Care in the Air
LPNs and EMS

Future Shock?
The Changing Face of Healthcare

Job Redesign Study
New Alberta Nursing Research

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The CLPNA is proud to present LeAnn Thieman, a licensed practical nurse for 30 years and coauthor of bestseller Chicken Soup for the Nurse’s Soul.

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Care in the Air
Nursing practice blended with emergency services education prepares a multi-skilled provider who can care at a new altitude.

Future Shock? The Changing Face of Healthcare
The face of healthcare is changing, but the one constant is the great spirits who enter the profession with their heart... and hold it close to their soul.
Two years ago we basked in the warmth of a boom – housing prices were skyrocketing and jobs were plentiful.

Now Iris Evans, Alberta’s Finance Minister, is forecasting a recession and job losses of up to 15,000 this year, with spending outpacing revenues in Alberta by $1 billion dollars.

This is a time of great change in Alberta. With change comes great uncertainty. And uncertainty can lead to fear.

John F. Kennedy once said, “When written in Chinese the word ‘crisis’ is composed of two characters - one represents danger and the other represents opportunity.”

Economic downturns can lead to opportunities for innovation. Innovation can occur by rethinking the way we, as nurses, function in the health sector. Alberta Health Services has already set the groundwork for restructuring, based on the focus of quality care, accessibility, and sustainability.

Coupled with that, management and government are increasingly aware that the LPN has a vital role on the health team. Emerging provincial research (see page 6) on Job Redesign has demonstrated that for RNs to work to their full scope LPNs must be part of the team. Based on this realization, new opportunities will arise for LPNs in areas where managers are open to implementing best practices. Increasingly LPNs are assuming new and different roles; demonstrating leadership in new and different ways.

CLPNA sees leadership development as a priority for education of our membership. Leadership training is still earmarked for funding, despite the impact on the amount of monies available through the Frederickson McGregor Education Foundation for LPNs. Seize the opportunity to take positions on committees in your work unit, step up to a formal leadership role in your workplace, in your College, in your community.

Another area the Foundation is supporting is LPN attendance at the 2009 Spring Conference. Details are on the website. Consider joining us in Calgary on April 15 at 6:30 pm for the Annual General Meeting to hear what the CLPNA has been up to; what we have planned for 2009 and to give us your thoughts! Then stay on for two more days of valuable learning, networking, and fun at the Conference.

The Honourable Ron Liepert, Minister of Health and Wellness, will be sharing the vision for health in Alberta, and Paddy Meade, Executive Operating Officer, Continuum of Care, Alberta Health Services will be providing insights on Alberta Health Services plan to operationalize this vision. And of course there are host of other motivational and informational presentations planned. We hope to see you there!

Finally, some wise words from Anais Nin:

There came a time when the risk to remain tight in the bud was more painful than the risk it took to blossom.

Seeking out and trying new and different roles including developing and exercising your skill as leader is a way for nurses to blossom. We encourage you to keep pace with current times, accept a new challenge, and show your colleagues and managers what you, as a nurse, are capable of…

Hugh Pedersen, President and Linda Stanger, Executive Director
Thanks to flexible hours, I can balance life and explore this beautiful province with my family whenever I want.

what’s your reason?

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The following is a summary of the final report of a research project funded by the Alberta Heritage Foundation for Medical Research (AHFMR) involving Registered Nurses, Licensed Practical Nurses, and Health Care Aides. The College of Licensed Practical Nurses of Alberta was involved on the Steering Committee for this project.

There is evidence to suggest that registered nurses spend insufficient time performing key functions associated with their defined role. The current practice of registered nurses is largely focused on the performance of tasks and activities related to meeting patients’ biomedical needs, and implies that insufficient attention is given to enabling patients and families to attain maximum health and well-being, which is the essence of professional nursing practice. The lack of focus on optimal role enactment represents an underutilization of nursing knowledge and skill and potentially compromises the quality of care.

The design of work can contribute to underutilization of professional knowledge and skills. The primary objectives in this research were to optimize enactment of the roles of registered nurses (RNs) and health care aides (HCAs) through job redesign and to determine the impact of job redesign on patient, provider, and unit outcomes. This study was conducted on two general medical patient care units in the Calgary Health Region in Alberta.

Quantitative and qualitative methods were employed and data were collected on the “Redesign” and “Control” Units prior to and following the implementation of redesign initiatives.

Although some structural and functional changes were made to work processes over the course of the study, the goal of achieving optimal enactment of registered nurses’ role was not accomplished. Progress was made in improving the utilization of HCAs and enhancing their perception of being valued as members of the nursing team. While the study failed to accomplish many of the intended goals, much was learned about the factors that are critical to the success of any initiative aimed at improving utilization of the health workforce.

The use of a population needs based approach to examine nursing providers’ roles (i.e., RNs, licensed practical nurses [LPNs] and HCAs) helped validate the gap that existed between ideal (i.e., optimal) and actual nursing practice and enabled staff to better understand how optimal enactment of their respective roles could positively influence patient and family outcomes. This, combined with observation data that revealed that RNs spent a considerable amount of their time performing work that could in many instances be performed by other members of the health care team reinforced the inefficiency and ineffectiveness of the service delivery model (i.e., modified primary nursing) that characterized the Redesign Unit. The conclusion drawn from this study is that a collaborative practice model incorporating RNs, LPNs, and HCAs is most likely to optimize the utilization of all members of the nursing team, at least for the type of patient population that was the focus of this study.

A key lesson learned is that engagement and commitment of leaders at all levels of the organization is needed to address the current underutilization of health care workers. As the study evolved, it became clear that significant change in the utilization of the health workforce cannot occur as long as the focus of the change initiative is a single patient care unit or program. A systems approach to workforce optimization is needed, guided by a clear vision that is understood and championed by leaders at all levels and a well articulated strategic plan. Failure to recognize in advance the extent of organizational support that would be needed to effect any change in role enactment at the service delivery level limited the job redesign approach that was attempted in this research.
**KEY MESSAGES**

**Optimal nursing role enactment requires an understanding of the characteristics and health needs of the patient population receiving care**

- Nursing providers’ roles in preventing illness and injury and promoting health and well-being requires elaboration of the profile of patients being served on the patient care unit or in other health care settings. Preventing avoidable complications or injuries requires an understanding of real or potential risk factors associated with particular population groups such as the elderly.
- Provider knowledge, skills, and abilities must be “matched” to the health needs of the population served in order to mitigate real or potential risk factors and prevent avoidable complications and injuries.
- Staffing decisions (i.e., determining the right number and mix of personnel) must be based on an understanding of population health needs.
- An understanding of the health needs of the patient population enables providers to make care decisions that are focused on meeting patient health needs rather than on simply “doing the tasks.”

**An all RN staffing model does not promote optimal nursing role enactment**

- When there is no potential to redistribute to other members of the health care team regulated work activities such as routine medication administration or treatments, as well as unregulated activities such as personal care, those tasks and activities must be performed by RNs. Routinely performing tasks and activities that could be done by others takes RNs away from essential role functions such as comprehensive assessment, patient and family teaching or support, discharge planning, and coordination of care.

**Optimal nursing role enactment requires a collaborative practice approach to care delivery**

- Optimal nursing role enactment is enhanced in an environment in which care is provided collaboratively with other providers and with patients and families.
- A collaborative practice approach requires that providers understand each others’ role accountabilities and their respective contribution to the care of patients and families.
- A collaborative practice approach requires that providers have knowledge and skill related to shared decision-making (e.g., providers and patients are involved in decisions about the plan of care), communication (e.g., what information needs to be communicated), conflict resolution, and negotiation skills.

**Successful job redesign at the unit or program level is contingent upon a systematic approach to change and expertise in change management at all levels of leadership**

- When embarking on job redesign, it is important that leaders at both the local (unit) and system (organization) levels have a clear vision of the goal to be accomplished and the outcomes to be achieved.
- Job redesign requires system support and often, redesign of system-wide structures and processes if change is to be implemented and sustained at the unit or program level, as well as throughout the organization. Substantive change in the utilization of health care providers cannot be achieved from a purely “bottom up” approach. The involvement and commitment of executive leaders is a critical success factor.
- Job redesign requires a participatory approach involving patients and families, staff, managers, and senior leaders. A network or alliance of providers, managers, and other leaders who share ideas, expertise, experiences, and practical approaches is a useful mechanism for engaging providers in the process of reconsidering how they work together in delivering patient care. Redesign teams can be a powerful structure to help motivate staff and provide knowledge, skills, and support for change initiatives.
- Strategies aimed at optimizing the utilization of health care providers (i.e., optimal role enactment) should incorporate a concrete and explicit focus on creating opportunities for all providers to acquire the knowledge and skills needed to engage in collaborative practice.

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For a listing of references or the full report please visit www.clpna.com.

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CARE | SPRING 2009 7
By Sue Robins

care in the air
view is action-packed on the Edmonton Municipal Airport’s tarmac through the picture windows of Advanced Paramedic Limited’s (APL) base – planes taking off and landing, ambulances driving around, and patients carefully shuttled between both modes of transport.

Occasionally an incubator is unloaded from a plane from rural Alberta, followed by a concerned new parent, and Neonatal Intensive Care Unit (NICU) staff are there waiting with APL staff to meet up with their young patient. The emergency services staff provides ground support to transport the baby safely to either the Stollery Children’s Hospital or the Royal Alexandra Hospital. The view out the window gives a clear snapshot to the world of pre-hospital care.

APL is the Emergency Medical Services provider for Alberta Health & Wellness’ Air Ambulance Program based in Peace River. They have a base and staff in Edmonton for air and ground support, and also provide on-site industrial medical services across western Canada. APL contracts services throughout Alberta, BC, Saskatchewan, the N.W.T, and the Yukon for both air and ground support for patients going to or from the hospital, with two air ambulance aircraft and three ambulances. They also offer a full range of private medivac services.

The APL team includes EMRs (Emergency Medical Responders), EMTs (Emergency Medical Technicians), EMT-Ps (Paramedics) and LPNs (Licensed Practical Nurses) like Charles Way and Lynn Cole.

LPNs are a fairly new introduction to the field of pre-hospital care in Alberta. Charles Way’s path to the field of emergency services began when he was young. “I used to watch the show Emergency when I was a kid. Remember Squad 51? Ever since then, I knew what I wanted to do,” he says.

Charles first became an EMR (Emergency Medical Responder) and medic for the Army Reserves in 1993. From there he completed his EMT certification and worked for many years for ambulance services throughout rural Alberta. He was one of the first responders to the 2000 Pine Lake tornado disaster from his base in Eckville.

He moved steadily from being an EMR to EMT to LPN. “I decided to become a nurse because my wife was looking to become an RCMP officer. EMT certification does not cross provincial borders if I was to move, but as a nurse I could move more easily,” explains Charles. He takes a pause, and says, “Plus there’s more job security as an LPN and better money.”

Ironically, his wife is now taking her RN in Medicine Hat. Although she did
not become an RCMP officer, her path to nursing also led Charles there. Charles went to NorQuest College in 1995, and loved it. “At NorQuest, the instructors were so great, and there’s lots of hands-on practical time.

The combination of LPN and EMT qualifications is a rare and in-demand combination. Charles found that his practice as an EMT changed once he became a nurse.

“Being an LPN has made me a better EMT. I understand more of the patient’s care, and can monitor chest tubes, suction trachs, and insert catheters – things my EMR/EMT colleagues cannot do.”

Because the knowledge of LPNs is grounded through the nursing process, they bring added value to emergency services. “My training as an LPN drilled into me that patient care is number one. I have a good anatomy and physiology background, and I think nurses in emergency care are a big benefit to the hospital staff when we bring a patient in. We understand the hospital terminology and can help out in the Emergency Department.”

Now Charles has his pick of jobs. He’s working in Thorhill, north of Edmonton, with Associated Ambulance’s ground ambulance service, he’s casual with APL at the base in Edmonton, and he picks up shifts at the Misericordia Community Hospital’s Emergency Department. Clearly, he is the type of person who looks for variety in his work.

Pre-hospital care isn’t for everybody. But those who work in the emergency field love it. Charles explains the process of being on call.

“When I’m on call, I carry both a phone and a pager. I get paged by Peace River dispatch and I call back and I’m given information about the call – like when the plane is coming in, the call sign that identifies the plane, and the condition of the patient.”

He has to make sure he’s within thirty minutes of the Municipal Airport, and there he meets the plane, gets a report from the flight crew, and either accepts the transfer of the patient to an Edmonton hospital, or accompanies the flight crew to the facility. Depending on the condition of the patient, Charles and others on the APL team may accompany the patient, or a Paramedic, Respiratory Technician or Physician may also be involved with the transfer. Dispatch staff at APL determine which health professionals are involved based on the information they have about the patient.

Once at the hospital, Charles stays with the patient, completes the chart, and then returns to the base. At the base, APL staff restock and clean equipment to be ready for the next call.

“I breathe, eat, and sleep work when I’m on call. I put on my uniform and remain in it for 24 hours so I’m ready to respond,” Charles confesses. “You don’t make many plans when you are on call. I’ve been paged when I’m sitting in a movie theatre – I make sure I’m sitting on an aisle so I can make a quick exit.”

When Charles was on call on Christmas Day, he was home for only an hour. The rest of the day was spent accompanying two flights and seven ground support transports. It is safe to say that the turkey went cold that Christmas.

“People have to be flexible and willing to use their scope of practice as far as it can go,” explains Carl Damour, who is the General Manager at APL’s main office in Peace River. “They are very autonomous and independent practitioners.”

Up in the air, there is no cell phone communication. Decisions have to be made by the attending staff without any consultation.

“The staff have to be very good decision makers - a lot can happen a ten
Lynn Cole is a new recruit to APL. She’s an LPN who started last December, and she sees differences between pre-hospital and hospital care.

“In pre-hospital care, you don’t have an eight patient workload, so it is not as physically demanding. But even though you only have one patient to care for, you have to be confident and comfortable with troubleshooting on your own. There’s no ‘go-to’ person in the air like there is in the hospital.”

Lynn works at Leduc Community Hospital in the medical-surgical ward, and while she works to her fullest in this smaller hospital, she was interested in investigating a different setting.

“I was hired by APL to accompany patients on flights, but I also did one day of ground support training to transport a patient who had a heparin drip. The EMTs/EMRs could not monitor the drip, but I can as an LPN.”

She has been a nurse for four years, and worked as a nurse’s aide for ten years before that. The profession of LPN attracted her because she wanted to work in a hospital environment, and to care for the patient as a whole. Now she’s ready for the challenge of emergency services.

She didn’t know there were opportunities outside of the hospital environment for LPNs, until she saw APL’s ad on the CLPNA website. She read the small print that said although APL’s main office is in Peace River, they were hiring for flight and ground support based out of Edmonton.

“I was interested in working in emergency care because it was out of my everyday routine. This job gives me extra responsibility, and I like seeing the other side of hospital care,” says Lynn.

“You have to be not afraid to fly in small planes,” she adds. And a good bladder is important too – some flights are up to four hours, with no bathroom facilities on board.

Carl Damour gives the history about introducing LPNs to the pre-hospital field.

“Two years ago, we thought – why are we not using LPNs in our company? I contacted the CLPNA to ask if there was anything preventing us from hiring LPNs. And no, there wasn’t.”

“LPNs are a perfect fit for longer flights because they are used to treating patients for longer periods of time. They know to do things like reposition patients so they don’t get bedsores, while other emergency staff might just be used to seeing patients for a few minutes at a time in an ambulance before they get to the hospital,” Carl continues.

Charles Way has a clear sense of the type of nurse who would enjoy emergency services. He says the biggest attributes are to be a quick thinker and a good troubleshooter. Assessment skills have to be top notch, too.

He finds the work very rewarding because he can see his treatment working right away. Charles has seen all sorts of patients in his career, from minor medical to major trauma. He’s even assisted in delivering five babies. He likes working in rural communities because sometimes there is up to a 45 minute response time to bring a patient into the hospital, so there is opportunity to use all his nursing skills to care for a patient.

The advantage to bringing LPN skills to pre-hospital situations is obvious to this owner of ground and air ambulance contracts in Alberta.

Carl from APL says, “We need both young LPN grads with new skills who are eager to learn, and mature LPNs who can use their knowledge and experience in the hospital when they are doing transitions with hospital staff. All our LPNs have to be interested in learning, have some hospital experience, and believe in the whole team concept – that everybody has a role in caring for the patient.”

Successful nurses in the emergency world have to be both self-starters and team players. The nature of pre-hospital care is that the team works with other emergency staff, like fire fighters and police officers at the scene, other emergency personnel in the ambulance, plus they work with hospital staff when they arrive at the hospital. But sometimes these nurses can work virtually alone, and that’s when the creative and critical thinking skills come into play.

Having some emergency services training can help identify if this is the right field for you. There is the 16 hour International Trauma Life Support Certification to start and Charles feels that having an additional EMR certification on top of being an LPN is invaluable (see sidebar).

“I’d really recommend that if LPNs are interested in emergency work they get their EMR training,” Charles says. “There is a very high demand for my type of skills. I could work whenever and wherever I wanted to.”

The types of learning picked up in pre-hospital training includes stretcher lifting, how to get patients out of their homes, and how to use the different types of equipment that are developed for the ambulance environment. Pumps may be hand pumps instead of the wall version, and all their equipment is of the portable variety. Most staff also have their Class 4 driver’s licence so they can drive the ambulance.

Charles has had some interesting experiences working on air ambulance flights.
Emergency Medical Education

A good way to investigate if pre-hospital work is right for you is to enroll in an ITLS (International Trauma Life Support) course. The next step is EMR certification – the combination of an LPN/EMR professional is hotly sought after in the emergency services field.

ITLS Courses

This program teaches skills in rapid assessment, resuscitation, stabilization, and transport of trauma patients. The 16-hour course is designed for providers who are first to evaluate and stabilize the trauma patient. Hands-on stations include: basic airway, spine management/rapid extrication, short back board, helmet management, log roll and long back board, traction splints, patient assessment and management.

There is also an advanced 16-hour course certification available.

For more information, contact the Alberta ITLS Chapter Coordinator at 780.733.3675 or SAIT’s Advanced Life Support Coordinator at 403.210.5966.

Alphabet Soup

EMR – Emergency Medical Responder. The entry-level position in the Emergency Medical Services field, EMRs take 160 hours of theory and practical classes – some of which are available by distance education.

EMT – Emergency Medical Technician. This is a 10-month course for those with EMR certificates that covers all aspects of pre-hospital emergency care.

EMT-P – Emergency Medical Technician – Paramedic. This is an intensive two-year full-time program. You must be an EMT to enroll in the EMT-P program.

These programs are offered by a number of private colleges, public schools and organizations in Alberta. For more information about Emergency Medical Professionals view the “Know Your Healthcare Team” Feature in this issue of CARE or visit the Alberta College of Paramedics website at www.collegeofparamedics.org for a list of approved EMR, EMT and EMT-P programs.
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EXECUTIVE SUMMARY

Workplace violence is an unfortunate reality in the lives of Canadian health care workers, with evidence suggesting that incidence rates in Canada are significantly higher than other countries with similar models of health care. It is defined by World Health Organization 154 as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation”. Workplace violence is often considered part of the job in the health sector and has therefore been more frequently overlooked than in other sectors until recently. Nurses in particular are at risk of being physically and emotionally abused at work.

It is clear that there is an immediate need for effective programs to reduce workplace violence towards nursing staff in Canada. This study involved a comprehensive literature review of workplace violence prevention programs utilized in health care and in nursing practice in particular, and an evaluation of the effectiveness of these prevention programs on their impact on the incidence of violence. The objectives of the study were to: 1) analyze and synthesize the research literature which proposes or evaluates the impact of workplace violence prevention programs, and 2) develop recommendations for a comprehensive approach towards violence reduction. The report’s findings will provide the framework for program initiative recommendations to be considered by policy makers. Additionally, areas in need of further study will be suggested on the basis of gaps revealed in the literature review.

Study procedures involved conducting a literature search for articles relating to workplace violence prevention programs. According to the reviewed literature, patients constituted the main source of all types of violence, and co-workers were an important source of non-physical violence. A number of risk factors that have been linked to workplace violence include patient characteristics (e.g., substance abuse, mental health conditions), nurse characteristics (e.g., age, level of...
nursing experience), organizational factors (e.g., understaffing, night shifts, culture and climate of work environment), physical design of work environment (e.g., poor security, inaccessibility, crowding), and community and social factors. Understanding contextual factors to workplace violence incidents is vital to curb violence against health care workers when conducting a risk assessment.

The literature identified two broad categories of workplace violence prevention strategies:

a) pre-incident strategies, which capture legislation/management (e.g., zero-tolerance policies, organizational policies, work design), the environmental design of the work environment, education and training on the management of workplace violence; and

b) post-incident strategies, which include some administrative functions (e.g., incident reporting) and psychological intervention for affected staff (e.g., CISD, counseling).

The main tenet of a zero-tolerance policy is that workplace violence in any form is unacceptable. It is suggested in the literature that implementation of a zero-tolerance policy may have a negative impact on the staff's confidence and skills in dealing with aggression.

Individually focused strategies to reducing violence typically involve educating staff on recognizing the warning signs of violent behaviour, preventing, diffusing, or resolving violent conflicts, familiarizing staff with organizational policies and procedures, as well as their legal rights and responsibilities. Post-event strategies also have a preventative role, given that appropriate intervention can avert future incidents. Previous studies have stressed the importance of continuous monitoring of violent events, seeing this as a necessary prerequisite for better understanding the violence and the establishment of prevention programs.

Many of the evaluation studies used questionnaires to measure educational impact of training sessions directed at prevention of violent or aggressive behaviour. Some measured perceptions of confidence or feelings of self-efficacy in management of aggressive patients. In these studies, participants were mostly small samples of nurses (registered and/or practical) and/or nursing aides, at times convenience samples of staff members who are exposed to risk of violence. Study settings were often hospital acute care psychiatry units exhibiting high rates of violent behaviour. Studies were often quasi-experimental with a pre-test/post-test design; however, not all of these studies employed control subjects in measuring impact of the intervention.

Studies that measured program impact on managing aggressive behaviour generally found positive changes in test scores and observed behaviour following training. Increased knowledge test scores reflect positive learning outcomes including risk factor identification, informed attitude changes and management of aggressive behaviour. The evidence suggests that relevant training programs also promote increased feelings of confidence in managing aggressive clients.

As to training's impact on incidence of violence, most but not all evaluation studies found a reduction in incidence of reported violent episodes. It was suggested that training may serve as a form of encouragement to report violent events by creating a more accepting, non-punitive attitude regarding violence towards staff. Despite its overall positive effect, there were concerns over the over-emphasis on training in curbing workplace violence as it places the burden of minimizing and managing violence onto the shoulders of individual nurses after training.

Important methodological limitations of the evaluation studies were identified. Sample sizes were small and often self-selected. In addition, study settings were typically small-scale and often involved only one or two organizations as study sites. With the additional limitation of low response rates, generalization outside assessed groups was usually not possible.

Recommendations

Policy

• A clear organizational policy towards workplace violence is a necessary antecedent for a prevention program to be maximally effective. The presence and publication/dissemination of a policy lets the employees know that management is committed to reducing violence in the workplace.

• Although zero-tolerance policies have been recently adopted by several health care organizations, caution should be taken in this approach. There is difficulty with fully implementing the ‘zero tolerance’ approach as it implies an attitude of punishment toward any aggressive behaviour, thereby negatively impacting aggression management.

• The great diversity of health care itself requires that the development of a policy towards workplace violence encompass all of employment situations. For example, policies for community care should be developed to address particular risks associated with that sector.

Risk Assessment and Environmental Modifications

• Prior to the implementation of any workplace violence prevention program, a risk assessment should be completed. Integration of effective threat and risk assessments will help to ensure that any interventions that are employed will be best suited to the particular situation. They can also highlight any necessary environmental modifications that may curb violence, and address how management and administrative practices can reduce violence.

• Frequency of assaults may be associated with a broad range of factors including staffing levels. Work reassignments, short staffing and temporary staffing have been associated with increased incidents of violence in health units.

• A risk assessment highlights the importance of accurate documentation of incidents. This documentation is invaluable to substantiate the need for novel programs and the identification of action plans. Some staff members view incident reporting as an implicit admission of professional failure. Risk assessment and a commitment from management demonstrate that the antidote to denial and
at issue

resistance to incident reporting is a continual effort to learn from incidents and to provide timely feedback. However, incident tracking and high-risk patient identification are only part of a larger violence reduction initiative and requires organizational commitment to coordinate the components.

Training/Educational Strategies
• Nurses need to be empowered to build confidence in their ability to manage potentially violent situations. This is best accomplished through aggression management programs and frequent refreshers that involve several components:
  - Methods for recognizing and identifying potentially violent situations
  - De-escalation strategies and other verbal engagement strategies for defusing potentially violent situations
  - Where appropriate, physical self defense techniques and patient restraint methods
  - Incorporation of aspects of risk assessment (i.e., environmental security processes)
• Leadership training needs to be provided to supervisors. This includes training in recognizing conflicts and in conflict resolution skills, the importance of early intervention, and supervisory/coaching skills.

Organizational Intervention
• Organizations need to take on a more active role in organizational change including staffing, workload, work culture and climate. High priority should be given to organizational intervention in preventing workplace violence.
• Work design modifications include increasing autonomy, enhancing communication about job duties and expectations, and clarifying supervisory chains of command.

Horizontal Violence
• A comprehensive policy for reducing workplace violence cannot exclude horizontal violence. A number of factors have been identified that affect the work climate and that may contribute to bullying and harassment in the workplace:
  - Lack of role clarity
  - Low job control or autonomy
  - Poor social support
  - Poor communication
  - Ineffective leadership/supervision
  - Strained and/or competitive work environments
  - Impending changes in the workplace have all been associated with higher levels of staff conflict, stress/burnout, turnover, and psychological and physical health complaints

Evaluation Research
• There is a need to collect longitudinal measures in order to assess the extent to which training effects may dissipate over time to identify optimum periods for providing refresher training.
• Future research needs to investigate effects of training on the number, type and severity of aggressive incidents, the number of assaults and injuries to staff as well as financial costs to organizations as a result of sick leave and overtime to replace injured staff.
• Sophisticated evaluation studies are needed based on designs employing larger samples and control groups, and allowing for the use of advanced statistical techniques so to properly examine the effectiveness of prevention programs.
• A national database should be developed using consistent operational definitions of workplace violence events.
• The majority of research on workplace violence prevention is focused on education and training program evaluation. Other aspects of violence prevention have not received the same level of attention and little is known about their effectiveness in isolation or their impact on the effectiveness of the training programs.
• Evaluation studies should include comparisons of different programs to see which one has the greatest relative utility.

Other Recommendations
Several implications that are highlighted in the reviewed studies and that can be considered in development of recommendations for workplace violence prevention programs are as follows:
• Human Resources. Positive results of interventions should be considered within a broader context of human resources. Studies have suggested a relationship between reduction in aggressive incidents and human resources policies including support and educative initiatives such as clinical supervision, an increase in regular permanent staff, and retention of experienced staff members, who tend to display greater tolerance attitude and better violence management skills.
• Faculties of Nursing. The literature has, for the most part, focused on nurses who are already in the workforce. However, given the high likelihood that student nurses will be exposed to workplace violence (either during their educational program or once they graduate), it would be prudent for nursing programs to develop awareness training in the identification and management of workplace violence.
• Sector specific interventions. Prevention strategies need to be sector specific, especially in sectors such as long-term care home care where workers are not as prepared as nurses in the hospital.
• Violence-type specific interventions. Develop programs that are violence-type specific so as to prepare health care workers to handle different types of violence situations ranging from assault, emotional abuse, to sexual harassment. For example, a zero-tolerance policy, inappropriate for external violence, may be effective in the case of horizontal violence.

The full report on this study is available at www.nhsru.com

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The Alberta College of Paramedics is a self-governing body currently designated under the Health Disciplines Act. Provincial legislation requires all active Emergency Medical Responders (EMRs), Emergency Medical Technicians (EMTs), and Emergency Medical Technologist-Paramedics (EMT-Ps) to be registered with the College. The College’s primary responsibility is to ensure its practitioners provide safe, competent, and ethical care to the citizens of Alberta.

Although currently designated under the Health Disciplines Act, the College will soon fall under the Health Professions Act (HPA), and so is setting strategic direction and implementing changes to align with and ease the transition to the new legislation.

To fulfill its responsibilities as a regulatory body, the College provides direction for and regulates the practice of paramedic practitioners; establishes, maintains, and enforces a code of ethics as well as standards for registration, practice, and continuing competency; and performs related duties in support of regulating the paramedic profession in the public interest.

All registered practitioners with the College are bound by the Code of Ethics, which defines ethical behaviour of a registered practitioner, the responsibility of a practitioner to his or her patient, and the responsibility of a practitioner to the profession. The Code of Ethics serves as an ethical compass directing a practitioner’s decisions regarding patient care and providing expectations by which to review a practitioner’s practice.

EDUCATION
The College regulates over 7,000 practitioners across three levels of practice: EMR, EMT and EMT-P. Each level is defined by its own scope of practice and has specific educational requirements. EMRs provide basic medical treatment, such as oxygen and spinal immobilization, and are qualified to provide care to a level greater than that of an advanced first aider. EMTs provide intermediate-level care referred to as Basic Life Support, and EMT-Ps provide Advanced Life Support, administer medications and perform advanced cardiac monitoring as well as invasive techniques.

Paramedic practitioners work in a variety of settings throughout the province. From urban to rural settings, hospitals to the remote oilfields, paramedic practitioners fill an essential role in Alberta’s health care industry.

In order to be eligible for registration with the College, applicants must either complete a certificate or diploma program approved by the College for the appropriate category of the practice of paramedicine, or receive approval through an equivalency process administered by the College’s Registration Committee.

The College’s Educational Institutions Program Approval/Audit Working Subcommittee provides support and policy advice to the Registration Committee, and ultimately to Council, in regard to the process and methodology used to determine if a program of study is deemed an “approved program” by the College for the purpose of registration of applicants. On an ongoing basis, the subcommittee conducts audits of previously approved programs and makes recommendations to the Registration Committee regarding programs retaining “approved program” status. Subcommittee work may be accomplished separately from or in conjunction with the Canadian Medical Association for EMT and EMT-P programs.
Programs are available from a variety of approved private and public educational institutions located throughout Alberta and British Columbia. Course length varies and depends on the school and the level of emergency medical education being completed. Once an applicant has successfully completed an approved program of study, he or she can then apply to write the provincial registration exam administered by the College. Exams are administered in Edmonton a minimum of three times per level throughout the year. Upon receiving a passing mark, applicants are then eligible for registration with the College.

Continuing competency goals are developed in relation to the scope of practice for practitioners in Alberta, which is defined under the HPA by the Alberta Occupational Competency Profile (AOCP). The AOCP provides a complete description of the knowledge, skills, attitudes and judgments expected of practitioners ranging from novice to expert. The AOCP was developed to comply with the requirements of the HPA and created through the consensus of practitioners registered with the College.

To ease the transition for practitioners and ensure public safety, the College has designed a Gap Training program to ensure that registered practitioners who completed the provincial registration exam prior to 2004 meet the required competencies outlined by the AOCP. Training received prior to February 2004 does not meet the broadened scope of practice introduced under the HPA, and training modules address each area in which additional training is required.

FUTURE OF THE PROFESSION
Under the HPA, the College’s role as regulatory body is advanced and refined. The HPA requires the College to carry out its activities and govern its regulated members in a manner that protects and serves the public's interest. To do this, the College relies on the involvement of its practitioners on College council, which upholds the interests of both the public and the profession. The Council represents the voices of those in, and those impacted by, the profession, and sets the strategic direction for the future.

Part of this future includes addressing the growing need for emergency medical service practitioners and addressing labour shortages in our health care system. The College has recently taken a lead role in working with counterparts in British Columbia to review regulatory requirements for practitioners in both provinces. The recent Trade, Investment and Labour Mobility Agreement between the Governments of Alberta and British Columbia seeks to enhance labour mobility between the two provinces, and the College has the goal of removing any barriers that may impede a practitioner from transitioning their career between Alberta and B.C. Similarly, the College is also working with counterparts at the national level to discuss labour mobility for paramedic practitioners.

As emergency medical services in Alberta continue to evolve, the College will continue its focus on governance under the HDA while looking forward to legislation under the HPA.
Health Quality Council of Alberta releases findings of first provincial Long Term Care Resident and Family Experience Surveys

In December 2008 the Health Quality Council of Alberta (HQCA) released the results of two surveys that examined the experience of long term care residents and their families across Alberta. Overall, 50% of those residents surveyed rated the care they get from nursing home staff as 9 or 10 out of 10. The survey found that from the residents’ perspective, items related to communication and respect had the strongest relationship to the overall care rating.

Overall, nearly half of the family members surveyed (45%) also rated the care at the nursing home as 9 or 10 out of 10. The survey found that the items that had the strongest relationship to family members’ overall care rating were related to staffing levels, care of residents’ belongings and the nursing home environment. In addition, the survey found that family members rated smaller nursing homes (those with fewer than 100 beds) more positively than large facilities.

This is the first provincial survey of its kind undertaken in Alberta and it establishes a baseline for measuring the experience of long term care residents and their families. The results provide Alberta Health Services, long term care operators and management, direct care providers, health professionals and Alberta Health and Wellness with the information they need to improve the quality of resident care and services as well as aspects of residents’ quality of life.

Residents and family members associated with over 170 long term care facilities across Alberta participated in the surveys. For the resident survey, nearly 3,500 face-to-face interviews were conducted, covering about 25% of Alberta’s long term care residents. For the family survey, 7,943 families completed a mailed survey for a response rate of 70.2%. This high response resulted in a low margin of error of ±1.1%.

The provincial technical reports and a summary of the findings are at: www.hqca.ca.

For more information about the HQCA’s long term care resident and family experience surveys, please contact Pam Brandt at 403.297.4091 or pam.brandt@hqca.ca.
I'm in a nursing home not because I want to be, but because my daughter, who cared for me for over 28 years, is no longer able to look after me with the safety that my severely frail and osteo-arthritis body requires. She nursed me through two cataract and two knee replacement surgeries, second degree burns from scalding bath water, a nasty leg ulcer, a fractured rotor cuff and pneumonia. And while my family and I would prefer me to be home, the simple fact is that my daughter, at almost 70 years, receiving inadequate help to give her much respite from taking care of me twenty-four hours a day, 365 days a year, was no longer able to lift me without endangering her own back and health.

My ailments, all too common for someone of my age, are also those of many of my fellow residents. I have macular degeneration, hearing loss, osteoarthritis, peripheral vascular disease, and I can no longer walk, requiring an uncomfortable mechanical lift to be transferred from bed to wheelchair. I am unable to attend to my personal needs, I cannot get out of the building without assistance and I am, for all intents and purposes, a virtual prisoner in my room. Family photographs are constant reminders of a former, far happier existence. A dirty window and partially open shade allow me to see the tree outside my window. I am fortunate that I do not suffer from Alzheimer's or dementia.

The TV and telephone must suffice to bring the outside world into my room. I can no longer read a newspaper, but I do know from the news that the health care system is, once again, being turned upside down and that there is an acute shortage of doctors and nursing staff. I also know that my entire pensioner’s income goes to paying for my residency in this ‘home’. 

Aside from my daughter who comes daily for three to four hours to take me for long walks in my wheelchair, I have few visitors.

I am that old lady at the end of the hallway, who has trouble adjusting to her new teeth, and who needs help with her personal care. I do not call for help frivolously. But please understand that my critical lifeline to your care is my ready access to the call bell. When you so frequently forget to pin it to my blanket, leaving it where I cannot reach it, you deprive me of my crucial link to obtain help. Your forgetfulness, or is it thoughtlessness, subjects me to unnecessary stress and anxiety. And when calling out from my room at the end of the hall, you don’t hear me, I am forced to rely on the possibility of another kind resident to hear me and be willing to investigate my cries. I am lucky that I have such a wonderful neighbor. But she should not have to be in this position.

Some of you have a ‘calling’ for the nursing profession and are, what I consider to be ‘naturals’; whereas for others, your work is merely a ‘job’, not a career. It is attitude, thoughtfulness, common sense, along with good training, that make the crucial difference for all my fellow residents who must rely on your goodwill to take care of our frail, handicapped bodies in as stress-free an atmosphere as possible.

Some of you treat me with great kindness, dignity, and
She happens to be 102 years old, but Emma is more like you than you might think. Her room at the extended care facility is lovingly decorated with family photos and greenery. Her bed is positioned so she can keep watch on the weather outside. She leaves her glasses off when I take out the camera for pictures. I do the same thing too – this is definite proof that a woman's vanity has no age. Emma has experienced many of the same things you have in your own life. She had a career – she was a seamstress in small town Saskatchewan. She designed figure skating outfits and graduation gowns. She created her own patterns, and did all her own sewing – the long seams by machine, and all the hems by hand.

She raised three children, two girls and a boy, and has a bounty of grandchildren and great-grandchildren. Emma loved to play the piano, and was an accomplished soloist. She'd play Christmas carols on the piano every Christmas Eve beside a candle-lit tree. Her hands are now fragile with paper thin skin, but they were once strong and skillful tools of her trades.

"I have had a rich life," Emma says.

She loved scenery all over the world, so she travelled often – across Canada, Hawaii, and all over Europe on annual trips with her husband. She continued travelling with her daughter when her husband passed away, and wintered for almost twenty years in Arizona. Emma speaks fondly of a trip to Italy, and describes a bus trip from Rome to Naples where she feared for her life aboard a crazy bus careening its way along the high cliffs of the Amalfi Coast.

They say the elderly feel invisible, but Emma is a vibrant, interesting woman who defies her years. She was clearly a beauty in her youth, and her loveliness shines through her soft eyes and her mischievous grin. She just needs a gentle touch and encouragement to share her wisdom.

I ask, ‘What advice would you give to younger people about happiness?’ Emma pauses, and her pale blue eyes well up. Then she answers.

"Happy to me means being able to dance." And though osteoarthritis has robbed her of waltzing on the dance floor, she clearly is still dancing in her heart.

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I have lived through two great wars, have been bombed out, and with my husband and children came to Canada in hopes to rebuild our lives. We succeeded through hard work and frugality, and in the process have contributed to the diverse fabric of our Canadian social, economic and cultural mosaic. I do not whine or ask for much at this stage in my life. However, I do ask that you never leave my room without ensuring that I have my call bell in my hand. In the meantime, my thanks must be verbal but my gratitude for not being forgotten or ignored, being dealt with gently and kindly, and called by my name, is eternal.

I wish it were in my power to reward you appropriately and to insure that your pay is commensurate with the very difficult, frequently back-breaking work that you do. Alas, I fear that time will only come when our elected officials must place relatives, or even themselves, into nursing homes. Only then can we hope that they will come to appreciate the true magnitude of the urgent need for adequate health care and nursing home funding. I doubt that I will live long enough to see that day.

I am just shy of my 102 birthday. Please call me Emma.

Emma’s 102nd Birthday was in January 2009.
To improve Alberta’s health system into the future, the provincial government is moving forward on Vision 2020, a report outlining a number of actions to build Alberta’s health system.

There are five goals in Vision 2020:
1. Providing the right service, in the right place, and at the right time;
2. Enhancing access to high quality services in rural areas;
3. Matching workforce supply to demand for services;
4. Improving co-ordination of care and delivery of care; and
5. Building a strong foundation for public health.

“A major theme of our Health Action Plan released in April was to ensure the future sustainability of Alberta’s health system,” said Ron Liepert, Minister of Health and Wellness. “A commitment in that action plan was to table a long-term health system sustainability plan, and phase one of the roadmap for achieving that goal is this Vision 2020 report. By linking the right services, in the right location, and at the right time, patients will get faster treatment. These types of efficiencies will, in turn, ensure our health system is sustainable for years to come.”

Actions to be implemented from Vision 2020 include: providing more health care in community settings — including more care options for seniors; integrating the skills of emergency medical technicians more fully into the health-care system; changing reimbursement incentives for health professionals to align with new ways of delivering care; and reviewing the role of small hospitals to ensure they meet local needs.

“Vision 2020 is about a stronger, more efficient and sustainable publicly-funded health system focused on patient needs,” said Liepert. “The next step will be to develop a joint implementation plan in the new year, complete with timelines and targets, between Alberta Health and Wellness and Alberta Health Services in order to put the report into action.” Vision 2020 was developed following a provincial health services optimization review, which was conducted to assess Alberta’s health needs and find opportunities to improve health service organization and delivery for the next 10 to 15 years.

Critical Incident Group Debriefing

ISSUES AND CONSIDERATIONS

By Randy Grieser, MSW, RSW, Director-Crisis & Trauma Resources Institute Inc.

Those who work in the helping profession are more likely than those in other professions to experience incidents that are often described as traumatic. As such, it is imperative that organizations develop a process for helping staff cope with incidents that cause distress.

Critical Incident Group Debriefing (CIGD) is one such method. CIGD is a short-term group intervention process that focuses on an immediate crisis. CIGD is one method that can be utilized to lessen the likelihood of participants experiencing symptoms of trauma and stress after a critical incident. This group debriefing process provides a place for participants to talk and share experiences, and for the facilitator to teach and provide information about the impact of critical incidents.

While CIGD can be very effective in many instances, there are times where CIGD may not be appropriate. For example, because of an issue of trust in a particular group, it may be more appropriate to utilize individual debriefing than group debriefing. It is important to note that every crisis situation is unique and will require thoughtful consideration to the following questions:

- Is this a safe environment (is there trust, is there rank in the room)?
- Who is suited to lead this debriefing? What are pros and cons of having an outside versus inside facilitator?
- How large will the group be?
- How soon after the crisis will CIGD happen?
- How many facilitators will be in the room? If more than one, how will they work together?
- Will attendance be mandatory?
- How long of a time should a group last?
- What if participants want to leave?
- Where will the debriefing happen?
- Should some members of the group be met with individually ahead of time?

The Crisis & Trauma Resource Institute Inc. (CTRI) is one of several organizations involved in the training of the group debriefing process. At their core, the different models of group debriefing have similarities and are focused on providing a structured environment for people to talk about their emotions and reactions to the event, with the purpose of lessening the likelihood of participants experiencing symptoms of trauma and stress after a critical incident. While there are similarities in the different models of group debriefing, CTRI brings unique perspectives driven largely by our background in counselling and therapeutic practices. We focus on the importance of providing a safe environment in natural groups to explore thoughts and experiences and view the teaching component as key to the debriefing process.

There is much discussion on whether group debriefing has the desired result of preventing post-traumatic stress disorder after traumatic incidents. The premise behind most of the critiques is that there is little evidence/research or in some cases inaccurate evidence/research on whether these processes work. In fact, on the contrary, some suggest there is evidence that this process has the ability to do more damage than good.

CTRI's perspective is to take these critiques seriously and not to become over zealous in our use of this model. It is important to have a thoughtful discussion about whether to use this process or not in each situation that arises. Following are some of the problems and benefits with group debriefing that have been identified:

Problems that may be associated with group debriefing:

- Minimal time for individual help.
- Creating a safe environment is difficult to accomplish in many situations. Also, a false sense of safety can result in self-disclosure that is regretted.
- Vicarious traumatization - some stories expressed may be distressing for others to hear.
- Negative energy (depending on what happens, people may leave the meeting more discouraged than encouraged).

Benefits of group debriefing:

- Normalization occurs (one learns that intense reactions are not just theirs).
- Teaching (learning about reactions and coping skills is usually beneficial).
- Time management (sometimes there is no time or resources to debrief every individual in a realistic time frame).
- Provides informal assessment opportunities.
- Additional resources are made directly available.

While CIGD is a very important part of helping organizations respond to unfortunate events, it is also a process that requires much consideration and reflection prior to implementing.

About the Crisis & Trauma Resource Institute Inc.

CTRI provides professional training and consulting services for individuals, communities and organizations affected by or involved in working with issues of crisis and trauma. CTRI will offer the workshop Critical Incident Group Debriefing in Calgary on May 27, 2009. For more details visit their website at www.ctrinstitute.com. The author of this article, Randy Grieser, will also be presenting on this topic at the 2009 CLPNA Spring Conference.
We nurses have it within our power to end the nursing shortage. With commitment and determination we solve complicated problems every day, and we can solve this one too.

Think about it. If each nurse recruits or retains just one nurse, we can end our own shortage in just a few years. We all know the benefits of that… improved staffing ratios, less burnout, and most importantly, better patient care.

That’s why, with the release of Chicken Soup for the Nurse’s Soul, Second Dose, I have initiated my Each One Reach One Nurse campaign. Look how simple this can be if we Each One Reach One Nurse:

Endorse nursing as a great career. When someone asks, “Are you a nurse?” do you share your passion and compassion, telling them how wonderful this profession is? (or do we complain too much?) What other career offers such diverse experiences? Part-time, full-time, bedside, boardroom, intensive care, palliative care, schools, clinics, infant to geriatric…the options are limitless. Remember to suggest nursing to middle-aged people seeking a career change.

Advise middle or high schoolers to join. This age group is deciding what they want to be when they grow up. Go to the school and/or career day. From Johnson and Johnson’s www.DiscoverNursing.com website, order free posters and videos to excite them about our profession. Suggest it as a career to babysitters, boyfriends, and baseball teams.

Counsel HCAs to get nursing designations. We’ve all worked with health care aides who have the compassion and capabilities to contribute at a higher level. Recognize that in them, and if possible help them find funding and opportunities to get a higher education.

Help a tired nurse stay in. When you recognize that a colleague is developing achy feet and an achy heart, offer support. Talk to administration about flexible working conditions. Suggest a transfer to a less demanding position. Ask him/her what they need to continue to serve.

One

Recruit a non-practicing nurse to return. When I ask my audiences, “How many of your know a nurse who is not currently practicing in our profession?” 20-30% of them raise their hands. Just think if we could increase our workforce by 20%! Invite that nurse to return to work in healthcare. Remind him/her of the many work-place options today. Help them find a refresher course to update their skills.

Encourage nurses to be instructors. Last year the US turned away 120,000 nursing students for lack of instructors and schools. Are you or a colleague ready to leave the demands of the bedside to teach? Do you know caring people with a Bachelor’s degree in another field? Help them explore MSN programs qualifying them to teach.

Assist and support a new nurse. Were you as appalled as I to learn that 20% of first year nurses quit? What are we doing to them? Take a new nurse under your wing. Help your facility set up a mentoring program. Ask the new nurse what he/she needs and offer that supportively.

Care for yourself and model that to others. It’s time to stop bragging or complaining about not taking breaks or eating lunch or going to the bathroom. Maybe if we role-modeled eating right and emptying our bladders promptly, our colleagues will too! Maybe if we stop agreeing to work exhausted doing overtime and double shifts, other staffing solutions will be found.

Honor and recognize your colleagues. Awards from administration are reaffirming and appreciated. We can reward one another too by acknowledging good work and thanking each other and all departments for the support they give. Write a note. Speak up. Ten seconds of expressed gratitude can provide hundreds of hours of boosted morale.

ONE NURSE

Every nurse can do every one of the strategies above. And when we do we will achieve what the government, money, and well-intention programs have not. If each one of us reaches out to one – just one – our ranks will grow and thrive from the grass roots level up.

And who better to do it than us?
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

LEADERSHIP – Giving Team Members What They Need to Succeed
> March 24 & 25, 2009

EFFECTIVE SUPERVISION – Directing, Coaching & Facilitating Your Team Members
> April 23 & 24, 2009

COMMUNICATION – Getting the Message Across
> May 28 & 29, 2009

WORKING TOGETHER – Building Effective Relationships in Your Workplace
> June 22 & 23, 2009

> Call Now!

For more information about this program, please contact Northern Lakes College toll-free at 1-866-652-3450, visit www.northernlakescollege.ca, or contact Erin Bampton at 780-644-6397 or email erin.bampton@norquest.ca

www.norquest.ca

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Future Shock

The Changing Face of Healthcare
A number of forces are coming together to present a monumental challenge for us as a nation, as healthcare providers, and as healthcare practitioners:

1 Healthcare is a Big Ticket Item in Canada

We spend a lot on healthcare - $172 billion, 10.7% of GDP, or $5200 per person in Canada in 2008. Approximately four of every 10 provincial budget dollars in Alberta are spent on healthcare.

We’re going to spend a lot more on healthcare:

- Our population is aging. The baby boomers (born between 1945 and 1965) are retiring. Between 2005 and 2010 the number of Albertans aged 45 and over will grow more than twice as fast as those under 45 years of age, and the fastest growth will occur in the 55 to 64 age group.
- It costs more to provide healthcare for an aging population. With today’s per capita health expenditure held constant, health expenditures are expected to increase by 30% in the next 30 years from the effect of aging alone.
- We’re living longer with chronic conditions. Over the past 20 years, the proportion of Canadians with hypertension has risen by 36%, with diabetes 75%, and with cancer 200%.
- Our healthcare expectations are rising as our society becomes more prosperous.

2 The Way We View Healthcare is Changing

Canadians want quality of life – with the best that medicine and technology can buy. They want minimum wait times, and access to care closer to, or even in, the home as they age. In addition to acute care, Canadians will demand and require far more extensive community care (e.g. home care, mental health, primary care, public health, etc.), and long term care. A public push to decentralize service will strain many services where there is desire to centralize for reasons of cost efficiency.

The technological revolution is advancing so quickly it enables consideration of the structural form and function of healthcare: how disease is treated, where disease is treated, and how healthcare practitioners interact with technology to provide patient care.

3 The Healthcare Workforce Challenge

The larger workforce that will be required to meet a significantly increased need is aging, translating to a looming labour shortage.

In 2007…

<table>
<thead>
<tr>
<th># Canadians employed in healthcare</th>
<th>1,000,000</th>
</tr>
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<tbody>
<tr>
<td>Nurses (RN, LPN, RPN) as proportion of total healthcare workforce</td>
<td>33%</td>
</tr>
<tr>
<td>Average age of nursing professionals</td>
<td>44.8</td>
</tr>
<tr>
<td>Average age of Alberta LPNs in 2008</td>
<td>41.2</td>
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</tbody>
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In 2005, the average age of nursing professionals was the highest it has ever been. Almost 40% of nurses were 50 years or older, outnumbering those aged 34 years and younger by almost two to one. A contributing factor to this aging trend is a general increase in the age of nursing graduates. Among those employed in 2005, 27.1% of LPNs in Canada were aged 30 or older at the time of graduation (13.2% of RNs).

In Alberta, the picture is modestly better. The average age of an LPN in Alberta is down from 45.3 in 2002. The average age at which most plan to retire is 60.5, up from 59.5 in 2002. However, 30% of the LPN workforce in Alberta is over 50, and 16.6% are older than 56. Given the CLPNA’s Strategic Plan goal to increase LPN registrants to 12,000 by 2012, the 26% of the LPN workforce aged 19-30 will not even be enough to sustain existing LPN numbers without a significant influx of new LPN immigration or LPN education enrollment if current trends continue.

It’s not just age that poses a challenge

The number of LPNs in Alberta has been increasing every year since 2000, but remains 20% below figures recorded in 1986.

Employment rates are high. In 2005, most nurses (93.0%) were employed. 55.4% of LPNs in Canada were employed full-time in 2005. While this suggests labour supply could be generated by shifting more LPNs to full-time status, part-time status is most likely a choice rather than necessity given the full-time employment rate has been stable for several years.

In spite of current economic challenges which will ease... eventually, our rapidly ageing population and labour force will amplify longer term labour shortages in key sectors including healthcare, and create more employment choice for workers. Job satisfaction is a tool of choice in being able to compete with forces - from ageing to labour force competition with other sectors - that work against the sustainability of the numbers of people in the LPN profession.

Etched in a stone in Venice Beach, California are the words, “I am a person who stands against the mountain and thinks of pebbles.” While demographic and workplace issues present challenges to be overcome, the CLPNA is actively working on recruitment and retention initiatives to ensure that the stones of a vibrant future for the LPN profession are being cast.
There are just a handful of times in life when you meet someone who in talking about change and transformation in their life, change you. That person is Kristina McGuire. Born in Montreal, Kristina is articulate and engaged in telling the story of healthcare through her eyes. She wears her heart on her sleeve. Her words and her passion inspire.

To understand her perspective, one must understand Kristina’s history. Her parents were both nurses. Her Dad is an RN trained in the Philippines. Her Mom is an LPN. Her Dad worked as an O.R. nurse at Calgary General and transferred to Peter Lougheed when the General closed. Her Mom worked in home-care for a long time as a nursing coordinator. Her sister is an LPN, completing the course at Bow Valley College in 2003, and presently working at Peter Lougheed Hospital.

We quickly arrive at her motivation for entering the nursing profession (after chatting about her husband Drew who she describes as her motivational coach) – her Dad. “He’s my hero,” she says with emotion. She says her Dad told her not to pursue nursing... it was an overworked and underpaid profession. “But he loved it,” she says, affectionately calling him a walking contradiction. “You could always see his love for nursing in his face. He was a storyteller about life and times in healthcare. He would always say education is the most important thing in life. Someone can take away a house and money, but they can’t take away your education. I remember family driving trips... Dad would quiz me on the names of the bones in the ears, the function of the liver, and any other matter of medical amusement.”

She also notes that her Dad comes from a family of 18 brothers and sisters – many of whom are nurses. I ask why that is. Kristina quickly answers, “Nursing is an honoured profession that plays a central role in Philippines life. Service and caring for fellow human beings is a part of the culture – where there’s no job that’s below you.” She adds, “Acts of service make you feel good. It’s rewarding to do something for someone else.”

We move on to talk about Kristina’s life. She says she tried to avoid becoming a nurse. She had tested waters elsewhere for years... teacher, working at a bank for five years, and working with film studios. But she says in retrospect she was waiting for a catalyst, and it was her Dad. “In November, 2005, just months after I got married, Dad was working an evening shift and got a bad headache. He was sent to the E.R. as a precaution, and had a CT scan. He had a subarachnoid hemorrhage, and almost died. I was brought to Foothills and met a nurse I became friends with. She took care of him. She told me about her impending trip to Darfur with Doctors Without Borders. More importantly, I saw what she was doing for my father. I knew right there what I wanted to do... what I had to do.”

I ask her if he’s proud of her choice. A tear wells up in her eye and she says “Yes he’s very proud.” She then goes on to talk about how she was so excited to buy scrubs, and the day she received her Health Region identification badge.

I ask Kristina about a patient interaction that stuck with her in her practicum experience at Bow Valley College. She replies, “It was my first patient – a woman with Alzheimer’s disease. I spent six weeks with her, by many accounts a challenging patient because she would repeat the same phrases over and over again. She was easily agitated, and there were general communication challenges. Her ‘light’ was mostly dim, but it would
It's humbling, and easy to care just a little more when you can step outside yourself.

I ask Kristina what kind of nursing role she wants to take on. She says she wants to go everywhere. ICU. E.R. She adores children. “As a girl, I would do home visits with Mom – mostly kids. I would watch her do tube feedings. The visits were recurring, so I would get to know the kids. So I grew up with kids with everything from cerebral palsy to seizure disorders. I saw nothing wrong with them … they were friends.”

And for the next ten minutes of our interview we transition to a world that is deeply personal… and informs wisdom.

I suggest to Kristina that she might find working with children too heart-breaking because I see her as a deeply empathetic person. She nods, but thinks she could do a world of good there. She then describes the details of a rebellious childhood, and it’s so different than who I see sitting across from me that I facetiously suggest that she’s lying. But she’s not… because there’s tears in her eyes. As she describes it, she learned behaviour modification at 13 years old, and she struggled for several years. It’s made her who she is.

There’s quiet for a moment – and I twist an analogy around in my mind related to metamorphosis - that a caterpillar is quite an interesting creature with all those synchronous legs, but it’s just a stepping stone to something even more beautiful. When time dictates, the caterpillar winds itself into a cocoon and later reveals one of nature’s great inspirations – a butterfly. Perhaps Princess Diana said it best – “If I am to care for people in hospital I really must know every aspect of their treatment and to understand their suffering.”

Suffice it to say that Kristina has learned nursing from the other side, and it grounds her in her driven nature, and the emotional investment she has in it. “She gives hope to others,” adds Ann-Marie Simpson, LPN, an Instructor at Bow Valley College, who is sitting in on the interview. “She even recently offered me advice that was both timely and wise based on her own life experience.”

When Kristina made the decision to pursue nursing, she was all in. She paid out of her own pocket to upgrade math and biology, and obtain a math tutor. She took a medical terminology course at Bow Valley College. She turned in her life’s RRSP savings to pay for the LPN course. She worked a night shift as a Nursing Aide at Foothills Hospital in oncology and sub-acute care while attending college.

Given her family background, I ask her why she pursued LPN as opposed to RN designation. “I wanted more than a textbook education… I wanted a hands-on education,” she says.

Kristina wants to work to her full scope of practice, and worries a bit about what she feels is a breakable glass ceiling for the LPN in situations where they’re not used fully. “I don’t want to have someone say to me I can’t do what I’m trained to do because I have different letters. I’d hate to think I can’t provide the best care possible to the best of my abilities.”

While the vibrancy of people like Kristina will continue to open the door wider for LPNs to walk through in terms of the ambitiousness of the work itself, it’s one of her last comments that provides a window to the soul of LPNs. “You have to love this. It’s not for the money.”

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careers@intercarecorpgroup.com

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CLPNA seeks Council Members

The College of LPNs of Alberta seeks LPNs interested in becoming involved in College affairs. Members residing in three election Districts are invited to let their name stand for election to the CLPNA Council by submitting a Nomination Package before May 31. This opportunity allows direct participation in the College’s Mission: “To regulate and lead the profession in a manner that protects and serves the public through excellence in Practical Nursing.” In June, LPNs in the election Districts will select their representative by mail-in ballot.

The Council is responsible for the overall general direction of the College operating on a broad policy and overall planning level. In particular, the Council is responsible for ensuring the College operates on a sound financial basis. The Council does not manage day-to-day operations, or the “means” of achieving outcomes. Formally, the Council deals with College business through the Executive Director. Further information about Council duties is available from www.clpna.com under “About the CLPNA.”

Council members attend two-day meetings every three months to review reports of College business and to plan upcoming goals.

SUBMITTING A NOMINATION

To place a name on the ballot for the Council election, interested members must submit a Nomination Package to the CLPNA before May 31. Nomination Packages and more information is available from www.clpna.com or by contacting the CLPNA. The College prepares and distributes ballots by mail to each member of the election District within 14 days following the close of nominations.

Become a part of this dynamic team!
The CLPNA Council recently implemented two changes to scope of practice for Licensed Practical Nurses (LPNs) in Alberta:

**Intravenous (IV) Push Medications**

*Effective immediately, LPNs in appropriate environments, can administer medications via peripheral intravenous push.*

**BACKGROUND**

This change is based on the evolving role for LPNs with IV medication administration and practice changes making IV push medication administration more common in a variety of settings. For several months now we have been engaged in conversation with several health regions examining the possibility of allowing LPNs in some acute care environments to administer specific medications via direct push, intravenously (IV).

LPNs in acute care are part of a multidisciplinary health team and many are now competent in medication administration via a peripheral IV. Some settings are moving away from the use of mini-bags and buretrols for dilution of medications for intravenous administration and are utilizing direct push methods for a wide range of IV medications.

The Health Professions Act, LPN Regulation 2003 - 13 (3), authorizes LPNs to administer fluids or medications via intravenous lines. The CLPNA Competency Profile 2nd Edition (2005) notes parameters around direct peripheral IV push medications (V-2-11). CLPNA currently authorizes the Renal Dialysis Specialty areas to administer direct peripheral IV medications due to the nature of this practice area and the advanced skill and expertise of those LPNs who have obtained the Specialty.

Because of these changes in practice and the fact that there are high levels of support in practice settings the competency of direct IV push is now considered an “Additional Competency”. This competency must be appropriate and supported within the specific practice setting through policy, procedure, and education (including theory, lab, and clinical supports) to ensure safe practice.

**Intravenous Initiation (IV starts)**

*Effective 2010, all graduates of Practical Nurse programs will have achieved competence in IV initiation.*

**BACKGROUND**

Initiation of a peripheral intravenous (IV) has been part of the Licensed Practical Nurse (LPN) scope of practice since 1997 and has been taught through on the job certification or post basic education. As the LPN role has evolved under the Health Professions Act more LPNs are assuming this competency to further compliment their role. Recently several large tertiary care sites have been providing widespread education for all their LPNs in intramuscular injections, IV medication administration, and IV initiation.

Currently, LPN students in Alberta learn all components related to peripheral intravenous care with the exception of initiation of the intravenous. Several other LPN jurisdictions in Canada include IV initiation in their basic education. Alberta PN programs will be introducing this new competency into curriculum for all 2010 graduates.
CONTINUING COMPETENCY PROGRAM (CCP) VALIDATION IS HERE!!

The CLPNA recently mailed out 400 CCP Validation packages to actively practicing LPNs across Alberta through a random selection process. In these packages, LPNs are expected to complete a four-part Validation that includes verification of learning completed in the past two years. This article is intended to clarify Part 1 and Part 2 of the Validation form.

Part 1) Verification of Participation in Learning

In this section, you tell us exactly what you did to complete the learning. Resources and strategies must be presented for every learning objective, i.e., course name, website address, journal or magazine name, article title, conference name. To verify the learning, documentation may include; certificates, letter of attendance, transcripts, conference agenda, or a concise Record of Professional Activities, including date of learning and hours involved.

Part 2) Transfer of Learning

This section is where you tell us how the learning changed the way you think about your practice. Has the learning changed your attitude, perception, or awareness about the particular competency? Did you acquire new knowledge and skill or just review areas you were already aware of?

The Validation process examines to what extent your learning has occurred and how you’ve applied this to your practice. Do you have a new understanding of the concept or techniques taught? Are you now looking at practice differently because of a new attitude or enhanced critical thinking? These signs indicate you successfully transferred your learning.

Watch for the Summer, 2009 issue of CARE for information on Part 3 and Part 4 of the CCP Validation where we examine changes in professional behavior and the declaration process that confirms your professional commitment.

Donate to Silent Auction

Consider donating handcrafts or other quality items to this year’s Silent Auction! The Fredrickson-McGregor Education Foundation for LPNs once again hosts their annual Silent Auction in conjunction with the CLPNA’s 2009 Spring Conference. This is a fun and exciting event where everyone can participate, out-bidding your fellow colleagues and receiving fantastic items! New items such as household goods, home decor, books, electronics, gift certificates, scrapbooking materials, handcrafted items, etc, are welcome.

Donations can be dropped off or mailed to the CLPNA office: St. Albert Trail Place, 13163 - 146 Street, Edmonton, AB, T5L 4S8, or brought to the Spring Conference Registration Desk on April 15 or the morning of April 16. Read more at www.clpnaconference.com

NSF FEE INCREASED

At the December 2008 meeting of the CLPNA’s Council, the Non-Sufficient Funds (NSF) fee was increased from $15.00 to $25.00. This fee is applicable if any payment to the CLPNA becomes NSF.

As per CLPNA Bylaws, Section 16, the Council of the CLPNA is responsible to establish fees, costs, levies or assessments.
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Executive Director and Registrar
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Fredrickson-McGregor Education Foundation for LPNs

TAKE A COURSE, GET A GRANT!

Taking a course to enhance your LPN practice? CLPNA members holding an Active Practice Permit may qualify for an Education Grant, and receive funding for course tuition cost.

<table>
<thead>
<tr>
<th>APPLICATION DEADLINES</th>
<th>FOR COURSE COMPLETION DATES BETWEEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 30, 2009</td>
<td>November 1, 2008 to October 31, 2009</td>
</tr>
<tr>
<td>July 30, 2009</td>
<td>February 1, 2009 to January 31, 2010</td>
</tr>
<tr>
<td>October 30, 2009</td>
<td>May 1, 2009 to April 30, 2010</td>
</tr>
</tbody>
</table>

There have been recent changes to the approval process for Grant Applications. Please read the Grant FAQs (Frequently Asked Questions) and access the Grant Application Forms on

HTTP://FOUNDATION.CLPNA.COM

EducationFoundation@CLPNA.com or (780) 484-8886

Helping you celebrate National Nurses’ Week
May 10-16, 2009

Door prize items are available at no charge from CLPNA for events planned during National Nurses’ Week. Submit your Nurses’ Week Kit Requests Form from www.clpna.com or 780-484-8886 before April 17.
Council Meeting of December 4-5, 2008:

- The 2009 Budget was presented and approved.
- Intravenous initiation was included into all basic practical nurse programs in Alberta for graduates completing after January 1, 2010.
- Intravenous push was added as an additional competency for Licensed Practical Nurse practice in Alberta effective immediately.
- The Extended Registration fee was eliminated from the fee structure effective January 1, 2009.
- The new fee for Consent to Release was established at $55.00 including GST effective immediately.
- The Non-Sufficient Fund (NSF) fee was increased from $15.00 to $25.00 effective January 1, 2009.
- The Diploma Practical Nurse Program offered by Columbia College was approved for three years effective December 2008 to November 2011 as per the recommendations of the Education Standards Advisory Committee (ESAC).
- Debbie Elliott was appointed as an Employer Representative from Edmonton (4th Term) to the Education Standards Advisory Committee (ESAC) to December 31, 2010.
- Hugh Pedersen, President; Peter Bidlock, Public Member; and Kristina Maidment were appointed to be on the Executive Director Evaluation Committee for 2009.
- Hugh Pedersen, President; Kristen Shardlow and Robert Mitchell were appointed to the Council Appeals Committee to December 31, 2009.
- Peter Brown and Jenette Lappenbush were appointed to the Nominations Committee for Spring Conference 2009.
- Kristina Maidment was appointed to compile Council Annual Evaluation for 2009.

Regulated Committee Re-Appointments

The following members and individuals re-appointed to the designated committees to December 31, 2010.

Hearing Tribunal Chairperson – Sheila Green (2nd Term)
Hearing Tribunal - Tobi French (2nd Term)
Hearing Tribunal – Larry Leduc (2nd Term)
Hearing Tribunal – Deborah Reed (2nd Term)
Hearing Tribunal – Kathryn Kennedy (2nd Term)
Complaint Review Committee Chairperson – Anne Lanz (2nd Term)
Complaint Review Committee – Barry Nesterchuk (2nd Term)
Education Standards Advisory committee (ESAC) – Pat Fox, LPN (3rd Term)
Education Standards Advisory committee (ESAC) – Penny Kuwaswy, Employer Representative (2nd Term)

Regulated Committee Appointments

The following members and individuals appointed to the designated committees to December 31, 2010.

Hearing Tribunal – Jamie Anderson (1st Term)
Hearing Tribunal – Jill Paton (1st Term)
Hearing Tribunal – Shelley Hendrickson (1st Term)
Complaint Review Committee – Margaret Devlin (1st Term)
Registration & Competence Committee – Ashley Holloway (1st Term)
Registration & Competence Committee – Dorothy Wurst-Thurn (1st Term)

LPNs can expect fewer approvals of Grant Applications, except for courses leading to specializations such as Operating Room, Orthopedics, and Immunization.

Due to recent economic downturn, the endowment for the Grant Program of the Fredrickson-McGregor Education Foundation for LPNs has declined in value and the interest from which Grant funds are distributed has diminished. Beginning with the October 31, 2008 Application period, the Foundation suspended approval on courses in the categories of Event Funding (non-credit courses) and Long Term Funding (Bachelor-degree courses) pending the growth of the endowment.

Members are invited to continue applying for Short Term Funding, especially for courses such as Operating Room, Orthopedics, Leadership, Mental Health, Gerontology, Immunization, IM/ID, Infusion Therapy, Chronic Diseases, and Foot Care.

Funding for the Grant Program was received by the College of Licensed Practical Nurses of Alberta from Alberta Health and Wellness to support continuing education needs of LPNs, and is distributed by the Selections Committee of the Fredrickson-McGregor Education Foundation for LPNs.
### Registations

<table>
<thead>
<tr>
<th>Membership Type</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alberta Initial Graduates</td>
<td>536</td>
<td>487</td>
</tr>
<tr>
<td>Re-Entry LPNs</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>OTHER CANADIAN REGISTRANTS</td>
<td>225</td>
<td>238</td>
</tr>
<tr>
<td>NON CANADIAN REGISTRANTS</td>
<td>12</td>
<td>23</td>
</tr>
<tr>
<td>Renewals</td>
<td>6467</td>
<td>6758</td>
</tr>
<tr>
<td>TOTAL</td>
<td>7264</td>
<td>7859</td>
</tr>
</tbody>
</table>

### Out of Province & International Registrations

- 1998: 53
- 1999: 34
- 2000: 41
- 2001: 74
- 2002: 90
- 2003: 80
- 2004: 81
- 2005: 124
- 2006: 205
- 2007: 247
- 2008: 601

### LPN Registration Trends

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of LPNs</th>
<th>Percentage of Loss/Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986</td>
<td>8646</td>
<td></td>
</tr>
<tr>
<td>1987</td>
<td>7894</td>
<td>-8.7%</td>
</tr>
<tr>
<td>1988</td>
<td>7225</td>
<td>-8.5%</td>
</tr>
<tr>
<td>1989</td>
<td>6956</td>
<td>-3.7%</td>
</tr>
<tr>
<td>1990</td>
<td>6736</td>
<td>-3.2%</td>
</tr>
<tr>
<td>1991</td>
<td>6651</td>
<td>-1.3%</td>
</tr>
<tr>
<td>1992</td>
<td>6545</td>
<td>-1.6%</td>
</tr>
<tr>
<td>1993</td>
<td>6378</td>
<td>-2.6%</td>
</tr>
<tr>
<td>1994</td>
<td>6196</td>
<td>-2.9%</td>
</tr>
<tr>
<td>1995</td>
<td>5562</td>
<td>-10%</td>
</tr>
<tr>
<td>1996</td>
<td>4963</td>
<td>-10.8%</td>
</tr>
<tr>
<td>1997</td>
<td>4723</td>
<td>-4.8%</td>
</tr>
<tr>
<td>1998</td>
<td>4606</td>
<td>-2.5%</td>
</tr>
<tr>
<td>1999</td>
<td>4342</td>
<td>-5.7%</td>
</tr>
<tr>
<td>2000</td>
<td>4431</td>
<td>2.0%</td>
</tr>
<tr>
<td>2001</td>
<td>4848</td>
<td>9.4%</td>
</tr>
<tr>
<td>2002</td>
<td>5172</td>
<td>6.7%</td>
</tr>
<tr>
<td>2003</td>
<td>5575</td>
<td>7.8%</td>
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<tr>
<td>2004</td>
<td>6037</td>
<td>8.3%</td>
</tr>
<tr>
<td>2005</td>
<td>6533</td>
<td>8.2%</td>
</tr>
<tr>
<td>2006</td>
<td>6864</td>
<td>5.0%</td>
</tr>
<tr>
<td>2007</td>
<td>7264</td>
<td>5.8%</td>
</tr>
<tr>
<td>2008</td>
<td>7859</td>
<td>8.1%</td>
</tr>
</tbody>
</table>

### LPN Gender Distribution

- Female: 94.3%
- Male: 5.7%

[+1.3% vs 2007]
statistics
Year ending December 31, 2008

Age of Active LPNs

Average Age: 2006 - 42.4 | 2007 - 42.2 | 2008 - 41.2

Distribution of LPNs by Health Region

<table>
<thead>
<tr>
<th>Health Region</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1 Chinook Regional Health Authority</td>
<td>405</td>
<td>425</td>
</tr>
<tr>
<td>R2 Palliser Health Region</td>
<td>285</td>
<td>294</td>
</tr>
<tr>
<td>R3 Calgary Health Region</td>
<td>1685</td>
<td>1808</td>
</tr>
<tr>
<td>R4 David Thompson Regional Health Authority</td>
<td>843</td>
<td>838</td>
</tr>
<tr>
<td>R5 East Central Health</td>
<td>377</td>
<td>380</td>
</tr>
<tr>
<td>R6 Capital Health</td>
<td>2399</td>
<td>2784</td>
</tr>
<tr>
<td>R7 Aspen Regional Health Authority</td>
<td>414</td>
<td>419</td>
</tr>
<tr>
<td>R8 Peace Country Health</td>
<td>374</td>
<td>374</td>
</tr>
<tr>
<td>R9 Northern Lights Health Region</td>
<td>127</td>
<td>131</td>
</tr>
<tr>
<td>Other Canadian</td>
<td>405</td>
<td>406</td>
</tr>
<tr>
<td>TOTAL</td>
<td>7264</td>
<td>7859</td>
</tr>
</tbody>
</table>
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)
Vacant
District 5 (RHA Region 7)
Jenette Lappenbush
District 6 (RHA Region 8)
Kristina Maidment
District 7 (RHA Region 9)
Kristen Shardlow
Public Members
Peter Bidlock / Robert Mitchell
Ted Langford
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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.

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 health care 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

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