It takes a TEAM

Members have once again answered RNAO's call for personal narratives that make up the annual collection of stories in the summer issue of *Registered Nurse Journal*. This year, we asked nurses to write about their experiences collaborating with other health providers. The stories feature members who work in the remote reaches of the Arctic Circle, in community geriatric care, hospice/palliative care, rehab and complex continuing care, and acute care. Their reflections offer compelling anecdotes that describe what interprofessional practice means to them. Thank you to each and every member who submitted a story for consideration this year.

COMPILED AND EDITED BY KIMBERLEY KEARSEY

Transition from RN to NP is easier with support from colleagues

By Lan Zhou

Nurse practitioners are required to exercise a high degree of independent judgment, provide comprehensive health assessments, and make clinical decisions to manage acute and chronic illnesses and promote wellness. For new NPs, the development of skills for this advanced practice role requires collaboration with other health providers such as RNs, RPNs, physicians, pharmacists, therapists, and social workers, particularly when caring for complex geriatric clients.

I graduated in 2013 from the MScN and primary health care NP program at York University. I was then hired to work in the geriatric medicine clinic at William Osler Health System, Etobicoke General Hospital. Although I already had 16 years of nursing experience in medical-surgical, ICU, post-anesthesia care units, and had done some NP clinical placements in the hospital, on a family health team, and in an NP-led clinic, I was still overwhelmed by the complexity of the geriatric patients in the clinic. Seniors can have complex health needs combined with socio-economic challenges.

One such client I helped was Cecile*, a 90-year-old widow with three children. She was suffering severe vascular dementia after a stroke two years earlier. She had a long medical history and her function was declining. She was dependant on her family for bathing, dressing and feeding. Cecile's appetite was very poor. She had difficulty sleeping, wandered, and tried to get out of the house at night.

If her family attempted to stop her, she would become very agitated and verbally and physically aggressive. The family was physically and psychologically stressed, and was struggling to make alternative care arrangements for their mom, who was on a one-year wait list for long-term care. They could not afford to hire a private personal care worker to provide respite care.

When Cecile came under my care, I knew I would need a lot of support given the complexity of her case. Fortunately, there was always a geriatrician working collaboratively with me. I also teamed up with other colleagues in pharmacy, community care, social work, and the Alzheimer's Society to offer Cecile care that was truly collaborative. Cecile was able to move into long-term care within one week, and her family really appreciated this outcome.

This experience showed me the importance of interaction and collaboration with other disciplines. It has significantly influenced me as I transition into this advanced role, and has allowed me to provide comprehensive, high quality of care to patients and their families.

** Pseudonyms have been used to protect privacy*

ILLUSTRATIONS: JULIA BRECKENREID

RNs tackle trauma in the north

By Jannine Bowen

In the late 60s, psychiatrist Leonard Stein published his now famous essay about the "doctor/nurse game." He wrote: "...the nurse is to be bold, have initiative, and be responsible for making significant recommendations, while at the same time she must appear passive. This must be done in such a manner so as to make her recommendations appear to be initiated by the physician." Revisiting that theory in the 90s, Stein admitted the "game" is no longer played. Any nurse working in an isolated, northern community is likely to agree with him. I do.

In the frozen, isolated tundra, above the Arctic Circle, our health centre serves about 900 Inuit people. There are three full-time nurses – supported by wonderful local staff – who are responsible for taking initiative and making recommendations for patient care, and often making life and death decisions on the spot.

One such instance was at 23:00 on a July night in 2012. The call came in that two young boys who had been drinking and smoking marijuana got on their all-terrain vehicles (ATV) to race up and down a gravel hill, and crashed. At the health centre that night: three community health nurses with combined expertise in emergency and ICU nursing. What follows is a testament to nurses' ability to come together to provide the best possible care, with the least amount of support. There were no "games" on this night.

A male teenager arrived on a piece of plywood and was taken to the only trauma room we had. As we started the primary survey and interventions, the crowd got bigger, the room got smaller and the nervousness grew. Above the crying, someone was screaming as they carried in the second teenager. "Where do you want him?"

"Right here on the floor in front of me," I said, glancing at the distracting deformity on his left leg. A local teenager did the primary survey: unconscious and not breathing. "Do you know CPR?" I asked him. He nodded. "Then start compressions."

We took the defibrillator leads from the first teenager and applied them to the second. No shockable rhythm. Two nurses continued on life-saving measures while the third connected with the on-call doctor by phone. After three rounds of life-saving measures, the code was stopped and we had to turn our attention back to the surviving teenager on the stretcher. The crowd continued to multiply. The crying escalated. With one boy clinging to life, the Medivac team was called, but our hearts were sinking in our chests as a mother bent over her lifeless son on the floor.

This shows the "doctor/nurse game" no longer applies. In the north, it is the nurse, the community, and the grace of God and his spirit that guide you to do the best you can as a team.

Team comes together to send patient home for Christmas

By Karimah Alidina

Interprofessional practice means working collaboratively and using evidence to provide the best quality, patient and family centred care. Having a multi-disciplinary team doesn't necessarily mean the care provided will be interdisciplinary. For me, interprofessional collaboration implies an interaction between different professions that is more organized and addresses common patient goals. When members of a team feel excited about collaborating, and when the outcomes are more co-ordinated, effective and timely, that is truly interdisciplinary care in action.

In December 2013, I was working at a hospice in Oakville when I had the pleasure to meet and care for a 43-year-old man named John.* He had bladder cancer. John had a very loving family, including a very young wife and toddler twins.

> "Talking to him made me realize that he knew it was his last Christmas, and he was hoping to go home for Christmas Eve."

When I first went to see John in his room, I saw him signing Christmas cards and individually wrapping the gifts for his family and friends. Talking to him made me realize that he knew it was his last Christmas, and he was hoping to go home for Christmas Eve.

John was retaining blood clots in his urine resulting in frequent blockages of the urinary catheter, requiring bladder irrigation. In order for him to go home, the team had to ensure his catheter drainage and pain was well managed away from the facility. The team, which included nurses, a palliative care physician, a hospice co-ordinator, and a personal support worker, met with John and his wife to develop a plan to support his goal of going home.

A urologist was also involved, who came to the hospice and performed a procedure to insert a larger catheter to prevent clot retention. The nurse and palliative care physician created a well-documented plan to manage John's pain at home.

Despite several challenges, John was able to go home that Christmas Eve. This is what truly interprofessional collaboration means to me. Each professional collaborated to ensure safe, high-quality care for the patient and his family.

It takes a TEAM

Collaboration translates into substantial change for TB patients

By Jane McNamee

As a nurse practitioner at Toronto's West Park Healthcare Centre, I have seen firsthand how collaboration can improve practice. I work for the Tuberculosis (TB) Service, a provincially designated treatment centre for complex cases of tuberculosis. We offer in-patient and out-patient services for sometimes drug-resistant cases of TB (known as multi-drug resistant or MDR TB). This requires multiple and potentially toxic medications for extensive periods of time. Amikacin is one such medication, and is only given intravenously over the span of several months.

For two years, I have wanted to implement a more concrete protocol for this medication because I have witnessed the damage it can cause, including permanent hearing loss. My chance to change practice came when the organization began hosting monthly education sessions. I volunteered with my colleague, a pharmacist, who also wanted to challenge current practice. Together, we presented basic information about Amikacin and the current TB guidelines for its use. My colleague was able to discuss recent studies, which support our concern that many patients suffer permanent hearing loss as a result of this medication.

Our goal was to draft a protocol to implement stricter monitoring for side effects and reduce the use of Amikacin. The existing practice certainly included monitoring, but it was ad hoc and lacked a formal structure. Our proposed new protocol was based on recently published Canadian TB Standards.

The fateful day of our presentation arrived, and I was worried about my just passable presentation skills. The assembled group included several physicians (with expertise in infectious disease and family medicine), respirologists, Toronto's medical officer health, and a number of other members of our team and the public health team. Despite my nerves, I was eager and passionate to implement change. The group was impressed with our synthesis of the material. We concluded by circulating a draft protocol based on our current practice. With all the key stakeholders around the table at the same time, the new protocol was reviewed and appropriate additions were made.

This protocol is now in practice on our unit. In fact, even before I was able to update the information, we began using it on our patient rounds the very day that we presented the material. I had no idea that in collaboration with others, I could achieve such substantial change.

Study group allows health professionals to collaborate through storytelling

By Michele Ivanouski (with contributions from Shannon Arntfield)

When working in a large health-care centre, staff can feel compartmentalized within their niche, whether it's newborns or geriatrics, emergencies or long-term care, diagnosing or treating. However, health-care providers do not work in isolation, and patient care plans can be the creation of many voices.

In 2011, a physician colleague, Shannon Arntfield, initiated the *Narrative Medicine Study Group* at London Health Sciences Centre. Within this interdisciplinary group, we use stories to teach that how care is delivered (the process) is just as important as what care is delivered (the content). This unique way of listening to patients has produced some surprising and inspiring results.

Each member of the group takes a turn leading the monthly meetings. We read and listen to stories from patients, families, and health professionals who have experienced care "on the other side of the fence" as a patient or family member. During one meeting, we used a foreign film to bring cultural end-of-life considerations to our discussions. Ideas flow freely between the group members, including dentists, ethics professionals, general practitioners and subspecialists, humanities professionals, medical students, midwives, nurses and university professors. It is a unique opportunity to share ideas in a non-judgmental and inviting environment. We wrap up each meeting by writing reflectively, in response to a prompt crafted by the facilitator.

In one story, an organ donor's family described their son's body as a treasure chest of jewels. This created a surprising difference of opinion among the group. Some felt this boy's life had been reduced to objects: his organs. Others felt his family was describing a sense of fortune, that his final gift would impact the lives of others.

The *Narrative Medicine Study Group* initiated a public patient experience evening at the London Public Library. Through this, health professionals have the opportunity to engage and learn from those who have experienced illness. Their stories challenge us. One patient felt that if care providers had made more eye contact with him when he was a teenager, rather than his father, he would have felt more involved with his diabetic treatments. Another patient suggested that if caregivers would express regret that a previous plan did not work, she would feel more open to accepting new ideas.

This group work helps us hear patient journeys through many different professional and patient voices, and it inspires patient-centred care in all areas. Stories give us clues as to how green the grass truly is, or is not, on a patient's side of the fence.. **RN**

KIMBERLEY KEARSEY IS MANAGING EDITOR AT RNAO.