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## **ISSUE 3 – FALL 2016**

**From Your Editors…**

**Welcome to the Spring 2018 LNCAC Newsletter. Thank you to all the members who submitted articles. We hope you enjoy the read!**

**Rosemarie Enokson**

**Heather Leonard**

**LNCAC Board Updates**

**Hello from the desk of the President of the Legal Nurse Consultants Association of Canada!**

The Legal Nurse Consultants association has been in existence since 2009. Since then there have been many changes in Leadership, membership and we are now recognized by the Canadian Nurses Association as an Associate Member. As a result, we are recognized as a professional specialty in nursing.

Our team has grown professionally in their collective experiences and in the general terms of reference and association activities of this organization. We strive to meet the needs of our membership and thusly, the clients they serve.

The organization had developed the LNCAC Standards of Practice and Guidelines in 2016 with the assistance of several members. That was a great accomplishment and a tool that will assist members in their practice going forward.

The website, thanks to the awesome efforts of our treasurer, Heather Johannesen, is amazing! There are links for education, meeting minutes, publications and much more. Remember to review the website for these resources.

Our Secretary, Rosemarie Enokson, faithfully provides you with minutes following all of our meetings and sets up the conferencing for those meetings, organizes the process for membership voting and maintains a meticulous membership list for the organization.

Dianne Dyer, our Director at Large has been working diligently to ensure your experience at the Annual General Membership meeting will meet your expressed needs. She has been an active asset to the Executive Board in the processes that face the team.

We thank our website sponsors, Connect Medical Legal Experts for their continued support. Without the support of such organizations, we would struggle to provide the resourcing our members have requested.

***Our Annual General Membership Meeting is being held June 2, 2018, at 0800 hours PST, 0900 hours MST and 1100 hours EST. Please mark your calendar and plan to attend. The teleconference login information will be sent out closer to the meeting date.***

**We have secured two speakers for the AGM. One is speaking on Forensic Nursing, the other is reviewing their LNC trial experience. GREAT INFORMATION BEING PRESENTED. Set your calendars!**

We are always looking for members to share their experiences at our membership meetings and/or to tell of their experience in our newsletter. Please contact any of the Executive Board if you are interested

The LNCAC is also searching for members to assist with some committee work to enable the association to provide the membership the support and resources they expect.

See/hear you all at the AGM! Remember, we have secured some amazing prizes - the chance to win is only available to those who attend the AGM on June 2, 2018

Thank you for your interest and participation.

Heather Preston

**Legal Nurse Consultant Association of Canada (LNCAC) Membership: An Enriching Experience**

**By Dianne Dyer RN, BN, MN and Legal Nurse Consultant**

As Director at Large of the LNCAC I want to share my experience with our Association to date and how this role has provided me with new opportunities and enriched my professional nursing knowledge. My new journey started in September 2015. At that time, I attended and completed the Legal Nurse Consultant (LNC) course in Canmore, Alberta. My choice to take the course was based on my interest in legal issues in nursing and how the law influences and intertwines with professional nursing practice and patient care. My work position at the time was as a leader in Nursing Regulatory Affairs in Alberta. In this role I was tasked with supporting and advising nurse leaders and staff on clinical practice issues and the best way to embed nursing regulation, professional practice standards and Codes of Ethics into practice in order to achieve safe competent care for patients.

Shortly after completion of the course I joined our Association and was encouraged to run for the Executive in the new role of Director at Large. I will admit that I was very nervous and uncertain about my new position as I was so new to this work.

That being said, I did what I could to move forward to connect with our membership through encouraging LNCAC sub-committee membership and through education.

I coordinated a few educational events over the last 2 years including a session with the Chief Executive Officer, Chantal Léonard, of the Canadian Nurses Protective Society focused on the role of the LNC and the work of our Association.

For the 2017 AGM I arranged two sessions with Alberta Malpractice lawyers. One session was called ***Practical Advice, Causation and Chain of Command*** by Jay Guthrie, QC Partner, Field Law, from Edmonton. The second session was called ***Nurse Defense Teams: The Litigation Process, Legal Standards of Care and How to Avoid Litigation*** by Melissa A. Rico, LLB Partner Carbert Waite LLP, from Calgary.

In all of these sessions we, as members of LNCAC, had the chance to talk to the respected legal experts about the topics and address our questions. In addition, I attended sessions offered by experienced LNCs related to case reviews as an LNC and their experience in the court system. All of these sessions were truly amazing learning opportunities and I learned a great deal about the law, the impact on health care and my evolving role as an LNC.

In June 2016 and 2017 I was honored to represent the LNCAC at the Canadian Nurses Association (CNA) annual meetings as a voting delegate for The Canadian Network of Nursing Specialties. At these events, I was provided the chance to attend a national Network meeting, represent LNCAC at a Network booth and vote on high level resolutions that not only impact Canadian registered nurses but national and international issues.

In summary my experience to date with the LNCAC has enriched my professional life as a registered nurse and I am very proud to be a member of our Association. I encourage you to get involved as, our success as an Association, is founded on everyone’s participation and your ideas. If you have any questions and wish to find out more about how to get more involved, please do not hesitate to contact me at [dmdyer@shaw.ca](mailto:dmdyer@shaw.ca)

*"Individually, we are one drop. Together, we are an ocean."*

Ryunosuke Satoro Japanese poet

**Building a Trusting Patient-Nurse Connection**

**By Lola Olorunfemi RN, BSc, BScN, MSN, LNC**  
  
  
Patient needs are vast ranging from physical emotional, psychological, mental, spiritual. Healthcare professionals tend to take patients from a holistic point of view unless in case of specific medical condition/ailment.

In my opinion, sometimes what patients and family need from caregivers, especially nurses, is to be emotionally present and available to acknowledge whatever situation they are going through with empathy.  
One of the best supports a nurse can give a patient/family is give them permission to express their emotions and themselves in the non-judgmental atmosphere. This builds confidence and trusts. (American Association of critical care nurses volume eight number 7 July 2016 )  
  
The motive is not trying to fix the problem or undo the medical ailment but assess their needs with empathy and just be there for them. Sometimes to cry with them, sometimes to just listen. This goes a long way on the way on the road to recovery or towards the end of life.

Giving the assurance that you know what you're doing, that you are present and acknowledge the situation builds trust and break barriers that foster nurse-patient trust.  
  
**References:**

American Association of Critical Care Nurses: building trust with patient through genuine Connection. Bold voices. 2016.Vol 8,No 7.   
  
Jha A, Pronovost P. Towards a safer health care system: the critical need to improve measurement. JAMA. 2016;315(17):1831-1832.

**Naloxone Distribution in the ED: Education the Key**

**By Jane Mark, RN, ENC(C)**

Emergency departments across Canada are struggling with a rise in opioid-related visits and deaths. Expert task force committees have been developed in Ontario and throughout Canada, who work in partnership with physicians, nurses, pharmacists, law enforcement and addiction leaders to develop sustainable strategies to deal with this issue. The goal is to inspire, develop, and implement research that will support policy change within our cities and towns.

The general public hears all too frequently, through television, news and obituary columns, about the victims of substance abuse and the increasing crisis of opioid-related deaths. It is often the emergency department (ED) nurses and physicians that deal firsthand with the emotional fallout, console family and friends, and work through the feelings of helplessness that we as health care professionals often experience. This article describes the journey of the ED at Peterborough Regional Health Centre (PRHC) which, in collaboration with Peterborough Police Service and other community partners, recently launched a program to educate and distribute take-home naloxone kits (THN) to patients with high-risk opiate dependencies.

Why did these community agencies see the need for a local naloxone strategy?

Prescribing rates for opioids in Peterborough are among the highest in the province. As of 2013, Peterborough had 15 deaths related to opioids, which was sixth highest out of 49 communities in Ontario. Peterborough also had higher ED opioid-related visits (63 per 100,000) compared with the provincial average of 28, placing the region as the seventhhighest in the province (ODPRN, 2015a)

In 2015, the latest statistics published from the Ontario Drug Policy Research Network (ODPRN) reported 734 opioid-related deaths in Ontario, with four out of five opiate deaths deemed as accidental (ODPRN, 2015b). By comparison, 481 people were killed in motor vehicle collisions in the same year.

Given these circumstances, local stakeholders were looking for options to increase access to naloxone for at-risk individuals. The distribution of naloxone kits was one idea identified and supported by all community partners in principle. We were able to operationalize this program through a grant received from the Ministry of Community Safety and Correctional Services in November 2016, which was applied for by Peterborough Police Service. In collaboration with the Peterborough Drug Strategy, Peterborough Public Health, Four Counties Addiction Services (Fourcast) and Peterborough AIDS Resource Network (PARN), the naloxone distribution program was launched at PRHC.

Education was a vital component of the program launch. Patients who present with an opioid overdose are often stigmatized due to their presenting complaint, and many staff had preconceived, negative perceptions of the opiate-dependent patient. Many staff members also had little knowledge of addiction, harm-reduction or mental health best-practice guidelines. There was a need to shift these perspectives by developing a better understanding of both the patient and their condition.

Some nursing staff knew of and supported the initiative prior to the announcement of the funding grant; the majority heard about the program for the first time through the local media outlets in November 2016. Concerns were raised about the validity of the program. PRHC is an exceptionally busy ED with high-acuity patients and more than 83,000 visits a year. Apprehensions were expressed by team members: How would we find time to educate patients and families? What does naloxone cost, and why would the opiate user get it for free when other lifesaving medications are costly for other groups of patients?

Why do nurses feel this way? In group discussions, specific themes emerged: general fatigue, burnout, compassion fatigue, and feelings of hopelessness for this subsection of patients. People also wondered if this would be a sustainable program or a “flavour of the month.” Many of these concerns pointed to a lack of knowledge and understanding of addictions and mental health issues.

There are many reasons why great initiatives fail, but the main cause is often a lack of education and communication. To support the naloxone distribution program, we needed to change the mindset of the ED staff to support the harm reduction strategy. We needed to provide quality evidence to the team of ED nurses and physicians to demonstrate that the preventive strategy of dispensing THN to appropriate patients in the ED would reduce patient deaths.

The ED managerial team, Noel Bennett and Stella Johnson, along with a collaborative team of experts, provided four hours of training to 120 nurses in small, interactive groups prior to the roll-out of the program. The educational members included Claire Hanlon, RN (Public Health), Cheryl Robinson, Addiction Counsellor (Fourcast), Chris Jardin, Prevention Education Coordinator (PARN) and ED Educator Lavern Hoy, RN (PRHC).

The education provided an overview of opiate statistics, how to respond to the opiate crisis, (with emphasis on the four pillars of addiction: treatment, prevention, enforcement and harm reduction), understanding substance use in general, case studies and videos. Nurses were given the opportunity to express their views on stigma and our challenges they have experienced in the ED in a safe and non-judgmental environment.

Staff were then provided with the pragmatic “who, when and how” steps for dispensing naloxone kits to patients. Physicians and nurses were also invited to attend a discussion with Dr. Aaron Orkin, an ED physician with Mount Sinai. Dr. Orkin is a patient advocate who helped develop Toronto’s take-home naloxone program, and the lead for the SOONER Project (Surviving Opioid Overdose with Naloxone Education and Resuscitation). I was personally fortunate to attend a workshop as a CNA (Canadian Nurses Association) delegate in March of this year.

All of this education was imperative for the success of our program. The education changed the perspective of the nursing staff – from a few health care providers understanding the validity of the program to the majority having a positive change in attitude and a commitment to the project.

PRHC went live with our naloxone distribution on February 15, 2017. PRHC was the second ED in Ontario to initiate THN and the first to dispense intranasal naloxone in our kits. The kits include two naloxone nasal sprays, non-latex gloves, and an emergency response card with five steps to save a life, (including a CPR overview). As nurses we advocate for patients with significant high risk of overdose, however, a physician order is required to dispense.

When we dispense the THN kits, we provide education and safety tips to patients and their families. We show two educational videos on an iPad: one on CPR and the other (“Naloxone 911”) produced by Peterborough City Police and EMS, explaining how Naloxone can save your life. The patient is also given the opportunity (with their consent) to have an addiction counsellor from Fourcast connect with them to provide support within the community. This counsellor is part of the Hospital to Home program/Fourcast and is in the ED Monday to Friday or available by phone after discharge. Many of our patients are linked with Fourcast and welcome the connection.

At the time of this article’s submission there have been 29 naloxone kits dispensed in our ED. My advice for other EDs in the province? Focus on education; it is imperative for your front line staff. Knowledge is the key to successful buy-in. Furthermore, advocating for further government funding is essential. Naloxone nasal spray is expensive and in order for the program to be sustained, the cost of the kits needs to be reduced. Naloxone should be as accessible as a First Aid Kit and AED in all public venues, and should be included in training for First Aid Courses and CPR classes.

As stated by Donald MacPherson, Executive Director of the Canadian Drug Policy Coalition and leading figure in drug policy harm reduction, “It is on our watch this is happening.” As ED nurses, we must educate ourselves, our patients and their families on drugs whose side effects include a high risk of death.

**About the Author**

Jane Mark RN, ENC(C), has worked as a Registered Nurse for 32 years, with 30 years in the ED at PRHC as a Charge/Staff nurse. Particular interest in Ontario Drug Strategy, Mental Health and Addictions. Presently working as a Patient Relations Consultant and Medical Assistance in Dying Coordinator at PRHC in Peterborough, Ontario.

**References:**

1Ontario Drug Policy Research Network- Rate of Opioid Use and Related Adverse Events by Ontario County 2013-2015

2ODPRN-Infographics Latest trends in opioid deaths-2015



**Final Notes**

We hope you enjoy the articles we’ve gathered for this edition of the LNCAC Newsletter.

If there are future topics that you would like to see addressed, please let us know. Alternatively, have you considered writing an article yourself? Tell us about your LNC journey, an interesting case you’ve reviewed, or a topic you are really passionate about.

It is a great way to hone your writing skills and to get your name out there. We are open to and welcome all your suggestions!

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