A Different Kind of Nursing: HIV NORTH

Caring for Caregivers

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Evidence: The Foundation of Nursing Practice

Florence Nightingale could be credited as the first nurse to practice evidence-informed decision making. In 1850, during the Crimean War, she noticed that the rising death rates in the hospital were associated with poor sanitation. After she implemented sanitization standards, the death rates of soldiers in her hospital decreased drastically. Similar to the modern use of evidence-based medicine, Florence Nightingale used observation to ‘test’ her hypothesis. The various terms, ‘evidence-based medicine’, ‘evidence-based practice’, and ‘evidence-informed practice’ may have varying degrees of interpretation; however, there is no dispute that ‘evidence’ is an essential component of quality nursing practice.

In Canada, licensed practical nurses (LPNs) are required to demonstrate integration of nursing knowledge, skills, behaviours, attitudes, critical thinking, inquiry, and clinical judgements as an entry to practice competency. In nursing, evidence-based practice (EBP) is the integration of the ‘best available clinical evidence’, ‘individual clinical experience’, and the ‘patient’s values and expectations’. Although nurses generally have a positive attitude toward EBP, research informs us that there is poor uptake in the application of this process. Consistently, research findings from around the world note that nurses indicate they are familiar with EBP processes; however, most note that they are more likely to ask their nursing colleagues and peers for practice information.

Because the majority of research on EBP in the nursing research literature is done by registered nurses on registered nurses, the CLPNA wanted to hear from our members about how they access evidence in their practice. In February 2016, we surveyed our members to get their feedback. Seven hundred and fifty LPNs responded to our survey about the sources of information they use in their practice. The top three sources LPNs mentioned were: information they gathered from their patients, information they learned in nursing school, and their organizations’ policy and procedure manuals.

We were very pleased to note that their answers reflect the three pillars of EBP (patients’ values and experience, individual clinical experience, and the best available clinical evidence). The CLPNA recognizes that there is a gap between ‘academic’ knowledge and ‘real’ world nursing. In order to address this gap we are introducing a new professional development webinar series that began in March 2016: Innovative Evidence-Based Practice Education: Battling Dr. Google and Nurse Jackie.

The webinar series consists of three interactive webinars designed to increase LPNs’ skills in EBP and their ability to carry out those skills in practice. The series has a strong clinical focus versus an academic application of EBP skills to demonstrate the relevance and utility of research for practice, and enhance the real-world application of EBP. Topics of interest include information literacy, the steps of EBP, and integration of evidence.

This webinar series has already been acknowledged for its innovative approach to teaching EBP. We will be presenting this approach to nurses from around the world at the Sigma Theta Tau International’s 27th International Nursing Research Congress.

Moving ahead, we continue to be committed to excellence in all areas of LPN practice. Our webinar series is a great addition to our toolkit, supporting our nurses to provide the highest quality care and respond to the needs of our changing health system.

Jo-Anne Macdonald-Watson, President and Linda Stanger, Chief Executive Officer
**The Diabetic Foot Assessment & Management**

**Executive Links**

**Foot ulcer and related complications are common, especially among people with diabetes. For optimal patient outcomes, the care of people with foot complications and ulcers requires a systematic approach to evaluate and address risk factors. This interactive workshop will describe underlying causes and clinical approach to different foot complications related to arterial disease, neurological conditions, diabetes, arthropathy, and autonomic neuropathy disorders. Participants will develop skills in vascular assessment using a Doppler, vibration and proprioception testing, callus care, and application of total contact cast. Discussion will provide vital time summary of best practices and options for multidisciplinary management, infection treatment (including management of skin and plantar wounds), footwear selection, skin and nail care, addition to comprehensive lifestyle modifications.**

**Who Should Attend?**

- Foot Care, Wound Care, and Infection Control Nurses
- Nurses in Acute Care, Critical Care, and Long Term Care Settings
- Nurses in Home Care and Rehabilitation Settings
- Adult Nurse Practitioners and Diabetes Educators

**De** Kevin Woo is an Assistant Professor at Queen's University, School of Nursing in Kingston, Canada. Kevin is also an adjunct research professor at the Western University teaching for their Masters of Clinical Science in Wound Healing Program. He is the Early Researcher Award recipient 2014-2019 from the Ministry of Research. He is the co-editor of Chronic Wound Care 2, a clinical source book for health care professionals. He served on expert panels to develop Best Practice Guidelines (BPG) in collaboration with Registered Nurses Association in Ontario for the Assessment and Management of Stage 1 to 4 Pressure Ulcers and Screening for Dementia, Depression and in older persons. Kevin maintains his clinical expertise and functions as an Advanced Wound Consultant at the West Park Health Centre, a specialized chronic care and rehabilitation hospital in Toronto. Additionally, he is the Web Editor for Advances in Wound and Brain Care Journal website and is a member of several editorial boards.

**Conference Fees:**

- $179.75 + $45.50 GST = $225.25 Middle Rate (or before May 24, 2016)
- $189.75 + $49.45 GST = $239.20 Regular Rate (after May 24, 2016)

*Prices includes conference sessions, lunch, coffee breaks, and handbook.

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**Neurology Through the Ages**

**Executive Links**

**Barb Bancroft, a widely acclaimed nursing teacher who has taught courses on what can only be described as a developing nervous system. Clinical correlations are made to human diseases. This workshop will focus on the develop.**

**Who Should Attend?**

- New Neuro Nurses, Pediatric Nurses, Adult Nurse Practitioners
- School Nurses, Primary Care Nurses
- Rehab Nurses, Med-Surg Nurses, Mental Health Nurses
- Acute, Long Term and Home Care Nurses
- Tele-Health, Correctional, & Occupational Health Nurses

**Conference Fees:**

- $169.75 + $45.50 GST = $215.25 Early Rate (or before May 2, 2016)
- $179.75 + $49.45 GST = $229.20 Middle Rate (or before May 30, 2016)
- $189.75 + $49.45 GST = $239.20 Regular Rate (after May 30, 2016)

*Prices includes conference sessions, lunch, coffee breaks, and handbook.*
Interprofessional practice (IPP) is central to promoting the health of Canadians and providing quality, patient-centred care. Historically, healthcare professionals have been educated, and then often continue to practice, within a profession-specific model often referred to as silos of practice. In nursing education, one of the areas where we see this model being perpetuated is the separation of nursing students into Bachelor of Science in Nursing (BScN) and Practical Nursing (PN) streams, with no intersection between the learning experiences of the nursing students enrolled in these two types of programs.

As faculty members teaching in the BScN and PN programs at the University of Ontario Institute of Technology (UOIT) and Durham College in Ontario, we got together to tackle the challenges that we felt this model posed. So why does this matter? While the value of interprofessional and intraprofessional education (IPE) in the health professions is commonly highlighted, gaps exist in the evidence specifically related to IPE implementation in nursing education. Even more importantly, little research and only modest practice innovation has occurred in the unique area of intraprofessional nursing education, where different types of nursing students learn together. As the role and scope of practice for Registered Practical Nurses (called RPNs in Ontario; aka LPNs in the rest of Canada) and RNs has transitioned in Ontario, the demand has increased for graduates of these programs to collaborate, work effectively together, and demonstrate respect for and understanding of each other’s role and the contributions all nurses make to healthcare. The natural starting point in developing this type of collaborative practice culture in nursing is within the very basis of nursing education.

THE PROJECT

While learning about each other’s roles and contributions to healthcare is valuable for BScN and PN students, learning with each other in areas where the curricular focus is similar is a critically important undertaking that has yet to be realized. In an effort to address this gap, a long-overdue innovation was implemented with the assistance of funding through a grant from the Registered Practical Nurses Association of Ontario (RPNAO) Role Clarity Fund. This project called for the creation of a pilot PN-BScN shared learning experience in a required course (1st year Hybrid Intraprofessional Health Assessment) that is common to both our PN and BScN programs. Faculty teaching health assessment in the BScN and PN programs at UOIT and Durham College collaborated fully on the development of this common course, including working out technical issues such as minor variations to term length between the programs, and the use of different learning management systems. The goal was to ensure a learning experience where students not only shared the same material and demon-
strated the same competencies, but also experienced the face-to-face and online learning components of the course together, in mixed BScN and PN classes.

OUTCOMES

Research ethics board approval (REB) was obtained from both UOIT and DC for all evaluative components of the project. Exploration of student perceptions was accomplished through a mixed method design, including pre- and post-online questionnaires and end-of-term face-to-face focus group interviews.

The online survey consisted of three components. In addition to collecting demographic information, students were invited to complete two standardized tools. The Readiness for Interprofessional Learning Questionnaire (Parsell & Bligh, 1998) is a 19 item tool, using a 5-point Likert scale. Highlights of data analysis reveal student perception that intraprofessional learning will enhance their effectiveness as team members, increase understanding of clinical problems, improve professional relationships post-registration, improve perceptions of other health professionals, and enhance communication. The Team Assessment Questionnaire (Hepburn, Tsukuda, & Fasser, 1996) is a 16 item tool in which participants are asked to rate their ability to complete a particular task using a 5-point Likert scale. Highlights of data analysis reveal that following completion of this intraprofessional learning experience, students felt they would be more likely to treat team members as colleagues, better able to identify the contributions to patient care that different disciplines make, demonstrate strengthened cooperation, more effectively participate in and address clinical issues within team meetings, develop and support interdisciplinary plans of care, and intervene to improve team functioning.

Additionally, four focus group interviews were conducted in the spring of 2015. Analysis of student perceptions shared through these interviews revealed their experiences of barriers and facilitators to intraprofessional education. In terms of facilitators, the dawning of a new awareness amongst learners was seen as a positive influence on intraprofessional learning (e.g., “I didn’t realize how much our scope overlapped” and “I had no idea how much we learned that was similar… that really opened my eyes to how we should be working together”). As well, learners described the emergence of a new vision of their future practice as a result of this experience (e.g., “I can totally see how I would be able to work more effectively with other nurses after this [course]” and “It just makes sense [to collaborate] now that I see how many similarities there are in our practice”). When speaking of barriers, technical issues related to the logistics and the challenges of working across institutions were experienced (e.g., “It could be confusing if we had to use different forms” and “Working through different learning systems was something I worried about”). Additionally, social issues were identified as a barrier to be considered when creating this shared model of intraprofessional education (e.g., “When we were given a choice, we didn’t always mix together that much” and “It might have been a good idea to force us to mix more”).

CLOSING THOUGHTS

Regardless of the challenges associated with transitioning to intraprofessional learning, the benefits are indisputable. As a result of this very successful pilot project, UOIT and DC have expanded this course offering to include the 2016-2017 academic year, with ongoing evaluation in place. The results of this course offering have the potential to significantly advance intraprofessional learning in nursing and provide insight into its effect on attitudes toward (and eventually comfort with) intraprofessional practice. Having experienced the learning in this pilot project, we are firm believers that the rewards for breaking down educational barriers between PN and BScN students have the potential to positively influence the very trajectory of the nursing profession in Canada.

To learn more about this research project, contact: Patricia.Munro-Gilbert@duhramcollege.ca.

References are available on request.
HIV NORTH
A Different Kind of Nursing
By Mark Kozub
The Licensed Practical Nurses (LPNs) of HIV North experience “a different kind of nursing”.

“It takes a special person to do what we do,” says Sue Belcourt, Executive Director of HIV North Society, a not-for-profit AIDS Service Organization (ASO) established in 1987. “What we offer here is a different type of nursing and all of our LPNs work to full scope of practice.”

Programs offered by HIV North include: education, focusing on community, corporate and school presentations to increase HIV awareness; outreach services provided on site at community partner agencies and in the downtown streets; an LGBTQ youth mentor program, which includes a weekly evening drop in; and a women’s drop-in, which offers support for women living high-risk lifestyles or working in the sex trade.

“We’re the only AIDS service organization north of Edmonton,” says Sue. She is proud of her staff and what they’re able to accomplish, given the fact that they serve such an enormous geographic region. HIV North has 24 staff: 17 in Grande Prairie, 6 in Fort McMurray and 1 in Peace River, through a partnership with the Sagitawa Friendship Centre. Among the staff are two LPNs in Grande Prairie (not including Sue, who is an experienced LPN herself,) and one LPN in Fort McMurray who works as a regional outreach worker.
In order to provide the necessary services, HIV North has expanded the standard LPN role. “Our street nurse in Grande Prairie (Tanya Swanberg, LPN) does hepatitis C and HIV testing, so she’ll do all the blood draws,” Sue explains. “We work closely with the physicians, looking at protocols, following up on test results. We do a bit of everything.”

Sue has even found herself stepping out of her usual executive director role if the situation calls for it. “I don’t work in a traditional nursing role but when we’re short-staffed, I do. If Tanya isn’t here and someone comes in bleeding all over the place or they have a sore or wound they want you to look at, it’s like, ‘Okay, I’ll take off my jacket and roll up my sleeves and get going!’ I love it! I wouldn’t be good at my job if I didn’t have all the nursing education. It makes me stop, assess, and really pay attention before I make a decision. That nursing education is foundational.”

The Road to HIV North

Sue’s path from LPN to executive director is an interesting one. She originally worked as an LPN in frontline nursing, providing home care and continuing care in Calgary. After going through significant life changes, she moved to Grande Prairie and once again worked in frontline nursing, but this time in surgery. From there, her professional development diversified greatly, from teaching to being a coordinator in a rural home support program to working overseas as general manager of a homecare company.

After a return to Canada, Sue held leadership positions within Alberta Human Services and Primary Health. This encompassed a variety of roles and responsibilities, including time as an Enhanced Clinic Practice Coordinator, supporting physicians in designing a training program to assist frontline nurses and nursing support team members to work to full scope within physician clinics. Also in Primary Health, Sue was a Care Coordination Team Lead, working with a multi-discipli-
ary team to provide enhanced health services to patients of local primary care physicians. In 2014, Sue found her current position with HIV North. “My nursing foundation has set me on a path of continuous learning and self-development and has allowed me the confidence to complete higher education to move into leadership positions,” she says, adding that her new role has provided her with “a unique opportunity in that I have been able to work with like-minded colleagues in a truly collaborative fashion. We have learned to trust each other, take risks and see the importance of always looking forward – gaining sight of the vision.”

Typical Day for a Street Nurse

Every Wednesday morning at the Rotary House in Grande Prairie, HIV North provides an outreach program in partnership with Alberta Health Services. Together, they provide testing, counselling, health assessment and education, and more to individuals who are considered a high risk for HIV. Often, these people are plagued with multiple addictions, mental health issues and come from a hard life on the streets.

The luckiest of them are those taking up temporary residence in the Rotary House, in tiny, sparse rooms that automatically lock for safety. It is here they hope to get a second chance. On this particular Wednesday morning, a female staff member enters the elevator with one of these lucky ones and asks how he’s doing today. He fights back the tears. Through a brave smile, he says, “Struggling.”

This is just another typical day at the Rotary House.

Tanya Swanberg has been a street nurse with HIV North off and on since 2012. It’s a role that gives her an increased range of responsibilities. “There is no such thing as a ‘typical day’ for me,” she says. “It depends on what comes through the door. We do testing for sexually transmitted infections (STIs), wound care, pregnancy testing, and a lot of advocacy.”

Come to the outreach program offered at the Rotary House in Grande Prairie every Wednesday morning and you will see an obvious sense of teamwork and respect between Tanya and Lois Cartwright, nurse practitioner with Alberta Health Services. “It’s a great combination,” says Lois, who spends the rest of her time providing primary health care to patients at the city’s Nordic Court. Because she specializes in addictions and mental health, Lois has a lot of shared clientele with Tanya. “We share a lot of knowledge with each other. Tanya may know information on a client that I don’t and vice versa. She may also be able to provide more information on what other services are available to them.”

“And where my scope of practice ends, Lois complements that,” Tanya notes. “If they need antibiotics for an infection, for example, Lois can write a prescription.”

That sense of partnership is vital. When it comes to serving those who are often plagued by mental health issues and many other harrowing social problems, “it takes a community,” says Tanya. “It takes people working together to help create that success.”
Help for Drug Addictions

There are some who see it as a controversial method for helping those with addictions: educating them on the ways to take drugs more safely. Tracy Pelgrim, LPN and Street Outreach Nurse at HIV North, has a much broader perspective on the issue.

“I have learned not to judge a book by its cover, because we’re all people and we’re all equal,” says Tracy, who heads up HIV North’s Take Home Naloxone program in Grande Prairie. “I’m not a religious person, but the hand that we’re dealt is not our choice. You have to treat everybody equally.”

Tracy’s wisdom is hard won. “I’ve been an LPN for 15 years now,” she says. “I was in college studying something entirely different and then my best friend passed away in a major car accident. I went through a rough time after that, quit my studies, and went to work in long-term care. From there, I decided I was going to go to school and study nursing and here I am, 15 years later.”

The naloxone program encourages drug users to use safely because, Tracy notes, “they’re going to use regardless.” And the drugs they’re using on the street these days come with much higher stakes. Take fentanyl, considered to be 100 times stronger than morphine. According to the Canadian Centre on Substance Abuse, between 2009 and 2014 there were at least 655 fentanyl-implicated deaths in Canada. That represents an average of one death every three days.

Naloxone minimizes the effects of overdose. “We’re teaching people the signs and symptoms of an overdose and how to inject the naloxone, which is into the muscle,” says Tracy. “We provide kits which have supplies, including naloxone and needles/syringes. People come to our office and we provide training to help save lives.”

In fall 2015 the naloxone program rolled out in Fort McMurray. Response so far has been encouraging. “A lot of the community is open to it. People are willing to spread the word,” says Caley Boyes, RN and take-home naloxone nurse for HIV North in Fort McMurray. “It will hopefully save some lives.”

Boyes adds that “wherever there are drugs, there are overdoses.” She notes that Canada is number one per capita for opiate use, according to International Narcotics Control Board.

“We Can’t Do This Alone”

As Executive Director, Sue Belcourt is quick to point out that there is no way HIV North can exist in a vacuum, particularly as it serves such a vast region. “We focus on partnerships and collaboration,” she says, “so we participate with our partners in the community.”

HIV North’s funding partners include Alberta Health, the Public Health Agency of Canada, the provincial government’s Community Initiatives Program, the Community Foundation in Wood Buffalo and Grande Prairie, the City of Grande Prairie, and the United Way in both Grande Prairie and Fort McMurray. In addition, HIV North benefits from its many community partners – and thankfully the list is far too long to include here.

“Street nursing is such an important component in caring for the vulnerable in our society. It’s a different but much needed type of nursing,” says Sue. The more hands on deck, the greater the understanding that there is a problem in our society – and a chance to fix it. “Awareness is the most important thing we do in our work,” she adds. “HIV is not going away. Lately, we’ve seen a rising trend. Numbers are coming up. That tells us there’s a lot more work to do.”
HIV stands for human immunodeficiency virus. If left untreated, HIV can lead to the disease AIDS (acquired immunodeficiency syndrome).

### New Developments in the World of AIDS

In July 2015, Vancouver hosted the 8th International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention. Dr. Carl Dieffenbach, director of the Division of AIDS at the National Institutes of Health (NIH) National Institute of Allergy and Infectious Diseases (NIAID) stated that “there’s been excitement in the vaccine world here at this meeting.”

Studies were presented regarding two primary vaccine strategies. The first applied lessons from the Thai vaccine trial (RV144) which showed that an experimental vaccine regime was both safe and modestly effective in reducing the risk of HIV infection. The second focused on the progress NIH has made in understanding how broadly neutralizing HIV antibodies develop. The theory is that stimulating the immune systems of people without HIV infection could produce these antibodies, which could protect against infection.

There is a great need for breakthroughs. According to the STI and HIV 2013 Annual Report from Alberta Health, Surveillance and Assessment, “rates of newly reported HIV have been increasing each year in Alberta.” In 2013, there were 255 newly diagnosed cases of HIV in Alberta, the third year in a row that the number has increased. Of those new cases, a total of 69.4 per cent came from people between the ages of 24 and 49. While HIV rates in Alberta have historically been higher among males, female rates increased from 3.6 cases per 100,000 females in 2012 to 3.9 cases in 2013.

### HIV/AIDS Timeline

- **1969**
  - The first known case of HIV in a human occurs in a man who died in the Congo.

- **1981**
  - The U.S. Centers for Disease Control and Prevention (CDC) published a report describing cases of a rare lung infection in five young, previously healthy, gay men in Los Angeles. This marks the first official reporting of what will become known as the AIDS epidemic.

- **1982**
  - First known cases in Italy, Brazil, Australia and Canada.

- **1985**
  - First known case in China.

- **1986**
  - World Health Organization (WHO) establishes the Global Programme on AIDS.

- **1997**
  - The U.S. Centers for Disease Control and Prevention (CDC) report the first substantial decline in AIDS deaths in the United States. Due largely to the use of highly active antiretroviral therapy (HAART), AIDS-related deaths in the U.S. decline by 47% compared with the previous year.

- **2013**
  - 33% decrease in new HIV infections since 2001.

- **2014**
  - An estimated 75,500 Canadians were living with HIV at the end of 2014, an increase of 9.7% since 2011.

  - Worldwide 36.9 million people were living with HIV. New HIV infections have fallen by 35% since 2000.

References available on request.
SENIORS’ FALLS IN CANADA

FALLS are the LEADING CAUSE OF INJURY among older Canadians: 20–30% of seniors experience 1+ falls each year.

FALLS CAUSE:

- **85%** of seniors’ injury-related hospitalizations
- **95%** of all hip fractures
- **$2 Billion** a year in direct healthcare costs

- Over **1/3** of seniors are admitted to LONG-TERM CARE following hospitalization for a fall
- The average Canadian senior stays in hospital **10 DAYS longer** for falls than for any other cause

- Falls **can result** in chronic pain, reduced mobility, loss of independence and even death
- **50%** of all falls causing hospitalization **HAPPEN AT HOME**

- **INJURIES** due to falls rose **43%** between 2003 and 2008
- **DEATHS** due to falls rose **65%** between 2003 and 2008

The **good news is** that falls are preventable and action can be taken by all.

READ THE FULL REPORT FOR MORE AT:

www.publichealth.gc.ca/seniors
As antipsychotics are reduced, residents wake up, start moving—and look for something to do. Not all care centres have recreation therapists (RTs), and even those who do must figure out how to occupy residents on evenings, nights and weekends. Fortunately, many activities don’t require an RT, expensive equipment or extra time—just opportunities for work, self-care, leisure, and rest and restoration.

**Work:** Residents might shovel snow, clear and clean tables, wipe handrails, deliver coffee and tea, stock the Keurig pods, dust or help clean the bird cage. A resident has an office in her room where she writes her memoirs. A former policewoman helps “watch” the medication cart. A family member brought in bread, baloney, mustard and mayonnaise weekly and the residents made sandwiches for the homeless. Some enjoy caring for lifelike dolls—though one woman complained after a few weeks that she was tired of babysitting!

**Self-care:** The more residents can do for themselves, the better they feel! Offer simple choices: the red sweater or the blue one? A resident cut his fingernails on the left hand; the HCA assisted with the right.

**Leisure:** Visiting with a pet, listening to children read, looking at photos, a simple, age-appropriate puzzle, browsing a Sears catalogue. A companion created a crossword puzzle about a resident’s life and family—she was so excited to know the answers!

**Rest and Restoration:** On bath days, hair is blow dried and curled, lipstick and powder applied. All day long residents are told how beautiful they look. Hand cream and a hand or foot massage are relaxing. Nap therapy helps people cope in the evenings.

**Butterfly moments:** Small interactions bring joy! Touch: a comforting hug, applying lotion to hands or face, holding hands. Share your life: bring in a photo of a baby, wedding dress, pet, renovation project, vacation or hobby—and talk about it. Interesting objects: seashells or starfish, a bowl of snow, table centre pieces, baby booties. Learn a few words in the resident’s first language. Wear something noticeable and fun: bright lipstick, a big hat.

For more ideas, see Person-Centred and Non-Pharmacologic Approaches in the AUA Toolkit, by searching for ‘AUA Toolkit’, or go to http://www.albertahealthservices.ca/auatoolkit.asp.

Verdeen Bueckert is a practice lead with the Appropriate Use of Antipsychotics (AUA) Project, an initiative of the Seniors Health Strategic Clinical Network (SCN). The Seniors Health SCN works with networks of people who are passionate and knowledgeable about seniors, challenging them to find new and innovative ways of delivering care that will provide better quality, outcomes and value.
Family caregivers have been referred to as the backbone of the healthcare system because they are vital, yet invisible, and often vulnerable themselves. In their role as health providers, LPNs can have a positive and supportive effect on their secondary clients, the caregivers. Through programs offered by the Alberta Caregivers Association (ACGA), health providers can learn about the caregiver experience and how to assess, assist and support caregivers to promote their own well-being and prevent caregiver burn-out.

Caregivers provide assistance to family members and friends with challenges owing to illness, disability or aging. There are more than 600,000 caregivers in Alberta, including people of all ages, cultures, and economic statuses. Caregivers provide 80% of the care required by patients living in the community and their unpaid labour saves the healthcare system billions of dollars every year.

Though the care they provide is essential, caregivers often go unrecognized and unsupported. This can have a profound impact on the well-being of the caregiver and consequently in their ability to care for their loved one. They suffer higher rates of depression and stress, and are at risk of burnout.

I have been a nurse for 40 years and through my work with the ACGA, I have come to realize the importance of educating health professionals to take an active role to support caregivers. Through ACGA educational programs, health providers gain a greater understanding of the caregiver’s lived experience and can thereby work to prevent caregiver burnout and depression by identifying, supporting and facilitating caregiver access to timely and appropriate resources and referrals.

Caregivers have told us that they feel appreciated and validated when health providers recognize them in their role. Here are some tips to engage and support the caregivers you meet in your practice:

Caring for Caregivers:
Alberta Caregivers Association Helps Educate Care Providers

By Debra Paches, BScN, RN, GNCC, Caregiver Navigator Coordinator, Alberta Caregivers Association
1. **Acknowledge them:** In our patient-centered system, the caregiver can be overlooked. One caregiver described her experience as, “My name is now ‘How’s your mother?’” Asking the caregiver how they are doing tells them that they matter too.

2. **Address their experience:** Guilt, anger, resentment, sadness and frustration are all common emotions for caregivers. Many caregivers are reluctant to admit that they are experiencing these challenging emotions and, as a result, don’t seek help until they are overwhelmed and burning out. It is important to normalize those emotions and encourage them to ask for help. “You seem to be managing well, but a lot of people in your situation find that they start to feel stressed or frustrated. These feelings are normal, and if you start to feel this way, let me know and I can refer you to resources.”

3. **Help them recognize stress:** Caregivers can become so focused on their care recipient that they don’t recognize that they have high levels of stress. Self-assessments can help and the caregiver should be encouraged to discuss the results and next steps with someone.

4. **Look for signs of burnout:**
   - Lack of energy
   - Frequently sick
   - Always exhausted
   - Neglects own needs
   - Lack of time for social connections
   - Difficulty relaxing when help is available
   - Acts impatient or irritable with their care recipient
   - Appears overwhelmed, helpless, or hopeless.

5. **Encourage self-care:** Help caregivers recognize that they may not have to do everything themselves. Ask them what they are doing for themselves and encourage them to access respite and other caregiver supports.

6. **Work with caregivers:** Caregivers spend a lot of time with the care recipients and likely know more about their needs than anyone else. Listen to what they have to say and include them in care planning.

7. **Provide referrals:** Navigating the system can be hard. Caregivers often don’t know who they should talk to or what resources they should ask for. Don’t assume that they are aware of services; sometimes caregivers are unfamiliar with common programs like Alberta’s Home Care program. You don’t need to know everything that is available, but can help them connect to someone who can help.

**Some key resources are:** The Alberta Caregivers Association, hospital social workers, Alberta Health Link, local information and distress lines, local Family and Community Support Services offices in rural areas, disease and disability-specific organizations (e.g.: Alzheimer Society of Alberta and Northwest Territories), Seniors Outreach workers.

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**Caregivers have told us that they feel appreciated and validated when health providers recognize them in their role.**

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The Alberta Caregivers Association is a grassroots organization grounded in the caregiver’s experience. Since 2001, the ACGA has been conducting research and developing supports to address the needs of caregivers. The following supports are available throughout the province:

**For Caregivers**

- COMPASS is a 9 week program, facilitated by a caregiver or professional, who guides the group in gaining an understanding of the caregiver journey and empowering them to promote their well-being.
- ACGA’s Caregiver Advisor provides one-on-one support and referrals to caregivers. They will also consult with care providers to find resources.
- Information Sessions are a drop-in opportunity to connect with other caregivers, gain knowledge and practical tools on subjects such as managing stress, setting boundaries and communication. These are offered free every 2 weeks at the ACGA and are also available to agencies and rural areas for them to present in their communities.

**For Care Providers**

- COMPASS Facilitator workshop — a 3-day program for professionals or agency staff who preferably have caregiving experience, and would like to learn how to facilitate the COMPASS program for their clients.
- Navigator Workshop — aimed at people who work with clients and their caregivers, this one-day program teaches health professionals to (1) Understand the caregiving experience, (2) Identify and assess caregivers’ needs, (3) Support caregivers to develop self-care attitudes and practices, and (4) Assist caregivers in connecting to resources and planning ahead. This workshop is available in several locations throughout the province in the spring of 2016. You are encouraged to call the ACGA for information about a program in your area at 1-877-453-5088.
Calgary’s Dr. Raj Bhardwaj discusses how women’s heart attacks are different than men’s

The myth still persists that heart attacks are a men’s health problem, but a new scientific statement from the American Heart Association says cardiovascular disease is the No. 1 killer of women worldwide.

This is the first time the association has addressed this specifically as a women’s issue, says the Calgary Eyeopener’s medical contributor, Dr. Raj Bhardwaj, a Calgary urgent care and family physician.

There are a couple of big takeaways from the association’s statement, says Bhardwaj, including that symptoms and risk factors for heart disease are very different for women than men.

“Normally, heart attacks are due to a “pipe getting clogged,” says Bhardwaj. That still applies to women but the key difference is that among women it’s more common for the pipe to rupture or split.

That’s just one of several differences between men and women, the report found.

Bhardwaj uses the “typical Hollywood heart attack” analogy to point out another difference. A man clutches his chest, has pain radiating down his left arm and into his jaw and he’s sweaty and pale. “That’s very typically a man’s heart attack.”

Atypical heart attack symptoms

About 20 per cent of women will have no chest pain when they’re having a heart attack. But other symptoms will happen that may be confusing to them — and even for the doctors and nurses who may be treating them.

Still, Bhardwaj says, 80 per cent of women will have chest pain as a symptom, whereas that occurs in more than 90 per cent of men.

But women’s heart attack symptoms can include:

• Shoulder pain or ache (twice as common among women)
• Sudden tiredness
• Back pain
• Indigestion
• Feeling of dread

Some of these lesser known symptoms can be problematic for women seeking medical attention.
Delay seeking medical help

“A lot of the time women will go to the emergency room saying, ‘I’m having this weird back pain, and I’m feeling really, really tired,’ and the doctors and nurses...won’t think of heart attack as even a possibility sometimes.”

Bhardwaj says that can mean that women won’t fare as well when they have a heart attack.

“They don’t recognize the symptoms so they delay going to see a doctor. And... even when they get to emergency, the doctors and nurses might not twig to that because we’re so focused on back pain or the tiredness, or a feeling of dread, which is very common.”

Another interesting finding is that the usual suspects, heart attack risk factors such as smoking, high blood pressure, diabetes, being overweight and sedentary and having high cholesterol, are all key heart attack indicators for both men and women.

But it appears some of these factors present bigger risks for women, namely, smoking and high blood pressure, while being overweight and developing diabetes is a significant risk for younger women. But cholesterol doesn’t seem to play as big a role, especially over the age of 65 for women.

Meanwhile, another emerging factor for women is stress and depression.

It all points to the fact that more research needs to be done on women’s health issues, says Bhardwaj. “We need a lot more research on women, that’s not just in heart attacks.”

Reprinted with the permission of CBC and the Calgary Eyeopener.
2016 marks 30 years of self-regulation for the Licensed Practical Nurse profession. That's a generation of LPNs governing LPNs; developing our own practice, registration, and conduct.

What an opportunity to reflect on where our profession has come from and where we are going! Changes encountered through our history and those on their way.

As trends in demographics and technology impact every health professional, let's learn from those who have been there through the decades, evolving for today and tomorrow.

You're invited to come along with us to our Annual General Meeting and Conference.
2016 marks 30 years of self-regulation for the Licensed Practical Nurse profession. That’s a generation of LPNs governing LPNs; developing our own practice, registration, and conduct. What an opportunity to reflect on where our profession has come from and where we are going! Changes encountered through our history and those on their way. As trends in demographics and technology impact every health professional, let’s learn from those who have been there through the decades, evolving for today and tomorrow.

You’re invited to come along with us to our Annual General Meeting and Conference.

**KEYNOTES**

**Are Celebrities Messing With Our Health?**

**Timothy Caulfield,** Canada Research Chair in Health Law and Policy and Professor - University of Alberta

There is a ridiculous amount of science-free health and nutrition advice floating around popular culture. And much of this information is conflicting, misleading or just plain crazy. Professor Caulfield explores why and how health information gets so twisted, including the increasingly important role of celebrity culture. He also reviews why this matters (and it does!) and what the best available evidence says about how to live a healthy lifestyle.

**Solving Medical Mysteries: The Nurse’s Role**

**Dr. David Clarke,** President - Psychophysiological Disorders Association

When no diagnosis is found for pain or other physical symptoms there is usually a link to one or more sources of psychosocial stress. Regrettably, few physicians have had formal training in assessing these. A screening process is presented that uncovers psychosocial issues thereby providing new options for treatment that can lead to improved outcomes.

See all speakers at [www.CLPNAconference.com](http://www.CLPNAconference.com)

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“Evolve: to change or develop slowly often into a better, more complex, or more advanced state: to develop by a process of evolution”

Merriam-Webster Online Dictionary

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Awards Dinner
Exhibitors
Celebration Luncheon

---

www.clpnaconference.com
Every night in hospitals and continuing care facilities across the land, older adults roam, call out and are very surprised to hear it’s 2 a.m. What can you do to help? The following strategies may improve sleep and reduce night wakings:

1. Stop the sleeping pills: Sedatives contribute to daytime hangovers and snoozing, which robs sleep from the night. The limited benefits (e.g., 25 extra minutes sleep per night with Benzodiazepines in the first two to four weeks) are offset by medication dependence, falls, confusion and interference with REM sleep. Seroquel helped 14 healthy young males with no sleep issues to sleep better – except for the two who dropped out due to orthostatic hypotension, and those who developed restless leg syndrome. But Seroquel didn’t help 25 people with insomnia – and these weren’t frail elderly patients. Most medications, including sedatives, have not been tested on older adults/those with multiple chronic medical conditions/on multiple medications. Think about how hung-over you feel after an antihistamine, and consider the magnified effects on frail elders.
2. Treat pain: And consider medical causes of discomfort such as benign prostatic hypertrophy and congestive heart failure. Dementia doesn’t cure pain, and the cognitively impaired are more likely to use behaviours rather than words to communicate. Look for irritability, restlessness, groaning, rubbing, and grimacing. Offer warm blankets and regularly scheduled analgesics.

3. Request a complete medication review: Hundreds of common medications block acetylcholine, a crucial neurotransmitter for REM sleep cycle regulation (as well as learning and memory, smooth muscle function, heart rate and contraction strength, movement and much more). Medications with anticholinergic properties include narcotics, diuretics, treatments for mood, blood pressure, heart failure, anticoagulation, sleep and psychosis. The cumulative effect of being on a number of these drugs includes insomnia, cognitive impairment, urinary retention, constipation, falls and loss of physical function. Of course, a medication review is a balancing act between risks and benefits of treatment; this is what pharmacists do best!

4. Consider other medication side-effects: Antipsychotics can cause agitation and restlessness – the need for constant movement. Statins can cause muscle and nerve pain. Acid-blocking medications prevent absorption of crucial minerals such as calcium, magnesium and iron, resulting in restless leg syndrome (among other problems). Diuretics can cause dehydration which results in confusion and increased risk of delirium. Again, a medication review may be in order.

5. Exposure to daytime light: An hour of daytime light converts the neurotransmitter melatonin to serotonin. This supports daytime alertness, which then allows sleep to occur at night. Help older adults get outside or face a window during the day. Blue spectrum light signals the brain to wake up!

6. Daytime activity: The average older adult only needs 8 hours sleep per day. The average facility-dwelling senior spends 83.5% of the time sitting or lying flat. An hour napping in a chair in the morning + a three hour afternoon rest + in bed by 7 pm = awake and ready to party by 11 pm! Consider short (30 – 45 minute) rests during the day and frequent position changes to support rest and comfort while protecting nighttime sleep.

7. Shhh!: Did you know shift change can be as noisy as a jack hammer? Could you sleep if you heard loud talking outside your door 32 times per night? That’s an average night for most residents/patients. The auditory system is permanently open – even during sleep. Loud noises increase cortisol, which also interferes with sleep. Whisper, wear quiet shoes and address disruptive noises such as ice machines, floor cleaning machines and slamming doors.

8. Minimize sleep interruptions: Older adults already sleep lightly and wake more frequently than young adults. Extra absorbent products, when properly applied, can reduce interruptions for nighttime incontinence care. Not everyone requires repositioning – e.g., those with intact skin who move even a little on their own. For the rest, use pillows to gently wedge and off-load, instead of turning and flipping.

9. Dim lights in the evening and minimize nighttime light: Avoid use of overhead lights at night. Try red cellophane filters on flashlights to avoid the stimulation of blue spectrum light during rounds. Eyelids don’t block out much light, so instead of leaving the bathroom light on, try a motion-activated night light to light the way to the bathroom.

10. Unit and person-centred strategies for night wakings: Not everyone will sleep at night. Consider providing helpful visual cues to let residents know it’s night time – wear a warm fleece housecoat at night (you’re cold anyway, right?). Assist residents to the bathroom, provide a snack or drink, then a warm blanket to settle back into bed. Have quiet activities available, or a safe place to wander.

A new grad once told me how terrible she felt about waking up patients at night. But an experienced nurse reassured her, “The patients aren’t here to sleep, they’re here to get better!” Sleep is what patients and residents need to heal and be at their best. So think twice before you wake someone up for that pill, roll that squeaky cart down the hall or turn on the lights to check blood pressures and announce the start of your shift. Does your patient have doubts about that cocktail of 18 pills? You should too. A good night’s sleep starts with a change in thinking, and the courage to challenge and modify routines to better support sleep. Good luck, and good night!

References available on request.

Verdeen Bueckert is a practice lead with the Appropriate Use of Antipsychotics (AUA) Project, an initiative of the Seniors Health Strategic Clinical Network (SCN). The Seniors Health SCN works with networks of people who are passionate and knowledgeable about seniors, challenging them to find new and innovative ways of delivering care that will provide better quality, outcomes and value.
Moving pictures have arrived at the Three Hills Health Centre, and staff are happy to put their patients in the spotlight.

The health centre received a new Shimadzu MobileArt Evolution X-ray unit this summer, and Donna McCook, Laboratory and Diagnostic Imaging Supervisor, says the unit is helping staff provide a new level of care for their most compromised patients.

“This is our first mobile X-ray unit,” says McCook. “Before, all patients had to come to the diagnostic imaging department for their X-rays. But if we get a patient where moving them can be harmful, the mobile unit is perfect because this can assist with keeping the patient stable.”

“For example, if we get a patient with breathing problems, cardiac arrest, or a long-term patient who’s bedridden, bringing the mobile X-ray unit to their bedside really saves time and contributes greatly to patient care.”

Dr. Adina McBain, Facility Medical Director at the Three Hills Health Centre, agrees with McCook, saying that the comfort of patients is always a key factor, and the fewer times they have to be transported, the better.

“There are times when it is not safe to send a patient to the diagnostic imaging department, so the portable machine allows us to capture X-rays at important stages of assessment, and this can potentially reduce the time to diagnosis or treatment,” says McBain. “Being able to bring the portable X-ray machine to patients also allows physicians to continue monitoring patients while the images are being collected.”

The mobile X-ray unit can take high-quality images and save them to a cassette tape. The physician can view the taped images in the X-ray room while the patient stays put.

The unit is compact and can be easily positioned in restrictive spaces. It comes with a shock-resistant body design and strengthened body cover, and uses a soft-touch bumper that automatically stops the unit when pressure is detected. It’s motorized, and the drive handle can be set at 4 cm, 6 cm, or 9 cm above the standard height, suited for taller users.

The mobile X-ray unit also has a built-in alarm that can be used to alert others that the unit is in the area in the case of crowded medical facilities. And finally, the keyless password entry on the system allows for easy access to the system for multiple users.

The health centre X-rays more than 250 patients monthly, totaling approximately 350 X-ray exams, as some patients receive more than one X-ray.

The mobile unit is available for use throughout the health centre, including use in long-term care, acute care and trauma, and site manager Ruth Wold says it enhances services.

“The unit is state-of-the-art for our facility and really helps us provide better care for our most compromised patients,” says Wold.

At a cost of just over $50,000 (including training), the unit was funded entirely by donations raised by the Three Hills Health Initiative Fundraising Committee through the David Thompson Health Trust.

“We raised a lot of the funds from our gala dinner in November 2014, as well as various fundraising events throughout the year,” says committee Chair Al Campbell. “We have a really supportive community that goes above and beyond for our health care, and I’m really proud to be part of such a caring group of people.”

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livebrookfield.com
You may know that CLPNA regulates the LPN profession, sets educational and practice standards, and manages complaints, but did you know about our wide array of supportive services?

1. Supporting your nursing practice
For the thousands of questions annually related to LPN competencies, scope of practice, standards of practice, regulations, and/or clinical practice, CLPNA’s practice consultants are only an email or call away. A fill-in form, “Ask a Practice Consultant”, is even available on the website. Consultation is provided to LPNs, students, employers, government and other healthcare providers. In turn, our consultants often refer to the latest Competency Profile for LPNs, 3rd Ed., or to the other pillars of guidance provided by the Legislation, Practice & Policy documents available on CLPNA’s website.

2. Investing in your professional development
Continuing education is always a hot topic. That’s why we hope all LPNs take advantage of everything we have to offer. No-cost, online courses through “Study with CLPNA” offer self-study opportunities in topics like Documentation 101, Pressure Ulcers and Jurisprudence. Launched last fall, the “Career Infusion Portal” assists with professional growth and workplace confidence. On the Portal, check out Career Directions, a seven-part guided video series created especially to plan nursing careers. Topical and timely subjects are captured through frequently released videos, webinars and workshops. Our biggest events are our annual Conference and Think Tank presenting the best international and local healthcare leaders.

3. Keeping you current
Sometimes it’s tough to stay up to date on your profession. That’s why our quarterly member magazine, CARE, focuses on “exploring the emotional and practical realities of healthcare”. News posts on our website share new information several times per week. Need it even faster? Our frequent emails and social media posts will update you in an instant. So catch us on Facebook, Twitter, LinkedIn, and YouTube. And don’t be shy about joining the conversation!

4. Giving you a break
A corporate wellness program is the latest addition to our member benefits. LPNs can receive up to a 20 percent discount at City of Edmonton sports and wellness facilities just by showing their CLPNA practice permit. Group home and car insurance discounts are also available. Armour Insurance gives an automatic 20 percent discount. The Personal Insurance even donates to the Fredrickson-McGregor Education Foundation with every LPN who signs up.

5. Providing opportunities to lead
We can’t do it alone. That’s why every day, LPNs push the profession forward through their volunteer activities with CLPNA. Committee members are appointed by CLPNA’s Council and legislated under the Health Professions Act (HPA) to make decisions of self-regulation to members, stakeholders, and the public in the areas of education standards, complaints of unprofessional conduct, and continuing competence. Value safe and ethical nursing practice? Those on our Hearing Tribunal and Complaint Review Committee meet regularly to review complaints against LPNs and determine penalties. 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). Even CLPNA’s Council is formed by volunteers, albeit they are ultimately elected into their positions. Keep watching for your opportunity!

All of the services and opportunities mentioned can be found on CLPNA’s website at www.clpna.com, or by calling 780-484-8886 or 1-800-661-5877 (toll free in Alberta).
2015 MEMBERSHIP HIGHLIGHTS

13921 total registrations
growth of 8%

REGISTRATIONS

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
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<tbody>
<tr>
<td>Alberta Graduates NEW Members</td>
<td>1017</td>
<td>1097</td>
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<tr>
<td>Out of Province NEW Members</td>
<td>614</td>
<td>657</td>
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<tr>
<td>International NEW Members</td>
<td>224</td>
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<tr>
<td>Reinstatements*</td>
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<td>Courtesy Members</td>
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<tr>
<td>TOTAL</td>
<td>12881</td>
<td>13921</td>
</tr>
</tbody>
</table>

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

OUT OF PROVINCE REGISTRATIONS

657 total out of province
2014 - 614

ACTIVE MEMBERS BY PLACE OF EMPLOYMENT

<table>
<thead>
<tr>
<th>Place of Employment</th>
<th>2014</th>
<th>2015</th>
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</thead>
<tbody>
<tr>
<td>Hospital (General/Maternal/Pediatric/Psychiatric)</td>
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<tr>
<td>Nursing Home/Long-Term Care</td>
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<tr>
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<td>1804</td>
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<td>Physician’s Office/Family Practice Unit</td>
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<td>824</td>
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<td>458</td>
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<tr>
<td>Educational Institution</td>
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<tr>
<td>Rehabilitation/Convalescent Centre</td>
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<tr>
<td>Mental Health Centre</td>
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<td>Association/Government</td>
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<tr>
<td>Business/Industry/Occupational Health Centre</td>
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<tr>
<td>Self Employed</td>
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</tr>
<tr>
<td>Nursing Stations (Outposts or Clinics)</td>
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<tr>
<td>Private Nursing Agency/Private Duty</td>
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</tr>
</tbody>
</table>

ACTIVE MEMBERS BY PLACE OF EMPLOYMENT

38.2 YRS average age
2014 - 38.7

AGE OF ACTIVE LPNS

- 19-25: 1838
- 26-30: 2735
- 31-35: 2434
- 36-40: 1784
- 41-45: 1454
- 46-50: 1050
- 51-55: 994
- 56-60: 830
- 61-65+: 802

TOTAL REGISTRATIONS GROWTH OF 8%
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

de 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.rpn ao.org/practice-education/e-learning
In our workplaces, co-worker abuse is often the elephant in the room. It's something people acknowledge is happening but they are often not properly equipped to deal with the issues in the right way.

Launch of www.ThingsNeedtoChange.ca

On January 28, nearly 300 health professionals tuned in when the College of Licensed Practical Nurses of Alberta (CLPNA) and four other Alberta health regulators launched information and tools to help create a more positive workplace. Because we believe Things Need to Change.

Issues, Solutions, Resources & One Good Thing a Day

Through www.ThingsNeedtoChange.ca, visitors are introduced to co-worker abuse issues that they may have encountered and some that may surprise them. The website also offers positive and constructive solutions to help deal with the problems in the best way possible. A highlight is the three shareable videos where common bullying situations play out from the patient’s perspective. The goal isn't to point fingers but to equip all of us to deal with the issues together.

Things Need to Change is a collaborative project by the College of Licensed Practical Nurses of Alberta, Physiotherapy Alberta College + Association, Alberta College of Speech-Language Pathologists and Audiologists, College of Hearing Aid Practitioners of Alberta, and Alberta College of Combined Laboratory and X-ray Technologists, and was funded by the Government of Alberta.
CLPNA Bylaws Amended

In March, the Council amended a number of CLPNA’s Bylaws to ensure they continue to reflect current business and governance practices. Member consultations occurred in early February. The previous Bylaws were adopted by the Council in June 2008.

Highlights of amendments:

• separation of the Executive Director and Registrar function;
• changing the title of Executive Director to Chief Executive Officer;
• changing the terms of District Council members from two 2-year terms to two 3-year terms (meaning one 3-year term; eligible for one re-election) (includes a transitional plan);
• reference to a Registration Committee has been deleted and replaced with a Competence Committee;
• all Council committees and subcommittees listed and described;
• elections process described in greater detail;
• eligibility for registration as an Associate member on the non-regulated members register clarified; and
• content reorganized for ease of reading.

Section 132 of the Health Professions Act enables college councils to make bylaws to address college business such as elections, fees, responsibilities assigned to various committees or positions and to “custom design” the college’s organizational structure.

Think Tank Report & Presentations

share “Health System of Tomorrow”

Imagine the health system of tomorrow. What role will hospitals play? What about home care? How will the work of licensed practical nurses (LPNs) and other professionals be impacted?

On November 20, the College of Licensed Practical Nurses of Alberta (CLPNA) took an in-depth look at the changing health landscape and the role of LPNs at their third annual Think Tank. Over 300 attendees heard from local, national and international leaders on care that enriches people’s lives and draws on everyone’s energy and talents.

Find out what these local, national and international leaders on care forecast in “Health System of Tomorrow: Report of the 2015 CLPNA Think Tank”, including Alberta’s Minister of Health, Sarah Hoffman. The report and presentations from the Think Tank are available at www.clpna.com/blog.

Part of the CLPNA’s mission is to provide leadership within the profession and support the evolution of a quality health system for Albertans. Think Tanks are one way that Council provides a learning opportunity for LPNs and their partners and stakeholders.
From Lethbridge to Red Deer to Cold Lake, LPNs are invited to run for District Representative to CLPNA’s Council for a new, longer term. Over the next few years, terms of office for all District Representatives are transitioning from a 2-year term to a 3-year term. The transition plan came into force upon Council’s approval of the updated Bylaws in March.

Interested LPNs residing in the South, South Central and North Central Election Districts must submit a Nomination Form by May 31. District Elections are held in June by electronic (email) ballot.

Council meets quarterly to plan and evaluate CLPNA’s Strategic Plan, policies and finances to achieve regulatory excellence. Successful Council members are team-oriented, servant-leaders focused on the future of the LPN profession.

**2016 ELECTION DISTRICTS:**

**DISTRICT 1:**
South Zone (Lethbridge, Medicine Hat & area)

**DISTRICT 3:**
South Central Zone (Red Deer & area)

**DISTRICT 5:**
North Central Zone (Jasper, Slave Lake, Cold Lake & area)

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

Continuing Competency Program Validation Begins in May

“Life-long learning for professionals is not an option — it is essential.”
(CAMRT, 2015)

Approximately 20 percent of eligible CLPNA members will be randomly selected to participate in the 2016 Continuing Competency Program Validation (CCPV) beginning May 2. Those chosen will be notified by email and mail to validate their Learning Plans for the previous two years (2014 and 2015). It is a requirement of the Health Professions Act that membership participation in a Continuing Competence Program is monitored.

CCPV uses an online submission process and planning is the key to success. CLPNA recommends regularly tracking learning. Tracking is made easy and efficient using the online Record of Learning at www.myCLPNA.com (remember to retain your CCP Records for a minimum of three years).

Although the member selection process is random, the Competence Committee and the Registrar may select specific members if deemed appropriate.

LPNs are required to keep their knowledge and skills current, and continually expand and add to those skills and knowledge. According to a survey conducted by the Canadian Association of Medical Radiation Technologists (CAMRT), there are many benefits to participation in a Continuing Competence Program:

- maintain established standards of practice
- professional and personal growth
- increase credibility and public confidence in the profession
- enhance professional image
- increase accountability in the delivery of high quality service

Thank you to the 2,100 LPNs who participated in the CCPV process in 2015. The commitment to your career and nursing profession is evident through the exemplary learning plans and the 99 percent completion rate. Well done!

**REFERENCE**
LPNs often express a keen interest in developing their careers. To help address these needs, CLPNA is pleased to provide Career Directions (available at www.clpna.com). Career Directions, developed by Gail Donner RN, PhD and Mary Wheeler RN, MEd, PCC, is a proven framework specific to supporting nursing and other healthcare professional’s careers. This online program is a great way for LPNs to help realize their career goals by taking charge of their careers and planning their futures with confidence and purpose.

The Career Directions online program is a guide for LPNs to use as they travel along their career journeys. It provides LPNs with an opportunity to review their career to date; learn strategies to assist in making future career decisions; and learn how to develop a career plan.

The five-phase Career Planning and Development Model designed by Donner and Wheeler forms the foundation for Career Directions. This model provides a process to move from recognizing career possibilities to taking action. The model is focused on professional development and is designed for LPNs to take greater ownership of their career and to prepare for ever-changing workplace environments.

Through a series of six online multimedia videos the program will introduce concepts, skills, and tools focused on career planning and development. Then, there is an opportunity to explore what each module means by completing activities. The activities are in downloadable PDF format that can be completed, revised and changed at any time. There are also links to additional resources, including information and tips on résumés and interviews.

The six modules include:

**Scanning:** Scanning or taking stock of the world in which you live will provide you with the information you need to understand your world and to identify possible opportunities for your career in the future. You scan your environment before beginning the process of planning your career.

**Assessing:** Assessing enables you to identify your values, experiences, knowledge, strengths and limitations, then completing a reality check of your self-assessment. A reality check expands our view of ourselves through reflecting on others’ perspectives.

**Visioning:** Once you have completed a realistic and comprehensive review of your values, beliefs, knowledge
and skills and have assessed these in the context of the real world scan you have completed, you are ready to think about your career possibilities and your career vision.

**Planning:** A strategic career plan is a blueprint for action and consists of the identification of goals, action steps, resources, timelines and evaluation of success. By creating a plan, you begin to move and to make decisions.

**Marketing:** Marketing involves the ability to identify your professional and personal qualities, attributes, and expertise so that you can effectively communicate what you have to offer and why you are the best person for the service that needs to be delivered.

**Sustaining:** Once you have a vision and plan, you need to find ways to integrate them into your day-to-day activities. Sustaining includes various strategies to help you with that, including family, friends, coaches, or mentors.

The program also includes web-based seminars led by a career coach, where you will have an opportunity to ask questions and learn more about the program. Stay tuned for more information.

For more information, go to www.clpna.com, “I Am a Member”, and “Career Infusion Portal” to learn more about the many opportunities and directions you may take in your nursing career, listen to Career Conversations, watch Career Videos and read Career Inspirations about CLPNA members. Questions or comments? Contact CLPNA’s Professional Development Consultants at profdev@clpna.com, 780-484-8886 or 1-800-661-5877 (toll free in Alberta).

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**NURSING WORD SCRAMBLE**

Unscramble the words to find common medical words and phrases.

1. anlclimgiouom
2. eortdcoiistorcs
3. rsggeaoctrimena
4. nurmlpoay
5. oftsnsnuiar
6. ilnarehombuiog
7. aaidvootlasnti
8. telpealst
9. kyirdinabn
10. cniaoutoalg
11. entosphoyo
12. tidanlhloe
13. htonepeancmai
14. aaticinpyha
15. iretnoson
16. siectduri
17. iciytxot
18. ogostiloyppahhy

Alberta’s nursing regulators developing guidance on physician-assisted death

Recent decisions by the Supreme Court and the federal government regarding physician-assisted death have raised questions among nurses about the impact on their practice. In a proactive step, the three nursing regulators in Alberta are working to establish collaborative guidelines for their members.

The Past: Federal law struck down

On February 6, 2015, in the Carter case decision, the Supreme Court of Canada struck down the federal law prohibiting physician-assisted death, introducing the right to physician-assisted death in Canada. This was to come into effect on Feb. 6, 2016; however, on Jan. 15, 2016, the Supreme Court granted a four-month extension to the federal government to consider its approach to physician-assisted death.

The Present: Preparing for change

The Supreme Court indicated that individuals who wish to seek physician-assisted death during the four-month extension may apply to a judge for authorization. A special joint committee on physician-assisted death, comprised of 11 members of Parliament and five senators, has been appointed to review, consult and make recommendations to the federal government on the legislative framework for physician-assisted death. The Carter case provides legal protection to physicians involved in physician-assisted death, so they can practice without risk of criminal prosecution. Nurses are also in need of this protection.

The Future: Joint guidance from Alberta’s nursing regulators

On June 6, 2016 a new right to physician-assisted death in Canada will become law. In preparation for this change, the College of Licensed Practical Nurses of Alberta (CLPNA) is working with the College and Association of Registered Nurses of Alberta (CARN) and the College of Registered Psychiatric Nurses of Alberta (CRPNA) to seek input from members, develop unified guidance and provide resources to professional nurses in Alberta related to best ethical and competent care to patients at or near the end of life. Nurses are intimately involved in end-of-life care processes and the role of the professional nurse in Alberta in the dying process needs to be recognized, articulated and protected in law.

In the absence of Criminal Code amendments providing protection to other members of the healthcare team, nurse practitioners, registered nurses, licensed practical nurses and registered psychiatric nurses cannot be involved in activities that could be seen as assisting or counselling physician-assisted death.

Now: What does this mean to Alberta’s nurses?

It is important that nurses continue to provide safe, competent, ethical nursing care. Nurses also have a duty to provide persons in their care with the information they need to make informed decisions, related to their health and well-being. Until legislation is established that protects nurses, any questions by patients seeking physician-assisted death must be directed to a physician or supervisor.

It is possible that during the four-month extension (February 6 – June 6, 2016) some patients in Alberta may seek a court order to access physician-assisted death. Whether any healthcare professionals other than physicians can assist with physician-assisted death during this period may depend on the content of the court order obtained by the patient.

Any licensed practical nurses who are asked to assist with physician-assisted death during the four month period, and in the absence of Criminal Code amendments providing protection to the healthcare team, should contact the CLPNA’s Practice Department at practice@clpna.com, 780-484-8886 or 1-800-661-5877 (toll free in Alberta) for advice.

The CLPNA will continue to work collaboratively and update its members on the developments of physician-assisted death in Canada.
Show & Tell Contest for National Nursing Week May 9-15

Let everyone know what nurses do, reward each other, celebrate your team! Use social media to enter CLPNA’s Show & Tell Contest for National Nursing Week from May 9-15. Daily winners will receive a variety of CLPNA-branded goodies and LPN product from the Fredrickson-McGregor Education Foundation for LPNs. Prizes are valued at up to $50.

On Monday, May 16, one grand prize winner will be selected from all entries received throughout the duration of the contest. The winner will receive a Special Goody Bag filled with CLPNA-branded product and a $100 VISA gift card (total prize value up to $200).

Daily Contest Entry Details

The Contest runs from May 9 – 15. See Contest Rules for details at www.clpna.com/blog:

1) SHOW - Post a photo of your Nursing Week event and post it to Twitter or CLPNA’s Facebook page (facebook.com/CLPNA) using the hashtag #CLPNANursesCare. (All pictures must comply with applicable privacy legislation including that required by your employer.)

2) TELL - Write a note about what makes you happy to be a nurse. Post it to Twitter or CLPNA’s Facebook page using the hashtag #CLPNANursesCare. (Please respect confidentiality.)

Winners will be announced at noon every day!

Silent Auction Fundraiser Seeks Donations

Support Alberta’s licensed practical nurses and their on-going post-basic education by generously donating items to their largest fundraising event of the year, the Silent Auction.

The Fredrickson-McGregor Education Foundation for LPNs hosts the annual event on April 27 and 28 as part of the 2016 CLPNA AGM & Conference in Edmonton. Over 300 delegates will try to outbid each other on hundreds of fantastic items.

In previous years, businesses and individuals have generously donated gift certificates, handcrafted items, garden and yard accessories, jewellery, gift baskets, electronics, trips, resort stays, clothing items, spa days, household goods, sports/theatre tickets and more. All items will be displayed with any provided business cards or brochures. Event proceeds will go to the Fredrickson-McGregor Education Foundation for LPNs. The Foundation distributes educational grants, awards and bursaries to members of the CLPNA to enhance their nursing knowledge, skills and ability, and honour their achievements.

Complete information and a Silent Auction Donation Form is available on the Conference website at www.clpnaconference.com or contact Donna Doerr, Foundation Assistant, at 780-669-1852 or foundation@clpna.com.
Are you Fit to Practice?

The College of Licensed Practical Nurses (CLPNA) is mandated to protect the public. LPNs are not only committed, but obligated, to provide safe, ethical, and competent care to Albertans. One of the fundamental steps in providing this type of care is being responsible for your own physical and psychological well-being.

It is valuable that LPNs understand their role in providing care and what it means to be not fit to practice or incapacitated. Incapacity is defined in s. 1(1)(a) of the Health Professions Act (HPA) as “suffering from a physical, mental, or emotional condition or disorder or an addiction to alcohol or drugs as defined in the Pharmacy and Drug Act, or other chemical that impairs the ability to provide professional services in a safe and competent manner”. Conditions such as stress and fatigue may also impair your judgment and cause you to not be fit to practice and to be incapacitated. Take note, if you are incapacitated then you are not fit to practice.

The majority of LPNs do have the ability to assess their health and can recognize when their fitness to practice is negatively influencing their ability to nurse. Assessing whether you are fit to practice as an LPN may seem simple, but when an individual is suffering from cognitive or mental health issues, substance abuse or addiction disorders, their judgment may be clouded and they may not be able to recognize their ability to provide safe, competent and ethical nursing care. It should be noted, when physical issues occur that require a physician managed treatment plan (i.e., orthopedic or abdominal surgery), these instances do not require reporting to CLPNA unless there are incapacity issues once return to work is achieved.

An LPN with insight does have the ability to take appropriate action to improve their health status, such as: removing themselves from practice until they are no longer incapacitated, managing their physical recovery or stressors and personal problems with counseling and therapy, or even participating in an Employee Assistance Program.
Unfortunately, there are LPNs who lack the ability to assess their own fitness to practice. It may be considered ‘unprofessional conduct’ when an LPN fails to recognize their health status is jeopardizing client care. An employer, coworker, or public member who has concerns about an LPN’s fitness to practice should report the matter to the Complaints Director. Placing a client in a potential risk of harm is unprofessional and there are consequences. Fitness to practice concerns may be dealt with through disciplinary processes.

If the Complaints Director has grounds to believe an LPN is incapacitated, whether or not there has been a complaint filed, the Complaints Director may invoke s. 118 of the HPA. Under s. 118, an LPN’s practice permit will be suspended and they may be directed to undergo a mental and/or physical assessment; as well, they could be ordered to undergo treatment. S. 118 will remain in effect until the Complaints Director is satisfied the LPN is no longer incapacitated and does not pose a threat to client safety.

The Code of Ethics and Standards of Practice compel LPNs to be accountable for monitoring and maintaining their own fitness to practice and professional conduct. It is crucial for an LPN to undertake the task of maintaining their own fitness to practice and to possess the ability to recognize if they are fit to practice and if they are incapacitated.

LPNs are required to report their fitness to practice on initial registration and yearly at registration renewal. They are obligated to report any changes to their fitness to practice throughout the registration year.

REFERENCES

- Health Professions Act - 1(1)(s) of the Health Professions Act (HPA)
- CLPNA’s Interpretive Document: Fitness to Practice and Incapacity
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...

The uniforms of these women tell us that they’re Certified Nursing Aides in training, circa 1950, checking exam results on their way to earning their pin and cap. The disparate ages of these trainees also tells a story about women joining the workforce post WW-II.

Today, those joining the LPN profession are younger than ever with the average age now 38.2 years. The largest group of practical nurses by age bracket is 26-to-30-year-olds (19.5%), followed closely by those aged 31 to 35 (17.3%). Back in 2006, 26-to-30-year-olds were also in the majority (13.2% of the workforce), but were matched by almost identical numbers of those 46 to 50 and 51 to 55 in age.

Whatever their age or uniform, CARE wants to thank all licensed practical nurses for their competence and professionalism, during National Nursing Week, and always.
Pharmacology Update for Nurses

BARB BANCROFT, RN, MSN, PNP
9000 Drugs, Where to Start? Differentiate Quickly Among the Classes of Drugs with the “Suffix” of Each Class
- The “statins”, the “prilis”, the “triptans” and the “sartans”
- The “prazoles” and the “afils”
- The “olols”, the “xols”, the “iolols” and the “dipenes”
- The “coxils” the “mibs”, and the “plasseones”
- The “concosules”, the “cyclcosers” and more

Clinical Uses and Mechanism of Action: The Key Things You Need to Know
- Analgesics; Drugs for Diabetes, Targeted Therapies
- Cholesterol-Lowering Agents, Anti-Hypertensives
- Anti-Fungal and Anti-Viral Agents

Understanding the Common Treatment Regimens for Selected Clinical Conditions
- Hypertension; Chronic Heart Failure
- Diabetes Mellitus Type 2
- Depression

You’re Taking WHAT?? Clinical Interactions Between Drugs, Alternative Therapies and Food
- The Effect of Grapefruit Juice on the Metabolism of Certain Drugs
- Foods with Potassium; Foods with Vitamin K
- St John’s Wort

Specific Mechanisms of Actions of Drugs in Popular Use
- The “Highway System” and the “prilis”
- The Nocturnal Liver and the “statins”
- The Proton Pump and the “prazoles”

Legal Issues in Nursing

Nursing Litigation and Canada’s Legal Landscape
- Definitions & Statistics; 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 Nurses 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 practice. 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 practice.

WHO SHOULD ATTEND?
- RNs, NPs, RPNs, & LPNs in All Areas
- Acute & Critical Care, Special Care Areas
- Geriatric, Home, Community, and Primary Care
- Outpost Nurses, Occupational Health Nurses; Transition Coordinators
- Nurse Practitioners, Tele-Health Nurses, Educators, Managers

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

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

Conference Fees:
- $169.95 + $8.45 GST = $178.45 Early Rate (on or before August 8, 2016)
- $179.95 + $8.95 GST = $188.90 Middle Rate (on or before September 6, 2016)
- $189.95 + $9.45 GST = $199.40 Regular Rate (after September 6, 2016)
Price includes conference sessions, lunch, coffee breaks, and handouts.

ROSEMARIE ENOKSON, RN, BScN
Chris Rokosh is a Legal Nurse Consultant and Certified Perinatal Nurse with over 34 years of experience. She is President and CEO of Connect Medical Legal Experts Inc., Canada’s first Legal Nurse Consulting firm. Connect Experts provides medical/legal education to health care professionals and nursing expertise to lawyers involved in medical malpractice and class action litigation. Chris is an invited lecturer at universities and conferences across Canada and the US. The Legal Nurse Consulting course she developed has been accepted as credit towards a Bachelor of Science in Nursing at universities across Canada. In 2010 she was named one of Canada’s top 100 entrepreneurs and has been nominated for the Royal Bank Women of Influence award.

Rosemarie Enokson is a Legal Nurse Consultant with over 25 years of nursing experience. She has worked neurosurgery, medicine, surgery, as a flight nurse and was a clinical educator in the emergency department for 14 years. Rosemarie is Senior Consultant with Connect Experts providing medical/legal education and nursing expertise to professional staff involved in medical malpractice. Rosemarie has personally reviewed over 50 cases and mentored/reviewed hundreds more. Rosemarie is a contributing author to the Connect Experts “Introduction to Legal Nurse Consulting” and “Legal Issues in Nursing” course, and has spoken at numerous nursing conferences regarding medical/legal matters.

Nurses at All Levels of Responsibility
Nurses in All Settings
Risk Managers
Quality Assurance Managers

Conference Fees:
- $169.95 + $8.45 GST = $178.45 Early Rate (on or before September 6, 2016)
- $179.95 + $8.95 GST = $188.90 Middle Rate (on or before October 3, 2016)
- $189.95 + $9.45 GST = $199.40 Regular Rate (after October 3, 2016)
Price includes conference sessions, lunch, coffee breaks, and handouts.
Missing the Message?

It’s mandatory for LPNs to provide their email address to CLPNA.

Update your Personal Profile at https://www.myclpna.com or contact info@clpna.com or 780.484.8886