PRACTICE

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

NURSES: WITH YOU EVERY STEP OF THE WAY

National Nursing Week
May 9 - 15, 2016

Volume 1, Issue 2 – May 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.

209 Blackmarsh Road, St. John's, NL A1E 1T1
Telephone: (709) 579-3843 or
Toll Free: 1-888-579-2576
Fax: (709) 579-8268
E-Mail: info@clpnnl.ca
Website: www.clpnnl.ca

COLLEGE BOARD MEMBERS

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

*Appointed by Government

OFFICE STAFF

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

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

Professional Practice Consultant
Wanda Lee Squires LPN

Administrative Officer
Debbie Pantin, BA

Administrative Assistant
Glenda Hayward

PRACTICE, presented by CLPNNL

Design & Layout: Kimberly Puddester

CONTENTS

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.

The College of Licensed Practical Nurses of Newfoundland and Labrador Welcomes New Board Member

Dacia Wallace – ZONE 1

Congratulations!

CONGRATULATIONS
to the Graduates who passed the CPNRE!

WAY TO GO!!!

99% of graduates passed the Canadian Practical Nurses Registration Exam.

SAVE the DATE

NOTICE OF THE ANNUAL GENERAL MEETING OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF NEWFOUNDLAND AND LABRADOR

The Annual General Business Meeting will be held on
June 17th, 2016 (Friday) from 12 pm – 1 pm at

209 Blackmarsh Road
St. John's, NL A1E 1T1

Agenda for the Annual General Business Meeting
Presentation of the Annual Report
Approval of the Financial Statements & Auditor's Report for 20015/16
Appointment of the Auditor for 2016/17
Presentation of Awards

If you plan to attend the Annual General Meeting please RSVP to the College's Office (Glenda Hayward) at 709-579-3843 ext. 200 or ghayward@clpnnl.ca prior to June 10th, 2016.

Happy National Nursing Week
to ALL Nurses Out There!

Whether you are a Licensed Practical Nurse, a Registered Nurse or a Nurse Practitioner, we all have a **VERY** important role to play in the lives of the people we care for.

This year's theme is, *"Nurses, with you every step of the way."* There is great truth in this statement. You may encounter a patient at their first visit to the Emergency Room on what turns out to be a long journey with cancer. You may be that nurse providing care and updates to a person's loved one who lives in Long term care when that person is out of province. You may be the nurse caring for a child in hospital who has developed type one diabetes or the nurse caring for that child during follow up appointments with the physician or eye clinic. You will ALWAYS find a nurse to help the individual, their family, or their loved one in need, *"every step of the way."*

Nursing Week is a time to reflect on all the great care that nurses provide to the public. Nursing is an important profession and we are rewarded with the knowledge that we can help change the lives of individuals while meeting their needs. Nurses show their caring, gentle, compassionate ways and touch the hearts of many. Mother Theresa once said, "It's not how much you do but how much love you put in the doing." This is true in the nursing profession today as we do not always have a lot of time to spend with our clients, due to increased workload, decreased staffing and other issues that occur within the workplace, but when it is the client's time for care, the nurse's focus is on that particular client.

Art Williams said, "I'm not telling you it's going to be easy, I'm telling you it's going to be worth it." No matter what type of shift you have had, knowing that you have made a positive difference in a person's life is very rewarding. Knowing that we touch the lives of so many people, whether that be clients, families, or communities, Licensed Practical Nurses should provide care with passion and enthusiasm and not look at the care as being "just a job."

Licensed Practical Nurses use the Standards of Practice and Code of Ethics, together with professional standards and competencies, workplace policies, and legal requirements, to guide our practice and behavior.

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

THE COLLEGE OF LICENSED PRACTICAL NURSES OF NEWFOUNDLAND AND LABRADOR WOULD LIKE TO WISH YOU A HAPPY NURSING WEEK 2016 AND MUCH SUCCESS IN YOUR NURSING CAREER.

Association of **Registered Nurses** of Newfoundland and Labrador

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

FOR IMMEDIATE RELEASE

Nursing professionals recognize National Nursing Week from May 9-15

St. John's, NL – May 9, 2016 – The Association of Registered Nurses of Newfoundland and Labrador (ARNNL) and the College of Licensed Practical Nurses of Newfoundland and Labrador (CLPNNL) join their counterparts across Canada from May 9-15 in recognizing National Nursing Week (NNW) and its theme, *"Nurses: With you every step of the way."*

Regina Coady, ARNNL President, said that NNW provides an opportunity to recognize the valuable contributions that registered nurses (RNs) and nurse practitioners (NPs) make throughout the province.

"Registered nurses and nurse practitioners are critical thinkers who endeavour to find solutions that improve access to health services and advocate for the health and well-being of individuals, families and communities," said Coady. Coady said it is imperative that RNs and NPs educate government, employers, other health care professionals and the public about the value they bring to the health care system through the delivery of highly-skilled, safe, ethical and quality nursing care.

Paul Fisher, CLPNNL Executive Director/Registrar, said that NNW also presents an opportunity to acknowledge the valuable contribution that the province's licensed practical nurses (LPNs) are making to the health of our population.

"LPNs have a fundamental role in health service delivery and improving access to high quality care across Newfoundland and Labrador. As key members of the health care team, we applaud LPNs for the countless ways they positively impact the lives of people in their care. Every day, LPNs demonstrate commitment to providing safe, effective, compassionate and ethical care to members of the public," said Fisher.

Across the province, nurses are at the forefront of effecting change in the delivery of quality health care. Throughout the week, nurses and employers will recognize and showcase RNs, NPs and LPNs. CLPNNL and ARNNL also encourage the public to become involved by acknowledging nurses for the positive impact they make to health care.

ABOUT NATIONAL NURSING WEEK

In 1971, the International Council of Nurses designated May 12 – Florence Nightingale's birthday – as International Nurses Day. In 1985, in recognition of the dedication and achievements of the nursing profession, the Canadian minister of health proclaimed the second week of May as National Nurses Week.

The name changed to National Nursing Week in 1993 to emphasize the profession's accomplishments as a discipline. The purpose of National Nursing Week is to increase awareness among the public, policy-makers and governments of the many contributions nurses make to the well-being of Canadians.

ABOUT ARNNL

ARNNL is the regulatory body and professional organization representing all registered nurses and nurse practitioners in the province. In pursuit of its mission, 'Nursing Excellence for the Health of the Population,' ARNNL exists so there will be accountability for self-regulation, professionalism, quality professional practice environments, and healthy public policy.

ABOUT CLPNNL

CLPNNL is the regulatory authority for the 2,300 licensed practical nurses in the province. CLPNNL's mission is protection of the public through the provision of efficient, ethical nursing care, regulation of licensed practical nursing practice, and licensure of practical nurses.

- 30 -

Media contacts:

Lynn Power, Executive Director, ARNNL
709.753.6183
lpower@arnnl.ca

Paul Fisher, Executive Director/Registrar, CLPNNL
709.579.3843
pfisher@clpnnl.ca

Designated Uniform Color for LPNs

And the winner is ...

Red Top and Black Pants

In November, 2015, following requests from many LPNs across Newfoundland and Labrador, the CLPNNL began the process to determine if LPNs were supportive of a designated uniform color and, if so, what the color/s should be.

Following a number of surveys and consultations with LPNs and various stakeholders, it was determined that LPNs in Newfoundland and Labrador were indeed supportive of having a designated uniform color. The majority of LPNs who responded to the survey felt that a designated uniform color would clearly distinguish LPNs from other workers and would promote professionalism in the profession.

Once support for a designated uniform color was determined, the CLPNNL continued the process to determine what those colors would be. The CLPNNL distributed 4 additional surveys. The response to all surveys was quite high and LPNs provided many, many comments, both within the surveys and via email directly to CLPNNL staff.

There are many and varying opinions on the uniform colors that should be selected to represent LPNs in the province. Some LPNs are very supportive of the colors chosen, while others are less supportive. It is important to note that wearing the designated uniform colors **is not mandatory**, and is the decision of each individual LPN.

The CLPNNL would like to thank all those LPNs who participated in this process. Your input and comments are much appreciated.

Reflections on Clinical

Written by Susan Langin, Practical Nursing Student, Centre for Nursing Studies, Class 2016

We had weeks of preparation - learning how to communicate with you; how to properly give you a bath without hurting you; how to be sure your vital signs were done properly, the cuff placed just right so I could hear, learning where to find your pulse; learning how to give you medication, how to be sure it is you and what you need at the right time; reading about you, understanding your different needs, likes and dislikes, and learning to talk with you and not at you. I learned that we needed to be mindful of the different needs people older than me might have, remembering to be professional yet empathetic. We had the best role models, teachers and instructors. We were ready!

And then I walked into your home. Nothing could prepare me for what I felt as I met you. The pictures on your walls let me know a little more about you. I was struck by the way you welcomed me, a stranger, into your world just a moment at a time. You are a mother, a father, a sister or brother. There are grandchildren and so many days gone by. As I cared for you and helped you with what you needed, I couldn't help but wonder what you were like at my age. I began to understand how this was about you - your needs, your dignity and your comfort. I asked if you were okay while I bathed you and asked what kind of cream you liked to use on your skin. You let me help you with your meal, whether it was to place a spoon in your hand, encourage you to swallow or just wipe your mouth when you couldn't quite reach it. I asked if you were too warm or not warm enough because I was genuinely concerned about one or the other. I checked on you while you slept to be sure you were okay. You were teaching me how to become a nurse.

I watched my classmates, some of whom I only knew by name, care for you, too. They taught me about teamwork and how important it is to check in with them as well. I learned from them when they didn't know I was watching. I saw such incredible compassion from each one of them and my heart filled with such respect. Sometimes hearing, "You are doing great," is what we need at that moment. I hope I was able to show them that I care about them, too. I met nurses and PCAs and support staff who helped and guided us with patience.

As I enter into my second week of learning with you I will remember my firsts. I will remember that very moment that you had an impact on me that left me without words. I can't help but wonder how you felt letting a stranger into your home and trusting that we would care for you the way you deserved.

Self-employment Document

The College of Licensed Practical Nurses of Newfoundland and Labrador is pleased in introduce our newest Practice Guideline titled "Self-Employment". The Practice Guideline, which was approved by the Board on April 15th, 2016, outlines the LPNs accountability and responsibilities when self-employed. This document also provides information on the considerations to follow when starting your own business. This document is available on CLPNNL's website www.clpnnl.ca. If you have questions, please contact Wanda Squires, Practice Consultant at wsquires@clpnnl.ca or phone 579-3843 ext. 206.

May is Celiac Awareness Month!

CANADIAN CELIAC ASSOCIATION MEDICAL FACTS

Celiac Disease - Hidden & Dangerous

What is Celiac Disease?

Celiac disease is a genetically-based autoimmune disorder in which specific peptides from wheat, rye and barley (collectively called gluten) trigger progressive destruction of the villi of the small intestine. Gluten consumption can result in deficiencies of iron, folate, calcium and the fat-soluble vitamins (A, D, E & K) and an increased risk of osteoporosis, infertility and specific cancers of the gut.

Dermatitis herpetiformis (DH) is an expression of celiac disease characterized by a blistering, intensely itchy skin rash. The rash is usually symmetrical and is found most frequently on the elbows, knees, buttocks and upper back. Patients with DH often present with mild or no gastrointestinal symptoms, but villous atrophy occurs in the majority of cases.

Pathogenesis

The pathogenesis of celiac disease involves three factors: genetic, environmental and immunologic. Greater than 97% of individuals with celiac disease have the HLA DQ2 and/or HLA DQ8 genetic markers. Gluten is the trigger for the immunologic response of celiac disease, and pregnancy, surgery, infection, including gastroenteritis, or severe emotional stress sometimes initiate acute symptoms in genetically predisposed individuals. Celiac disease is an inherited condition and therefore first-degree and to a lesser extent second-degree relatives are at higher risk of having unrecognized celiac disease.

Prevalence

Recent research reveals that celiac disease affects between 0.5 - 1% of the population of the USA, which is similar to the prevalence reported in Europe. World prevalence is estimated at 1 in 266 and celiac disease is now recognized as one of the most common inherited diseases.

Symptoms

The symptoms of celiac disease can occur at any age. The number and severity of symptoms associated with untreated celiac disease vary greatly from person to person. In many cases the disease is silent and is discovered only by blood screening. The presence of obesity or constipation does not exclude the diagnosis of celiac disease.

The following symptoms may occur singly or in combination:

- anemia-iron, folate, vitamin B_{12} deficiency
- deficiency of vitamins A, D, E, K
- abdominal pain, bloating/cramping/gas
- indigestion and nausea
- recurring/persistent diarrhea
- constipation
- extreme weakness and fatigue
- weight loss
- lactose intolerance
- dermatitis herpetiformis
- elevated transaminases (liver enzymes)
- recurrent aphthous ulcers (canker sores)
- easy bruising
- bone/joint pain
- edema of feet and hands
- menstrual irregularities
- infertility in both men and women
- recurrent miscarriages
- migraine
- depression
- peripheral neuropathy, ataxia, epilepsy with occipital calcifications
- delayed puberty
- dental enamel abnormalities

Additional symptoms in children:

- vomiting
- irritability and behavioural changes
- delayed growth/short stature

Associated Conditions

Celiac disease frequently occurs in combination with other conditions. If a person has a family history of celiac disease or has symptoms of celiac disease along with any of the following diseases, screening for celiac disease should be considered:

- type 1 diabetes mellitus
- osteoporosis
- other autoimmune diseases (e.g., • Down syndrome autoimmune hepatitis, autoimmune • Turner syndrome thyroid disease)
- lymphoma

Diagnosis

Recent Canadian and US studies report significant delays in diagnosis. The similarity of the symptoms with those of other diseases often leads to misdiagnoses such as irritable bowel syndrome, lactose intolerance, chronic fatigue syndrome and diverticulosis, which results in even further delays. Excellent new serological blood tests including the **IgA endomysial (EMA)** and **IgA tissue transglutaminase (TTG) antibody tests** are now available to screen for celiac disease in individuals with mild or atypical symptoms and those in high risk groups. False negative results can occur with these tests. IgA EMA and TTG will be falsely negative in individuals with IgA deficiency which occurs in 3-5% of patients with celiac disease. False positive results can occur but are rare. **An intestinal biopsy, while an individual is on a gluten-containing diet, is required to establish the diagnosis.**

A GLUTEN-FREE DIET SHOULD NOT BE STARTED BEFORE A BLOOD TEST AND BIOPSY HAVE BEEN COMPLETED, since it can interfere with making an accurate diagnosis.

Treatment

The **ONLY TREATMENT** for celiac disease, including those patients with DH, is a **STRICT GLUTEN-FREE DIET FOR LIFE**. Patients with DH may also require treatment with dapsone to alleviate the itching. A gluten-free diet enables the gut to recover and can reduce the risk of developing many of the complications of untreated celiac disease. Because of the complexity of the gluten-free diet, patients should be referred to a qualified dietitian with expertise in celiac disease, for nutrition assessment, education and follow-up. Regular follow-up with a physician is also recommended. All persons with celiac disease should be encouraged to join the Canadian Celiac Association (CCA) and their local CCA chapter for valuable practical information and ongoing support: http://www.celiac.ca.

The safety of oats in celiac disease has been extensively investigated. Clinical studies have shown that small amounts of **pure**, **uncontaminated oats** are safe for most adults and children. Most commercially available oats are contaminated with wheat, rye or barley, however pure, uncontaminated oats are now being produced in Canada. Individuals with celiac disease must ensure that the oats they are eating are free from gluten contamination. The CCA position statement on oats can be found on the CCA website at http://www.celiac.ca.

References and recommended reading:

Guideline for the Diagnosis and Treatment of Celiac Disease in Children: Recommendations of NASPGHAN http://www.naspghan.org/PDF/PositionPapers/celiac_guideline_2004_jpgn.pdf NIH Consensus Development Conference Statement on Celiac Disease June 28-30, 2004. http://consensus.nih.gov/2004/2004CeliacDisease118PDF.pdf Rashid, M., Cranney, A., Zarkadas, et al. Celiac disease: evaluation of the diagnosis and dietary compliance in Canadian children. Pediatrics 2005;116:e754-e759. http://pediatrics.aappublications.org/cgi/content/full/116/6/e754? Zarkadas M, Cranney A, Case S, et al. The impact of a gluten-free diet on adults with coeliac disease: results of a national survey. J Hum Nutr Dietet 2006;19:41-49. http://celiac.ca

CANADIAN CELIAC ASSOCIATION L'ASSOCIATION CANADIENNE DE LA MALADIE COELIAQUE

5025 Orbitor Drive, Building 1, Suite 400

Mississauga, Ontario, Canada L4W 4Y5

Web: www.celiac.ca Email: info@celiac.ca

Phone: 905-507-6208 Toll Free: 800-363-7296

PAB approved: 14 August 2006

Canadian Celiac Association

NATIONAL CONFERENCE

Waves of change ... oceans of possibility!

www.ccaconference.ca

June 24-26, 2016
Holiday Inn (Government Centre)
St. John's, NL

- **Leading-Edge Research**
- **How to Travel Gluten Free**
- **Celiac Comedian**
- **Vendors and Free Stuff!**

Register at

www.ccaconference.ca

What Happens to the Fee I Pay When I Renew my License?

Licensed Practical Nurses (LPNs) are self-regulating professionals. Self-regulation means that the government has granted a professional group, such as licensed practical nurses, the privilege and responsibility to regulate themselves. In essence, society contracts with the practical nursing profession to regulate its own members in order to protect the public from harm that could be caused by licensed practical nurses in the course of their practice. Self-regulation acknowledges that a profession itself is in the best position to regulate its members because their specialized body of knowledge makes external regulation difficult and impractical. LPNs understand licensed practical nursing better than anyone else so it simply makes good sense for the public to have professionals regulate themselves as long as they do so in the public interest. When there is a conflict between public interest and professional self-interest, regulatory bodies such as the College of Licensed Practical Nurses of Newfoundland and Labrador (CLPNNL) are mandated to support the public interest. A Licensed Practical Nurse should always reflect on this statement – *"My Practice is My Responsibility"*.

To maintain the privilege to practice as a LPN, you pay a fee each year to renew your license. These fees allow the CLPNNL to effectively and efficiently regulate LPNs in the interest of the public and carry out the requirements set in the *Licensed Practical Nurses Act (2005)* and Regulations (2011).

One of the requirements of a self-regulating profession is that it be financially self-supporting; as a result, CLPNNL's main source of revenue is licensure fees. Although CLPNNL pursues strategies to generate additional revenue and reduce expenditures, the results have minimal impact on the overall financial condition.

The revenue collected from licensure fees is used to cover operating expenses associated with carrying out regulatory and non-regulatory functions of CLPNNL. The regulatory functions are required by law under the Licensed Practical Nurses Act and Regulations. Non-regulatory functions are those that enhance the Practical Nursing Profession. The functions of the College include:

- Setting education standards for LPNs;
- Evaluating Practical Nursing Programs;
- Licensure of Practical Nurses;
- Administering the discipline process in accordance with the LPN Act & Regulations;
- Informing the public about the LPN profession and advertising the Standards of Practice of LPNs;
- Development of documents on the Scope of Practice and Standards of Practice for LPNs;
- Promotion of the Scope of Practice, Standards of Practice, Code of Ethics and Competencies of LPNs;
- Development and implementation of a Continuing Competency Program (CCP);
- Membership in the Canadian Council for Practical Nurse Regulators (CCPNR);
- Professional Liability Insurance for LPNs as required by legislation;
- Continuing Education activities;
- Publication of PRACTICE magazine and/or Newsletters;
- Information technology support (database, website and soon to be online licensure renewal process); and
- Operational costs (i.e. salaries, office supplies, postage, heat, lights, property and business taxes, insurances, telephone, internet, equipment, and office premises and property maintenance).

LloydSadd
INSURANCE BROKERS

LLOYDSADD.COM

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 (LPN) 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 an 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 organizations confidentiality.

The policy includes coverage for all active members of the college or association, retired members and graduates waiting licensing, providing 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.

June is ALS Awareness Month

ABOUT US – Amyotrophic Lateral Sclerosis Society

WHAT IS ALS?

ALS, sometimes called Lou Gehrig's disease or motor neuron disease, is a rapidly progressive fatal neuromuscular disease. It is characterized by degeneration of a select group of nerve cells and pathways in the brain and spinal cord, which leads to progressive paralysis of the muscles.

WHO GETS ALS?

ALS can strike anyone. ALS is not contagious, does not discriminate, and can strike at any age. The usual age of onset is between age 55 and 65, but people under age 20 have been diagnosed. ALS is usually fatal within two to five years of diagnosis. In the majority of cases the cause is unknown. In about 5-10% of cases there is a hereditary pattern.

WHAT ARE THE EARLY SYMPTOMS?

ALS usually becomes apparent either in the legs, the arms, the throat, or the upper chest area. Some people begin to trip and fall, some lose the use of their hands and arms, some find it hard to swallow, and some slur their speech.

WHAT ARE THE EFFECTS OF ALS?

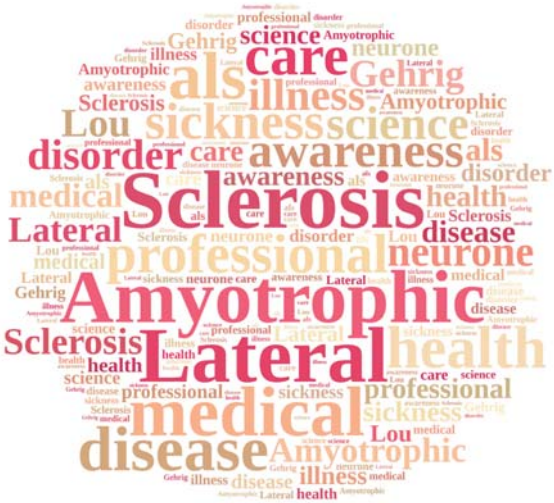
Because ALS frequently takes its toll before being positively diagnosed, many patients are debilitated before learning they have contracted ALS. The disease does not usually affect the senses - taste, touch, sight, smell and hearing - or the mind.

ALS wreaks a devastating effect on patients as well as their families. As they cope with the prospect of advancing disability and death, it consumes their financial and emotional reserves. It is a costly disease in its later stages, demanding both extensive nursing care and expensive equipment.

WHAT CAN BE DONE ABOUT ALS?

Although recent scientific research has resulted in significant new knowledge, much more research is being conducted in areas relating to genetic predispositions, viral or infectious agents, environmental toxins, and immunological changes.

If you designate your donation for research, it will go directly to fund research for better treatment and a cure for ALS.



IS THERE HOPE FOR PEOPLE WITH ALS?

At the present time, there is no treatment that significantly prolongs life. Research is investigating ways to reverse the disease, and there may eventually be a cure for ALS.

Many people with ALS say that they live life more fully now with much joy - even knowing what is to come. In the meantime, good planning together with medical and social management eases the burden on the person with ALS and family caregivers.

www.als.ca/coast_to_coast/

2016
Walk for ALS Locations

Clarenville/June 12
Registration 1:00 Walk 2:00 pm @ Easy Street Pub
Contact: Cal Cole 466-2430
cal.cole@nf.sympatico.ca

Cavendish/June 12
Registration 1:00 Walk 2:00 pm @ Main Street
Contact: Elaine Sooley 588-2482
elainemsooley@hotmail.com

Corner Brook/June 12
Registration 1:00 Walk 2:00 pm @ Bennett Hall
Contact: Cheryl Power 634-9499
alssocietyofnfld@nf.aibn.com

Stephenville/June 12
Registration 1:00 Walk 2:00 pm @ Knights of Columbus
Contact: Doris Snow 643-2365
Max Snow 643-3314
maxpeg69@nf.sympatico.ca

St. John's/June 12
Registration 12:00 Walk 2:00 pm @ Royal Canadian Legion (930 Boulevard)
Contact: Jerome Collins 368-5493
KJCOLLINS@nlhc.nl.ca
Madonna Kavanagh 240-0403
madonna.kavanagh@yahoo.ca

Smith's Harbour/June 12
Registration 1:00 Walk 2:00 pm @ John Smith Centre
Contact: Jennifer Whelan 252-2016
jenniferjillw@hotmail.com

Gander/June 12
Registration 1:00 Walk 2:00 pm @ Lions Club
Contact: Jennifer Hiscock 256-2354
kevjenhiscock@nl.rogers.com

Wabush/ June 12
Registration 1:00 Walk 2:00 pm @ Royal Canadian Legion
Contact: Keila Adams @ 944-7835
keila.vallis@gmail.com
Belinda Grouchy @ belindaagrouchy@crrstv.net

Whiteway/June 12
Registration 1:00 Walk 2:00 pm @ Jimmy Rowe's Walking Trail
Contact: Jolynn Jackson 588-2760
jolynnjackson@yahoo.ca

Glenwood/June 12
Registration 1:00 Walk 2:00 pm @ Lakewood Academy
Contact: Gertie Smith 679-2139
gertiesmith@nf.sympatico.ca

Lewisporte/June 12
Registration 1:00 Walk 2:00 pm @ Woolfrey's Pond Trail
Contact: Judy Wells
judywells71@eastlink.ca

ALS SLA

WALK for ALS

ELECTRONICS in the Workplace

It used to be that "tablets" were what we gave to clients to treat a medical condition. Today there are smartphones, cell phones and tablets in the workplace and everywhere else we look. Since a large portion of the general public owns a mobile device, it is not surprising that these devices are finding their way into workplaces, including nursing practice environments. Given the existence of mobile technology in all aspects of life for a majority of the population, it is important that LPNs consider the appropriateness of technology in the workplace.

From a knowledge perspective, mobile technology can be a valuable tool to link health care professionals with resources such as drug guides, practice guidelines, and other clinical information. However, from a professional perspective, LPNs must be cognizant of how they use electronics in the workplace as well as the public perception associated with the use of electronics by LPNs while in the workplace.

Whether you are employed in long term care, acute care, community care or any other health care setting, it is always important to follow employer policies. Many employers have policies to avoid cell phone/media usage in the workplace. However, there are also exceptions when the employer supports the use of electronic devices. For example, the employer may condone the use of a digital camera to take images of a wound to monitor the healing process or to take pictures of residents to be placed on the Medication Administration Record (MAR) for accurate client identification, thus contributing to safe medication practices. Using technology in this way is appropriate as it contributes positively to client care.

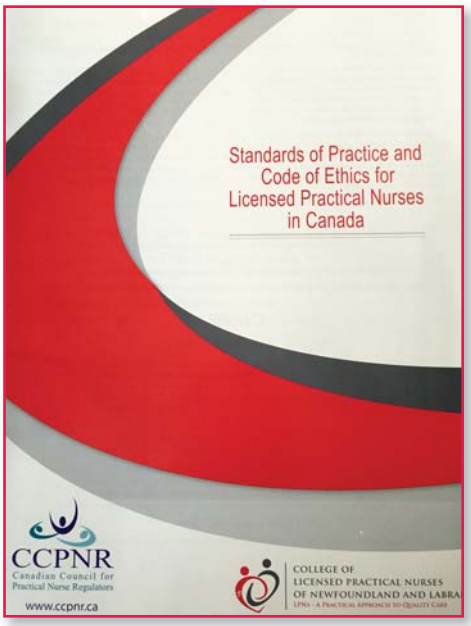
LPNs should be aware that the clinical use of a personal mobile device for client-related care requires employer authorization. Using a mobile device in the workplace without authorization, in particular a personally-owned mobile device, is inappropriate and may result in a breach of client confidentiality. If client information is placed on a personal mobile device and subsequently deleted, the client's information may still remain on that device, depending on the security features of the device. Clients have a right to privacy and confidentiality. The means by which their personal health information is collected, stored and communicated must follow appropriate policies and procedures.

BYOD - bring your own device - is a growing trend in many workplaces and some employer policies may allow the use of a personal device for work purposes. Employer protocols and organizational infrastructure lead to added features and functionality, such as encryption, to ensure confidential information is protected. Without this protection, any information stored on the device, including email, voicemail, videos, text messages or pictures, may be exposed to unauthorized access if the device is lost, stolen or lent to someone else. Ideally, employers who require an employee to use a mobile device for work-related purposes should provide the employee with a device that has appropriate security features, such as encryption technology.

LPNs have an ethical and legal obligation to safeguard client confidentiality and privacy at all times.

The personal use of mobile devices in the workplace may lead to concerns that the LPN is not available to attend to client care. Furthermore, client safety may be placed at risk if a LPN is distracted by his/her mobile device while providing client care. In addition, professionalism will be questioned if, for example, nursing staff are seen accessing a mobile device when call bells are ringing. Unless it is required on the unit by your employer, the best practice is to leave your cell phone in your work bag or locker and not in your pocket.

The CLPNNL Standards of Practice and Code of Ethics (2013) outline the following principles which the LPN should adhere to:



Standard 1.6 – *Take action to avoid and/or minimize harm in situations in which client safety and well-being are compromised.*

- The LPN should not be using their mobile device when carrying out client care.

Standard 3.8 – *Practice within the relevant laws governing privacy and confidentiality of personal health information.*

- The LPN is required to always follow employer policies regarding social media and electronic devices. The LPN is required to follow the Personal Health Information Act (PHIA) to safeguard client information.

Principle 1.1 – *Maintain the standards of practice, professional competencies and conduct.*

- The LPN is required to follow the standards of practice and employer policies and to maintain professionalism in the workplace.

Principle 2.3 and 2.3.4 – *Respect and protect client privacy and hold in confidence information disclosed except in certain narrowly defined exceptions. Maintain professional boundaries in the use of electronic media.*

- The LPN should only discuss a client's health condition with professionals who are directly caring for the client. The LPN must not disclose any information about the client, health facility or their regulatory body on social media such as Facebook or Twitter.

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

- If a staff member is using a cell phone, and you believe that this behavior is impacting client care, you are required to report this behavior to the appropriate authority.

The following recommendations will help minimize the risks of using social media:

- Maintain professional boundaries in the use of electronic media. As with face-to-face relationships, the nurse has the obligation to establish, communicate and enforce professional boundaries with clients in the online environment. Do not seek or accept online "friend" requests with current or former clients and/or family members.
- Promptly report any identified breach of confidentiality or privacy.
- Be aware of, and comply with, employer policies regarding the use of social media, employer-owned computers, cameras and personal devices in the work place.
- Do not make disparaging remarks on social media about employers, employment settings, or co-workers.
- Do not make threatening, harassing, profane, obscene, sexually explicit, radically derogatory, homophobic, transphobic, or other offensive comments.
- Do not post content or otherwise speak on behalf of the employer or the profession unless authorized to do so, and follow all applicable policies of the employer.

Inappropriate use of social media could be considered a breach of the Standards of Practice, Code of Ethics and/or LPN Act and Regulations and this may result in an allegation of professional misconduct. LPNs must be mindful of employer policies, relevant provincial and federal laws, and the practice standards and code of

ethics. The careful and conscientious Licensed Practical Nurse may enjoy the personal and professional benefits of social and electronic media without violating a client's confidentiality or privacy.

Adapted by Wanda Squires LPN, Practice Consultant CLPNNL, from the following:

ARNNL's Access magazine September 2014, Regulatory notes: Electronic Devices in the workplace - Considerations for Registered Nurses By: Michelle Osmond

CLPNNL's Standards of Practice and Code of Ethics (2013)

CLPNNS's Position Statement – Social media (2013)ARNNL's Access magazine September 2014, Regulatory notes: Electronic Devices in the workplace - Considerations for Registered Nurses By: Michelle Osmond

CLPNNL's Standards of Practice and Code of Ethics (2013)

CLPNNS's Position Statement – Social media (2013)

Nursing Education and Research Council
Nursing Grand Rounds
2016

Eastern Health

Date	Topic	Presenter	**Location / Webinar Registration**
May 26	RNs and LPNs: Let's Talk About **Scope of Practice**	Siohbainn Lewis RN BN MN Wanda Lee Squires LPN	**Room 625, Southcott Hall LAMC** https://attendee.gotowebinar.com/register/1412723277348987650
Jun. 23	Impact of a Standardized Uniform on Registered Nurses in Newfoundland and Labrador	Andrea Barron RN BN MN Elizabeth Hynes RN BN MN Gladys Schofield RN BN MN Karen Street RN BN MN	New Cafeteria Conf. Rm, LAMC https://attendee.gotowebinar.com/register/2361636996491782402

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

Remember:

Attendance at Nursing Grand Rounds can be used as credit towards Continuing Competency Programs.

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

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

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, every LPN in every practice setting in NL will be required to participate in the CCP every year to maintain their license. Participation in CCP is in addition to working the required number of practice hours.

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 for LPNs. The goal is to protect the public by ensuring health professionals 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.

When applying for licensure for 2018-2019, LPNs will be required to declare that they have completed the CCP requirements for the 2017-2018 licensure year on the annual renewal form. LPNs who declare compliance with the CCP are issued a license and will be eligible to be selected for the annual audit.

The CLPNNL will be providing education sessions in the coming months to prepare LPNs to participate in the CCP. Watch your email for dates and the web site for additional information.

Compassion in a Touch – Canadian Nurse

By Stephanie Keddy, RN, BSN

Stephanie Keddy breaks through the barriers of isolation precautions

"I need to go to the bathroom," she said. I was covering for this patient's nurse while she was on break. I washed my hands and walked to the isolation precaution rack to put on the yellow gown. I donned a mask with a visor that covered my mouth and nose and shielded my eyes, washed my hands, and pulled on gloves. Theoretically, I was now protected from catching the illness this patient might have.

"I'm not contagious," she said, assessing me.

I nodded in agreement and shrugged my shoulders. "Those are the rules — just in case."

"I know. I've been through this before, so I understand why you have to. But I can tell, I don't have contagious pneumonia," she offered.

I pulled the flimsy aluminum walker around in front of her, to facilitate the transition to the bathroom. The oxygen prongs were pressed up into her nose, the tubing bisecting her cheeks and wrapping over her ears, reconnecting below her chin. Her breathing was rapid and laboured.

Following behind the walker, I kept the oxygen tubing and a Foley bag from becoming tangled as she spun back to sit on the toilet.

"Do you need a minute?" I inquired, more for my own sake than hers. She nodded. I slid the door closed and walked away from the bathroom, peeling off the sticky gloves, then washed my hands, pulled off the gown, mask and visor, and washed again.

Before long, the rapid beeping of the bathroom-assist call bell snapped me out of my night-shift stupor. Deep breath and big sigh. Hands to wash. Gown, mask and visor, gloves to put back on.

We made our way back to the bed, where she plopped herself down. Her breathing was more laboured. With every exhale, she pressed her lips tightly together and blew as if trying to cool down hot soup. Eyes downcast, eyebrows knit together, she concentrated on slowing her breathing.

She rocked backward and sprawled across the bed, then slowly swung each leg up. I raised the head of the bed, and we waited for her breathing to settle. Breathlessness, so often paired with helplessness, is never easy to watch. My heart ached as I looked at her through my shiny visor.

She looked up with eyes full of sadness and gratitude. "Thank you."

I muttered "no problem" as I turned to exit though the curtain; then her stoic features crumbled and she began to cry.

I reached for the box of tissues on the side table and placed it in her lap, stepping back to my original position. I watched and waited for her to speak.

"I'm sorry. I hate needing help. I have always helped everyone else. My kids. My husband…he was like a kid; he never helped with anything. My mom...when she got sick, I looked after her until she died. This isn't me. This isn't what I wanted. I look back and think about everything that has happened in my life. The bad things: as a child I was sexually abused, and my dad would bring home mistresses while my mom was away. And the good things: I used to be a dancer. I taught my granddaughter how to dance and put her through lessons. I used to be thin and beautiful, would you believe it? I still have so much to say. I want to tell people my story. I'm not ready to die. But I can't live like this. This is no way to be. I can't believe I'm sitting here crying. I'm sorry. This isn't like me; it's the first time I've cried."

I stood there, heart racing, wanting to rip off the mask so she would be able to see my whole face. Desperately trying to come up with the right response, I noticed I was already holding her hand — an automatic unconscious effort to offer comfort. I had been rubbing my gloved thumb back and forth over her knuckles and the back of her hand while she talked.

I asked about her daughters and granddaughters. Did any of them live nearby? Could they visit so she could share her stories? I told her it is OK to be upset. Sometimes a good cry is exactly what we need.

Against my better judgment, I stole a glance at the clock while she was looking away. Already 05:55. She caught me. They always do.

"You have more important things to do. I know how busy you are," she said, picking up on my thoughts.

I told her, "Everything else can wait; this is where I need to be right now." I squeezed her hand. She squeezed back.

In that moment, I understood what it means to be fully present as a nurse and that listening with compassion can be the best care we can give. I had learned this in school but had not truly accepted it. I vowed to remember this lesson always.

Dabbing away her tears with a balled-up tissue, she looked up at me. "Thank you…You know what the best part of talking to you has been?"

I shook my head.

"The way you have been holding my hand."

Stephanie Keddy, RN, BSN, works in heart health services at the Royal Jubilee Hospital in Victoria.

Reprinted with permission from the Canadian Nurse Magazine, March 2016 issue

Distance Education Program and Course Offerings For Licensed Practical Nurses

2016-2017

The Centre for Nursing Studies is pleased to offer the following program/courses.

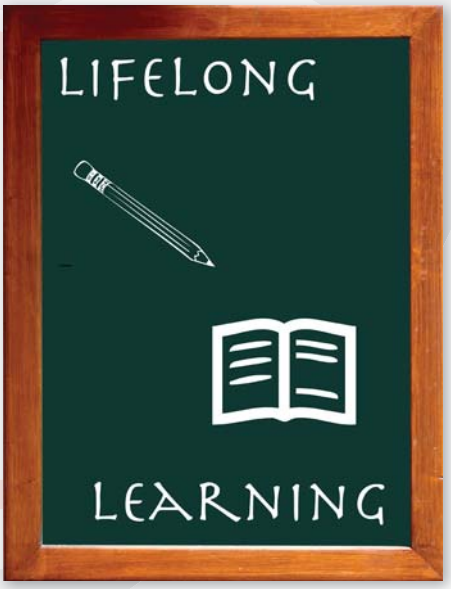
Start dates vary and will be offered **pending sufficient registration**. Send your registration form early. Payment will be requested once we have sufficient registration.

Licensed Practical Nurses:

- Re-Entry Program (September 2016 and January 2017) $2,500.00
- 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 (Two offerings – Fall 2016) $500.00

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

- Intramuscular Injection
- Intradermal Injection
- Intravenous Therapy Administration
- Blood & Blood Products Administration
- Immunization
- IV Medication Administration
- IV Initiation
- Hypodermoclysis
- Central Venous Access Device



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

Centre for Nursing Studies

20th Anniversary Dinner & Fundraiser

June 16, 2016 – Reception 6:00 – Dinner 7:00
Holiday Inn, Portugal Cove Road

Tickets $60.00 per person
Open to all current and former faculty, staff, students, graduates and friends of the Centre for Nursing Studies

Proceeds from this event will support the Health Care Foundation's Comfort in Care Program

For further information or to purchase a ticket, please contact:

Laura Keough
(709) 777-8164
laura.keough@mun.ca

The Canadian Network for the Prevention of Elder Abuse (CNPEA)

@CNPEA | www.CNPEA.ca

CNPEA RCPMTA

The Canadian Network for the Prevention of Elder Abuse (CNPEA) is a non-profit, national organisation focused on elder abuse prevention and response. We connect people and organisations to foster the exchange of information and advance policy and program development on issues related to preventing the abuse of older adults. Our vision is a Canadian society in which older adults are valued, respected and live free from abuse. The Knowledge Sharing Hub was created to provide a platform for sharing information and to increase the capacity of organisations and networks to prevent and respond to elder abuse.

From a nursing perspective, the CNPEA Knowledge Hub has valuable information and tools to support your practice. Under a "resource" tab, the site provides both policy and practice tools assembled from Canadian and provincial/territorial studies, applying a pan-Canadian perspective to Elder Abuse and encouraging cross-provincial/territorial collaboration via the Hub.

The CNPEA Knowledge Sharing Hub has many interesting tools, blogs and resources which can direct you to the most appropriate area for knowledge about Elder Abuse. For example: if you suspect elder abuse to your patients or family members look under "What is Elder Abuse"; the "get help" for Newfoundland and Labrador provides many services able to offer help and information in your region. The Hub also has links to tools to assess elder abuse such as CASE: the Care-giver Abuse Screening.

Not only does the Hub provide links for help but it also provides informative and current research. Studies such as: The National Survey on the Mistreatment of Older Canadians, A Prevalence Study and Looking Beyond the Hurt: A Service Providers Guide to Elder Abuse.

The Hub has many interactive features,

- Blog posts such as: Minimizing Institutional Harm among Criminally Accused Individuals with Dementia by Heather Campbell and,
- A Nationwide Evaluation of NICE's Pocket Tools by Sander Hitzig.
- Webinars such as Intergenerational Solutions To Elder Abuse: Kids And Seniors Work It Out

The Hub also provides opportunities to involve the community in knowledge about elder abuse, under, "event" you will find listings for upcoming webinars, conferences and information on how to participate in World Elder Abuse Awareness Day, which happens on June 15.

Joining CNPEA is easy-and free!

- Follow the link at cnpea.ca
- Click on "Get Involved" and enter contact information

You will receive monthly newsletters of the latest happenings and events.

You can also register as a Hub user and post your own content

- Click on "login"
- Register for a free account to share your own elder abuse resources and tools.
- Write a blog post or participate in message board discussions.

Questions? We would love to hear from you! Email us at cnpea1@gmail.com. Find us on Twitter, Facebook and LinkedIn and share the CNPEA with your contacts!

This article was provided by CNPEA, 2016.

What You Need to Know About the Zika Virus

ZIKA VIRUS: QUESTIONS AND ANSWERS

WHAT IS ZIKA VIRUS DISEASE?
Zika virus has caused outbreaks of mild illness from time to time since its discovery in Africa in 1947.

WHAT COUNTRIES CURRENTLY HAVE OUTBREAKS OF ZIKA VIRUS?
In late 2015, Zika virus was reported for the first time in a number of countries in Central and South America and has since spread to most of the Caribbean. The World Health Organization website has an up to date list of affected nations:
http://www.who.int/csr/don/archive/disease/zika-virus-infection/en/

HAVE THERE BEEN ANY CASES IN CANADA?
Yes, a small number of Canadian travel-related cases have occurred, with more expected.

HOW IS IT SPREAD?
Zika virus is transmitted by the *Aedes* mosquito, which also spreads the dengue and Chikungunya viruses. It is a day-biting mosquito with highest activity in the hours just after sunrise and just before sunset. This mosquito is not suited to a northern climate therefore local transmission in Canada is highly unlikely.

There have been reports of the virus spreading through sexual contact.

Though it is unlikely that the Zika virus will infect Canada's blood supply, Canadian Blood Services has asked potential donors to donate prior to leaving to the country or wait one month after returning to Canada if they have travelled to a country with Zika virus.

WHO IS AT RISK?
Anyone who is living in or traveling to an area where Zika virus is found (including Mexico, the Caribbean, and many parts of Central and South America) who has not already been infected with Zika virus is at risk for infection.

WHAT ARE THE SYMPTOMS?
The most common symptoms of Zika virus disease are fever, rash, joint pain, or conjunctivitis (red eyes). Symptoms typically last 2 to 7 days.

Only about 20% of people that get infected with Zika will actually get sick and the illness is usually mild. As a result, many people might not realize they have been infected.

HOW IS IT DIAGNOSED?
Anyone who develops symptoms of Zika virus infection within 2 weeks of travel to an affected area should seek medical care and report of their travel history. This is especially true for pregnant women.

Infection with Zika virus is diagnosed by symptoms, travel history and laboratory tests. Blood and urine tests can be used to diagnose infection. As well, it is important to get tested for other viral diseases, namely dengue and Chikungunya.

WHAT IS THE TREATMENT FOR ZIKA VIRUS PROTECTION?

There is no specific vaccine or medication to treat Zika virus infection.

Treat the symptoms by resting, drinking plenty of fluids, and taking acetaminophen for fever and pain. Aspirin or other non-steroidal anti-inflammatory medications such as ibuprofen should be avoided until dengue virus infection is ruled out.

WHAT CAN BE DONE TO PREVENT INFECTION WITH ZIKA VIRUS?

There is no vaccine and no specific antiviral treatment for Zika virus, therefore prevention is very important. Travelers are advised to use appropriate measures to protect against mosquito bites. This includes use of repellants, protective clothing, and bed nets.

HOW DOES IT AFFECT PREGNANT WOMEN AND NEWBORNS?

There have been reports of an increase in some birth defects in newborns and other poor pregnancy outcomes in women were infected with Zika virus during their pregnancy. One of these conditions is a rare but serious birth defect of the brain called microcephaly (a condition in which the baby's head i s smaller than expected). The link between Zika virus and microcephaly is still being investigated.

At this time there is nothing to suggest that pregnant women are more susceptible or suffer more severe symptoms.

Pregnant women in any trimester are therefore advised to consider postponing travel to any area where there is Zika virus transmission. If travel cannot be avoided, consult your doctor in advance and make sure steps are taken to avoid mosquito bites.

Further information on prevention of mosquito bites can be found at:
http://travel.gc.ca/travelling/health-safety/insect-bite

For further information:

- **Public Health Agency of Canada, Canadian Recommendations on the Prevention and Treatment of Zika Virus**
  - http://www.healthycanadians.gc.ca/publications/diseases-conditions-maladies-affections/committee-statement-treatment-prevention-zika-declaration-comite-traitement-prevention/index-eng.php
- **Countries with Zika virus transmission**
  - http://www.who.int/csr/don/archive/disease/zika-virus-infection/en/
- **Travel health for Canadians**
  - http://www.phac-aspc.gc.ca/tmp-pmv/index-eng.php

This article had been reprinted from the Government of Newfoundland and Labrador website
http://www.health.gov.nl.ca/health/publichealth/pdf/Zika_Q_A_for_Public.pdf

Tobacco use continues to be the leading cause of preventable illness and death in Newfoundland and Labrador. Tobacco use is a major risk factor for chronic disease including cancer, heart disease, stroke and respiratory illnesses. In fact, 50% of all people who smoke die as a result of their tobacco use.

The Newfoundland and Labrador Smokers' Helpline (SHL) is a free, confidential service that anyone in Newfoundland and Labrador can call to receive free information and resource materials, or to speak to a counsellor for advice and support. The SHL provides support by telephone, email, web-based services, and group programs. Proactive follow-up is available, and encouraged, to assist individuals to reach their goal of becoming and staying smoke-free.

The CARE (Community Action and Referral Effort) Referral Program is an easy and effective tool that healthcare providers can use to refer individuals to the SHL for help in becoming smoke-free. The referral only take 1-2 minutes to complete and follows these main steps:

1. **Ask** if the client uses tobacco OR has recently quit;
2. **Advise** about the benefits of being tobacco free and that support is available;
3. **Refer** the client to the Helpline by completing a CARE Referral form
4. **Send** the CARE Referral Form to the SHL:
    - By faxing to 709-726-2550
    - By scanning and emailing to shl@nf.lung.ca
    - Through online referral system (contact SHL for more information)
5. If a person declines the referral, provide the SHL toll free number/website and encourage them to call when they are ready.

When a referral is received at the Helpline, a counsellor will call the client, discuss the SHL services and begin to assist in developing a plan to quit smoking.

According to the University of Ottawa Heart Institute, more than 60% of people who smoke want to quit, 40% will make at least one attempt to quit each year, but only 5% will succeed without support. Research shows the most effective method for smoking cessation is a combination of counselling, like that offered by quitlines, and pharmacotherapy, such as nicotine replacement or cessation medications.

The effectiveness of quitlines has been well documented in research and literature and quitlines are considered a best practice in tobacco cessation. People who try to quit with the help of best practice counselling and pharmacotherapy experience 2 to 4 times the success with quitting long term.

Studies have also demonstrated quit attempts and motivation for quitting increases when smoking cessation is addressed by a healthcare provider. Direct referrals, like CARE Referrals, are 10 times more likely to result in patient contact as compared to simply recommending the Helpline to an individual or passing on the Helpline number. This increased contact has been shown to increase quit rates.

The SHL encourages all healthcare providers to get involved in the CARE Program. For more information or materials, call 1-800-363-5864 or visit www.smokershelp.net.

July 28, 2016 is World Hepatitis Awareness Day!

Hepatitis A

What is hepatitis A?

Canadian Liver Foundation
Fondation canadienne du foie

Hepatitis A is most common in countries where food and water may get contaminated due to poor hygiene practices. However, occasional outbreaks of hepatitis A do occur in Canada. Hepatitis A does not lead to a chronic illness, but is a potentially serious infection in the elderly and in persons who have chronic liver disease. If you were born in a country where hepatitis A is common, you have likely already been infected with HAV. The good news is once you have been exposed to HAV and have recovered, you will develop lifelong protection against it which means you will never get hepatitis A again.

I have hepatitis A. What can I expect?

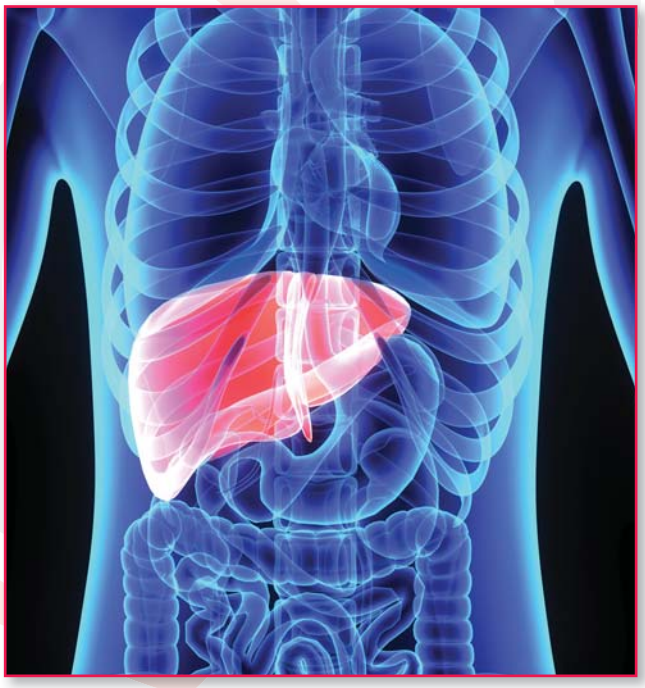
Not all people infected with HAV will have symptoms. Pre-school children often have no symptoms, and, in general, children will have milder symptoms than adults. Symptoms may occur 15 to 50 days from the time you first come in contact with HAV.

Typical symptoms of an acute HAV infection include: fatigue, nausea and vomiting, abdominal discomfort, jaundice (yellowing of the whites of the eyes and skin), dark urine, low grade fever and loss of appetite.

The older you are when you get HAV, the more likely that you will experience more severe symptoms. Some people feel sick for one to two weeks, while in others the symptoms may last several months. Hepatitis A rarely causes death. However, persons with pre-existing chronic liver disease, including chronic hepatitis B and C, are at increased risk of serious complications from this infection.

How did I get hepatitis A?

Hepatitis A is spread through close contact with an infected person, or by eating HAV contaminated food or drinking water. Because the virus is found in the stool of infected people, eating food prepared by an infected person, who does not wash his/her hands properly after using the washroom, is one way of getting the virus.



Eating raw or undercooked seafood and shellfish from water polluted with sewage, or eating salad greens that are rinsed in contaminated water are other ways of becoming infected. Sharing drug-use equipment, or having sexual contact with an infected person can also give you hepatitis A.

Can I protect myself from getting hepatitis A?

There is a safe and effective vaccine that can protect you from getting hepatitis A. The vaccine is usually given in two doses six months apart. The vaccine will give you protection for up to 20 years. A combined vaccine for hepatitis A and hepatitis B is also available. Since up to 40% of the reported

cases of hepatitis A occur in travellers, it is advisable to protect yourself with HAV vaccination six weeks before you leave.

Consider these additional safety precautions:

- Wash your hands frequently and thoroughly especially after using the washroom, before preparing food and before eating.
- Avoid raw or undercooked food.
- If you are travelling to countries with high rates of hepatitis A:
    - drink bottled or boiled water and use it for brushing your teeth
    - drink bottled beverages without ice
    - avoid uncooked food including salads
    - avoid food from street vendors
    - peel and wash fresh fruits and vegetables yourself

How is hepatitis A treated?

There is no drug treatment for hepatitis A. The disease will eventually run its course and an infected person will recover completely although recovery time varies for each person. Recovery from this virus infection means that you are protected for life from getting it again.

Hepatitis B

What is hepatitis B?

Hepatitis B is a type of liver disease caused by the hepatitis B virus, and is one of the most common forms of viral hepatitis (the others are hepatitis A and hepatitis C). Many people who become infected with hepatitis B never feel sick and recover completely. Others get a brief, acute illness with fatigue and loss of appetite, and their skin and eyes turn yellow (a condition called "jaundice"). Fewer than 5% of adults who get acute hepatitis B develop chronic hepatitis and about 1% of adults get acute liver failure. However, up to 90% of infants and children infected with hepatitis B are unable to clear the infection and become chronically infected. Chronic infection can lead to cirrhosis (severe scarring of the liver) and/or liver cancer later in life.

What is chronic hepatitis B?

Anyone who is unable to clear the virus after six months of initial infection has chronic hepatitis B. The risk is greatest for infants born to mothers who have hepatitis B: infants infected with the virus at birth, who do not receive hepatitis B immune globulin (HBIg) and vaccination, have a 90% chance of developing chronic hepatitis B infection. Although most people with chronic hepatitis B will have inactive disease and will remain healthy and symptom-free, some will have active disease that may lead to cirrhosis or liver cancer years after becoming infected with the hepatitis B virus.

How is the hepatitis B virus spread?

A person who has acute or chronic hepatitis B can spread the infection to other people through his/her blood and other body fluids or by sexual contact. Hepatitis B is not spread by water, food, or by casual contacts.

How is hepatitis B diagnosed?

Diagnosis is made through blood tests. The tests may show the following results:

- A positive hepatitis B surface antibody test (anti-HBs) indicates that you have been infected some time in the past and recovered completely or that you have been successfully immunized against hepatitis B infection. You are immune to the hepatitis B virus. You will not get hepatitis B infection and you cannot infect anyone. There are several hepatitis B antibodies, but only anti-HBs gives immunity.
- A positive hepatitis B surface antigen test (HBsAg) shows that you are still carrying the hepatitis B virus. Presence of the virus can mean either acute (recent, self-limited) or chronic (long-lasting) infection. If the virus continues to show up in your blood for longer than six months, then you have a chronic infection.
- A positive hepatitis B core antibody test (anti-HBc), in the absence of other markers of infectivity, means a resolved past infection. This test is used by the Canadian Blood Services to screen all blood donors.
- A completely negative result (anti-HBs, HBsAg, anti-HBc all negative) means that you have never been exposed to the hepatitis B virus nor been immunized. In that case you can benefit from immunization.

Is there treatment for hepatitis B?

The objective of treatment of chronic hepatitis B is to prevent the development of cirrhosis, liver failure and liver cancer. However, not all hepatitis B patients will develop these complications. The challenge is to identify those patients whose liver disease may progress to cirrhosis and offer them treatment. There are two types of treatment available: (i) injections called standard interferon alpha-2b and pegylated interferon alpha-2a, and (ii) oral antiviral medications which include adefovir, entecavir, lamivudine, telbivudine and tenofovir. Interferon-alpha is a natural product of the human body, known to interfere with the reproduction of a virus after infection. For treating chronic hepatitis B, interferon alpha works by enhancing the body's immune activity against the hepatitis B virus. It is only effective once the immune system has become activated against the hepatitis B virus. Standard interferon alpha-2b is given by injection three times per week for up to 48 weeks. Pegylated interferon alpha-2a which is a long-acting form of interferon is injected once weekly for up to 48 weeks.

Adefovir, entecavir, lamivudine, telbivudine and tenofovir work directly against the hepatitis B virus by suppressing the virus from multiplying. These drugs are taken by mouth once a day and are generally well tolerated with almost no side effects. The duration of treatment with these drugs depends on the exact type of hepatitis B virus and the response of the patients. In some cases, indefinite therapy is necessary. However, the main problem with oral antiviral therapy is the development of drug resistance. When drug resistance occurs, the medication will no longer be effective in suppressing the virus. If resistance to one oral antiviral medication develops, a combination of two antiviral medications is usually required.

Hepatitis C

What is hepatitis C?

Hepatitis C is a liver disease caused by the hepatitis C virus (HCV). It was called non-A non-B hepatitis for most of the 1970s and 1980s until the hepatitis C virus was first identified in 1989. Hepatitis C is spread through blood-to-blood contact. HCV is completely unrelated to either hepatitis A virus or hepatitis B virus. Although all three forms of hepatitis cause liver disease, the ways you can get these infections are different.

How does someone get hepatitis C?

Hepatitis C is spread from blood-to-blood contact. The most common means of transmission is through injection drug use, even if the drug use was many years ago or happened only once. Sharing needles or any drug-related equipment that are contaminated with the hepatitis C virus is enough to spread the infection.

In countries where universal precautions were lacking, hepatitis C was spread through health care practices such as childhood immunization, dental work, surgery and transfusion. In Canada, the risk of getting HCV from transfusion is now extremely low because of the universal testing of all blood donors.

Activities such as tattooing and body piercing, which may be performed without sterile precautions, sharing toothbrushes and razors, or any kind of blood-to-blood contact with an infected person can also spread the hepatitis C virus. The risk of getting HCV infection through ordinary household or workplace interactions is extremely low.

Can I have children or breastfeed if I have hepatitis C?

The risk of passing hepatitis C from mother to a child during birth is approximately 5%, so most newborns of mothers with HCV infection will not get the virus. Fathers who have HCV are very unlikely to pass the virus to their children. Breastfeeding does not appear to transmit hepatitis C unless nipples are cracked or bleeding

What are the symptoms of hepatitis C?

Most people with hepatitis C have no symptoms and may feel quite healthy. Occasionally, some people may experience a rash or joint pains. If the liver becomes damaged, then someone might experience fatigue, jaundice (yellowing of the eyes and skin), abdominal swelling, ankle swelling or internal bleeding.

How do I know if I have hepatitis C?

Many people with hepatitis C are unaware they have it and can carry it unknowingly for decades. Only a blood test can detect the hepatitis C virus infection. If you think you may have been exposed to HCV through high-risk behaviour, use of contaminated needles or materials, blood or blood product transfusion, or another reason, you should see your physician and get tested for hepatitis C.

What happens if I test positive?

If you test positive for antibodies to HCV, your physician should do a follow-up blood test to see whether actual viral material (HCV RNA) can be found in your blood, along with blood tests to check the state of your liver.

Up to 40% of people infected with HCV will have a mild, brief disease and get rid of the virus completely soon after being exposed. In this case, the antibodies to HCV usually remain detectable in the blood but the actual viral material does not. If the virus does not disappear after six months, it is termed a chronic infection. Most people who get hepatitis C will have HCV infection for the rest of their lives without treatment.

Can I be cured?

Yes, you can be cured of HCV infection.

What are the treatment options?

Since 2010, enormous progress has been made in treatment of chronic hepatitis C. New therapies called direct acting antivirals (DAAs) are pills that act on the virus itself to eradicate it from the body, unlike older medicines like interferon injections which work by stimulating an immune response. These new treatments are very effective and can achieve cure rates of over 90%. In most situations now, there is no need for interferon, which was responsible for many of the side effects previously associated with HCV treatment. The new treatment combinations require shorter treatment durations (between 8 to 24 weeks), have reduced side effects and appear to be effective at all stages of the disease. Because these new therapies are very new, they remain very expensive. As such, drug coverage from both government and private companies may require that your liver disease has progressed to a certain stage before they are willing to cover the cost of these drugs.

Your primary care physician may refer you to a specialist to determine whether you are eligible for treatment. A specialist will help you decide which drug therapy is best for you based on the severity of your liver disease, your virus genotype and whether or not you have been treated in the past. If you are not presently eligible for treatment, it is important that you make sure to have your liver monitored at least once a year to follow the progression of the disease. You are strongly advised to have regular check-ups for your liver. Although liver failure and cancer can be the end results of this disease, your physician can identify liver changes long before this happens. Treating HCV drastically reduces these outcomes.

What happens as the disease progresses?

Most people with chronic hepatitis C feel well for many years. However, in one out of four cases, chronic hepatitis C can lead to more serious problems including cirrhosis (scarring of the liver), liver failure and liver cancer. Hepatitis C is one of the most common reasons why people need to have liver transplants in Canada. The earlier you find out that you have hepatitis C, the more likely it is that treatment could be successful.

How can I protect others?

If you have been diagnosed with hepatitis C there is no need to become socially isolated, but there are common-sense precautions you should take to avoid spreading the virus:

Do not give blood

- Do not share razors or toothbrushes
- If you use drugs, do not share needles or other drug-related equipment
- Inform health professionals who care for you and may be exposed to your blood that you have hepatitis C
- Although sexual transmission is rare, inform your sexual partner(s) that you have hepatitis C and take appropriate precautions
- There is no vaccine for hepatitis C prevention.

Revised 2015
http://www.liver.ca/files/PDF/New_format_info_sheets_-_2011_-_english/CLF_InfoSheet_HepatitisC_E.pdf

Frequently Asked Questions

What are High Alert Medications?

The Institute for Safe Medication Practices (ISMP) (2014) defines High-Alert Medications as "drugs that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are clearly more devastating to patients".

These medications carry a higher risk of client injury or death if administered incorrectly. High-Alert medications have a narrow therapeutic index, making them dangerous because small changes in dosage or blood medication levels can lead to life-threatening adverse events. An independent double check (IDC) is an error prevention strategy where a second nurse verifies that the client, drug, dosage and route are correct and match the physician's order. IDCs support safe administration of all medication including, high alert medication. According to the ISMP, IDCs can prevent up to 95 percent of errors before they reach the client. Other prevention strategies include limiting interruptions during medication administration, reducing confusion around drug names and standardization of drug labeling, storage, concentrations and dosages. Combining multiple error prevention strategies can reduce errors even further. Staff participation in prevention strategies is necessary to ensure overall success of error-reduction strategies. Vigilance, knowledge, standardization and safeguards are vital in achieving the goal of making high alert medications errors "never" events and ensuring client safety.

For an updated list of High-Alert Medications you may refer to the ISMP website at:

http://www.ismp.org/Tools/highalertmedications.pdf

Examples of High-Alert medications are but not limited to the following:

Antineoplastics	Calcium Chloride IV	Calcium Gluconate IV
High Potency Narcotics	Hydromorphone	Insulin (IV or subcutaneous)
Magnesium Sulfate IV	Oxytocin IV	Potassium Phosphate IV
Potassium Chloride (concentrated) IV	Sodium Chloride (Hypertonic saline > 0.9%) IV	Unfractionated Heparin IV

Printed with reference to Frequently Asked Questions CLPNNS College Reporter Fall 2015 vol. 3

My employer is requesting that I start doing catheterizations. I think I learned to insert a catheter during my PN program but I graduated in 2003 and I cannot remember. What should I do?

When your employer is requesting that you complete a particular skill, the LPN should always start with this question:

Am I educated and authorized to complete that care or carry out that skill on this particular unit?

Let's look at *educated* – the LPN should ask themselves, did I learn this skill as part of my program? Did I learn it from participating in an in-service with the clinical educator? Did I complete a post-basic module on this? Have I practiced this skill? Have I put theory and practice together and demonstrated my competence in this skill?

The next component that the LPN should consider is authorization –is there an employer policy which allows me to provide this care or complete that skill on the unit where I am currently working?

If you answer yes to the questions above, then you can complete that care/skill because you are educated, competent and authorized to do so.

In this particular case, the LPN is unsure if she learned about catheterizations in the PN program. If the LPN completed catheterization as part of her education program more than 13 years ago and has not completed the skill of catheterization since, it is best practice for that the LPN complete education/upskilling in this area. The education should include both a theory and clinical component.

The other key point in this question is that the employer is requesting that the LPN complete this skill. If the employer requires the LPN to provide this care/complete this skill in the area where the LPN is working and the employer policy supports this practice, then the LPN is obligated to participate in the education and training required to become competent to complete this care.

Health care is continually changing and there will always be new policies, new instruments, and new techniques. In the interest of public protection, LPNs must keep abreast of these changes. As necessary, the LPN should participate in continuing education, whether formally or informally, to obtain new knowledge required to provide safe, competent care.

Participate in CLPNNL Committees, Working Groups and Liaison Programs

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

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

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

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

- Dr. Leonard A. Miller Centre
- Presentation Convent
- Harbour Lodge Nursing Home
- Interfaith Citizen's Home

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

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

209 Blackmarsh Road, St. John's, NL A1E 1T1
709.579.3843 • Toll Free 1.888.579.2576 • info@clpnnl.ca