Fall 2015

the pulse

practical news for licensed practical nurses

CONTENTS

- CLPNNL Welcomes New Board Members
- Public Information
- Mission, Vision, Values
- New Administrative Deadline for Annual Licensure Renewal 2016-17
- Thank You Janice
- REMINDER: Keep your informaion up-to-date!
- Notice of the College of Licensed Practical Nurses of Newfoundland and Labrador Board Elections
- CLPNNL Welcomes New Practice Consultant, Wanda Lee Squires LPN
- 2014/15 CLPNNL AWARDS
- Proof of Licensure on CLPNNL Public Registry
- Participate in CLPNNL Committees, Working Groups and Liaison Programs
- National Nursing Week 2015
- The 2015 Provincial Nursing Forum
- Annual General Meeting (AGM) and Awards Recognition 2014/15
- From Hospital to Home: Supporting Implementation of Infant Safe-Sleep Guidelines
- Practice Pointers
- Did you know ...
- Legal Issues in Nursing: Communication
- Blood Glucose Monitoring — What Does the Evidence Say?
- Lyme Disease in Newfoundland and Labrador

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

CLPNNL Welcomes New Board Members

CLPNNL welcomes two new public representatives who have been appointed to the Board of CLPNNL by Hon. Steve Kent, Minister of Health and Community Services in accordance with the *Licensed Practical Nurses Act (2011)*.

Ms. Patricia Barrett is a Recreation Development Specialist at Western Health, Corner Brook. Ms. Barrett has a Bachelor of Physical Education and Recreation from the University of New Brunswick. After working more than 20 years in the health system, Ms. Barrett is happy to contribute her knowledge and experience to the work of the Board of CLPNNL in fulfilling its mandate of public protection in the regulation of Licensed Practical Nurses.

Mr. Anderson Noel has a diverse background in the marine and navigation industry. Mr. Noel is a Master Mariner with a Diploma of Technology in Nautical Science, as well as numerous professional certifications. Mr. Noel brings his years of leadership experience in project management, as well risk management and safety, to contribute to CLPNNL Board decisions in the interest of public protection.

Patricia Barret

Dawn Lanphear

CLPNNL is pleased to welcome **Ms. Dawn Lanphear**, BN, Med., RN to the CLPNNL Board as the Centre for Nursing Studies (CNS) representative. Ms. Lanphear is a faculty member and guidance counsellor at the CNS. She has worked with the Practical Nursing Program and PN students for many years. Ms. Lanphear is very knowledgeable regarding PN education and will be a valuable voice and contributor to CLPNNL Board decision making.

PUBLIC INFORMATION

The PULSE is the official Publication of the College of Licensed Practical Nurses of Newfoundland and Labrador

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COLLEGE BOARD MEMBERS

Ms. Jane Pardy	Chairperson, Public Representative *
Ms. Connie Winter	Zone 1 Licensed Practical Nurse Eastern Region
Ms. Judy Pike	Zone 1 Licensed Practical Nurse Eastern Region
Mr. Christopher Matthews	Zone 2 Licensed Practical Nurse Eastern Region
Ms. Pearl Blake	Zone 3 Licensed Practical Nurse Central Region
Mr. Ernest Green	Zone 4 Licensed Practical Nurse Western Region
Mr. Scott Carroll	Zone 5 Licensed Practical Nurse Labrador/Grenfell Region
Ms. Patricia Barrett	Public Representative *
Mr. Anderson Noel	Public Representative *
Ms. Dawn Lanphear	Centre for Nursing Studies
Mr. Paul Fisher	Executive Director/Registrar (Non-voting)

*Appointed by Government

OFFICE STAFF

Executive Director/Registrar
Mr. Paul D. Fisher LPN, CI, BAHSA

Director of Professional Practice & Policy
Ms. Wanda Wadman RN, BAA(N), MN

Professional Practice Consultant
Ms. Wanda Lee Squires LPN

Administrative Officer
Ms. Debbie Pantin, BA

the PULSE, presented by CLPNNL

Design: Kimberly Puddester

The PULSE is published three to five times a year. CLPNNL welcomes feedback and suggestions from readers on this newsletter at info@clpnnl.ca

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.

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.

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 the licensure application 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.

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.

Thank You Janice

The board and staff of CLPNNL say **Thank You to Janice O'Neill!** Janice retired from CLPNNL after 12 years of exemplary service as the Practice Consultant. We wish Janice a happy and restful retirement!

Left to right: Jane Pardy, Chairperson (Consumer Representative), CLPNNL, and Janice O'Neill LPN, Practice Consultant, CLPNNL.

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

NOTICE OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF NEWFOUNDLAND AND LABRADOR BOARD ELECTIONS

Election of LPNs to the Board of CLPNNL for Zones I and III

We are seeking nominations for the election of two LPNs to the Board of the CLPNNL for Zones I and III (1 LPN for each Zone). Each position is for a three year term (January 1, 2016 – December 31, 2018). For more information on the nomination and election process, please contact the office of the CLPNNL or visit www.clpnnl.ca. It is important that LPNs begin to identify those members who will best serve in the public interest to further the objectives of the College.

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.

SCHEDULE FOR THE ELECTION PROCESS FOR ZONES I AND III

September 25, 2015 – Nomination forms mailed to Liaison LPNs in Zones I and III for distribution.

October 23, 2015 at 1630 hrs. – Deadline for receipt of completed nomination forms at the office of CLPNNL

November 2, 2015 – Election Ballots mailed to each LPN for Zones I and III

December 4, 2015 at 16:30 hrs. – Deadline for receipt of completed election ballots in the CLPNNL office

December 11, 2015 – Counting of election ballots by the CLPNNL

December 14, 2015 – Notification of election results to candidates

December 16, 2015 – Notification of election results to membership

Please take an interest in your profession and consider nominating someone or running for office yourself! Remember, nominations close **October 23, 2015, 1630 PM**.

CLPNNL Welcomes New Practice Consultant, Wanda Lee Squires LPN

Wanda Lee Squires

The CLPNNL is pleased to announce the appointment of Ms. Wanda Lee Squires to the position of Practice Consultant effective September 10th, 2015. In this role, Ms. Squires will provide leadership and consultation on matters concerning professional practice and continuing competency. Ms. Squires will provide consultation to LPNs and key stakeholders relevant to current LPN practice and will contribute to the development of policy documents and practice guidelines.

Ms. Squires has more than eleven years of LPN practice in the areas of acute care, including both medicine and surgery, obstetrics, and long-term care. Ms. Squires graduated from Bow Valley College, Calgary, Alberta in 2004. For the past 6 years, she has been employed in acute care, long-term care, OPD and protective care in Bonavista, NL. Ms. Squires brings a wealth of clinical experience to the position of practice consultant. Her commitment to the role of LPNs in an evolving health system and her passion for nursing and the provision for excellence in nursing practice make her an ideal LPN for the role of practice consultant. We extend a warm welcome to her.

Please contact Ms. Wanda Lee Squires, LPN with all your practice questions at wsquires@clpnnl.ca or 579-3843, Ext. 206.

2014/15 CLPNNL AWARDS

The **Anne Keough Excellence in Leadership Award 2014/15** was presented to **Scott Carroll LPN**, currently employed at the White Bay Central Health Centre, Roddickton, NL.

This award acknowledges that Scott consistently demonstrates excellence in leadership and commitment to the practical nursing profession, leads by example, demonstrates professionalism, respect and integrity and collegiality in all aspects of practice and advocates for quality nursing care.

Scott is a leader who delegates appropriately, seeks advice and guidance from peers as required, and provides quality care to clients. He is an avid supporter of advancing the LPN Scope of Practice. Scott is very client focused and advocates for safe, competent and ethical nursing practices. Congratulations Scott!

Left to right: Janice O'Neill, Practice Consultant, CLPNNL, Scott Carroll LPN, Sheila Sullivan LPN, Paul Fisher, Executive Director/Registrar.

The **Excellence in Practice Award 2014/15** was presented to **Sheila Sullivan LPN**, currently employed at Presentation Convent, St. John's, NL. This award recognizes Sheila for consistently setting high standards and demonstrating excellence in nursing practice.

Sheila is a very caring and compassionate nurse who initiates change and improvements in the best interest of the residents. She is an excellent mentor to new staff and students. She displays great leadership abilities and is always willing to share her wealth of knowledge with others. Sheila leads by example and demonstrates compassion and dedication for her work. She demonstrates great competence and excellent decision making capabilities. Congratulations Sheila!

Proof of Licensure on CLPNNL Public Registry

Members and employers can check the current licensure status of any LPN by accessing the public registry at www.clpnnl.ca and clicking on licensure information. Employers and managers are encouraged to ensure their LPN employees are licensed for the 2015/16 year. Practicing as a LPN without a valid license is a serious offence and is considered professional misconduct. This offense may be subject to sanctions including a fine of $50.00 per day per shift worked up to $1,000.00 and may also be subject to disciplinary action in accordance with the *Licensed Practical Nurses' Act (2005).* It is a personal risk to practice without a valid license as you do not have any liability insurance coverage from CLPNNL when you do not hold a current license.

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.

National Nursing Week 2015

National Nursing Week 2015 was celebrated May 11th to 17th with the theme

Nurses: With You Every Step of the Way.

The 2015 Provincial Nursing Forum

"Enhancing Communication: RNs and LPNs, Let's Talk"

The Provincial Nursing Forum was co-hosted by the Department of Health and Community Service, CLPNNL and the Association of Registered Nurses of Newfoundland and Labrador (ARNNL). This education event, titled "*Enhancing Communication: RNs and LPNs, Let's Talk*," was held at the Sheraton Hotel, St. John's on June 15th and 16th, 2015. The Forum included a communications workshop with keynote speaker and facilitator Barb Langlois, as well as education sessions on leadership, scope of practice and self-regulation. In addition, both the CLPNNL and ARNNL held annual meetings and awards recognition events. Dawn Lanphear gave a very thought provoking presentation on Mindful Leadership. The Forum was well attended by more than 200 registered nurses and licensed practical nurses, bachelor of nursing and practical nursing students. Paul Fisher, Executive Director CLPNNL said that this education is very fitting in today's health care environment where effective collaborative relationships among nurses promote the best outcome for clients. A culture of collegiality between RNs & LPNs is essential for a work environment to provide high-quality client care. In this province, we are fortunate to have a strong positive working relationship between the regulatory organizations for LPNs & RNs. All nurses need to ensure that this strong positive collaborative working relationship is evident in their day-to-day work environments which contribute to good outcomes for clients.

Paul Fisher, Executive Director/Registrar CLPNNL, Regina Coady, President ARNNL and Hon. Steve Kent, Minister of Health and Community Services.

Dawn Lanphear, BN, Med., RN, Guidance Counsellor, Centre for Nursing Studies.

The CLPNNL would like to say thank you to the presenters from the Practical Nursing Program, Centre for Nursing Studies. We enjoyed the following two very informative presentations:

- Caring and Aging with Pride (Students 1-4)
- Social Isolation and Loneliness (Students 5-9)

CNS PN student presenters. Right to Left: 1. Laura Sullivan, 2. Emily Gardner 3. Rachel Bourgue, 4. Lhey Power, 5. Scott Bowering, 6. Kristal Pike, 7. Sandi Ford, 8. Shauna Taylor, 9. Roberta Congdon.

Practical Nursing Students in attendance.

Annual General Meeting (AGM) and Awards Recognition 2014/15

More than 90 licensed practical nurses and practical nursing students attended the 2014/15 AGM and Awards Recognition. The highlights of the CLPNNL progress towards achieving its mission were presented by Jane Pardy, Chairperson, CLPNNL.

Ms. Pardy highlighted that 2014/15 marked a significant milestone in the history of the profession with the implementation of National Standards of Practice and Code of Ethics.

In addition, on January 20th, 2015, the CLPNNL held the grand opening of the new office building located at 209 Blackmarsh Road, St. John's. This new building will allow the CLPNNL to maintain and enhance services of the organization.

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.

This Annual Report highlights activities in meeting the goals and objectives of the Strategic Plan.

The full report is provided in the 2014/15 CLPNNL Annual Report. http://www.clpnnl.ca/attachments/annualreport20142015.pdf to read and/or download a copy.

Jane Pardy, Chairperson, CLPNNL Board, presenting annual report.

Jane Pardy, Chairperson, CLPNNL Board, Hon. Steve Kent, Minister of Health and Community Services, and Paul Fisher, Executive Director/ Registrar CLPNNL.

From Hospital to Home: Supporting Implementation of Infant Safe-Sleep Guidelines

by Michelle Earle-Crane MN RN, Michele Power MN RN, and Kathleen Stevens PhD(c) RN, faculty members, Centre for Nursing Studies

The purpose of the *Joint Statement on Safe Sleep: Preventing Sudden Infant Deaths in Canada* (2011) is to provide healthcare professionals with evidence-based guidelines for preventing sudden infant death syndrome (SIDS) and unsafe sleep practices. For example, research showed that one third of all SIDS cases could have been be prevented if pregnant women did not smoke. Also, since the start of the 1999 *Back to Sleep Campaign* the number of parents who place infants on their backs has greatly increased and the rate of SIDS has decreased more than 50%. These guidelines were developed in collaboration with experts in this area; Canadian Pediatric Society, Canadian Foundation of Child Health, Health Canada, and Public Health Agency of Canada (PHAC). These guidelines are used to educate parents and caregivers regarding how to provide a safe sleep environment for infants and decrease the risk of SIDS. PHAC (2014) provides online resources such as a brochure and video that outline the steps parents can take to provide a safe sleep environment for their infant such as: avoid exposure to smoke pre and postnatally, breastfeed, place infant supine for sleep at all times, provide a safe sleep environment that has a firm, flat surface without quilts, pillows, comforters, or bumper pads, and place the infant to sleep in a crib, cradle, or bassinet next to an adult's bed.

Safe sleep guidelines should be implemented before the infant is discharged from hospital. However, sometimes newborns need to be supported to make the transition to extrauterine life. For example, swaddling is sometimes necessary to maintain body temperature and/or positioning aids may be necessary to assure optimal positioning. After this initial period of adjustment, it is important to implement safe sleep guidelines. Inconsistent implementation of safe sleep guidelines during hospitalization has been associated with increased caregiver anxiety and decreased knowledge and confidence regarding safe sleep practices at home (Grazel, Phalen, & Polomono, 2010). Therefore, within Eastern Health a *Safe Sleeping Practices for Newborn Infants* policy was developed (Toope, 2013). The intent of this policy is to demonstrate consistent implementation of safe sleep guidelines in the hospital setting. Through teaching and modeling by nurses to parents, the goal is to promote these practices in the home environment.

To determine the impact of this policy, a descriptive-comparative study was undertaken in the Neonatal Intensive Care Unit (NICU), Janeway Children's Health and Rehabilitation Centre. The study examined changes in parental knowledge, anxiety, confidence, and utilization regarding safe sleep practices after policy implementation. Ethical approval was obtained and 62 mothers and 2 fathers completed the pre-policy questionnaire and 66 mothers completed the post-policy questionnaire. After policy implementation, parents reported the following in relation to safe sleep practices: increased knowledge; increased understanding of discharge instructions; increased confidence and decreased anxiety at time of discharge and arriving home; increased consistency between what was taught and what was seen in NICU; and increased utilization at home.

These research findings have implications for nursing education, practice and research. Content in nursing curriculum should reinforce the importance of consistency between discharge teaching and nursing behaviors in all practice settings. As well, a policy for safe sleep progression is important in any practice setting where nurses provide care to newborns and their families. Furthermore, consistency between discharge teaching and modeling of safe sleep practices impacts parental behavior at home. Research in other clinical settings will further determine the impact of such a policy and promote understanding of parental choices regarding safe sleep practices.

References:

Government of Canada, Canadian Pediatric Society, Canadian Institute of Child Health, The Canadian Foundation for the Study of Infant Deaths. (2011). *Joint statement on safe sleep: Preventing sudden infant deaths in Canada*. Retrieved from http://www.phac-aspc.gc.ca/hp-ps/dca-dea/stages-etapes/childhood-enfance_0-2/sids/pdf/jsss-ecss2011-eng.pdf

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Public Health Agency of Canada. (2014). *Safe sleep for your baby*. Retrieved from http://www.publichealth.gc.ca/safesleep

Toope, D. (2012). *Safe sleeping practices for newborn infants* (270CWH-NB-30). Eastern Health: St. John's.

PRACTICE POINTERS

A LPN from my unit has to float to another area today and it is my turn. I am unfamiliar with the unit. Even though I know that in order to address client care needs, LPNs are sometimes required to float to other areas, I have some questions and concerns.

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

A Every LPN must work within their scope of practice, i.e. what he/she is educated, competent and authorized to do. If a client you are assigned requires care that is not within your scope of practice but is within the scope of another available care provider, then you are not the one to carry out that care. You have a responsibility to verbalize any limitations when discussing your client assignment, to seek guidance, ask questions and seek realignment of the assignment when appropriate.

Q **What if I am not comfortable in the new and unfamiliar area?**

A You must remember that the key to quality client care is your competence, not your comfort. When you came into work you were competent to care for the clients in your usual work area. Moving to a new area does not necessarily mean you are not competent. You may not be highly proficient or fast but you still have the ability to carry out the nursing process. The key is in being able to identify which competencies are required to carry out client care and evaluate whether you currently have those competencies. If not, seek guidance.

Whether floating or not it is paramount that our actions and decisions are always in the best interest of the client which includes ensuring that the most appropriate care provider is assigned to meet the client's needs.

References:

The ACCESS. ARNNL. (May, 2015)

Did you know …

Acetaminophen is a drug ingredient found in nearly 500 different over-the-counter and prescription medicines, including common pain relievers and cold and flu medications. Although considered safe when used as directed, taking more than the maximum recommended dose (4,000 milligrams per day for adults) can cause liver damage, and in severe cases acute liver failure which can be fatal.

What you can do:

- Always read the product label and follow the instructions. Ask your pharmacist or doctor if you have questions.
- Know if the product contains acetaminophen, the amount to take, how frequently to take it, and when to stop. Avoid taking more than one acetaminophen product at a time.
- Talk to a health professional before taking acetaminophen if you have risk factors that increase your risk of liver damage, such as liver disease or drinking alcohol regularly.
- For a listing of acetaminophen products, search for the active ingredient "acetaminophen" in Health Canada's Drug Product Database (http://webprod5.hc-sc.gc.ca/dpd-bdpp/index-eng.jsp).
- Know who to call if you suspect you have taken too much acetaminophen. Check with your provincial poison control centre (http://www.capcc.ca/) if you have concerns.
- Report adverse reactions to a health product to Health Canada. Call toll-free at 1-866-234-2345, or visit MedEffect Canada (http://www.hc-sc.gc.ca/dhp-mps/medeff/report-declaration/index-eng.php) for information on how to report online by mail or by fax.
- Stay connected with Health Canada and receive the latest advisories and product recalls using social media tools (http://www.hc-sc.gc.ca/home-accueil/sm-ms/index-eng.php).
- Find out more at Canada.ca (http://www.healthycanadians.gc.ca/drugs-products-medicaments-produits/drugs-medicaments/acetaminophen-eng.php).

Legal Issues in Nursing: Communication

By Chris Rokosh, RN, Legal Nurse Consultant

When medical errors cause lasting injury, the patient can sue both the doctor and the nurse. This can result in a medical malpractice lawsuit. Nurses who have been through this experience describe it as extremely difficult -- as difficult as other catastrophic life events such as death, divorce and job loss. The experience of being sued affected their work life, personal life, health and well-being. Emotions such as shock, shame, anger, depression and fear were common. Many nurses felt so isolated by their peers that they left their jobs. You don't want this to happen to you.

The outcomes of malpractice lawsuits affect patients, healthcare professionals, public funding and the institutions that provide healthcare. But a workplace culture of denial and shame can keep us from talking about the errors that lead to lawsuits, or using them to learn and improve. So let's start a conversation about the most common nursing issues that result in malpractice lawsuits, with a goal of gaining knowledge, avoiding errors and improving patient safety. Because really, isn't that why we're all here?

This article will focus on the source of more medical malpractice lawsuits than any other: communication. Communication issues are so common that research shows that as many as 70% of medical errors involve some form of communication breakdown between the doctor and the nurse. The courts view communication as a critical part of any nurses' job. The nurse is seen as 'the eyes and ears' of the often-absent doctor and it is accepted that doctors rightly depend heavily on nurses to keep them fully informed of the patients' condition. The nursing and medical experts who review malpractice cases say that nurses are required to relay important information to the doctor according to hospital policy and the standards of care, and then to document that they have done so. Professional associations direct nurses to communicate appropriate information to appropriate members of the healthcare team through designated channels.

Throughout my career as a Legal Nurse Consultant, I have reviewed more than 1000 medical malpractice lawsuits, many of which focused, in part, on what the nurse did or didn't tell the doctor. The most common scenario involves a change in a patients' condition, and either no communication with the doctor or a phone call followed by documentation that simply states 'doctor aware'. The nursing notes do not say what doctor is aware, what they

were told or what their response was. If the patient later develops an injury and launches a lawsuit, the doctor will often say 'Yes, the nurse phoned me. But she didn't tell me how serious the situation was. If she had, I would have attended to the patient immediately.' Without supportive documentation in the medical record this can result in a showdown of the nurses' word against the doctors'. It will be up to the judge to decide who said what and whether or not the nurse met the standard of care. Let's learn more about this from a medical malpractice case involving a lack of communication between a doctor and a nurse.

One summer evening at 7:38 p.m., 17-year-old Will Johnston was struck by a car as he crossed the street on his skateboard. The force of the impact fractured his right tibia, threw him onto the hood of the car and smashed the windshield. He was taken to the E.R. by ambulance where it was noted that his right leg had an obvious deformity and his right calf was very swollen. The toes on his right foot were cyanosed. His foot had normal sensation but limited movement and decreased pulses. Will was in a lot of pain and had multiple doses of IV morphine.

At 10:45 p.m., Will was transferred to the O.R. for Intramedullary Nailing of the right tibia. Following surgery, the incision was covered with Sofratulle and gauze, and his leg was stabilized with a back 'slab cast' and wrapped with a tensor bandage. Will was transferred to the recovery room 'in good condition'.

Shortly before 1:00 a.m., he was transferred to the nursing unit where he was cared for by LPN Donna.

At 1:45 a.m., Nurse Donna documented that Will was awake, swearing and complaining of 'excessive pain'. His right toes were described as 'pink and warm' with normal movement. Nurse Donna noted that Will only had 'fair relief' from the multiple doses of IV morphine he had been given post-operatively.

At 2:00 a.m., Nurse Donna documented that that Will was awake and oriented. The colour, sensation and movement to his right foot were described as 'good' with a capillary refill time of less than 3 seconds. Will was noted to have 'severe weakness' and tingling in his right leg. Overnight, Nurse Donna documented information regarding Will's medications, intake and output, but there was no further assessment of the colour, warmth, sensation and movement of Will's foot for the remainder of her shift.

At 8:00 a.m., day shift LPN Lucinda started her shift. She described Will as confused. He was not able to correctly identify the month or where he was. He only opened his eyes when he was spoken to. His right leg was again noted to have 'severe weakness' and he refused assistance with bathing, stating 'Leave me alone!'. Serosanguinous drainage was noted on pillow underneath Will's leg. Nurse Lucinda did not document colour, warmth, sensation or movement.

At 9:20 a.m., Will was noted to be 'yelling and complaining of pain'. Nurse Lucinda documented that she reassured Will's parents that the amount of pain and drainage were 'normal for the surgery'.

At 12:00 noon, Nurse Lucinda documented, 'Right leg remains in slab cast, small amount of sanguinous drainage on upper side. Foot cool, toes swollen and dark, patient states is not able to wiggle toes because it hurts. Has tingling sensation. Will monitor.'

At 1:00 p.m., physiotherapist Steve arrived to teach Will how to walk with crutches. He described Will as 'anxious ++, yelling out when moved'. He refused to get out of bed.

At 1:25 p.m., orthopedic resident Dr. Smithson arrived on the unit. He noticed that Will had decreased sensation in his right foot and was unable to point or flex his toes. Dr. Smithson removed the cast, measured the pressures in the calf muscles, and diagnosed post-traumatic compartment syndrome. Will was taken back to the OR for fasciotomies to relieve the pressure. Following surgery, he developed multiple complications. The leg became infected and necrotic in spite of surgical intervention and arterial grafting. Fourteen days later, it was amputated below the knee.

Will remained in hospital for several weeks. Eighteen months after his discharge, his family filed a multimillion-dollar lawsuit against the doctor and the hospital, claiming, among other things, that nurse Donna and nurse Lucinda failed to communicate important information to the doctor or the charge nurse. They claimed that the standard of

care *required* them to tell someone about Will's pain, weakness, sensory loss and colour change. They also indicated that if the doctor had been called earlier, Will would not have lost his leg.

Do you think the nurses met the standard of care?

Compartment syndrome is a potentially life-threatening condition caused by high pressure in a closed fascial space. The most common site of compartment syndrome is the lower leg (Abramowitz and Schepsis 1994) and young men with traumatic soft tissue injury are known to be at particular risk (McQueen et al 2000). It is a potentially devastating complication of tibial fractures and requires prompt recognition and intervention, as early intervention is critical to avoid permanent damage to the muscles and the nerves.

Symptoms of compartment syndrome may include pain that is disproportionate to the injury, pallor of the affected limb, altered sensation (numbness, tingling), tension of the affected muscles, pulselessness below the level of the swelling and, as a late sign, paralysis. Postoperative narcotic administration may mask the pain which is often the first symptom of compartment syndrome, therefore it requires careful monitoring for the other symptoms

The nursing plan of care for a patient with a traumatic fracture of the tibia must include, among other things, knowledge and awareness of the possible development of compartment syndrome along with careful and frequent monitoring of the affected limb for colour, warmth, sensation, movement and pulse strength. Monitoring may be required as frequently as every hour, but certainly every 4 hours in the early postoperative period. Monitoring guidelines are often established by hospital policy or care plans or may be provided by doctors' orders.

Signs and symptoms of compartment syndrome must be reported immediately to the charge nurse and/or responsible physician. The nursing standard of care would be to notify the physician immediately, requesting a 'hands on' assessment of the patient. The nurse must provide an accurate clinical picture of patient status and raise the level of concern. If the physician does not respond promptly to the nursing request for assessment, the nurse must act in the best interest of the patient and persist in finding appropriate medical attention. This may require repeated pages/ phone calls to the physician, refusing to take doctors' orders over the phone, notifying the nursing supervisor or accessing the appropriate 'Chain of Command'.

The lawyer representing Will in this malpractice lawsuit asked other nurses to review the medical record to determine whether or not nurse Donna and nurse Lucinda had met the standard of care. Their opinion was that Donna and Lucinda had not met the standards in two important areas: by not assessing Will's leg as thoroughly and frequently as required by hospital policy, and by not reporting his pain, weakness, colour change and sensory loss to the charge nurse or the doctor. Their opinion was that nurse Donna should have reported these changes no later than 2:00 a.m. when she documented that Will had severe weakness and tingling in his right leg. Since this did not happen, their opinion was that nurse Lucinda should have performed a full assessment of the leg at 8:00 a.m. and asked the doctor to see Will right away.

The reviewing nurses said that these failures represented a lack of nursing knowledge and critical thinking as well as a failure to meet the standard of care. They also said that the lack of communication contributed to a delay in treating Will's compartment syndrome which ultimately led to the loss of his leg. Based on this information, the case settled out of court for an undisclosed amount of money. The doctor in this case was also sued, but 'let out' of the lawsuit when it was discovered that he did not know that anything was wrong with Will's leg because the nurses had not communicated with him. By the time the resident examined Will on rounds, the compartment syndrome had already caused irreversible damage.

Use this case study to spark a conversation on communication with your colleagues. How would you rate the level of communication in your workplace? Have you ever witnessed, or been part of a situation, where communication caused a problem? Did the patient suffer as a result? What are the designated channels of communication in your workplace? Do they work? If not, what actions have you taken to fix or improve the situation? What will you do better now that you know what you know?

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 in the US.

Blood Glucose Monitoring — What Does the Evidence Say?

One of the largest expenditures in diabetes management is blood glucose test strips — it is estimated that total spending in Newfoundland and Labrador exceeds $6 million every year. But is this investment providing a similar magnitude of benefits for patients?

A 2009 CADTH systematic review on self-monitoring of blood glucose (SMBG) revealed the following:

- For people with type 1 or type 2 diabetes using basal bolus insulin regimens, SMBG should be individualized to guide adjustments in insulin therapy.
- In adults with type 2 diabetes using basal insulin, SMBG should be individualized, but testing of up to 14 times per week should suffice in most cases.
- Most adults with type 2 diabetes using oral antidiabetes drugs (without insulin) do not require routine SMBG. Periodic testing may be needed for select patients, such as those with unstable glucose levels, acute illness, changes to drug therapy, risk of hypoglycemia, pregnancy, and jobs where hypoglycemia poses danger. Periodic testing in these select patients should be linked to specific actions (e.g., prevention or management of hypoglycemia, self-directed dosage adjustment).

Most adults with type 2 diabetes controlled by diet alone should not require routine SMBG. These patients will benefit more from focusing on other aspects of diabetes self-management, and testing less frequently will free up limited health care dollars without negatively affecting patient health.

Since the publication of CADTH's 2009 review, additional questions have been posed pertaining to the care of older people living with type 2 diabetes in long-term care settings. According to a 2013 CADTH review of guidelines for the management of diabetes in long-term care, existing guidelines recommend that: 1) laboratory tests be performed when diabetes is suspected; 2) glucose levels be tested every three to six months; and 3) the frequency of blood glucose testing be individualized. The review noted that these guidelines pertain to all residents of long-term care facilities, not specifically to frail elderly residents.

In June 2015, CADTH published a summary with critical appraisal of the evidence on diabetic diets for frail elderly long-term care residents with type 2 diabetes. According to this report, the available recommendations suggest that regular diets, instead of "diabetic diets," may be used for elderly nursing home residents with type 2 diabetes. One guideline recommends that, for frail diabetic older people, diets rich in protein and energy may be used to prevent malnutrition. It should be noted, though, that these recommendations are based on low-quality evidence.

In Newfoundland and Labrador, CADTH collaborated with Western Health (http://www.westernhealth.nl.ca/) and Central Health (http://www.centralhealth.nl.ca/) to facilitate changes in the policy and practice of blood glucose monitoring of residents with type 2 diabetes in long term care. This collaboration resulted in a series of evidence reviews and customized tools for health professionals and other care providers. The first tool was a handout containing a summary of the evidence; a description of the potential impact of reducing testing on residents, their families, and the health system; and a "road map" for changing practice in health care facilities. In addition, a pamphlet providing plain language guidance on the topic to families and caregivers was produced. The most recent tool is a guidance card for licensed practical nurses and other health professionals in long-term care on recognizing the signs and symptoms of hypoglycemia and how to treat residents when hypoglycemia is suspected.

CADTH has produced a variety of tools to facilitate the incorporation of their evidence-based recommendations on blood glucose monitoring into health care practice. These tools are available for free on CADTH's website at https://www.cadth.ca/resources/evidence-bundles/evidence-diabetes-management. For additional information, and to find out more about the customized tools previously mentioned, contact Sheila Tucker, CADTH's Liaison Officer for Newfoundland and Labrador, at SheilaT@cadth.ca.

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.

Government of Newfoundland and Labrador
Department of Health and Community Services

August 31, 2015

Re: Lyme Disease in Newfoundland and Labrador

Dear Health Professional,

We are writing to update you on Lyme disease in Newfoundland and Labrador and to bring your attention to communication activities we have planned. As Lyme disease is an emerging disease in Canada, with endemic areas in British Columbia, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia, we feel it important that you have up-to-date information on Lyme disease and the implications for residents of Newfoundland and Labrador.

Lyme disease is a notifiable disease under the Newfoundland and Labrador *Communicable Disease Act* and all cases diagnosed clinically or with laboratory confirmation must be reported to the Chief Medical Officer of Health. For more information about notifiable diseases, visit the website: http://www.health.gov.nl.ca/health/publichealth/cdc/cdc.html#basic

To better understand the distribution of blacklegged ticks (the vector for Lyme disease) across the province, the Animal Health Division of the Forestry and Agrifoods Agency, in partnership with the Public Health Agency of Canada (PHAC), and Memorial University, conducts ongoing passive and active surveillance. There are currently no areas of Newfoundland and Labrador that are endemic for Lyme disease. It is thought that there are also no established populations of blacklegged ticks in the province but that rather, those ticks that are found are transient and likely arrive to the province on migratory birds. Surveillance activities have shown that of the low numbers of ticks discovered, approximately 20% are infected with *Borrelia burgdorferi*, the species of bacterium that causes Lyme disease. As such, the risk of exposure to Lyme disease in Newfoundland and Labrador remains low. For more information about provincial surveillance activities, visit http://www.faa.gov.nl.ca/agrifoods/animals/health/lymedisease.html

As the risk to the majority of Newfoundland and Labrador residents remains low, the Department of Health and Community Services is targeting awareness and education information to those groups who are at an increased risk of exposure to ticks and Lyme disease due to spending time outdoors. These include:

- Tourists
    - Marine Atlantic
- Recreation groups and organizations that may reach :
    - Campers;
    - Hunters/fishers;
    - Birders;
    - Golfers;
    - Hikers;
    - Bikers; and
    - Outfitters;
- Outdoor occupations (e.g. forestry technicians, landscapers, land surveyors, wildlife officers, etc.):

P.O. Box 8700, St. John's, NL, Canada A1B 4J6 t 709.729-3433 f 709-729-4647

- Occupational health and safety advisors;
- Parks administration;
- Recreation programming leaders; and
- Property maintenance workers.

The Department of Health and Community Services is disseminating important Lyme disease awareness and education information via email and website to the above identified community groups. The information will include risk areas of Lyme disease in Canada, messaging on tick bite prevention, and information to help people recognize the signs and symptoms of Lyme disease. The key messages included in the correspondence will be:

- While there are currently no areas in Newfoundland and Labrador identified as high risk for exposure to Lyme disease, it is still possible to be exposed.
  - The risk of contracting Lyme disease increases in rural, forested, woodland environments compared to urban areas.
  - The risk of contracting Lyme disease increases when travelling in parts of Canada, the United States, and internationally, where Lyme disease is endemic.

- When you are in high risk areas or are engaging in outdoor activities, prevent tick bites by:
  - Wearing appropriate clothing such as closed-toe shoes, long pants, and long sleeves. Tuck your pants into your socks so ticks can't crawl up your legs. Wearing light coloured clothing make ticks easier to spot.
  - Applying an insect repellent containing DEET or Icaridin to exposed skin and to clothes. Always follow the label directions when applying repellent.

Prevent potential transmission of Lyme disease from tick bites by:

- Completing a thorough tick check on you, your children, and your pets when returning from outdoor activity, especially in high risk areas for Lyme disease. Immature ticks can be very small, so be sure to check carefully.
- Removing any ticks you find attached to you, your child, or your pet promptly. Ticks must be attached for at least 24 hours to transmit the bacteria. Information about proper technique for removing ticks can be found at
  http://www.faa.gov.nl.ca/agrifoods/animals/health/lymedisease.html

If you develop signs and symptoms of Lyme disease, especially if you've been visiting a province with known Lyme disease areas, see your family doctor. Information on the signs and symptoms of Lyme disease can be found at
http://www.health.gov.nl.ca/health/publichealth/cdc/lyme_disease.pdf

For your information, please see the attached resources. If you have any additional questions regarding Lyme disease, please contact your local Regional Health Authority or call the Healthline at 811.

Sincerely,

David J. Allison MD, FRCPC
Chief Medical Officer of Health
Department of Health and Community Services
Government of Newfoundland and Labrador

Newfoundland Labrador

Protection from Lyme Disease

Lyme disease is an emerging disease in Canada that is caused by the bite of an infected blacklegged tick. These small ticks are found in Canada, including on the island portion of Newfoundland and Labrador, as well as in the United States and internationally. The preferred habitat for these ticks is tall grass, brush, and forested areas.

Currently there are no areas in Newfoundland and Labrador that are believed to have permanent populations of blacklegged ticks. However, blacklegged ticks, including some infected with Lyme disease, are found each year around the province. These ticks likely arrive on migratory birds. While the risk of Lyme disease in Newfoundland and Labrador is considered low, residents are encouraged to take preventive measures to protect themselves from tick bites.

Those who are most at risk for exposure to ticks and Lyme disease include:

- Travelers to known Lyme disease risk areas
- Outdoor enthusiasts (e.g. campers, hikers, hunters, fishers)
- Persons with outdoor occupations
- Families living or playing in areas with suitable habitat for blacklegged ticks
- Pets

To protect yourself from tick and insect bites:

- Use an insect repellent such as DEET or Icaridin (always read product label directions before applying)
- Cover as much of your skin as possible, tuck pants legs into boots or socks
- Wear light-colored clothing to be able to spot ticks on your clothes more easily
- Walk on well-travelled trails wherever possible to avoid grass, brush, or shrubs
- Check yourself, your family and pets after being in an area where ticks may be present

Websites for more information:

How to remove a tick: http://www.faa.gov.nl.ca/agrifoods/animals/health/ticks/removeticks.html

Lyme disease in humans: http://www.health.gov.nl.ca/health/publichealth/cdc/infectioncontrol/lyme_disease.pdf

Ticks and Lyme disease in NL, please visit:

Ticks and Lyme disease in NL: http://www.faa.gov.nl.ca/agrifoods/animals/health/lymedisease.html

Websites for healthcare professionals:

Please see the Provincial Disease Control Manual for more information about Lyme disease:

http://www.health.gov.nl.ca/health/publications/diseasecontrol/s6_vectorborne_and_other_zoonotic_diseases.pdf

Public Health Laboratory website http://publichealthlab.ca/service/lyme-disease-borrelia-burgdorferi/

August 2015 CDC-23