A Brave New World

Pressure Injuries Update

CLPNA Social Media Fact Sheet
Renal Update!  
...to pee or not to pee

EDMONTON, May 8, 2017  •  CALGARY, May 9, 2017

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

BARB BANCROFT, RN, MSN, PNP

Join us for another one of Barb's illuminating sessions! This one-day workshop begins with the embryological development of the kidney and the clinical implications for clinical practice. The discussion then reviews the anatomy and physiology of the kidney correlated with structural and functional conditions. A number of disease processes discussed such as glomerulonephritis, nephro lithiasis, nephritic syndromes, polycystic kidney disease, the diabetic kidney, the kidney in shock, acute tubular necrosis, acute and chronic renal failure, kidney stones and autoimmune disease and the kidney. In addition, the effects of aging and the effects of drugs on the kidneys will be emphasized. Lab tests to be discussed include the BUN, Serum creatinine, creatinine clearance and urinalysis.

WHO SHOULD ATTEND?
- Renal Nurses, Dialysis Nurses, Cardiac Nurses
- Med Surg Nurses; Critical Care Nurses
- Diabetes Nurses, Nurse Practitioners and Educators
- Acute, Long Term and Home Care Nurses
- Tele-Health and Occupational Health Nurses

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 positions at the University of Virginia, the University of Arkansas, Loyola University of Chicago, and St. Xavier University of Chicago. Barb is known for her extensive knowledge of pathophysiology and as one of the most dynamic nursing speakers in North America today. Delivering her material with equal parts of evidence-based practice, practical application, and humour, she has taught numerous seminars on clinical and health maintenance topics to healthcare professionals, including the Association for Practitioners for Infection Control, The Emergency Nurses’ Association, the American Academy of Nurse Practitioners, and more.

Drug Use in Pregnancy

Identification, Treatment, & Outcomes for Mom & Babe

CALGARY, May 29, 2017  •  EDMONTON, May 30, 2017

The World of Drug Use: Crack, Crack, Oxy, Weed, Speed, & Ecstasy
- Manufacture & Use of Methamphetamine, Cocaine, Opium, Marijuana, & Ecstasy
- The Difference Between Crack & Crack
- Snorting, Smoking, Injecting, Snorting, Bumper Boozing, & Wilder’s Oxygen
- Speed Balling, Ice, Crystal, Rollers, & Special K
- Opium & Bath Salts: Dangerous Drugs Hide Within

Identifying Physiologic Symptoms of Maternal Use
- Major Clues that a Mom is using: What are the Signs?
- Physical Complications of Use: Allergies, Poor Lora, Meth Mist Zit
- Possible Maternal Physiologic Effects of Meth, Cocaine, Marijuana, Oxy & Hydro
- Complications: Changes in Fetal Heart Rate and Uterine Responses to Vasomotorers
- When Labor Drugs Given by the Nurse Interact with Other Drugs in the Mom’s System
- Pain Control for the Mom: Using Oxy & Hyderos or Methadone
- Buprenorphine (The New Methadone)

Maternal Lifestyle and Behavioural Red Flags
- Distilling the Myths of a Drug User “Looks Like”
- Maternal Issues of Intimate Partner Violence, Isolation, Illegel Activities, and Infections
- What in the Maternal History may Lead you to Suspect Drug Use?
- Deskilling Mysteries of Maternal Behaviours while High on Opioids or Cocaine
- Co-occurring Mental Illnesses

Neonatal Symptoms and Care of the Prematurely Exposed Newborn
- Differentiate Neonatal Symptoms of Ulcers versus Document Exposure
- Neonatal Abstinence Scoring (NAS). When do we Start and how Often do we Assess?
- What is the Difference between Neonatal Withdrawal and “Drug Affected”?
- Special Nursing & Environmental Care Interventions for the Neonate
- Considerations when the Mom wants to Breast Feed

Potential Outcomes of the Infant Exposed Prenatally to Drugs
- Who experiences “Opioid Deposition Syndrome”?
- Potential Outcomes of Perinatal Marijuana & Oxy Exposure at 4 to 9 Years of Age
- Where does Prematurity fit into the Drug Exposure Puzzle?

Quarrying in the Quagmire of Maternal Drug Use Assessment
- Which Questions will elicit Factual Maternal History of Drug Use?
- Why do some Patients tell some Nurses Everything & Others Nothing?
- Using the 4 Ps: Use in Pregnancy, Partner, Parents, or Prior to Pregnancy
- Staying Non-Judgemental in Difficult Situations

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

MAUREEN SHOGAN, MN, RNC

It is estimated that up to twenty percent of all newborns are exposed prenatally to alcohol, illicit drugs, and prescription opiates. Identifying the mother and her newborn are the first steps required for individualized treatment for the specific drugs. Neonates are extremely sensitive to the environment which must be altered by creative nursing interventions. Nurses can potentially have greatest impact, since women are most likely to be receptive to treatment while pregnant or immediately postpartum. Participants will leave equipped to assess mothers and their newborns and intervene with individualized care.

WHO SHOULD ATTEND?
- Obstetrical Nurses; LD/O, Midwives, Ante and Postpartum; Fetal Assessment Nurses, Lactation Consultants
- Neonatal Nurses: Level 1, 2, 3 Nursery Staff; Neonatal Nurse Practitioners
- Childbirth, Obstetrical and Neonatal Educators; Managers
- Women's Health Practitioners; Intimate Partner Violence Counsellors; Selected Gyne & Public Health Nurses
- Social Workers, Drug Addiction Counsellors, Sexual Health Counsellors

Maureen Shogan is a Neonatal Clinical Nurse Specialist in an NICU and Mother-Baby Unit at Deaconess Hospital in Spokane, Washington, and Neonatal Nurse Consultant to 23 community hospitals. A graduate of Sacred Heart Nursing School, Gonzaga and Washington State Universities, she has experience as an NICU manager, transport nurse, clinical educator and parenting educator. Maureen has served on the editorial boards of Neonatal Network, Mother Baby Journal, and JOCNN, and has taught at national and regional workshops for NANN, AWHONN and others. Maureen has worked with chemically addicted pregnant and parenting moms for over 20 years and is a consultant to the Washington and Idaho Departments of Child Welfare and Social Services.

$179.00 + $8.95 GST = $187.95 Middle Rate (on or before April 24, 2017)
$189.00 + $9.45 GST = $198.45 Regular Rate (after April 24, 2017)
Contents | Spring 2017

4 | From the College

5 | Nutrition Guidelines for Cardiovascular Disease

8 | Cover Story
A Brave New World
The decision to pursue a better life moves three medical professionals to cross the globe and become LPNs in Alberta. This is the story of their journey.

14 | Reclaiming Dignity in Healthcare:
Small Gestures of Caring

16 | Advancing Policy to Optimize the Role of Licensed Practical Nurses

20 | 2017 CLPNA AGM & Conference

22 | A New Way of Looking at Pressure Injuries

26 | Research
LPNs More Effective with Well-Informed Managers

27 | Why Rehabilitation Must be Part of Acute Care

28 | Technology
Apps for Today’s Nurses

29 | Looking to Boost Your Nursing Competence?

31 | The Operations Room
News for CLPNA members

CARE is published quarterly and is the official publication of the College of Licensed Practical Nurses of Alberta. Reprint/copy of any article requires consent of the Editor of CARE magazine.

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The LPN profession in Alberta grew by 8.4% in 2016. This increase includes one of the highest numbers of international applicants in CLPNA’s history. The CLPNA greatly values the contributions brought to the nursing profession by immigrant nurses and supports them through transparent policy, customer service, education and practice supports.

Canada is a country that celebrates diversity, which is evident in the LPN profession. Although internationally educated nurses come from all parts of our world, the majority come from the Philippines, India, the United States and the United Kingdom. We look upon the diversity of our members as an advantage, one that strengthens nursing service in Alberta.

The decision to come to Canada in search of a better life is a story that many of our members share. The great lengths our nurses go to in order to become regulated nurses in Canada highlights their commitment not only to their vision, but also to the profession of nursing. Many LPNs, like the ones interviewed in the feature article, *A Brave New World*, pg. 8, come from different healthcare backgrounds and practice experiences. Yet they share the same stories of persistence, dedication and commitment to succeed. Their ability to re-educate as necessary and adapt to a new country, culture, language and healthcare system is a profound display of resilience.

The competencies of nurses educated in another country are vast. They bring a breadth and depth to their practice as an LPN because of their education and experience. The CLPNA sees internationally educated nurses rising to the challenges they face by successfully meeting rigorous regulatory and practice requirements.

For native Albertans and Canadians, it is difficult to imagine moving a world away to find a better life. We respect those who venture far from their home to immigrate and integrate into our culture, both in nursing and in our communities.

Thank you to all immigrant nurses for the contributions you make to healthcare and the profession.

Valerie Paice, President and Linda Stanger, CEO

We look upon the diversity of our members as an advantage, one that strengthens nursing service in Alberta.
Nutrition Guidelines for Cardiovascular Disease

Alberta Health Services wants to provide current, consistent healthy eating messaging to patients, LPNs and other healthcare providers. New guidelines for adult cardiovascular nutrition are now available, and are broken into three sections: Heart Healthy, Hypertension and Heart Failure. Full guidelines can be found online at www.albertahealthservices.ca/info/Page8249.aspx.

These resources aim to:
• Promote evidence-based nutrition care for cardiovascular disease
• Promote consistent nutrition messaging by health professionals
• Help healthcare professionals determine when a dietitian referral is appropriate.

HEART HEALTHY

There are many nutrition and lifestyle modifications that can improve heart health and lower the risk of cardiovascular disease (CVD). Following the recommendations in this guideline can help individuals decrease risk for CVD, achieve and maintain a healthy body weight and manage cholesterol. Encourage and support your patients to make healthy diet and lifestyle changes to reduce their risk for CVD:

• maintain healthy body weight
• moderate alcohol intake
• be physically active
• avoid trans fat
• limit saturated fat
• stop smoking
• follow a Mediterranean or vegetarian dietary pattern
• limit added sugars
• increase soluble fibre
• increase omega-3 fats

Healthy diets emphasize fresh or frozen vegetables and fruit; good sources of fibre; lower-fat milk and alternatives; low sodium; fish and seafood; and moderate intake of lean unprocessed meat and poultry.

HYPERTENSION

Hypertension is common in the adult Canadian population, and is the number one modifiable risk factor for stroke and renal disease. Nurses can talk to their patients about these lifestyle modifications to improve their blood pressure and reduce their risk of hypertension:

• choose a heart healthy eating plan
• increase soluble fibre
• reduce saturated fat and choose healthy unsaturated fats
• minimize salt intake
• minimize intake of food and beverages with added sugar
• manage and measure weight
• reduce alcohol intake
• regulate use of natural health products
• aim for healthy physical activity
• stop smoking
• encourage stress management

Most patients are unaware that they have high blood pressure, as they do not experience any symptoms. Risk factors for the development of hypertension include family history, obesity, physical inactivity, stress, smoking, excess chronic alcohol intake and high dietary sodium intake.

HEART FAILURE

Dietary and lifestyle modifications can help improve severity and symptoms of heart failure (HF). Help patients manage the underlying conditions for HF by treating hypertension, encouraging regular physical activity and discouraging smoking. Nutrition education should focus on:

• management of sodium intake
• management of fluid intake
• achieving and maintaining a healthy weight
• discouraging illicit drug use
• limiting or refraining from alcohol
• managing use of natural health products
• increasing omega-3 fatty acids

The Heart Failure Nutrition Guideline for Primary Care has a list of 24 key questions addressing the dietary and lifestyle interventions listed above.
CLPNA 2016 YEAR IN NUMBERS

1215
Alberta Graduate registrations
2015 - 1097

517
Out of Province registrations
2015 - 657

261
IEN registrations
2015 - 150

15,082
total registrations

92%  8%

8.4%
growth in registration

38 YRS
average age of LPNs

186
new complaints received
90% of candidates passed CPNRE Exam on 1st write

Top Places of Employment

- Hospital: 4850 members, 39.0% compliance
- Nursing Home: 3419 members, 27.5% compliance
- Community Care*: 3353 members, 27.0% compliance

Continuing Competency Validation

- 2395 members selected
- 97.4% member compliance

Professional Development

- 11 webinars
- 1290 attendees
- 4 workshops
- 198 attendees
- 1 'Building Successful Mentoring Relationships' Workshop

9 practical nurse programs
4 research projects

*Community Care includes: Community Health / Health Centre, Home Care Agency, Physician’s Office / Family Practice Unit
A BRAVE NEW WORLD

Stumbling Blocks… and Stepping Stones

By Chris Fields
An anesthetist and two bachelor degree nurses pick up all they know, and travel across the world to begin a new life in Canada. They join more than 17 million immigrants who have come to Canada since Confederation in 1867. They are part of a Calgary community that speaks 140 languages. Meet Nisha Babu, Susantha Mudiyan, and Veerpal Sidhu, (above, left to right), three individuals who have come to Canada and are now practicing as licensed practical nurses (LPNs) at Carewest George Boyack Continuing Care in Calgary.

Their story roots sound similar: Nisha obtained a Bachelor of Nursing in Tamil Nadu, India – a south Indian state famed for its Dravidian-style Hindu temples - and worked in India and Bahrain. Susantha completed a five-year medicine degree plus a one-year internship and worked as an anesthetist in a teaching hospital in Sri Lanka for 10 years. Veerpal – who admits she was scared of medicine as a child – completed a three year nursing program in Punjab, India and worked in India prior to immigrating to Toronto at the encouragement of her in-laws.

Photos by Leroy Schulz
Their stories have a common theme: a decision to pursue a better life, to accept struggle along the way, and to sacrifice shorter term for the perceived benefit of the longer term.

“I was a medical officer back home,” Susantha says, as he talks about how he came to Calgary in 2010 and took the LPN course at Bow Valley College. “We came to Canada because we wanted to create opportunities for our children.” Susantha is clearly proud of his 18-year-old who has just started course work at the University of Alberta and is interested in neuroscience.

Veerpal says the move to Canada has opened the doors to better opportunities for her child, now in Grade 12 and considering university options. “Here you can be anything you want to be in life and can change your mind at any time you like,” Veerpal says, as she describes the challenges of education in India including the importance of getting into the paid-school system in younger years if you have career aspirations. Mid-stream adjustments to educational paths are made difficult by inflexible university programs...or the hopeful expectations of parents.

To sacrifice is also a professional consideration. New beginnings are a “back to the start” proposition.

For Nisha, a job as a registered nurse (RN) in India with significant professional scope and responsibility was followed by seven years in Bahrain as an RN amidst a more hierarchical medical system, and a move to Canada that resulted in six months of unemployment and some resulting uncertainty about the move. Rebuilding a path forward required tenacity – a hallmark of Susantha, Veerpal, and Nisha’s stories.

Nisha’s contacts in the Malayalee community (the South Indian cultural group to which she belongs) opened the door to considering a health care aide opportunity. She discovered she didn’t have the required certification so she took the Robertson College Health Care Aide Program, a certification process for uncertified health care aides in Canada with directly related work experience. With certification in hand, Nisha got a job in 2015 at Carewest George Boyack. Later that year, Nisha applied to the College of Nurses of Ontario to challenge for her LPN designation, passed her exam on her first attempt, and has since qualified for registration in Alberta with the CLPNA. She has worked as an LPN since. Considering her past nursing experience, Nisha’s ambition is to continue her nursing journey in Canada and has begun the process to do so.

Susantha, whose wife is also an LPN, went to Bow Valley College to complete an LPN program. This decision came from what he describes as a health professional assessment...
system that doesn’t apply to every job category, like his previous experience as an anesthetist. For him, to become what he once was would take too many hours away from the hard-earned life his family lives now, and he is very happy with the LPN profession.

Veerpal is one of few international applicants in Canada with both a working RN and LPN designation, in two different provinces. But even this state of unusual has been quite a story, beginning with a position first in Ontario as a Registered Practical Nurse (the equivalent of LPN in Alberta), followed by her Ontario application for RN assessment which Veerpal successfully passed in 2010. Following this, Veerpal and her husband moved to Calgary. Veerpal now spends two weeks a year working at the RN Review Centre to maintain her RN designation in Ontario.

“The desire to succeed in a new country, which includes inherent struggles to overcome obstacles, has a big benefit to Canada’s work environments in the form of work ethic,” says John Mutikani, Client Service Manager, 3rd Floor at Carewest George Boyack Continuing Care. John, who is from Zimbabwe, cites additional benefits including a diverse workforce that works well with a client base that is culturally diverse itself. “The interaction of cultures and backgrounds enriches approaches,” John notes, as he cites an example whereby Canadians tend to be on a first name basis with facility residents while other cultures use a more formal ‘Mr. or Mrs.’ approach. “The result is an interesting
What a beautiful thing hope and a new blank canvas is in this place we call Canada. How hard newcomers work to make a better life and step into opportunities.

‘in-between’ mix of interaction that brings the world to this facility,” John observes.

The benefits do not come without hiring challenges.

John says that language is the biggest barrier for an immigrant professional who wants to work in Canada, which is why the most suitable employees come from countries where English is taught in schools. John also notes that the hurdles of assessment processes, exams, and licensing boards can be confusing to some and a mountain to climb for others.

“If you immigrate to Canada, you have typically made a trade-off in your mind between a change of medical role in exchange for desire to pursue a better life, however people define that,” John notes.

John and Susantha both observe a unique challenge for immigrant professionals who come from a variety of medical backgrounds: scope of practice in the mind. To explain, Susantha describes how he used to work in a surgical theatre with complex and highly acute surgical patients. “While there is a sizeable core of medical knowledge consistent across professions and countries,” Susantha says, citing taking care of the neck while doing lifts as an example, “you have to mentally remind yourself what your function is today and right now. You can’t over-reach or over-step despite your previous life telling you that you know these things.”

There are ties that bind all of us together as humanity, and you can see it in Nisha, Veerpal and Susantha when conversation turns to what it’s like to work in a long term care facility.

“Dementia is challenging,” Veerpal says, noting that its impacts span from depression to aggression to poor cognition, including families at the core of the dynamic. “It can take some time, working across all disciplines, to develop a care plan in this context but to me the job is simple as its core: help the person, and make the right decisions.”

Nisha talks about how heartwarming it is to see the smiles from residents when they see caregivers. “I think of my grandparents when I see my patients. I treat everyone like I do my grandparents.”

CLPNA’s IEN Registration Process

The CLPNA registers over 250 internationally educated nurses (IENs) annually. In 2014, the CLPNA, along with all the other nursing regulators in Canada, harmonized the initial steps of the registration process through the establishment of the National Nursing Assessment Services (NNAS). When an IEN seeks registration in Canada, the first step in that process is to apply to the NNAS for an advisory report. The advisory report, when completed, will be issued to the CLPNA, and the IEN can apply to the CLPNA for registration. The CLPNA will assess the IEN for equivalent competence and consider both education and experience when making this decision. The CLPNA process is based on the principles of prior learning assessment and recognition. This process of assessment provides assurance to the public, the profession and the employer that the IEN has the knowledge, skills and abilities to practice competent, committed care as an LPN in Alberta.
Susantha describes his ‘best day’ as the day he encountered a resident who was short of breath, completed an assessment that suggested pneumo-nia, and processed it through care providers to successful hospital treatment and a return to the facility.

“Doing any kind of work with mindfulness is satisfying,” Susantha says, and he works to dispel any perception that working in a long term care setting is somehow easier. Today’s long term care residents often live as long as they can indepen-dently, and then enter a facility with a complex inter-action of medical conditions including diabetes, heart disease, and hypertension.

For those who are well established in Canada, it is perhaps easy to overlook what it means to build new roots in a different place and a different culture. What a beautiful thing hope and a new blank canvas is in this place we call Canada. How hard newcomers work to make a better life and step into opportunities. There is no taking anything for granted. There is a humbleness in the voices of Nisha, Susantha and Veerpal that suggests appreciation for what they have, while avoiding anything to do with conversation about what they don’t have.

Because of her journey, Veerpal says she is a more confident woman who is unafraid of any challenge. Nisha would like to complete a Master’s of Nursing and return to India to pay it forward for a next generation of medical professionals. Susantha’s ultimate happiness comes from watching his kids unfurl their wings into life’s possibilities in Canada.

There’s an adage that says “the only difference between stumbling blocks and stepping stones is the way in which we use them.” Through the tenacity by which stumbling blocks are viewed as stepping stones, Canada is a richer place for the spirit of its newcomers.
Use of the term dignity in healthcare and ethics has, of late, been the subject of scrutiny; Ruth Macklin’s (2003) short and critical dissection of the term in global bioethics, for example, launched an ongoing discussion in bioethics literature. Does dignity remain useful in ethical discourse and application? Is it subject to definition and, if so, by whom? Macklin’s basic thesis is that dignity falls under the realms of respect and autonomy, and therefore unnecessarily muddies ethical waters. One problem with dignity is its ambiguity in the face of human difference – a legitimate concern. What constitutes dignity in death, for instance, is an unsettled question. Another problem with dignity is that it tends to emerge predominantly in high stakes ethical scenarios: end-of-life discussions (e.g., the ethics of euthanasia, assisted-suicide, and end-of-life treatment) and nascent human life discussions (e.g., the ethics of embryonic research, genetic cloning, and fetal right-to-life). As legitimate and complex as these various issues are, they tend to escalate differences and disintegrate helpful dialogue.

In this short piece, I consider dignity in its somewhat more mundane manifestation: the sense of respect for individuals seeking basic care – their privacy, their agency, their bodies, and their integrity – within structures created for efficiency and best practices. I do so because dignity, however one understands it, is at least as ethically weighty in the smaller gestures of care for one another as it is in high stakes ethical scenarios. In the Roman Catholic/Christian tradition, within which I work, dignity is understood as inherent to every person prior to any social assessment of his/her value, by virtue of our shared creation in God’s image (Catholic Health Alliance of Canada, 2012, p. 14). Beyond any religious commitment, however, we share a commonsense understanding of dignity that invites us to be mindful of care beyond cure: we respect privacy and confidentiality, we are gentle while relaying difficult news, and we are particularly attentive to the vulnerable among us, whose decision-making capacities might be compromised. Contrary to Macklin, therefore, I suggest that dignity remains an important concept in ethical dialogue and its practice.
We share a commonsense understanding of dignity that invites us to be mindful of care beyond cure.

Case in point: While recently seeking outpatient care at a hospital clinic, I received, for the most part, professional and skilled care from people who facilitated follow-up care as well as possible. I assume that my caregivers were vaguely mindful of the dignity of their incoming patients. More ethically curious to me was the structure and processes through which care occurred and in which dignity was possibly recognized but attentive only to the basic norms of respect, privacy, and confidentiality.

Over three visits to the clinic, I witnessed troubling structural and process-driven management of personal aspects of dignity. For instance, mobility-compromised patients using walkers, canes, or crutches, many of whom were elderly, were required to carry their belongings (including winter attire) around in a large plastic bag, once they had changed for x-rays. Such a scenario assumes, of course, that said patients were making their way through the public corridors of the building in scant cotton gowns.

I also witnessed an odd demonstration of confidentiality policies at work. Patients were required to wait behind the line on the floor in the interests of privacy while persons ahead gave personal information at the various check-in desks. Following that, patients were identified in the small waiting area and, if mobility limited, the nurses would come to them to discuss their health issues and the procedure for the day. While staff were quite considerately taking pains to ease the burden for some patients, they were also having easily overheard confidential conversations in a crowded waiting area. Interestingly, in a small UK study on healthcare practice and human dignity, this practice was specifically noted as a common breach of patient dignity (Baillee & Gallagher, 2012). Attention to such aspects of patient care would likely reveal more respectful and dignified means of moving patients efficiently through their appointments and tests.

All this is to say that respect for privacy and confidentiality seems implemented in basic ways to assure policies are being met and due diligence is undertaken, particularly with respect to legal requirements, but the policies themselves are incapable of meeting a more robust perception of intrinsic worth and our ethical requirements therein. Patients are left subject to the revelation of personal, private information, bodily diminishment (scrubs always trump hospital gowns in healthcare encounters), and the struggle to transport their possessions with them through the institution.

As noted above, the concept of dignity has in recent decades been co-opted by pressing, high-profile issues within healthcare ethics; assisted death, stem cell procurement, and genetic testing, for example. Perhaps more proactive attention to the implementation of dignity in the smaller, subtler actions within healthcare and in the physical structuring of care, could better facilitate the flourishing of every patient in our midst. Small initiatives aimed at alleviating patients’ experiences of indignity or diminishment, like storage space for belongings or designated space for confidential discussions, would be more attentive to patient dignity. This would also be attentive and respectful to the professional standards and interests of care providers, without necessarily reducing efficiency.

To be sure, there are logistical details that are prohibitive across the healthcare spectrum. However, taking the notion of dignity seriously seems to be the care aspect of healthcare that we are providing. In turn, a personal and embodied sense of respect includes attending to the various small ways that dignity is compromised for individuals, even when not confronted with the seemingly weightier healthcare issues at the beginning and end of life.

Enacting a more robust sense of dignity in the smaller acts of care could also facilitate the habit of mindful attention to shared human dignity in more pressing circumstances. If we acknowledge the diminishment of dignity and authority that comes with wearing a flimsy gown through the public corridors of a hospital, we might be more acutely aware of its diminishment in larger spheres.

Most healthcare providers are committed to giving competent and compassionate patient care. They work hard in difficult circumstances that are often beyond their control. Dignity, as a component of care, is the very least we can offer when pain and suffering are inevitable. It invites us to be intentional about the ways in which we offer care to the persons before us, and their experiences in our midst. It invites us to understand that privacy and confidentiality go beyond lines on the floor, privacy notices and signs, files in locked drawers, and that respect extends beyond the beginnings and ends of lives. Dignity is more commonly enacted in small ethical moments of caring in mundane circumstances; moments that, in fact, define the nature of our practice.

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REFERENCES:
Introduction: Statement of the Problem

In 2015, the Organization for Economic Co-operation and Development (OECD) reported that Canada’s overall health status performance lags in terms of overall quality of care compared to its peer nations, while its health expenditures are among the highest. In response, Health Canada’s Advisory Panel on Healthcare Innovation recommended that while we need to continue to provide quality health services, efficiencies need to be found to reduce spending and fully utilize existing resources.

Health systems are often slow to adapt and make appropriate changes to suit the needs of their communities. Canada’s changing population dynamics mean there will be more demand for care at multiple levels and in multiple domains. This combination of inefficiency, demographic changes, and the slow pace of adaptation means new models of care are urgently needed.

While there are various models of care across the country, research shows that collaborative care models (CCMs) provide the most efficient use of health services. Evidence from the Canadian Institute of Health Information demonstrates variability of nursing utilization at provincial and regional levels. We suggest, as does a 2014 Canadian Academy of Health Sciences (CAHS) report, that this variability is due to outdated health professional legislation and entrenched professional cultures; they note, “health professional scopes of practice and associated models of care tend to be organized on the basis of tradition and politics rather than in relation to the evidence”.

This paper argues that irrespective of known barriers, for CCMs to work effectively, policies must be adapted to ensure role optimization of all health professionals. It is imperative that provincial and territorial policy and decision makers build trusting coalitions with professional colleges. Together, they should implement a harmonization of nursing utilization policies to fully optimize the nursing workforce. When nurses are utilized to their full scope of practice, there are positive patient outcomes and increased efficiencies.

Background

There are widespread concerns about the state of health care across Canada, including costs, quality, health human resources (HHR), and outcomes. These concerns are going to increase in the near future. Projections from Statistics Canada suggest that Canada’s population will continue to grow over the next 50 years to reach between 40.0 million and 63.5 million people by 2063. The proportion of seniors is expected to grow rapidly in the coming decades; by 2030, close to one in four persons (22.2%) will be aged 65 years or over. Additionally, by 2063, the number of Canadians aged 80 years and over could reach nearly 5 million.

Transformative thinking is needed to adapt policies and regulations. CCMs are the best option to provide positive patient and provider experiences as well as better system level outcomes. The 2014 report by the Canadian Academy of Health Sciences argued that optimizing health professions’ scopes of practice is best done in an interdisciplinary team model, stating: “An [interdisciplinary team] model must be flexible to best utilize the scopes of practice of team members within an accountable and regulated environment in the context of patient, community, and population healthcare needs”.

Furthermore, the World Health Organization recognizes collaborative care as “providing comprehensive services by working with patients, their families, caregivers, and communities to deliver the highest quality of care across settings”. The Institute for Healthcare Improvement’s Triple Aim framework also proposes a collaborative approach to optimizing health system performance.

In Canada, effective CCMs include interdisciplinary team care, where all professionals work at optimal scope. When they are able to adapt to systemic, legislative, and regulatory changes in a seamless manner, they are able to ensure care is person-centered and of the highest quality.
Table 1: Common barriers to optimization of scope (all health professions)

<table>
<thead>
<tr>
<th>Author and Year</th>
<th>Document Type</th>
<th>Barriers Noted</th>
<th>Geographic Focus</th>
</tr>
</thead>
</table>
| College of Licensed Practical Nurses of Alberta (CLPNA), 2014. | Report | • Rigid legislation and regulations  
• Professional protectionism  
• Professional hierarchies  
• Mistrust between health professionals  
• Poor communication between health professionals  
• Being asked to work below competency level  
• Focus on tasks instead of role in patient care | Alberta |
| Canadian Health Services Research Foundation, 2005. | Report | • Professional protectionism  
• Misunderstanding/ lack of knowledge of other health professionals’ contributions to team-based care  
• Mistrust between health professionals  
• Poor communication between health professionals  
• Being asked to work below competency level  
• Focus on tasks instead of role in patient care | Alberta and Saskatchewan |
| White, 2008. | Peer-reviewed journal | • Misunderstanding/lack of knowledge of other health professionals’ contributions to team-based care  
• Professional protectionism  
• Being asked to work below competency level  
• Focus on tasks instead of role in patient care | Edmonton, Calgary, and Saskatoon |
| Commission on the Future of Health Care in Canada, 2002. | Report | • Misunderstanding/lack of knowledge of other health professionals’ contributions to team-based care  
• Professional protectionism  
• Being asked to work below competency level  
• Focus on tasks instead of role in patient care  
• High workload, job stress, burnout, extra hours | National |
| Health Council of Canada, 2005. | Report | • Misunderstanding/lack of knowledge of other health professionals’ contributions to team-based care | National |
| Oelke, 2008. | Report | • Professional hierarchies  
• Mistrust between health professionals  
• Poor communication between health professionals | Western Canada |
| Harvey, 2011. | Peer-reviewed journal | • Lack of evidence and evaluation frameworks  
• High workload, job stress, burnout, extra hours | VCH Region in British Columbia |
CCMs should be supported with clear communication among practitioners, require designated care coordinators, use a clearly defined decision-making framework, provide competency training on collaborative care, and utilize an accessible, adaptive medical record system to evaluate health outcomes.\textsuperscript{12}

CCMs can only succeed if health professionals’ scopes of practice are optimized by balancing professional roles based on practitioners’ relative competencies. When there are overlapping scopes and differing levels of competency, as in nursing, successful CCMs have to be flexible and adaptive. A scoping review of Canadian health professional optimization revealed common barriers to scope optimization.\textsuperscript{16,17,18,19,20,21} See Table 1.

These identified barriers map directly onto barriers identified in a recent study on the factors associated with optimal use of LPNs in Alberta.\textsuperscript{14} See Table 2. This study found that Alberta is under-utilizing LPNs and this is the result of limiting LPNs’ scope of practice.\textsuperscript{14}

**A Solution**

When nurses practice to optimal scope, there is acceptance, teamwork, and increased job satisfaction.\textsuperscript{14} Alberta Health Services’ Patient First Strategy includes a collaborative care model called ‘CoAct’. Under this initiative, care providers act as high-functioning teams. The utilization of CoAct has seen substantial improvements in six targeted performance measure areas.\textsuperscript{22}

Like many other health professions in Canada, LPNs are a self-regulated profession; they are accountable to the public, the profession, to other members of the healthcare team, and to their employers. The Canadian Council for Practical Nurse Regulators (CCPNR) is a body that aligns LPN base competencies across the country. LPNs adhere to jurisdictional legislation and regulation, with standardized Entry to Practice Competencies\textsuperscript{23}, Requisite Skills and Abilities\textsuperscript{24}, Code of Ethics\textsuperscript{25} and Standards for Practice\textsuperscript{26}. Actual practice is defined through each province’s legislation and regulation and subsequently, by the healthcare organizations providing service.

There are many good examples of LPNs working at optimal scope of practice. These roles have been developed due to strong leadership, vision, innovation, and commitment to advanced roles for LPNs. The implementation of these ‘new’ LPN roles addressed the needs of the patients and subsequently evolved because of increasing healthcare demands. Some of the full scope roles Alberta’s LPNs are performing include:

- Clinical care coordinators and case managers in supportive living

### Table 2: Factors that influence LPNs’ scope of practice\textsuperscript{a}

<table>
<thead>
<tr>
<th>Factors</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual (LPN preferences)</td>
<td>• Experience</td>
</tr>
<tr>
<td></td>
<td>• Education</td>
</tr>
<tr>
<td></td>
<td>• Personal motivation</td>
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<td></td>
<td>• Time since graduation</td>
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<tr>
<td>Team (Unit level utilization)</td>
<td>• Client assignment</td>
</tr>
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<td></td>
<td>• Professional territoriality of registered nurses</td>
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<tr>
<td></td>
<td>• Staff awareness of LPN scope and competencies</td>
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<tr>
<td></td>
<td>• Team leadership</td>
</tr>
<tr>
<td>Organizational (policy and procedural)</td>
<td>• Staffing models</td>
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<tr>
<td></td>
<td>• Formal and informal practices</td>
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<tr>
<td></td>
<td>• Limiting policies and practices</td>
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<tr>
<td></td>
<td>• Availability of resources</td>
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<tr>
<td></td>
<td>• Roles ambiguity</td>
</tr>
<tr>
<td>System (legislative and regulatory)</td>
<td>• Inconsistent understanding of regulation</td>
</tr>
</tbody>
</table>

• Team members in emergency departments and palliative home care
• Managers of care transitions and patient navigation
• Working in community engagement and community support roles.

Evaluation of the impacts of these full scope roles, however, is lacking. Many projects are done as pilot initiatives and the processes and outcomes are not documented or accessible for health system decision making. This failure to communicate results makes scaling and spreading innovative programs challenging.

A similar limitation was also noted in the CAHS report: “It is also important to consider that the work of many HHR projects may not be documented, as scholarly output may not have been a priority for the project” (p. 31). Because much of the impacts and outcomes exist only in ‘grey’ literature, there is an urgent need for published evaluations and impact assessments to aid resource planning.

There are a number of excellent evidence-based tools for health human resource planning. For example, the Staff-Mix Decision-Making Framework for Quality Nursing Care is recognized as an evidence-informed tool to guide nursing resource planning. Additionally, a recent study from Vancouver Coastal Health, using a similar framework, demonstrated that implementing a collaborative practice model in both acute and residential settings resulted in substantial return on investment without sacrificing quality and safety.

Conclusion

The need for health leaders to address these barriers to scope optimization is imminent if they want to build capacity for collaborative care and facilitate higher quality and sustainable healthcare. At the provincial level, skilled leadership and informed partnerships will build trust to make effective changes to legislation and regulation.

At the organization level, regulators and organizational leaders can proactively engage in sharing information to increase awareness of policy variations and practice inconsistencies. At the unit level, health leaders can help to empower managers and staff to recognize both the full scope of LPN practice and individual LPN competencies. LPN regulatory bodies can help by contributing to policy discussions and providing information to employers about the LPN scope of practice and competencies. These actions are crucial to match the right LPN to the right setting with the right patient assignments.

References available on request.
Celebration70! recognizes the transitions and highlights in the history of the Licensed Practical Nurse profession, motivating us toward the future.

Delegates will network and be inspired by the work of those that have gone before us, those among us and those yet to be.

Come join us as we celebrate the 70th anniversary of the LPN profession at this great venue with some new surprises in our program, and of course, the Awards of Excellence for the LPN profession.

April 26 - 28
Grey Eagle Resort & Casino, Calgary, Alberta
Dr. Brian Goldman, Host of ‘White Coat, Black Art’ on CBC Radio One

Dr. Brian Goldman hosts the award-winning current affairs radio series ‘White Coat, Black Art’ on CBC Radio One where he demystifies what goes on inside medicine’s sliding doors – with edgy topics that include whistle blowing, burnout, racism, and how to get to the head of the line. He’s written two books, ‘The Night Shift: Real Life in the Heart of the ER’, and ‘The Secret Language of Doctors’.

Cecilia Bloxom, APR, ABC

As the Senior Director, Strategic Communications for Canadian Patient Safety Institute, Cecilia Bloxom is dedicated to the mission of safe healthcare for all Canadians. Cecilia is the executive lead on Canadian Patient Safety Week and the Co-Chair of Canada’s Virtual Forum on Patient Safety and Quality Improvement. She will share SHIFT to Safety, a new program designed to empower you with the tools and information you need to keep patients safe, whether you are a member of the public, a practitioner, or a leader.

Invite Your Colleagues!

We’re offering special programming and reduced rates.

A two-part workshop, A Celebration of Health Care Aides and the Integration of a Palliative Approach, is open to all care providers but is tailored to the HCA. And we’re offering HCAs lower fees to attend for a single day or the entire event when invited by an LPN.
In early April 2016, the National Pressure Ulcer Advisory Panel (NPUAP) announced several changes and updates related to pressure ulcers.1

Terminology

One of the most significant updates is a change in terminology from pressure ulcer to pressure injury to more accurately reflect the nature of pressure-related trauma. In the past, the term pressure ulcer was used to describe both stage 1 pressure ulcers and deep tissue injury, even though the skin is intact in both instances and no “ulcer” is present. Under the updated system, pressure injury is used to describe the results of all types of pressure-related trauma, regardless of whether the skin is intact or ulcerated. The term suspected is no longer used to describe deep tissue pressure injuries.

Staging

The panel made updates to the stages of pressure injury. Stages are now identified using Arabic numbers 1, 2, 3, and 4 instead of Roman numerals. Two types of pressure-related injury were given their own labels: medical device-related pressure injury and mucosal membrane pressure injury.

Medical Device-related Pressure Injury: These injuries result from the use of medical devices designed for therapeutic or diagnostic purposes. These injuries may conform to the shape or pattern of the device used by the clinician to provide care. They should be staged using the NPUAP staging system.

Mucosal Membrane Pressure Injury: These are pressure injuries found on the mucous membranes with a history of use of a medical device and are not staged.

Why is this important?

• Accuracy – clinicians can more accurately describe the skin injury related to pressure.
• Patient safety – clinicians can more accurately report pressure related incidents.
• Medical device pressure injuries – clinicians can report pressure injuries due to medical devices as they are now recognized in the updated staging system.

What are the clinical implications?

• Policy change – clinicians should use the new definitions when reporting and documenting skin injury related to pressure.
• Education revisions – educators should access the NPUAP definitions and photos online to ensure a consistent approach to assessment, reporting and documentation of pressure injuries.

Pressure Injury Defined

Pressure injury is defined as “localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.”1
Healthy Skin

Stage 1 Pressure Injury:
Non-blanchable erythema of intact skin

Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature or firmness may precede visual changes. Colour changes do not include purple or maroon discolouration; these may indicate deep tissue pressure injury.

Blanchable and Non-blanchable skin
**Stage 2 Pressure Injury:**
Partial-thickness skin loss with exposed dermis

Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe:

- moisture-associated skin damage (MASD) including incontinence associated dermatitis (IAD)
- intertriginous dermatitis (ITD)
- medical adhesive related skin injury (MARSI)
- traumatic wounds (skin tears, burns, abrasions)

**Stage 3 Pressure Injury:**
Full-thickness skin loss

Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss, this is an Unstageable Pressure Injury.

**Stage 4 Pressure Injury:**
Full-thickness skin and tissue loss

Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
**Deep Tissue Pressure Injury**

Persistent non-blanchable deep red, maroon or purple discolouration

Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin colour changes. Discolouration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full-thickness pressure injury (Unstageable, Stage 3 or Stage 4).

Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

**Unstageable Pressure Injury**

Obscured full-thickness skin and tissue loss – dark eschar

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed.

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**Chester Ho** has a clinical and research interest in pressure injuries in persons with spinal cord injury. He is an Associate Professor and the Section Chief of Physical Medicine & Rehabilitation at the University of Calgary.

**Janet L. Kuhnke** is an Enterostomal Therapist and nursing faculty at the St. Lawrence College BScN Collaborative Program in Cornwall, Ontario.

**Heather L. Orsted**, Director of Education and Professional Development at the Canadian Association of Wound Care, is an experienced adult healthcare educator, program developer and author with a special interest in knowledge mobilization and wound prevention and management.

**Reference**


This article originally appeared in Wound Care Canada, 2016;14(2):10–13 and has been reproduced with permission from the Canadian Association of Wound Care (cawc.net).

Illustrations are courtesy of the National Pressure Ulcer Advisory Panel (NPUAP) and © 2016 NPUAP. Illustrations by Knighttime Designs.
Providing more information to managers and leaders about licensed practical nurse scope and education is just one of the ways to help LPNs work more effectively, according to a recent study sponsored by the CLPNA. The study explored how LPNs are distributed within Alberta Health Services and what factors affect LPNs’ ability to practice to their full scope. Based on some earlier work, the project focused on emergency departments (ED), mental health units, and labour and delivery units (L&D) for this project.

Results from HR and patient data showed that just over half of EDs and L&D units and three-quarters of mental health units included LPNs in their staffing. LPN staffing was inconsistent across AHS zones. On average, North Zone staffed the most LPNs. The data also showed that patient intensity and acuity did not predict LPN distribution. Given this, staff and management were interviewed on EDs, mental health, and L&D units around the province to understand how LPNs are utilized and identify any variability around the province. Most LPNs were happy with their work and felt like valued members of their teams. LPNs who were unhappy tended to work in teams that they said did not value LPNs. Many thought they were using as much of their scope as possible. Although ED and L&D LPNs felt their schooling had prepared them well for the job, most mental health LPNs thought they could have used more education on the topic. Non-LPN staff were not always aware of what LPNs’ education includes and had questions about their ability to provide specialized care. Many also thought LPNs did not receive enough training on critical thinking but agreed that their technical skills were great.

There also tended to be confusion around what LPNs can and cannot do. This was true on almost all units without LPNs and, surprisingly, on some units with LPNs. Although most interviewees could name specific activities that LPNs were not allowed to do, many had questions about the full range of LPN skills and competencies. Some interviewees noted, “It can be hard to get accurate information about LPN scope since different sources have conflicting or outdated information or vague and confusing wording.” LPNs’ scope has increased so rapidly over the last several years that it can be tough to keep track of, and it can be hard to get accurate information about LPNs’ scope since different sources have conflicting or outdated information or vague and confusing wording. Some units without LPNs were open to the idea of adding them; others were adamantly opposed to it. Reasons given were issues with role confusion between registered nurses (RNs), LPNs, and health care aides; LPNs’ perceived lack of education and experience in specialty areas; and threats to RN jobs.

Overall, to help LPNs work effectively and introduce LPNs on units without them, more information needs to be given to managers and leaders about LPN scope and education, different nursing roles need to be clearly defined, and leaders need to play an active role in building strong team environments and holding all staff accountable for being welcoming and supportive to all providers.

For more on this study, contact Dr. Leah Phillips in the CLPNA’s Research Department at lphillips@clpna.com or 780-484-8886.
Can technology make looking after yourself easier? It can certainly try. These apps aim to help you watch your diet, achieve your goals, and remember to get to that dentist appointment on time.

**My Fitness Pal – Calorie Counter & Diet tracker / Free / iOS and Android**

This free app and website tracks diet and exercise to help you achieve your optimal caloric intake and exercise. A large database of foods makes it relatively easy to record what you eat, and allows you to enter your exercise as well. It remembers what you’ve eaten in the past, making it easy to add those foods again. It also allows you to connect with friends for motivation and support.

**Coach.me – Goal tracking, Habit Building & Motivation / Free / iOS and Android**

This habit tracking app aims to help you form new, better patterns in your daily life. Set the goals or habits you wish to track, set targets and reminders to hold yourself responsible, get support and celebrate milestones with their online community. Paid coaching is also offered if you want more guidance along the way to your goal.

**Cozi Family Organizer / Free / iOS, Android and Windows**

This is the mobile version of the family calendar on the fridge. It lets you keep your family’s activities and appointments all in one place, plus create and share lists for groceries, chores and to-dos. The whole family can share an account, so you can set reminders and add appointments for everyone to see. There’s also a recipe box and a family journal to help you remember special moments.

The CLPNA and CARE magazine do not endorse the apps shown above. Please exercise your own judgement and the rules of your employer when choosing to use healthcare apps or mobile technology in your workplace.
Many older people leave hospital frailer than when they started. Some of that is preventable, but much of the damage done by acute illness is baked in to how frailty works. Some of it is repairable. That is why rehabilitation must be part of acute care: if we cannot prevent damage, we should at least treat it, especially damage that we inflicted unnecessarily.

The gist of it is easy enough. When frail patients are unwell enough to come to hospital, they typically are not thinking, functioning and moving like they were before they became ill. That is usually why they come. That, and whatever other symptoms (breathlessness, pain, something red or swollen) signal a problem. Even when fixing the precipitants, modern care often does nothing to address the worse thinking / mobility / function in which the problems were packaged. Such complexity of need defines frailty.

Frailty is not new, but population aging means that it is coming to attention. We must help healthcare decision-makers to understand that even when care does not harm, there will be a gap between what cognition, mobility and function are like once the precipitants have been treated, and what people need in order to return home. The time is ripe for healthcare providers to hear this message.

Once the message is heard, the arithmetic is simple. For many patients, the number of things that they have wrong (i.e., their degree of frailty) at the end of their acute care stay is too high for them go home. That is why they require rehabilitation.

QED. Well, not quite.

To get there, someone must measure the degree of frailty at baseline. Conveniently, this can be estimated by asking about mobility, function and the like two weeks prior to admission. For the gap between the degree of frailty at baseline and the degree of frailty on admission to be known that too must be measured. None of this is especially new. To the requirement to “take a history”, we must simply add that it include some indication of problems in cognition, mobility and function. Likewise, to “do an exam, assess and diagnose”, we must stipulate that what is being examined allow us to know whether, when and how the patient might be able to return home.

This knowing precisely what people were like two weeks before they became ill needs to be clear to the care team. It gives them a specific way to talk to patients and carers about what must be achieved for the person to go home. How close to health two weeks ago do we need to come? Knowing what to aim for clarifies the gap between the patient’s degree of frailty and the degree of frailty that carers can manage. Aiming to close that specific gap is not some magic incantation, but a specific, auditable, patient-centred goal-oriented program.

From this, it is easier to move to the next step in better care. The people with the biggest gaps usually will be those who were frail at baseline. That is because they are the most vulnerable: the poor get poorer.

And there’s the rub. Frail people do worse not just due to their illness, but to their treatment. It’s not just that they are more susceptible to adverse drug reactions. A lot of what we do in hospital is harmful. No one benefits from sleep deprivation, or inadequate pain control, or not being mobilised, or inadequate nutrition, or being alone, but mostly, we get away with it. Not so for frail patients, especially when they are acutely ill. So some part of lessening the need for rehab to be part of acute care is to make acute care less hazardous.

Rehabilitation must be part of acute care if we wish to have fewer older people leave hospital frailer than when they started.

Kenneth Rockwood is a geriatrician at the Halifax Infirmary and Professor of Geriatric Medicine at Dalhousie University. This article is reprinted with his kind permission.
Looking to **BOOST** Your Nursing Competencies?

Recipients of an Education Grant from the Fredrickson-McGregor Education Foundation are given the opportunity to extend their learning past their basic courses. The opportunities available enable the LPNs of Alberta to further explore areas of study related to their work, subsequently widening their scope of practice.

By providing education grants, awards and bursaries, the Foundation directly contributes to the enhancement of LPN knowledge, skills and abilities. The Foundation honours outstanding academic and professional achievements of LPNs, and reimburses them for continuing their education.

Nobody knows the benefits of receiving an Education Grant better than the recipients themselves. Past beneficiary Trish Ferguson, LPN, says that the funds she received enriched her nursing practices so much that she now donates to the fund.

> “The benefits of being able to further my studies were far beyond what I imagined. The opportunities are endless and have been so beneficial that I want to help give other nurses the chance to bring their practice to the next level.”

Fellow recipient Brenda Kalisch, LPN, has watched the profession advance since she started nursing in the 1980s. She emphasizes how essential the fund was to her nursing practice, noting “Above all else, the fund actually walks the walk of one of the major mandates of the CLPNA, which is continuing education.” All too often, regulatory colleges preach lifelong learning, she says, “but few actually practice what they preach and help their professionals get to where they are encouraged to be.” The CLPNA is a major fundraiser and supporter of the Foundation.

Both recipients have seen the profession evolve over the years and are grateful for the ability to extend their education far past the basics. Brenda reminisces about the introduction of medication administration and how far the profession has come. “I have been supported in improving my nursing abilities, and I am grateful and impressed beyond measure.” Trish Ferguson furthers the sentiment by saying, “Thanks to the increase in my competencies, I am able to better care for my patients and I feel like a valued professional.”

Receiving financial support from the Fredrickson-McGregor Education Foundation for LPNs is easier than most think. For more information regarding potential opportunities to further your nursing practice, please visit the Foundation’s website at http://foundation.clpna.com.
Connecting LPNs to other health professionals with your interests in mind.

**CONNECTIONS**

Alberta Gerontological Nurses Association  
www.agn.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.rpnao.org/practice-education/e-learning
Staying Professional on Social Media: Fact Sheet

Between smartphones, tablets, computers and other digital devices, the opportunity to use social media is almost constantly at our fingertips. Since social media can be used to connect with people in our personal lives as well as professional organizations and colleagues, it can be difficult to understand the difference between what is personal and what is professional.

Because of this, use of social media is being increasingly recognized as an emerging source of professional misconduct for many professions. For healthcare professionals, the main issues that arise with use of personal social media accounts involve maintaining therapeutic boundaries, upholding clients’ privacy and confidentiality, and keeping a professional image that upholds the integrity of oneself as a professional and the profession as a whole.

The CLPNA has developed a Fact Sheet Staying Professional on Social Media – Guidance and Strategies for the Licensed Practical Nurse to provide members of the College of Licensed Practical Nurses of Alberta (CLPNA) with information on responsible use of personal social media accounts. To keep up with best practice the LPN should:

- Avoid accepting/requesting friend/follower requests from clients and their family members using social media;
- Not reveal personal contact information to clients;
- Avoid offering health-related advice in response to questions and comments on social media and instead refer information seekers to the appropriate healthcare access point;
- Avoid posting confidential and/or identifying information about clients;
- Not share media (images, video, sound clips) from care environments;
- Not reveal place of employment on social media accounts intended for personal use;
- Enhance privacy settings and keep personal account(s) private and protected with a strong password;
- Not use social media to degrade, vent or share negative information about a client, co-worker or employer;
- Not post, like, or comment on posts that could be considered inappropriate or misunderstood if taken out of context;
- Always present oneself in a professional manner;
- Be aware of and follow employer policies on the use of technology and social media in and out of the workplace; and
- Follow a professional responsibility to report breaches of privacy and/or confidentiality as well as unprofessional or unethical conduct of themself and others.
Working Towards Change on Pink Shirt Day

90% of Alberta’s licensed practical nurses say they’ve witnessed a nurse bullying another nurse. This statistic is alarming, and the CLPNA is working hard to bring solutions to our nurses that are realistic and effective.

This year, during recognition of the annual anti-bullying Pink Shirt Day, and in continued support of ThingsNeedtoChange.ca, CLPNA participated in a webinar with Alberta Health Services Human Resources to learn about appropriate coping techniques for bullying in the workplace:

- Attributing bullying behaviors to someone’s personality is not an acceptable excuse. Stopping bullying in its tracks calls for a team effort, one that includes a commitment from every member of the workplace.

- Confrontational response towards a person exhibiting bullying behavior is never an effective approach. Instead, initial tactics should include a more gentle response, such as “I noticed you were quite short with me in front of a patient this morning. Is everything ok?”

- It’s important to be in tune with the level of hostility of the bully. With some bullies, one-on-one confrontation can make the situation worse. In circumstances like this, speak with your direct supervisor or a Human Resources representative.

A proactive approach and an open dialogue gives healthcare professionals the opportunity to more easily solve differences and work collaboratively which ultimately leads to more positive patient outcomes. Please visit CLPNA.com for more information.
Nominations to CLPNA Council Welcome Province-wide

Due to a change in term length, most of Alberta’s LPNs are eligible to run in this year’s CLPNA Council Elections. Four of the most populous Districts will be holding elections in June for District Representatives.

Edmonton and Calgary are electing for three-year terms, while Grande Prairie and Fort McMurray are one-year terms. The unusual one-year terms are a result of the Council Terms of Office Transition Plan approved last March. By 2018, all Districts will be on a staggered schedule of three-year terms.

Edmonton will see a fresh face this year, as District 4’s representative Diane Larsen ends her tenure in August. Council members are restricted to two consecutive terms of office in the same district.

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.

To run, eligible LPNs must have an Active Practice Permit from CLPNA and reside in the Election District. Nomination Forms must be submitted by May 31. District Elections are held in June by email ballot.

To discover your District, use the “Find my Election District” document to look up your town or city of residence.

Nomination Forms and complete information available from www.clpna.com under “Council”, or by contacting info@clpna.com, 780-484-8886 or 1-800-661-5877 (toll free in Alberta).

Annual Validation Asks LPNs to Confirm Learning

“Well, success depends in a very large measure upon individual initiative and exertion, and cannot be achieved except by a dint of hard work.”

- Anna Pavlova

The hard work of LPNs will be up for review when one in five CLPNA members participate in the annual Continuing Competency Program Validation. Starting May 1, several thousand LPNs will be asked to verify completion of their 2015 and 2016 Learning Plans.

According to Alberta’s Health Professions Act, LPNs are required to keep their nursing knowledge and skills up-to-date through the Continuing Competency Program (CCP). Through the Program, LPNs engage in activities that contribute to the continuing development of nursing competencies. LPNs advance their professional practice with lifelong learning, building an individual learning plan, and contributing to quality nursing practice and best possible client outcomes.

CCP Validation monitors LPN participation in this program. It ensures accountability through assessment of the validity of a member’s Continuing Competence documents and evaluation of whether learning has been integrated into practice.

With initiative and planning, CCP Validation can be easy using the online submission process. Plan ahead to achieve success. CLPNA recommends LPNs regularly track their continuing education using the online Record of Learning, located on their member profile at https://www.myCLPNA.com. Complete details about CCP and CCP Validation can be found on www.clpna.com under “Members”.

2017 ELECTION DISTRICTS

Three-Year Term
DISTRICT 2: CALGARY (& area)
DISTRICT 4: EDMONTON (& area)

One-Year Term
DISTRICT 6: NORTH WEST (Grande Prairie & area)
DISTRICT 7: NORTH (Fort McMurray & area)
Competency Profile Updates to Nutrition/Hydration, Elimination

Effective January 31, CLPNA updated the Nutrition/Hydration and Elimination sections of the Competency Profile for LPNs to increase clarity of scope of practice.

Revisions include (changes italicized):

- Addition of “intraosseous” to the list of multiple routes under E-6-1 Demonstrate knowledge and ability to assess and provide nutrition/hydration by multiple routes.
- Addition of “discontinue” to E-6-5 Demonstrate knowledge and ability to monitor, regulate, and discontinue Total Parenteral Nutrition (TPN).
- More explanation in the Note: LPNs are not authorized to provide the restricted activity of initiating the administration of TPN.
- More explanation in the Note: LPNs are not authorized to insert urological devices, for the purpose of aiding elimination, using a guide-wire or stylet.

The Competency Profile describes “the knowledge, skills, behaviors, judgments and attitudes required by a LPN in Alberta as outlined in the Health Professions Act LPN Regulation 2003, and CLPNA Standards of Practice.” Adjustments are made periodically to the document as nursing and healthcare practices evolve.

CLPNA recommends all LPNs ensure their copy of the Competency Profile includes this update. The documents, Competency Band E-6, Nutrition/Hydration, and Competency Band E-7, Elimination, may be found on www.clpna.com under “Competency Profile for LPNs”.

Questions? Contact CLPNA’s Practice Consultants at practice@clpna.com, 780-484-8886 or 1-800-661-5877 (toll free in Alberta).

Opioid Crisis: Fentanyl Info & Resources

Alberta Health Services’ recent statistics show the continuing rise of deaths and emergency care visits related to fentanyl and other opioid overdoses in Alberta.

In the interest of public safety, the College of Licensed Practical Nurses of Alberta urges licensed practical nurses to educate themselves on this topic: first, to learn the signs and symptoms of opioid overdose and the use of naloxone to reverse an overdose, and secondly, but no less importantly, to protect themselves from the dangers of opioid exposure.

StopODs.ca

Continuously updated resources for health professionals are available from Alberta Health Services at www.StopODs.ca, or by searching www.clpna.com for “opioid”.

In October, the CLPNA announced their support for the development of supervised safe injection sites, and the future role of the licensed practical nurse in this and other harm reduction services.

Questions? Contact CLPNA’s Practice Consultants at practice@clpna.com, 780-484-8886 or 1-800-661-5877 (toll free in Alberta).
Contest Showcases National Nursing Week 2017 on Social Media

It’s national celebration time for the family of nurses!

LPNs are invited to enter CLPNA’s Show & Tell Contest for National Nursing Week (May 8-12) to show off their team and tell everyone what makes a happy nurse. Entries will be accepted on Instagram, Facebook, and Twitter using #CLPNA NursesCare.

Winners will receive a variety of CLPNA-branded goodies and LPN product from the Fredrickson-McGregor Education Foundation for LPNs. On the final day, a grand prize winner will be selected from all entries received.

HOW TO ENTER

The Contest is open from May 8-12, 2017. Contest entries must comply with CLPNA’s Social Media Fact Sheet. Please do not post your facility name, or show patients or patient care areas.

1. SHOW your National Nursing Week event pictures

Share a photo of your National Nursing Week event. Post it to Instagram or Twitter or CLPNA’s Facebook page using the hashtag #CLPNA NursesCare. Entries on Facebook must be made in the comments section of the official Contest Entry post.

2. TELL what makes you a happy nurse

Write a note about what makes you happy to be a nurse. Post it to Instagram or Twitter or CLPNA’s Facebook page using the hashtag #CLPNA NursesCare. Entries on Facebook must be made in the comments section of the official Contest Entry post.

Winners will be announced daily! The Grand Prize winner will be selected on May 12.

Complete Contest Rules available at www.clpna.com, search “National Nursing Week 2017”.

Silent Auction Seeks Donations

The Frederickson-McGregor Education Foundation holds a vital role in supporting ongoing post-basic education of LPNs in Alberta. The foundation honours excellence in practice by encouraging LPNs to strive to enhance their competencies.

Since its establishment in 2006, over $2 million in funding has been approved. By assisting LPNs with their continuing educational goals, the foundation is able to enrich recipients’ nursing knowledge, skills and abilities.

The Silent Auction held during the CLPNA Annual General Meeting and Conference is the single largest contributor to the foundation. The success of the fundraiser relies on the generosity of donors.

The Frederickson-McGregor Education Foundation is seeking donations of all shapes and sizes for this year’s conference held April 26-28, 2017. Auction items typically include, but are not limited to:

- Gift certificates
- Handcrafted artisanal items
- Garden and yard accessories
- Jewelry
- Electronics
- Household goods
- Sports and theatre tickets

All contributors will be provided with the opportunity to display their business card and/or brochure alongside their donation.

For further information including Donation Forms, please visit the Frederickson-McGregor Education Foundation website at http://foundation.clpna.com or contact Donna Doerr, Foundation Assistant, at (780) 669-1852 or foundation@clpna.com.
HEARING TRIBUNAL DECISION

Substance abuse leads to LPN suspension and fine

Publication Ordered by the Hearing Tribunal Related to a Matter of Unprofessional Conduct of Nicole Armstrong

The College of Licensed Practical Nurses of Alberta (CLPNA) is charged with the responsibility of protecting the public from unethical, unskilled, or unsafe nursing practice. There are times when the competency or conduct of a licensed practical nurse (LPN) is questioned; when this happens CLPNA will receive notification and a complaint is generated. It becomes CLPNA's responsibility to resolve the complaint in order to ensure the public remains protected and an LPN's practice and conduct meets the competencies, standards and ethics expected of an LPN.

On May 6, 2015, CLPNA received a serious complaint against Nicole Armstrong from the Red Deer Regional Hospital where she was employed. It was alleged Ms. Armstrong consumed an illicit drug during a shift while on a scheduled break.

At the onset of the complaint process, steps were taken to ensure public safety. The Director of Professional Practice placed a condition on Ms. Armstrong’s practice permit requiring her to participate in random drug screening and maintain negative results. Subsequently, she failed to provide a valid urine drug screen. This failure resulted in an interim suspension of her practice permit until all disciplinary processes were complete.

An investigation into the complaint revealed evidence to support 'unprofessional conduct' where Ms. Armstrong consumed an illicit drug while on a scheduled shift; patients under her care would be at a potential risk of harm if Ms. Armstrong was under the influence of an illicit drug while providing care; and lastly there was a significant fitness to practice concern. The matter was referred to a Disciplinary Hearing held in Red Deer on October 19 and 20, 2016.

It is the professional obligation of an LPN to cooperate during all disciplinary proceedings and this includes attending a hearing; the unwillingness to cooperate is considered unprofessional conduct. Ms. Armstrong was aware of the date and location of the hearing; however, she elected not to attend the hearing with or without her counsel. The Hearing Tribunal considered the need to protect the public and decided, after CLPNA put in an application, to continue with the hearing in her absence.

The Hearing Tribunal found the alleged conduct was proven and it amounted to unprofessional conduct. Ms. Armstrong's conduct demonstrated several serious and significant ethical breaches and showed a serious lack of judgment which clearly harms the integrity of the regulated profession. The Hearing Tribunal found she used poor judgment in using an illicit drug and then returning to work after her break to continue her shift. Her actions posed a serious risk in failing to maintain the required mental and physical wellness to meet the responsibilities of her role as an LPN. Ms. Armstrong's actions were in breach of the Code of Ethics, and her ability to practice safely and competently was compromised. Additionally, the Hearing Tribunal determined Ms. Armstrong did not deal with her health issues even when admitting she used cocaine outside of work hours.

The second task of the Hearing Tribunal was to determine penalties required to resolve the complaint. The Hearing Tribunal recognizes these penalties must be fair, reasonable, and proportionate, and must ensure the public is protected from unsafe nursing practices.

The penalties ordered in this case were intended, in part, to demonstrate to the profession that this type of...
unprofessional conduct is not tolerated, and act as a deterrent to others. Therefore, the Hearing Tribunal ordered a summary of the decision be published. Ms. Armstrong received a reprimand, and her practice permit will remain suspended until she can satisfy CLPNA she is fit to practice by submitting to a comprehensive Substance Use Return-to-Duty Assessment by CannAmm Occupational Testing Services. She is to follow any treatment plan recommended by CannAmm, and submit to both a health and mental health assessment to verify she is fit to practice within the meaning of the CLPNA’s Interpretive Document entitled “Fitness to Practice and Incapacity”. If Ms. Armstrong submits the required documents and is granted permission to reinstate her permit, there will be a condition on her permit for a period of two years requiring she attend for random drug screening tests.

The Hearing Tribunal may consider costs when determining orders. When the Hearing Tribunal made a decision on penalty in this case, hearing costs were awarded to CLPNA. Ms. Armstrong will be responsible for any cost associated with the required assessments and/or treatment. Ms. Armstrong was ordered to pay a total of $40,000; the first installment is due on or before 30 days after receipt of the decision and the remainder over a period of 24 months. It is appreciated this is a costly penalty; however, the costs involved to conduct an investigation and disciplinary hearing are steep.

Further, during this hearing, there was evidence Ms. Armstrong has serious criminal charges against her; she was awaiting a trial with the criminal court system. If the Hearing Tribunal has reasonable and probable grounds to believe an LPN has committed a criminal offence, they can direct the Hearings Director to send a copy of the Hearing Tribunal’s written decision to the Minister of Justice and Attorney General in accordance with s. 80(2) of the Act. Given the nature of Ms. Armstrong’s current criminal proceedings, the Hearing Tribunal found it was not necessary to make a direction under section 80(2) of the Act.

It should be clearly understood LPNs have the obligation to cooperate in all aspects of the disciplinary process. At a disciplinary hearing, the investigated member is given the opportunity to present their argument. Therefore, the importance of the investigated member being present at the hearing is in their best interest to ensure procedural fairness. The onus is on CLPNA to establish a balance of probabilities the facts as alleged in the Statement of Allegations occurred and that it rises to the level of unprofessional conduct as defined in the HPA.
I’M NOT TELLING YOU IT’S GOING TO BE EASY,
I’M TELLING YOU IT’S GOING TO BE WORTH IT.

~Art Williams~

@CLPNA
Stroke Update!

EDMONTON, June 5, 2017 • CALGARY, June 6, 2017
0830 to 1600 hrs

BARB BANCROFT, RN, MSN, PNP

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

Who Should Attend?

- Medical, Surgical, ICU, and ER Nurses
- Acute & Long Term Care Nurses in Urban & Rural Settings
- Rehabilitation and Special Care Unit Nurses
- Rehabilitation Therapists with an Interest in Stroke

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

$169.** - $8.45 GST = $177.45 Early Rate (on or before April 24, 2017)
$179.** - $8.45 GST = $187.95 Middle Rate (on or before May 25, 2017)
$189.** - $9.45 GST = $198.45 Regular Rate (after May 23, 2017)

Interpretation of Lab Tests

CALGARY, September 19, 2017 • EDMONTON, September 25, 2017
0830 to 1600 hrs

BARB BANCROFT, RN, MSN, PNP

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

Who Should Attend?

- RNs, LPNs, NPs, RPNs in All Areas; Acute, Critical Care, Geriatric, Community Care and Primary Care
- Outpost Nurses, Occupational Health Nurses
- Nurse Practitioners, Educators, Managers

Barb Bancroft's approach to interpreting lab tests is a "must have" for nurses in all areas and nurses at all levels. You will leave the seminar with a number of practical tools that can be applied to your patients in the hospital, in the primary care facility, or in the ICU.

The WBC and differential is discussed as it relates to viral infections, bacterial infections, and parasitic infections. Iron deficiency anemias will be differentiated from B12 and folate acid anemias and you'll get some helpful hints for patients with lead as a cause of anemia. The lipid profile will be discussed, as will liver function tests and clinical correlations. Various drugs will be correlated with their effects on lab tests, including chemotherapy, antibiotics, statins, and other lipid-lowering agents.

$159.** + $7.95 GST = $166.95 Super Early Rate (on or before June 12, 2017)
$169.** - $8.45 GST = $177.45 Early Rate (on or before August 14, 2017)
$179.** - $8.95 GST = $187.95 Middle Rate (on or before September 11, 2017)
$189.** - $9.45 GST = $198.45 Regular Rate (after September 11, 2017)