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cover story

8 No Bridge Too Far
Innovation requires creative thoughts and ideas. One nursing unit shows the way, highlighting new horizons.

Cover Photo:
Kristy Dubois, LPN - by Chris Fields

feature

14 Breaking the Silence
This new feature takes a deeper look at living with mental illness with an honest, open, and enlighten approach.
Be The Master - The Leader - The Model

You cannot control what happens to you, but you can control your attitude toward what happens to you, and in that, you will be mastering change rather than allowing it to master you.

- Brian Tracy

Working in the health sector in Alberta is stressful for staff and management. There has been a constant state of change, and we know you have been exposed to challenges associated with the uncertainty caused by this change. These are interesting times, and they will likely remain uncertain while the new system takes shape.

We talked in the last issue of CARE about Alberta Health Services’ proposed shift in nursing ratios. These preliminary discussions have led to uncertainty amongst the nursing professions and uncertainty has translated into challenges in the front line environment.

While much of this change is out of our control, we can control how we react to it. Do we allow fear and uncertainty to control how we give patient care and deal with our colleagues? Or do we maintain a professional perspective, take the high road, and focus on what’s really important – quality patient care rooted in a culture that respects and values all providers. We each have a choice in how we respond.

Nursing is a nurturing profession, where our focus is to support patients to reach their optimum state of wellness. As Nurses, we need to keep this approach in mind when dealing with everyone on our team. Let’s think about the work environment we create together, as it affects our students, new grads, and particularly our patients. We have a responsibility to represent the Profession of Nursing in a positive way, by remembering the Privilege that it is.

Many of us remember the changes of the mid-1990’s in healthcare here in Alberta. This was a very difficult time not so unlike today. Despite the challenges, many in our profession, who were struggling to keep their positions, stepped up to the plate and tackled mandatory upgrading requirements. We managed the change then, and we can effectively manage it again.

Finally, the LPN role is increasingly expanding in this new environment, and this is a continuing positive change. But even positive change can be uncertain. We have witnessed many LPNs effectively taking on this challenge. The CLPNA supports you in this evolution. Many of you have waited for years to have the opportunities that are available today. It is because of each of you, and your continued commitment to excellence, that this is occurring.

The College will continue to work with Alberta Health Services, other stakeholders, and membership to ensure the LPN profession continues to meet the needs of the system. We each have a place in creating respectful environments and by accepting this responsibility we feel more in control of our own destiny.

WE can model the leadership needed to create a truly caring health system focused on quality, sustainability, and most importantly, the patient.

Hugh Pedersen, President and Linda Stanger, Executive Director
Another day, another life saved.

The Alberta Union of Provincial Employees – Alberta’s largest union – represents about 6,000 Licensed Practical Nurses province-wide. These dedicated LPNs are among more than 15,000 front-line nursing care employees, and more than 33,000 health care employees represented by AUPE.

AUPE is committed to ensuring that all health care employees are recognized for the important role they play in quality public health care.

Alberta Union of Provincial Employees. Your working people.
Do Bugs Need Drugs? is a community education program about the wise use of antibiotics. The program started as a pilot in 1998 in Grande Prairie, and now it is available throughout Alberta and British Columbia and in other health units across Canada. We have found that the public has many misconceptions about antibiotics and that nurses play a key role in educating the community about what antibiotics can and cannot do.

Nurses are an important source of medical information in the community, particularly that type of informal advice given to family members, neighbors, and friends. One of the most common questions that nurses receive is how to manage respiratory infections. Concerns about influenza and H1N1 have led many more requests for advice. A recent issue of the American Journal of Nursing reported that nurses are often asked about respiratory tract infections (RTIs) including use of antibiotics. The study also noted that nursing programs offer little or no training about therapies for respiratory infections and the indications for appropriate antibiotic use.

The information below is from the Do Bugs Need Drugs? program (www.dobugsneeddrugs.org). We hope you find it helpful in discussing antibiotic use with patients, family, and friends.

Not all bugs are created equal

Many patients have misconceptions about when antibiotics will work. In a survey conducted by the National Information Program on Antibiotics, over half of adult Canadians thought that antibiotics were effective against viral infections. Explain to patients that the right treatment for their RTI depends on what is making them sick. Antibiotics work against bacteria but not against viruses.

Most RTIs are caused by viruses and antibiotics will not help. Pneumonia, one of the most serious respiratory infections, can be caused by viruses or bacteria. Antibiotics are an important therapy for bacterial pneumonia.

<table>
<thead>
<tr>
<th>ILLNESS</th>
<th>CAUSE</th>
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<tr>
<td>Colds</td>
<td>Virus</td>
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<tr>
<td>Influenza</td>
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<td>Sore throat</td>
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<td>Bronchiolitis</td>
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<tr>
<td>Sinusitis</td>
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<td>Pneumonia</td>
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Many patients believe that if they have not recovered in a week or so, their RTI must be bacterial. This is another misconception. Viral RTIs can go on for weeks. About 25% of patients with a cold will still have symptoms after 14 days. For bronchitis, 45% of patients will be coughing at two weeks, and 25% at three weeks. Recovery from a viral RTI can take a long time and, unless symptoms worsen, it does not mean you have a bacterial infection. Reassure patients that respiratory infections take a long time to resolve and that antibiotics will not speed up their recovery.
Green sputum or nasal discharge is a normal part of recovery from an RTI and does not mean the infection is bacterial. Help patients understand that the colour changes seen in respiratory secretions during an RTI are a result of the inflammatory process. The green or yellowish colour occurs whether the infection is viral or bacterial.

**Use antibiotics wisely**

Encourage patients to view antibiotics as potent medicines. In the past, using antibiotics when not really needed was considered low risk. One example was the practice of treating children with antibiotics to prevent otitis media. Current evidence clearly shows there are risks associated with antibiotic use, even when used appropriately. The risks for the patient are that antibiotic use leads to carriage of resistant bacteria and a greater chance that the next infection will be caused by resistant organisms. The risk for the community is a greater number of infections that cannot be successfully treated with antibiotics.

Antibiotic resistance is not an easy concept. People often think they are resistant when it is bacteria that become resistant. When bacteria are exposed to an antibiotic, some of them will develop ways to avoid being killed by the antibiotic. These bacteria are/have “antibiotic resistance”. If you or the next person becomes infected with resistant bacteria, antibiotics that would have worked in the past are no longer effective. This results in treatment failures and sometimes death.

Antibiotic resistance is an unwanted and unavoidable after-effect of antibiotic use, whether they are used for the right or wrong reasons. Help patients understand the risks and why it is important to use antibiotics only when they are really needed.

Patients may often feel they need an antibiotic because “it worked the last time” or because of the severity of their illness. Explain that, if their illness was viral, their recovery was not related to antibiotic therapy and would have occurred anyway. Likewise, explain that viral infections can be quite severe and that it is the organisms and not their symptoms which determine whether antibiotics will work. Help patients understand that antibiotics are serious drugs with serious consequences.

**Handwashing is the best way to stop the spread of infections**

- Since curative treatments for viral infections are limited, the best thing you can do is not get sick in the first place. Eighty percent of respiratory tract infections can be spread by the hands. Handwashing is the best way to stop the spread of infections.

- Review the steps of handwashing with adults and children.
  
  For public washrooms:
  1. Wet your hands
  2. Apply soap
  3. Rub hands together for 20 seconds making sure to do the palms, between the fingers, backs of hands, thumbs, wrists and fingertips and nails
  4. Rinse your hands
  5. Dry hands with a disposable towel
  6. Use the towel to turn off the taps and let yourself out the washroom door

Children can be encouraged to rub their hands together for 20 seconds by singing Twinkle Twinkle Little Star or the ABC song. Older adults prefer A Bicycle Built for Two. Don’t worry, they’ll teach you if you’re not familiar with the song yourself!

- Remind patients about the important times to wash their hands:
  - Before eating or preparing food
  - Before breastfeeding
  - After using the toilet or helping a child use the toilet
  - Before and after diapering
  - After blowing your nose or wiping a child’s nose
  - After handling shared objects

- Stress the importance of not spreading germs. Teach patients to cough and sneeze in their sleeve. This avoids getting germs on the hands and in the air.

- Explain that germs cause illness when they enter the body through the mucous membranes. Advise patients to keep their hands away from their eyes, nose and mouth, because these are the places where germs get in to cause illness.

- Last, encourage patients to receive an annual influenza vaccine.

Antibiotics have saved countless lives and are one of the most important tools of modern medicine. Antibiotic resistance prevents antibiotics from working. Help patients to know how antibiotics should be used.

For more information about Do Bugs Need Drugs? visit the website, www.dobugsneeddrugs.org. To learn more about the print resources that are available (at no charge in Alberta) please contact us at: info@dobugsneeddrugs.org or 1-800-931-9111. Do Bugs Need Drugs? is supported by Alberta Health and Wellness.
No Bridge Too Far

By Chris Fields

New Horizons at Unit 52
The story of Unit 52 can be thought of in the context of bridges. The bridge building occurring on Unit 52 is multi-faceted - between RNs and LPNs, between professional roles, and between the past and the future in health care delivery. Recently, LPNs stepped onto this Unit for the first time, in tandem with the introduction of a collaborative practice model that steps boldly into the future. And like most success stories, there’s a passionate beating heart delivering this bridge – Unit Supervisor, Lilie Eikenberry, RN.

Lilie has the broad experience that is required to effect change. She’s been at PLC since 2002. She’s been nursing for 20 years. She understands the LPN scope of practice, having been a clinical nurse educator from 2005 to 2007. She has taught both formally and informally as an educator and is passionate about an expanded role for health care teams.

Lilie had a big challenge when she took over patient care manager duties on the Unit in October 2007 – a 40% RN vacancy, staff burnout from overtime and workload, and a tough budget to manage. “It took me two days to think about an LPN role in Unit 52 that expanded to the fullest scope,” Lilie says, referring to her objective to increase staff levels within a prescribed budget. The LPN recruiting process started soon after. “It’s a win-win-win for LPNs, RNs, and patients,” Lilie says. “LPNs are fully qualified to perform well in the Unit. The budget reality is I could generate higher staff numbers by hiring LPNs and NAs. I could maintain RN numbers while reducing their workload and burnout. I could also improve the staff to patient ratio.”

In February, 2008 the first LPN rotation was implemented. Today, there are 17 LPNs working on the Unit, and the LPN to RN ratio has been as high as 80% with continued positive patient outcomes. Lilie indicates any RN fears of job loss are not borne out by the reality on Unit 52. “There are more RNs on the Unit than there were three years ago,” Lilie says. “The simple fact is we couldn’t staff the Unit on a 100% RN basis. It wouldn’t have been responsible or sustainable in terms of budget and quality of care.”

I ask Lilie how she has managed to cross what is a chasm in other environments where LPNs continue to be under-utilized and under-valued. “Continuing education provided to other medical professions about the LPN role and skill set has been key,” Lilie says. “There’s a vigilance required to defend and communicate decisions to peers on an ongoing basis. I also made it clear to the Unit that the initiative to introduce LPNs would not fail.” To arrange the chess pieces in her favour, Lilie recruited for high level competencies in the first LPN hires – to get the best of the best to smooth the transition.

Discussion then quickly turns to another key catalyst for LPN integration and

Unit 52 is no ‘run of the mill’ unit. Focused on oral-maxillo-facial surgery, “belly button up” general surgery, and ENT (ear, nose, throat), there is a high level of acuity and patients have complex needs. The Unit is extremely busy; in a 35 bed unit, average occupancy last year was 34.8 patients. Turnover is high with an average patient stay of two to three days. The Unit also has a more intensive medical teaching function than the norm.
patient-driven care - the use of a collaborative care model dedicated to mind, body, and spirit-encompassing total patient care and extensive team play. The Unit’s work style is to nurture staff conversation rather than assignment of tasks (supporting critical thinking), and their approach is “efficacy, personal and team integrity, and excellence in quality of care.” Foundations for success are described as “leadership, support, and competency.” “This is collaborative practice, not team nursing,” Lilie says. “There’s no hierarchy. The housekeeper has as much value to our standard of care as the most senior RN, and we share a collective accountability to our patients.” Support and mentorship are critical underpinnings. “We have a ‘grow our own’ perspective,” Lilie says. “It’s essential to get the right people in, but it’s also essential to nurture the personal and professional growth of people while at work. We have a duty to help others who may be struggling.”

Filling an interm vacancy, Lilie hired a highly skilled RN as a clinician, with her sole role to support staff and nurture critical thinking. A Unit-based Scheduler, shared with another unit, was added to foster work-life balance for staff. Think of it as a sports coach — knowing staff, their family-based needs, and their strengths. The work schedule is negotiated, posted in three month blocks, and is open to staff shift trading. All planned vacations are approved and 90% of unexpected vacation requests are approved. Schedules are creatively adjusted to maximize exposure to educational opportunities — with an expectation that knowledge acquired will be brought back and shared with the team. “There was lots of overtime a year ago,” Lilie says. “Reducing overtime has created this opportunity to develop more flexible schedules that allow for staff to be happier. Life and family are important. Happy staff equals better care.”

There are Collaborative Practice Rounds every Thursday – broader than most other Unit Rounds, and more holistic. “Most units focus on discharge,” Lilie says. “Our goal here is quality of care received, and we work hard to prevent re-entry into the system by addressing all patient needs.” A holistic approach to patient care includes assessment of families and supports, encouragement of family participation, and inclusion of a total patient need-driven with a range of health professionals from all disciplines, not just nursing. Communication continues daily, with shift reports conducted in person as nursing shifts change.

To ensure knowledge is shared and staff is able to perform to their maximum capability, LPNs receive the same orientation education program as RNs when they are brought into Unit 52. The result has been no critical incidences, because as Lilie indicates “everyone looks out for each other and has the best interest of all patients at heart.” Lilie also believes a philosophical focus on total quality care assignment rather than purely patient assignment has led to higher staff satisfaction because staff is empowered to act as situations arise.

“I love how much we’re able to do on the Unit, and how busy, challenged, and valued I feel on a day to day basis.”

The practical benefits are being realized. “Recently an LPN noticed a patient’s central line was leaking,” Lilie says. “The situation was an emergency; she clamped the line and took action while practicing within the LPN scope of practice, potentially saving the patient’s life. If she had no knowledge of how central lines were done — which is covered in orientation — the outcome may not have been as good.”

The bar for quality of care is set high. If a staff person can’t meet that standard, Lilie indicates there is significant educator support provided to that individual to nurture individual skills and critical thinking development. But it’s also a double-edged sword. “You don’t get to stay here unless you are motivated to do your best and share accountability.” I ask Lilie how accountability and conflict is addressed. “There’s no talking in the back room here,” she says. “You talk to the person directly, and provide interactive critique. It’s OK to not know. We’re not punitive. We work together to step up and prevent error, acquire knowledge, and learn from mistakes.”

Kristy Dubois, LPN recounts a situation that brings all the good things being done on the Unit together into a dynamic and empowering decision making environment. “A patient called out from a room as I passed by and I immediately went in. The patient was having great difficulty breathing…he was blue. I called a Code 66 (patient not breathing), and remained with the patient. I directed the code team and staff. The only thing I couldn’t do was to chart during the code – which an RN came in to do. The intervention saved him. I amazed myself with what my training and experience had generated in terms of instinct and action. It’s an experience that has stuck with me and motivates me.”

Lilie indicates the collaborative focus on the Unit is clear, and each nurse develops a therapeutic nursing relationship with their patients. Therefore, if the condition of a patient an LPN is assigned to changes, the LPN is not pulled away from the patient, and if RN support is required it is provided – ensuring continuity of care.

Kristy graduated in October, 2008 and completed her preceptorship on Unit 52. She has a familiar story that lies at the heart of nursing. An accountant for seven years, Kristy wanted to be a nurse since Grade 6. Life threw a few curve balls, but the passion to be connected with people and care in a nursing environment never faded. Feeling she could be a better mom by turning to nursing, she put the accounting career in a drawer, absorbed a pay cut, took the LPN course for its “fast track schooling and hands-on learning,” and has not regretted the decision for one minute. “I love my job with every breath. I feel more connected to people, their lives, and their need to feel cared for in a time of vulnerability.”

Kristy notes, “I love how much we’re able to do on the Unit, and how busy, challenged, and valued I feel on a day to day basis.” It’s a sentiment echoed by Lilie who notes that, “LPNs are truly performing to full scope of practice. As fast as the scope changes, we’re expanding the LPN role.”
Kristy indicates she feels empowered by the team atmosphere on the Unit, indicating that not being afraid to ask for help or help others is central to the functioning of the team. She also feels empowered to get involved when she sees an interesting patient condition she wants to learn more about. “Today there’s a patient with a large abdominal wound. I asked if I could change the vac dressing because I’m interested in it and want to learn something new. An RN will mentor me as I perform this skill for the first time, including the patient teaching needed. I appreciate the opportunity to always be learning something new here...because it’s encouraged.”

Kristy also talks about a patient first focus, “We have four to five patients typically assigned to us on a day shift, but if we have a more acute patient, the patient load is lightened to spend increased time with that patient. It makes it easier to talk to patients...to give them comfort. We have time to ask how their day is going. Sometimes a patient isn’t told about their outcome and they have questions. We have time to answer...it’s a good feeling.”

I ask Kristy about what makes life good for her on the Unit. She talks about a number of small things that, taken together, nurture the spirit of the person and feeds the desire to come back for more every day. “Twelve hour shifts were difficult for me given I’m a single Mom. The Unit generated an eight hour shift to accommodate those with needs like mine. Collaboration is constant and daily. If you need something, people are there for you. Everything is done to maximize ongoing education to provide a constant learning environment. As a relative newbie there’s lots of support for new staff. There’s a circle of learning around the patient.”

What does the patient have to say about ‘service’ on Unit 52 I ask? “We get to know patients,” Kristy says. “Patients tell us illness aside, they love time spent with the staff on the Unit and they appreciate our standard of care.” As Lilie notes, “Everybody knows you as an individual, patient, and family. Staff cry when people die. It’s our expression of humanity.”

I ask Lilie what she sees through her eyes in terms of the Unit today compared to what it was a year ago. She says she sees positive changes in the small things that make a big difference both professionally and personally. “Turnover has settled lately....staff leave but it’s to be closer to home or because the family moves not because they don’t like working on the Unit. It feels happier. Staff joke around with each other more. There’s better communication with patients. We’ve been able to add one additional nurse per shift.”

For hard work there’s a softer side of kinship in common purpose. A Banff Park Pass can be signed out. Coffee cards, thank you cards, and desired time off have been used to reward performance. A jacket (donation) was recently bought for everyone on the Unit – a brand that celebrates team spirit.

Lilie pauses when I ask what role the RNs have played in the integration of LPNs into the Unit. “It couldn’t have been done without senior RN staff,” she says. “A year ago when standard competencies were being evaluated in the Region, senior RNs on the Unit indicated they didn’t see the need for LPNs on the Unit. I’ll bet if you ask them the same question today, they’ll say that LPNs are part of the team and part of the family – and there would be a hole in our Unit without them.”
Helen Paget, RN, volunteered to preceptor the first two LPNs in Unit 52 a year ago. Her only previous exposure to LPNs was a long time ago when an LPN was a Certified Nursing Aide. Helen indicates the high acuity of the Unit was challenging for the first LPN’s – who, like most new nurses to the unit, were missing some education in key areas such as IV meds, tubes, and procedures. A year down the road now, Helen acknowledges that staffing is generally pretty good, and work satisfaction for all nurses on Unit 52 is better. “As a mentor, I never turn the quest for knowledge down - be it LPN or RN. We’re committed to high standards. We make people think, and work for answers on Unit 52. It’s critical thinking skills and the whole patient perspective that differentiates our approach to work. The grounding here is great if you want to be the best nurse in the world.”

Does the story end there? Well yes and no, and it’s still evolving.

“We’re there,” Lilie says, referring to integration of the LPN into Unit 52. We talk about the challenge of navigating the grey areas between RN and LPN scopes of practice. “Our RNs have a better understanding of their competencies and those of the LPN here…because we’ve worked through it,” Lilie says. “We’re also so focused on holistic care, which clarifies roles in a team work environment. Everybody is getting it…and it changes how one thinks about things. It’s more abstract, but it’s entwined with the critical thinking skills needed for today’s health care challenges.”

Lilie indicates the staff vacancy rate is now zero. “People are waiting in line to work in the Unit,” Lilie says, a fact Lilie attributes to a budding reputation, and work with Colleges/Universities to host practicum and preceptorship placements. What clouds the picture is recent restructuring that has seen the change of regional health authorities in favour of a single umbrella – Alberta Health Services. Lilie’s responsibility as Patient Care Manager has been shifted to Unit Supervisor, but she remains responsible for the unit with the support of a Manager who oversees two separate units.

“Have patients.” It’s a play on words, but it lies at the centre of a now year-long effort to re-think how healthcare is provided at a Unit level, and the advanced role an LPN can play in a highly acute environment. The result of LPN integration into the Unit has been delivery of a quadruple bottom line: increased availability of staff; delivery of a higher standard of care to patients; a better staff patient ratio than other units; and more cost effective health care provision. Professional performance is more about respect and expertise and less about title.

It’s been said that we are told never to cross a bridge until we come to it. Yet this world is owned by people who have crossed bridges in their imagination far ahead of the crowd. On Lilie’s office door are magnetic words that can be arranged in any fashion by anyone walking by. A grouping of words says “Help. Hard week. They lead.” Just another week for Unit 52 – building bridges… and delivering them.
Nursing courses through the veins in our family. It all started with my grandmother, Marie Delorme (nee Stolz). To quote my Grandma, “Standing on the stage of the Paris Theatre on Laverandrie Street in Winnipeg along with 200 nurses, in our white uniforms and carrying a bouquet of red roses, and tears in my eyes, my dream was coming true. I have visualized this since age four, and seeing my dad, who made it possible, in the audience made it perfect.” Grandma was talking about her graduation day from the St. Boniface Hospital School of Nursing in 1944.

Marie Delorme (nee Stolz). Grandma grew up near Humboldt, Saskatchewan. Grandma’s family was poor and Grandma thought she would never be able to go to nursing school. Grandma’s dad paid for her to go to Winnipeg where Grandma worked and went to nursing school at St. Boniface Hospital School of Nursing. Grandma graduated from nursing school in 1944 and practiced nursing at hospitals in Vancouver and Kelowna, BC; Hanna, Alberta and Melfort, Saskatchewan. In 1974, her 18 yr old daughter, Joan, was talking about going into nursing so Grandma thought it was a good idea that she go back into the nursing profession that she so loved after a leave of absence to raise her children. In 1974, Grandma went to Saskatoon and took a refresher course at St. Paul’s Hospital and then went back to work at the Melfort Hospital. In 1979, Grandma decided to take a position at Parkland Long Term Care in Melfort where she worked her way up to supervisor and she stayed until she retired in 1987.

Joan Briens (nee Delorme) grew up in St. Brieux, Saskatchewan. She spent her childhood watching her mother, Marie, tend to the sick and injured and decided that nursing was the career for her. Joan graduated from the Kelsey Institute of Applied Arts and Sciences in Saskatoon with a diploma in nursing in 1976, Joan started work at the City Hospital in Saskatoon where she has remained until the present. For the past year, she has also been employed at the Royal University Hospital. Joan has worked in a number of units during her career including general surgery, ICU, CCU, progressive care unit, pre-assessment clinic and day surgery and is now a clinical support/resource RN.

Stacey Green (nee Delorme) grew up in Saskatoon, Saskatchewan. My mother told me that I had always wanted to be a nurse from about the age of 3. I spent summers with my Grandma Marie who was the only nurse in the village of St. Brieux. She was always being called at all hours to help out in the community; whether there was a car accident, someone was sick or someone needed assistance with their medicine, I remember going out to some emergency calls with her and seeing her in action. When I went to Melfort to visit her, I remember waiting for her to complete her shift at Parkland Long Term Care where I got to know the other nurses and residents.

I loved her stories of when she was in nursing school having to wear a cape while outside and her uniform having to be just perfect. Later, when I was a nurse, I found her stories fascinating as she described which medicines were being used for which conditions and how they did things years earlier, like having to taste urine to see if there was sugar in it to help diagnose diabetes. Her Grandfather died of diabetes in 1924, the year insulin was developed. My grandmother was selfless and I truly admire her, and therefore she inspired me to want to become a nurse.

I married and with the support of my husband, I moved to Camrose to take NorQuest College’s Practical Nurse Program. I graduated from the program in 2005 and started working at Mountain View Centre, Good Samaritan Society in Hinton. In 2006, I also started working at the Hinton Healthcare Centre in medical/surgical. I then took the Initiation of IV Therapy Course and later in 2006, started working in the Operating Room and Endoscopy at the Hinton Healthcare Centre. In 2007, I completed the Peri-Operative Course for LPNs and in 2008 the Immunization Course for LPNs. I thoroughly enjoy my position and am so grateful that I have my “dream job!” I truly am here for the patients and am so proud to be an LPN. I am pleased about all of the continuing education courses that are out there for LPNs and am excited to see what the future holds regarding our scope of practice.

I will always keep in mind what Grandma said, “Remember life is a journey-enjoy the ride.”

Picture: My Dad, Gary Delorme, created this picture to give to all three of us after my graduation.
Silence can be scary when you hear voices. Parents will tell you that when their children are too quiet, they instinctively know something is wrong. To a person with a mental illness, stigma often takes the form of silence.

I have been living with Schizophrenia since I was 5 years old, when my mother was diagnosed after the birth of my youngest sister. We were “that” family with the sick mom. As I grew up, and learned what the word schizophrenia meant, that my mother and my great grandmother both had it, I was scared of getting it myself. When I passed my 30th birthday, without getting sick, I thought I was safe. I was wrong.

For some people, mental illness comes on gradually. For me, it happened like a light switch going off. One minute I was sitting in a neighborhood eatery having a cup of tea, and the next minute, I fell into complete psychosis. I remember thinking, as I was being escorted down a corridor under a large sign that said “Psychiatry,” that my life was over. Fortunately, I was wrong about that as well.

When people first meet me, I look for signs in their face that they “know.” I look at myself in the mirror, and hardly recognize the man I am now. Gone is the thin young scientist who went prospecting for meteorites at the South Pole. The man in the mirror is overweight, and graying in hair and beard. I ask myself if I look normal. I’m not sure I know what normal is anymore. I see in my reflection someone in a suit and tie that go well together, mostly because I leave such things up to my wife, but I still wonder if people look at me and think that I am just playing dress up in my father’s clothes. Can they see my illness in my eyes?

When first diagnosed, people fell away from my life. I guess I expected to lose friends, not so much out of fear, but because we would no longer have anything in common. My well planned career path in academia and research disappeared overnight. What I didn’t expect however, was the reaction of my family. Some I suppose were afraid of me. I know others were embarrassed. One even suggested that I should sterilize myself so I couldn’t pass the illness on to any further. In the beginning, I didn’t have much opportunity to grieve for the loss of the life I had known, because the older medications that were available in 1992, primarily sedated. I was barely capable of watching a half hours worth of television. Reflecting on my situation was really beyond my grasp.

Later when the new non-typical anti-psychotics came on the market, I was able to regain some of my lost capabilities, and began to re-engage with the academic community. I may not have been capable of field work, or classroom instruction, but I knew I could make a contribution. I began to publish research papers on what my wife calls areas of science only uber-geeks understand. Still, when corresponding or collaborating with other researchers on projects, there would come out of the blue, the silence. Abruptly in the middle of a joint project, they would break off communication. I have never hidden my illness, but when someone would find out, they would usually run away, often without a word of explanation.

I had gotten used to being shunned and feared. When I met my future wife, I was afraid to tell her about my illness. I longed for someone to share my life with, but still carried the scars of women running away at the mention of the “S” word. When I finally got up the courage to tell her, she said, “that’s interesting, so what.” I thought perhaps that she just didn’t understand what the word meant.

What I didn’t know at the time was that in her former legal practice she had represented scores of mentally ill clients. She has that rare ability to separate the person from the disease. She said that if I was trying to scare her off, I’d have to find something else.

Being married to someone with Schizophrenia has additional obstacles that regular marriages don’t face. We had to convince my priest that I was competent to marry in the church. When people first met her, they asked if she also had schizophrenia. The people who didn’t ask, just assumed, and were shocked when they eventually found out. It seemed as if no one could believe that a normal woman would willingly marry a man with this illness. My family looked for reasons to dislike her, to distrust her, and actively tried to get her deported. As an American, she didn’t have the automatic right to stay in the country just because we were engaged. We had to marry civilly first in order to protect her from deportation. As devout Catholics, getting married in the church was very important to us, but it took months to finally get our wedding scheduled. Two days before the service, our priest called us to tell us that my family had so many concerns about the marriage, he would have to postpone the wedding until he could investigate.

When you are disabled, you often have to depend on your family, especially in the beginning. It is hard for them to let go later when you are capable of handling...
your own affairs again. When I made my last medication change to Risperidol Consta, I had an almost miraculous improvement in my condition. A constant yet lower dose of a medication lessons all the side affects these powerful drugs can have on your system. I was much less sedated, and went from sleeping 12-14 hours a day to a more normal 7-8 hours. That’s an additional 40 hours a week that I am awake. In addition to being awake longer, my cognitive abilities have returned to a level very close to what they were before I became ill. When you have Schizophrenia, assertiveness can be misinterpreted as aggression, especially when your family has become accustomed to your needing their help to make decisions. When I started to reclaim my life, they responded with fear.

Eventually, our wedding was rescheduled, but I remain estranged from some of my family members. I still love them and miss them, but I have come to understand that I can’t force them to be in my life. Maybe someday there will be a cure for Schizophrenia, and the fear will subside. Maybe someday I will look in the mirror and recognize the man standing there again.

Watch for future compelling articles from Dr. Mardon in this new feature series. Learn more or contact Austin directly at www.austinmardon.org.

Dr. Austin Mardon was awarded the Order of Canada in 2006 for his advocacy on behalf of the mentally ill. In his youth, he was a member of a joint NASA/NSF meteorite recovery mission to the South Pole. He holds degrees from the Universities of Lethbridge, Texas A&M, South Dakota State and Greenwich. He has authored 184 scholarly works including additions to Nature and Science. In 2008, he was inducted into the International Academy of Astronautics.
A recently completed provincial risk assessment on the re-use of single-use syringes in surgical, dental and endoscopic procedures has determined that the risk to public health was very low. As a further safety measure, health professionals across Alberta were directed to eliminate this practice in October 2008.

"The practice of re-using syringes to administer sedation to surgical patients through IV lines was once widespread," said Dr. Richard Musto, Alberta's Acting Chief Medical Officer of Health. "While best practices have evolved, we know the practice likely continued sporadically in other areas of the province until a clear directive to stop was issued in October 2008. I want to assure former surgical patients and all Albertans that the risk of transmission of infection has been found to be very low, and that the appropriate practice has been brought to the attention of health professionals across the province."

A province wide risk assessment was co-ordinated by the Acting Chief Medical Officer of Health after the re-use of single-use syringes to administer sedation through intravenous lines to multiple patients was reported at the High Prairie Health Complex, the Vermilion Health Centre and the Lloydminster Hospital last year.

A risk assessment in High Prairie resulted in a chart review of patients who had undergone dental and endoscopic procedures at the High Prairie Health Complex. Patients were contacted to offer testing for blood-borne pathogens. In addition, the Minister of Health and Wellness directed the Health Quality Council of Alberta to investigate the situation in High Prairie and make recommendations. That report is expected this spring.

When the practice was identified in Vermillion and Lloydminster, Dr. Gerry Predy, the Acting Chief Medical Officer of Health at that time, directed all regional Medical Officers of Health to review procedures in their jurisdictions in order to identify and stop similar practices. The College of Physicians and Surgeons of Alberta also directed their members to review their own practices.

"The re-use of these single-use devices highlights the need for continued vigilance on the part of every individual involved in the delivery of health care for any practice that can put patients at risk," added Musto. "I want to commend and thank the health professionals who reported this practice. As inappropriate practices are identified and corrected, we will ensure that the lessons are shared widely across the system to improve health care quality and patient safety. We will continue to work with Alberta Health Services to ensure consistent compliance with the provincial infection prevention and control standards."

The re-use of single-use syringes to administer medications through IV lines has also been identified in Saskatchewan. Both provinces’ Chief Medical Officers of Health will be sharing the results and recommendations of their reviews with their counterparts across the country.

**BACKGROUNDER**

*High Prairie Health Complex patient look back*

Following an initial risk assessment of the practice of re-using single-use syringes at the High Prairie Health Complex, patients were contacted to offer testing for blood-borne pathogens. That look back is nearing completion, with 1,270 of 1,380 (92 per cent) potentially affected patients contacted and 1,105 tested. To date, there has been no identified link between any infection and the re-use of a syringe to add medication to an intravenous line.

**Comprehensive Provincial Risk Assessment**

After the practice of re-using single-use devices to administer medication through intravenous lines to multiple patients was also identified in Vermillion and Lloydminster, the Acting Chief Medical Officer of Health directed Alberta Health Services to convene a working group to complete comprehensive risk calculations related to this practice in Alberta and make recommendations.

Many factors were considered in the calculations, such as:

- The probability of syringe re-use occurring.
- The probability that, if a syringe was re-used, transmission of an organism to a patient would occur.
- The probability that, if transmission occurred, disease would ensue.
- The prevalence of blood-borne pathogens in the local population.

The risk assessment methodology and recommendations were provided for review to an expert group of the Public Health Agency of Canada. The group supported the methodology and recommendations.

For a review of the Health Quality Council of Alberta report and recommendations on this please view www.hqca.ca
What is Chiropractic and What do Chiropractors do?

With close to 80% of the population experiencing back pain at some point in their lives, it is little wonder that almost a million Albertans seek care from Alberta’s 950 Doctors of Chiropractic each year.

Chiropractic is a health care profession encompassing a range of health care practices that diagnoses, treats and helps prevent disorders and conditions related to the spine, nervous system and musculoskeletal system (including back, neck and head pain).

Doctors of Chiropractic are primary contact health care professionals; you do not need a referral to see a chiropractor. Chiropractors believe in treating the individual as a whole, practicing without drugs or surgery, and focus on patients’ musculoskeletal and nervous system function in relation to the whole body.

As a result of more than seven years of post-secondary education, chiropractors are additionally trained to recommend therapeutic and rehabilitative exercises, as well as provide nutritional, dietary, and general health and wellness counseling. Chiropractors will often consult with and refer to other health care providers to serve the best interests of their patients.

What happens during a chiropractic treatment?

On the first visit, patients fill in a health history form and review their history and current health with the chiropractor prior to the initial assessment.

The chiropractor will then use a variety of diagnostic techniques, including physical examination, orthopedic and neurological testing, imaging systems and direct palpation of joint movement to determine what areas of the patient’s body are not working properly. When the patient’s condition is assessed, the chiropractor will recommend a course of treatment.

The primary treatment is a chiropractic adjustment, a gentle, controlled and directed pressure that helps to restore the spine’s ability to function and relieve nerve interference. Chiropractors also use related therapies such as mobilization, massage, heat, cold and laser as treatment methods.

Cost

An initial consultation is typically between $60 and $100 depending on the extent of the assessment. Treatments after the initial assessment range between $40 and $50 per visit. It is entirely appropriate to ask what the fees are when booking a first appointment.

Many extended health care plans (e.g., Blue Cross or Great West Life) offer coverage for chiropractic treatments. For patients who suffer an injury in a motor vehicle accident, coverage may also be available from your auto insurance provider at no charge.

Workers’ Compensation

Many chiropractors in Alberta are WCB authorized as a primary contact if you are injured at work. According to WCB data (2005) chiropractic has proven to be a safe, effective, drug-free, non-invasive health care option, with patients expressing high degrees of satisfaction in both treatment and results. In Alberta, chiropractic is consistently one of the best clinical and cost-effective treatments for injured workers, with a 95 percent patient/treatment satisfaction rating and a lower than average expenditure rate per patient claim.

Chiropractic in Alberta

Alberta was the first jurisdiction to license chiropractic in Canada, and the very first Canadian Chiropractic Profession Act was legislated in Alberta in 1923. The Health Professions Act (HPA) is the current legislative framework for chiropractic, and under the HPA chiropractic is regulated by the same standards that govern all other regulated health care professions including the medical and nursing professions.

The Alberta College and Association of Chiropractors

In Alberta, the chiropractic profession is represented by the Alberta College and Association of Chiropractors (ACAC), which is both a self-regulating college and an association. Committed to pro-
tecting the public, ensuring accountability, and improving Albertans’ health and well-being, the ACAC represents the interests of the public and its registered members within Alberta’s legislative framework.

Association activities are committed to raising awareness about the effectiveness and benefits of chiropractic care, and dedicated to helping Albertans live healthier lives through public service programs like:

- **Pack it Light. Wear it Right**: a backpack safety program
- **Best Foot Forward**: a program designed to prevent seniors from falling
- **Back Health in the Workplace**: an awareness program about the potential for workplace back injuries
- **Fit in 15**: a program designed to encourage people to adopt just 15 minutes of exercise each day

The ACAC regulatory college is responsible for protecting public interest, registering practitioners, establishing and enforcing high standards of practice, and ensuring registered Alberta chiropractors provide quality health care.

**Becoming a Chiropractor - Education**

Chiropractic students complete a minimum of seven years of post-secondary education, including a four-year academic program of over 4,500 classroom hours. Areas of study include:

- Anatomy
- Physiology
- Disease
- Pathology
- Biochemistry
- Clinical sciences
- Nutrition
- Body mechanics
- X-ray diagnosis

In addition to classroom hours, students must treat patients in a supervised clinic setting during their last year of education.

**Requirements for Practicing in Alberta**

For a chiropractor to practice in Alberta, they must first graduate from an accredited chiropractic college, as well as pass stringent national and provincial board examinations.

After meeting all educational and licensure requirements, practitioners are granted registration with the ACAC and awarded a license to practice in Alberta. Following licensure, chiropractors participate in annual practice reviews and an ongoing Continuing Competence program to ensure they remain up-to-date with treatment protocols and record keeping, and that they maintain clinical competency and currency of professional knowledge.

**Chiropractic & Science**

The American College of Physicians endorsed and published a Clinical Practice Guideline (CPG) entitled *Diagnosis and Treatment of Low Back Pain* in the October 2, 2008 issue of Annals of Internal Medicine that clearly showed that medical and chiropractic practice guidelines with respect to low back pain are fundamentally the same. The CPG is also endorsed by the American Pain Society.


Furthering the acceptance of chiropractic as mainstream health care, there has been continued widespread growth in chiropractic research chairs and professorships across Canada. Significant chiropractic research is being conducted at Canada’s most prestigious learning institutions including: McGill University, Dalhousie University, McMaster University and Institute for Work & Health, as well as the Universities of: Alberta, Calgary, British Columbia, Guelph, Manitoba, Ottawa and Toronto.

**Patient Satisfaction**

Consumer Reports 2009 Survey: *Chiropractic most satisfying treatment for back pain*. The Consumer Reports Health Ratings Center survey released April 2009 revealed that chiropractic treatment was the most satisfying treatment for back pain. According to the survey, approximately 80% of adults in the US have had back pain at some point in their lives, which is the same percentage that Statistics Canada reported of Canadians in 2006. Hands-on treatments were rated as very helpful by lower-back pain sufferers with chiropractic receiving the highest rating.

Chiropractic services received the highest rating for access and second highest rating for patient satisfaction in the 2006 Health Quality Council of Alberta survey.
Chiropractic Research Summaries
August 2009

Chiropractic is a healing discipline firmly grounded in science. Chiropractic has been researched and assessed extensively in terms of both safety and effectiveness. There have been at least six formal government studies into chiropractic worldwide over the last 25 years and all have concluded that contemporary chiropractic care is safe, effective and cost effective.

In addition, there have been countless scientific clinical studies assessing the appropriateness, effectiveness, and/or cost-effectiveness of spinal manipulation or chiropractic manipulation, most notably for low back pain. The Canadian Institutes for Health Research (CIHI) now offers research grants in partnership with the Canadian Chiropractic Association to chiropractors and other scientists for high quality, chiropractic research.

Clinical Effectiveness

The Results of a six-year study from the Bone and Joint Task Force on Neck Pain and its Associated Disorders into the causes, prognosis and treatment of neck pain were published in the peer reviewed journal Spine in 2008. Key findings included that manipulation and mobilization are safe, effective and appropriate treatment approaches for most patients with disabling neck pain and the risk of vertebrobasilar artery stroke (VBA stroke), a very rare form of stroke is exactly the same for neck pain patients whether they consult a doctor of chiropractic or a primary care medical physician. The report indicates that it is likely that patients in the early stages of VBA stroke are presenting to both chiropractors and family doctors because of neck pain and headache due to pre-existing vertebral artery dissection which is a risk factor for VBA stroke.

Annals of Internal Medicine (2008)
In the October 2, 2008 issue of Annals of Internal Medicine, the American College of Physicians (ACP) published new clinical practice guidelines for the treatment of low back pain. The guidelines concluded that spinal manipulation be considered for acute and sub acute low back pain. In essence, the medical and chiropractic practice guidelines for low back pain are fundamentally the same.

Chiropractic’s efficiency and effectiveness is further supported by studies published in the British Medical Journal (BMJ) and the American Medical Association’s Archives of Internal Medicine. The BMJ UK Back Pain, Exercise and Manipulation (BEAM) study (Dec 2004; 329: 1377) identifies clear outcomes that support both clinical efficacies along with cost-efficiencies related to spinal manipulation relative to “best care in practice trials.”

Submitted by the Alberta College and Association of Chiropractors
The Safety Net: A Nursing Perspective

Raising Nurses’ Awareness of the Scope of the Problem with Safety in Healthcare and of the Science of Patient Safety

By Linda Nykolyn, RN, BScN

This article is the first in a series focusing on the critical role of nursing in keeping patients safe from harm. The article addresses the scope of the problem of safety in healthcare and introduces the need for nurses to learn about the science behind patient safety.

Major accidents like the space shuttle Challenger, the Tenerife airline disaster, and the nuclear reactor explosion at Chernobyl involved the lives of many people and received headline news. They grabbed our attention and left us all wondering what went wrong. Through media exposure and public outcry, high-risk industries such as aviation and nuclear power have addressed their safety issues and have implemented solutions to ensure accidents such as these do not happen again.

By comparison, accidents or adverse events in healthcare involving patient injury and loss of life typically involve one patient at a time and seem less dramatic.1 Discussion and investigation into an adverse event is usually done behind closed doors and rarely do these singular occurrences reach the headlines or draw public attention. Without the same pressure and impetus to improve patient safety performance as experienced by other industries, healthcare is decades behind its high-risk counterparts in improving safety, even with serious consequences.2

For example, evidence from national studies shows that an unpardonable number of patients are being harmed by the same system that is supposed to provide care, comfort, and promote optimal health:

- 44,000 to 98,000 people die annually in U.S. hospitals from medical errors1
- 9,000 to 24,000 people die annually in Canadian hospitals from adverse events3

The question on the minds of healthcare leaders and care providers is, “How is this happening?” Healthcare providers are among the most educated and dedicated workforce in any industry.1 They have all been taught about the Hippocratic Oath - first do no harm. What is causing these errors that lead to adverse events and patient deaths?

In order to answer these questions, we need to turn our attention to the science of patient safety. It is a new body of knowledge that has entered healthcare, the nursing profession, and all other health disciplines. As a specific field of study, patient safety was in its infancy when most nurses attended nursing school. In fact, many nurses were taught that patient safety simply meant to be careful to not make an error. However, much has been learned about patient safety over the past decade through the transfer of knowledge from other high-risk industries like aviation to healthcare that has been generated from root cause analysis of their own significant disasters as previously mentioned. We have greater understanding of how errors happen and how they can be prevented. A broader definition of patient safety now includes the “avoidance, prevention, and amelioration of adverse outcomes or injuries stemming from the processes of health care itself.”4

Areas of patient safety knowledge important to nursing include human error, routine violations, human factors engineering, systems thinking, structured communications, teamwork, error detection strategies, error analysis, and safety design. Because many of these concepts may be unfamiliar, nurses in the workforce must actively participate in a learning process to integrate this knowledge into their daily practice. To facilitate this process, articles in this series will introduce you to several of these safety concepts. Stay tuned for the next article which examines human error and describes the person approach versus the systems approach to error.

Hear the Passion
The Voice of the LPN

Dorian Rivers-Orlesky
Resident Services Manager/
LPN in Calgary
Years of Practice: 10

Why did you become an LPN?
I was chasing a childhood dream of being a nurse. When the RN role became more of paper pusher, and less personal; I decided the LPN role would be best for me, as it helps mind, body and soul.

What would you say to someone interested in becoming an LPN?
It’s the most rewarding work I’ve ever done. You go home at the end of the day knowing you’ve made a difference in someone’s life.

If you weren’t an LPN, what would you be?
I’m not sure…

What’s the most rewarding aspect of your job?
Seeing the seniors laugh, and the families happy that their parents are happy.

What’s your most memorable moment as an LPN?
Everyday is memorable.

Evelyn Wiesbrot
LPN in High River
Years of Practice: 44

Why did you become an LPN?
I was always interested in the nursing profession, notably in children and seniors and found my niche in caring/loving seniors. They are all so loving. If one small thing I do for them can make them smile or feel good, it’s all worth it.

What would you say to someone interested in becoming an LPN?
I definitely would encourage anyone to enter the nursing profession as an LPN. There are many opportunities for them to explore, many fields to choose from. It’s a very rewarding career.

If you weren’t an LPN, what would you be?
I don’t know…

What’s the most rewarding aspect of your job?
Seeing seniors smile and enjoying their day at the adult day support program. Thanking me for making their “special day”.

What’s your most memorable moment as an LPN?
Many moments of laughter, hugs, despite ups and downs. Changes. I enjoy my position as an LPN, but I graduated in 1965 and have seen many changes in professional development.

Caron Enns
LPN-HCA Facilitator/
LPN in Calgary
Years of Practice: 13

Why did you become an LPN?
I had two aunts in the profession and they mentored me to join this career.

What would you say to someone interested in becoming an LPN?
It is one of the most rewarding jobs, next to being a mom!

If you weren’t an LPN, what would you be?
Probably a veterinarian… still caring!

What’s the most rewarding aspect of your job?
Knowing I made a positive difference in someone else’s day.

What’s your most memorable moment as an LPN?
My daughter received a burn to her arm, and one day I was changing her dressing and cleaning her wound, she looked up at me and said, “Mom, I am so glad you are such a good nurse. It didn’t even hurt.”
There are 3 ways to motivate people to work harder, faster and smarter:
1. Threaten them.
2. Pay them lots of money.
3. Make their work fun.

In today’s workplace, threatening people has not been effective. Paying them lots of money (even if you can afford it) has only shown short-term success. Only number three, making their workplace enjoyable, has a track record of effecting real change. It is time managers learned how to create an atmosphere that is challenging, creative and fun for employees as well as for themselves.

HOW FUN IS PRODUCTIVE

Imagine a work world where people love their work environment, and they are calm, stress-free and happy all day long. People who are in good spirits are more likely to be productive. Their mental attitude produces increased oxygen, endorphins, and blood flow to the brain, which enables them to think more clearly and creatively. They are more relaxed, more accepting of others, and more likely to share their sense of humor.

Laughter creates a bond that brings others together; people like to be with employees who are having fun. Creativity, intuition and flexibility are key to successful operation of organizations today. In stimulating environments, employees enjoy their time at work and they will also excel at work. Attracting customers is easier in an environment of hospitality. A fun workplace is not only more productive, but it attracts people and profits.

A TEST: IS YOUR STAFF SUFFERING FROM TERMINAL SERIOUSNESS?

Scan your workplace and take note:

- Do you regularly catch people laughing or smiling at work?
- When something funny happens do people stop and appreciate it?
- Does your organization have fun activities at least monthly?
- Do you have tools (fun giveaways, draws) to invite patients to participate in having fun in your environment?
- Are managers usually optimistic and smiling at work?

If you answer no to two or more of these questions, your staff probably suffers from “terminal seriousness,” which is negatively affecting morale and productivity.

More Benefits of Humor in the Workplace

Dr. Norman Cousins said, “Laughter is an igniter of great expectations.” Children laugh an average of 400 times a day and that number drops to only 15 times a day by the time people reach age 35. Preschoolers must know something we don’t. Laughter releases endorphins (a chemical 10 times more powerful than the pain-relieving drug morphine) into the body with the same exhilarating effect as doing strenuous exercise. Laughing increases oxygen intake, thereby replenishing and invigorating cells. It also increases the pain threshold, boosts immunity, and relieves stress.

Humor also levels the playing field to create an atmosphere that encourages honest dialogue, open communication, and increased risk-taking. Creating more equality in power or control shows people respect and builds pride in their work.

This is just a sampling of the benefits of having fun in your workplace. Hopefully now you are convinced you could use a “fun injection” in your own place of employment.

Help people belong to your organization and not just work there by giving them a way to solidify and build rapport.

About the Author

Jody Urquhart is a speaker and author who is passionate about spreading the message of fun and meaningful work.

www.idoinspire.com
13 STEPS TO CREATING A FUN WORKPLACE:

1. **Give up the notion that professionalism means being serious all the time.**
   It’s possible to take yourself lightly and still be competent and productive. Start to promote the benefits of humor at work.

2. **Define what fun is in your workplace and what it is not.**
   (e.g. harmful humor, off-color jokes, sexual humor, humor tarnishing the organization)

3. **Organize a “Fun Committee” for dreaming up fun “stuff” to do during and after work.**

4. **Add fun to meetings.**
   Bring in fun things such as Nerf balls, a basketball and hoop, or party blowers. Start a meeting with a humorous story or joke.

5. **Collect and share your favorite cartoons and jokes.**
   Create a Joke Board or a Humor Newsletter. Look for tools to disseminate fun and funny things daily.

6. **Let customers know you are a fun company.**
   Do something just for fun (organize fun customer events, dress for fun, share funny things with customers) and give employees tools to create a fun relationship with customers (stickers, candy for children, dog biscuits for dogs, humorous buttons with the company logo). This makes work more fun for employees and it strengthens the relationship with customers. Dick Snow of Ben and Jerry’s Ice Cream says, “We believe that we’re in the entertainment business and selling ice cream is just a part of what we do. In our stores the counter is our stage and the customers are our audience.” Disneyland has the same kind of approach. Employees are part of an entertainment experience, and they aren’t just doing a job.

7. **Gather your co-workers for the “Joy of Work” hour.**
   Everyone must talk about something good at work. Take turns telling stories about the things that make work a joy. Each person should contribute ideas on how to make work more fun.

8. **Have a fun recognition program.**
   Fun is not a reward for performance, but can be a way to encourage employees to perform. For example, you could create “games” out of productive activity...who can motivate the most patients in a hospital to smile and say something funny to the head nurse. Playful and goal-oriented fun is best.

9. **Respond to fun when it happens.**
   Funny things occur all the time, but if you are obsessed with left-brain analytical thought, you might find it hard to stop and respond. Natural spontaneous humor is a blessing. Stop and take a moment to give employees and customers an opportunity to see the fun in the event.

10. **Commit to being fun and it will change your approach to work.**
    Start slowly with a few activities and communicate your desire to create a more relaxed workplace. Don’t expect things to turn around overnight.

11. **Put fun things and activities in the staff room.**
    This allows people to take their mind off of the seriousness of work for a short period, so they come back to work with a more positive and balanced perspective.

12. **Encourage staff to leave work behind at the end of the day.**
    Employees shouldn’t be so consumed with work that it affects their family life and leisure activities. Find fun ways for employees to “unload” at the end of the day or week. Create a ritual like writing a “to do” list and posting it on the board. By doing this, you commit to not thinking about the things on the list until the next day.

13. **Encourage employees to develop their own style of having fun.**
    A nurse anesthetist at a hospital in Michigan often sings to his patients to help them relax prior to surgery. Patients have appreciated this so much that they have told family and friends about the experience. It is not uncommon now for the hospital staff to get requests for “The Singing Anesthesiologist” when they are scheduling their surgery.

   Remember that employees create fun in the workplace, not managers. It’s a manager’s job to orchestrate fun activities (and not get in the way of them).
Licensed Practical Nurses (LPNs) have been providing nursing care in the province of Alberta for over sixty years. For the past 23 years, the LPN profession has been self-regulated. The LPN scope of practice has evolved with many specialized competencies including perioperative nursing, dialysis, and advanced orthopedics.

Traditionally, Orthopedic Physicians performed all casting on their patients. In the 1960s and 1970s, orderlies and similar health care workers were trained in cast application in emergency rooms and cast clinics, they were called Orthotechs. As time progressed, Orthopedic Physicians called for a broader knowledge and skills base for assessing and caring for these patients.

It was in the late 1980's when Dr. D. W. C. Johnston, Chief of Orthopedics, University of Alberta Hospital, encouraged development of an advanced orthopedic program for LPNs with support of the College of Licensed Practical Nurses of Alberta (CLPNA). Dr. Johnston developed course objectives by assessing the role of Orthotechs in various cast clinics and emergency rooms.

A course was developed and delivered by a team of experts, including: Judy Hunt, R.N., B. Med.Sc., B. Sc.N., Instructor, NorQuest College and Roger Cousineau, R.N., B.Sc.N., Assistant Unit Supervisor, Plaster Room, University of Alberta Hospital. The course was reviewed by Dr. Johnston and CLPNA.

The Advanced Orthopedic Specialty program for LPNs has been successfully delivered by NorQuest College since this initial pilot. The program expands LPN scope of practice by teaching advanced orthopedic procedures and prepares the LPN to work in a cast room, emergency department, orthopedic physician's office or orthopedic patient care unit.

The NorQuest Advanced Orthopedic Specialty program key outcomes include:

- Orthopedic assessment skills for children and adults with multiple trauma, orthopedic pathology and complications
- Specialized knowledge and skills to care for clients with casts, splints, braces, traction, external fixation and amputations

The program is currently delivered in the following manner:

- Self-paced home study
  - 20 week pre-requisite Advanced Anatomy and Physiology for Orthopedics
  - 32 week core program (Five-day, week long workshop - available in Edmonton or other locations if student numbers permit)
  - 300 hour preceptor led clinical practice (can be completed in the LPNs home community if all competency elements are addressed and suitable mentors are available)
- Tutorial help throughout the program is available from a qualified orthopedic specialty instructor.

Orthopedic Specialist LPNs (Ortho LPNs) are highly skilled and respected in the workplace. They are sought out for their exceptional ability in casting, splinting, and providing advanced orthopedic care. The advanced orthopedic knowledge combined with the LPNs comprehensive assessment, critical thinking skills, and nursing knowledge provides a broad base of competencies for Ortho LPNs. In fact, they are often seen as experts in their field and are involved in the orientation of Medical Residents to the skill of casting.

There are currently 159 Ortho LPNs in Alberta. The average age of this group is slightly higher than general LPN membership (41.2) at 47 years of age. They are distributed throughout the province with the majority in larger centers at tertiary care emergency departments and cast clinics.

There are few Ortho LPNs in rural areas providing Orthopedic Specialty services. There is great opportunity to enhance the quality of care for Albertans by targeting this education for rural based LPNs. This could assist rural physicians who currently apply casts and provide orthopedic interventions and would potentially enhance the job satisfaction, recruitment and retention for LPNs in these settings.

In the past, several participants in the Provincial Advisory Committee for the
Orthopedic Program commented that there is a problem with vacancies and an inability to recruit LPNs with the Orthopedic Specialty into these roles. The results of this shortage impact acute and emergency services, and as a result, Physicians apply casts and perform other orthopedic procedures that could be performed by Ortho LPNs.

The Advanced Orthopedic Specialty program supports education requirements for LPNs as a progression into an advanced orthopedic area of practice. The program meets current practice standards and is approved by the Education Standards Advisory Committee through annual updates and a comprehensive review every five years. Demand for this program has increased as our health system evolves.

The value of regulated professionals providing advanced orthopedic interventions is clear. A nursing approach to care provides a holistic view of the orthopedic patient while maintaining continuity of care in an expanded sense. By maintaining a current practice permit with the CLPNA, Ortho LPNs have errors and omissions liability insurance and they must maintain competence and report annually through the Continuing Competency Program of the CLPNA. Ortho LPNs also have the rights and responsibilities authorized under the Health Professions Act as a member of a regulated profession.

For more information on the Advanced Orthopedic Specialty program for LPNs, contact NorQuest College at LPNConEd@norquest.ca or call 780-644-6000.

For questions about the role of the Ortho LPN, contact practice@clpna.com or call CLPNA at 780-484-8886.

Active Video Games: A Good Way to Exercise?

In recent years, a new type of video game has emerged: the active video game, which gets people out of their seats and moving around as they play the game. Wii and other active gaming products have become incredibly popular. Almost six million units of Wii sold in its first five months on the market, and other products such as DanceDanceRevolution have received lots of attention as well.

Many people are wondering if active video games are a good way to exercise, but academic research investigating this question has been slow. That being said, the research that has been done has yielded promising results about the physical and psychological outcomes of playing active video games.

This report covers the following topics:
• Types of active video game products
• The outcomes of active video games: what the research says so far
• What we still need to learn
• How these games can help us

Rural Route to Active Aging guides are free again

To recover costs, we were charging $2.50 + postage for print copies of Rural Route to Active Aging: A Guide for People Who Want to Stay Active as They Age. Due to a grant from the Alberta Sport, Recreation, Parks & Wildlife Foundation, we are able to provide the guides for free again, though we may still need to charge postage for larger orders.

For more information or to place an order, contact Lynda Matthews-Mackey at lyndamathews-mackey@ualberta.ca.

View the full report and guide as well as many other resources online at www.centre4activeliving.ca

The Alberta Centre for Active Living is affiliated with the University of Alberta Faculty of Physical Education and Recreation and is supported by the Alberta Sport, Recreation, Parks & Wildlife Foundation and the Government of Alberta.
Hypertension has been diagnosed in 70 million adults globally and almost 6 million adult Canadians while in Alberta, high blood pressure affects roughly 500,000 adults. An ongoing survey conducted by Statistics Canada has, and still indicates Alberta to be the province with the lowest treatment rate within patients diagnosed with hypertension. The Alberta Hypertension Initiative and Canadian Hypertension Education Program (CHEP) hope that Licensed Practical Nurses can help reverse this trend. CHEP recognizes that staying current on best practice guidelines can help reverse this trend. CHEP recognizes that staying current on best practice guidelines is challenging, and LPNs face increasing workloads along with a rapidly changing work environment. To help you stay current on hypertension recommendations, the Alberta Initiative provides the latest peer reviewed, evidence based materials as produced by CHEP. Further, Alberta health professionals can attend free, accredited training sessions focusing on CHEP and Blood Pressure Canada (BPC) hypertension resources (www.hypertension.ca/tools/ab).
NURSING AND HIGH BLOOD PRESSURE

Nurses are often in an ideal position to influence and counsel patients who are diagnosed with hypertension. The resources produced by CHEP and BPC can be used as an aid to ensure patient compliance and commitment to lifestyle changes. The Brief Action Tool is a resource developed specifically for patient counseling and contains a 3-step program which includes (1) knowing and understanding your BP numbers; (2) making small lifestyle changes for improved cardiovascular health; and (3) patient ownership – home BP monitoring and medication adherence. Although health professionals feel confident in their skills to counsel patients, the resources are developed to further engage and motivate patients. Past research has shown that health professionals that use CHEP and BPC resources perform better on hypertension questionnaires\(^3\). In fact, a 2007 survey of Canadian RNs indicated that although a large majority of nurses are confident in assessing cardiovascular risk, counseling patients with hypertension and taking a blood pressure reading, almost half did not correctly answer a series of hypertension clinical knowledge questions, including how to define a hypertensive reading. As mentioned, the questionnaire demonstrated that those who often to always used CHEP recommendations performed better on all questions.

Q: At what blood pressure reading (mm Hg) would you consider a patient hypertensive assuming no co-morbidities?
A: 140/90 mm Hg. (51% answered correctly)

STAYING INFORMED – ALBERTA HYPERTENSION INITIATIVE

In order to improve hypertension management, CHEP has launched the Alberta Hypertension Initiative, which is working to disseminate the latest hypertension information and resources to healthcare professionals across the province. In addition to resources that help health professionals stay current, there are also several tools specifically for patients to aid in the understanding of hypertension. Through increased dissemination, the initiative hopes to increase health professional knowledge on hypertension for improved treatment and patient care. In this regard, LPNs can play a leadership role. Alberta LPNs work in a variety of healthcare settings, meaning they are often in frequent contact with hypertensive patients. LPNs are in a key position to screen for hypertension, educate patients on hypertension, and work with the health care team to manage hypertension.

The unique initiative serves as a pilot project providing a basis for a national education and hypertension management resource campaign. For more information, visit the website (www.hypertension.ca/tools/ab) to sign up for new information as it is released, educational (train the trainer, hypertension workshops) sessions, or to download and order educational resources for you or your patients.

For more information visit: www.hypertension.ca/tools/ab
Contact: Nicole Kelly 403-220-7103 nmkelly@ucalgary.ca

Our Practical Nursing faculty are committed to preparing you to write your Canadian Practical Nursing Registration Exams. Our program offers:

- an advanced technological component
- diverse practical placements
- a supportive team environment

Learn more at lethbridgecollege.ca/health

Join a unique health team

Cheyenne Blackwater
Practical Nursing ’08

NorQuest College and Northern Lakes College have combined their resources to present the certificate program, Essential Leadership Skills for Health Care Professionals. Learn how to motivate and inspire your team!

Delivered in two-day course modules, this program can be tailored to virtually every workplace and provides the flexibility for participants to focus on their own unique needs.

> Upcoming Courses

PERFORMANCE MANAGEMENT – Optimizing Results
> September 22 & 23, 2009

INTERVENTION – Managing Team Members with Personal Problems
> October 27 & 28, 2009

RESOLVING CONFLICT – Reaching an Agreement at Work
> November 23 & 24, 2009

> Call Now!

For more information about this program, please contact Northern Lakes College toll-free at 1-866-652-3456, visit www.northernlakescollege.ca, or contact Erin Bampton at 780-644-6397 or email erin.bampton@norquest.ca

www.norquest.ca
Sheana Mahlitz, LPN - District 4 (Capital Health)

Sheana began her health care profession as a Health Care Aide, and today is one of only nine LPNs working for Alberta Health Services, Primary Care Division, School Health Team in the Edmonton area. After graduating from NorQuest College in 2007, she extended her practice by obtaining both the Mental Health Aide Certificate and the Immunization Certificate. Her varied practice has led her from long-term care to sub-acute, from working as a Psychiatric Aide to Gynecology/Oncology.
December 1
Deadline for 2010 Registration Year

To avoid paying additional fees, ensure your 2010 Registration Renewal form is post-marked or received by CLPNA on or before Tuesday, December 1, 2009.

Registration Renewal forms received after Thursday, December 31, including incomplete forms returned to the member for completion, are required to pay the reinstatement fee.

2009 Practice Permits expire midnight on Thursday, December 31. Please note the CLPNA office is closed on Friday, January 1, 2010.

If you have not renewed your 2009 Practice Permit, you are no longer authorized to practice as a Licensed Practical Nurse in Alberta, as per Section 43 of the Health Professions Act. Practicing without a valid Practice Permit constitutes unprofessional conduct under the Health Professions Act and you may be subject to sanctions.

2010 Registration Renewal Reminders

- Expect your 2010 Registration Renewal form to arrive in the mail before September 30. If you do not receive it, contact CLPNA at 1-800-661-5877, 780-484-8886 or email info@clpna.com.
  - According to the Health Professions Act, members have a responsibility to notify CLPNA of any changes to their contact information such as address, phone number, and email address.

- Members on the Pre-Authorized Payment Plan are required to submit a complete 2010 Registration Renewal form on or before Tuesday, December 1, 2009. A late fee will apply if received by CLPNA after Tuesday, December 1, 2009.

- Practice Permits cannot be issued to members who submit an incomplete Registration Renewal form. Incomplete forms will be returned to the member by mail and will result in a delay in processing and/or additional fee(s).

- Participation in the Continuing Competency Program is required. Be prepared to identify **TWO MANDATORY** learning objectives. See the article on page 33 for more information about these requirements.

- An additional fee will be charged on Registration Renewal forms received after Tuesday, December 1, 2009, this includes Registration Renewal forms with post-dated cheques.

- If your Registration Renewal form is received after Thursday, December 31, 2009, and you have not practiced in 2010, you will be required to pay a Reinstatement fee of $50.00 in addition to the Active Practicing Registration fee of $250.

- Duplicate Practice Permits and tax receipts are available for an $11 administrative fee (subject to change).

**IMPORTANT MEMBER INFORMATION**

Practicing without a valid Practice Permit is unprofessional conduct and may result in serious sanctions against you. Members found practicing without a valid Practice Permit in 2010 may face charges of unprofessional conduct and sanctions including a fine of up to $1,000 per incident of unprofessional conduct.

### 2010 REGISTRATION FEES FOR LICENSED PRACTICAL NURSES

<table>
<thead>
<tr>
<th>Fee</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>$250.00</td>
<td>Renewal of Practice Permit on or before 1-Dec-09</td>
</tr>
<tr>
<td>$280.00</td>
<td>Renewal of Practice Permit after 1-Dec-09 and prior to 31-Dec-09</td>
</tr>
<tr>
<td>$300.00</td>
<td>Reinstatement of Practice Permit after 31-Dec-09</td>
</tr>
<tr>
<td>$50.00</td>
<td>Associate Practice Permit - Non-Practicing LPN</td>
</tr>
</tbody>
</table>
Win a night at a four-star resort, dinner, and $250! Submit your completed 2010 Registration Renewal form by November 13, and you’ll be automatically entered to win!

Prize includes a one-night stay at the four-star Edmonton Marriott at River Cree Resort (home of the 2010 CLPNA Spring Conference), a gift certificate for fine dining at Sage Steakhouse, and reimbursement of your 2010 Registration Renewal fee. Engage in highly unexpected forms of onsite recreation - from two NHL-sized hockey rinks to a lively casino, with over 750 slot machines and 50 table games, and three restaurants, a centre bar and a Starbucks café. Or just enjoy the elegant room with plush bedding, and breathtaking views.

Tips to Complete a Registration Renewal Form

- Read the Registration Renewal form carefully. Confirm your address and employment information and make any necessary changes.

- Enter LPN Practice Hours, excluding vacation and sick time.

- If you are retiring, going on maternity leave, changing your career, or you are on long term disability, please complete and submit your Registration Renewal form so that our records are accurate.

- Your Registration Renewal form is a legal document. By signing the form, you are declaring that all the information on the form is true and correct.

- During Registration Season there is a high volume of faxes.
  - It is the responsibility of the registrant to ensure the form is received by CLPNA.
  - Many faxes are illegible or incomplete (missing one page) and are returned to the member by mail, further delaying your renewal.

Make renewing your Practice Permit easy! For your convenience, the CLPNA has included a self-addressed envelope with your Registration Renewal form. Please put a stamp on the envelope and submit your Registration Renewal form back to the CLPNA prior to November 13, so your name can be entered in the Early Bird Draw!

If you have any questions about your current registration or renewing your registration, please contact CLPNA’s Registration Department at 780-484-8886, toll-free at 1-800-661-5866, or email info@ clpna.com.
How can I subscribe to PAP?
The PAP subscription form is mailed to members with the 2010 Registration Renewal form or can be requested from CLPNA. To subscribe, return a completed PAP subscription form and a void cheque with your completed 2010 Registration Renewal form.

REMEMBER: The Registration Deadline for CLPNA to receive your 2010 Registration Renewal form is December 1, 2009. Additional fees will apply to all Registration Renewal forms received after December 1, 2009.

Do I have to sign up for PAP every year?
Once you have signed up for PAP, payments will continue until CLPNA receives written notice from you to cancel your PAP subscription.

What if I’m already a subscriber?
For current subscribers, there are three options available on the 2011 PAP form:

• Continue on PAP; banking information remains the same.
• Continue on PAP; banking information has changed. Enclose new banking information with the PAP form.
• Cancel PAP for the 2011 Registration year.

If I’m currently on PAP, am I automatically registered for the 2010 Registration year?
No. Subscribers who have paid their 2010 Registration fee through PAP are not registered until your completed 2010 Registration Renewal form is received, assessed, and approved by the CLPNA to ensure you meet the requirements for an Active Practice Permit.

What happens if my payment is returned Non-Sufficient Funds (NSF)?
If a payment is returned NSF on the 1st of the month, a second automatic withdrawal will be attempted by the bank within five banking days. If the second withdrawal attempt returns NSF, a $50 payment is required ($25 PAP payment + $25 NSF fee) to remain on PAP. Please note: These are CLPNA fees; your bank will charge NSF fees as well. Non-sufficient funds, a change in bank accounts or a closed account will result in a $25 NSF charge for each occurrence. If two payments are returned by your bank within the year, you will be removed from PAP for the balance of that year, and your payments to date will be refunded.

What if my bank information changes?
Send a new voided cheque or new banking information form from the bank, with your name, your CLPNA Registration Number and address by mail or fax to CLPNA, “Attention: Finance Department”, at least seven business days prior to the 1st of the month.

How do I cancel my PAP subscription?
To cancel your PAP subscription, submit a written request for cancellation “Attention: Finance” to CLPNA with your full name, CLPNA Registration Number and current address, by mail or fax, or email barb@clpna.com. Fees paid to date will be refunded.
How do You get Your DUCKS in a Row?

CONTINUING COMPETENCY PROGRAM (CCP)
Steps for 2010

As part of annual Registration Renewal, LPNs participate in the Continuing Competency Program (CCP) by completing Section “L” of the 2010 Registration Renewal Form.

In order to successfully complete a self-assessment of your knowledge, skills and professional practice, complete the newly revised CCP Self-Assessment Tool available in your Competency Profile (2nd Edition) binder or online at www.clpna.com under the “Members”, “Continuing Competency Program”, “Downloadable Documents from Profile”, or contact CLPNA at info@clpna.com or 780-484-8886.

1. Complete the CCP Self Assessment Tool
   • Rate your professional practice relevant to all LPN roles in Step 1
   • Determine other specific competencies in your LPN role in Step 2

2. Build a learning plan in Step 3
   • Choose a minimum of 2 learning objectives for 2010
   • Using the Competency Profile, identify competency number
   • Note resources and strategies to meet objectives
   • Set a timeline for completing your learning plan for 2010
   • Evaluate your learning through your answer to “How will I think and behave differently following this education?”
   • Using the above information, complete all four columns of Section “L” of your 2010 Registration Renewal Form

3. Track your learning throughout the year
   • Keep a copy of your 2010 Registration Renewal form
   • Document your learning:
     - Certificates
     - Attendance letters
     - Filling out a concise Record of Professional Activities
   • File documentation in a safe place - then you are ready when it’s your turn to complete the CCP Validation

CLPNA OFFICE HOURS
Holiday Season

Dec. 24 – 8:30am to 12:00pm
Dec. 25 – Closed
Dec. 28 – Closed
Dec. 29 & 30 – Regular Hours
Dec. 31 – 8:30am to 12:00pm
Jan. 1, 2010 – Closed

Regular Office Hours
Monday to Friday
8:30am to 4:30pm
Closed for Statutory Holidays

It’s Flu Season
Get Your Shot
GERONTOLOGY ASSOCIATION INVITES LPN MEMBERS

It is our pleasure to extend an invitation to the members of CLPNA the opportunity to join the Alberta Gerontological Nurses Association as full members with in our provincial special practice group.

The central purpose of AGNA is to bring together Nurses who are interested in gerontology and whose intent is to improve the health, wellness and quality of life of older adults.

The mission of AGNA is to provide leadership in promoting excellence in gerontological nursing in Alberta, with the objectives:

• To promote high standards of gerontological nursing in Alberta
• To promote and provide continuing learning opportunities in gerontological nursing
• To advocate, foster, and participate in activities which promote the health and quality of life of older adults in the Alberta community
• To promote networking opportunities for nurses
• To promote and disseminate gerontological nursing research
• To present the views of AGNA to government, educational, professional and other appropriate bodies
• To assist in developing a supportive, healthy work-life environment for gerontological nurses in Alberta

Membership with AGNA includes the opportunity to participate as committee members, run for office on the executive committee and includes voting privileges. AGNA membership also includes membership with our larger national body the Canadian Gerontological Nursing Association. At this time the CGNA is in the process of reviewing its membership roles and opportunities, therefore, LPNs who become members of AGNA will become associate members of CGNA until CGNAs’ membership process reviews are complete.

Information on membership applications and chapter contacts can be found on the AGNA website.

Bonnie Launhardt RN MN
President

AGNA
Alberta Gerontological Nurses Association
www.agna.ca
Build on your Nursing Skills at Bow Valley College

Bow Valley College’s Practical Nurse Diploma is recognized as one of western Canada’s best. We offer full- and part-time programs in class and online, as well as specialized programs for internationally-educated nurses and those re-entering the profession. We are also active in applied research—advancing nursing practice and keeping our programs relevant and up to date.

Your Bow Valley College tuition may be covered by the Fredrickson-McGregor Education Foundation for LPNS. Access a grant and keep up to date with the latest nursing practices and advancing research to continue providing the highest quality care in nursing.

BUILD ON YOUR NURSING SKILLS AND EXPERTISE WITH THESE COURSES JUST FOR LPNS:

- Leadership for Licensed Practical Nurses - Online
- Immunization Certificate
- Adult Health Assessment
- Applied Pharmacology with Medication Therapy
- Care of the Agitated Client ➤
- Documentation Refresher ➤
- Infusion Therapy – Blood, Fluid, and Medication ➤
- Injectable Medications ➤
- Intramuscular and Intradermal Injections
- Intravenous Medication Administration ➤
- Pharmacology Refresher ➤
- PN Courses Eligible Cont Ed Discount ➤
- Immunization Online for Homestudy (online) ➤
- Basic Foot Care ➤

- Course eligible for 10% BVC Alumni discount

TO FIND OUT MORE ABOUT YOUR ALUMNI BENEFITS CONTACT US TODAY!

403-355-4666
ALUMNI@BOWVALLEYCOLLEGE.CA
WWW.BOWVALLEYCOLLEGE.CA/ALUMNI
Can LPNs push IV medications? If so, where can LPNs access education and what parameters are there around what meds they can give?

IV push medications were added to LPN scope of practice in December of 2008 (See Competency Profile, V-2-10 and information on the website). Just as with other medications, there are no parameters around what medications an LPN can administer. This assessment must be made in the practice setting based on the client needs, nurse competencies, and environmental supports.

The education for IV push has not been added to LPN basic education and is a post-basic competency that employers can provide through on-site certification. MacEwan College has post-basic modules that many employers utilize for all their nurses in IV starts and IV medication administration.

Can LPNs administer Immunizations? Is there post-basic education available?

Administration of vaccines is a Restricted Activity and a Specialty of LPN practice that requires formal, approved education. An education program is currently available by distance education through Bow Valley College. This education is required to administer any vaccine including flu shots, vaccination updates, and immune globulins. You must be competent with intramuscular and intradermal injections before enrolling into the Immunization program.

Upon successful completion of the Specialty, the LPN should notify CLPNA with proof of certification to complete the authorization. There may be funding available through the Fredrickson-McGregor Education Foundation for LPNs (http://foundation.clpna.com) for this Specialty education. To locate information on Immunization Specialty from www.clpna.com, click on “Members”, “Continuing Education”, “Post Basic Education”, then follow the link to “Immunization Certificate Course”.

Where can I take an IV Initiation course?

This education is available at MacEwan College or you can complete employer certification in I.V. Initiation. Either way, the necessary theory, lab, and clinical supports must be accessed to achieve competence. For further information, see our website under “Post-Basic Education”.

Contact our Practice Consultants at practice@clpna.com or 780-484-8886
Committee Members Required

CLPNA is looking for LPNs interested in joining the Hearing Tribunal, the Complaint Review Committee and the Registration & Competence Committee. Please take the time to consider these important opportunities! Closing date for resume submission is Friday, November 20.

Committee members are appointed by Council and legislated under the Health Professions Act (HPA) to make decisions of self-regulation to members, stakeholders, and the public in the areas of education standards, complaints of unprofessional conduct, and continuing competence.

■ Committee Membership

Qualifications: Active Practice Permit and in good standing with the CLPNA. Minimum of three years nursing experience.

Expectations: Committee members are appointed for a two-year term and may be re-appointed for a second term. Terms commence on January 1. Attendance is supported at the Annual General Meeting/Spring Conference.

Compensation: CLPNA reimburses committee members for travel expenses related to committee meetings/commitments and offers a per diem to compensate salary replacement. Orientation and relevant materials are provided to all committee members.

■ Hearing Tribunal

The purpose of the Hearing Tribunal is to ensure the public is protected from unethical or unsafe practitioners. The Hearing Tribunal functions in a quasi-judicial role as active participants in the hearing of investigated complaints. The Hearing Tribunal:

- Ensures fairness by hearing the allegations of the complainant, the response from the investigated person, and evaluating the evidence from any witnesses
- Determines if the conduct of the investigated person constitutes unprofessional conduct

This committee meets on demand five to 15 times a year depending upon the varying number and type of complaints received. Hearings are often held in Calgary and Edmonton, but may be scheduled anywhere in Alberta.

■ Complaint Review Committee

The Complaint Review Committee's powers and duties include reviewing and ratifying settlements under Section 60 (alternative complaint resolution) and conducting reviews under Section 68 (review of dismissal of complaint) under the HPA. This committee usually meets by teleconferences one to five times per year, but may meet at the CLPNA office.

■ Registration and Competence Committee

The Registration and Competence Committee's purpose is to protect the public from incompetent or ineligible applicants to the Licensed Practical Nurse profession and to make recommendations to Council on continuing competence requirements and the assessment of those requirements. This committee meets on demand. Meetings may be infrequent.

Interested in participating on a Committee?

Forward your resume to CLPNA, Attention: Tamara Richter, or email tamara@clpna.com by Friday, November 20.

For more information on Committee opportunities, go to www.clpna.com under “About CLPNA”.

the operations room
CLPNA Council

President
Hugh Pedersen

Executive Director/Registrar
Linda Stanger
linda@clpna.com

District 1 (RHA Regions 1, 2)
Marie Boczkowski

District 2 (RHA Region 3)
Donna Adams

District 3 (RHA Regions 4, 5)
Jo-Anne Macdonald-Watson

District 4 (RHA Region 6)
Sheana Mahlitz

District 5 (RHA Region 7)
Jenette Lappenbush

District 6 (RHA Region 8)
Vacant

District 7 (RHA Region 9)
Vacant

Public Members
Peter Bidlock / Robert Mitchell
Ted Langford

To contact Council members please call the CLPNA office and your message will be forwarded to them.

CLPNA Staff

Tamara Richter
Director of Operations
tamara@clpna.com

Teresa Bateman
Director of Professional Practice
teresa@clpna.com

Sharlene Standing
Director of Regulatory Services
sharlene@clpna.com

Linda Findlay
Practice Consultant / CCP
lindafindlay@clpna.com

OUR MISSION

To lead and regulate the profession in a manner that protects and serves the public through excellence in Practical Nursing.

OUR VISION

Licensed Practical Nurses are a nurse of choice, trusted partner and a valued professional in the healthcare system.

The CLPNA embraces change that serves the best interests of the public, the profession and a quality healthcare system.

By 2012 the CLPNA expects:

• To be a full partner in all decisions that affect the profession
• LPNs to embrace and fully exploit their professional scope of practice and positively impact the nursing culture
• LPNs actively involved in planning and decision making within the profession and the healthcare system
• LPNs to assume leadership and management roles provincial, nationally and internationally within the profession and the healthcare system
• An increase in LPN registrations to 12,000 by 2012
• LPNs to actively promote and support the profession
• Employers fully utilizing LPNs in every area of practice
• The scope of practice to evolve in response to the unique and changing demands of the healthcare system

COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Log On to clpna.com

• CLPNA Publications
• Pertinent Information
• Learning Modules
• Competency Profile
• Job Listings

and more...

CLPNA Office Hours
Regular Office Hours
Monday to Friday
8:30am to 4:30pm
Closed for Statutory Holidays
Working for AHS provides a real opportunity to develop my career, plus Alberta offers a great place to raise my children. It's truly the best of both worlds.

what’s your reason?

There are many reasons why you should choose Alberta Health Services (AHS) as a career option.

For starters, AHS is one of the leading healthcare systems in Canada, responsible for overseeing the planning and delivery of health supports, services and care to more than 3.5 million adults and children.

Plus, our organization is home to great employment opportunities at over 400 sites situated in both rural and urban locations throughout Alberta.

What’s more, working at the AHS enables a better quality of life, not only for our staff, but for their families – providing the kind of lifestyle that you’ll only find in Alberta. Our flexible hours will allow you plenty of time to juggle your other passions.

To learn more about career opportunities and lifestyle advantages, or to apply, please visit:

www.albertahealthservices.ca
www.healthjobs.ab.ca

ADVANTAGES
- excellent wages & benefits
- urban & rural opportunities
- work life balance
- relocation assistance
- full time or part time positions
- new & established facilities
- opportunities for growth
- flexible hours
- diverse workforce
- world class education, recreation & leisure
- making a meaningful difference
early bird gets the room

Win a night at a four-star resort, including dinner, and $250!

Submit your completed 2010 Registration Renewal form by November 13 to be automatically entered in the “Renew Early & Win” Draw!