Northern Health Physicians
Partners in Wellness

Public Health Newsletter for Northern Health Physicians

Volume 13 . Number 3 . March 2017 ● Page 1 of 4

REMINDER: Research Project: Physical Activity - barriers and facilitators in Northern primary care practice

***The deadline has been extended to April 1st** to submit your feedback into a research project regarding physical activity barriers and facilitators in Northern primary care*

Cara McCulloch is a second year student in the Northern Medical Program, conducting a research project exploring physical activity promotion in primary care. Completion of this survey should take roughly 15 minutes of your time.

The research aims to determine:

- What are the barriers and what facilitators **to physical activity prescription for primary care providers** in Northern BC?
- What do primary care providers perceive as the barriers and facilitators **to participating in physical activity for their patients**?

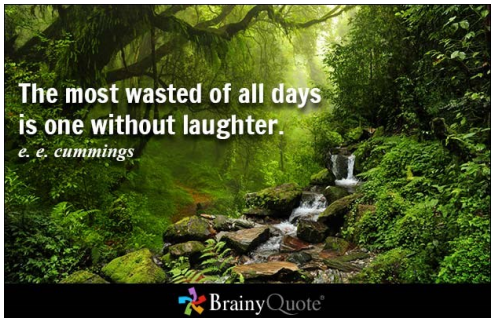
The project is supported by Dr. Sandra Allison (Chief Medical Health Officer) and Kelsey Yarmish (RegionalDirector, Population Health) at Northern Health, as well as Dr. Chelsea Pelletier (PhD) at the University of Northern British Columbia.

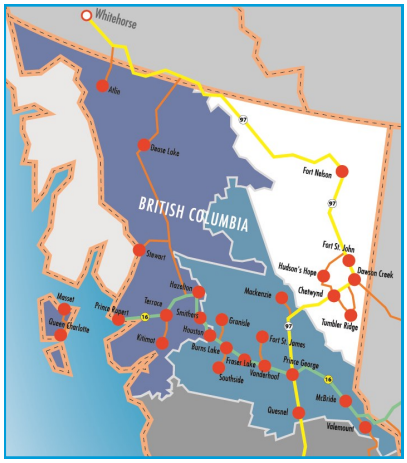
To sweeten the pot, and add even more incentive, upon completion of the survey you will be entered to a Starbucks gift card!

For further information regarding this survey, watch for the announcement and invitation by email. Or you can access the survey at: http://fluidsurveys.com/surveys/northernhealth/barriers-and-facilitators-to-pa-in-northern-bc/.

All Northern Health primary care providers are requested and encouraged to assist with this important survey through your participation.

Inside this Issue:





Northwest

Atlin, Dease Lake, Houston, Hazelton, Masset, Kitimat, Port Clements, Prince Rupert, Smithers, Stewart, Terrace, the Village of Queen Charlotte

Northern Interior

Burns Lake, Fort St. James, Fraser Lake, Granisle, Mackenzie, McBride, Prince George, Quesnel, Valemount, Vanderhoof

Northeast

Chetwynd, Dawson Creek, Hudson's Hope, Fort Nelson, Fort St. John, Tumbler Ridge

MHO Contacts *during office hours*

Dr. Sandra Allison, Chief MHO
Ph: 250-565-7424; Cell: 250-612-2582
sandra.allison@northernhealth.ca

Dr. Raina Fumerton MHO-NORTHWEST HSDA and ACTING MHO-NORTHEAST HSDA
Ph: 250-631-4261; Cell: 250-641-1758
raina.fumerton@northernhealth.ca

Dr. Andrew Gray MHO-NORTHERN INTERIOR HSDA
Ph: 250-565-7461; Cell: 778-349-4398
andrew.gray@northernhealth.ca

Dr. Ronald Chapman, MHO and VP Medicine
Ph: 250-649-7653; Cell: 250-961-3234
ronald.chapman@northernhealth.ca

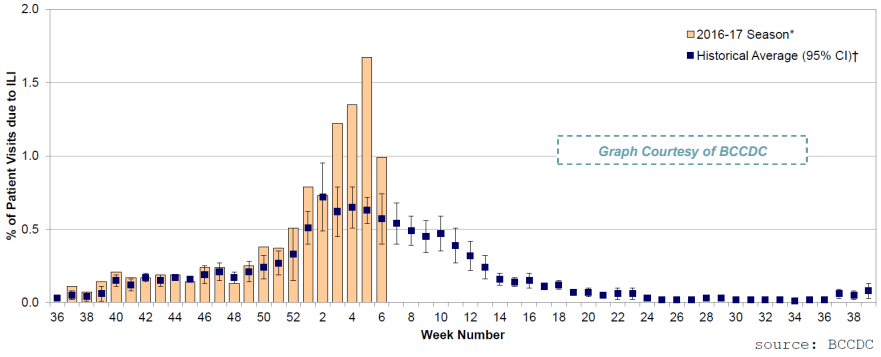
After hours calls to UHNBC Switchboard 250-565-2000 and ask for MHO on-call

northern health
the northern way of caring

Influenza Update

In week 6, 498 patients were tested for respiratory viruses at the BCCDC Public Health Laboratory (PHL). Of these, 122 (24%) tested positive for influenza, including 94 (77%) with influenza A [44 A(H3N2) and 50 with subtype pending], 27 (22%) with influenza B and one (1%) patient co-infected with influenza A and B. Overall influenza positivity continued to decline, falling below 30% in week 6 and concurrent with a decrease in test volumes. Influenza A(H3N2) remains the most frequently detected type/ subtype; however, an increasing number of influenza B viruses (comprising about one-quarter of influenza detections in week 6) have been detected in recent weeks.

Percent of patient visits to sentinel physicians due to influenza-like illness (ILI) compared to historical average, British Columbia, 2016-17



* Data are subject to change as reporting becomes more complete. One hospital ER site that reported ILI rates ≥5% was excluded from the graph.
† 10-year historical average for 2016-17 season based on 2004-05 to 2015-2016 seasons, excluding 2008-09 and 2009-10 due to atypical seasonality; CI=confidence interval.

Cumulatively since week 40 (starting October 2, 2016), 3014 (33%) patients tested positive for influenza at the BCCDC PHL, including 2896 (96%) with influenza A [1957 A(H3N2), 6 A(H1N1)pdm09 and 933 subtype pending], 117 (4%) with influenza B and one patient co-infected with influenza A and B. So far during the 2016-17 season, influenza A(H3N2) has been the dominant subtype among influenza detections. Elderly adults ≥65 years old are disproportionately represented among influenza detections, although younger age groups are also affected.

Source: BC Centre for Disease Control Influenza Surveillance Reports: Report No. 14, Feb 5-11, 2017 *(Week 6)*
http://www.bccdc.ca/dis-cond/DiseaseStatsReports/influSurveillanceReports.htm

Naloxone update:
Training resources and scope of practice for nurses and allied health professionals

Take Home Naloxone Kits

- Naloxone is an effective antidote to opioids; it works by reversing the effects of opioid overdose.
- The Take Home Naloxone (THN) program provides kits free of charge to clients at risk.
- The THN program is in most communities. For a full list of sites see: https://northernhealth.ca/Portals/0/Your_Health/OverdosePrevention/Take-home-naloxone-sites-Nov2016.PDF

Summary of Key Points

- Northern Health now supports all staff to administer naloxone and first aid in cases of suspected opioid overdose.
- All staff carrying, administering, or dispensing naloxone must complete the appropriate education (see below). The average time to complete the Learning Hub education is one hour available at: https://learninghub.phsa.ca/.
- When any NH-employed staff choose to administer naloxone and first aid, whether during working or non-working hours, potential liability concerns are covered by either NH liability insurance or the *Good Samaritan Act*.
- An order is required to administer naloxone to an inpatient in an inpatient area of a hospital. **Anticipatory (prn) orders should be obtained for naloxone for all inpatients who are prescribed an opioid or are at risk of an opioid overdose.**
- Staff who respond to a suspected opioid overdose outside of a hospital must call 911 and initiate rescue breathing.
- Staff who discover a suspected opioid overdose in a hospital setting must activate the usual emergency response and initiate rescue breathing.

Scope of Practice - Nursing Administration:

- RNs, RPNs and LPNs may administer naloxone, without an order, for the purpose of treating suspected opioid overdose:
  - outside of a hospital setting
  - for persons anywhere on hospital property who are not inpatients, and
  - for inpatients who are not at the time in an inpatient area of the hospital.
- The RN, RPN or LPN must follow the Clinical Practice Standard "*Naloxone Administration in the Management of Suspected Opioid Overdose*" available at: https://ournh.northernhealth.ca/PoliciesProcedures/DST%20Published%20Policies/1-22-6-020.pdf
- *and* complete the Learning Hub module: ***"Naloxone Administration"***

An order is still required for naloxone administration for inpatients in inpatient areas.

(Continued on page 3)

Naloxone update:

Training resources and scope of practice for nurses and allied health professionals, Cont'd.

(Continued from page 2)

Dispensing:

- RNs and RPNs may dispense a Take Home *Naloxone* kit without an order from NH sites or programs (including hospital sites) to clients at risk of an opioid overdose or to family and friends of those who are at risk for overdose.
- LPNs *may* dispense a Take Home Naloxone kit without an order from NH sites or programs outside of a hospital to clients at risk of an opioid overdose or to family and friends of those who are at risk for overdose. An LPN requires an order from a physician to dispense a kit from a hospital setting.
- All nurses must follow the Clinical Practice Standard *"Dispensing and* distribution *for persons at risk of opioid overdose: Take Home Naloxone Kits"* available at: https://ournh.northernhealth.ca/PoliciesProcedures/DST%20Published%20Policies/1-22-6-030.pdf
- All nurses who dispense the kits must also complete the Learning Hub module: ***"Distributing and Dispensing Take Home Naloxone Kits".***

All nursing regulatory colleges support the administration and dispensing of naloxone. Please see the appropriate College's website for further information.

Scope of Practice: Allied Health Professionals, Unregulated Care Providers and Support Services Staff:
(Occupational Therapy, Physiotherapy, Social Work, Dietitians, and unregulated care providers (e.g. recreation therapy, life skills and community home support workers and support services staff)
Administration:

- Recently the provincial government announced a change to the *Health Professions Act* (HPA) that allows any health care professionals to assess and treat suspected opioid overdose with naloxone and first aid, available at: http://www.bccollegeofsocialworkers.ca/wp-content/uploads/2016/09/Gen-Reg-HPA.pdf
- The settings in which naloxone administration may occur include:
  - outside of a hospital setting
  - for persons anywhere on hospital property who are not inpatients, and
  - for inpatients who are not at the time in an inpatient area of the hospital
- The Colleges of OTs, PTs and SWs have recognized the changes to the HPA and have announced their intention to support registrants to administer naloxone for opioid overdose. In order to administer naloxone, registrants are responsible for acquiring the necessary training, adhere to clinical practice standards, and maintain current knowledge of policies, legislation, programs and issues related to this competency.

Unregulated care providers or support services staff whose work may involve an encounter with a person at risk of opioid overdose should be trained and prepared to use naloxone in response to a suspected opioid overdose.

- Northern Health supports all allied health professionals, unregulated care providers and support services staff to consider their need to take this competency training in order to reduce the risk of death as a result of an opioid overdose. Staff must follow the Clinical Practice Standard "*Naloxone Administration in the Management of Suspected Opioid Overdose*" available at: https://ournh.northernhealth.ca/PoliciesProcedures/DST%20Published%20Policies/1-22-6-020.pdf
- and complete the Learning Hub **module: "*Administration of Naloxone*"**

Dispensing and/or Distributing:

- At this time, NH will support the distribution of Naloxone Kits by social workers who have the appropriate training and competencies: Learning Hub module ***"Dispensing and Distribution of Take Home Naloxone Kits."***
- Social Workers who distribute Take Home Naloxone Kits must follow this Clinical Practice Standard, "Dispensing and Distribution for Persons at Risk of Opioid Overdose: Take Home Naloxone Kits" available at: https://ournh.northernhealth.ca/PoliciesProcedures/DST%20Published%20Policies/1-22-6-030.pdf
- All other allied health professionals or unregulated care providers should refer at risk clients to a Take Home Naloxone Site at: https://northernhealth.ca/Portals/0/Your_Health/OverdosePrevention/Take-home-naloxone-sites-Nov2016.PDF.

Professional colleges are in the process of developing statements to support this regulatory change. Please contact your college with specific questions about their current position.

For more information, please contact:

- **Clinical and Take Home Naloxone Program Questions:** Reanne.Sanford@northernhealth.ca
- **Scope of Practice and Professional Standards:** ProfessionalPractice@northernhealth.ca

Source:
Dr. Andrew Gray, MHO, NI HSDA

Mumps Refresher

Mumps has been in the news lately due to cases among professional hockey players. There have been no recent cases in northern BC, but your patients may be wondering what they can to do protect themselves against mumps.

About mumps

Mode of transmission: contact with respiratory secretions (contact or droplet), including by coughing, sneezing, sharing drinks, kissing, or contaminated surfaces

Incubation period: 12-25 days

Clinical presentation:

Acute parotitis (unilateral or bilateral tender swelling of the parotid), or inflammation of other salivary glands, typically preceded by a prodrome of fever, myalgia, malaise, headache, anorexia, or non-specific respiratory symptoms. Orchitis, oophoritis, or viral meningitis occur in a minority of cases, and are usually self-limited.

Complications such as infertility are rare.

Diagnosis requires laboratory confirmation by BCCDC:

- If 0-5 days from symptom onset: **buccal swab for viral PCR** (Starplex, S160V, blue top), ideally collected at Stensen's duct after milking the parotid gland
- If 6-14 days from symptom onset: **urine specimen for viral PCR** (sterile container), placed on ice or refrigerated and shipped immediately
- Ideally, acute and convalescent serology (IgM and IgG) should also be drawn, 3-5 days after symptom onset, and then 10 days to 3 weeks after symptom onset

Please call your MHO if you suspect mumps, as prompt control measures may be necessary.

How can mumps be prevented?

Immunization is the most effective way to prevent mumps. It is always worthwhile to verify whether a patient's immunizations are up to date.

A two-dose vaccination schedule with the MMR vaccine is 88% effective against mumps. In Canada, this schedule has been provided routinely to children born since 1996. In BC, the vaccine is given at 12 months and at 4-6 years old.

For the cohort born from 1970 to 1996, only one dose was provided. **People in this age group may benefit from receiving a second dose if they are at risk of exposure to mumps**. There is no harm in giving an additional dose if a patient's vaccination history is unclear.

People born before 1970 can generally be assumed to be immune due to prior infection.

Further reading

1. See the BCCDC Communicable Disease Manual for more details on this and other aspects of mumps at: http://www.bccdc.ca/health-professionals/clinical-resources/communicable-disease-control-manual/communicable-disease-control.

Source:
Dr. Andrew Gray, MHO, NI HSDA