Research: Does Exercise Help Dementia?
From Childhood Cancer to Nursing
We need full-time or part-time nursing instructors.

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Albertans live on a roller coaster: our economic boom-bust cycle. This is a reality of the impact oil prices have on the Alberta economy. Many of us have lived through this cycle regularly during our careers as nurses. We have experienced the lows of staffing cuts, reduction in education opportunities and project abandonment. We have also experienced the highs when spending in healthcare is flush, special funding is available for programs, ample opportunities exist for education, workshops and conferences, and job opportunities abound.

This boom-bust cycle has historically been very difficult on the LPN profession. LPNs were in high demand in bust times and not as sought after in boom times. However, this phenomenon seems to be changing in recent cycles. LPN positions are growing annually, opportunity exists in a wide variety of settings, some very new roles are appearing, and in boom times these positions aren’t eliminated; rather they are reinforced.

We believe many things have influenced this trend.

First, the Health Professions Act (HPA) was introduced into Alberta in the late 1990’s to manage issues associated with authorizing health professionals to appropriately and autonomously provide their full range of health services. The Act and subsequent Regulation enables autonomous professional practice supported by a defined scope of practice, education and continuing competence. LPNs have risen to this challenge, with a broad and flexible scope of practice, along with autonomy, accountability and responsibility to provide safe, quality care.

Second, over the last decade the health system has been working to integrate the philosophies of the HPA. This is an enormous undertaking within a historically hierarchical health system. There are players who are not going to agree on the approach or results of management decisions around this, particularly when it involves prudent decisions associated with staffing. This has been very evident in the last few years, as the health system tries to re-balance teams and enhance utilization of professionals, as well as increase the support from unregulated care providers.

Finally, turf is a big issue that needs to be managed with facts and common sense. But when it comes to turf, good sense doesn’t always prevail in decision making. Some of the players have power, lots of power, and they are not afraid to wield it when they feel threatened. We believe this contributes to the fact Alberta has one of the lowest staff mix ratios of LPNs per population in Canada; in fact, we are third from the bottom according to the Canadian Institute for Health Information (as reported in CARE magazine, Winter 2013, pg.15). Protection of turf damages collaboration; where one thrives, the other cannot.

There are many challenges during bust times, but ultimately we must remember the reason we became nurses in the first place. For most of us, it was a true desire to care for patients, the very people that fund the system we work within.

During a time when everyone is reassessing spending and resource utilization, this is no time for distraction. It takes STRONG leaders with compassionate hearts and a sound business approach to make prudent fiscal decisions considering the best interests of our patients. It also takes committed nurses, dedicated to fulfill their role in the system.

As for Licensed Practical Nurses – our profession is ready. We are a reasonable and sensible approach to quality care. We are collaborative by nature, and have one of the most evolved scopes of practice in the country. And our stats prove (see pg 33) we are young, eager, and able to be more fully employed and utilized in the healthcare system.

Boom or Bust - LPNs are a logical addition to any high-functioning team that is truly focused on the patient.

Jo-Anne Macdonald-Watson, President and Linda Stanger, Executive Director
WITHOUT ENOUGH NURSING STAFF
ALBERTA SENIORS SUFFER.

CARING FOR THE ELDERLY IS THE ALBERTA WAY.

Elderly Albertans helped build this province. They’ve earned the right to live in a safe, nurturing and dignified environment, whether at home or in an assisted living facility. But not all our seniors enjoy that. Many seniors home operators refuse to provide enough nursing staff to ensure quality care, especially for residents with more complex medical needs. Tell the government to show leadership and demand better from seniors home operators. Standing up for seniors: that’s the Alberta Way.

Call your MLA toll-free at 310-0000 and demand better care for seniors.

TheAlbertaWay.com
Consider the following scenario: a senior experiencing chest pain goes to the emergency department of a local hospital. During the visit, there are no beds available. The patient waits for treatment on a gurney in the hallway for many hours. Feeling tired, hungry and in pain, he becomes frustrated and upset with the long wait. He tries to express the frustration he is feeling, and attempts to leave the hospital against medical advice. The patient is then detained in hospital under the Mental Health Act (2012). The patient later contacts the Office of the Alberta Health Advocates (OAHA) with a concern that his rights have been violated, and that he was unable to access the healthcare services he needed in a reasonable and timely manner.

What is the Office of the Alberta Health Advocates? In January 2014, when Alberta’s Health Act was proclaimed, the new Health and Senior’s Advocates joined the Mental Health Patient Advocate, together forming the Office of the Alberta Health Advocates. This Office is a place where Albertans may find help navigating their way through the healthcare system, share the personal story of their healthcare experience, or learn about Alberta’s Health Charter or the legislated patient rights enshrined in the Mental Health Act. When contacting the OAHA, Albertans

By Jody-Lee Farrah MSW, RSW & Ryan Bielby, RSW
Office of the Alberta Health Advocates
can expect to learn about mental health, healthcare, and seniors’ programs and services available throughout the province.

Alberta’s Health Advocates, through the legislated and ministerial mandates, are helping to bridge the gaps for Albertans who are seeking healthcare in a system often viewed as complex and confusing. In particular, when something goes wrong in a person’s healthcare experience and a complaint arises, the OAHA can assist the person to gain resolution of their concerns. The OAHA is actively assisting Albertans to address complaints by referring and connecting the person to the right complaint resolution process. In addition to the OAHA’s mandate to refer Albertans to existing complaints resolution processes, the Health Advocate may conduct a review into a complaint where an aspect of a person’s healthcare experience may not be in keeping with the Health Charter. The Mental Health Patient Advocate may carry out an investigation when a complaint arises concerning patient rights under the Mental Health Act.

When a person contacts the OAHA, they can expect to be met by a streamlined intake process, and to have their concern addressed by the Mental Health Patient Advocate, Health Advocate, or Seniors’ Advocate. Many, if not the majority, of issues, questions, and concerns have the potential to cross all three jurisdictions of the OAHA.

In the scenario above, we see aspects of this patient’s healthcare experience which extend to the jurisdiction of all three Advocates. In determining how to best assist this patient to resolve his complaint, the matter would be considered by all three Advocates. In responding to this patient, the OAHA staff will collaborate, putting their knowledge and resources together to support the patient through what can be a difficult healthcare journey. The goal is to ensure that the patient’s experience is consistent with the expectations set out in the Health Charter and that his rights under the Mental Health Act have been protected where necessary.

Licensed Practical Nurses (LPNs) are on the front line of patient care. At any point, an LPN may wish to reach out to the OAHA for advice, support and guidance when advocating for patients in their care. When we collaborate in patient care, we improve healthcare outcomes for all Albertans. We look forward to a continued relationship as the work of the OAHA progresses within Alberta’s healthcare system.

For more information about the Alberta Health Advocates or the Alberta Health Charter, please contact the Office of the Alberta Health Advocates at (780) 422-1812; outside Edmonton at 310-000; or online at www.albertahealthadvocates.ca.
Blood Relations
by Chris Fields

Make no little plans; they have no magic to stir blood and probably themselves will not be realized. Make big plans; aim high in hope and work.

Daniel Burnham (1846-1912)
“Blood counts of too many or too few,” says Dr. Lesley Street, hematologist, describing the focus of the Calgary South Health Campus Hematology Clinic that recorded 2200 patient visits in 2014. “Red or white blood cells, iron, platelets…sometimes cancer and sometimes not.”

“What sets us apart is that as an ambulatory hematology clinic, we are able to manage patients, often with chronic diseases, quite well,” says Dr. Street, who is one of three hematologists at the Clinic. “People require ongoing follow up, and with strong collaboration and teamwork, we are able to deliver good quality care.”

To her knowledge, Donna MacDermott, Licensed Practical Nurse (LPN), is the only LPN working in a hematology clinic setting. “I check in patients, complete a health history, and repeat with follow ups that can extend for years for specific kinds of blood disorders,” Donna says, describing her typical work day. That’s a humble description for what the team describes as Donna’s initiative in taking an active role in assisting doctors with key clinic procedures like bone marrow biopsies and transfusions, serving as an advocate for total person care by stepping across gaps to communicate with doctors about needed lab requisitions, and in accessing extended resources such as pharmacy, social workers, or dietitians. There’s also a strong role in educating and coaching patients in management of their condition.
Dr. Street notes that in terms of the nursing role, in other medical environments LPNs can typically have multi-patient responsibility, or a single role within the continuity of patient care. “Here, the LPN assumes accountability for the flow of test ordering, reporting, and communication follow up with the doctor within the chain of collaboration. We have set parameters, for example, for what constitutes an alarming test result and when a doctor should be called. Donna’s work in this area sets her apart, and this non-traditional LPN role has been aided by Donna’s initiative to do things like develop a detailed intake history form (including medication, chronic conditions, family history and social context). This approach provides focus and efficiencies for hematologists, and represents a much deeper LPN role than the ‘call a name and take vital signs’ approach.”

“Combined with the small size of the clinic and the ability for each of us to see every patient right through the chain of interaction, we look after people, not just process,” Donna adds.

“Communication is so important to my role,” Donna notes. “A patient goes on ‘Dr. Google’ and they get scared. My job is to reel that in...to set expectations and bring some peace of mind.” Donna describes her work with patients to include outlining what a bone marrow biopsy is and how to prepare for it, what to expect when going to another unit to have a phlebotomy to treat hemochromatosis, or reviewing material provided by groups such as the Leukemia & Lymphoma Society.

“Donna took it upon herself to contact the various societies for information,” says Dr. Street. “We often break significant news of diagnosis so it’s nice to have that information here and readily available.”

“Donna is a self-directed learner,” says Lynda Elliot, unit clerk, referring
to Donna’s recent sign up to complete online modules focused on lymphoma and leukemia. Donna says that she has completed a leadership course that will help her. She says that she would want to treat patients the way she would want to be treated. Donna says, “If it was me, I would want to know about my condition as quickly as possible, so we do everything we can to quick-book tests. I will often ask a patient to call me and leave a message if they have a question and can’t reach me,” Donna says. “The patient will say, ‘Oh yeah, I’ve heard that before and no one calls back.’ I have one rule: always check messages and call back before going home.”

Dr. Street reveals a deeper trailblazing role Donna has had in the clinic. “There’s no cookbook for a new clinic. Donna has been instrumental in setting up the clinic, and in the development of roles and procedures contained within a set of comprehensive orientation manuals,” Dr. Street indicates the manuals guide both the tightly-knit team of five in the clinic (LPN, unit clerk, and three hematologists) and the eventual needs of staff newcomers. “Hematologists have distinct preferences for certain types of procedures, and preferred types of syringes or biopsy needle sizes. It’s all in there.”

Donna says anything that makes it easier for a doctor, or will save time is evaluated, initiated and documented to fulfill a patient-centric mandate. This has included collaborative and fundamental adjustment of a patient-booking template to reduce wait times on site. “We didn’t have enough time with patients and needed to adapt,” Donna says. “Even today when we have a new diagnosis of a serious condition, we’re quick to be out in the waiting room letting people know what we’re doing and why we’re a bit delayed. In context, people are understanding.”

Beyond the clinical lies the beating heart of the clinic: it’s personal. The clinic team’s description of their patient-care approach sounds like a progressive customer service model.

“I treat my patients the way I would want to be treated,” Donna says. “If it was me, I would want to know about my condition as quickly as possible, so

Combined with the small size of the clinic and the ability for each of us to see every patient right through the chain of interaction, we look after people, not just process.

Donna also notes that they treat the whole person, not just the blood condition. “One day a patient came to see us. He had very high blood pressure. I suggested he have it immediately looked at. A year later, he came back with a thank you, indicating he went to emergency, and subsequent treatment and medication meant he was still alive and well.” Lynda notes with a laugh that the clinic “mostly eats the same page in terms of quality of patient experience.”

Quality of patient experience forms a broader guiding vision for the South Health Campus itself: “To enhance the experience for patients and families by building on the principles of Patient and Family-Centred Care.” An expressed goal is to consider the patient and family perspective in every interaction. A pillar of their operating philosophy is collaborative practice. Donna says the words aren’t pie in the sky; the philosophy is communicated by senior management in thematic wellness emails, in quarterly Town Hall meetings, in a hiring philosophy that seeks patient-centric spirit, and in details like wellness brochures in waiting rooms. It’s this deeper philosophy that Dr. Street indicates will serve the Hematology Clinic well even as greater demand and growth of clinic size puts pressure on personalized care.

Continuity of care, personal care, and treating of the whole person are considered hallmarks of the Hematology Clinic’s service approach. A “secret sauce” that holds it together is personal initiative, passionate patient service, and a good dash of LPN confidence that comes with 28 years of experience. Some might facetiously say their blood type is coffee and think little more about the five litres of life-sustaining fluid in our bodies. For one LPN in a pioneering role in a hematology clinic, blood runs a much deeper course that connects caregivers, patients, and hospital philosophy as family.
About the South Health Campus

Opened in 2013 with an investment of $1.3 billion.

Approximately 2400 full-time staff, 180 physicians, 269 inpatient beds, and 11 operating rooms.

Estimated to service 200,000 outpatient visits among 60 outpatient clinics, and perform 2,500 births every year.

Includes a broad range of inpatient and outpatient services, with a focus on wellness services and facilities. These wellness services make illness prevention, management and community health education an important focus of the campus.

Serves Calgary, surrounding rural areas, and is a referral centre for southern Alberta.
Diabetes Update!

GRANDE PRAIRIE, April 27, 2015

BARB BANCROFT, RN, MSN, PNP

The Differences Between Various Types of Diabetes:
- Type 1, Type 2, Gestational & Secondary
  - Risk factors associated with each
  - Pathophysiology associated with each
  - Clinical manifestations associated with each

Long-Term Health Implications of Each Type of Diabetes:
- Complications of Type 1 Diabetes—Microvascular Disease
- Complications of Type 2 Diabetes—Macrovascular Disease
- Complications of Gestational Diabetes—What is the Risk of Developing Type 2 Diabetes? Implications for the Fetus
- Long term complications of Secondary Diabetes

Controlling Blood Sugar for each Type of Diabetes:
- Exercise, Diet, Weight Loss in Type 2 Diabetes
- Types of Insulin Regimens; Types of Oral Hypoglycemic Drugs
- Drugs Classified as Insulin Sensitizers
- Control of Diabetes During Pregnancy

Prevention and Treatment of the Long-Term Complications of each Type of Diabetes:
- Nephropathy in Type 1 and Type 2 Diabetes
- Coronary Artery Disease in Type 1 and Type 2 Diabetes
- Neuropathy in Type 1 and Type 2 Diabetes
- Retinopathy in Type 1 and Type 2 Diabetes

Discuss the Various Tests used to Follow All Types of Diabetics:
- Serum glucose monitoring; Hemoglobin A1C
- Urinary Albumin, Microalbuminuria
- Lipid profiles
- Neurological testing for neuropathy
- Yearly eye exams

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

Legal Issues in Nursing

LETHBRIDGE, May 11, 2015

CHRIS ROKOSH, RN, PNC(C)
ROSEMARIE ENOKSON, RN, BScN

Nursing Litigation and Canada’s Legal Landscape
- Definitions & Statutes; The History of Litigation
- Clinical Areas Most Likely to be Sued; Trends and Issues in Nursing Litigation

The Stages of a Lawsuit; From Date of Adverse Event to Trial
- How an Adverse Event Becomes a Lawsuit
- If You are Sued, What Happens to You and Your Job?
- What Parts of the Lawsuit Will You Be Involved In?

The Four Factors Required to Prove Nursing Negligence
- Establishing the Nurse Duty
- Determining the Breach in the Standard of Care
- Identifying the Injury
- Establishing Causation

The Top Five Nursing Negligence Issues with Case Studies
- Nursing Assessment; Communication
- Medication Errors
- Use of Medical Equipment; Infection Control
- Nursing Documentation that will Defend You in the Event of Litigation
  - What the Experts say About Nursing Documentation
  - What the Courts say that Your Documentation Must Show
  - Examples of Bad, Good, and Better Documentation

Along with the changes to the ways healthcare is managed and delivered, there has also been a change in the legal issues that are a priority for nurses. This workshop is intended to provide a review of how liability issues may develop in a nurse’s practise. Through understanding the framework of risk to clients and nurses, the goal of this workshop is to assist nurses in making proactive judgements that will guide them to avoid harm for their clients and to safeguard their practise.

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

WHO SHOULD ATTEND?
- Nurse in Acute Care Settings
- Home Care Nurses
- Continuing Care Nurses
- Nurse Practitioners
- Critical Care Nurses; ER, ICU
- Discharge Planners
- Ambulatory Care Nurses
- Nurse Educators

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

Conference Fees:
- $279.00 + $9.45 GST = $287.45
- $289.00 + $9.45 GST = $298.45

Price includes conference sessions, lunch, coffee breaks, and handouts. REGISTRATION IS NOT COMPLETE WITHOUT PAYMENT

WHO SHOULD ATTEND?
- Nurses at All Levels of Responsibility
- Nurses in All Settings
- Risk Managers
- Quality Assurance Managers

Conference Fees:
- $169.00 + $8.45 GST = $177.45
- $179.00 + $8.95 GST = $187.95
- $189.00 + $9.45 GST = $198.45

Price includes conference sessions, lunch, coffee breaks, and handouts. REGISTRATION IS NOT COMPLETE WITHOUT PAYMENT
Katie McMahon was ten years old when she woke with severe growing pains in her knee. A trip to the family doctor the next day led to an x-ray, and soon after, she had a diagnosis of osteogenic sarcoma. On September 30, 1996, Katie underwent a Van Ness rotation. Her right leg was partially amputated above the knee, and her lower leg and foot were rotated 180 degrees and reattached, allowing the ankle joint to function as a knee joint. She then underwent fourteen months of chemotherapy to treat her cancer.

One of Katie’s strongest memories from this time is ‘the awesome nurses’.

“I wanted to be another kid’s favourite nurse someday,” says Katie. She loved the nurses who would joke and laugh with her, and treat her like a normal kid.

“They treated me like a person, not just a patient.” She has fond memories of being taught to fill her IV, access her central line and being taught sterile techniques. Her decision was made at the tender age of ten: she would be a nurse herself one day.

Katie shared her plan with her surgeon – and ran into her first roadblock. “You won’t be able to stand for 12 hours at a time,” he told her. “You won’t be a nurse, she heard. Find something else.

“My mom says I was always stubborn,” Katie laughs. She became even more determined to make her dream to be a nurse come true.

That refusal to give up led Katie to the Practical Nurse program at NorQuest College in Edmonton, and then to her current job as a pediatric surgery nurse at the Stollery Children’s Hospital. She works with some of the same nurses who inspired her, and on her first day of orientation, encountered the surgeon who discouraged her all those years ago. She greeted him cheerfully and got on with her work: a 12 hour day on her feet.

Katie acknowledges that her experience with cancer influences her nursing style, both with her young patients and their families. She tries to take the extra time to listen to stressed-out parents without judgment. She remembers how hard her illness was on her family and feels it gives her a bit more understanding of what these families are going through.
She relates to the kids on another level, too – “not better, just differently,” she says. With Katie’s time as a patient not that far behind her, she remembers what worked best for her.

“I don’t treat them like they’re going to break,” she says, noting that sick children receive plenty of sympathy, but often welcome being treated like ‘real kids’ too. Oncology colleagues often invite Katie to share her story with their patients. She is a living example of what can be achieved after a journey with cancer.

Katie says she has had to fight a little harder to prove what she can do. There have been colleagues who felt she belonged behind a desk because of her amputation. To a casual onlooker, her movement is natural, her prosthetic nearly unnoticeable. She adapts her movements at work as needed -- kneeling instead of squatting, for example – and sensibly notes that doing so is better for her back anyway.

Katie has known since she was 10 years old that nursing was right for her. She’s still on that path, working toward completing her Oncology certification, so she can be a pediatric oncology nurse like the ones who inspired her all those years ago. She fits that in between planning her upcoming wedding, and of course, her 12-hour shifts at the Stollery.

One step at a time, Katie’s dreams are coming true.

Katie has known since she was 10 years old that nursing was right for her. She’s still on that path, working toward completing her Oncology certification, so she can be a pediatric oncology nurse like the ones who inspired her all those years ago. She fits that in between planning her upcoming wedding, and of course, her 12-hour shifts at the Stollery.

One step at a time, Katie’s dreams are coming true.

Why did you become a nurse?
Email your story to care@clpna.com and maybe we’ll share it in an upcoming issue.
Highlights from CLPNA’s 5 Minute Communications Survey

There are more than a few interesting results from the CLPNA members surveyed in November regarding their uses and preferences for CLPNA’s communications and marketing. Over 1500 LPNs participated. The results will help guide CLPNA activities over the next year.

SOCIAL MEDIA & MOBILE DEVICES

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<th>LPNs using Social Media</th>
<th>Facebook</th>
<th>Pinterest</th>
<th>Google+</th>
<th>YouTube</th>
<th>Instagram</th>
<th>Twitter</th>
<th>LinkedIn</th>
<th>All Nurses</th>
<th>Tumblr</th>
<th>Don’t use Social Media</th>
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<td>81%</td>
<td>42%</td>
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Employer expects LPNs to use smartphones/tablets on the job

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<td>82%</td>
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CONTINUING EDUCATION

Most interesting subjects for advanced education:
1. Leadership
2. Chronic Disease Management
3. Emergency Care
4. Medical/Surgical Nursing
5. Palliative/Hospice Care

Most popular topics for a future CLPNA Video/Webinar:
1. Leadership & Autonomy for LPNs
2. Preparing for Continuing Competency Program Validation
3. Understanding the Continuing Competency Program
4. How Nursing & Health Legislation Impacts Your Work
5. Looking Professional versus Nursing Professionally: Expectations in Practice

CARE MAGAZINE

Most interesting topics for CARE magazine:
1. Continuing education courses/articles
2. Nursing practice articles
3. Research articles
4. Features about LPNs
5. Provincial / national healthcare news

How would you prefer to receive CARE magazine?

- Online edition only: 28%
- Printed edition only: 72%
Clear, concise and comprehensive language is the goal for written, verbal and electronic communication. Because a team of care providers requires access to current client data, updates, or changes in a client’s condition, documentation needs to be completed in a timely and competent manner. Your assessments and interventions, according to the care plan, should always be client-focused and your documentation should reflect this. This article will discuss some common documentation deficiencies, and strategies to minimize these; how the nursing process links indirectly and directly to documentation methods; and the importance of accurate documentation in, and about, adverse events.

**Documentation Deficiencies**

Many care providers are quick to point out documentation deficiencies. See if any of these sound familiar:

- **Illegible or unreadable handwriting.** It’s preferable to print your client notes if you have challenges with legible handwriting. If you handwrite clients’ information, ask your colleagues if they can read your handwriting.
- **A printed signature.** When your client notes are completed, your signature should be written, not printed. A cursive signature is more difficult to reproduce or falsify.
- **Failing to record pertinent health or medication information.** Remember that past health-related experiences or medications prescribed help the team make the best choices.
- **Failing to record nursing actions.** Documenting what you do for and with your client is very important and should include the outcomes or results of your interventions.
- **Failing to record medications given, or document a discontinued medication or treatment.** This can have drastic consequences if a client receives another dose of medication which may be injurious or life-threatening.
- **Failing to record medication reactions.** If a client has a serious or even minor allergic reaction to a medication and is given it again, it could result in serious injury or death.
- **Recording on the incorrect health record.** A chart or patient record that has recording of another client’s care raises suspicion in the legal system, and can cause incomplete or no care for the client. The competency of the caregiver who has charted on the incorrect patient is then in question.
- **Not providing adequate detail of changes in the client’s condition.** Work on finding a balance between excessive wordiness and necessary client details. Missing details have often been cited in lawsuits as inadequate or incorrect care.
- **Transcribing orders incorrectly or transcribing inaccurate orders.** Special precautions must be taken with telephone orders. If the prescribing health professional uses words you are not familiar with, it is your responsibility to ask for repetition and clarification or have another care provider listen to the orders.
- **Incomplete records.** If pages or specific forms of a client record are missing, this raises suspicion in the legal system and may give evidence of poor care. Removing pages from a client’s record is an illegal activity.
Spelling and Grammar

Misspelled words and substandard grammar create undesirable impressions for the reviewers of your notes. It may be helpful to have a quick reference page at the documentation desk or carry a notebook with correct spellings for commonly used terms. An experienced colleague can give feedback on your client notes and documentation. Other helpful strategies are:

- Refer to a standard and a current medical dictionary at the charting desk or documentation area.
- Post a list of commonly misspelled or confusing words, especially ones linked to medications.
- If using spell check or electronic charting, make it a habit to double check the context, as these systems are not foolproof. For example, a spell check system does not know the difference between “anal” and “oral”.

Abbreviations

In the past decade, there has been much discussion and controversy over using correct and appropriate abbreviations. Have you spent extra time trying to find out what an abbreviation means in a client’s notes, delaying client care so client safety was not compromised? Are you using prohibited abbreviations or terms?

There are published lists of prohibited abbreviations and terms that should not be used, as they have been found to jeopardize client safety (Brunetti, Hicks & Santell, 2007). Check with your employing agency or facility’s policies and procedures. It is best practice to spell out the word when in doubt!

The Nursing Process

Competent care providers view documentation as an extension of the nursing process, and use the nursing process as a guide or framework to ensure accurate documentation. Planning is the “thinking step” of the nursing process about the interventions you will perform for each of a client’s health problems. It is about what you will do in priority sequence for the client. You do not normally chart or document this step, but you may make brief, confidential paper notes.

It is necessary to document in the appropriate place in the client’s record all you did for the client, because in the legal system, undocumented care means that it was not done.

The emotional status of clients is also often excluded from assessment details (Brenner, Dimitroff & Nichols, 2010). This study found that in some client experiences, caregivers did not document an assessment of a client’s emotional status and the emotional support they provided. Remember also to perform a pain assessment, as pain is often a warning sign of a significant change in a client’s condition.

Nursing diagnoses may get burdensome if a client has numerous health issues and several corresponding interventions for each health problem on the care plan; however, you should keep these in mind as you document. Documenting outcomes proves that you followed up on a concern and demonstrates how the client responded to your intervention.

Other strategies for accurate documentation include:

- Document only the care you provide and never ahead of time. Unregulated care providers complete their documentation if they have had client interventions.
- If you find the preceding entry in the progress notes was not signed, then you should locate the care provider as soon as possible to sign his or her notes.
- When documentation continues from one page to the next, you should sign the bottom of the completed page and the top of the next page with the date and time, and state that it is continued from the previous page (Lippincott Williams & Wilkins, 2006).
- Do not document complaints from staff, poor care, or accusations. Keep your documentation strictly client-focused.
- What about co-signing and countersigning? Generally the meaning of co-signing is shared accountability and means that you witnessed or participated in the care or event. This makes you legally responsible for entries or documentation that you co-sign. Countersigning usually means that you reviewed the entry and approved the care or orders given. An example of countersigning would be signing your name and designation after reviewing and checking a physician’s medical orders.
- In documentation, you generally do not use names of roommates or visitors, as this is a breach of their confidentiality.

Documentation Methods

Many care providers have used various documentation systems or methods throughout their careers. Some documentation systems function better in certain healthcare settings. Generally, an employing agency or facility chooses a docu-
Adverse Events

Adverse events are unexpected events that have increased potential or risk to contribute to client harm or injury. These events have the potential for lawsuits. The following adverse events require particular attention when documenting:

- **A client or visitor fall**, no matter how minor it may seem. Injuries from falls may not be evident for hours or days, and falls are a common source of lawsuits.
- **Equipment failure**, which has a great potential to harm or injure a client.
- **An unplanned return to surgery**, as care interactions prior to the surgery will be scrutinized.
- **Medication errors**. Although all medication errors are reported, ones that require intervention must be documented precisely – and a care provider cannot predict which medication error will require intervention.
- **A hospital or facility-acquired infection**. This could result in client injury or even death.
- **An unexpected death of a client**, whether in care or not. Evidence of injury, or sudden death may not occur until after client’s discharged.
- **Threat of a lawsuit or a personal threat** from a client or family requires prompt attention and complete documentation.
- **Client injuries from criminal activity or abuse** must be documented very carefully, as these injuries generally are discussed in court cases.

In this article you have learned about many common documentation deficiencies and what you can do to correct or minimize these. You now understand how the nursing process links both directly and indirectly to documentation. If adverse events occur, you want to be sure to use extra care and attention in your documentation. By considering and applying this information, you will be well on your way to mastering accurate documentation.

References available on request.
“Authentic — being true to one’s own personality, spirit, or character”

- Merriam-Webster Online

Storytellers and expert presenters will share their strength, wisdom and expertise by showcasing authentic practices in work and life at this year’s conference.

Join the College of Licensed Practical Nurses of Alberta (CLPNA) at the Rimrock Resort Hotel in Banff, Alberta for the 2015 CLPNA AGM & CONFERENCE.

April 29 - May 1
Rimrock Resort Hotel, Banff, Alberta

April 29 - AGM 4:30 pm
April 29 - Conference Opening Keynote 7:30 pm

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Speaker Highlights

Scott Harrison
Scott Harrison is an experienced Registered Nurse, Registered Midwife and Nurse Practitioner with a long clinical background in working with indigenous and marginalized communities, people living with HIV/AIDS and problematic substance use. He is Masters trained in both advanced practice nursing and cultural theory. His present role is Director, HIV/AIDS and Urban Health with Providence Health Care, Vancouver and is the Past President of the Canadian Association of Nurses in HIV/AIDS Care. Scott is passionate about social justice, non-oppressive practice and educating healthcare providers and leaders about power, privilege and relational practice.

Jesse Miller
Jesse Miller is an international public speaker who has addressed thousands of participants by presenting to and consulting for schools and companies on the topics of social media awareness, mobile communications and associated behaviours and online content evaluation. Using behaviour changing presentation techniques, Jesse has an unmatched ability to motivate his audience to evaluate their online profiles and how to access privacy and connectivity issues. Jesse is a trusted resource to numerous school districts in Canada and a trusted partner to numerous public safety agencies who use his expertise to address issues that occur on social media requiring evaluation and investigation and delivering a measurable response to an audience who previously had little idea of their vulnerabilities when participating in online environments.

2015 LPN Awards of Excellence
Award recipients will be honoured at the AGM & Conference Awards Dinner and Ceremony on April 30.

Annual General Meeting
This year’s CLPNA Annual General Meeting takes place at 4:30 pm on Wednesday, April 29. For important information, conversations and updates that will affect your practice, be sure to participate!

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Background:

In 2012, the World Health Organization declared dementia a public health priority, citing the high global prevalence and economic impact on families, communities, and health service providers. Persons diagnosed with dementia often have unique needs as they tend to be older and present with acquired impairment in memory, associated with other disturbances of higher cortical function, or personality changes. Exercise programs are among the lifestyle factors identified as a potential means of reducing or delaying progression of the symptoms of dementia.

Questions:

i) Do exercise programs improve cognition, activities of daily living (ADLs), challenging behaviour, depression and mortality in older persons with dementia?

ii) Do exercise programs have an indirect impact on family caregivers’ burden, quality of life, and mortality?

iii) Do exercise programs reduce the use of healthcare services in older persons with dementia and their family caregivers?

Our Approach:

Randomized controlled trials (RCTs) were identified from searching ALOIS (www.medicine.ox.ac.uk/alois), the Cochrane Dementia and Cognitive Improvement Group’s Specialized Register of dementia studies. All RCTs were included in which older adults diagnosed with dementia were allocated to either an exercise program or usual care to determine the effect on the outcomes identified in our review questions. At least two authors independently assessed the retrieved articles for inclusion and risk of bias, and extracted data. Data were analyzed using RevMan 5.2 software and standardized mean differences were calculated. Data for each outcome were synthesized using a fixed-effects model, unless there was substantial heterogeneity between studies, then a random effects model was applied. Adverse events were also evaluated.

Highlights of the findings:

Sixteen trials with 937 participants met the inclusion criteria. However, the required data from three trials and some of the data from a fourth trial were not published and not made available. The included trials were highly heterogeneous in terms of subtype and severity of participants’ dementia, and type, duration and frequency of exercise. Only two trials included participants living at home. Our meta-analysis of eight trials suggested that exercise programs might have a significant impact on improving cognitive functioning. However, there was substantial heterogeneity between trials (I² value 80%), most of which we were unable to explain. We repeated the analysis omitting one trial, an outlier, which included only participants with moderate or severe dementia. This reduced the heterogeneity somewhat (I² value 68%), and produced a result that was no longer significant. Including six trials in a meta-analysis revealed a significant effect of exercise programs on the ability of people with dementia to perform ADLs.

However, again we observed considerable unexplained statistical heterogeneity (I² value 77%). This means that there is a need for caution in interpreting these findings. In further analyses, we found that the burden experienced by informal caregivers providing care in the home may be reduced when they supervise the participation of the fam-
ily member with dementia in an exercise program (one study), but we found no significant effect of exercise on challenging behaviours (one study), or depression (six studies). We could not examine the remaining outcomes, quality of life, mortality, and healthcare costs, as either the appropriate data were not reported, or we did not retrieve trials that examined these outcomes.

Implications for practice and policy:

Healthcare providers who work with persons with dementia and their caregivers should feel confident in promoting exercise programs among this population, as decreasing the progression of cognitive decline and dependence in ADLs will have significant benefits for persons with dementia and their family caregivers’ quality of life, and possibly delay the need for placement in long-term care settings. No trials reported adverse events related to the exercise programs.

The analysis of one trial that examined the burden experienced by family caregivers providing care in the home revealed that this burden can be reduced by supporting the person with dementia to participate in an exercise program. Thus, encouraging caregivers to also participate may have a beneficial impact on their quality of life.

There were insufficient numbers of trials to be able to conduct subgroup analyses that would determine which type of physical activity (aerobic, strength training, or a combination) and at what frequency and duration is most beneficial for specific types and severity of dementia. Clearly further research is needed to be able to develop best practice guidelines that would be helpful to healthcare providers in advising persons with dementia living in institutional and community settings.

Authors’ conclusions:

There is promising evidence that exercise programs can have a significant impact in improving ability to perform ADLs and possibly in improving cognition in people with dementia, although some caution is advised in interpreting these findings. The programs revealed no significant effect on challenging behaviours or depression. There was little or no evidence regarding the remaining outcomes of interest.

The full research summary 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.

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CAREER OPPORTUNITIES
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□ opportunities for growth
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According to the National Coordinating Council for Medication Error Report and Prevention, a medication error is defined as ‘Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional…’ Based on a U.S. Food and Drug Administration study of fatal medication errors between 1993 and 1998, the most common causes of medication errors were performance and knowledge deficits (44%) and communication errors (16%). Children and older adults were identified as particularly vulnerable population groups for medication errors.

Have you ever made a medication error? I know I have; and to date I have never met a nurse who hasn’t. Sadly, these errors occur much too frequently. In fact, medication errors constitute the greatest number of adverse events in healthcare. Fortunately, many of the errors do not result in harm. For instance, a nurse may give a patient Tylenol when ibuprofen was ordered. As long as the patient doesn’t suffer an adverse reaction, this error would not result in a lawsuit.

On the other hand, if a nurse administers a medication that results in serious injury or death, the patient can sue the nurse and may also sue the doctor, pharmacist and hospital. Multiple parties can be sued due to the fact that there may be many contributing factors, and many individuals, who play a part in the ordering, dispensing, administration and developing the processes for giving medications.

Medication administration is considered a basic nursing skill, one of the most common and frequent tasks nurses perform. Nurses have long been required to administer medication by a well-known set of 5 ‘rights’: right drug, right dose, right patient, right route, right time. Some additional ‘rights’ now include the right reason, right response, right documentation, right to refuse and right to education. Nurses are expected to stay knowledgeable about the actions, side effects and contraindications of all medications they give. This is no small task, but a highly necessary one, particularly when caring for high-risk population groups or administering multiple medications to the same person. Nurses are also expected to question any medication orders that are unclear, unusual or unsafe. Doctors can make mistakes and sometimes order the wrong medication or the wrong dose. It’s considered nursing responsibility to recognize errors before administering the medication and to clarify the order with the doctor. Let’s learn more about this by examining a fictional case study with an adverse outcome.

CASE STUDY

At 5:20 p.m., 82-year-old Elizabeth presented in the emergency room of a rural hospital with complaints of abdominal pain. Over the past 3 days, she had been experiencing crampy left lower quadrant pain and had been unable to have a bowel movement. She was nauseous, feeling unwell and her abdomen was distended and tender. Bowel sounds were barely audible. Temperature was elevated to 38.2 degrees Celsius and her white blood cell count was elevated. Medical history included a previous stroke with right-sided weakness, high blood pressure, smoking, mild dementia and a history of bowel cancer. Current medications included calcium and vitamin D supplements, Valsartan HCT for high blood pressure and low-dose aspirin. Elizabeth was severely allergic to penicillin and bees. She was admitted to hospital with a working diagnosis of bowel obstruction and told to remain NPO overnight. The doctor ordered IV fluids, IM morphine and IV Ancef. Consultation was arranged with a gastroenterologist and diagnostic testing was requisitioned for the following morning.

At 10:25 p.m., Elizabeth arrived on the medical unit and was assigned to LPN Belinda. Nurse Belinda completed an initial physical assessment and filled out the admission paperwork. She clearly marked the penicillin allergy in all of the required places and placed an allergy band onto Elizabeth’s arm. Vital signs were stable and Elizabeth denied pain at the time of admission. She had been given a dose of morphine in the emergency room. Elizabeth was drowsy, so Belinda settled her into bed, oriented her to her room, reminded her to remain NPO and showed her how to use the call bell. Belinda went back to the desk to complete her charting, and then into the medication room to prepare the next dose of IV Ancef.

At 12 midnight, Belinda was on her break. Nurse Winnie, who was covering for her, quietly entered Elizabeth’s room and hung the minibag of IV Ancef that Belinda had prepared. Elizabeth seemed to be sleeping soundly, so Winnie did not wake her or check her armband.
Anaphylaxis is a serious, potentially life-threatening allergic reaction. Elizabeth was doing. She seemed to be sleeping, but Belinda noticed that she was restless, frequently rubbing her eyes and scratching her arms. The IV Ancef had infused and Belinda removed the mini-bag and left the room.

Shortly after 1:00 a.m., Belinda made rounds and stopped in to see how Elizabeth was doing. She seemed to be sleeping, but Belinda noticed that she was restless, frequently rubbing her eyes and scratching her arms. The IV Ancef had infused and Belinda removed the mini-bag and left the room.

At 2:15 a.m., Elizabeth rang her call bell, saying that she felt like she couldn’t catch her breath. When Belinda entered the room, she found Elizabeth sitting up in bed, struggling to breathe. Her face was swollen, her lips were blue and she was finding it difficult to swallow. She was complaining of abdominal pain and her skin was covered in bright red hives. Belinda attempted to take Elizabeth’s vital signs, but the patient was so restless that Belinda was unable to obtain either a blood pressure or a pulse. Belinda rang the call bell and asked her charge nurse to come right away.

At 2:27 a.m., Elizabeth collapsed onto the bed and stopped breathing. The E.R. doctor was called and he paged the anesthetist as he made his way to Elizabeth’s room. The doctors were unable to intubate Elizabeth due to swelling in her airway.

At 3:12 a.m., Elizabeth was pronounced dead. The cause of death was listed as an anaphylactic reaction to the medication Ancef. Seven months after Elizabeth’s death, her daughter filed a lawsuit against both the doctors and nurses. She alleged, among other things, that Nurses Belinda and Winnie were negligent in administering Ancef to a patient who had a serious allergy to penicillin without careful observation for signs of an allergic reaction.

She further alleged that if Nurse Belinda had recognized and responded to Elizabeth’s restless eye-rubbing and arm-scratching shortly after 1:00 a.m. as potential signs of an allergic reaction, steps could have been taken to save her mother’s life.

Do you think the nurses met the standard of care?

Anaphylaxis is a serious, potentially life-threatening allergic response marked by swelling, hives, decreased blood pressure and dilated blood vessels. In severe cases, the patient can go into shock which can be fatal. Anaphylaxis occurs when the immune system develops a specific allergen-fighting antibody (called immunoglobulin E or IGE) that initiates an exaggerated response in the body. When exposed to the substance later, the body can produce a large amount of histamine which leads to the development of the symptoms above. It may begin with itching of the eyes and face, then progress within minutes to difficulty breathing and swallowing, abdominal pain, vomiting, diarrhea and hives. Medications are known causes of anaphylaxis.

Ancef or cefazolin is a cephalosporin antibiotic used to treat many types of bacterial infections. Although it is in a different class of drugs from penicillin, cross-sensitivity reactions can occur in up to 10% of patients. Caution and careful observation are advised when administering Ancef to a patient with a penicillin allergy. If any signs of an allergic reaction occur, the nursing plan of care includes immediate discontinuation of the Ancef and notification of the physician. The physician may then order epinephrine and other emergency measures such as oxygen, IV fluids, IV antihistamines, steroids, blood pressure medications and airway management.

The lawyer hired a nursing expert to review the medical records and provide opinion on whether or not Nurse Belinda and Nurse Winnie breached the standard of care. The nursing expert emphasized that medication administration is so much more than a task to be completed. It requires critical thinking, skill and knowledge. She further stated that nurses must be knowledgeable of the actions, side effects and contraindications of all medications they administer. She stated that penicillin and Ancef are two commonly-administered medications in the hospital setting, so it was expected that Nurse Belinda and Nurse Winnie would be knowledgeable of the potential for cross-reaction.

Based on this, the nursing expert determined that the nurses failed to meet the standard in three areas: failing to question the physician for ordering Ancef, administering Ancef to a patient with a serious penicillin allergy without providing careful monitoring, and failing to intervene to signs of an allergic reaction shortly after 1:00 a.m. when Elizabeth was rubbing her eyes and scratching her arms. All of the experts who reviewed the case stated that nursing and medical intervention at 1:00 a.m. would have most likely prevented Elizabeth’s death.

When the nurses were asked if they knew of the potential for cross-reaction, they responded that they did not. They said that because the doctor knew of Elizabeth’s penicillin allergy, and ordered Ancef anyway, they assumed it was safe to give. They were simply following doctor’s orders. Their lack of knowledge coupled with the failure to recognize and respond to early signs of an allergic reaction provided little defense in the lawsuit. This case settled out of court. Both Nurse Belinda and Nurse Winnie were disciplined by their professional body, required to take a course in safe medication administration, and undergo a period of supervised practice.

Start a Conversation

Use this case study to spark a conversation about medication administration with your colleagues. What are your thoughts on one nurse administering a medication that another nurse has prepared? How would you rate the safety of medication administration in your workplace? Have you ever witnessed or made a medication error? Did the patient suffer as a result? What is the process for reporting a medication error in your workplace? Does the process allow for open discussion, learning and improvement? If not, what can you do to promote safer medication practices? What will you do differently now that you know what you know? Want to learn more? Watch for more articles coming up in CARE magazine!
Research: Digital Health Tools Making a Difference

The first quantitative research conducted with Canadian nurses about their use of digital health technologies in practice has demonstrated that a majority see the benefits in using digital health tools and consider themselves confident using electronic clinical information systems and tools in clinical practice.

The survey, a joint initiative of the Canadian Nurses Association and Canada Health Infoway (Infoway), was conducted by Harris/Decima earlier in 2014. One thousand, six hundred and ninety nurses, from every province and territory, responded, and results were analyzed from the 1,094 respondents working in clinical care.

Digital health tools were being used by three-quarters of these respondents, with 56 per cent using a combination of electronic and paper tools and 20 per cent using electronic only. There was a wide variance in electronic-only use based on respondents’ clinical settings.

The most common uses of electronic tools were for entering and retrieving clinical patient notes (65 per cent), ordering lab tests (54 per cent) and listing patient medications (54 per cent). Respondents indicated a high level of confidence using the tools (83 per cent), even though nearly one-third (32 per cent) stated they had not received adequate training.

Respondents were clear about the benefits of digital health tools: 78 per cent said the tools had the potential to improve the continuity of patient care, 78 per cent said they could improve communication between care team members, and 72 per cent said they could improve patient safety.

The survey also revealed some of the barriers to fully realizing these benefits. Access to digital health tools was raised as a major concern: 49 per cent said they did not have adequate access to tools, and 57 per cent said the types of tools in use in their practice were not adequate for their role. Multiple logins was another concern. Very few respondents (14 per cent) said they were consulted extensively about decisions to introduce electronic clinical information systems and tools into their workplace.

“Addressing these barriers can present opportunities to enhance patient care, clinician satisfaction and productivity,” says Maureen Charlebois, Infoway’s chief nursing executive. “Infoway is very focused on working together with nurses and other clinical leaders to help accelerate the development, adoption and effective use of digital health in practice across Canada.”

“The survey has provided valuable insight into how the health community can intensify the implementation of digital health tools, what strengths can be built upon and what gaps we need to close,” says CNA CEO Anne Sutherland Boal.

This article was originally printed in the June 2014 edition of Canadian Nurse magazine and is reprinted with their permission.
Physical Assessment Pearls

BARB BANCROFT, RN, MSN, PNP

Okay… so you only have 5 minutes!

- The Patient’s History, the Chief Complaint, Signs and Symptoms
- Using the PQRSFT Mnemonic as a Framework
- AASS – Associated Symptoms, Absent Symptoms, or ALARM Symptoms
- Revisiting the “Vital Signs”; The Importance of Critical Thinking
- For Example: Using the PQRSFT 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 Meals
- 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 Hemoptysis
- Enhancing GI & GU Exams – From Quadrants to Abdominal Sounds
- The Most Important Thing in a Gyn Exam
- The 10-Minute Neuro Exam
- Skin: Lesions, Rashes, IVs, & Cancer
- What You Need to Know about Something Called the “Likelihood Ratio”

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

Diabetes Update!

BARB BANCROFT, RN, MSN, PNP

The Differences Between Various Types of Diabetes:

- Type 1, Type 2, Gestational or Secondary
- Risk factors associated with each
- Pathophysiology associated with each
- Clinical manifestations associated with each

Long-Term Health Implications of Each Type of Diabetes

- Complications of Type 1 Diabetes – Microvascular Disease
- Complications of Type 2 Diabetes – Macrovascular Disease
- Complications of Gestational Diabetes – What is the Risk of Developing Type 2 Diabetes?
- Implications for the Fetus
- Long-term complications of Secondary Diabetes

Controlling Blood Sugar for each Type of Diabetes

- Exercise, Diet, Weight Loss in Type 2 Diabetes
- Types of Insulin Regimens; Types of Oral Hypoglycaemic Drugs
- Drugs Classified as Insulin Sensitizers
- Control of Diabetes During Pregnancy

Prevention and Treatment of the Long-Term Complications of each Type of Diabetes

- Nephropathy in Type 1 and Type 2 Diabetes
- Coronary Artery Disease in Type 1 and Type 2 Diabetes
- Neuropathy in Type 1 and Type 2 Diabetes
- Retinopathy in Type 1 and Type 2 Diabetes

Discuss the Various Tests used to Follow All Types of Diabetes

- Urinalysis, Albumin, Microalbuminuria
- Lipid profiles
- Neurological testing for neuropathy
- Yearly eye exams

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 “FQRSFT + AASS” way. Barb provides examples of how to use this mnemonic to get the most important information in the least amount of time. Barb will then guide you through assessment basics: where to “listen”, where to “look”, and where to “feel” if you only have a minute. Barb correlates anatomy, physiology, and pathophysiology for each major system discussed. Refresh your knowledge on all the info you can glean from a basic vital signs evaluation. Barb will also discuss various drug classes and the side effects that can confound a physical exam. Join us!

Who Should Attend?

- Nurses in Acute Care Settings
- Critical Care Nurses; ER, ICU
- Home Care Nurses
- Discharge Planners
- Nurse Practitioners
- Ambulatory Care Nurses
- Nurse Educators
- Continuing Care Nurses

Barb Bancroft is a widely acclaimed nurse educator who has taught courses on AdvancedPathophysiology, Pharmacology, and Physical Assessment to both graduate and undergraduate students. Also certified as a Pediatric Nurse Practitioner, she has held faculty positions at the University of Virginia, the University of Arkansas, Loyola University of Chicago, and St. Xavier University of Chicago. Barb is known for her extensive knowledge of pathophysiology and 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.

Conference Fees:

- $169.99 + $8.45 GST = $177.45 Early Rate (on or before April 20, 2015)
- $179.99 + $8.95 GST = $187.95 Middle Rate (on or before May 19, 2015)
- $189.99 + $9.45 GST = $198.45 Regular Rate (after May 25, 2015)

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

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

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To register:
Call toll-free 1.866.738.4823 or visit NursingLinks.ca
What’s the balance between resident safety and providing a home-like environment in a Continuing Care setting? Finding that balance was one of the guiding principles behind a new resource to help support staff manage infection prevention and control in Continuing Care facilities.

Alberta Health Services (AHS) Infection Prevention & Control (IPC) has developed a new, online and interactive resource to help support staff caring for residents living in Continuing Care settings. The Continuing Care Resource Manual guides staff in managing the care of those residents who have a known or suspected infectious disease or condition. The resource manual focuses attention on routine practices emphasizing point-of-care risk assessments. It includes: a disease and condition table, information sheets, signs for additional precautions, Antibiotic Resistant Organism management guide and an overall emphasize on routine practices. There are links throughout the manual to information sheets outlining Routine Practices or Additional (Isolation) Precautions as well as signs which explain the procedures required.

Additional information such as a glove fact sheet, instructions on using N95 respirators for visitors, FAQs, practice scenarios and much more can be found on the IPC continuing care webpage at http://www.albertahealthservices.ca/9237.asp.
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For Gerontological Nurses
Alberta Gerontological Nurses Association (AGNA)
www.agna.ca or info@agna.ca
AGNA invites LPNs to join their educational and networking association for those interested in caring for older adults.

For Emergency Room Nurses
Emergency Nurses' Interest Group of Alberta (NENA-AB)
http://nena.ca
ENIG invites LPNs to join them as they promote the specialty of emergency nursing through learning opportunities, networking and nursing research.

For Nurse Educators
Canadian Association of Schools of Nursing (CASN)
www.casn.ca or 613-235-3150
CASN invites LPN educators to join their special interest groups for Internationally Educated Nurse Educators, Nurse Practitioner Education, Palliative and End of Life Care Education.

For Operating Room Nurses
Alberta Operating Room Team Association – LPN (AORTA)
www.clpna.com/members/aorta-affiliate/
AORTA welcomes LPNs with or without an Operating Room Specialization to expand and update their nursing knowledge through educational sessions and to bring together nurses interested in this specialty.

Alberta Gerontological Nurses Association
www.agna.ca
Alberta Hospice Palliative Care Association
http://ahpca.ca
Alberta Innovates
www.albertainnovates.ca/health
Canadian Agency for Drugs and Technologies in Health
www.cadth.ca
Canadian Association of Neonatal Nurses
www.neonatalcann.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
Canadian Virtual Hospice
www.virtualhospice.ca
Community Health Nurses of Alberta
www.chnalberta.ca
Creative Aging Calgary Society
www.creativeagingcalgary.com
Education Resource Centre for Continuing Care
www.educationresourcecentre.ca
John Dossetor Health Ethics Centre
www.uaalberta.ca/bioethics
Mount Royal University
www.mtroyal.ca
National Institutes of Health Informatics
www.nihi.ca
Reach Training
www.reachtraining.ca
Selkirk College
www.selkirk.ca
UBC Interprofessional Continuing Education
www.interprofessional.ubc.ca
Under Re-Construction — the LPN Competency Profile Gets an Overhaul!

The CLPNA embarked on a very comprehensive and ambitious review and update to the 2005 LPN Competency Profile in September 2014. Considering the Competency Profile was first developed in 1997-1998, with the 2nd Edition published in 2004-2005, there are many competency changes, updates, and new areas being examined.

This review engages thousands of participants including licensed practical nurses, practical nurse educators, employers, specialty educators, interest groups, and other stakeholders. Consultations have occurred through numerous face-to-face and webinar focus groups, teleconferences and interviews to collect data. New and revised competency areas requiring further feedback have been circulated to LPNs with rich data collected. Involvement of licensed practical nurses in this consultation included a wide representation of roles, clinical experience and specializations.

Engaging a large number of LPNs from across Alberta is what makes this project a success, as it’s about understanding what LPNs know and what they do. Teresa Bateman, Director of Professional Practice at the CLPNA, is leading the project along with the Practice team, and comments, “Our 3rd Edition Competency Profile will be a very valuable resource, showcasing the knowledge, skills, attitudes and behaviours of the profession. I am sure the new edition will surprise and enlighten many, as our team has been inspired by the tremendous growth in roles and competencies for LPNs over the last 10 years.”

This review is ambitious with a seven-month schedule for completion. The 3rd Edition Competency Profile is set for release at the CLPNA Annual General Meeting on April 29, 2015 in Banff. The new Profile will be available at www.clpna.com or by contacting the CLPNA.

The CLPNA extends sincere thanks to all involved in this project. Your generous donation of time and energy to describe your knowledge, expertise and roles is sure to position the profession well in the future.
Run for Council in Calgary, Edmonton & North Zone

Influence the direction of the LPN profession!

In the Edmonton, Calgary, Grande Prairie and Fort McMurray areas, LPNs are invited to run for District Representative to CLPNA’s Council. Nomination packages must be submitted by May 31. District Elections will be held in June by electronic (email) ballot.

Council meets quarterly to plan and evaluate CLPNA’s overall direction, policies and finances. Successful Council members are team-oriented servant-leaders with a discerning eye on the future of the LPN profession.

Nomination packages are available at www.clpna.com/about-clpna/council, or by contacting info@clpna.com, 780-484-8886 or 1-800-661-5877 (toll-free in Alberta).

Any CLPNA members have asked that the Continuing Competency Program Validation (CCPV) begin earlier and before summer. We heard you! This year CCPV launches May 4 with approximately 20% of eligible members randomly selected to participate.

Those chosen to participate will be notified by email and mail, or you can see the “Validation” tab on your Member Profile at https://www.myCLPNA.com. You will be required to validate your learning for the previous two years (2013 and 2014) and complete an online CCPV submission. You may also be required to submit proof of your learning.

It is possible to be chosen for CCPV every second year through the random selection process. Be prepared. CLPNA recommends you track your learning regularly. Tracking is easy using the CLPNA Record of Professional Activities or other organized method. Any learning that enhances your nursing practice is applicable for the Continuing Competency Program, whether you complete a certificate course, read a best practice article, or research pertinent information online. A list of suggested learning activities can be found at www.clpna.com.

Get ready for CCPV!
Organize today. Be prepared. You may be one of “the chosen”.

CCP VALIDATION BEGINS IN MAY
2014 MEMBERSHIP HIGHLIGHTS

12881
total registrations
growth of 9.5%

REGISTRATIONS

Alberta Graduates NEW Members 979 1017
Canadian Out of Province NEW Members 646 614
International NEW Members 166 224
Reinstatements* 370 387
Re-Entry 0 3
Renewals 9605 10636
Courtesy Members 0 0
TOTAL 11766 12881

*Reinstatement = a member whose practice permit has lapsed at least one day.

OUT OF PROVINCE REGISTRATIONS

614
total out of province
2013 - 639

ACTIVE MEMBERS BY PLACE OF EMPLOYMENT

Hospital (General/Maternal/Paedeiatric/Psychiatric) 4390
Nursing Home/Long Term Care 2952
Community Health/Health Centre 1766
Physician’s Office/Family Practice Unit 745
Home Care Agency 374
Educational Institution 179
Rehabilitation/Convalescent Centre 138
Business/Industry/Occupational Health Centre 106
Mental Health Centre 90
Association/Government 68
Self-Employed 50
Nursing Stations (Outposts or Clinics) 7

38.7 YRS
average age
2013 - 39.1

AGE OF ACTIVE LPNS

19-25 1712
26-30 2486
31-35 2088
36-40 1591
41-45 1334
46-50 1065
51-55 807
56-60 813
61-65+ 785
Survey Contest Winners

The CLPNA thanks everyone who participated in our many surveys this fall. Survey results significantly help improve member service.

Participants were randomly selected to receive $50 gift cards to Indigo/Chapters in appreciation.

Winner for the Registration Renewal Satisfaction Survey are: Beverly Lenes, Amber House, Nancy Key, Pam Bender, and Keith Bronce. For the Communications Survey, winners are: Marlene Begg, Marian Banks, Jaime Horner, Annette Raasch, and Charlynn Ursu.

Request Special Event Kits for National Nursing Week
May 11-17, 2015

The CLPNA is supporting celebratory events during National Nursing Week, May 11 to 17, with complimentary Special Event Kits. Members can request a Special Event Kit containing LPN-branded items, such as lip balms, pens, bags, etc., to use as door prizes or event giveaways. The request deadline is April 10.

Request forms for Special Event Kits are available at www.clpna.com or by contacting info@clpna.com or 780-484-8886. Kits are first-come, first-served. Product type and quantity depends on the number of expected attendees and number of requests received by CLPNA. There is no guarantee of receiving one item per attendee.

Post your event pictures on Twitter with #CLPNANursesCare or to our National Nursing Week posts on Facebook.

SPRING SURVEY

Who’s Your Favourite Fictional Nurse?

Nurses are popular characters in fiction, popping up in books, on television and in the movies. Fictional nurses range from angels of mercy to cold-hearted villains, but it’s the characters with a believable combination of compassion and imperfection who resonate the most.

Maybe that’s why thirty years later, M*A*S*H’s Margaret “Hot Lips” Houlihan still came out on top.

Others favourites:
Rory Williams (‘Doctor Who’, TV),
Christina Hawthorne (‘HawthoRNe’, TV),
All the nurses from “Call the Midwife”

<table>
<thead>
<tr>
<th>Hot Lips Houlihan ('M<em>A</em>S*H', TV)</th>
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Some CLPNA staff set the goals; some help everyone else reach them. Specialists. Experts. Unique skill sets. For our Finance, Communications and Human Resources personnel, their talents lie in supporting the goals of the LPN profession.

Barb Rigney manages all financial aspects of the CLPNA. A Chartered General Accountant (CGA) since 2000, she’s been Finance Officer since 2009. Motivating her is “feeling good about working in the healthcare profession with LPNs who are dedicated to the care of others.” The staff appreciates her gardening skills and the delicious farm produce she brings in all summer. She’s a creative jewelry maker, and loves spending time with her grandchildren.

Gina Bernardo is responsible for the overall administration of the financial books, accounts, and records of CLPNA and other accounts as Finance Assistant. She has a Bachelor of Science in Business Administration (Accounting), and a Masters in Business Management, so, it’s not surprising that she’s working towards a CGA designation. At CLPNA for nearly 4 years, she loves that “everyone works together as a team to achieve our goals”, and interacting with LPNs. She enjoys volunteering for Santa’s Anonymous.

Carolyn Black in Communications is a writer, content creator, technical guru, and webmaster for CLPNA’s multiple websites, CARE magazine, mass emails, social media platforms, surveys, news releases and more. From news to photos to tweets, she has a passion for clear messages and technology, and is “pleased her university education in education and administration ended up being remarkably useful”. A pop culture lover and voracious reader, her current obsessions include developing her website and marketing startup, and planning a trip to Disney World. This is her tenth year at CLPNA.

Donna Doerr, Human Resources and Foundation Assistant, joined CLPNA in July 2014. Donna earned an HR Management Certificate from the University of Alberta along with her Registered Professional Recruiter designation. Donna also is the Grant Administrator and Secretariat to the Fredrickson-McGregor Education Foundation for LPNs. “We are involved with some very exciting initiatives this year, constructing a new website, a new logo, and donation options, coming soon!” When she is not walking her Great Dane, she enjoys hot yoga and flower gardening.

Barb Bancroft Seminar: Clinical Focus on Geriatrics

Barb Bancroft, our most popular Conference speaker ever, is back!

With her trademark blend of humour and nursing smarts, Barb will be presenting a 3-day seminar series on a “Clinical Focus on Geriatrics” in Grande Prairie, Edmonton, and Calgary. Seminars can be registered for individually. The sessions are 8:30 am to 3:30 pm, and the registration fee includes lunch.

Member Fee $125, Non-Member Fee $165

The CLPNA is pleased to host these events as part of our Strategic Plan to prepare LPNs for changing demographics in all care settings. Seminars are open to all health professionals.

For registration information and fees, see www.clpna.com or contact info@clpna.com, 780-484-8886 or 1-800-661-5877 (toll-free in Alberta).
Hearing Tribunal Decision
Bullying Behaviour Leads to Discipline

In February 2012, the College of Licensed Practical Nurses of Alberta received a complaint from an employer regarding the conduct of a Licensed Practical Nurse. The College investigated the complaint and determined there were multiple allegations of unprofessional conduct and sufficient information to proceed with a Hearing before the Hearing Tribunal. The Hearing Tribunal ordered publication of this decision to promote general deterrence, and in doing so, promote protection of the public.

The Allegations surrounded the Member’s disruptive behavior including co-worker intimidation, invading personal space, and communicating with co-workers in an inappropriate and disrespectful manner causing distress in the workplace.

The Hearing Tribunal met for two days in May 2014 and heard evidence from multiple witnesses, including the Member.

The Hearing Tribunal heard evidence from the witnesses that described the Member’s behavior as intimidating, bullying and disrespectful. Co-workers of the Member felt threatened by the Member’s actions. Her actions were found to have caused unnecessary stress to the staff and contributed to an unhealthy and negative work environment. The Hearing Tribunal considered the nature and gravity of the Member’s actions as being shocking and very serious. As an LPN, she was responsible for maintaining an environment that promoted and fostered a respectful relationship. In addition, she was responsible for effective communication with co-workers.

The Hearing Tribunal considers fostering a healthy work environment with co-workers as one of the most important requirements of the profession, as represented within the CLPNA’s Code of Ethics and Standards of Practice.

At the conclusion of the Hearing, the Hearing Tribunal determined that the Member was guilty of unprofessional conduct. The Hearing Tribunal determined that the Member must be held responsible for her actions. The Hearing Tribunal ordered her to review several documents (includ-
Due to the seriousness of the Member’s conduct, the Hearing Tribunal imposed a disciplinary order requiring her to pay a portion of the hearing costs in the amount of $12,000.

This article is a summary of the Hearing Tribunal decision. This article is not intended to provide comprehensive information of the complaint, findings of an investigation or information presented at the hearing.

RESOURCES AVAILABLE

Conflict Management and Team Building Courses mentioned in the article are available at http://www.coursepark.com


FOR RELATED LEARNING, ACCESS THE FOLLOWING DOCUMENTS AT WWW.CLPNA.COM:

CLPNA's Co-Worker Abuse Documents addressing various aspects of the co-worker abuse situation are:

- Practice Guideline: Addressing Co-Worker Abuse in the Workplace
- Fact Sheet: Co-worker Abuse is a Threat to Patient Safety
- Fact Sheet: Did You Know – Abuse is a Learned Behaviour in Nursing
- White Paper: Mental Injury in the Healthcare Workplace
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...

“Courage, integrity and a sense of humour are the three essentials of your new profession.”

Canada’s first graduates of a training program exclusively for nursing aides heard these words at their October 1947 graduation. Margaret Corney of Calgary, seen here (and we love her big smile), was the first among 57 graduates to receive her diploma and crest after 10 months of training. The program was newly open to civilians after beginning as a course to qualify ex-servicewomen post-WWII, and in time, the profession would evolve into today’s practical nursing profession. Rae Chittick, president of the Canadian Nurses’ Association, also told the new aides that nursing requires a deep understanding of human nature – still as true today, almost 70 years later.
Expand your skills and professional competencies with these courses and programs for LPNs, many of which are available online:

- Advanced Education in Orthopaedics for LPNs (certificate program)
- Medical Device Reprocessing Technician (NEW certificate program)

**Online courses**

- Foundations of Anatomy and Physiology for Orthopaedics (ADVO 1101)
- Adult Health Assessment for Nurses (AHAN 1000)
- Infusion Therapy for Nurses (IVTH 1010)
- Medication Administration: Intramuscular and Intradermal Injections (MEDA 1001)
- Pharmacology Therapeutics and Medication Administration (PTMA 1000) – also available via distance

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**REGISTER OR APPLY TODAY!**

780.644.6000  |  toll-free 1.866.534.7218

For more information about continuing education for LPNs:
LPN.ConEd@norquest.ca  |  780.644.6282

For information about orthopaedic classes:
ortho@norquest.ca  |  780.644.6366

Step Forward
norquest.ca
2015 CLPNA AGM & CONFERENCE | April 29 - May 1
Rimrock Resort Hotel, Banff, Alberta

REGISTER TODAY
This event is expected to sell out!

Apply for $150 Off Your Registration Fee
more info online

www.clpnaconference.com