PRACTICE

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

A Practical Approach to Quality Care

Volume 1, Issue 3 – September 2016

PRACTICE

The College of Licensed Practical Nurses of Newfoundland and Labrador PRACTICE magazine includes a wide array of information on nursing regulation, nursing licensure, nursing practice and many other health related topics. PRACTICE is 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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*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.

Annual General Meeting (AGM) Update

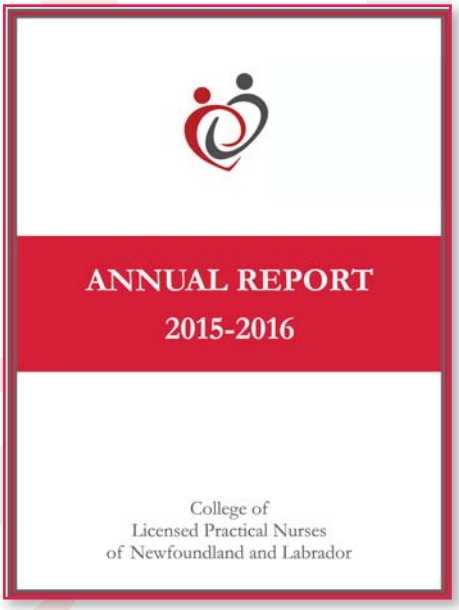
The CLPNNL's Annual General Meeting (AGM) was held on June 17, 2016, at the CLPNNL building, 209 Blackmarsh Road, St. John's, NL.

The Board of the CLPNNL remains committed to the vision, mission, mandate and values of the organization. It works in collaboration with government, educational facilities, employers, LPNs and other key stakeholders focusing on initiatives to advance the profession and strive for excellence in the regulation of LPNs in Newfoundland and Labrador.

Chairperson Jane Pardy highlighted the following data from the 2015/16 licensure year which help the CLPNNL progress towards achieving its mission:

- CLPNNL works closely with the Centre for Nursing Studies (CNS), as the parent institution for the Practical Nursing (PN) program, as well as the College of the North Atlantic (CNA), which delivers the program through a brokering agreement with the CNS. We continue to graduate high-caliber PNs at each educational institution in NL. This past year the passing rate for the Canadian Practical Nurses Registration Exam (CPNRE) was 99% in the province of Newfoundland and Labrador;
- CLPNNL supports Internationally Educated Nurses (IENs) to obtain licensure in this province. CLPNNL has seen an increase in the number of IENs applying for licensure this year compared to other years;
- CLPNNL has seen a demand for LPNs in the province of NL. Last year the CNS had an intake of 100 PN students whereas this year there are 200 PN students in the program.

The full report is provided in the 2015/16 CLPNNL Annual Report which can be found at www.clpnnl.ca.



2016 AWARD WINNERS

The College of Licensed Practical Nurses of Newfoundland and Labrador (CLPNNL) would like to congratulate the 2016 Excellence award winners.

At the CLPNNL Annual General Meeting that was held on June 17, 2016, *The Anne Keough Excellence in Leadership Award* was presented to Kimberly Hogan, LPN, from the Bonavista Health Centre, Bonavista.

The Excellence in Practice Award was presented to Diann Priddle, LPN, from the Sir Thomas Roddick Hospital, Stephenville.

Both of these Licensed Practical Nurses show exceptional knowledge, skill, judgment, and compassion for their work and the clients they care for. Congratulations!

Accountability Interpretive Document

On June 17, 2016 the Board of the CLPNNL approved an interpretive document on ACCOUNTABILITY. The CLPNNL develops Interpretive Documents to provide direction, promote clarity and give further explanation for LPNs in relation to the expectations identified within the Standards of Practice and Code of Ethics (2013). This Interpretative Document provides direction for LPNs in relation to accountability. This document is available on the CLPNNL website at http://www.clpnnl.ca/attachments/Accountability2016.pdf.

CLPNNL IS SEEKING NEW BOARD MEMBERS

Election of LPNs to the Board for Zones II and V

We are seeking nominations for one LPN to be elected to the Board of the CLPNNL for each of Zones II and V (total of two LPNs). Each position is for a three-year term (January 1, 2017 – December 31, 2019). For more information about the election process, please contact the CLPNNL Liaison person for your facility, the CLPNNL office, or visit www.clpnnl.ca. A copy of the By-laws that outlines the catchment areas for Zones II and V is available on the website.

SCHEDULE OF THE ELECTION PROCESS FOR ZONES II AND V

Nomination forms mailed to Liaison LPNs for distribution **prior to September 30th, 2016**

Deadline for receipt of completed nomination forms at the CLPNNL office is **October 28th, 2016 at 1630 hrs.**

Election ballots will be mailed to each LPN for Zones ll and V on **November 5th, 2016**

Deadline for receipt of completed election ballots at the CLPNNL office is **December 6th, 2016 at 1630 hrs.**

Counting of completed election ballots by CLPNNL takes place on **December 13th, 2016**

Notification of election results to candidates on **December 16th, 2016**

Notification of election results to membership on **December 19th, 2016**

Proudly Wearing the RED and BLACK

In June, CLPNNL invited LPNs across the province to submit photos of themselves, either individually or in groups, wearing the new designated uniform colours in the work place. The contest closed on June 30th. We were thrilled to see so many of you in your red and black.

On July 5th, the names of all those in the submitted photographs were entered into a draw for an Apple iPad Mini and we are pleased to announce that PAM MARTIN is the lucky winner. Pam is employed at St. Luke's Home in St. John's. Congratulations, Pam!

There will be further giveaways over the coming months as we continue to promote the new designated uniform colours for LPNs, so watch your inbox.

*Pictured above **Left**: Pam Martin, winner of the Apple iPad mini.*

*Pictured above **Right**: **Front row (L-R)**: Dacia Wallace, LPN, Zone 1 Board member; Paul Fisher, LPN, Executive Director/Registrar; Tanjit Kaur, LPN, Zone 1 Board member; **Back row (L-R)**: Christopher Janes, LPN, Zone 3 Board member; Wanda Squires, LPN, Practice Consultant; Ernest Green, LPN, Zone 4 Board Member; Christopher Matthews, LPN, Zone 2 Board member.*

Pressure Injury: Update in Staging and Terminology and Review of Prevention Strategies: Part I of II

Authors:
Mary Beresford RN, BN, MN, IIWCC(08)—Eastern Health Long Term Care
Valery Goulding RN, BN, GNC (C)—Eastern Health Long Term Care
Alicia Hennebury BN, RN, IIWCC(13)—Eastern Health Long Term Care

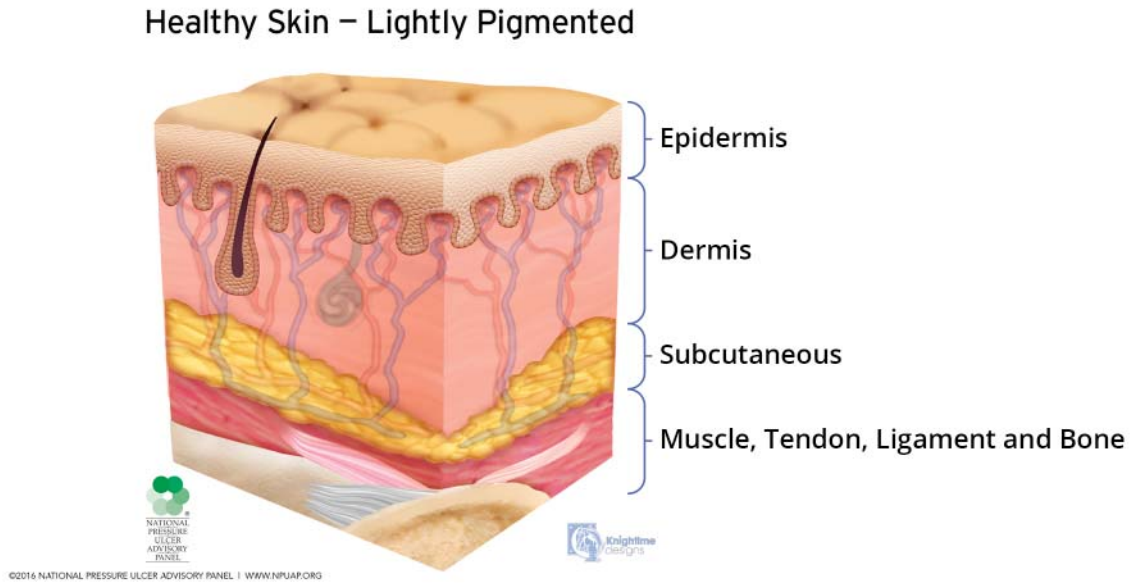
In April 2016, the National Pressure Ulcer Advisory Panel (NPUAP) changed the terminology from "Pressure Ulcer" to "Pressure Injury" and updated the stages of pressure injury. As well, pressure injury stages are now labeled using Arabic numbers instead of Roman numerals, e.g., Stage 3 versus Stage III. These changes more accurately describe the different stages of injury, especially injuries where the skin remains intact but clinical assessment indicates damage to underlying tissue.

It is essential for all Licenced Practical Nurses (LPNs) in all practice areas to be knowledgeable of pressure injury staging and informed of the changes in terminology. Part I of this series will review the new terminology in relation to the different stages of pressure injury. A brief review of pressure injury prevention strategies will follow in Part II.

Pressure injury is defined as:

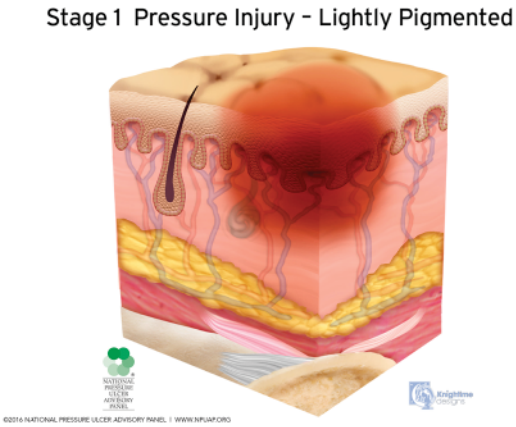
Localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (NPUAP, 2016).

To understand the level of damage in the different stages of pressure injury, it is essential to know the anatomy and function of the skin and underlying tissue. The overall function of the epidermis, dermis, subcutaneous tissue, muscle, tendons, ligaments, and bones are: protection, thermoregulation, elimination of waste products, synthesis of Vitamin D, sensation, support and movement. A break in the epidermis is not normal. All pressure injuries must be identified and staged using the NPUAP criteria. All components of an assessment, care plan and evaluation must be communicated through complete and accurate documentation.

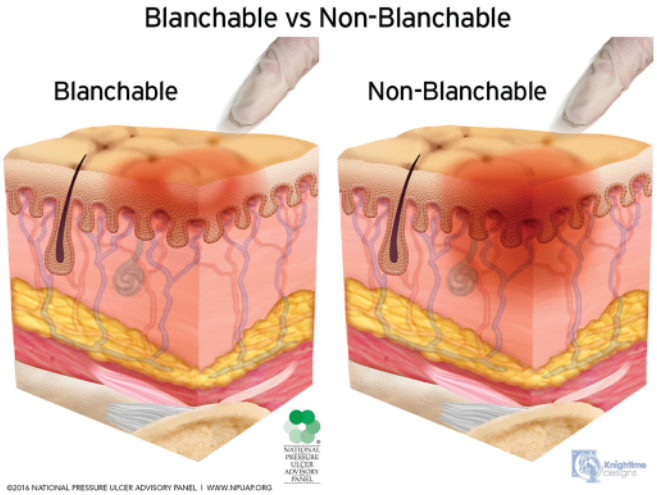


Stage 1 Pressure Injury is defined as:

Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury (NPUAP, 2016).

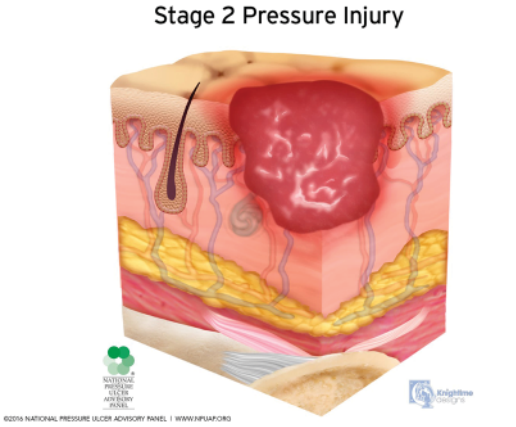


To assess for a Stage 1 Pressure Injury, apply slight pressure over the reddened area to determine if it blanches (turns white). Normally, perfused tissue will blanch with slight compression as the blood shifts out of the capillaries. With relief of compression, the blood is free to flow back into the undamaged capillaries. In a Stage 1 Pressure Injury, with slight compression, the tissue remains reddened because the capillaries are damaged and blood has leaked into the surrounding tissue.



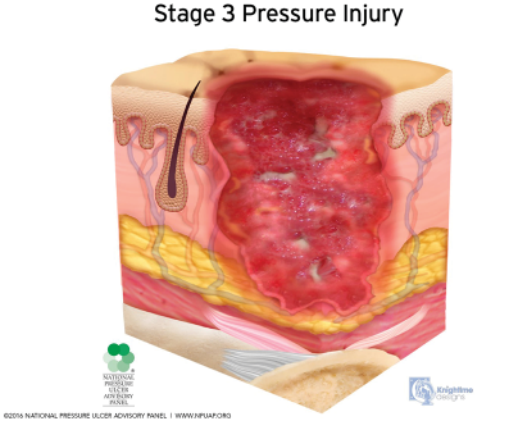
Stage 2 Pressure Injury is defined as:

Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence-associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions) (NPUAP, 2016).



Stage 3 Pressure Injury is defined as:

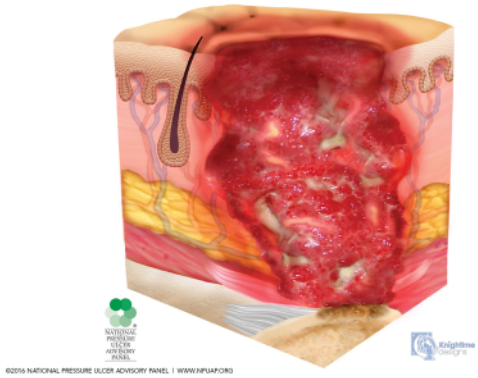
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury (NPUAP, 2016).



Stage 4 Pressure Injury is defined as:

Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury (NPUAP, 2016).

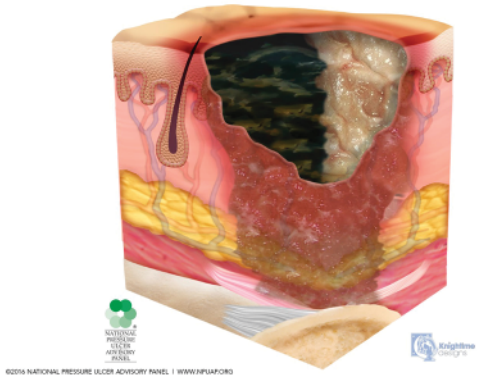
Stage 4 Pressure Injury



Unstageable Pressure Injury is defined as:

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed (NPUAP, 2016).

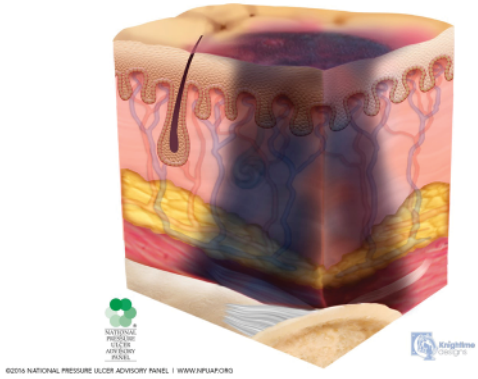
Unstageable Pressure Injury – Slough and Eschar



Deep Tissue Pressure Injury (DTPI) is defined as:

Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions (NPUAP, 2016).

Deep Tissue Pressure Injury



LPNs have an integral role as part of the nursing team in both preventing and managing pressure injuries. Being knowledgeable and informed of pressure injury staging and the changes in terminology helps the nurse identify and stage pressure injuries using the NPUAP criteria. This foundation prepares the nurse with tools and skills in order to communicate effectively with team members, incorporate appropriate interventions in the plan of care and complete thorough and consistent documentation. In Part II a brief review of pressure injury prevention strategies will be presented.

Pressure Injury Staging and Images are used with the permission of the National Pressure Ulcer Advisory Panel, August 4, 2016.

National Pressure Ulcer Advisory Panel (2016, August 4). Pressure Injury Staging and Images. Retrieved from http://www.npuap.org/resources/educational-and-clinical-resources/

Medical Assistance in Dying (MAiD)

Legislation regulating the provision of Medical Assistance in Dying (MAiD) was passed by the federal government on June 17, 2016. Bill C-14 allows for eligible individuals to receive medical assistance in dying. In addition, it establishes safeguards to protect clients and provides protection for health care providers who participate in MAiD within the parameters of the legislation. CLPNNL has developed a practice guideline that describes the expectations for LPNs in relation to MAiD. This practice guideline can be found at http://www.clpnnl.ca/attachments/MedicalAssistanceinDyingGuideline.pdf

What is MAiD?

MAiD refers to the process where an eligible healthcare provider (Sec 241.1 of the *Criminal Code*[1]):

- prescribes and administers a medication to a client, at their request, that causes their death; or
- prescribes or provides a medication to a client, at their request, so that they may self-administer the substance and in doing so cause their own death.

The Nursing Role in MAiD

Nurses have a significant role in providing end of life care to clients and their families, whether the process is medically assisted or not. Nurses must have the knowledge, skill, ability and judgement to provide safe, competent, ethical and compassionate end of life care in accordance with applicable laws, rules and standards.

The CLPNNL provides the following guidelines for LPNs:

1. LPNs may aid in MAiD under the direction of a physician.
2. The current scope of practice for Nurse Practitioners (NPs) in NL does not authorize NPs to provide MAiD[2].
3. If requested, LPNs may support access to accurate and objective information about MAiD to clients so that they may make informed decisions about their care.
4. LPNs should not initiate a discussion on MAiD with clients.
5. LPNs must have the knowledge, skill, ability and judgement to provide safe, competent, ethical and compassionate end of life care.
6. If the LPN has reason to believe that the client does not meet the eligibility criteria or all mandatory safeguards are not in place, the LPN must immediately discuss this with the client's health care team.
7. LPNs may insert an intravenous line that will be used for the administration of the medication that will cause death.
8. LPNs are **NOT** authorized under any circumstances to administer the substance that causes the death.
9. LPNs may be present to provide end of life nursing care during the administration of the medication that will cause death.
10. LPNs must document their involvement in MAiD in accordance with the standards of practice and employer policy.

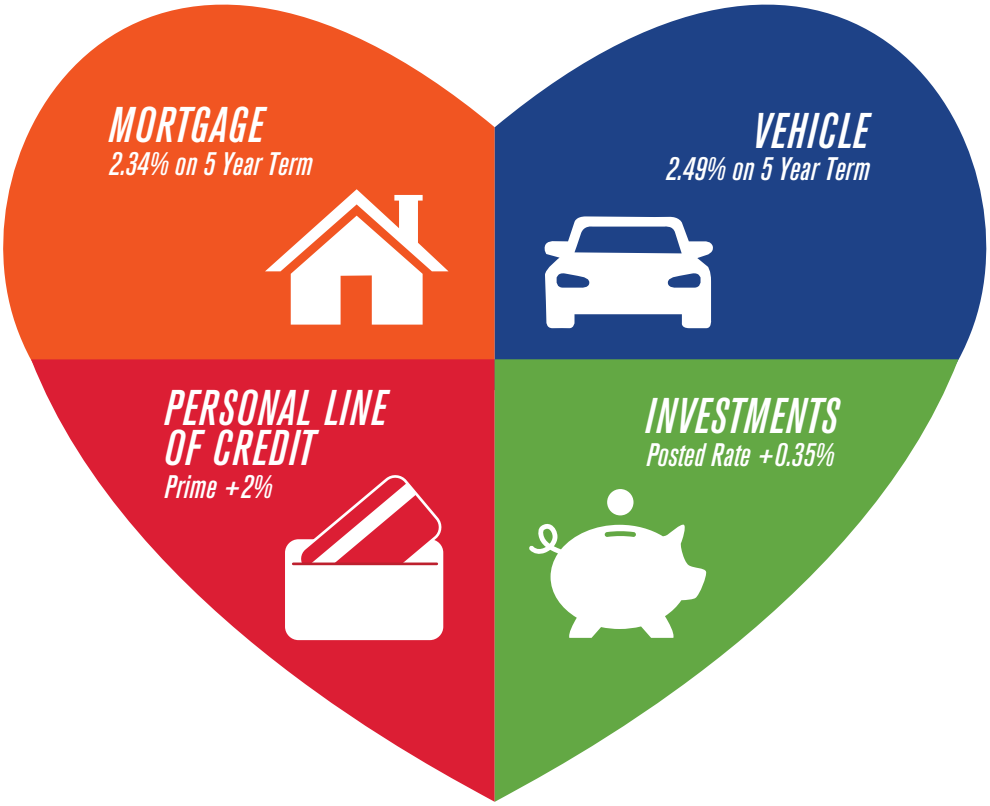
Conscientious Objection

The LPN may decline to participate in MAiD if it conflicts with their moral beliefs and values. If the LPN chooses not to participate in MAiD, the LPN must notify the manager immediately so that alternate arrangements for nursing care can be made. The LPN's personal beliefs about MAiD should not be expressed to the client and/or family. The LPN must also continue to provide safe, competent, ethical and compassionate care in a professional, nonjudgmental, and non-discriminatory manner until alternative care arrangements can be made to meet the client's needs or wishes.

1 An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), ASSENTED TO June 17, 2016, Bill C – 14.

2 Registered Nurses and Nurse Practitioners – Aiding in Medical Assistance in Dying (2016). Association of Registered Nurses of Newfoundland and Labrador.

NEWFOUNDLAND AND LABRADOR
CREDIT UNION



LPN | CARE PACKAGE

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

As a Licensed Practical Nurse you care for your patients. Every day you are called upon to comfort, to administer care, to consult and to do your utmost to deliver healthcare under often challenging circumstances. At NLCU, our members often say they stay with us because "we care". So consider this bundle of special offers and more-than-competitive interest rates for LPNs a "Care Package" of sorts.
You can benefit from any one or all of these special rates.
We at NLCU, applaud all that you do.

NLCU

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* Annual Percentage Rate (APR) means the cost of borrowing for a loan expressed as an interest rate. It includes all interest and non-interest charges associated with the loan. Rates subject to change without notice. All loans and rates subject to credit approval.

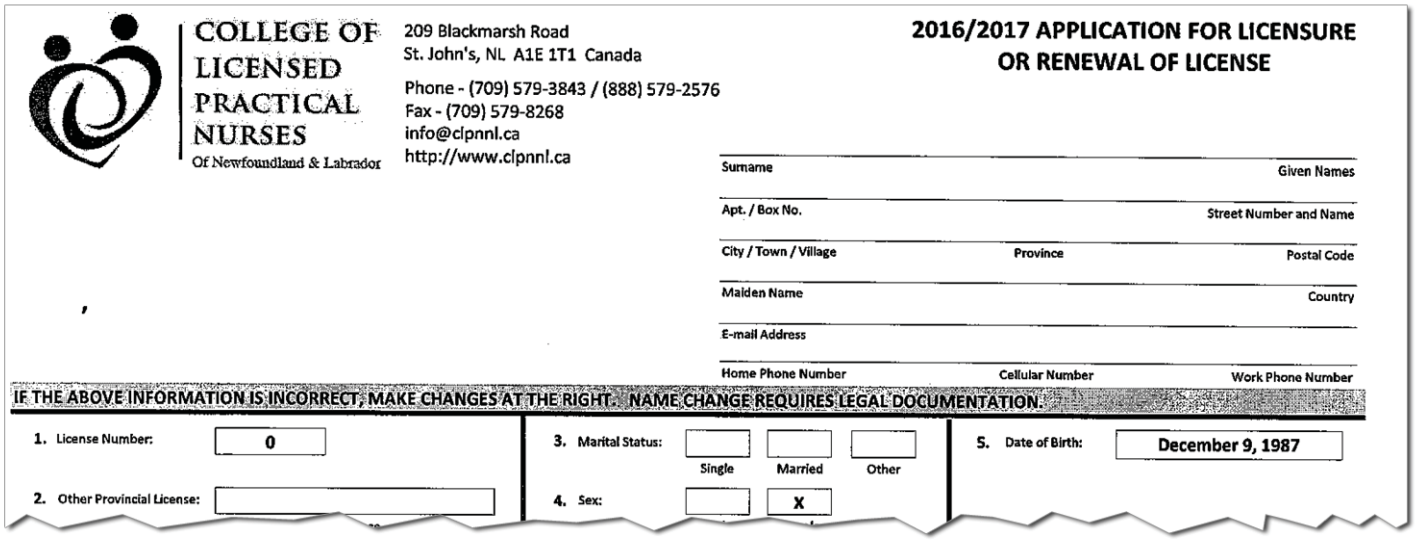
Administrative Deadline
for Annual Licensure Renewal 2017-18

A new administrative deadline for annual licensure renewal applications came into effect last licensing year. This policy requires all LPNs seeking to renew their license to submit licensure applications and fees prior to March 1st each licensure year. While license renewals must be received by March 1st, the existing license will not expire until March 31st, as always.

LPNs who do not renew their license by March 1st will be required to pay a late fee of $57.50 (HST included) in addition to the annual licensure renewal fee due March 1st of each licensure year. In addition, the regular reinstatement fee of $76.33 (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 (for 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
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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

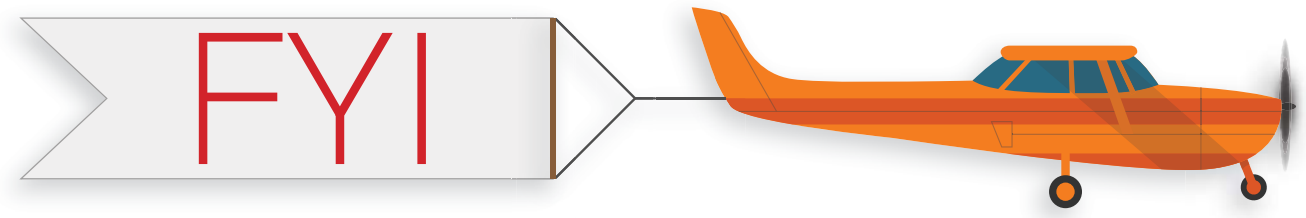
For those LPNs who participate in payroll deduction for the payment of their annual licensure fees through their employer, please ensure that the appropriate payroll staff are aware of this new deadline so that licensure fees can be collected and submitted to the CLPNNL prior to the March 1st deadline.

Important Information Regarding License Renewal for 2017-2018

For the 2017-2018 licensure year, CLPNNL will be introducing optional online registration and payment through the CLPNNL website. However, LPNs will still have the option of coming to the office to renew their registration or mailing their registration, in addition to payroll deduction.

For the following year (2018-2019), online registration will be mandatory, even for LPNs who pay their fees by payroll deduction.

As we migrate to online registration it is essential that we have valid email addresses on file for all LPNs.



Important Information Regarding the 2017-18 Licensing Fee for Licensed Practical Nurses in Newfoundland and Labrador

On July 1, 2016, the Government of Newfoundland and Labrador increased the HST rate from 13% to 15%. Licensed Practical Nurses in Newfoundland and Labrador who are renewing their license for the 2017-18 licensing year will see this increase reflected in their renewal fee. With the HST increase, the renewal fee effective July 1, 2016, is $330.75.

REMINDER: Keep Your Information Up-To-Date!

Under the College of Licensed Practical Nurses of Newfoundland and Labrador By-Laws (2014) Section 34 - Accuracy of Personal Information, all LPNs are required to keep their information on file with CLPNNL up-to date. This includes:

- Name change
  (copy of legal documentation required)
- Mailing address
- Email address
- Employment information
- Phone numbers

If you have recently changed any of the above information, please contact CLPNNL by phone or email to update your file.

PRACTICE
Newfoundland Labrador

Practice NL is one of the many services provided by the Government of Newfoundland and Labrador to support Health Authorities within the province.

Continuing Nursing Education Portal

Practice NL has a web portal for Continuing Nursing Education. This portal is one component of a broader provincial initiative facilitated by the Department of Health and Community Services to support the workplace and community integration of Internationally Educated Nurses (IENs).

This portal houses resources for both nurses and Regional Health Authorities including online courses (modules) and downloadable guides.

These modules constitute continuous learning activities. Following completion of each module you will select the amount of continuous learning time (one clock hour = 1 continuous learning hour) spent completing the module, to a maximum of 2 hours. You will then be able to print a certificate of completion, indicating your selected continuous learning hours for your continuous learning portfolio.

Listed below are some of the current modules that are offered through Practice NL.

- Communications in Nursing
- Medication Administration
- Mentorship – Nurses mentoring Nurses
- Scope of Practice
- IEN – internationally educated nurses
- Jurisprudence

Jurisprudence is a module that informs LPNs about the regulations within our nursing practice. The module informs LPNs about their professional roles and responsibilities. Learning objectives also include increasing awareness of current practice issues and personal and professional confidence while adapting and integrating into a health care setting.

LPNs may choose to do any of these modules as part of their continuous learning. This will become a great source for learning when the Continuing Competency Program is initiated. For more information please visit www.practicenl.ca (click on the Continuing Nursing Education Portal) to select courses or call 1-888-299-0676 (toll free in NL) for more information.

CONTINUING COMPETENCY PROGRAM (CCP)

A Requirement for LPN Licensure

TIME TO PREPARE

On April 15th, 2016, the Board of the College of Licensed Practical Nurses of Newfoundland and Labrador (CLPNNL) approved a Continuing Competency Program (CCP) for LPNs in Newfoundland and Labrador. Beginning in April 2017, in addition to working the required number of practice hours, all LPNs in NL will be required to participate in CCP every year to maintain their license.

CLPNNL has the legislated responsibility to protect the public by promoting the provision of safe, competent, ethical and compassionate nursing care by LPNs. LPNs are accountable for their own practice and actions at all times and have a professional obligation to attain and maintain competence relevant to their specific area(s) of practice.

In keeping with this responsibility, the CLPNNL is implementing the mandatory CCP. The goal is to protect the public by ensuring that LPNs are competent in their practice. The CCP was developed in consultation with LPNs across the province. LPNs in most provinces of Canada are required to complete a CCP every year to be eligible for a license to practice.

A CCP is a formal system of assessing the knowledge, skills and judgment of a professional practitioner. The CCP promotes safe, ethical and competent life-long nursing practice. It requires LPNs to identify opportunities to broaden their knowledge base, increase their skill capacity and enhance their individual scope of practice, ultimately achieving professional growth and continually improving competence throughout their nursing career.

Each year, LPNs will complete a self-assessment by reflecting on their practice and comparing their *current practice* to the Standards of Practice. Based on this self-assessment, LPNs will develop a learning plan to identify the learning activities that they will participate in to meet their learning need. LPNs will be required to complete 14 hours of continuing education each year, 7 of which should be formal learning hours. The CLPNNL will provide examples of formal and informal learning activities to guide LPNs in their planning.

Beginning in October 2016, there will be education sessions to prepare LPNs to participate in the CCP. Exact dates and times for the webinars will be posted on the CLPNNL web site and sent via e-mail.

Substance Use Disorder in Nursing

Patricia is a LPN on a busy surgical unit with many post-operative clients. She is a highly skilled LPN who is well liked and respected for the high quality nursing care she provides. Over the past year, Patricia has experienced significant personal issues in relation to a divorce and the custody of her 3 young children. She says that she is "stressed out" and "not sleeping well." As her long-time co-worker and from your own experiences, you completely understand the impact of this type of personal turmoil and you want to do whatever you can to support Patricia.

Over the past few months, you have noticed that Patricia often appears distant and withdrawn. She continually seems tired, forgetful and unable to focus. Sometimes she lashes out at co-workers for something that seems insignificant.

Patricia leaves the floor often to "make a phone call", "go to the bathroom", or "get something from the locker room." Even though Patricia often needs your help to finish her assigned nursing care, she sometimes volunteers to give pain medication to your clients "to thank you for supporting her." You have tried to talk to Patricia about what you see and she insists that she is OK and that things will get better soon. You are concerned about your friend and co-worker but you are also very concerned about the impact of Patricia's behavior on clients.

A few weeks ago, you read an article on Substance Use Disorder in Nursing and now you are beginning to wonder if there is something more going on with Patricia in addition to the stress she is experiencing. Once you reflect on what you have read, what you see, and your Standards of Practice and Code of Ethics, you realize that you have no choice but to have a conversation with the unit manager. Even if Patricia is not involved in drug use, you realize that something is impacting negatively on the level of care she is providing.

Substance Use Disorder (SUD) may range from alcohol or drug abuse to dependency or addiction. Addiction is the compulsive use of drugs or alcohol and the inability to stop using them despite all the problems caused by their use. A person with an addiction is unable to stop drinking or taking drugs despite serious health, economic, occupational, legal and social consequences.[1] No one is immune from developing a SUD. It can affect anyone, regardless of economic circumstances, age, ethnic background, gender or occupation.[2]

There are often indicators that signal that a nurse may have a problem. While it may be difficult to determine if what you are seeing in a colleague are signs of impairment or simply stress-related behavior, there are three things to watch for, including, a) behavior changes, b) physical signs, and c) drug diversion.[3]

Behavioral changes may include fluctuations in job performance, absences from the unit for extended periods of time, frequent trips to the bathroom, arriving late or leaving early, and making an excessive number of mistakes, including medication errors.

Behavioral changes may be physical, including subtle changes in appearance that may escalate over time; increasing isolation from colleagues; inappropriate

1 SUBSTANCE USE DISORDER IN NURSING: A Resource Manual and Guidelines for Alternative and Disciplinary Monitoring Program, 2011, National Council of State Boards of Nursing, Inc.

2 A Nurse Manager's Guide to Substance Use Disorder in Nursing, 2014, National Council of State Boards of Nursing, Inc.

3 What You Need to Know About Substance Use Disorder in Nursing, 2014, National Council of State Boards of Nursing, Inc.

verbal or emotional responses; and diminished alertness, confusion or memory lapses.

The nurse may turn to the workplace for access to drugs. This may lead to frequent offers to medicate co-workers' clients for pain and frequent reports of ineffective pain relief from clients. Narcotics discrepancies may also be evident, such as incorrect narcotic count, large amounts of narcotic wastage, and numerous corrections of medication records.

As well as warning signs that may indicate a problem, your colleague may arrive at work visibly under the influence of alcohol or drugs. In this situation, ensure protection for the clients by reassigning them to another care provider and notifying the supervisor.

It is often very difficult for nurses to report a co-worker no matter what the cause. Loyalty, friendship and fear may leave the nurse questioning what to do to help. **However, nurses have an ethical and professional responsibility to protect clients and this must come first**. LPNs have a **Duty to Report**. Indicator 1.6 of the Standards of Practice[4] says LPNs take action to avoid and/or minimize harm in situations in which client safety and well-being are compromised. The Code of Ethics[4] identifies the LPN's ethical responsibility to report to appropriate authorities and take other action in a timely manner to ensure a client's safety and quality of care when unethical or incompetent care is suspected. As well as ensuring protection of clients with early reporting, early intervention may lead to greater treatment success and an increased likelihood for the nurse to recover and return safely to work.

Substance Use Disorder by nurses has the potential to jeopardize care and place clients at risk. Early reporting will protect clients and lead to early intervention for the nurse. LPNs should know the warning signs of SUD and intervene as necessary. Regardless of the reason, LPNs have a duty to report when client care is impacted by a co-worker's performance.

[4] Standards of Practice and Code of Ethics for Licensed Practical Nurses in Canada, 2013, CCPNR.

CLPNNL will soon have a new look in the online world. In October, CLPNNL will reveal its new website.

Be sure to check it out at www.clpnnl.ca.

September is OVARIAN CANCER Awareness Month!

Ovarian Cancer Canada
Cancer de l'ovaire Canada

THINK YOU'VE BEEN CHECKED FOR THE MOST FATAL WOMEN'S CANCER?

THINK AGAIN.

THERE IS NO RELIABLE SCREENING TEST FOR OVARIAN CANCER, AND NO VACCINE TO PREVENT IT.

HERE'S WHAT YOU NEED TO KNOW

All women are at risk for developing ovarian cancer. However, a woman is at higher risk if:

- She is over 50 years of age
- Her family has a history of ovarian, breast, endometrial (uterine), or colorectal cancer
- She is of Ashkenazi Jewish descent
- She has a genetic mutation associated with ovarian cancer

The following factors reduce the risk of ovarian cancer:

- Use of oral contraceptives
- Full-term pregnancy
- Tubal ligation
- Removal of the fallopian tubes, and ovaries

HERE'S WHAT YOU NEED TO DO

Speak to your doctor about your risk for developing ovarian cancer to determine whether preventive action is right for you.

OVARIAN CANCER IS DIFFICULT TO DETECT

Signs of this disease are easily overlooked because they can signal a variety of conditions. Common symptoms are:

- Bloating
- Difficulty eating
- Abdominal discomfort
- Change in urinary habits

Speak to your doctor if you notice new symptoms that persist for three weeks or longer. If ovarian cancer is suspected, see a gynecologic oncologist for specialized care.

For further information, visit
ovariancanada.org

Printed with permission from the Ovarian Cancer Canada Foundation www.ovariancanada.org

September is PROSTATE CANCER Awareness Month!

Prostate Cancer

Prostate cancer is the most common cancer to affect Canadian men. One in eight men will be diagnosed with the disease in their lifetime.

Prostate cancer is a disease where some prostate cells have lost normal control of growth and division. They no longer function as healthy cells.

A cancerous prostate cell has the following features:

- Uncontrolled growth
- Abnormal structure
- The ability to move to other parts of the body (invasiveness).

It is important to note that not all clusters of cells growing in a mass are cancerous, and that a prostate with an irregular shape is not necessarily cancerous either. It is advisable to ask your doctor what it may be.

Prostate cancer can be slow-growing and some men who develop prostate cancer may live many years without ever having the cancer detected. It is important to get screened regularly so that if you do develop prostate cancer, the appropriate action can be taken. A significant proportion of prostate cancers, if untreated, may have serious consequences.

Common signs and symptoms of prostate cancer may include:

- Difficulty urinating
- Urgent need to urinate
- Frequent urination, especially at night
- Burning or pain when urinating
- Inability to urinate or difficulty starting or stopping urine flow
- Painful ejaculation
- Blood in the urine or semen

Symptoms are not always present especially in the early stages of prostate cancer. If detected and treated in its earliest stages (when cells are only in the prostate), your chances of survival are greatly increased. Early detection is key.

Printed with permission from Prostate Cancer Canada www.prostatecancer.ca

Prostate Cancer Canada
prostatecancer.ca

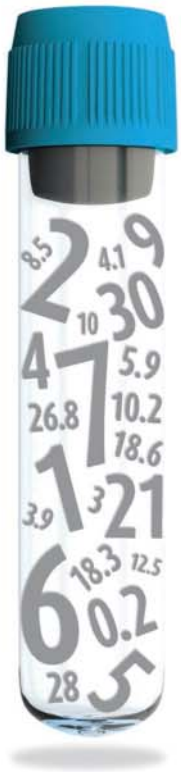
PSA : Know Your Number

Risk Factors

Age: Risk for prostate cancer increases with age.

Race: Men of black African or black Caribbean descent have increased risk for prostate cancer.

Family History: Men with a first degree relative (brother, father, son) with prostate cancer have an increased chance of getting the disease.



Did you know?

The PSA test is a simple blood test, taken from your arm, that measures the amount of prostate specific antigen in your blood.

While there are controversies with the PSA test, high numbers serve as a powerful **red flag** for further investigation.

Prostate Cancer Canada Recommends

At Age

UNDER 40	40 - 70	70 +
At high risk? Talk to your primary care provider about prostate cancer.	Get a PSA test in your 40's to establish your baseline.	The decision to end PSA testing should be based on individual factors.

Years

PCC advocates for shared decision making between doctor and patient

For more information, visit prostatecancer.ca

Prostate Cancer Information Service
1-855-PCC-INFO (1-855-722-4636) or email support@prostatecancer.ca

Medication incidents that could have been prevented at the prescribing stage

By Jim Kong, Kacy Park, and Certina Ho

Systems-based vulnerabilities are reflected in the volume and type of medication errors, and anonymous reporting demonstrates a commitment to an open culture of sharing and quality improvement by healthcare professionals. For a patient, a medication error can range from a near-miss to patient death, with varying degrees of severity in between. The prescribing stage represents the patient's first contact within the medication-use process and is an important milestone in helping to guide patients to positive outcomes and better health. Thus, to be able to definitively address medication incidents and prevent patient harm, ISMP Canada conducted a multi-incident analysis focusing on the prescribing stage of the medication-use process to highlight potential areas for improvement.

Incidents were retrieved from ISMP Canada's Community Pharmacy Incident Reporting (CPhIR) program from the period between January 2010 and April 2015. Inclusion criteria included all levels of harm to patients with the exception of "No Error". The decision to exclude data from hospital reporting programs allowed ISMP Canada to gain an understanding of the more broad prescribing landscape of the community setting, which expands our exposure to medication errors in a non-formulary-limited prescribing environment. A total of two main themes and seven subthemes were identified by this analysis.

Therapeutic Plan Error

Therapeutic plan error refers to medication incidents that occurred during the prescribing stage as a result of any therapeutic oversight of a patient's pharmacotherapy plan. The four subthemes that fall under this category include Incorrect Dose, Medication Discrepancy, Allergy, and Drug-Drug Interactions. A prescriber's intentions are not always clearly outlined, and there is a lack of a standardized format for prescribers to confirm recommendations or aspects regarding dose appropriateness. These issues highlight the need for a readily-available, compre-

Table 1. Recommendations to prevent Therapeutic Plan Errors

Subtheme	Contributing Factors	Recommendations
Incorrect Dose	Lack of process to confirm recommendations or therapy appropriateness	Use standardized order sets Increase access to therapeutic information resources Patient education on signs and symptoms of over/under-dosing of medications
Medication Discrepancy Allergy Drug-Drug Interactions	Lack of appropriate clinical decision support system Alert fatigue Lack of relevant patient information	Implement user-friendly clinical decision support system Check-point barriers for high-risk alerts Utilize mandatory data entry fields when gathering information from patients Conduct Best Possible Mediation History (BPMH) during initial interaction with patients Involvement of patients and caregivers to ensure compliance of medication therapy

hensive medical information platform for healthcare professionals to refer to when prescribing medications. Any gap in patient medication history knowledge lends itself to mistakes being made at all stages of the medication-use process, with the prescribing stage acting as the initial onset for this cascading effect. Recommendations based on the hierarchy of effectiveness and best medication practices are outlined in Table 1.

Therapeutic Plan Execution Error

The second main theme of this multi-incident analysis was therapeutic medication plan execution error which refers to mediation incidents that occurred due to the technical aspects of the prescribing stage. This includes subthemes such as Incomplete Prescription, Illegible Writing, and Wrong Patient. With the multitude of drug products on the current market, there is an increased need for vigilance when providing prescriptions to patients. Although the technical aspects of a prescription are often overlooked as minor issues, occurrences still have the potential to cause severe patient harm. The implementation of computerized physician order entry (CPOE) systems remains a powerful tool to help prescribers prevent medication errors. Recommendations based on the hierarchy of effectiveness and best medication practices are outlined in Table 2.

Prescribers currently have more point-of-care tools or resources at their disposal than ever before and the opportunities to mitigate patient harm are vast. The proper use of clinical decision support systems and order entry sets can help overcome the therapeutic and technical limitations of prescribing, helping prescribers achieve their desired and optimal patient outcome H

Jim Kong is a Consultant Pharmacist at the Institute for Safe Medication Practices Canada (ISMP Canada); Kacy Park is a PharmD Student at the School of Pharmacy, University of Waterloo; and Certina Ho is a Project Lead at ISMP Canada.

Table 2. Recommendations to prevent Therapeutic Plan Execution Errors

Subtheme	Contributing Factors	Recommendations
Incomplete Prescription	Lack of forcing functions/ reminders for data entry fields	Utilize CPOE systems with mandatory prescription fields* Utilize pre-printed order sets Independent double checks Staff education regarding mandatory prescription data entry fields
Illegible Writing Wrong Patient	Lack of process to ensure prescription legibility Lack of process to confirm patient identity	Utilize CPOE systems* Incorporate process for ensuring prescription legibility before providing prescription to patient Alerts for similar patient profiles Utilize two separate patient identifiers at each stage of the medication-use process

***CPOE systems may introduce other safety challenges in the medication use process. Therefore, always assess the risks versus benefits of using a new system in the workplace/workflow before widespread implementation.**

This article originally appeared in Hospital News Volume 29, Issue 6 edition.

Medical Imaging in Canada

By Kasia Kaluzny, MSc
Knowledge Mobilization Officer at CADTH

Many of your patients have probably had some kind of medical imaging exam performed — from the classic X-ray to specialty medical imaging such as computed tomography (CT), magnetic resonance imaging (MRI), or single-photon emission computed tomography (SPECT). You've probably noticed that the field of medical imaging is evolving and growing, and new types of imaging modalities are becoming available. There are now advanced machines that combine imaging modalities, such as hybrid positron emission tomography (PET) and CT (called PET-CT for short).

Medical imaging technologies can be used for diagnosing and monitoring a range of diseases and conditions, from cancer to internal injuries. They can also be used to guide surgeries and other treatments. As the technology advances, so too do the uses.

But taking a step back, how does medical imaging look in Canada as a whole? Are the technologies available where they are needed? These are some of the questions we were hearing at CADTH (an independent agency that finds, assesses, and summarizes the evidence on health care technologies).

So in 2015 we began collecting data to develop a large inventory — the Canadian Medical Imaging Inventory — to find out where medical imaging equipment is located and how it's being used. The inventory revealed that most imaging machines are located in hospitals in major urban areas, where the population is highest. The regions with the greatest number of machines were Ontario, Quebec, British Columbia, and Alberta. The less populated provinces and territories have fewer machines, with the lowest numbers in the Northwest Territories, Yukon, Nunavut, and Prince Edward Island (PEI). The other east coast provinces — Nova Scotia, New Brunswick, and Newfoundland and Labrador — as well as Manitoba and Saskatchewan, were in the middle with a relatively moderate number of machines.

Interestingly, when counting the number of imaging machines per population, some of the less populated regions actually have a greater number of CT and MRI units per number of people, but the population is geographically dispersed so the machines may still be difficult for patients to access.

We created the inventory using a survey that captured information on

six specialty imaging modalities (CT, MRI, SPECT, PET-CT, PET-MRI, and SPECT-CT). It includes results from a total of 374 facilities in Canada; however, not all medical imaging facilities responded to the survey. Although the information is not entirely complete, the inventory provides us with the best and most current view of the landscape of medical imaging in Canada. It's an important foundational piece — a key starting point for making decisions about how these technologies are used and managed.

Most (90%) of the facilities that responded are publicly funded. Most were hospitals, but tertiary care centres, free-standing facilities, and community hospitals also participated. Not all of their machines are stationary — some of the MRI machines identified by the inventory are mobile, meaning they move from one facility to the next based on agreements.

All medical imaging equipment eventually needs to be replaced as a result of wear and tear, technological progress, and changes in clinical practice and population needs. The inventory provides a "lay of the land" and can be used as a resource to guide decisions on purchasing new machines, decommissioning old ones, and managing how they are used and shared. For example, in the territories and in PEI, where some modalities are absent, patients might need to travel to another province to obtain the type of imaging exam they need. Partnerships across provinces and territories could make the experience easier for patients.

CADTH is also exploring other issues in medical imaging. We recently published an Environmental Scan report that looks at the criteria and processes used across Canada to identify, prioritize, and fund the replacement or upgrade of medical imaging equipment. The report found that most provinces have processes in place, they use mechanisms to minimize costs (e.g., by working with purchasing groups), and they have contingency funds set aside for unexpected needs. Many of the decisions — about prioritization and funding — are made at the regional or local level. In Alberta, Manitoba, Nova Scotia, Quebec, and PEI, funding decisions are made at the provincial level.

Snapshot of Findings from the Canadian Medical Imaging Inventory

- Overall, Canada has seen a growth over the last three years in the number of medical imaging machines installed and operated.
- Most medical imaging scanners are used for clinical purposes; a small portion of the time, they are used for research.
- CT is the most widespread imaging modality in Canada, with the highest number of units (538 total), followed closely by MRI (340 total), and then the nuclear imaging modalities.
- The least common modality is PET-MRI (2 total; research use only), but it is also the newest specialty imaging modality and its clinical use is expected to grow.
- Hybrid modalities such as PET-CT have replaced single modality PET scanners.

CADTH has also conducted several reviews of the evidence for specific medical imaging uses, including a recent review of low-dose CT for lung cancer screening, and a recent review of the safety and guidelines related to ionizing radiation in pregnant women.

What's next? Based on feedback we're hearing from clinicians, radiology groups, and other stakeholders, it's clear there is a need for evidence to inform decisions on optimal use of medical imaging. This will be a key area for CADTH project work, now and in the coming years. Medical imaging is a complex field, and there is much to be studied and done to help achieve a sustainable medical system where all Canadians, no matter where they live, have access to appropriate, safe, quality medical imaging services.

To read more about the findings of the inventory and other related CADTH reports, visit our medical imaging evidence bundle: www.cadth.ca/imaging.

CADTH is an independent, not-for-profit organization responsible for providing Canada's health care decision-makers with objective evidence to help make informed decisions about the optimal use of drugs and medical devices in our health care system.

This article has been modified from its original version, which was published in the June 2016 edition of Hospital News — Canada's health care news and best practices.

Distance Education Program and Course Offerings for Licensed Practical Nurses

2016-2017

The Centre for Nursing Studies is pleased to offer the following distance education courses. Start dates vary and courses will be offered **pending sufficient registration**. Payment will be requested once sufficient registration is received.

Licensed Practical Nurses:

- Re-Entry Program (September 2016 and January 2017) $3,500.00
- Post Basic Gerontology Program (September 2016) $1,000.00
- Post Basic Perioperative Program (September 2016) $3,500.00
- Post Basic Mental Health Program (September 2016) $1,000.00
- Advanced Footcare Management Course $500.00

LPN Post Basic Competency Modules: (September 2016) *$100.00 each*

- Intramuscular Injection Module
- Intradermal Injection Module
- Intravenous Initiation Module
- Intravenous Therapy Administration
- Intravenous Medication Administration Module – Prerequisite: IV Therapy Administration Module
- Blood and Blood Products Administration Module – Prerequisite: IV Therapy Administration Module
- Central Venous Access Device (CVAD) Module – Prerequisite: IV Therapy Administration Module
- Hypodermoclysis Module – Prerequisite: IV Therapy Administration Module
- Immunizations Module – Prerequisite: IM and ID Modules

To register or for more information contact:

Centre for Nursing Studies
www.centrefornursingstudies.ca
100 Forest Road, St. John's, NL A1A 1E5
Tel: (709) 777-8162 Fax: (709) 777-8176
Email: tracey.evans@mun.ca

Lupus Canada

Lupus is an autoimmune disease and can affect **ANYone. ANYorgan. ANYwhere.**

OCTOBER IS LUPUS AWARENESS MONTH

Lupus is a silent disease with 1000 faces. Every case is different…

- More than 1:1000 Canadian men, women and children are affected.
- Between the ages 15-45 women are nine times more likely than men to be diagnosed with Lupus
- Lupus is a serious condition but in most cases it can be treated and controlled
- Before symptoms specific to lupus occur flu-like symptoms may appear such as: severe fatigue, unexplained weight loss or gain, headaches, hair loss, hives, or high blood pressure

For more information please call 1-800-661-1468 or visit www.lupuscanada.org

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November is Diabetes Awareness Month!

DIABETES IS A GROWING EPIDEMIC.

EVERY THREE MINUTES, A CANADIAN IS DIAGNOSED WITH THE DISEASE.
CHANCES ARE, DIABETES WILL AFFECT YOU OR SOMEONE YOU LOVE.

THE CANADIAN DIABETES ASSOCIATION IS

HERE TO HELP

with information, support, understanding and hope.

To learn more, visit **diabetes.ca**
or call **1-800-BANTING** (226-8464).

Canadian Diabetes Association
diabetes.ca | 1-800-BANTING

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CONDUCT unbecoming...

"Wow, that party was amazing! I had a great time, and I decided not to drink alcohol because I wanted to drive Peggy home. Good thing, because she had a few too many drinks last night. Did you see what she was doing? And the way she was acting around those people? I especially did not like the fact that she was wearing a shirt that said 'I'm a Nurse.' What does that say for our profession?"

After reading this, everyone has undoubtedly formed an image of Peggy. Even though Peggy was off duty, do you think she showed respect for herself and the practical nursing profession? Could this behavior affect her professional integrity?

The answers to these questions may be found in the *LPN Act (2005)*, Sections 13-27, as well as in the *CLPNNL Standards of Practice and Code of Ethics (2013)*.

Appendix B of the *Standards of Practice and Code of Ethics* defines **Conduct Unbecoming** as "conduct exhibited inside and outside the actual practice of the profession that would be reasonably regarded by members of the profession as dishonorable, disgraceful, or unprofessional."

Section 13 c) iii) of the *LPN Act* states that "conduct unbecoming of a Practical Nurse is conduct deserving of sanction."

Peggy was wearing a shirt that said, "I'm a Nurse." This clearly identifies her as a nursing professional. Peggy is a Licensed Practical Nurse who is well liked by the staff and clients she cares for. At the party, Peggy's actions were inappropriate; she was disrespecting herself, as well as her profession.

This type of behavior is considered conduct unbecoming as this LPN was seen as being dishonorable, and unprofessional.

Although LPNs have every right to have a personal life outside of their professional life, LPNs must always conduct themselves with respect for their personal and professional life. They must be aware of their actions at all times as their actions outside of work could affect their professional integrity.

If the LPN's conduct in their personal life is inconsistent with the standards and ethical values of the profession and is made public, this may have a negative effect on the nursing profession.

The public associates the nursing profession with respect, honesty and caring attitudes. If the public were to view the nursing profession as "nurses who like to get drunk" this type of conduct would bring disrespect to the profession and undermine the public trust in nurses. Demonstrating such conduct is inconsistent with the Standards of Practice as well as the Code of Ethics. CLPNNL has the authority to bring disciplinary action against a LPN who exhibits such conduct.

CLPNNL encourages LPNs to consistently think about how their behavior and actions affect how they are viewed as members of the nursing profession.

Institute for Safe Medication Practices Canada
REPORT MEDICATION INCIDENTS
Online: www.ismp-canada.org/err_index.htm
Phone: 1-866-544-7672

A KEY PARTNER IN
CMIRPS Canadian Medication Incident Reporting and Prevention System
SCDPIM Système canadien de déclaration et de prévention des incidents médicamenteux

ISMP Canada Safety Bulletin

Volume 16 • Issue 3 • April 21, 2016

Safety Considerations with Newer Inhalation Devices

Over the past few years, several new devices for the administration of inhaled medications have been introduced in Canada. Some of these devices are used to administer newly marketed medications, whereas others contain previously available drugs in a different administration format. A reported concern about one of these devices prompted a review of all new inhalers from a safety perspective. This bulletin provides proactive consideration of the potential safety issues related to these devices for discussion during patient counselling, with the goal of preventing medication incidents.

Reported Concern

A concern about the inadvertent aspiration of a capsule when using the Seebri Breezhaler was reported to ISMP Canada. Administering a dose with the Seebri Breezhaler entails removing the capsule from its foil packaging, placing it in the inhaler chamber, and piercing the capsule by pressing the buttons on either side of the device so the powdered contents of the capsule can be then inhaled through the mouthpiece. First-time users may incorrectly place the capsule into the inhaler mouthpiece instead of the chamber that is designed to hold the capsule. When the capsule is placed in the mouthpiece the patient may swallow or aspirate the capsule in its entirety, resulting in erroneous route of administration or, more critically, creating a choking hazard.

Background

Inhaled medications are the cornerstone of managing asthma and chronic obstructive pulmonary disease (COPD). Typically, patients self-administer these medications using either metered-dose inhalers (MDIs; e.g., salbutamol inhaler) or dry powder inhalers (DPIs).[1] Some DPIs are available preloaded with the medication already inside the device (e.g., Symbicort Turbuhaler), whereas others are supplied empty with a requirement for loading or insertion of the medication before each dose is inhaled (e.g., Spiriva Handihaler). With the introduction of several new formats of DPIs (i.e., Breezhaler, Ellipta, Genuair), along with a soft mist inhaler (SMI; e.g., Respimat), healthcare providers must familiarize themselves with the safe and effective use of all of these inhaler devices so that they can impart key information to patients and their caregivers.

Device Design Enhancements to Promote Safety

It has been reported that up to 94% of patients demonstrate incorrect inhaler technique, which can lead to underdosing and poor disease control.[2] The new devices incorporate different design concepts intended to improve patients' ability to use their devices correctly and safely:

- Presence of a dose counter: allows the patient to see when the supply of medication is low. This feature

was previously available on some DPIs, however not on MDIs.
- Longer duration of aerosol generation and low aerosol velocity: reducing dependence on the patient's coordination and inspiratory flow (Respimat SMI).[3]
- Inability to activate the device when all of the medication has been used: once the last preloaded dose has been taken and the device is empty, the mechanism to prepare another dose is locked, and the patient is prevented from administering "empty" doses.

Strategies to Support Optimal Use of Inhalation Devices

Prescribers

- Ensure that prescriptions for inhaled medications include the medication name and strength, the device name, and the desired dose, particularly if the medication is available in more than one device format.
- When prescribing any inhalation device, consider pertinent patient characteristics, such as inspiratory flow, cognition, and manual dexterity.
- Provide opportunities for patients to access videos on proper inhalation devices while in the office.

Respiratory Educator/Nurse

- Ensure that patient counselling includes a demonstration of how the inhalation device is to be used. The Ontario branch of the Canadian Lung Association has a series of helpful how-to videos: https://www.on.lung.ca/inhalationdevicevideos
- Ask the patient to demonstrate inhaler technique (using a placebo inhaler).
- Provide opportunities for patients to access videos on proper inhalation devices while in the office.

Community Pharmacists

- In addition to providing written instructions, reinforce proper and safe use of the inhalation devices.
- Ask the patient to demonstrate inhaler technique (using a placebo inhaler) both when filling new prescriptions and periodically when refilling existing prescriptions. Such demonstrations can create opportunities to correct improper technique, which may be a contributing factor for patients who continue to experience difficulty with symptoms of asthma or COPD. For devices using capsules, emphasize the need to place the capsule in the piercing chamber.

Healthcare Organizations

- Distribute this bulletin to healthcare providers to support awareness of the new inhalation devices.
- Post the summary chart included as the last page of this bulletin in patient care areas for reference and to help staff and physicians when they are providing instruction to patients. The chart provides an overview of the new inhalation devices, the medications they deliver, and selected safety considerations to be shared with patients. It supplements the information provided by the manufacturers.

Acknowledgements

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The pictures in the summary chart are provided courtesy of (in the order in which they appear in the chart): Novartis Pharmaceuticals Canada Inc. (Breezhaler), AstraZeneca Canada Inc. (Genuair), and Boehringer Ingelheim (Canada) Ltd. (Respimat).

Safe Use of Newer Inhalation Devices

Breezhaler (dry powder inhalers)

Usual Dose: Contents of 1 capsule inhaled daily[4-6]

Onbrez Breezhaler
indacaterol 75 mcg
per capsule

Seebri Breezhaler
glycopyrronium 50 mcg
per capsule

Ultibro Breezhaler
indacaterol 110 mcg /
glycopyrronium 50 mcg
per capsule

Safety Considerations and Counselling Tips:

- Capsules are for inhalation only; they must not be swallowed.[4-6] Capsules can mistakenly be placed into the inhaler mouthpiece, resulting in inadvertent swallowing and/or aspiration of the entire capsule.
- If swallowed by accident, skip the dose.
- Capsules are packaged separately from the inhaler and must be inserted into the capsule chamber.[4-6] The mouthpiece must be opened to prompt capsule placement inside the capsule chamber.
- If the chamber is not immediately emptied after use, pieces of the capsule can remain inside and impede the free flow of product for the next dose.
- Discard the capsule directly into the garbage without touching. Wash hands.

Ellipta (dry powder inhalers)

Usual Dose: 1 inhalation daily[7-10]

Anoro Ellipta
umeclidinium
62.5 mcg / vilanterol
25 mcg per actuation

Arnuity Ellipta
fluticasone 100 or
200 mcg per actuation

Breo Ellipta
Fluticasone 100 or
200 mcg / vilanterol
25 mcg per actuation

Incruse Ellipta
umeclidinium 62.5 mcg
per actuation

Safety Considerations and Counselling Tips:

- The foil packaging and desiccant must be discarded immediately after opening.[7-10]
- The coloured cap should be opened before inhaling the dose. There is an audible "click" when the dose is ready to be inhaled.[7-10]
- If the device cover is opened and then closed without inhalation of the loaded dose, that dose will be lost.[7-10] If a dose is lost, another dose can be loaded by opening the device cover again; double-dosing will not occur.
- If the device is tipped past horizontal, medication can fall out of the mouthpiece.
- When there are less than 10 doses remaining, the left half of the counter shows red.

Genuair (dry powder inhalers)

Usual Dose: 1 inhalation twice daily[11,12]

Duaklir Genuair
aclidinium 400 mcg /
formoterol 12 mcg per actuation

Tudorza Genuair
aclidinium 400 mcg per actuation

Safety Considerations and Counselling Tips:

- To prepare for inhalation, the coloured button should be pressed and then released. The coloured control window will change from red to green when the dose is ready to be inhaled. Do not hold down the button while inhaling.[11,12]
- During dose inhalation, there is an audible "click". Upon proper inhalation of the dose the coloured control window will change back to red. Keep breathing in even after the "click" to ensure delivery of the full dose.[11,12]
- When a red striped band appears in the dose window, obtain a new inhaler. The device will "lock" when the last dose has been loaded.[11,12]
- Some patients experience an unpleasant taste - rinse mouth and swallow water.

Respimat (soft mist inhalers)

Combivent Respimat
ipratropium 20 mcg /
salbutamol 100 mcg per actuation
Usual Dose: 1 inhalation 4 times daily[13]

Inspiolto Respimat
tiotropium 2.5 mcg /
olodaterol 2.5 mcg per actuation
Usual Dose: 2 inhalations daily[14]

Spiriva Respimat
tiotropium 2.5 mcg per actuation
Usual Dose: 2 inhalations daily[15]

Safety Considerations and Counselling Tips:

- Insertion of the cartridge before first use may require more force than expected; cartridges should be preloaded by the pharmacy before dispensing. Priming is required before first use.[13-15]
- Before initiating the dose, the lips should be tightly closed over the mouthpiece without covering the air vents (on the sides of the mouthpiece).[13-15]
- When approximately a 7-day supply of medication remains in the device, the red pointer will enter the red zone of the dose counter on the base.[13-15]
- Spiriva is also available in a DPI format (Handihaler) that delivers a different dose.[16]

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CMIRPS SCDPIM
Canadian Medication Incident Reporting and Prevention System
Système canadien de déclaration et de prévention des incidents médicamenteux

The Canadian Medication Incident Reporting and Prevention System (CMIRPS) is a collaborative pan-Canadian program of Health Canada, the Canadian Institute for Health Information (CIHI), the Institute for Safe Medication Practices Canada (ISMP Canada) and the Canadian Patient Safety Institute (CPSI). The goal of CMIRPS is to reduce and prevent harmful medication incidents in Canada.

HIROC

The Healthcare Insurance Reciprocal of Canada (HIROC) provides support for the bulletin and is a member owned expert provider of professional and general liability coverage and risk management support.

ISMP CANADA

The Institute for Safe Medication Practices Canada (ISMP Canada) is an independent national not-for-profit organization committed to the advancement of medication safety in all healthcare settings. ISMP Canada's mandate includes analyzing medication incidents, making recommendations for the prevention of harmful medication incidents, and facilitating quality improvement initiatives.

Report Medication Incidents

(Including near misses)

Online: www.ismp-canada.org/err_index.htm
Phone: 1-866-544-7672

ISMP Canada strives to ensure confidentiality and security of information received, and respects the wishes of the reporter as to the level of detail to be included in publications. Medication Safety bulletins contribute to Global Patient Safety Alerts.

Stay Informed

To receive ISMP Canada Safety Bulletins and Newsletters visit:
www.ismp-canada.org/stayinformed/

This bulletin shares information about safe medication practices, is noncommercial, and is therefore exempt from Canadian anti-spam legislation.

Contact Us

Email: cmirps@ismp-canada.org
Phone: 1-866-544-7672

ISMP Canada Safety Bulletin – Volume 16 • Issue 3 • April 21, 2016

Professional Liability and Licensed Practical Nurses

April 14, 2016

Professional liability issues are of great concern today. There was a time when health practitioners were not lawsuit targets; clients would never consider bringing forth an action against people who helped them. Times have changed. Today the public and legal system have high expectations and are more inclined to initiate a lawsuit.

Organizations, employees and services are being scrutinized by the public like never before. When adjudicating cases, the courts base their judgments on increasingly higher standards of care and responsibility.

Licensed practical nurses (LPNs) have daily contact with people and patients in their work. These people are dependent upon your skillful care and extensive knowledge. Professional Liability Insurance helps protect you from allegations of errors, omissions and negligent acts whether or not they have merit.

As an LPN, the legal system views you as a professional, meaning you are expected to have extensive technical knowledge and training in your area of expertise. You are also expected to perform the services for which you were hired according to a professional code of conduct and within the scope of practice. If an LPN fails to use the degree of skill expected of them, they can be held personally responsible in a court of law for any harm they cause to another person. Not only can your professional reputation be damaged in a lawsuit, but your personal assets may be at risk.

As a member of the College of Licensed Practical Nurses of Newfoundland and Labrador, you are automatically provided with Professional Liability coverage. Included in your annual membership, your association or college provides a Professional Liability policy with a $2,000,000 per claim limit and an annual program aggregate of $50,000,000. The program covers the LPN for faults, errors, omissions and negligence for services rendered while acting within their scope and duties. The basis of the policy is to provide protection for:

- Defense costs associated with defending an allegation, even if the allegation is false
- Settlement costs if the LPN is found negligent
- Additional limits over employer limits
- Helping shield the personal assets of members

Your insurance company is equipped with a team of analysts, adjusters and legal professionals to ensure claims are adequately handled and proactively managed. Their expertise is critical in guiding you through the claims process, while respecting your privacy and the organization's confidentiality.

The policy includes coverage for all active members of the college or association and retired members. Graduates awaiting licensing are also provided coverage as long as they are working under the guidance of another health professional. Since the policy is intended to only cover errors and omissions resulting from your professional practice, it is important to note there are exclusions. Some of the notable exclusions include:

- Deliberate, Dishonest and Fraudulent Acts
- Fines and Penalties
- Libel and Slander
- Abuse and Sexual Misconduct
- Issues outside of your scope of practice
- Disciplinary allegations

In a hospital or other care facility, your employer will likely maintain a Professional Liability policy on behalf of the facility and its employees. In this circumstance, the program provides excess coverage in the event the facility coverage is insufficient. If the LPN does not work in a facility which provides Professional Liability coverage, this program becomes primary to protect the individual. For licensed practical nurses who are self employed or who do contract work this liability insurance is critical protection. Providing your work in these roles falls within your scope of practice, you are covered.

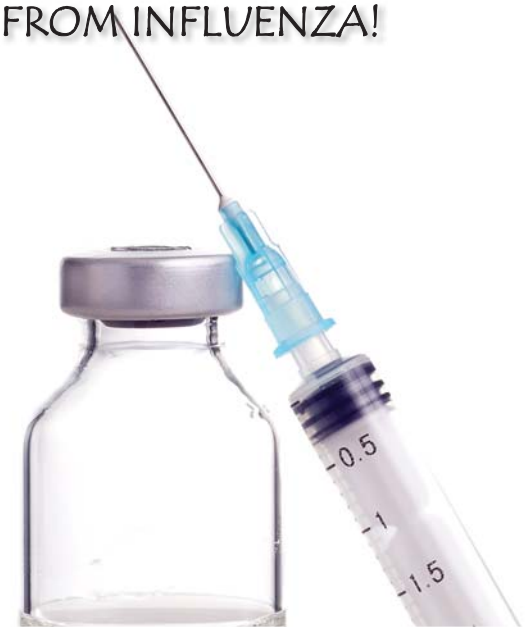
This program has been developed with the College of Licensed Practical Nurses of Newfoundland and Labrador for the benefit of the members and the public. It is important to understand your coverage and know you have protection against errors in your day-to-day work.

It's flu season...

GET YOUR PROTECTION FROM INFLUENZA!

IT'S A FACT: INFLUENZA IS MUCH MORE THAN A BAD COLD

Commonly known as "the flu", influenza is an infection that can be caused by several types of influenza viruses. These viruses spread easily during the winter months and infect the nose, throat and lungs. The symptoms have sudden onset, are far more serious than the common cold and include headache, chills and a dry cough followed by body aches and fever. The fever may decrease on the second or third day but full recovery from influenza may take a few weeks. Some people may carry the virus without getting sick themselves but they can still past it on to others who can get seriously ill.



INFLUENZA CAN LEAD TO SEVERE COMPLICATIONS EACH YEAR

While most people recover fully, influenza may lead to more severe and life-threatening illnesses, such as pneumonia and even death.

IMMUNIZATION IS THE BEST PREVENTION

Good nutrition and exercise contribute to your general health; these alone will not protect you from the influenza virus. Immunization every fall is the only prevention measure that has been proven to prevent influenza and reduce complications caused by influenza. The vaccine provides protection for the current season only; therefore it is recommended to have a flu vaccination annually.

HAND WASHING MAKES A DIFFERENCE

Clean, Cover, and Contain is always a good message to help prevent disease. Clean your hands, cover your coughs and sneezes and contain your illness by staying home to rest.

WHO SHOULD GET THE INFLUENZA VACCINE?

While the Newfoundland and Labrador immunization program recommends and provides influenza vaccine for all persons 6 months of age and older, influenza vaccine is especially important for people who are at risk of developing complications from influenza. It is also important to immunize people who are able to spread influenza to those who are at higher risk of influenza–related complications, such as health care providers and other caregivers. Some of the high risk groups include people with

chronic conditions requiring doctor's care, persons who are morbidly obese, those in residential care, children age 6 to 59 months, persons age 60 years and over, pregnant women, Aboriginal people, health care workers, household contacts of people at high risk of influenza complications, essential services workers and poultry and swine workers. Immunization should not be delayed because of minor acute illness, with or without fever

WHO SHOULD NOT GET THE INFLUENZA VACCINE?

- People with moderate or severe acute illness
- People with a known allergy to any component of the vaccine
- People who have had a serious allergic reaction to a previous does in the past
- Infants less than 6 months of age

ARE THERE SIDE EFFECTS FROM INFLUENZA VACCINE?

All influenza vaccines are very safe. People who receive an injection may get a sore arm (redness, swelling and tenderness), others may have a fever, headache or muscle aches, but these are mild and only last a day or two. Persons receiving the intranasal spray vaccine, in addition to headache and fever, may have reduced appetite, runny/stuffy nose and fatigue. Severe side effects and allergic reactions are rare. If you have other side effects, let your community/public health nurse know. You will be asked to stay in the clinic for 15 minutes after you receive the influenza vaccine for observation.

This article has been reprinted from the Government of Newfoundland and Labrador's website:
http://www.health.gov.nl.ca/health/publichealth/cdc/Influenza_Fact_Sheet.pdf

PROTECT YOURSELF and THOSE **AROUND YOU:**

- ✓ Clean your hands often.
- ✓ Keep your hands away from your face.
- ✓ Clean and disinfect surfaces and objects that you touch often.
- ✓ Cough and sneeze into your arm, not your hand.
- ✓ Stay home if you are sick.

To find out where to get your flu vaccine or to learn more about the ImmunizeCA app, visit **Canada.ca/flu**

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This ad has been reprinted from the Government of Canada's website:
http://healthycanadians.gc.ca/publications/diseases-conditions-maladies-affections/fact-sheet-flu-grippe-faits-feuillet/index-eng.php

Know the Flu Facts

1 The Flu can be a serious disease.

- **Flu** is very contagious and can spread **quickly** and **easily**.
- You can pass the flu on to others who may be at **risk** of **serious complications,** before you even know you are sick.
- The **flu** is responsible for about 12,200 hospitalizations and 3,500 deaths per year* and **can affect everyone**, including those who are healthy.

2 You need to get vaccinated every year.

- The **effects** of the **flu vaccine** can **wear off**, so you need to get a **new one every year** to stay protected.
- **Flu viruses change** each year. Experts create a **new vaccine** to protect you **each flu season**.

3 You can't get the Flu from the flu vaccine.

- The viruses in the **flu vaccine** are either killed or weakened and **cannot give you the flu**.

4 The Flu vaccine is safe.

- The **flu vaccine** has **benefited millions** of Canadians since 1946.
- Most people don't have reactions to the **flu vaccine**; those who do may have soreness, redness or swelling at the injection site.
- Severe **reactions** to the vaccine are **extremely rare**.

5 Everybody wins when you get vaccinated.

- By getting the **flu vaccine**, you **protect yourself and others** because you are less likely to spread the flu.
- It's a **simple action** that can **save lives**.

* National Advisory Committee on Immunization. Statement on Seasonal Influenza Vaccine for 2015–2016.

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Frequently Asked Questions

Q **I am a new LPN and I have noticed that my co-worker speaks poorly to one of the residents in my place of work. The co-worker is verbally abusive to the resident and I am unsure what to do or who I should report this to. What should I do?**

A LPNs must report any situation where there is harm to a client. This harm includes but is not limited to abuse of any type. If you do not report these instances, you are as liable as the person doing the harm.

LPNs have a duty to follow/meet the LPN standards of practice. LPNs must act in honesty and good faith, be diligent of the client's needs and always act in the best interest of the client. LPNs must always be thinking, "And how will this benefit my client?" LPNs must follow policy and legislation when meeting the needs of the client.

Licensed Practical Nurses have a duty to provide care. Duty to provide care is defined as the requirement for a licensed practical nurse to provide safe, competent, ethical and compassionate care (in accordance with the Standards of Practice and Code of Ethics) to a client or clients within a defined period of time (i.e.: 0730-1930). Following the Standards of Practice, LPNs are accountable for their practice and responsible for ensuring that their practice and conduct meet the standards of the profession and legislative requirements. The following are statements within the Standards of Practice and Code of Ethics that will guide you in making the best decision.

1.6 – Take action to avoid and/or minimize harm in situations in which client safety and wellbeing are compromised.

1.10 – Maintain documentation and reporting according to established legislation, regulations, laws and employer policies.

3.3 – Support and contribute to an environment that promotes and supports safe, effective and ethical practice.

4.6 – Maintain professional boundaries in the nurse/client therapeutic relationship at all times.

4.7 – Communicate in a respectful, timely, open and honest manner.

Ethical Principles:

2.4 – Act promptly and appropriately in response to harmful conditions and situations, including disclosing safety issues to appropriate authorities.

2.5 – Report to appropriate authorities and take other action in a timely manner to ensure a client's safety and quality of care when unethical or incompetent care is suspected.

4.1 – Take appropriate action to address the unprofessional conduct of other members of the inter-professional team.

As self-regulating professionals, LPNs in NL are accountable and responsible to ensure clients are provided safe, competent, ethical and compassionate nursing care (CLPNNL, 2013). As part of meeting their standards of practice and code of ethics, licensed practical nurses have a legal and ethical duty to report incompetent, unethical or impaired practice of any health care professional.

It is important that LPNs understand that the duty to report extends beyond their own profession and applies equally whether the care provider is regulated by a governing body or not.

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 the CLPNNL, please send your name confidentially 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. The CLPNNL would like to extend a warm thank you to all liaisons for their 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.

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

- Dr. Leonard A. Miller Centre
- Presentation Convent

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

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