PRACTICE

COLLEGE OF
LICENSED PRACTICAL NURSES
OF NEWFOUNDLAND AND LABRADOR
LPNs - A Practical Approach to Quality Care






Practical Nursing across the Lifespan

Volume 1, Issue 1 – January 2016

PRACTICE

The College of Licensed Practical Nurses of Newfoundland and Labrador is excited to introduce its first edition of PRACTICE. This informative publication will include a wide array of information on nursing regulation, nursing licensure, nursing practice and many other health related topics. PRACTICE will be published electronically three times a year. CLPNNL welcomes feedback, suggestions and submissions from readers on this publication at wsquires@clpnnl.ca.

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COLLEGE BOARD MEMBERS

Jane Pardy	Chairperson, Public Representative *
Tanjit Kaur	Zone 1 Licensed Practical Nurse Eastern Region
Vacant	Zone 1 Licensed Practical Nurse Eastern Region
Christopher Matthews	Zone 2 Licensed Practical Nurse Eastern Region
Christopher Janes	Zone 3 Licensed Practical Nurse Central Region
Ernest Green	Zone 4 Licensed Practical Nurse Western Region
Vacant	Zone 5 Licensed Practical Nurse Labrador/Grenfell Region
Patricia Barrett	Public Representative *
Vacant	Public Representative *
Dawn Lanphear	Centre for Nursing Studies
Paul Fisher	Executive Director/Registrar (Non-voting)

*Appointed by Government

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PRACTICE, presented by CLPNNL

Design & Layout: Kimberly Puddester

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MISSION

The College of Licensed Practical Nurses of Newfoundland and Labrador (CLPNNL) protects the public through the promotion of efficient, ethical nursing care, regulation of licensed practical nursing practice, the licensure of Practical Nurses and setting the strategic direction for the organization.

COLLEGE OF
LICENSED PRACTICAL NURSES
OF NEWFOUNDLAND AND LABRADOR
LPNs - A Practical Approach to Quality Care

VISION

To foster a professional environment where Licensed Practical Nurses (LPNs) are respected, valued as integral members of the nursing team and provide quality health care services in Newfoundland and Labrador.

VALUES

We Believe:

- Licensed Practical Nursing practice is founded on professionalism, compassion and caring;
- Licensed Practical Nurses are accountable for their actions;
- Licensed Practical Nurses take responsibility for lifelong learning aimed at building and maintaining professional competency; and
- Partnerships with key stakeholders are essential to enhancing the profession.

The CLPNNL has the legislative responsibility for regulating the practice of LPNs in Newfoundland and Labrador. In doing so, it serves to protect the public. It supports the Vision and promotes the Values of LPNs by providing leadership and supporting the integrity of the profession.

Seeking New Board Members for Zones I & V

Due to the recent resignation of two elected board members in Zones I and V, the Board is required to appoint replacements for the balance of those terms. The Zone I position is for a two year term and the Zone V position is for a one year term. If you are interested in being considered for one of these appointments and meet the criteria as outlined in the By-laws please forward a resume with a cover letter to pfisher@clpnnl.ca prior to February 15th, 2016. For additional information about the Zone allocations, etc., please consult the By-laws at http://www.clpnnl.ca/attachments/clpnnlbylaws2014.pdf.

The Board is comprised of eleven (11) members – six (6) elected LPNs, one (1) appointed representative from the Centre for Nursing Studies, three (3) appointed public representatives, appointed by the Minister of Health & Community Services and the Executive Director/Registrar (non-voting). The Board meets approximately four (4) times a year including an Annual General Meeting.

College of Licensed Practical Nurses of Newfoundland and Labrador Election Results

The following LPNs have been elected to the board of the College of Licensed Practical Nurses of Newfoundland and Labrador for a three year term (January 1, 2016 – December 31, 2018):

ZONE 1 – Tanjit Kaur
ZONE 3 – Christopher Janes

Congratulations!

Outgoing CLPNNL Board Members

The CLPNNL would like to take this opportunity to recognize the excellence these board members have brought to the College of Licensed Practical Nurses of Newfoundland and Labrador Board. These LPNs (Judy Reid, Connie Winter and Pearl Blake) have served to help protect the public in advancing the role of the LPN in Newfoundland and Labrador. Your time, energy, skill, competence and compassion have been a tremendous contribution. The CLPNNL thanks you!

Pictured above: Judy Reid (January '12-December '15), Connie Winter (January '07-December '15), Pearl Blake (January '07-December '15) with Jane Pardy- current chairperson of the Board.

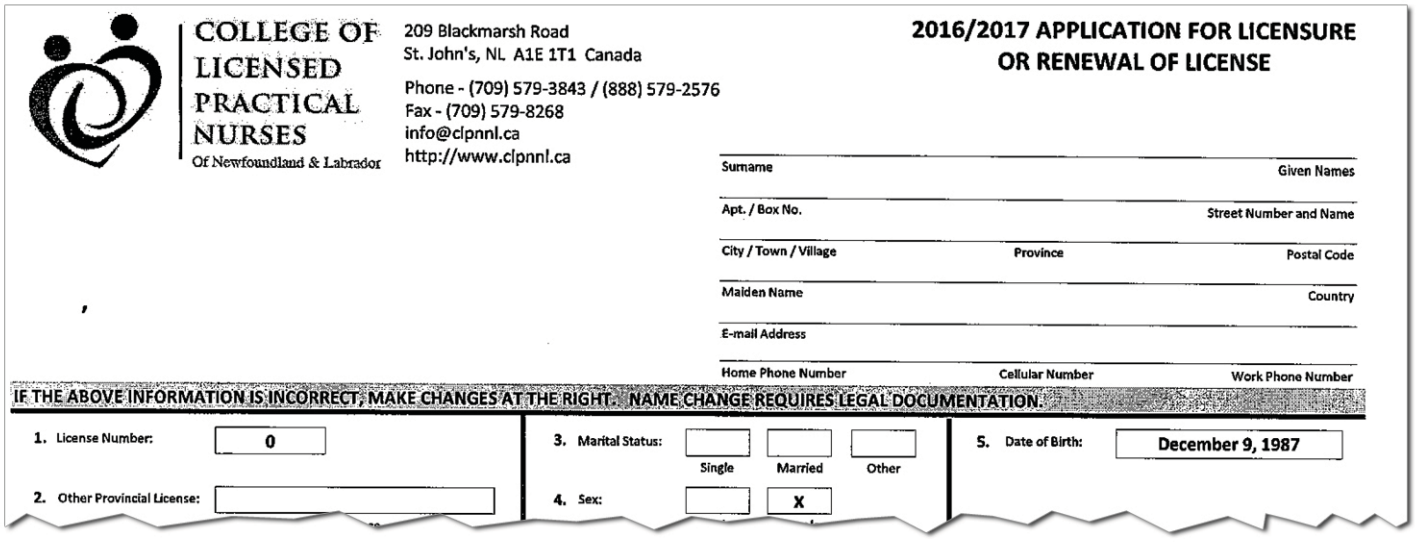
New Administrative Deadline
for Annual Licensure Renewal 2016-17

A new administrative deadline for annual licensure renewal applications will come into effect for the 2016-17 (April 1, 2016 – March 31, 2017) licensure year. This change of policy will require all LPNs seeking to renew their license to submit licensure applications and fee prior to March 1st each licensure year, however the licensure expiry date will remain unchanged at March 31st.

LPNs who do not renew their license by March 1st will be required to pay a late fee of $56.50 (HST included) in addition to the annual licensure renewal fee due March 1st of each licensure year. In addition, the regular reinstatement fee of $75.00 (HST included) will also apply for those LPNs who fail to renew their license prior to April 1st.

The LPN Act (2005) and the LPN Regulations (2011) have established criteria and requirements for licensure renewal. To meet the requirements, a LPN may require documentation from a third party (example, verification from another regulatory body or practice hours from an employer) or direct follow-up by CLPNNL staff to clarify information provided. A March 1st administrative deadline provides 30 days in advance of the license expiry date to review and complete the application process. The new deadline supports the CLPNNL's public protection mandate by reducing potential health service delivery interruptions that may occur if a LPN is prevented from working on April 1st as he/she does not meet licensure renewal requirements.

In 2014, approximately 60% of the LPN membership submitted their licensure renewal applications after March 1st. Approximately 40% of the LPN membership submitted their renewal applications after March 15th and approximately 10% of the LPN membership submitted their renewal applications on March 31st.



COLLEGE OF LICENSED PRACTICAL NURSES
Of Newfoundland & Labrador

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http://www.clpnnl.ca

2016/2017 APPLICATION FOR LICENSURE OR RENEWAL OF LICENSE

Surname | Given Names
Apt. / Box No. | Street Number and Name
City / Town / Village | Province | Postal Code
Maiden Name | Country
E-mail Address
Home Phone Number | Cellular Number | Work Phone Number

IF THE ABOVE INFORMATION IS INCORRECT, MAKE CHANGES AT THE RIGHT. NAME CHANGE REQUIRES LEGAL DOCUMENTATION.

1. License Number: 0
2. Other Provincial License:
3. Marital Status: Single | Married | Other
4. Sex: X
5. Date of Birth: December 9, 1987

For those LPNs who participate in payroll deduction for the payment of their annual licensure fees through their employer, please ensure that the appropriate payroll staff are aware of this new deadline so that licensure fees can be collected and submitted to the CLPNNL prior to the March 1st deadline.

"FOR THEIR OWN GOOD": AGING & PATERNALISM IN PRACTICE

What Health Professionals Need to Consider

- *In what ways might your personal biases and attitudes impact your professional practice?*
- *What is the impact of paternalism on service delivery?*
- *What are some of the ethical, professional and practice considerations?*
- *How are systems responding to the aging demographic?*
- *How do we support human rights within paternalistic systems?*

TUESDAY, FEBRUARY 16, 2016

2 p.m. - 4 p.m.

In-person: *Health Sciences Centre, Main Auditorium OR*
Webcast: *http://www.arnnl.ca or https://www.nlasw.ca*

No registration required. This event is offered free-of-charge.
RNs requiring CCP Certificates can register at **www.arnnl.ca**.

Panel Presenters:
Henry Kielley MSW, RSW, *Consultant, Seniors and Aging Division, Department of Seniors, Wellness, and Social Development;*
Carey Majid BA, LL.B., *Executive Director, Newfoundland and Labrador Human Rights Commission;*
Annette Morgan RN, BN, MN, *Administrator, Agnes Pratt Home;* and
Daryl Pullman MA, PhD, BEd, *Professor of Medical Ethics, Director, Health Research Unit, Division of Community Health and Humanities, Faculty of Medicine.*

Moderators:
Pam King-Jesso RN, BN, MN, *Nursing Consultant, Policy & Practice, Association of Registered Nurses Newfoundland and Labrador*
Annette Johns MSW, RSW, *Associate Director of Policy and Practice, Newfoundland and Labrador Association of Social Workers*

Association of Registered Nurses of Newfoundland and Labrador

Newfoundland & Labrador Association of Social Workers

College of Licensed Practical Nurses of Newfoundland and Labrador

Memorial University of Newfoundland School of Nursing

January is Alzheimer Awareness Month!

10 WARNING SIGNS

Whether you're experiencing possible symptoms or are concerned for someone you care about, the Alzheimer Society has developed the following list of signs to look for:

1. Memory loss affecting day-to-day abilities – forgetting things often or struggling to retain new information.
2. Difficulty performing familiar tasks – forgetting how to do something you've been doing your whole life, such as preparing a meal or getting dressed.
3. Problems with language – forgetting words or substituting words that don't fit the context.
4. Disorientation in time and space – not knowing what day of the week it is or getting lost in a familiar place.
5. Impaired judgment – not recognizing a medical problem that needs attention or wearing light clothing on a cold day.
6. Problems with abstract thinking – not understanding what numbers signify on a calculator, for example, or how they're used.
7. Misplacing things – putting things in strange places, like an iron in the freezer or a wristwatch in the sugar bowl.
8. Changes in mood and behaviour – exhibiting severe mood swings from being easy-going to quick-tempered.
9. Changes in personality – behaving out of character such as feeling paranoid or threatened.
10. Loss of initiative – losing interest in friends, family and favourite activities.

If you are concerned about any of these signs, talk to your doctor.

The Soulful Sounds of Dementia – Music Therapy

Music has power— especially for individuals with Alzheimer's disease and related dementias. And it can spark compelling outcomes even in the very late stages of the disease.

When used appropriately, music can shift mood, manage stress-induced agitation, stimulate positive interactions, facilitate cognitive function, and coordinate motor movements.

This happens because rhythmic and other well-rehearsed responses require little to no cognitive or mental processing. They are influenced by the motor center of the brain that responds directly to auditory rhythmic cues. A person's ability to engage in music, particularly rhythm playing and singing, remains intact late into the disease process because, again, these activities do not mandate cognitive functioning for success.

Music Associations. Most people associate music with important events and a wide array of emotions. The connection can be so strong that hearing a tune long after the occurrence evokes a memory of it.

Prior experience with the piece is the greatest indicator of an individual's likely response. A melody that is soothing for one person may remind another of the loss of a loved one and be tragically sad.

If the links with the music are unknown, it is difficult to predict an individual's response. Therefore, observe a person's reaction to a particular arrangement and discontinue it if it evokes distress, such as agitation, facial grimaces or increasing muscular tension.

Top Ten Picks. Selections from the individual's young adult years—ages 18 to 25—are most likely to have the strongest responses and the most potential for engagement.

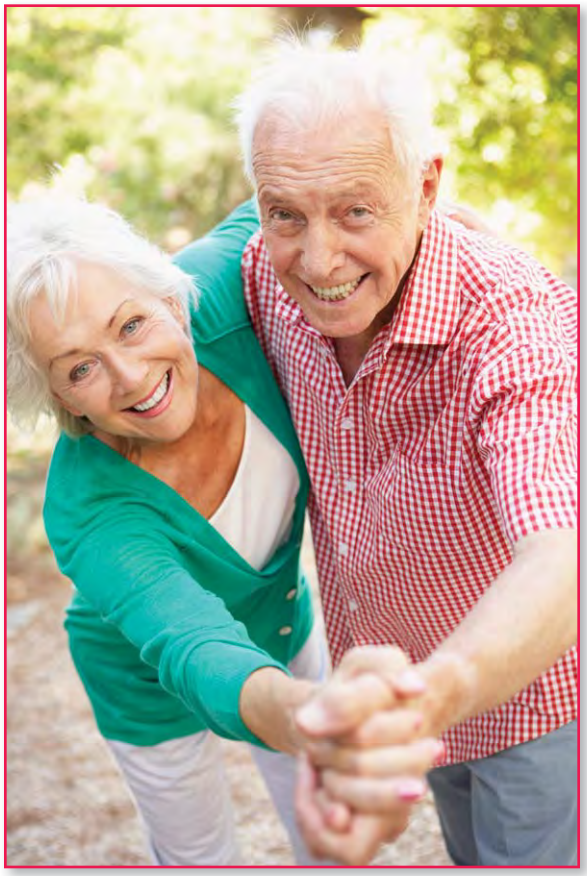
Unfamiliar music can also be beneficial because it carries no memories or emotions. This may be the best choice when developing new responses, such as physical relaxation designed to manage stress or enhance sleep.

As individuals progress into late-stage dementia, music from their childhood, such as folk songs, work well. Singing these songs in the language in which they were learned sparks the greatest involvement.

Sound of Music. Typically, "stimulative music" activates, while "sedative music" quiets. Stimulative music, with percussive sounds and fairly quick tempos, tends to naturally promote movement, such as toe taps. Look to dance tunes of any era for examples. Slightly stimulative music can assist with activities of daily living: for example, at mealtime to rouse individuals who tend to fall asleep at the table or during bathing to facilitate movement from one room to another.

On the other hand, the characteristics of sedative music—ballads and lullabies—include unaccented beats, no syncopation, slow tempos, and little percussive sound. This is the best choice when preparing for bed or any change in routine that might cause agitation.

Responses that are opposite of those expected can occur and are likely due to a person's specific associations with the piece or style of music.



Agitation Management. Non-verbal individuals in late dementia often become agitated out of frustration and sensory overload from the inability to process environmental stimuli. Engaging them in singing, rhythm playing, dancing, physical exercise, and other structured music activities can diffuse this behavior and redirect their attention.

For best outcomes, carefully observe an individual's patterns in order to use music therapies just prior to the time of day when disruptive behaviors usually occur.

Emotional Closeness. As dementia progresses, individuals typically lose the ability to share thoughts and gestures of affection with their loved ones. However, they retain their ability to move with the beat until very late in the disease process.

Ambulatory individuals can be easily directed to couple dance, which may evoke hugs, kisses or caresses; those who are no longer walking can follow cues to rhythmically swing their arms. They often allow gentle rocking or patting in beat to the music and may reciprocate with affection.

An alternative to moving or touching is singing, which is associated with safety and security from early life. Any reciprocal engagement provides an opportunity for caregivers and care receivers to connect with one another, even when the disease has deprived them of traditional forms of closeness.

How-to of music therapy:

Early stage

- Go out dancing or dance in the house.
- Listen to music that the person liked in the past—whether swing or Sinatra or salsa. Recognize that perceptual changes can alter the way individuals with dementia hear music. If they say it sounds horrible, turn it off; it may to them.
- Experiment with various types of concerts and venues, giving consideration to endurance and temperament.
- Encourage an individual who played an instrument to try it again.
- Compile a musical history of favorite recordings, which can be used to help in reminiscence and memory recall.

Early and middle stages

Use song sheets or a karaokeplayer so the individual can sing along with old-time favorites.

Middle stage

- Play music or sing as the individual is walking to improve balance or gait.
- Use background music to enhance mood.
- Opt for relaxing music—a familiar, non-rhythmic song—to reduce sundowning, or behavior problems at nighttime.

Late stage

- Utilize the music collection of old favorites that you made earlier.
- Do sing-alongs, with "When the Saints Go Marching In" or other tunes sung by rote in that person's generation.
- Play soothing music to provide a sense of comfort.
- Exercise to music.
- Do drumming or other rhythm-based activities.
- Use facial expressions to communicate feelings when involved in these activities.

Contributed by Alicia Ann Clair, Ph.D., MT-BC, professor and director of the Division of Music Education and Music at the University of Kansas in Lawrence. "How-to" section contributed by Concetta M. Tomaino, DA, MT-BC, vice president for music therapy and director of the Institute for Music and Neurologic Function at Beth Abraham Family of Health Services, Bronx, NY.

For more information, connect with the Alzheimer's Foundation of America's licensed social workers. PH: 866.232.8484. Real People. Real Care.

What Do We Really Know About the Effectiveness of Stool Softeners?

While not a topic of general conversation, maintaining regular bowel movements is critical for good health and well-being. Almost a quarter of the population is affected by constipation at some point in their lives, and one in five community-dwelling seniors experience chronic constipation.

Everyone seems to have a different idea of the "normal" number of bowel movements in a week, but most will define constipation in terms of uncomfortable symptoms such as hard stools, difficulty passing stools, abdominal cramping, and an inability to completely pass stool. Everyone wants fast relief.

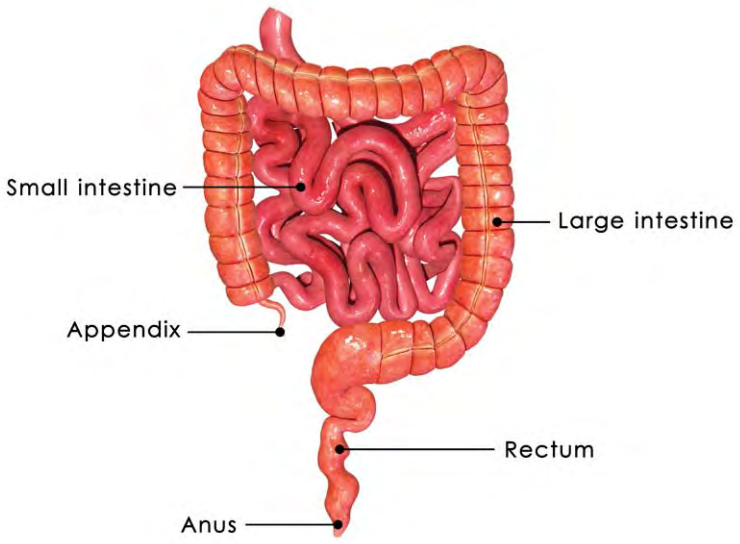
Constipation can be affected by diet, medical conditions, and a multitude of medications. Commonly used pharmacologic options to treat constipation include bulking agents (e.g., psyllium), osmotic laxatives (e.g., lactulose), stimulant laxatives (e.g., sennosides, bisacodyl), and stool softeners. Stool softeners such as docusate are widely used because they are easily tolerated and have no significant drug interactions, but do they really work?

CADTH — an independent, evidence-based agency that assesses health technologies — finds and summarizes the research on drugs, medical devices, and procedures. CADTH was recently asked to review the evidence for docusate in prevention and treatment of constipation. The literature search found only five small studies, limited to elderly patients in long-term care and patients taking opioids.

There was no good evidence for the use of docusate in these patients. The results showed that docusate did not increase the number of bowel movements, and did not improve symptoms such as abdominal cramps or the feeling of incomplete evacuation. Two studies showed that adding docusate to sennosides was no more effective than giving sennosides alone. Most surprising was that docusate did not soften stool consistency or make it easier to pass stools.

What does this mean for patient and resident care? Docusate may be inexpensive, but the absence of evidence suggests that there is simply no cost-benefit to these medications. It may be considered safe, but if a patient puts off trying another medication while waiting for docusate to work, it could potentially prolong or worsen their symptoms. And at a health system level, the common use of docusate in "bowel protocols" for long-term care residents and hospitalized patients may be costing a great deal in time and money.

Some practices, such as the use of stool softeners in residents in long-term care, are so long-standing that we no longer demand evidence for them. In many cases, it's worth taking a second look.



To learn more about CADTH, visit www.cadth.ca, follow us on Twitter: @CADTH_ACMTS, or talk to your Liaison Officer in Newfoundland and Labrador, Sheila Tucker: SheilaT@cadth.ca. Permission to reprint given by CADTH.

This article originally appeared in the November 2014 edition of Canadian Healthcare Network.ca and has been edited for this publication.

Treatments for Constipation: A Review of Systematic Reviews (2014) CADTH Rapid Response Report: Summary with Critical Appraisal.

Dioctyl Sulfosuccinate or Docusate (Calcium or Sodium) for the Prevention or Management of Constipation: A Review of the Clinical Effectiveness (2014) CADTH Rapid Response Report: Summary with Critical Appraisal.

Stool Softeners for the Prevention and Management of Constipation: A Review (2014) CADTH Rapid Response Report in Brief.

CARING & AGING with Pride

Authors: *Laura Sullivan, Rachel Bourque, Lhey Power and Emily Gardiner, Practical Nursing Students, Centre for Nursing Studies.*

(This article provides a summary of the presentation titled **Caring and Aging with Pride** presented at the Provincial Nursing Forum, June 9, 2015.)

The older population face many challenges; issues surrounding sexual orientation is one challenge that we feel is monumental. The aging lesbian, gay, bisexual, transgender, intersex, query/questioning (LGBTIQ) population became our passion when researching the challenges these seniors face integrating within their demographic. Some LGBTIQ seniors are being denied the care that they require, or are simply choosing not to seek help in fear of discrimination, which can lead to an overall deterioration of their health and wellness. LGBTIQ seniors are at higher risk for mental health issues, such as depression, suicide, addiction and substance abuse, as well as physical and medical issues (Haghiri-Vijeh, 2013). There is the assumption that heterosexuality is the only type of sexual orientation in the older adult population. This is referred to as heteronormativity. This term is linked to the traditional male and female roles. Many LGBTIQ seniors feel that they have to fit into expected traditional roles. They may live their lives taking drastic measures "to fit in" and will sometimes marry and have children because it is an expectation in society. This can be detrimental to their individual well-being and family structure.

As nursing students, the importance of holistic care is stressed in the practical nursing program. Florence Nightingale was considered to be one of the pinnacle figures of the nursing world. She was one of the first nurses to take healing to the next level with the goal of healing the whole person. Nursing takes a "mind-body-spirit-emotion-environment" approach in the way we manage and work with clients. Sexual orientation is as much a part of every human being as is eye color. Sexual orientation should not influence the quality of care. As health care professionals, regardless of the client's sexual orientation, it is important to provide the care that every human being has a right to and deserves. Nursing is more than treating an illness, it involves providing holistic care considering the unique needs of the client. Heightening our own awareness regarding differences in sexual orientation will make us better nurses.

Educating health care professionals has been identified as an important way of raising awareness and improving services for this population. We feel that improving communication and providing support will best facilitate relationship building for LGBTIQ seniors. For the aging LGBTIQ population, love often means a lifetime of waiting. Would you want to wait?

Reference:

Haghiri-Vijeh, R. (2013). The importance of including the needs of the LGBTIQ community in the millennium development goals and education of healthcare professionals. Journal of Global Citizenship & Equity Education, 3(1), 68-79.

February is Heart and Stroke Awareness Month!

LEARN THE SIGNS OF STROKE

FACE is it drooping?

ARMS can you raise both?

SPEECH is it slurred or jumbled?

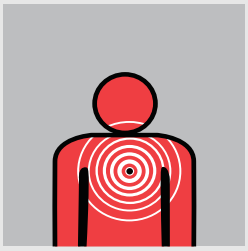
TIME to call 9-1-1 right away.

ACT **F A S T** BECAUSE THE QUICKER YOU ACT, THE MORE OF THE PERSON YOU SAVE.

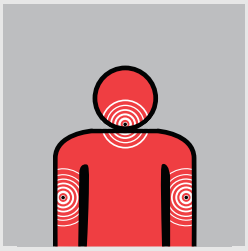
HEART & STROKE™ FOUNDATION

Learn more at
heartandstroke.ca/FAST

LEARN THE SIGNS OF A HEART ATTACK

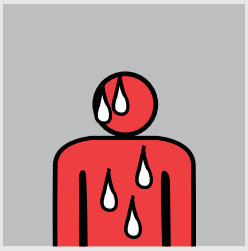


CHEST DISCOMFORT (uncomfortable chest pressure, squeezing, fullness or pain, burning or heaviness)



DISCOMFORT IN OTHER AREAS OF THE UPPER BODY (neck, jaw, shoulder, arms, back)

SHORTNESS OF BREATH



SWEATING

NAUSEA

LIGHT-HEADEDNESS

CALL 9-1-1 OR YOUR LOCAL EMERGENCY NUMBER RIGHT AWAY.

HEART & STROKE™ FOUNDATION

Learn more at heartandstroke.ca/heartsigns

Nursing Education and Research Council

Nursing Grand Rounds

2016

Date	Topic	Presenter	**Location / Webinar Registration**
Jan. 28	Conflict Management in the Workplace	Leslie O'Keefe MA RSW	New Cafeteria Conf. Rm, LAMC https://attendee.gotowebinar.com/register/8189790794053271810
Feb. 25	**Pronouncement and Certification of** Death by Registered Nurses	Maxine Power-Murrin RN MEd	New Cafeteria Conf. Rm, LAMC https://attendee.gotowebinar.com/register/2324289885031067394
Mar. 31	Exploring Ethical Dilemmas in Nursing	Jacintha Penney BA MTS MHSc(bioethics) PsyD	New Cafeteria Conf. Rm, LAMC https://attendee.gotowebinar.com/register/6196110131081481730
Apr. 28	The Nurse, the Chart and the Law	Canadian Nurses Protective Society	New Cafeteria Conf. Rm, LAMC https://attendee.gotowebinar.com/register/2503858825544580354
May 26	RNs and LPNs: Let's Talk About **Scope of Practice**	Siohbainn Lewis RN BN MN Wanda Lee Squires LPN	**Room 625, Southcott Hall LAMC** https://attendee.gotowebinar.com/register/1412723277348987650
Jun. 23	Impact of a Standardized Uniform on Registered Nurses in Newfoundland and Labrador	Andrea Barron RN BN MN Elizabeth Hynes RN BN MN Gladys Schofield RN BN MN Karen Street RN BN MN	New Cafeteria Conf. Rm, LAMC https://attendee.gotowebinar.com/register/2361636996491782402

Please note that all rounds will occur from 1400-1500 hours on the last Thursday of the month
Nursing Grand Rounds will not be held during July & August due to the holiday seasons

For additional information please contact Eastern Health Professional Practice - Nursing 777-7792

Legal Issues in Nursing: Assessment

By Chris Rokosh, RN, Legal Nurse Consultant

The following paragraph summarizes the event leading to a medical malpractice lawsuit involving 17 year old Will Johnston, who suffered from a fractured right tibia when he was hit by a car. The tibia was successfully repaired, but post-operatively, Will developed severe pain in his leg and became confused and irritable. The nurses caring for him documented signs of weakness and changes to the color, warmth, sensation and movement in his right foot, but they failed to communicate this information to the doctor. Will was ultimately diagnosed with compartment syndrome, had a below-the-knee amputation, and filed a multimillion dollar lawsuit, suing both the nurses and doctors for the loss of his leg. When the nursing care was examined, it was determined that the nurses had failed to meet the standard of care in two key areas: by not communicating important clinical information to the doctor and by not assessing Will's leg according to hospital policy. This article will focus on the issue of nursing assessments; more specifically, medical malpractice lawsuits claiming that the nurse performed inadequate assessments.

All nurses are tasked with the responsibility of providing safe, ethical and competent care. We are also responsible and accountable to ensure that our practice meets both professional standards and legal requirements. This requires that patient assessments are done according to doctor's orders, current standards of care, best practice guidelines, facility policy and, most importantly, according to each patient's individual condition. The court's view is that nurses have a specialized body of knowledge and that they are expected to use critical thinking to respond appropriately to information obtained through their assessments. In some situations, nurses are require to assess patients without the assistance of subjective information, such as during periods of sleep, recovery from anesthesia, in pediatric care or when working with unconscious or mentally compromised patients. But in all situations, the expectation is that if the patient's condition changes, so will the detail and frequency of nursing assessments. This means that you may need to assess patients more frequently if they become unstable or develop complications. Seems pretty straightforward, doesn't it?

Many medical malpractice lawsuits include allegations that the nurse did not assess the patient often enough or that they didn't assess them at all. You may be familiar with the saying 'nothing written, nothing done'. Many nurses are. This saying comes from a 1974 Supreme Court of Canada case called *Kolesar vs. Jeffries*. Although it is often used in reference to a lack of nursing documentation, it's really based on a lack of nursing assessment. The case involved a young man who had a spinal fusion and was returned to the surgical unit in satisfactory condition. The next morning he was found dead. There were no written entries in the medical record between 10 p.m. and 5 a.m. on the morning when his death was discovered. The nurse testified in court that she had measured pulse and respiration rates every half hour over night, and that they were always normal. She just hadn't written anything down. But the absence of documentation led the judge to believe that nothing was charted because nothing was done. This highlights both the importance of performing assessments according to the standards of care, and the necessity of documenting that you have done so. Let's learn more about this issue by examining a case study involving the assessment of a patient on a medical unit.

CASE STUDY

At 2:30 p.m., a 47-year-old woman named Margaret arrived in the emergency department complaining of a sudden onset of upper abdominal pain, nausea and vomiting. She came to the hospital directly from the airport after spending two weeks at an all-inclusive resort in Mexico. Her medical history was

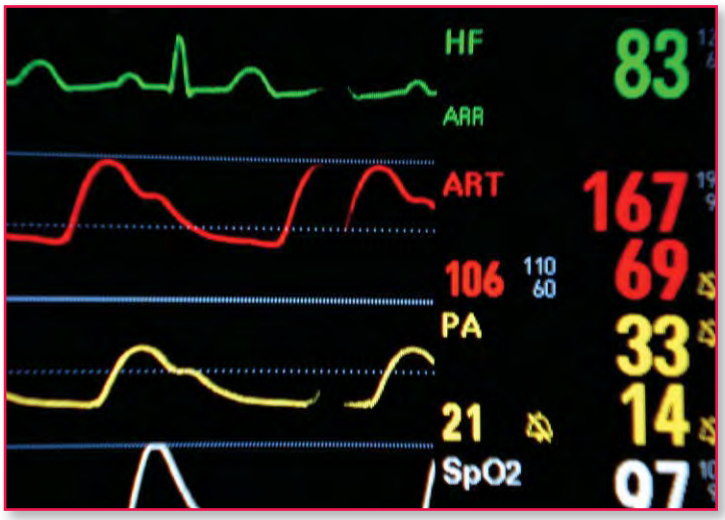
significant for hypertension and chronic back pain. She was a smoker and admitted to occasional heavy alcohol use, especially in the past two weeks. Surgical history included a tonsillectomy many years ago, a hysterectomy 6 years ago and dental surgery. Current medications included vitamins, hormone replacement therapy, Tylenol #3 (for back pain), and Labetalol (to control blood pressure). Her vital signs on admission were temperature 37.8 degrees, BP 176/88 mmHg, pulse 90 beats per minute and respirations 24 breaths per minute. Laboratory tests revealed an elevated white blood cell count and an elevated serum amylase. Her abdomen was tender and slightly rigid. Margaret was diagnosed with acute pancreatitis and admitted to the medical unit. The doctor provided orders for IV fluids, antibiotics, additional lab and diagnostic testing, and consultation with an internist. Margaret was to remain NPO overnight and provided with medication orders to control pain and nausea. Vital signs were ordered as per protocol.

At 8:45 p.m., Margaret arrived on the medical unit and was assigned to LPN Amy who was working a 12 hour night shift. Nurse Amy performed an initial physical assessment and completed the admission paperwork. Margaret denied having any pain or nausea. Temperature remained at 37.8 degrees. BP was 168/90 mmHg, pulse was 84 beats per minute and respirations were 22 breaths per minute. Nurse Amy oriented Margaret to her room, reminded her that she was NPO and showed her how to use the call bell. She also gave Margaret a warm blanket, settled her into bed and encouraged her to get some sleep.

At 10:20 p.m., Nurse Amy returned to Margaret's room to change her IV bag and check her vital signs. Temperature was now 37.0 degrees, BP was 102/58 mmHg and pulse was 116 beats per minute. Respirations were not measured. Margaret again denied having pain or nausea, but complained of feeling cold. Nurse Amy gave her another warm blanket and encouraged Margaret to use her call bell if she needed anything during the night.

Between 11:00 p.m. and 6:00 a.m., Nurse Amy documented that she performed Q1H rounds and that Margaret appeared to be sleeping with quiet, easy respirations. She also noted that the IV was infusing as ordered. Margaret did not ring her call ball or get up to the bathroom overnight.

At 6:15 a.m., Nurse Amy entered Margaret's room



to check her vital signs. When Nurse Amy touched Margaret's arm, she noted that her skin felt cool to the touch. Although Margaret opened her eyes when she was spoken to, she did not respond to the questions Nurse Amy asked her. Nurse Amy was unable to obtain a blood pressure or temperature and the pulse felt weak. Respirations were shallow and Margaret was breathing at a rate of 6 breaths per minute. Nurse Amy left the room to get another blood pressure monitor, thinking that the one she had wasn't working right. But she wasn't able to obtain a reading on the second machine either. She then rang the call bell and asked the charge nurse to come to the room. By the time the charge nurse arrived, Margaret had lost consciousness and stopped breathing.

At 6:27 a.m., a Code Blue was called. Margaret was resuscitated, intubated and taken to the ICU. Her remaining hospital stay was long and complicated, and included a diagnosis of sepsis, three laparotomies to remove sections of ischemic bowel, pneumonia and a brain injury due to prolonged hypoxia. Fifteen months after her hospitalization, she was still unable to return to work as an accountant and had developed insulin-dependent diabetes. It was uncertain that she would ever be able to return to full-time employment. Margaret filed a lawsuit against the hospital claiming, among other things, that Nurse Amy had failed to assess her vital signs properly during the first night of her admission. Margaret claimed that Nurse Amy was expected to know that a decrease in BP accompanied by a rise in the pulse rate can indicate the onset of shock in a patient with pancreatitis. She also claimed that Nurse Amy was required to communicate the 10:20 p.m. vital signs to the charge nurse or the doctor, alleging that that earlier medical intervention could have prevented, or lessened, her injuries.

Do you think Nurse Amy met the standard of care?

Pancreatitis is an inflammation of the pancreas, the large gland behind the stomach that is responsible for the release of digestive enzymes into the small intestine and the release of insulin or glucagon into the bloodstream. Pancreatic inflammation happens when the digestive enzymes are activated before they are released into the intestine and begin attacking the pancreas itself. The most common causes are gall stones and chronic alcohol use. There are two forms of pancreatitis: acute and chronic. Acute pancreatitis affects approximately one per cent of the population (Lam and Lombard, 1999) and about 70 per cent of attacks are mild. However, of those individuals who develop severe forms of the disease, one in four will die (Forrest et al, 1995).

The main symptom of pancreatitis is a sudden onset of abdominal pain in the epigastric region that may radiate to the back and be associated with nausea and vomiting (Alexander et al, 2000). A serum amylase more than four times the upper limit is diagnostic of pancreatitis. Physically, the patient may appear acutely unwell with signs of shock, abdominal tenderness and guarding or rigidity (Henry and Thompson, 2001). The nursing plan of care includes the administration of analgesia, antibiotics and anti-nausea medications, IV fluids, accurate measurement of intake and output, and regular observation of vital signs. In the acute stage, it may be necessary to take the patient's blood pressure, pulse, temperature and respirations every hour and respond to the results accordingly. Signs and symptoms of septic or hypovolemic shock, such as falling BP, rising pulse, lack of urinary output and decreased temperature must be reported immediately due to the risk of injury to the patient. The lawyer representing Margaret in the lawsuit retained a nursing expert to review the medical records and determine whether or not Nurse Amy had met the standard of care. The reviewing nurse discovered that at 10:20 p.m., Nurse Amy had drawn a small downward arrow next to the blood pressure and a small upward arrow beside the pulse. This indicated that Nurse Amy recognized that the blood pressure had fallen and that the pulse had risen, yet she had failed to reassess the vital signs until nearly 8 hours later. When Nurse Amy was asked why she didn't reassess Margaret's vital signs, she referred to the doctor's orders which said to monitor vital signs as per protocol and the unit policy which said to assess vital signs QID. She said that Margaret had looked tired and unwell at 10:20 p.m. and said that it was important for her to get some rest. She also said that she had never looked after a patient with pancreatitis.

The nurse expert responded that hospital policies provide minimum guidelines for assessment and that doctor's orders can only be altered if the doctor is made aware of a change in the patient's condition. She also said that regardless of Nurse Amy's inexperience with pancreatitis, it is the expected knowledge of all nurses that unstable vital signs in an acutely-ill patient can indicate impending decompensation. The nurse expert stated that patients can present as stable, but very quickly become unstable, and that there are no hospital policies or doctor's orders that can adequately cover all of the emergency situations that develop on medical units. For that reason, nurses are required to use critical thinking in situations involving the risk of injury, and to assess patients more frequently based on their clinical condition. She confirmed that a nurse does not need a doctor's order or change in hospital policy to assess vital signs more frequently than ordered. Her opinion was that Nurse Amy failed to meet the standard of care by not revising the plan of care to include reassessment of Margaret's vital signs within 15 to 30 minutes and urgent communication with the charge nurse or the doctor no later than 10:30 p.m. This case settled out of court for an undisclosed amount of money.

Start a Conversation

Use this case study to spark a conversation on nursing assessment with your colleagues. Note any similarities between this case and the *Kolesar vs. Jeffries* judgement which sparked the 'nothing written, nothing done' saying that we're all so familiar with. Were you able to identify issues with both communication and assessment? How would you rate the level of nursing assessments in your workplace? Have you ever witnessed, or been part of a situation, where a lack of assessment caused a problem? Did the patient suffer as a result? What currently guides your patient assessments? Is it doctor's orders, hospital policy, what the charge nurse says, the 'culture' on your unit or the patient's clinical condition? What will you do differently now that you know the outcome of this case?

This article was written by Chris Rokosh RN, PNC(C), Legal Nurse Consultant and president of CanLNC Incorporated. Chris is a popular speaker on legal issues in nursing across Canada and the US. Visit www.CanLNC.ca for a list of available courses. Reprinted with permission from CLPNA's CARE.

Continuing Competency Program

COMING SOON – A REQUIREMENT FOR LICENSURE

In the coming months, the College of Licensed Practical Nurses of Newfoundland and Labrador (CLPNNL) will introduce a Continuing Competency Program (CCP) for LPNs. A Continuing Competency Program promotes safe, ethical, competent and compassionate life-long nursing practice by requiring LPNs to identify opportunities to broaden their knowledge, increase their skill capacity and enhance individual scopes of practice. Ultimately, LPNs who participate in CCP will experience professional growth and improve their competence throughout their nursing career. The CCP will assist the CLPNNL in carrying out its mandate of public protection.

Nursing environments are becoming increasingly complex and challenging, with new and emerging knowledge, health technologies, treatment protocols, and evidenced-based standards and guidelines. The CCP will support LPNs to obtain new knowledge, maintain competency and ensure practice is supported by best evidence.

Currently, the CLPNNL ensures that candidates applying for initial licensure meet the entry-level competencies and standards. There is, however, no formal process to ensure competence throughout the nursing career. Once CCP is implemented, LPNs will be required to reflect on their nursing practice, complete a self-assessment, develop learning goals and participate in education and other learning activities. LPNs who apply for licensure renewal or licensure reinstatement will have to declare on the application that they have completed the CCP components as well as the required nursing practice hours.

Over the coming months, CLPNNL will provide education on the CCP requirements through teleconferences and webinars. CLPNNL staff will be available to answer your questions and address your concerns. Watch the website for additional information.

Participate in CLPNNL Committees, Working Groups and Liaison Programs

The CLPNNL is continually seeking LPNs to provide valuable input into committees and working groups. If you would like to contribute to your profession by participating in the work of CLPNNL, please send your name confidentiality to Wanda Wadman at wwadman@clpnnl.ca.

The CLPNNL Liaison Program was developed to provide Liaison LPNs the opportunity to work with the CLPNNL Board and staff by supporting the sharing of information. Liaisons are volunteer LPNs who have agreed to provide information to their workplace colleagues and provide the CLPNNL with communication from these colleagues. The Liaison LPNs provide a valuable service to the CLPNNL by posting important information in the workplace regarding elections, new documents, policies, position statements, education sessions, national nursing week, practice awards and CLPNNL services. These are just a few of the means by which Liaison LPNs assist the CLPNNL and its members. What you do does not go unnoticed. It is valued and appreciated. The CLPNNL would like to extend a warm thank you to our Liaison LPNs for your commitment to the LPN profession. If you have any practice concerns, please forward them to your workplace Liaison LPN or contact Wanda Squires LPN, CLPNNL Practice Consultant at wsquires@clpnnl.ca.

A meeting of the Liaison LPNs throughout the province is planned for February 2016. We would love to hear from you!

The CLPNNL is currently seeking Liaison LPNs for the following sites:

- St. John's Long term care (west tower)
- Dr. Leonard A. Miller Centre
- Presentation Convent
- Waterford Hospital
- Carbonear General Hospital
- Harbour Lodge

If you would like to become the Liaison LPN for one of these sites you can contact Wanda Squires at wsquires@clpnnl.ca.

Uniform Survey

The CLPNNL recently completed a survey to determine if Licensed Practical Nurses in Newfoundland and Labrador were supportive of having a designated uniform for LPNs. The survey was completed by 963 LPNs. The results indicate significant support to have a designated uniform for LPNs with the following findings:

92% indicated that they currently wear a variety of colored and patterned uniforms in the workplace.

81% felt that wearing a variety of colored and patterned uniforms does not distinguish them from other workers.

83% of LPNs felt that a designated color uniform would more clearly identify LPNs to colleagues and the public, and would promote professionalism among the practical nursing profession.

The survey asked LPNs to indicate their color preference for a designated uniform from among 4 options. In addition, LPNs were invited to provide comments. There were many comments with similar suggestions for color options and combinations which were not among the choices provided in the survey. A follow-up survey will be completed in January 2016. The next survey will ask LPNs to select from a number of color options and combinations that were suggested in the many comments provided by LPNs.

March is Liver Awareness Month!

Where does liver health really begin?

You might not realize it but every day you make decisions that affect your liver health. Your choices of household products, food items and daily activities can have positive or negative effects on your liver.

The Canadian Liver Foundation invites you to take a tour of your home using our **Liver Healthy Home Checklist** to see how you can make your home and your daily routines liver healthy**.**

Liver Healthy Home Checklist

Kitchen

- **Fill your cupboards and refrigerator with low fat, high fibre foods and keep salty and sugary snacks to a minimum.** A healthy, well balanced diet can help keep your liver functioning at peak levels and you, in turn, will feel better and have more energy. On the other hand, an unhealthy diet can lead to obesity – a leading cause of fatty liver disease.

Living room

- **If you drink alcohol, do it in moderation.** No more than one to two drinks at a time and never on a daily basis. Women process alcohol slower than men and therefore tend to be more susceptible to alcohol-related liver damage.

- **If planning a trip, be sure to get immunized against hepatitis A and B.** Hepatitis A can be contracted through contaminated food and water. Hepatitis B is spread through direct contact with blood or body fluids. You can be at risk of contracting these serious liver diseases both in Canada and abroad.

Bathroom

- **Store medications and vitamins out of reach of children or in child-proof containers.** Adult medications and supplements can do serious harm to a child's liver if they are accidently swallowed or are used inappropriately to treat an illness.

- **Do not mix medications and/or herbal supplements without talking to your doctor or pharmacist.** Prescription and non-prescription medications and herbal supplements can do damage to the liver if not taken as directed. Never mix medication with alcohol. Combining alcohol and acetaminophen, for instance, can lead to acute liver failure.

- **Always wash your hands after going to the bathroom.** Hepatitis A is a liver disease that can be spread when someone does not wash their hands properly after going to the bathroom and then touches something you eat.

Laundry Room/Garage

- **When cleaning or painting, ensure the room is well-ventilated and/or wear a mask.** Since the liver has to de-toxify everything you breathe in, exposure to airborne chemicals can damage your liver.

Backyard

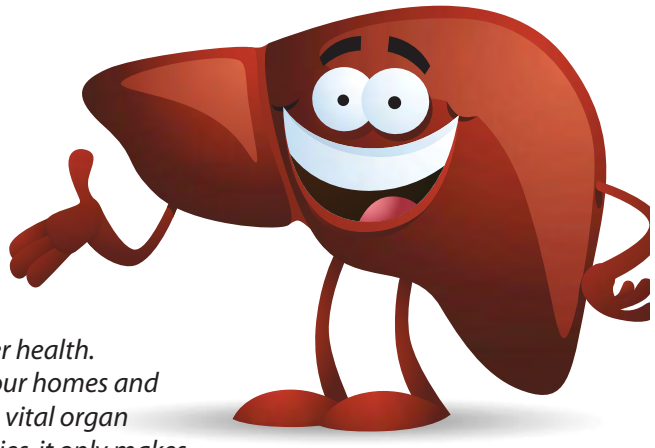
- **Take precautions to avoid exposure when using weed control chemicals or spraying for bugs**. Another option is to investigate more organic methods for maintaining your lawn and gardens.

- **Take every opportunity to get outside and enjoy some exercise.** Exercise helps keep your body – and especially your liver – strong and better able to defend itself against viruses, disease and pollutants.

CANADIAN LIVER FOUNDATION / FONDATION CANADIENNE DU FOIE

For more tips on how to protect your liver health, please contact your local chapter or visit www.liver.ca

10 Steps *happier* to a healthier liver



Few of us realize that each day we make decisions that affect our liver health. Our choices about what to eat, how to treat an illness, how to clean our homes and even our extracurricular activities can help or hurt the liver. Since this vital organ performs over 500 different functions to nurture and protect our bodies, it only makes sense to learn what we can do for it in return. The good news is that some of the most prevalent forms of liver disease – fatty liver disease, viral hepatitis and toxic hepatitis – can often be prevented through lifestyle changes or simple precautions.

The following are 10 ways to help keep your liver healthy and happy.

1. **Eat lots of dark leafy greens, rich coloured fruits** (e.g. oranges, apples) and cruciferous vegetables (e.g. broccoli, brussels sprouts, cabbage). The healthier your diet, the healthier your liver.
2. **Cut back on sugar** – stop drinking pop, reduce (or eliminate) sugar from your coffee or tea. Sugar can have a similar effect on the liver as alcohol. Too much can lead to a build up of fat in the liver cells and eventually lead to fatty liver disease.
3. **Replace chemical cleaning products with organic or environmentally friendly products.** It's the liver's job to rid your body of toxins so reducing the amount of chemicals you are exposed means the liver won't have to work as hard.
4. **Leave the car at home and walk as many places as possible.** Exercise can help you maintain a healthy weight which in turn can reduce the risk of fatty liver disease.
5. **Ask your doctor for a liver test.** Many liver diseases will have no symptoms until the liver is severely damaged. Early diagnosis offers better odds for successful treatment.
6. **Get immunized against hepatitis A and B.** These are the only two liver diseases that can be prevented by vaccine.
7. **Read labels carefully** and ask your doctor or pharmacist before combining herbal remedies, vitamins, over the counter and prescription medications. All medications and supplements meet in the liver and can sometimes trigger dangerous interactions.
8. **Pamper yourself – but do it safely.** Ensure tattoos, piercings, manicures and pedicures are performed by licensed practitioners with single-use or sterilized equipment. Contaminated equipment or inks could expose you to hepatitis B or C.
9. **Consume alcohol in moderation or not at all.** Excessive drinking can lead to fat buildup and scarring in the liver. If you're pregnant, on medication or have liver disease, avoid alcohol completely. If you are healthy, aim for less than 10 drinks per week for women and 15 drinks per week for men – and never on a daily basis.
10. **Quit smoking.** Smoking can contribute to the development of liver cancer, if you already have liver disease.

liver.ca

Canadian Liver Foundation
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Bringing liver research to life
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Safe Administration of PRN Medications ...*My Story*

By Wanda Squires LPN, Practice Consultant CLPNNL

Its 0100hr and just as I sit for the first time tonight, ring, ring goes the buzzer.

As I walked down the hallway to where I could see the light of the buzzer, I realized it was Mrs. Smith who was ringing.

Mrs. Smith is a new resident at the long term care facility where I currently work. She arrived here four days ago from her home. Mrs. Smith had hip surgery two months ago following a fall where she broke her hip. Mrs. Smith is 77 years old. Prior to coming to long term care she was living on her own at home. Mrs. Smith has a history of drug addiction and use to smoke two packages of cigarettes a day.

I walked into Mrs. Smith's room and turned off her buzzer. I said to her, "Hi I am Rita, the nurse that gave you your medications earlier. What can I do for you?"

Mrs. Smith answered by saying "I am dying in pain, it's so bad, my hip is so bad, I need something, I can't sleep, the pain is keeping me awake."

At first I thought, will I go ahead and give the medication without asking why or should I follow the Standards of Practice and Code of Ethics to provide the best possible care for the best outcome of the client.

Immediately I visually assessed Mrs. Smith and saw that she was holding her hip with her hand and her facial expression showed pain. I also remembered that Mrs. Smith had a drug addiction in the past.

I asked Mrs. Smith to show me where the pain was and to rate the pain on a scale from 0-10 where 0 was no pain at all and 10 was the worst pain imaginable.

Mrs. Smith said her pain was an 8.5 out of 10. I assured Mrs. Smith that I would look at her medication record to determine if there was a pain medication ordered on an "as needed"- PRN basis.

PRN (pro-re-nata) medications are medications prescribed to be given only when the client requires them. A PRN prescription must include the frequency with which the medication may be given, such as Q4H PRN. This time frame means that the client must wait at least 4 hours between doses. The purpose of the medication must also be identified in the order (prescription). For example for sleep, pain, nausea, etc.

I reviewed the MAR (medication administration record) and saw that Mrs. Smith was ordered Tylenol 500mg x 2 po Q4H PRN for pain. I looked to see if Mrs. Smith had any regular timed pain medication in the last while, perhaps at HS with her other medication.

Mrs. Smith had Torodol (anti-inflammatory) at HS (2100hr) however she did not have any analgesic.

I walked back to Mrs. Smith's room and discussed with her that she could have Tylenol if she needed it for pain. I informed Mrs. Smith that Tylenol was a pain reliever and asked if she had any concerns. Mrs. Smith told me that she had taken Tylenol in the past and it was effective. I went back to the MAR and while doing my three checks (right: drug, route, time, dose, patient) I prepared the medication. The PRN medications were packed differently than routine medications. They were stored separately in a different location.

I went into Mrs. Smith's room and checked the medication with her again. I asked her name and date of birth and if she had any allergies. I then confirmed with her the medication I was about to give. Mrs. Smith said her pain was still 8.5/10.

I gave Mrs. Smith the medication and proceeded to the medication cart to sign for the medication that I just gave. Next I documented on Mrs. Smith's chart why I gave the PRN medication, including my assessment and the time the medication was administered.

At 0200hr I went back to Mrs. Smith's room to evaluate the effect of the pain medication. I saw that Mrs. Smith was sleeping soundly, I knew then that the Tylenol was indeed effective. I documented that on her chart.

It is really important to know the client/residents history prior to administering medications to them as it helps the nurse identify why they are receiving certain types of medications.

In this scenario Mrs. Smith had a drug addiction in the past and maybe she was looking for Tylenol because of that. However, in this case it was related to her hip surgery.

As a LPN, I carried out my professional responsibility by understanding the indications and actions of the PRN medication, assessing the need to administer the PRN medication, and evaluating the effectiveness of the medication.

Licensed practical nurses may not administer a PRN medication for a purpose other than the one identified in the order. You are accountable.

CONGRATULATIONS GRADUATES!

The College of Licensed Practical Nurses of Newfoundland and Labrador would like to take this opportunity to congratulate the 2015 graduating classes of the Practical Nursing Program. We wish you all the best in your nursing career!!

THE PROCESS INVOLVED IN THE REVIEW AND REVISION OF THE PRACTICAL NURSING CURRICULUM IN NEWFOUNDLAND AND LABRADOR

Submitted by: Jeanette Cronin MN RN, Janice Marsh MN RN, Centre for Nursing Studies, NL

BACKGROUND

The province of Newfoundland and Labrador (NL) is currently experiencing an unprecedented shortage of Licensed Practical Nurses (LPNs). Over the past number of years, the scope of practice for LPNs has expanded and therefore, additional theory and clinical skills were added to the program without any formal process of a curriculum revision. The increase in student attrition and the shortage of LPNs in NL served as the impetus for a complete review and revision of the current PN curriculum. The Centre for Nursing Studies (CNS), in consultation with the Government of Newfoundland and Labrador and the College of Licensed Practical Nurses of Newfoundland and Labrador (CLPNNL) commenced the task of completing a review and revision of the current 16-month curriculum in January, 2015. The revised curriculum commenced September 2015.

PURPOSE

The purpose of this publication is to:

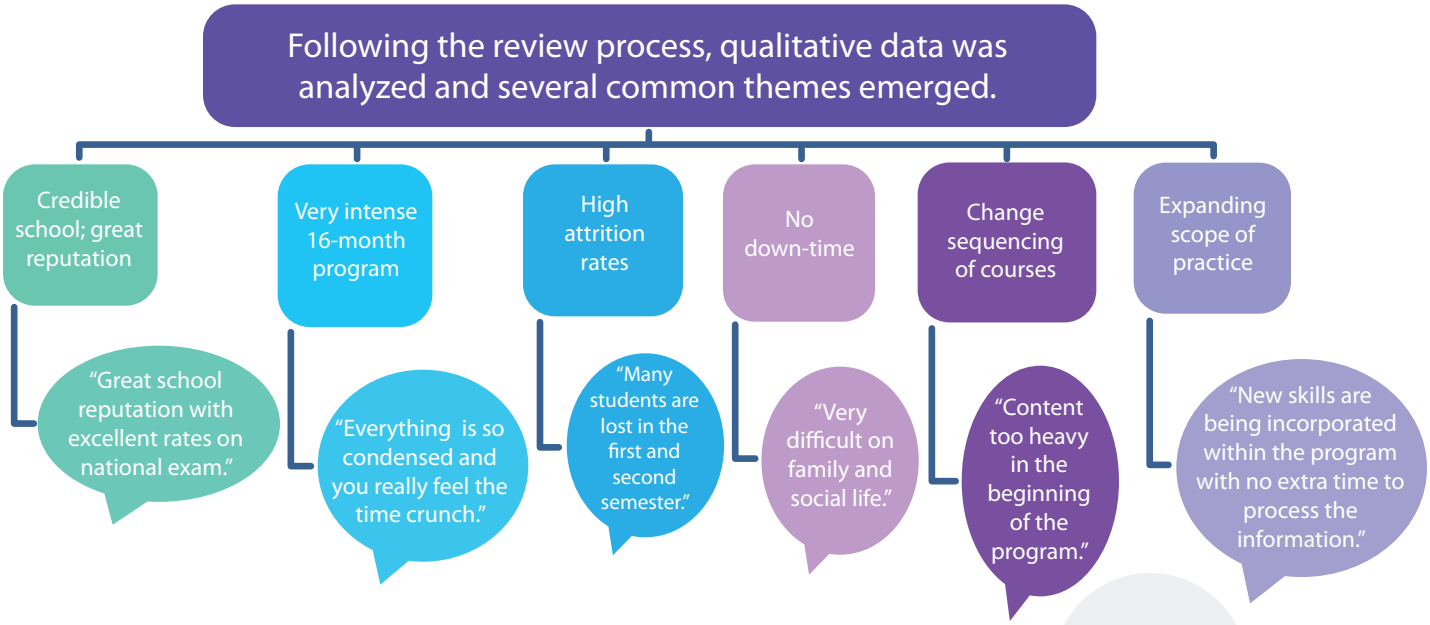
- Outline the process that was undertaken to establish a sound PN curriculum that is manageable for students, and effective in decreasing attrition rates.
- Provide an overview of the data collected, both formally and informally.

METHOD

Two CNS faculty consulted with key informants to obtain data that assisted in the review and revisions. The following participants presented valuable feedback:

- Administration, Centre for Nursing Studies
- Faculty
    - Theory Course Leaders
    - Laboratory Faculty Focus Groups
    - Clinical Faculty Focus Groups
- Professional Officiates from the CLPNNL
    - Executive Director/Registrar
    - Director of Professional Practice & Policy
- Practical Nursing Student Focus Groups (Class of 2015)
- Survey Monkey – survey was disseminated to recent graduates from the Practical Nursing Program (Classes 2012-2014)
- Environmental scan of other Practical Nursing Programs across Canada

GENERAL FINDINGS



LPN SURVEY RESULTS (%)

ITEM DESCRIPTION	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
The program provided a variety of good and relevant courses.	0.00	0.00	51.11	48.89
The program enhanced my problem solving and critical thinking skills.	0.00	2.27	56.82	40.91
I was given enough time during the program to understand many concepts that I had to learn.	11.11	44.44	28.89	15.56
Courses in the program were beneficial and contributed to my overall professional development.	2.22	0.00	60.00	37.78
Program requirements were reasonable within the 16 month program.	13.33	35.56	40.00	11.11
Program requirements were achievable within the 16 month program.	2.22	15.56	66.67	15.56

DISCUSSION

Based on the feedback from the review, it was evident that while the program was sound, it needed to be more manageable for students. With the expanding scope of practice, new competencies were added to an already demanding program. High attrition rates made it challenging to recruit and retain LPNs in NL. In addition, faculty agreed that the workload was much heavier in the first and second semesters of the program, and there was minimal time to process course content. In turn, the revised curriculum incorporated changes that included:

- sequencing of courses to build on the complexity of content;
- a more flexible schedule;
- inclusion of new competencies outlined by the Canadian Practical Nurse Registration Blueprint.

IMPLICATIONS

The revised Practical Nursing Program was accepted by the CNS and the CLPNNL in the Summer of 2015. An evaluation of the revised curriculum will be completed at the end of the 16-month program. It is anticipated that attrition rates will decrease with the revised curriculum and thus, help increase the supply of LPNs in NL.

ACKNOWLEDGEMENTS

The authors would like to thank those who contributed to the review and revisions of the Practical Nursing Curriculum offered by the Centre for Nursing Studies:

- Department of Health and Community Services (Government of NL)
- College of Licensed Practical Nurses of Newfoundland and Labrador
- Faculty, Staff and Administration at the Centre for Nursing Studies
- Practical Nursing Students at the Centre for Nursing Studies
- Licensed Practical Nurses who participated in the survey
- Faculty at Brokered sites

Frequently Asked Questions

What is the difference between Scope of Practice and Scope of employment?

The professional/Legislated Scope of Practice is the outer limits of LPN practice set by the LPN Act. The professional scope outlines the competencies, abilities and role of the LPN and it can only be changed by changing the legislation.

The individual scope of practice is specific to each nurse in their current practice context. The individual scope is always smaller than the professional scope because it refers to each nurses' ability in their everyday practice. Individual scope can be expanded through new knowledge and learning new activities or skills.

It is important to understand the difference between individual scope of practice and scope of employment. Having the competency to perform a skill (individual scope of practice) in one area or clinical setting, does not automatically mean a skill can be performed in another setting. Employers must support the performance of skills from one area to another with policy and practice resources (scope of employment). Typically, lack of transferability (e.g.: the LPN can complete a skill in one area but not in another area within the same hospital) is associated with the differing levels of practice supports from one area to another. For instance, some LPNs practicing in the renal dialysis unit (RDU), have achieved the competency (individual scope of practice) to access AV fistulas for the purpose of drawing blood for routine lab testing. This practice is permitted in the RDU because there are resources – expert nurses, equipment, policy – in place to assist the LPN in the performance of the skill or manage any unexpected client situation that may be encountered. Outside the RDU, these clients are cared for on the inpatients area. Typically the same types of resources (expert nurses, equipment, policy) are not as readily available and this will have an impact on how the LPN would manage any unexpected client outcomes that may occur during or after the performance of the skill. Even though the individual LPN may have the competency to perform this task (individual scope of practice), the employer policies (driven by the availability of resources) limits the practice to the RDU (scope of employment).

The LPN should always keep in mind that scope of practice is what the LPN is educated and authorized to perform. Ask yourself ... Did I learn that as part of my training? Am I authorized by CLPNNL to perform that skill? Scope of employment is what the employer/agency you are working for has set in place in their policy that states what the LPN is allowed to do in that particular working area. Keep in mind that your scope of employment may change from unit to unit.

Adapted with permission from CLPNNS - The College Reporter Spring 2015

What if I'm expected to do things I don't know how to do?

Every LPN must work to full scope of practice where employer policy states that you can do so. If you are assigned to a patient and that patient requires care that is not within your scope of practice because you have not yet acquired the skill, then it is your responsibility as a professional LPN to verbalize this to the nurse in charge so that the assignment of care can be adjusted. When the employer policy states that a particular skill is within your scope of employment and you have not yet acquired the education, it is your responsibility to obtain that knowledge so that you meet the requirements for your practice area.

Shared Scope of Practice Workshop

A Shared Scope of Practice Workshop was held at the Centre for Nursing Studies on November 3, 2015. In attendance were the 4th year BN students as well as the 4th semester PN students. Presenters included Wanda Squires CLPNNL, Siobhiann Lewis ARNNL, Rod Hayward SJLTC, and Michelle Power and Charlene Lomholt Mortensen, faculty from the Center for Nursing Studies.

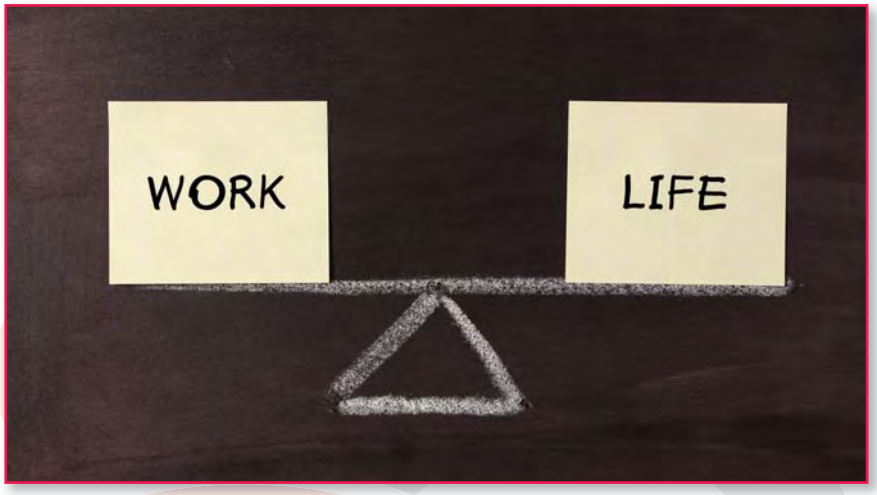
Falling off the "Work-Life Balance" Beam

Nurses are among an ever-growing number of working professionals who feel overwhelmed and frustrated in their attempts to balance work and life in today's constantly changing, high-demand, technology-driven work environment which promotes '24/7 connectedness'. It is widely recognized that significant changes to the work environment over the past few decades have resulted in a culture where the line between our personal and work lives is increasingly blurred and the once-sought "work-life balance" is no longer viewed as an achievable, realistic goal. Many experts like former executive and speaker Teresa Taylor challenge the concept as illogical and simply impossible (Taylor, 2013).

We all know someone who we perceive has achieved balance personally and professionally. How do they do this? They've learned to blend and optimize work commitments, personal time and technology in order to achieve overall productivity in all areas of work and life. The key is successfully adopting the emerging philosophy of "work-life integration", which research supports is quickly becoming the norm in building better work-life practices. Blending personal and professional commitments through effective use of technology and time management requires self-awareness, self-identity, authenticity, flexibility and one's own sense of control. (Schachter 2012).

Craig Chappelow of the Centre for Creative Leadership in Greensboro, N.C., in association with Ellen Ernst Kossek, Ph.D., professor at Michigan State University and author of the 2004 book, Work and Life Integration: Organizational, Cultural and Individual Perspectives, have created an online self-assessment tool which helps individuals identify and understand to what degree family and personal time is interrupting work, and vice versa. Recognizing that understanding one's own behaviours and possible alternatives is critical in moving toward successful integration of personal and professional commitments. Their work identifies the following behavioural patterns, none of which are preferable over the others:

- Integrators: those who weave work and personal activities together throughout the day.
- Separators: those who seek balance by establishing separate blocks of time for work and life commitments – one does not intrude on the other.
- Work Firsters: work takes precedence over all else, protecting work time over family time.
- Family Firsters: those who allow family and personal time to interrupt work.
- Cyclers: those who switch back and forth between cycles of integration and deliberate separation.



Mr. Chappelow (2012) recommends adjusting personal strategy depending upon job demands and whether your existing approach is ineffective and resulting in increased stress, maintaining "the more we assume actual leadership of our own lives, instead of waiting for someone else to do it for us, the better prepared we are to deal with this unending juggle".

Literature has shown that having a flexible calendar and purposefully scheduling time for exercise, leisure, and social interactions intertwined with work obligations allows for greater control over one's time. This can be tricky if you work a shift rotation; however, with a little creativity and determination integrating work and life can be mastered. Another key strategy is to plan ahead – setting annual personal and professional goals and breaking them down to what needs to be achieved daily, weekly, monthly and per quarter. This will increase focused productivity into achievable portions.

Of equal importance to the success of integration is the perceived amount of control you feel in managing the boundaries between your work and personal life. Individuals who demonstrate a high level of boundary control, exercising the ability to decide when to focus on work, family, or blend the two, have a higher success rate overall. Individuals with low boundary control are, not surprisingly, most affected by the stress of trying to manage it all.

As a take-away, experts offer this advice. First, stop attempting to balance work and life. Second, work towards integration instead, which requires keen self awareness and control to determine what works best for your individual situation. Recognize that there is no "one size fits all" approach, but rather endless possibilities for what successful worklife integration can look like.

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