledge or skill or judgment in the provision of professional services; contravened the HPA, CLPNA’s Code of Ethics and Standards of Practice; contravened other relevant legislation; or engaged in conduct that harms the integrity of the regulated profession. It was determined the conduct of the member was unprofessional and of a serious nature. It is essential to understand LPNs under investigation are compelled to fully participate in all of the complaint processes; there may be consequences if the LPN does not fully cooperate.

At a disciplinary hearing, the investigated member is given the opportunity to present their argument. The onus is on CLPNA to establish a balance of probabilities that the facts as alleged in the Statement of Allegations occurred and that it rises to the level of unprofessional conduct. The arguments presented by both parties at a disciplinary hearing are the fairest way a decision can be reached by the Hearing Tribunal.

The second task of the Hearing Tribunal is to determine the penalties required to resolve the complaint, if the LPN is found to be unprofessional. The Hearing Tribunal recognizes its orders with respect to penalty must be fair, reasonable, and proportionate. There are several factors the Hearing Tribunal will take into consideration when determining penalty, including the unprofessional conduct of an LPN who refuses to participate in the proceedings.

The Hearing Tribunal, in this case, determined the member engaged in unprofessional conduct which placed patients at a potential risk of harm. It is an option for
Penalties ordered by the Hearing Tribunal are intended to demonstrate to the profession and the public that unprofessional conduct is not tolerated and there are consequences.

the Hearing Tribunal to consider costs when determining orders. It has been noted in recent Hearing Tribunal's decisions, awarding costs and fines happens more often than not. When the Hearing Tribunal made a decision on penalty in this case, hearing costs were awarded to CLPNA and the member was ordered to pay a total of $33,800. The Hearing Tribunal acknowledges this is a high cost to a member; on the other hand, the costs involved in conducting an investigation and proceeding with a disciplinary hearing are enormous. This member, as any LPN referred to a hearing, was given the opportunity to attend and take accountability for their actions. When an LPN makes the decision not to cooperate in the disciplinary proceedings, the Hearing Tribunal felt it is appropriate for the member to be responsible for the costs.

Penalties ordered by the Hearing Tribunal are intended to demonstrate to the profession and the public that unprofessional conduct is not tolerated and there are consequences when unprofessional conduct is determined. Demonstrating accountability and taking responsibility for one's actions goes a long way in front of the Hearing Tribunal.

This article is a summary of the Hearing Tribunal's Decision. It is not intended to provide comprehensive information of the complaint, findings of an investigation, or information presented at the Hearing.
end of shift

If your COMPASSION does not include YOURSELF, it is incomplete.

- Jack Kornfield -

@CLPNA
Risk Assessment of Violence

EDMONTON, November 21 2016 • CALGARY, November 22, 2016
0830 to 1600 hrs

DR. PHILLIP J. RESNICK, MD

Predicting Violence - Can it be Done?
- The Demographics of Violence in Prime Individuals
- What is the Risk of Violence in Psychiatric Diagnosis?
- 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 vs. Predatory Violence
- History of Family Violence and Other Important Factors

Current Assessment of Dangerousness
- Behavior 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 Stalking Victims

Homicide-Suicide: Who Commits Them and Why
- Spousal/Lover Homicide-Suicide: The Role of Conflict, Non-Conflict and Age
- Felicidal Suicide: Profile of the "Family Annihilator"; Role of Altruism
- Mass Murderers: Precipitating Events: The Plan and What Factors Predict the Killer's Decision to Suicide

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

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 malingering and deception. He has consulted on or
provided expert testimony on 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 = $187.45 Early Rate (on or before October 11, 2016)
- $189.00 + $9.45 GST = $198.45 Middle Rate (on or before November 7, 2016)
- $199.00 + $9.95 GST = $208.95 Regular Rate (after November 7, 2016)

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

Infectious Diseases Update

Shampoos, Tattoos, and Barbeques: What’s New in the World of Infectious Disease?

EDMONTON, November 28, 2016 • CALGARY, November 29, 2016
0830 to 1600 hrs

BARR BANCROFT, RN, MSN, PNP

Barb Bancroft is a widely acclaimed nursing teacher who has taught courses on
Advanced Pathophysiology, Pharmacology, and Physical Assessment to both graduate
and undergraduate students. She is 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
enormous knowledge of pathophysiology and as one of the most dynamic nursing speakers
in North America today. Delivering her material with equal parts of evidence based
practice, practical application, and humour, she has taught numerous seminars on clinical
and health maintenance topics to healthcare professionals, including the Association for
Practitioners for Infection Control, The Emergency Nurses Association, the American Academy
of Nurse Practitioners, and more.

** Updated With New Content! **

Few areas in healthcare are changing as rapidly as infectious diseases. This
one day seminar provides an up-to-the minute update on current issues in
infectious diseases. Major infectious disease trends will be reviewed, including:
global warming and travel, bioterrorism, food-borne illnesses, infectious agents
and their relationship to acute and chronic disease. New vaccines, new diseases,
and new drugs will also be reviewed. A seminar you don't want to miss for both
your patients' and your own benefit!

WHO SHOULD ATTEND?
- RNs, RPNs, LPNs; All Front Line Nursing Staff
- Infection Control, Public & Occupational Health Nurses
- Educators, Managers, NPs, & Telehealth Nurses

Conference Fees:
- $169.00 + $8.45 GST = $177.45 Early Rate (on or before October 17, 2016)
- $179.00 + $8.95 GST = $187.95 Middle Rate (on or before November 14, 2016)
- $189.00 + $9.45 GST = $198.45 Regular Rate (after November 14, 2016)

CARE | FALL 2016 39
Complete your 2017 Registration Renewal online by **November 1** 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 complete 2017 Registration Renewal for an Active Practice Permit by November 1, 2016. The winner’s name will be publicly announced.*