Alberta Health Services

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The NP News

Welcome to Autumn!

Is it just me, or does time go by incredibly fast?! As we move through the next few months of 2020, as the weather gets cooler, people move indoors, and children return to school, please, do not forget the vital lessons learned during the early months of this pandemic. We are resilient, and together we are stronger. We know how and what to do; we will get through this challenge, one day at a time, together. Stay healthy, stay safe, and take care of one another!

The focus of this edition of ***The NP News*** is raising awareness of the rising incidence of hypertension in older women. Highlights from the 2020 Hypertension Guidelines are included. This is timely! October 17th, 2020 is World Hypertension Day.

Stay tuned! Key messages from the 2020 Guidelines for Management of Hypertension in clients with stroke, pediatric patients, and during pregnancy will be included in the next edition of the ENews.

Past editions of ***The NP News*** can be found online:

https://insite.albertahealthservices.ca/Page9108.aspx

Hypertension in Older Women

Increased blood pressure is a leading cause of death and disability; the risk increases with age.

Unfortunately, in Canada, for almost a decade the rates of diagnosing, treating, and controlling hypertension in women over the age of sixty years have been decreasing; consequently, there has been a corresponding increase in the rates of cardiovascular death and disability.

Controlling hypertension is one of the most effective means to reduce death and disability, especially in those at higher risk.

Cardiovascular disease (CVD) is preventable through adoption of best clinical practices.

There is an URGENT need to increase the rates of diagnosing, treating, managing, and controlling hypertension in older women.

A call for all levels of government, all clinicians, health professional associations, and health charities, has been put forth by **Hypertension Canada**, the **College of Family Physicians of Canada**, **Canadian Pharmacists Association**, and **Heart and Stroke Foundation of Canada** to emphasize the importance of reengaging and taking action!

This information was shared by Dr. Donna McLean, RN, NP, PhD, CCN(C), MacEwan University, Misericordia Hospital, Edmonton, and Norm Campbell, CM, MD, DSc (hon) FRCPC, Professor Emeritus, University of Calgary.

Hypertension Canada's 2020 Comprehensive Guidelines for the Prevention, Diagnosis, Risk Assessment, and Treatment of Hypertension in Adults & Children

Diagnosis and Treatment of Hypertension in Adults

- Hypertension remains the most prevalent risk factor for CVD in Canada.
- Standardized blood pressure measurement, using validated protocols and devices, is recommended.
- Frequency and timing of screening can be tailored to each patient.
- Risk factors for hypertension include diabetes; kidney disease; low consumption of fresh fruits and vegetables; and sedentary behaviour.
- Use of out-of-office 24-hr Ambulatory BP Monitoring (ABPM) or Home BP monitoring (HBPM) is recommended for all adults with elevated in-office BP to rule out white coat, suspected and masked hypertension.
- Adults with confirmed diagnoses of hypertension should have a baseline CVD risk assessment (screening for diabetes, hyperlipidemia, and renal disease; target organ damage; and routine lab testing).
- There is a need to rule out pregnancy in all hypertensive women of reproductive age; repeat testing during follow-up visits.
- Health behaviour changes are strongly recommended as 1st line interventions to lower blood pressure (increasing activity, decreasing intake of alcohol, etc.).
- Optimization of lipid levels with use of statin medications in high-risk patients is recommended
- Use of ASA for primary prevention of CVD is no longer recommended in people with hypertension.
- Revised recommendation for 2020 - reduce alcohol consumption (or abstain) to reduce blood pressure and prevent hypertension.
- Hypertension Canada encourages use of clinical judgement and shared decision making when identifying BP target to ensure feasibility in the patient's clinical, social, and economic context.
- Patients with CVD or elevated risk should aim for a target systolic BP of ~120 mm Hg.
- ACEIs, ARBs, CCBs, and long-acting thiazide-like diuretics are still recommended as 1st line treatment in adults with uncomplicated hypertension; B-Blockers can also be used safely as 1st line therapy in younger patients (but only if uncomplicated hypertension).
- When possible, use of a single-pill combination should be considered to improve efficacy, efficiency, and tolerability of treatment.
- Hypertension frequently coexists with other conditions, and comorbidities influence therapeutic decision making. Polypharmacy complications and competing risks should be considered carefully.
- Adults with DM and CKD might also benefit from a target systolic BP of 120 - 130 mmHg.

Resistant Hypertension

- Resistant hypertension is defined as BP above target despite use of 3 or more BP-lowering drugs at optimal doses (preferably including a diuretic and usually a renin-angiotensin-aldosterone system blocker and a CCB).
- Accurate in and out-of-office BP measurement is essential for management.
- Other reasons for apparent resistant hypertension should be eliminated before diagnosing true resistant hypertension, including nonadherence, white coat effect, and secondary hypertension.
- Adding spironolactone, bisoprolol, doxazosin, amiloride, eplerenone, or clonidine to the baseline regimen decreases BP significantly, with the greatest BP-lowering effect shown with use of spironolactone.
- Patients with resistant hypertension should be referred to providers with expertise in high BP diagnosis and management.
- Use of digital tracking and/or e-health interventions may improve hypertension management, reduce risk of CVD, and improve client health and well-being.

For additional information, please visit hypertension.ca and download Hypertension Canada's 2020 Guidelines

Nurse Practitioner to Know

Please tell us your name & a little bit about yourself.

My name is Nan Cox-Kennett and I am an extrovert with a capital 'E' who loves to share knowledge. Maybe that is just a fancy way for me to say, "I love to talk!" Whether it's about the most recent podcast I'm listening to (Malcolm Gladwell's Revisionist History), the book I'm currently reading (Robert Galbraith Cormoran Strike novels), or cool medical cases – I'm happy to share.

Where do you currently work?

Since 2005, I have been the Nurse Practitioner at the Cross Cancer Institute Edmonton in the Department of Hematology and Bone Marrow Transplant Team. I was the second Nurse Practitioner hired within Oncology and the first for this team. Initially I worked alongside my physician colleagues in a collaborative practice which was great to reinforce learning and develop acceptance for the role. Over time, my role has transitioned to an independent outpatient practice with my physician colleagues having their clinics down the hall for easy access for complex cases or new chemotherapy startups. Within Oncology, we are blessed to have a wide scope of practice and I feel confident to care for my patients' complex needs whether they are on chemotherapy/novel agent treatment or just learning about their illness.

Where did you go to school?

I completed my Master of Nursing at the University of Alberta when the program was still in its infancy. At that time, you were trained as a specialist within your field and the NP national exam had not started yet. I'm pleased to see the program has transitioned to train as a generalist Nurse Practitioner first to ensure strong foundational knowledge. I wish that had been my experience.

Why did you become a nurse practitioner?

I became a Nurse Practitioner by accident. Back in the 1990s, there were massive layoffs within Alberta and my nursing position was eliminated. I followed the supervisor I trusted to hematology. Within a few weeks, my skills were being put to the test as the chemotherapy protocols called for different assessment skills, complex patient teaching, and heightened awareness of the emotional turmoil caused by a cancer diagnosis. I eventually became the Clinical Nurse Educator and one day was invited by the department's Clinical Nurse Specialist, to consider the Nurse Practitioner program because the hematology division was considering hiring a NP for this role. I was drawn to the autonomy, the teaching, and the ongoing patient connection.

What do you enjoy about your role?

As I have a few more grey hairs now, I often ask myself, why am I still in this? What keeps me going? Why not retire, especially during these tumultuous times? And it comes down to this… every day in some small way, I know I am making a difference. I see it when a patient takes a calming breath after I have explained their new diagnosis of chronic leukemia. I see it when a patient makes a complex decision about their treatment after being presented with the evidence for each of their options. I feel it in the warmth from a grateful family member after watching our team handle a complex drug reaction. I know it when I have a room full of staff or students have an 'A-HA' moment after something ridiculously complex about a new treatment has been explained in a language that everyone can relate to or understand.

What are the challenges?

Cancer treatment is a rapidly evolving field. The chemotherapy of 2005 is no longer (or rarely) prescribed now. The new medications are more complex, more targeted, and often have a myriad of side effects beyond just myelosuppression. The treatments are more personalized based on genetics or molecular mutations within the cancer cell. Keeping up to date is a constant challenge.

NP to Know continued...

Are you/have you been involved in any research

I have a shared research interest with Edith Pituskin from the Faculty of Nursing University of Alberta. She and I have explored the cardiac toxicity of bone marrow transplant (BMT) and worked with the Mazenkowski Heart Institute to launch a post-transplant rehabilitation program treating the event as a “chemo-attack” on the heart with the ultimate goal of helping patients recover and reduce risk of future cardiac events.

Are you/have you been involved in teaching?

Over the years, I’ve been a preceptor, a NP mentor, and teacher. I’ve enjoyed intermittent teaching at the University of Alberta for the Nurse Practitioner program for a couple of semesters and found it a great way to keep my knowledge up to date and link with the next generation of NPs. I chair the allied health sessions at the Canadian Conference on Lymphoproliferative Disorders (CCOLD) annually and have been known to teach a session or two there. I have also done a few webinars for the Canadian Association of Nurses in Oncology and the RAH Nursing Day.

What do you see as the future role of NPs?

I’m excited about the future for NPs but I remain concerned about the sustainability of positions within acute care. For NPs in unique ‘one of a kind’ roles, I’m cognizant that there is a need to have transition plans for maternity and retirement to ensure our positions are not lost within the system.

If you could change one thing about nursing in Alberta, what would that be?

I wish we had a “Nurse Practitioner Intern” program to encourage those nurses who have shown promise – much like that CNS did for me. This type of program used to exist at the Cross Cancer Institute – a nurse could receive partial financial support while taking their MN and train alongside an existing NP/physician during semester breaks. This home grown approach could allow niche groups to add a Nurse Practitioner to their team and/or create built in transition plans.

Collaborative Corner

A team of 35 employees came together for team building. Although they were young, bright, and enthusiastic, the team members would not share information or solutions with each other. The leader felt they were focused on self and not enough on team. She started with a fun team activity to teach the value of working together and sharing more.

She brought the team into the cafeteria. Hundreds of different colored balloons were placed around the room. Everyone was excited, but not sure what was happening. In the center of the room was a box of uninflated balloons. The team leader asked each person to pick a balloon, blow it up, and write their name on it. They were advised to be careful. If their balloon popped, they were out of the game.

About 30 team members successfully blew up their balloons and wrote their name on it. They were asked to leave their balloons and exit the room. Five minutes later they re-entered the room and were told to find their named balloon among the hundreds of balloons in the room. They were warned to be careful. If they popped a balloon, they would be disqualified.

While being careful, yet trying to go as quickly as possible, each team member looked for their balloon. After 15 mins not one person was able to find it. They were told this part of the game was over. They were moving onto the next round.

The leader told each member of the team to find any balloon with a name on it and give it to the person with that name. Within a couple of minutes every member of the team had their balloon. Take away messages: We are much more efficient when we are willing to share with each other. We solve problems better when we work together.

Adapted from the writing of Michael G. Rogers

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