Hot off the Press: Revised Competency Profile

Legal Issues: Infection Control & Equipment Errors
Interpretation of Lab Tests

With BARB BANCROFT, RN, MSN, PNP

Windows on an Inner World: the White Blood Cells
- Importance of WBCs: Mature and Immature Cells
- Functions of Each of the WBCs: Neutrophils- Segs and Bands; Monocytes; Basophils and Eosinophils; Lymphocytes
- Up, Down and All around - Which Changes in WBC’s indicate:
  - Acute inflammation, Infection and Neutropenia?
  - Chronic Inflammation, TB?
  - Allergies and Viral Infection?

Interpretation of the Serum Protein Electrophoresis
- Albumin and its Functions
- Globulins - Alpha One (HDL), Alpha Two, Beta (LDL and VLDL)
- What you Need to Know about the Gamma Globulins
- Drugs and the Lipoproteins
- The Clinical Conditions Associated with Variances of the Serum Proteins

The Role of the Red Blood Cells and the Correlation to your Patient’s Illness
- Maturation Process of the RBC; Normoblasts, Reticulocytes, Erythroblasts
- Essential Substances Necessary for RBC Production
- Role of Iron, Amino Acids, Folic Acid, B12, Pyridox, Kidneys & Good Genes

Determining RBC Function; CBC, MCV, MCH, Retic Count - What Changes in Values Mean
- Common Clinical Conditions Associated with Variances in RBC Function
- The Anemias - Iron Deficiency, Megaloblastic Anemia, Folic Acid Deficiency, Sickle Cell Anemia; Drug Induced Anemias

The Body’s Enzymes: What You Must Know To Know About:
- AST, ALT, CK, Amylase, Lipase; When and Why They Elevate
- What do the Elevations Mean for Liver Function, Cardiac Function, Muscle Integrity and Pancreatic Function?

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

Insulin Update!

With JILL MILLIKEN, RN

Insulin Foundations
- Research & Guidelines
- Insulin Pharmacokinetics and Pharmacodynamics
- Insulin Types & Regimens
- Variables Affecting Blood Glucose

Insulin Adjustment
- Basic Principles of Insulin Adjustment
- Advanced Titration
- Assessment and Efficacy

Insulin Delivery Devices
- Overview of All Currently Available Insulin Delivery Devices.
- Teaching and Assisting Injection Site Technique
- The “Psychology” of Preparing to Inject Insulin

Practicalities of initiating insulin
- Essential Teaching for Insulin Use
  1. Hypoglycemia Awareness, Prevention, Cause, and Treatment
  2. Timing Medications. Effects of Meals and Activities

Blood Glucose - Learning the Ups and Downs
- Insulin Sensitivity Factors
- Testing Blood Glucose When, Who, and How... (much)?
- Making Sense of Glucose Patterns and Trends
- Continuous Glucose Monitoring

In the Community
- Can we Strive for Improved Glucose Control in the LTC Setting?
- Practical Aspects of Managing Diabetes in the Elderly
- Diabetes Case Management

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

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 this seminar with a number of practical pearls 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 folic 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.

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

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’s American Nurses Practitioners, and more.

Conference Fees:
- $169.45 + $8.45 GST = $177.45 Early Rate (on or before July 27, 2015)
- $179.45 + $8.95 GST = $188.95 Middle Rate (on or before August 24, 2015)
- $189.45 + $9.45 GST = $198.45 Regular Rate (after August 24, 2015)

This one day workshop is designed to enhance the knowledge of nurses working with insulin in any setting. An in-depth understanding of the products, coupled with a philosophy of “insulin intuition” will enhance the participant’s confidence in working with insulin. A detailed explanation of hypoglycemia and how it manifests in various situations will provide overall improvement in your client’s diabetes management. With insulin use on the rise, so is the need for the health professional to provide timely and effective intervention and counselling to their insulin requiring client. This workshop will provide the participant with the tools needed to assist their client in maintaining or restoring optimal glucose control using insulin.

WHO SHOULD ATTEND?
- RNs, LPNs, 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

Jill Milliken RN (CDE 1998-2008) is a diabetes consultant in private practice who has dedicated her career to improving the lives of people with diabetes through awareness, education and advocacy. Jill has developed educational tools and resources to assist people using insulin and their care providers for over 15 yrs. She has presented over 100 conferences and workshops across Canada and abroad and participated in the design and implementation of several international research studies. Jill was a reviewer of the book “Pumping Insulin” and is acknowledged for her contribution to the book “Diabetes for Dummies” for Canadians (2nd edition). She has co-authored several research studies in the area of exercise and Type 1 diabetes. Her awards include two Bayer awards through the DES section of the CDA, the CONNY award through Loyalist College, the Premiers’ award (nominee) and the Queens’ Jubilee Medal for advocacy in Type 1 diabetes in Canada by the Government General. Provincial oversee of insulin pumps in Ontario is a direct result of advocacy work pioneered by Jill Milliken.

Conference Fees:
- $169.45 + $8.45 GST = $177.45 Early Rate (on or before August 24, 2015)
- $179.45 + $8.95 GST = $188.95 Middle Rate (on or before September 21, 2015)
- $189.45 + $9.45 GST = $198.45 Regular Rate (after September 21, 2015)
From the College

Conversations Matter
Advance Care Planning

RESEARCH
Rural & Remote Nursing

COVER STORY
Zero to a Hundred
The team at Grande Prairie’s QEII Hospital embraces change to meet the challenges of an exceptionally busy Emergency Department.

Work Smart with Client Information Technology

Mental Illness Deserves Aggressive Treatment

CLPNA AGM & Conference Recap

LPN Awards of Excellence

Legal Issues in Nursing
Infection Control & Equipment Errors

RESEARCH
Researching Ebola

The Operations Room
News for CLPNA members
As a province, Alberta needs to capitalize on our investment in educating nurses, and make every effort to retain this valuable resource...
CAREER OPPORTUNITIES
Licensed Practical Nurses

For more information email careers@albertahealthservices.ca

Discover a culture of care based on collaboration and values.
We are currently seeking LPN's with Dialysis Specialty Education for our Nephrology Programs across the province.

Alberta Health Services (AHS) provides the highest quality patient care by placing the needs of our patients, families and communities first. With a strong commitment to work/life balance, competitive benefits and a collaborative work environment, we know we have a career that will fit you.

New grads — nursing in rural communities could qualify you for up to $20,000 in Canada Student Loan Forgiveness.

what’s your reason?

www.albertahealthservices.ca/careers

For more information email careers@albertahealthservices.ca
Alberta Health Service’s Advance Care Planning/Goals of Care Designation provincial policy and procedure came into effect across Alberta last April. It was developed based on prior zone-based policies, clinical experience and broad consultation with clinicians and other experts. Patient and family representatives were also consulted, providing their feedback and helping shape the policy and tools.

What is Advance Care Planning?
Advance Care Planning is a way to help you think about, talk about and document wishes for health care. It’s a process that can help you make healthcare decisions now and for the future.

What are the benefits?
If there is a time when you aren’t able to speak for yourself, it’s important that your loved ones and your healthcare team understand your wishes for healthcare. None of us know what tomorrow might bring, or know how our health will be in the future. Planning today makes sure that your wishes are known, no matter what the future holds.

Advance care planning may bring comfort and peace of mind to you, your family, and those who may have to make healthcare decisions on your behalf.

Who is it for?
Absolutely everyone, no matter what their age is. We can all benefit from advance care planning. If there’s an unexpected event or change in your health and you aren’t able to make decisions about your healthcare, planning ahead makes sure that your wishes are known.

When is a good time to start?
Now. It is important to start talking about your wishes now, before you have a health crisis.

Conversations Matter
Decisions about Goals of Care Designations usually come up through conversations between you, your Alternate Decision Maker or loved ones, and your healthcare team. Although advance care planning conversations don’t always result in determining goal of care designation, they make sure your voice is heard when you cannot speak for yourself.

A Goals of Care Designation is a medical order used to describe and communicate the general aim or focus of care including the preferred location of that care. A person’s Goals of Care Designation is usually determined by matching their values, beliefs and care wishes with expert clinical advice regarding appropriate medical care that can serve those preferences.

As part of Advance Care Planning, there are three approaches to care:

Medical Care
Focuses on medical tests and interventions to cure or manage a person’s illness, but does not use resuscitative or life support measures.

Comfort Care
Focuses on providing comfort for people with life-limiting illness when medical treatment is no longer an option.

Resuscitative Care
Focuses on prolonging or preserving life using medical or surgical interventions, including, if needed, resuscitation and intensive care.

Within these three main approaches to care there are subcategories called Goals of Care Designations, which are used to further define and communicate an individual’s Goals of Care to healthcare providers.

Your Goals of Care Designation, along with a copy of your Personal Directive and any other advance care planning documents is kept in a plastic Green Sleeve. Keep your Green Sleeve on or near your fridge, as that is where healthcare providers such as Emergency Medical Services will look for it if they come to your home. Any time you go to the hospital or to any healthcare provider, take your Green Sleeve with you, and be sure to take it with you when you leave. If you don’t have a Green Sleeve, ask your healthcare provider how to get one.

For more information on Advance Care Planning, visit: www.conversationsmatter.ca
Rural and Remote Nursing Practice: Improving Nursing Service and Access to Care

Research from the School of Nursing at the University of Northern British Columbia

CLPNA’s rural members were asked to take part in a survey aimed specifically at them to help improve nursing services and access to care in their own backyards. *Nursing Practice in Rural and Remote Canada II* is a study from the School of Nursing at the University of Northern British Columbia.

The 2014 survey included all four types of nurses, and provides a better understanding of the complexity of rural/remote nursing practice, especially with respect to primary healthcare. It addresses significant gaps in our understanding about the personal, professional and community factors involved in recruiting and retaining LPNs, RNs, RPNs, and NPs in rural and remote communities.

A decade after the initiation of the research, it is evident that knowledge gaps are emerging. Health human resource planning and the accessibility, quality and sustainability of rural healthcare continue to be of concern nationally and provincially. Following are the key messages and recommendations from this valuable study.

**Key messages:**

1. The terms rural and remote continue to lack accepted and universal definitions.
2. There is a lack of published literature about the contributions of all types of nursing personnel to rural and remote health.
3. The strategies to address issues relating to rural and remote health are focused on a deficit rather than a strength-based model.
4. Recruitment and retention of healthcare professionals including nurses continues to be a challenge in rural and remote settings.
5. There has been a rise in financial supports such as loan forgiveness programs for individual nurses who wish to work in rural and remote settings.
6. Provision of care for Aboriginal peoples continues to need investment to ensure that there are sufficient numbers of Aboriginal nurses and that non-Aboriginal nurses care for this population within a cultural safety framework.
7. Evaluation of advanced practice in rural and remote settings in Canada is limited.

**Based upon our documentary analysis, we propose the following recommendations:**

1. Identify initiatives used by all nursing personnel to prepare and support registered nurses, registered psychiatric nurses, practical nurses, and nurse practitioners to work in rural and remote communities.
2. Initiate forums including webinars with nurse educators and administrators to discuss lessons learned related to nursing education rural-focused initiatives.
3. Identify the number of Aboriginal nursing students and practicing nurses planning to work or working in rural and remote settings on a yearly basis to help determine the success of preparing and retaining this specific group of nurses.
4. Track the use of scholarships, bursaries and loan forgiveness programs on recruitment and retention of nurses in rural and remote locations.
5. Initiate an evaluation of nursing practice in rural and remote settings that will focus on outcomes such as health status and patient satisfaction.
6. Initiate an evaluation of advanced practice in rural and remote settings that focuses on outcomes such as health status and patient satisfaction.

Find out more about the study, researchers and results at http://ruralnursing.unbc.ca/wordpress/.
by Mark Kozub

ZERO TO A HUNDRED

Photography by Owen Murray
In the Emergency Department of the Queen Elizabeth II Regional Hospital in Grande Prairie, LPNs are part of the team – and they get the adventure of a lifetime.

The doors open. A concerned young mother with three early school-age children enters, clutching the hand of a six-year-old girl with glassy eyes and a nasty cough. Just behind them, paramedics are transporting an elderly woman on a stretcher. Not far from where I’m sitting, I see a disheveled man in his thirties, notably intoxicated, a middle-aged woman hunched over with abdominal pains, and a 60-something patient clutching his chest.

And now the paramedics have just wheeled in a young man with particularly vicious and messy gunshot wounds. Trailng behind is another young man, appearing to be at the dangerous apex of drug-induced psychosis.

Welcome to a typical day in the Emergency & Trauma Department (ED) at the Queen Elizabeth II Regional Hospital (QEII RH). “It’s an adrenaline rush,” says Lisa McKinnon, who’s spent 12 years as an LPN and the past three here in the ED. “You could be having a nice, calm day where everyone’s getting seen in a timely manner and then, BANG, you’ve got a cardiac arrest and you’ll get three, maybe four nurses tending to it and then BANG, you get another trauma. You go from zero to a hundred and back down again.”
To say the staff here is busy would be a grotesque understatement. “We are the trauma capital per capita of Alberta,” says Shelley Scorgie, RN, Unit Manager of the ED at the QEII Regional Hospital since 2006. “We currently see over 60,000 visits a year, which is anywhere from 150 to 200 visits a day, and our highest acuity patients have markedly increased since September.” She sighs. “We are not a quiet place.”

The QEII RH was opened in 1984, when the population of Grande Prairie was 25,000. Now the city boasts a population of 75,000 and that doesn’t include those who come from the sprawling area this regional hospital serves, including communities from northwestern Alberta and northeastern British Columbia, such as High Level, Dawson Creek, Grande Cache, Fort Nelson and Fort St. John.

In the north, you’re forced to be innovative. In order to serve the ever-growing onslaught of healthcare demands of a growing and dynamic population, Shelley, her staff and a leadership group had to think outside of the box. In 2007, they created a Fast Track unit staffed by one LPN and one physician. “It sees primarily our non-urgent visits, while in the main side we have space for 15 stretchers, seven treatment chairs and a results waiting area designed to address the urgent and emergent patients,” explains Shelley. “Because that main space has so many demands on it, it’s generally full. That forces us to put some of our intermediate patients through the Fast Track area as well, rather than keeping them in the waiting room.”

The second strategy they brought to the ED was the concept of Urgent Treatment Chairs, used to treat higher acuity ambulatory patients. It is staffed with a combined LPN and RN nursing team to ensure full care for all patients treated in the area.

The Changing LPN Role

The transition from LPNs working to their full-scope role in the QEII RH ED has been well planned and supported. “If there was a role in the department that we were developing, we knew we needed to look at what skills are required to do that job and find the best person to do the job,” says Shelley. That has meant finding LPNs willing to stretch and pioneer this new role.

Changing staffing and culture isn’t easy. The existing teams here had to adapt to the new processes and staff mix. Thankfully, Lisa McKinnon and Joyce Rossiter are exemplary LPNs who have more than embraced the challenges. “Now I’m more driven for education that’s based on my daily responsibilities,” says Lisa.
During the change process, Lisa and Joyce felt the support of leadership. “I had reached a point where I was terrified of burning out and I went to Shelley about it,” says Joyce, a 26-year nursing veteran and an LPN with the ED for eight years now. “Shelley said, ‘We’ll look after you.’ And she has never failed to support me.”

Award-winning Teamwork

Essential to success in the QEII RH ED is teamwork. Here, on any given day, you will see unit clerks, ED attendants, LPNs, paramedics, RNs, physicians and other health disciplines working together as one incredibly well-oiled machine. This particularly high level of positive integration amongst healthcare players isn’t common enough in hospitals. “Healthcare providers come in all designations, whether it be an LPN, a paramedic, an RN, a unit clerk, ED attendants or other supporting disciplines,” says Shelley. “I can’t say it enough: I have fantastic staff and it’s changed the culture of the department.”

The traditional role of the LPNs in the ED was changed to bring it in line with full scope of practice when the department introduced its Fast Track area. As this area sees less acute emergency patients, LPNs are the perfect fit to provide care for them independently. “There was nothing in that role that an LPN couldn’t do,” says Shelley, adding that wherever necessary the LPNs were provided with required additional education such as giving immunizations.

Paramedics like Marilyn Ringness, with 23 years of experience to her credit, are also used to their full capacity. “Marilyn is capable of looking after monitored patients because that’s within her scope of practice, so she works side by side with the RNs,” says Shelley.

“We are heading into a time when there aren’t enough health professionals so we need to look at innovative ways of staffing our units. Here, the medics and LPNs are part of the team,” she continues. “I don’t see those hierarchies anymore. We’ve changed the culture.”

So impressive is this culture change that in May of this year, Shelley was given the Interprofessional Development Award (Non-LPN) at the LPN Awards of Excellence, held during the annual CLPNA conference. “When I heard about this award, it made me laugh. ‘I got nominated for WHAT?’” she says, indeed with a laugh. “It just feels like we come to work every day and we do the best we can. I don’t take credit for this award. It is the team that deserves the recognition. It is the core team that has changed the culture here.”

In 2011, as part of a provincial incentive program to improve patient flow – referred to as the AHS Lean Quality Improvement Initiative – the >
QEII RH assembled a core, multidisciplinary team. It included Shelley, a leader contracted by AHS, nursing, lab services, diagnostic imaging, patient registration, IT staff who worked directly with patient care flow, a paramedic (Marilyn) and Dr. Tom Peebles, who has been Chief of Emergency at the QEII RH since 2006.

The core team consisted of the right players. The intent was right too. Everyone was sharing their views openly and honestly – and really listening.

“That was one of the best years of my career, being on the core team,” says Marilyn. “In an organization of this size, it’s a big boat and it turns slowly. But in that year we were a speed boat.”

The Fast Track at the QEII RH ED was recognized by the AHS Lean Consultants as being the most efficient Fast Track unit they have evaluated in all of North America.

“Because of Joyce’s key role in Fast Track, she was excited for this news. “When I heard that, it just boosted my confidence in what I was doing,” says Joyce. “That validated who I am as a nurse.”

The Importance of Physician Support

Also essential to the success of the core team was physician support and leadership. “Dr. Peebles was very engaged in our core team and our Lean processes and continues to advocate for the department,” says Shelley. “You need a champion. What we know of the physician group is if you don’t have them onboard, things don’t fly well.”

Dr. Peebles first started working in the department in 2004. Within less than two years, he was appointed Chief of Emergency. “It was not

How They Got Buy-In from the Docs

There are 13 physicians in the Emergency & Trauma Department of the QE II Regional Hospital in Grande Prairie. Getting buy-in from all of them – especially in a matter of change – is exceptionally difficult, according to Dr. Tom Peebles, Chief of Emergency. “We’re all individual, autonomous practitioners for the most part and we have a significant age demographic difference and come from different multi-cultural groups. Plus,” he says with a laugh, “doctors hate change.”

Getting physicians on board with the AHS Lean Quality Improvement Initiative was vital. Practically any change initiative can either fly or fall based on buy-in of the doctors (or lack thereof).

In order to convince his fellow physicians that the Lean process was well worth supporting, Dr. Peebles had to appeal to their logic. “The physician is the one who has the most patients... We have to see every patient who comes in the door. And we are the most limited resource,” says Dr. Peebles. “So if I could go to a physician and say, ‘Look, we’re going to do these changes and they’re going to suck for a while, but in the end it’s going to improve the patient flow so you’re going to be able to see more patients instead of them getting frustrated and not staying in the waiting room,’ it wasn’t hard to get the buy-in.”
“It still isn’t.”

The processes put in place by the core team were informed by a vision: to get the right people with the right skill set in the right space. The team started looking at other health professionals: LPNs, RNs and paramedics to see how their department could be staffed in a way that’s both budget conscious and right for the patients.

“We had to look at how to triage our patients so they could get into the right treatment space so that we weren’t blocking critical space that, frankly, we didn’t have,” Dr. Peebles explains. “It made a huge difference to patient care. Once we were able to demonstrate that with statistics, the naysayers got buy-in pretty quick.”

The most impressive change was in the decrease in the percentage of patients who leave before even seeing a physician. They usually leave due to long wait times. These patients represent the highest risk for the department, as they may indeed be sick and require treatment they don’t receive. If a patient can see a doctor sooner, they’re far more likely to follow through with their treatment plans.

Efficiencies within the ER have seen the number of these patients drop from 16 percent to 4 percent, with an average of 6 and 7 percent currently.

“If it weren’t for the processes we have in place, we’d really be struggling right now,” Dr. Peebles admits. “We’ve created a culture of flow now, which is awesome. We have flow processes that allow us to always keep things moving. Everybody that comes in, even the new recruits, they learn it, they know it and they adapt it into their daily work life.”

Their “daily work life” might entail seeing to the needs of a fretting mother with a child who has a horrible cough, caring for the victims of a motor vehicle collision, managing anxious family members, or saving someone from the brink of death.

Here, it’s zero to a hundred and back down again, but at any speed, the patients served are in competent and capable hands.
As a group, you can save more on your home and auto insurance

Get a quote today and you could win $30,000 towards an eco-friendly trip of a lifetime! Learn more at thepersonal.com/mywinningquote.

No purchase necessary. The contest ends on December 31, 2015. The draw will take place on January 15, 2016. Total of one (1) prize to choose between a travel voucher worth $30,000 (CAN) exchangeable for an eco-friendly trip from a travel agency chosen by The Personal, or a cheque for $30,000 (CAN). Contest rules and details available at thepersonal.com/mywinningquote.

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

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

TheAlbertWay.com

A message from

The Alberta Way.com
Technology is rapidly becoming the model for health information services. Most Canadian healthcare facilities and agencies today incorporate some type of record-keeping technology, including electronic documentation. The Canadian Nurses Protective Society (CNPS) (2014) reported from a Health Canada Information Way study that approximately 75% of nurses use information technology in practice and 50% use a combination of paper-based and electronic documentation. Electronic systems consist of complex, interconnected software applications that process and transport client records and other health information to and from the healthcare team. This data guides the team in providing safe, client-centred care while at the same time identifying client needs. The intersection of client information technology with electronic health records, documentation and mobile applications is discussed here, along with the responsibilities of prudent care providers.

Electronic Health Record

As the general population becomes more computer literate and with increased government support, the electronic health record (EHR) is rapidly becoming the standard. The client’s EHR contains the same components as a paper-based one and requires the same principles of accurate documentation. Electronic systems automatically record a care provider’s name, along with the entry date and time. A care provider may use drop-down menus to enter assessment data or significant client notes. Drop-down menus may be interpreted differently by care providers and may result in client safety issues (CNPS, 2014). Errors may also occur when cutting and pasting client notes (Kelley, Brandon & Docherty, 2011). From a legal standpoint, communication between healthcare providers may be inadequately documented in electronic records (CNPS, 2014). Some researchers even suggest that electronic documentation creates distance between care providers and decreases time spent in caring for clients (Laitinen, Kaunonen & Astedt-Kurki, 2010). Research has shown mixed results when comparing paper-based systems to electronic ones (Kutney-Lee & Kelly, 2011).

Electronic Capabilities

Electronic documentation has many obvious advantages. It generally speeds up the time required to document and improves accuracy and legibility, if a care provider knows how to use the system correctly. Electronic systems reduce reliance on memory as client information may be completed in real time or immediately after. Electronic documentation systems can reduce redundancies, as recopying information...
has been known to increase errors. Most systems assist in the standardization of care by using the nursing process and providing specific pathways to enter client events. There may be mandatory reporting fields so significant information is not omitted. Some systems require a brief narrative; others a full narrative on client particulars (CNPS, 2014).

*You should remember that once you have access to various types of client information, the computer may guide you to a decision, but it will not make a clinical decision for you.*

**Issues and Challenges**

Although client information technology is here to stay, it poses several concerns and challenges. Electronic or computer-based systems are expensive to design, implement and maintain. Employing facilities or agencies have specialized departments dedicated to the maintenance of technology and electronic records. These systems demand increased and costly staff training.

A care provider must have keyboarding skills and frequently the ability to enter progress notes using a narrative format. A healthcare provider who relies solely on electronic documentation may interact less with colleagues and reduce collaboration with other providers whose verbal input could ensure quality client care. Electronic systems may malfunction and routine maintenance may prevent the access of timely client information. There must be a back-up system, usually hand-written, to record client information. There is risk of hackers (individuals who gain unauthorized access to computer databases) who violate client confidentiality or disrupt systems by deleting or changing client information.

Protecting client confidentiality is a major issue for healthcare providers who document electronically. If precautions are not taken, a client’s record can remain open for others to view until the care provider logs off manually or a time-out feature closes the record. Your password should not be known or used by anyone else as it is your electronic signature. Remember to follow your employing facility or agency’s policies and procedures if this should occur. Usually a supervisor or the information technology department must be notified immediately.

**Mobile Devices**

Increasing numbers of care providers use smart phones and other mobile devices to communicate and share client information with team members or with clients using text messaging or e-mail (CNPS, 2013). If you use mobile devices, you must be clear on personal and professional expectations and consequences.

There is much controversy whether mobile devices with applications (apps) should be permitted while care providers are on active duty. Depending upon the employer and healthcare environment, mobile devices with apps may assist in timely and safe care. Some employers encourage care providers to use their own personal devices, while others have shared mobile ones. For example, you may look up medication dosages and side effects, or locate employer policies and procedures easily on a mobile device. Some care providers take photographs of wounds or skin conditions and send these for assessments.

Mobile devices can succumb to breaches of client confidentiality. Encryption (an electronic security process that prevents unauthorized use) prevents unapproved individuals access to confidential information. Mobile devices are targets for thieves, which can result in huge breaches of client confidentiality. Infection control becomes an issue when mobile devices are shared in a workplace setting. Mobile devices can also become time wasters and distract from safe and quality client care.

Technology in healthcare is here to stay and its use is expanding exponentially. It has great merit for the enhancement of safe and quality client care. A prudent care provider keeps current of client information technology developments and is well versed on its capabilities and limitations. You must know your personal and professional responsibilities when using information technology in your nursing practice, as it can greatly enhance or detract from client-centred care.

References are available on request.
There are few things in life scarier than being told your child has cancer. When parents are sitting in a doctor’s office trying to absorb their new reality, the thing that must cross their minds is that they want to fight the cancer with everything they can. What if their doctor suggested that they begin with the cheapest, least effective, older chemotherapies, and try something stronger or more expensive in 6 months if their child wasn’t showing improvement? I suspect at the very least those parents would find another doctor as quickly as possible. An oncologist treating a patient in such a manner without explaining to the child’s parents that there were better treatments would be facing a serious malpractice lawsuit, and possibly even charges for reckless endangerment.

If, however, your child has just been diagnosed with schizophrenia, that is often exactly what happens. Instead of aggressively treating the illness with the best medications from the beginning, those with mental illnesses are often taken through a string of older medicines and lowest doses for months or even years. This is in part because there is no blood test for things like schizophrenia or bipolar disorder, and sometimes the diagnosis is based on which drug the patient responds to best. Psychiatric medications, just like cancer medications, have a host of very serious side effects, and therefore doctors can be hesitant to prescribe them. However, research and experience has shown us that just as cancer is best beaten when diagnosis is made early and treated aggressively, the prognosis for those with serious mental illnesses is also dramatically better when it is diagnosed early and treated aggressively. The longer someone with schizophrenia goes without treatment, or repeatedly stops and starts treatment, the more damage is done to their brain, affecting their cognitive functioning and long-term prognosis.

I have no doubt that my stability is primarily due to me staying on my medication. If I’d had access 22 years ago when I was first diagnosed to the medication I currently take, I can only imagine what I might have been able to accomplish. Unfortunately, sustained release neuroleptics were not in existence in 1992. With them, I might have been able to continue my academic career. I lost that career, but this medication has given me my life back.

Even when a psychiatrist wants to try a patient on the medication I take, they can’t just prescribe it. They have to fill out special forms for the province saying that the patient hasn’t responded to the less expensive medications. Doctors shouldn’t have to beg for the best for their patients. I am extremely grateful that these long-acting injectables are on the formulary, with some having been added recently. I remember when they weren’t, and the terror I faced when there was discussion about removing my medication from the formulary.

When a teenager or young adult becomes ill with schizophrenia, and it takes months or years for them to receive a diagnosis and find a medication that makes their symptoms manageable, they lose that time from their most productive years. Anything that can put someone back into their lives with the least amount of disruption isn’t just a win for them, it is a win for their family, their friends, and all of our society. Any barriers that remain, bureaucratic or financial, should be eliminated. We should support those doctors, researchers and companies who are working on even better medications. I owe my life to them. Forty percent of people with schizophrenia attempt suicide within the first 10 years after diagnosis. Ten to fifteen percent are successful. This is such a horrific illness with so much stigma and hopelessness attached to it that it can seem impossible to live with it, but it can be lived with, and I am a testament to that.

When cancer is diagnosed early and treated aggressively, a life can be saved. When schizophrenia is diagnosed early and treated aggressively, a life and a mind can be saved. I not only live with schizophrenia, I thrive in spite of it. I want everyone else suffering with mental illness to have the same second chance I have been given.

Dr. Austin Mardon was a respected young scientist when he developed schizophrenia. He has dedicated the rest of his life to advocacy for the mentally ill, and was awarded the Order of Canada in 2007 for his work. The story of his incredible life can be discovered in his book, Tea With the Mad Hatter.
mid laughter and tears, “getting real” was accomplished at the 2015 CLPNA Annual General Meeting & Conference. Knowledgeable speakers and expert storytellers led attendees on a journey of self and patient-discovery over the three-day educational event.

Rounding out the affair were healthcare exhibits, bubbly receptions, the very popular silent auction, and a sparkling awards ceremony, all hosted by the College of Licensed Practical Nurses of Alberta. Over 350 licensed practical nurses, managers and affiliated health professionals participated from April 30 to May 1.

The CLPNA’s 30th anniversary will be celebrated at the next AGM & Conference on April 27-29, 2016 at the Delta Edmonton South in Edmonton. More at www.CLPNAconference.com.


“If a patient has lost their faith in humanity, lend them yours…”
- Elizabeth Anderson
A tremendous group of nurses were showered with applause by their peers at the annual CLPNA Awards Dinner on April 30. All of the nominees and the winners of this year’s LPN Awards of Excellence are truly something special, and represent all the diversity and dedication of their professions. The College of Licensed Practical Nurses of Alberta (CLPNA) is proud to honour them.

LPN winners received a commemorative crystal award and $1000. Award recipients are selected by a committee of the Fredrickson-McGregor Education Foundation for LPNs on behalf of CLPNA.

**PAT FREDRICKSON EXCELLENCE IN LEADERSHIP AWARD**

Honouring LPNs who consistently demonstrate excellence in leadership, advocacy, communication and a passion for the profession.

**Winner: John McCullough, LPN**

John McCullough’s exceptional skills in open communication and change management have moved Devonshire Care Centre closer towards their goal of exceptional person-centered care.

John leads by example. He takes time to get to know each of the 71 residents, their life stories, likes and dislikes, and even implemented an admission summary so that staff is also aware of residents’ personal preferences. Role modeling gentleness, he supports families and residents in their struggle with loss of abilities or cognition. And he continuously works with families and residents to set priorities of care and care planning.
Devonshire Care Centre noted at their recent Leader’s Forum what a strength and asset John is to the corporation. His active involvement and leadership on nearly a dozen committees, both at his own facility and regionally, have positively influenced the clinical priorities of the entire organization.

**RITA MCGREGOR EXCELLENCE IN NURSING EDUCATION AWARD**

Honouring an LPN nursing educator or a designated preceptor in a clinical setting who consistently demonstrates excellence in providing education in the workplace.

**Winner: Darcy Shenfield, LPN**

Darcy Shenfield’s leadership and hard work brought her to the role of Educator for the West-Central Region of the Good Samaritan Society’s Education Team. Darcy has a pivotal role in the development and implementation of education services throughout five different sites. Her innovative, creative and positive learning environment is highly anticipated by her students and staff, resulting in receiving the Innovation and Creativity Award (2003), and the Teamwork Award twice (2006 & 2013) from the organization.

Darcy’s contacts with external groups have been of particular benefit. She is very closely aligned with the Alzheimer’s Society and was one of the first Educators to teach the Supportive Pathways course. Additionally, she has worked with Norquest as a tutor both through the GSS workplace program, and instructs in a casual position since 2004. She also chairs a not-for-profit agency, Parkland Turning Points, that helps individuals and families experiencing domestic violence.

**LAURA CRAWFORD EXCELLENCE IN NURSING PRACTICE AWARD**

Honouring LPNs who display exemplary nursing knowledge, promote an atmosphere of teamwork, mentor team members, and show pride in the profession.

**Winner: Stacey Hall, LPN**

On a daily basis, Stacey Hall, LPN, meaningfully impacts the lives of patients and caregivers, forever changing everyone she comes in contact with for the better.

After working on an extremely busy unit at the Stollery Children’s Hospital, Stacey joined the Pediatric Neurosurgery team as a research assistant where she was instrumental in founding the Alberta Pediatric Neurosurgery Database (APND). To do so, Stacey relied on her extensive medical/surgical knowledge and worked tirelessly with the entire healthcare team to create better and more efficient care for patients.

This amazing contribution is merely the tip of the iceberg. Stacey is the assistant director of community initiatives for the Neurosurgery Kids Fund (NKF), supporting children with brain or spinal cord injury. She volunteers hundreds of hours to co-direct Camp Everest, a sleepaway camp, and Lil’ Everest, a family day camp. Stacey initiated the “Cup of Comfort” program that, last year alone, provided over 10,000 cups of coffee to caregivers too stressed to leave their child’s bedside. And if that was not enough, she leads the bereavement program.

**INTERPROFESSIONAL DEVELOPMENT AWARD**

Recognizing non-LPN health care leaders who are instrumental in building quality practice environments.

**Winner: Shelley Scorgie, RN**

Through her exceptional leadership ability and support of all practitioners, Shelley Scorgie, RN, has created a multidisciplinary team free of traditional hierarchical constraints.

As the Manager of the Queen Elizabeth II Hospital Emergency Department in Grande Prairie since 2006, there are many examples of Shelley’s inclusion of LPNs. She developed two highly successful ER patient flow strategies relying on the full scope of practice for LPNs. The first strategy was a Fast Track Unit staffed by one LPN and one physician. This made huge improvements to patient wait times and was recognized by the AHS Lean Consultants as the most efficient Fast Track Unit in all of North America. The second strategy Shelley supported was the concept of Urgent Treatment Chairs to treat higher acuity ambulatory patients staffed with a combined LPN and RN nursing team.

As her award nomination states, “The improvements in patient care through the implementation of novel patient care strategies...were the direct result of Shelley Scorgie and her leadership”.

A complete list of this year’s Award Nominees is available at [http://foundation.clpna.com/awards](http://foundation.clpna.com/awards).
In this final article on nursing negligence lawsuits, we will discuss two issues: infection control and equipment errors. First, infections. Most patients enter the healthcare system hoping to leave healthier than they arrived. But in some cases, patients acquire infections known as healthcare-associated infections or HAIs. An HAI is defined as an infection acquired in a hospital, long-term care facility, outpatient clinic or home care setting that was not present at the time the patient entered for care.

The 2013 Canadian Report on the State of Public Health in Canada identified that more than 20,000 patients acquire HAIs every year. More than 8000 die. The death rates from Clostridium difficile have more than tripled since 1997. Since 1995, methicillin-resistant Staphylococcus aureus (MRSA) infections have increased more than 1000 percent. Patients at the greatest risk are those that are very young, very old, have weakened immune systems or live with one or more chronic illnesses. Highly concerning for all of us is that up to 50 percent of bacteria causing these infections are resistant to one or more antibiotics. Also concerning is that 80 percent of the infections are spread by healthcare workers, patients and visitors.

Lawsuits involving infections in individual patients can be challenging because so many people may be involved in the care, making it difficult to determine exactly how or when the infection was transmitted. On the other hand, lawsuits involving large numbers of patients who all develop the same infection, known as class action lawsuits, have been more successful. You may recall a case involving Canadian Blood Services several years ago related to the spread of HIV and hepatitis C. More recently there have been lawsuits against hospitals and long-term care facilities for outbreaks of Clostridium difficile and tuberculosis. These lawsuits can reflect badly on healthcare facilities and the nurses who work in them due to the fact that infection rates are considered a patient safety measure. Let’s take a look at a lawsuit involving a postoperative infection where the nurses were sued: not for causing the infection, but for their lack of response to the signs and symptoms of infection.

CASE STUDY

32-year-old Steve fell while snowboarding. An X-ray revealed a compound fracture of the tibia and fibula of his left leg. Surgery was performed and the leg was stabilized with a ‘back slab’ cast. Steve arrived on the surgical unit at 5:15 p.m. where he was cared for by LPN Christine. Nurse Christine described Steve’s left foot as swollen, warm and bruised. Pedal pulses were strong. At 6:20 p.m. Steve was awake, alert, and oriented. He was given IM Demerol for pain.

At 7:30 p.m., (nursing change of shift) LPN Janice took over Steve’s care, describing his toes as pale and cool to touch. By 9 p.m., Steve was noted to be very uncomfortable, refused to wiggle his toes and stated the pain in his left leg was increasing. His temperature was elevated to 38.5 degrees. Nurse Janice gave Steve two Tylenol #3 tablets.

Overnight, Steve was unable to sleep due to pain. His left leg was noted to have slight redness and swelling around the incision and his toes were cool. He was given Tylenol #3 tablets and IM Demerol. His temperature remained elevated.

At 8:00 a.m., Nurse Christine was back on shift. Steve was extremely uncomfortable and described his pain level at an 8 on a scale of 1-10 in spite of a recent injection of Demerol. His leg was warm to the touch. His toes were cool and pale. Temperature was 38.6 Degrees.

At 8:45 a.m., Steve dangled his legs over the bedside but refused to try crutches. The lab reported an elevated white blood cell count of 14.3 mcL.
At 12:00 noon, Steve was irritable and told Nurse Christine that his leg was on fire. Nurse Christine assured him that pain was normal after surgery and administered two tablets of Tylenol #3.

At 1:30 p.m., the surgeon arrived on the unit. He did not examine Steve because he was (finally) sleeping. The surgeon asked Nurse Christine how Steve was doing. She reported that although he had some episodes of elevated temperature and pain, he was anxious to go home. The surgeon discharged Steve and provided a prescription for Tylenol #3.

At 3:20 p.m., Nurse Christine documented that Steve had left the hospital with his family. Vital signs were not checked before discharge.

At 11:20 p.m., eight hours after discharge, Steve’s left leg was hot, red, and very swollen. Steve was crying with pain. His wife called an ambulance. When Steve arrived in the ER, he was pale and unresponsive. Temperature was 39.1 degrees, respirations were 42, BP was 72/48 and pulse was 132. Steve was diagnosed with sepsis and taken back to the OR where infected tissue was removed from his left leg. He was admitted to the ICU for 13 days. Recovery was long and difficult and Steve required four additional surgeries. He was left with significant weakness, deformity, and scarring of his left leg and continued to walk with a cane fifteen months after the accident.

Steve wondered if his injuries would have been less serious if the infection had been treated earlier. He was concerned that the nurses did not take his symptoms seriously and was unhappy that he had not seen the surgeon before discharge. He was also very concerned that he would never return to his job as a carpenter. Eighteen months after surgery, Steve filed a lawsuit claiming that Nurses Christine and Janice had failed to meet the standard of care by not recognizing and reporting obvious signs of infection.

Do you think that the nurses met the standard of care?

As nurses, we have a significant role to play in infection control. Washing hands, cleaning the environment and sterilizing equipment are proven to prevent infections and prevent patients from harm. The lawyer hired a nursing expert to review the medical records and provide opinion on whether or not the nurses breached the standard of care. The expert stated that infection control is one of the most basic of skills and that nurses are required to recognize and respond to signs of infection. The expert determined that the nurses failed to monitor Steve’s condition appropriately, failed to recognize some well-known signs of infection and failed to communicate important information to the physician. You may notice that this case involves elements of two other litigation issues discussed in previous articles: assessment and communication.

Equipment Errors

Now let’s talk about equipment errors. Medical equipment includes IV pumps, BP monitors, PCA pumps, cautery equipment and even beds, wheelchairs and lifts. Injuries can happen when the equipment is either not used properly (such as when an IV pump is programmed to deliver too much or too little fluid or medication), or when information obtained from the equipment is not interpreted properly (such as when the temperature gauge in a bathtub is ignored). Both nurses and their employers have a key role to play in the safe use of equipment. Nurses must apply skill and knowledge, and employers have a responsibility to train and support nurses on the equipment they provide to nurses.

For a case study on equipment errors, please watch the powerful and thought-provoking video titled ‘Transparency, Compassion and Truth in Medical Errors’ (https://www.youtube.com/watch?v=qmaY9DEzBzI). This video, about a child who died when the nurse turned off the alarms on the machine that was monitoring his heart, addresses this issue better than I ever could in this article. Use it to refocus your commitment to protecting patients from harm.

Start a Conversation

Use this article and video to spark a conversation with your colleagues about infection control and equipment errors. What are your thoughts on Steve’s case? Have you ever overlooked or downplayed potential signs of infection? Did the patient suffer as a result? Do you perform hand hygiene as often as you should? Have you ever wrongly used medical equipment or felt unsure about how to interpret the information you received? Are you well trained on the medical equipment that you use every day? If not, what can you do to advocate for more education? What will you do differently now that you know what you know?

This article was written by Chris Rokosh, RN, PNC(C), Legal Nurse Consultant and president of Connect Medical Legal Experts (formerly CanLNC Incorporated). Chris is a popular speaker on medical legal issues across Canada and in the US. For more on this topic, watch for dates and locations of upcoming Executive Links workshops on ‘Legal Issues in Nursing’ featuring Chris Rokosh.

For more on this topic, email info@clpna.com for the LPN-only link to our Legal Issues in Learning video.
The recent Ebola outbreak devastating West African regions was first detected in March of 2014. Since spreading, the initiation of isolated cases in Spain and the United States have occurred, thereby becoming the worst outbreak of the Ebola virus on record. The Ebola virus is contained within the Filoviridae family of viral hemorrhagic fevers. Due to the aggressive nature of this disease, it must be recognized that there is an immediate need to reassess and reinforce nursing knowledge and skills related to infection prevention and the use of personal protective equipment (PPE). In addition, teaching about the expanded precautions used in the care of Ebola cases can serve to reinforce the safety and protection of healthcare providers and the public.

The Impact of Ebola

The Ebola virus is an infectious and commonly fatal disease symptomatic of fever and severe internal bleeding. Initially, Ebola is spread to humans from wild animals, most commonly the fruit bat. Concerning the spread from human to human, “[t]he most common cause of transmission of the Ebola virus is through exposure of the bodily fluids of an infected individual, to the mucosal tissues, or abrasions in the skin of an uninfected individual” (Manuel, MacDonald, Alani, & Moralejo, 2014, p. 2). Patients with Ebola “are not infectious before the onset of symptoms, but become increasingly contagious with each stage of the disease and remain infectious while the virus remains in their blood or bodily fluids” (Canadian Nurse, 2014, p. 17). Early symptomatology appears non-specific and consists of fever, body aches, followed by flu-like symptoms. As the virus develops, multiple tissues and organs can hemorrhage leading to a mortality rate of 50%. The amount of virus contained in blood and body fluids increases as symptoms worsen, thereby increasing risk of transmission (Manuel, MacDonald, Alani, & Moralejo, 2014). Due to the infectious nature of this disease, healthcare workers caring for these patients are at a significant risk of contracting Ebola.

Previous Best Practice

The first recorded Ebola case was identified in 1976 and quickly spread to other patients by the use of contaminated needles. This outbreak was confined to one African village where the re-using...
Frontline healthcare workers, such as nurses, care for patients with Ebola and must have the ability to recognize Ebola symptoms and implement the relevant protocols.

By adhering to the above noted precautions, the safety of the healthcare worker becomes a top priority in addition to the safety and care of patients (Canadian Nurse, 2014). By decreasing the potential for viral transmission and contamination and by “remain[ing] constantly vigilant to prevent the spread of infection while providing care” (Potter et al., 2014, p. 619), nurses can effectively protect the medical-surgical client in the acute care setting. Current best practice regarding the treatment of Ebola is to aid in the ability to tolerate fluids as the use of antiemetics and antidiarrheal therapy limit life-threatening dehydration and shock, thereby preventing the client from becoming hypovolemic. Intravenous fluid therapy and electrolyte replacement therapy aid in delivering adequate fluid volume (Chertow et al., 2014).

Teaching to Protect the Client

Healthcare providers can initially educate clients with suspected or confirmed Ebola and those who are immune compromised and at increased risk of contraction by “recommending the avoidance of non-essential travel to affected countries” (Wan Mohamed Noor et al., 2014, p. 6). It is important to increase client awareness regarding preventative steps to take if travel to affected areas has occurred and what signs and symptoms to watch for. Hand washing should be encouraged as well as an explanation of PPE and how it effectively aids in transmission prevention. Teaching regarding the avoidance of bodily fluids is essential. By “[t]eaching about the expanded precautions used in the care of Ebola [patients, it] reinforce[s] the understanding of principles and create[s] interest in infection control” (Manuel, MacDonald, Alani, & Moralejo, 2014, p. 2).

Case Scenario

A 24-year-old female student from the province of Alberta travelled to Sierra Leone to complete a research project on the effectiveness of bat bioacoustics monitoring. While caving, she has fallen and broken her right leg. Upon admittance to an acute-care medical unit the following findings are noted: pulse 110, blood pressure 140/90, temperature 39.2 C, SpO2 96%, respirations 22/min. Client states “I felt so dizzy and fell.” She is complaining of a severe headache, nausea and vomiting, has noted bloody diarrhea and abdominal pain for the last 2 days. Her condition is progressively worsening and she is only taking small sips of water. She is showing signs of dehydration such as cracked dry lips, dry mucous membranes and associated muscle cramping. She is alert and orientated at present with a Glasgow Coma Scale (GCS) of 15.
Client-Centered Goal: Client will not have a knowledge deficit related to the transmission of the Ebola virus.

Outcome: Client will show their understanding of the importance of proper infection control precautions and their effect on decreasing the transmission of the Ebola virus by repeating three ways in which Ebola transmission can be decreased after a one-hour teaching session.

Interventions: The nurse will educate the client as to why she is in an isolated room by explaining that “the initiation of contact and droplet precautions” (Canadian Nurse, 2014, p. 18) are implemented if Ebola is suspected based on symptoms and exposure.

The nurse will explain that the donning of protective suits is necessary due to the infectious nature of this disease, as healthcare workers caring for these patients are at significant risk of contracting Ebola (Manuel, MacDonald, Alani, & Moralejo, 2014).

Evaluation Statement: This outcome can be met by the client demonstrating their understanding of the importance of PPE and isolation precautions by repeating three ways in which Ebola transmission can be decreased.

Conclusion

The early detection of the Ebola virus is key to containing and preventing transmission. By ensuring the adherence to proper safety precautions, both the nurse, client and future clients in a medical-surgical unit in the acute care setting are protected from potential exposure.

Alyssa Bossi and Ashley Tewitz are second-year nursing students in the Licensed Practical Nurse program at Norquest College. Alyssa is a dedicated, passionate and respected student who strives for excellence in all aspects of the nursing program. Ashley integrates her research skills by actively collaborating with her colleagues and demonstrates a strong communication skill set. Harrison Applin, PhD, RN, is a nursing educator at Norquest College. He advocates and believes in student success by modelling and mentoring students in the Pharmacology and Acute Care Nursing Foundations courses. Article references available from care@clpna.com.
Save 20% on your home and auto insurance. Simply because we love the job you do.

You deserve better rates and better service. That’s why Armour Insurance has developed NurseAssure, a group insurance plan endorsed by your CLPNA to give special discounts for Licensed Practical Nurses in Alberta.

If you’re a member of the CLPNA you already qualify for Nurse Assure Group Rates.

Complete a quote online or over the phone and we’ll give you a $10 Tim’s card! Just use promo code TIMCARE.

armourinsurance.ca/clpna
1-855-475-0959

*Some conditions may apply. Please contact Armour Insurance at 1-855-475-0959 for full details. Must complete a quote using promo code TIMCARE to qualify.
resources

CONNECTIONS

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

Alberta Gerontological Nurses Association
www.agna.ca

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

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

Canadian Association of Neonatal Nurses
www.neonatalcann.ca

Canadian Association of Schools of Nursing
www.casn.ca

Canadian Association of Wound Care
www.cawc.net

Canadian Orthopaedic Nurses Association
www.cona-nurse.org

Canadian Hospice Palliative Care Nurses Group
www.chpca.net

Community Health Nurses of Alberta
www.chnalberta.ca

Creative Aging Calgary Society
www.creativeagingcalgary.com

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

LEARNING LINKS

Study with CLPNA
www.studywithclpna.com

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

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

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

Alberta Innovates
www.albertainnovates.ca/health

Canadian Virtual Hospice
www.virtualhospice.ca

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

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

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

Learning Nurse
http://learningnurse.org/

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

Reach Training
www.reachtraining.ca

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

UBC Interprofessional Continuing Education
www.interprofessional.ubc.ca
The CLPNA is pleased to announce the June release of the newly revised Competency Profile for Licensed Practical Nurses, 3rd Edition (2015). The Profile is the result of a rigorous and ambitious review process that formally began in September 2014 and involved over a thousand participants. This process resulted in a broad and thorough consultation, identifying and verifying the competencies of the LPN profession in Alberta, with licensed practical nurses, practical nurse educators, employers, specialty educators, interest groups, and other stakeholders.

Highlights of the Competency Review process indicate a few key findings:
- Community Health encompasses so much more today and includes areas of practice like corrections, group homes, hospice, primary care, chronic disease management, public health, school health, and outreach nursing.
- Leadership has many streams for LPNs with opportunities in many sectors not even considered ten years ago.
- Advanced roles exist in many areas of Acute Care (neurovascular, cardiology, maternal/newborn, NICU, emergency/urgent care and endoscopy).

To enhance understanding of scope of practice, several competency areas were added to the Profile, identifying the ongoing changing role, education and practice for LPNs that has occurred over the last ten years.

The changes reflected in the Profile include additions of new areas currently taught in the basic practical nurse program, with many areas of advanced practice acquired following graduation. The language throughout the Profile is more academic with enhanced detail.

The following chart outlines the new, enhanced or changed competency areas. Although it may appear there are many scope of practice changes, it is important to note, there are only TWO changes to scope of practice within the updated Profile, as indicated.

Some basic competency areas have been stretched to facilitate the goals of the CLPNA Strategic Plan and to address new competency requirements for novice LPNs entering practice today. These areas include: Gerontology/Dementia, Palliative Care, Leadership (informal/formal), Community Health, Mental Health and Addictions, and Professionalism (accountability, responsibility, professional boundaries, fitness to practice). Many LPNs have advanced their knowledge in these areas. However, for those LPNs who have not, CLPNA will continue to examine and promote appropriate continuing education opportunities.

The Competency Profile for LPNs, 3rd Edition, marks a clear maturing of the profession of the Licensed Practical Nurse and will guide the profession well in the coming years. CLPNA extends a sincere “Thank You” to all who took part in the review process; the success of the project is due to the participation and commitment of all those involved.
Strategic Plan sets fresh goals for LPN profession

The College of Licensed Practical Nurses of Alberta (CLPNA) believes everyone in the health system needs to be looking forward and working together to create a high quality, responsive health system that meets the challenges of the future. As part of CLPNA’s commitment to ensuring the LPN profession is equipped with the skills of tomorrow, the Council develops an annual Strategic Plan to guide CLPNA’s plans for the next three and 10 years.

This year’s Strategic Plan contains many changes from the 2014 edition including a transformed Vision statement, and many Business Plan items.


LPN progress highlighted in CLPNA’s 2014 Annual Report

The role of the College of Licensed Practical Nurses of Alberta is to act in the public interest by ensuring the care Albertans receive from Licensed Practical Nurses is safe, competent, ethical and relevant. The Annual Report (http://annualreport2014.clpna.com) presents the highlights as the CLPNA honoured this commitment in 2014.

Improvements continue in all key areas including policy development, registration, education, complaint management and leadership. These include new practical nurse program approval standards; an updated Competency Profile for LPNs; and a 9.5% increase in total registrants to 12,881 LPNs.

COUNCIL DISTRICT REPS ANNOUNCEMENT EXPECTED

LPNs in four CLPNA Election Districts will learn about their new Council members in late July.
Council nominations closed on May 31, 2015 for Calgary (District 2), Edmonton (District 4), Grande Prairie (District 6) and Fort McMurray (District 7).

If two or more nominees are received for a District, an election by emailed ballot is held in June. Results are published on www.clpna.com. If a District receives only one eligible nominee, the nominee becomes a Council member by acclamation.

Through Policy Governance, the Council is responsible for establishing, maintaining and monitoring Bylaws, Regulations, Standards of Practice, and Code of Ethics, and approving practical nurse education programs. More at www.clpna.com/about-clpna/council.

Radio ads share LPN professionalism with everyday Albertans

Two radio ads focused on the professionalism of Licensed Practical Nurses were on air in Calgary and Edmonton from April 13 - May 10. Created by the College of Licensed Practical Nurses of Alberta, the ads speak to everyday people faced with loved ones in need of care - those who rely on the knowledge and compassion of LPNs each day.

One 30-second commercial features LPNs in an acute care setting in hospital, the other in dementia care. Seven stations across diverse genres broadcast the ads, including powerhouse 630 CHED.

The ads help meet the CLPNA’s Strategic Plan goal to “enhance communication and public awareness strategies to inform stakeholders of the competencies of the LPN”.

The #1 Question about CCP Validation

Each year during CLPNA’s Continuing Competency Program Validation (CCPV), questions arise from participating LPNs that help improve the process.

Most common is how to “describe (the) impact” of each learning objective on their nursing practice. The answer requires a detailed evaluation. Here are some questions to help guide your answer:

1. Why did you choose this learning objective?
2. What have you learned?
3. How did the learning change the way you think and behave in your practice?
4. How will this learning affect your practice in the future?

More than 2100 Licensed Practical Nurses in Alberta are participating in this year’s CCPV. Participants were notified in May by email and mail.

CCPV monitors Licensed Practical Nurse participation in the Continuing Competency Program and is a mandatory part of registration with CLPNA under the Health Professions Act.

Questions? Visit www.clpna.com under “I Am a Member”, or contact practice@clpna.com, 780-484-8886 or 1-800-661-5877 (toll free in Alberta).
Attend for FREE:
Geriatrics Seminars Qualify for Grants

You don't want to miss Barb Bancroft's upcoming seminars on “Clinical Focus on Geriatrics” coming to Edmonton and Calgary. You may be eligible to attend for FREE! LPNs with an Active Practice Permit from CLPNA and who live in Alberta may qualify for 100% reimbursement for these seminars through the Education Grant Program.

**Barb Bancroft Seminar: Clinical Focus on Geriatrics**

<table>
<thead>
<tr>
<th></th>
<th>Edmonton</th>
<th>Calgary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sept. 9</td>
<td>Nov. 17</td>
</tr>
<tr>
<td></td>
<td>Polypharmacy: The Pearls, the Perils, and the Pitfalls</td>
<td>Polypharmacy: The Pearls, the Perils, and the Pitfalls</td>
</tr>
<tr>
<td></td>
<td>Sept. 10</td>
<td>Nov. 18</td>
</tr>
<tr>
<td></td>
<td>The Neurology of Aging</td>
<td>The Neurology of Aging</td>
</tr>
<tr>
<td></td>
<td>Sept. 11</td>
<td>Nov. 19</td>
</tr>
<tr>
<td></td>
<td>The “OLD TICKER”: The Geriatric Heart</td>
<td>The “OLD TICKER”: The Geriatric Heart</td>
</tr>
</tbody>
</table>

Attend one, two, or all three seminars!

Seminars run from 8:30am - 3:30pm.
The registration fee includes lunch.

**Registration Fee:** CLPNA Members – $125 (incl. GST) per Seminar. Non-Members – $165 (incl. GST) per Seminar.

Barb Bancroft RN, MSN, PNP is a widely-acclaimed national speaker, noted for her humorous, entertaining and information-packed seminars. She is author of four books. Her latest is, “Kiss My Asparagus: An Essential Guide to Nutrition’s Role in Health and Disease”.

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

**SUMMER SURVEY**

What’s your favourite part of **Summer**?

What’s not to love about our Alberta summers? The long hours of daylight, heading out on vacation, and finally thawing out in the hotter temperatures were all top choices. Oddly enough, no one chose having the kids home from school. Maybe it’s not too late to sign them up for summer school.

Gardening, outdoor sports, and music festivals were other popular choices.

39% warmer temperatures
11% longer daylight
11% camping
17% vacations
One of the pillars of responsibility for the College of Licensed Practical Nurses of Alberta (CLPNA) under the Health Protections Act is protection of the public through a formal complaints process.

The tight-knit Complaints Department carefully handles about 200 files annually. The top three complaints involve practicing without a permit, clinical competency and medication administration issues. In 2014, 40% of complaints were settled through informal resolution, rather than going to a formal hearing. Read more at www.clpna.com/complaints or the 2014 Annual Report.

Sharlene Standing is Complaints Director, as well as Director of Regulatory Services. She ensures CLPNA’s complaints process protects the public by adhering to all legislative and regulatory laws. As an LPN herself, she’s “confident CLPNA’s complaints processes achieve the organizations legislated mandate to protect the public”. Over her last decade working with CLPNA, she’s earned an undergraduate degree in Human Service Administration and a Master of Arts in Leadership.

Sandy Davis, Complaints Consultant/Investigator, enjoys open and direct communication with the members and employers. Her role provides the opportunity to work on strategies with members and employers to improve practice. With 33 years’ LPN experience, she brings a wealth of understanding to the complaints management process. She holds a Bachelor of Applied Human Service Administration and Certification as a Private Investigator.

Susan Blatz, Complaints Consultant, has 27 years of LPN experience which prepared her for this dynamic role. Her extensive knowledge and experiences as an LPN give her unique insight into the complexity of the complaints process. “Working to keep the public safe is rewarding but can be challenging at times,” she says. “It’s important and satisfying to help improve LPNs nursing practice”. She is pursuing a degree in General Studies.

Katie Emter, Investigator, believes she “helps LPNs become more aware of their professional responsibilities and ethics”. She’s spent 20 years investigating complaints about LPNs as a provincially licensed private investigator. Her broad education and experience includes a background in law enforcement, human resource and business management, and conducting investigations under the Protection of Persons in Care Act.

Bonnie McEwen, Complaints Assistant/Hearings Director, appreciates her dynamic team and the variety of responsibilities as she provides administrative support to the Complaints Department. She finds “every day is different”, and gleans satisfaction in assisting LPNs, various committees, employers and members of the public.

Clockwise from left: Bonnie McEwen; Susan Blatz; Sandy Davis; Sharlene Standing; inset: Katie Emter

Getting to know our… Complaints Department

Seeking Donations for LPN Continuing Education

I would like to thank the Fredrickson-McGregor Education Foundation to helping us achieve our goals through continuing education… – Avinash Jared, LPN

To give more Education Grants to more Licensed Practical Nurses, donations are being sought by the Fredrickson-McGregor Education Foundation for LPNs. The popular Education Grant Program has approved 3500 LPNs for $1.5 million in grants since 2006.

Every donation, no matter the size, makes a real difference in supporting LPNs to pursue continuing education, from one-time gifts to automated monthly contributions. And all donations are tax-deductible.

Donations can be made on the Foundation’s recently rebranded website, http://foundation.clpna.com, or by contacting the Foundation Assistant at foundation@clpna.com, 780-484-8886 or 1-800-661-5877 (toll free in Alberta).

The non-profit Fredrickson-McGregor Education Foundation for LPNs distributes educational grants, awards and bursaries to CLPNA members.
Difficult Decisions: 
Evidence is Everything

Case Study*

Lillian*, LPN, was employed as a staff nurse on a medical unit that holds 25 beds. Nurses on the unit work either eight or twelve hour shifts and Lillian worked both day and night shifts. In 2013, after Lillian had worked on the unit for a number of years, the facility received several medication packages (trazodone, oxazepam and lorazepam) which were recovered from Lillian’s home. The matter was investigated by the facility and it was determined that Lillian took home medications on several occasions. Lillian was terminated by the facility and the matter was reported to the CLPNA.

The CLPNA conducted an investigation. It was determined that Lillian and her husband had become estranged and that he had reported the matter to the police, informing them that Lillian was consuming the medication removed from the facility. The police returned the medication to the facility. During the course of the investigation process, Lillian acknowledged that she had taken the medication packages home from the unit and that she failed to return them to the facility. However, she stated that she removed the packages of medication from the facility without realizing she had done so, explaining that she accidentally took the packages home in her pocket on various occasions but she did not discover the packages until she emptied her pockets at home. Lillian adamantly denied consuming the medications for her personal use.

The matter was referred to a Hearing Tribunal. The question to be determined was whether Lillian’s conduct fell below the accepted Standards of Practice and Code of Ethics for an LPN and was unprofessional conduct as defined in the Health Professions Act. The allegations were that:

a) Lillian removed, and did not return, medication from the facility on multiple occasions; and
b) Lillian personally consumed the medication that was removed from the facility.

Lillian admitted she demonstrated a lack of judgment because she failed to return the medication to the facility when she discovered the medication in her uniform pocket. She did not admit to consuming the medication for her personal use. There was no evidence from the employer that there were any competency related issues and Lillian was viewed as a good nurse by her employer.

Several questions may come to mind when examining Lillian’s circumstances, including:

• How could a nurse accidently take home medications on several occasions?
• How could a nurse realize she has taken home medication and then fail to return the medication to the Facility?
• Does the nurse have a substance abuse problem?
• Is the husband being vindictive and making trouble for the member?
These same questions are likely to be asked by the Hearing Tribunal presiding over the hearing. This may result in the Hearing Tribunal inappropriately relying on assumptions or generalizations as proof of unprofessional conduct. This would be inappropriate.

When making decisions a Hearing Tribunal must rely on evidence. Assumptions about what could have happened cannot be considered. An effective decision will include a discussion of the:

- a) Key findings of fact relevant to the decision that is being made;
- b) Principal evidence on which those findings of fact are based (e.g., witnesses, documentary evidence, member’s admission of unprofessional conduct);
- c) Major points in issue which show consideration of the main factors relevant to the decision;
- e) Law or policy relied on to reach the decision (e.g., Standard of Practice, Employer Policy); and
- f) Reasoning process followed by the Hearing Tribunal.

A Hearing Tribunal must rely on evidence to prove allegations of unprofessional conduct against a member. Typically direct evidence (meaning eye-witness accounts or documents which speak for themselves) is utilized to prove allegations in a discipline hearing as direct evidence proves a fact in question without the need for any supporting evidence or inference.

In the absence of such direct evidence, it is more difficult to support an allegation of unprofessional conduct related to any substance abuse issue. However, that does not mean that it is impossible. An allegation may be proven solely on circumstantial evidence (meaning indirect proof which relies on an inference to connect it to a conclusion). Circumstantial evidence, taken as a whole, can be sufficient to establish the requisite inferences which show that the only plausible “chain of events” or facts are those that prove the allegation. It follows that inferences may only be drawn from other facts which have been established and that there is good reason to select that particular inference over others. Although circumstantial evidence can be as persuasive as direct evidence, it often takes an accumulation of circumstances to demonstrate what one piece of direct evidence can prove without any additional evidence or inference.

On conclusion of the Hearing, the Hearing Tribunal meet in private to deliberate and to determine, on a balance of probabilities, if one or both allegations were proven.

In this fictional case study, the Hearing Tribunal determined there was insufficient evidence, both of the direct and circumstantial type, to support an allegation that Lillian consumed the medication. There was an absence of direct evidence, as there was no firsthand eyewitness account of Lillian consuming the medication on multiple occasions. While Lillian’s husband informed the police that she consumed the medication, there was no direct evidence that he saw her consume it.

Further, there was insufficient circumstantial evidence to show that the only plausible “chain of events” was that she consumed the medication. There was a lack of performance issues on the unit which were indicative of a substance abuse issue and a lack of a past history of substance abuse. In the absence of direct evidence, there was not enough evidence to draw the conclusion that Lillian consumed the medication. Therefore, the Hearing Tribunal could not find that this allegation was established.

However, due to Lillian’s admission, there was direct evidence to support the first allegation: that Lillian removed, and did not return, medication from the facility on multiple occasions. The Hearing Tribunal determined that this was unprofessional conduct.

Having determined that one of the allegations was proven and that the allegation amounted to unprofessional conduct, the Hearing Tribunal was required to determine an appropriate sanction. The sanctions which could be ordered include:

- a) a reprimand;
- b) a practice suspension;
- c) a requirement for Lillian to meet with a Complaints Consultant to reflect on the unprofessional conduct and identify strategies to avoid similar circumstances in the future (e.g., review employment policies, CLPNA Standards of Practice, Code of Ethics); and
- d) hearing costs.

Ultimately, the goal of the Hearing Tribunal’s decision on sanctions is to protect the public through ensuring that the LPN is adequately prepared to practice in a safe, competent, and ethical manner. As a result, the sanctions ordered by a Hearing Tribunal are generally remedial in measure.

Given the facts proven in Lillian’s case, a sanction(s) that is remedial in nature is the most appropriate result. A practice suspension would be unlikely.

*This is a fictionalized case study.*
There is no question that effective communication is the foundation of successful relationships, and plays an integral role within the nursing process, from gathering patient information on admission to patient teaching upon discharge, and everything in between. Effective communication impacts nursing practice and efficacy of patient care moment by moment.

The professional nurse is required to be a skilled verbal communicator, as well as being aware of the impact that non-verbal communication (kinesics) has on effective nurse-patient relationships. The ability to understand and utilize effective nonverbal communication is instrumental to connecting with patients, clients and families, conveying valuable information and patient teaching, while fostering strong, respectful relationships.

By definition, kinesics, non-verbal communication, is the systematic study of the relationship between non-linguistic body motions which serve as cues between individuals engaged in conversation (Merriam-Webster, 2015). Kinesics encompasses such things as eye contact, touch, distance, environment and personal appearance to mention a few. It is equally important to recognize that speech and written text also contain elements of non-verbal communication, including volume, tone, rate, voice quality and inflection, and in writing, the choice and arrangement of words, handwriting style, or the use of bold or capitalized font.

Studies have shown that non-verbal communication represents approximately 60% or higher of all interpersonal communication, a learned behavior from infancy by way of the social-emotional connection or bonding process. Over time we have learned to interpret facial expressions, tone of voice and other non-verbal cues on a subconscious level.

As nurses, it is important to establish an effective, professional relationship with individuals in care. Our conversations must be therapeutic and goal-oriented in nature, with the intention of positively impacting the restorative healing process (Holland, 2013). William Carlos Williams said, “it is not what you say that matters but the manner in which you say it” (ThinkExist.com Quotations, 2015). We as caregivers need to show that we are empathetic and are listening to our patients, just as we need our patients to listen to us.

To become a more effective communicator, it is important to be cognizant of the body language and non-verbal cues of others, as well as your own. There is increased trust, clarity and understanding when non-verbal cues match the spoken word; when they do not, mistrust, tension and confusion often result (Segal, Smith, Boose, & Jaffe, 2014).

Non-verbal communication can provide, as defined by Wertheim (2008): repetition, contradiction or substitution of a verbal message, as well as complementing or accenting what is being said.

Simple suggestions for creating positive body language and improving non-verbal communication skills are:

1. **Push your shoulders back.** Stand taller, projecting confidence, but not arrogance.

2. **Distribute your weight evenly over both feet.** A broad and unwavering stance conveys confidence and self-assurance.

3. **Hold hands loosely at your sides.** A relaxed posture shows that you’re approachable.

4. **Look the person in the eye.** Eye contact is powerful and shows you’re not afraid to engage in conversation.

5. **Tilt your head to one side.** This demonstrates you are listening intently and concentrating on what is being said.

6. **Silent encouragement.** Non-verbal encouragement like head nods signify that you’re engaged in the conversation (Coogler, 2012)

These are just some tips to elevate your interpersonal communication by refining your kinesics skills today!

References available on request.
Despite modern medicine's advances, the lowly pressure ulcer represents a major health threat to patients with reduced mobility, chronic disease, and the elderly. They can affect mobility, nutritional intake, elimination and psychological well-being.

A comprehensive Pressure Ulcers eCourse is now available from the CLPNA to provide nurses with the motivation, knowledge and skills to more effectively assess, prevent and treat pressure ulcers.

The course consists of six modules, and includes pain management, repositioning, cleansing and surgery. Learning activities include 123 components, from narrated video presentations, unit quizzes, learning games / simulations, handouts, links to other resources and a choice of final examinations. Scoring over 80% on the final exam results in a personalized certificate of course completion. Course modules and exams are provided without fee as part of CLPNA's educational strategy.

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...

Pioneers take many forms. It may not look like it, but this group of women broke new ground to enter Alberta’s operating rooms just over 20 years ago. “Each day brought new and exciting experiences for us”, said Rebecca Byblow and Janice McCullum, two of seven LPNs who graduated in August of 1994 with their certificates from the Operating Room Pilot Program at the Royal Alexandra Hospital in Edmonton. “This is a terrific new role for LPNs”, they said at the time, and it continues to provide opportunities for excellence today.

Back row from left:
Regina Leonard, Program Coordinator; Rebecca Byblow, Henriette (Rita) Geusebroek, Twyla Baerg

Front row from left:
Barb Lachance, Brenda Kuzyk, Shonna Wicks, Janice McCullum
BART BANCROFT, RN, MSN, PNP

Only the Exciting Stuff you Need to Know About Neuro Anatomy
- Why TIME is BRAIN: Neurontogenesis and Plasticty
- A Brief Tour of your Brain and Cerebral Nerves
- Blood Supply to the Brain and Spinal Cord

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

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

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

Managing the Risk Factors - Control the Hyper!
- Hypertension: BP Management; Considerations for the Elderly
- Hypercholesterolemia, Medication
- Hyperglycemia: Obesity, Inactivity & Alcohol
- Hypersanglogluia: The Pill, Obesity and Cloting Risk
- A Word about Brain Boosters

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

Strokes in Children & Young Adults

** Brand New Workshop! **

**HEART FAILURE UPDATE**

With

CHRIS COLTMAN, RN, BScN

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

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

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

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

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

** Brand New Workshop! **

**STROKE UPDATE!**

**Different Strokes for Different Folks**

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

EDMONTON, November 3, 2015  •  CALGARY, November 9, 2015
0830 to 1600 hrs.

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 phenomenon. Barb will focus on the classic clinical presentations for both hemorrhagic and ischemic strokes based on specific etiologies 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 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.

Conference Fees:
- $169.95 + $8.45 GST = $177.45 Early Rate (on or before September 21, 2015)
- $179.95 + $8.95 GST = $188.95 Middle Rate (on or before October 19, 2015)
- $189.95 + $9.45 GST = $198.45 Regular Rate (after October 19, 2015)

**HEART FAILRE UPDATE**

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

EDMONTON, November 23, 2015  •  CALGARY, November 24, 2015
0830 to 1600 hrs.

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

WHO SHOULD ATTEND?

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

Chris Colman, a graduate of the UofA Bachelor of Science in Nursing program, has been engaged in cardiac surgical nursing for over 20 years. He has worked in a variety of settings and countries, including Montreal, London (England) and in Riyadh, Saudi Arabia. Chris has over 13 years of teaching experience, and has taught a number of sessions on a variety of topics where his passion for teaching and cardiac care shows. He is currently the Clinical Nurse Educator in the Cardiovascular Intensive Care Unit at the Pfoothills Medical Centre in Calgary.

Conference Fees:
- $169.95 + $8.45 GST = $177.45 Early Rate (on or before October 13, 2015)
- $179.95 + $8.95 GST = $188.95 Middle Rate (on or before November 9, 2015)
- $189.95 + $9.45 GST = $198.45 Regular Rate (after November 9, 2015)
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