Celebrating 85 years • A conversation with the Health Minister • Spotting colon cancer

Registered Nurse JOURNAL

January/February 2010

A peaceful end

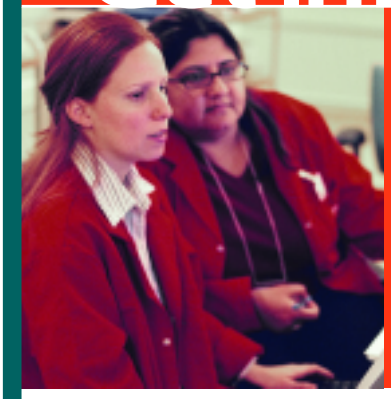
The art and science of palliative care need additional support so more people have gentler deaths.

PM 40006768

RNAO Announces...

February is Nursing and eHealth Month!

Get informed Get involved



Make eHealth Your Priority

- Nursing and eHealth Education Program: www.rnao.ca/eHealth_Course
- Nurse peer leader strategy involving 14 Nurse Leaders who facilitate eHealth education and knowledge sharing
- eHealth Champion Workshops across Ontario with 500 current eChampions
- Nursing and eHealth Toolkit focusing on eHealth implementation
- Nurse Managers and eHealth Initiative

and much more! Contact jboyce@rnao.org for more information.

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Registered Nurse JOURNAL

Volume 22, No. 1, January/February 2010

THE LINEUP

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85 years

FEATURES

Cover illustration: Sandra Dionisi

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A trip through RNAO's history

Work on this issue of *Registered Nurse Journal* began in a most unusual place – at the bottom of dusty boxes long packed away in a storage room. Inside, were treasures that chronicle the association's past 85 years. Photos and programs from annual general meetings gone by reflect the growth of RNAO membership, and the issues of the day. That includes, in 1965, an announcement that the meeting would adjourn early so every member could walk up the street to Queen's Park to demand that politicians give nurses the right to collectively bargain for their contracts. When I stumbled upon that photo, I realized that some things really do remain the same, regardless of the year. The passion to create a better profession, and better patient care, is a theme that pops up again and again.

There were also some more surprising items in the boxes: a bedpan; a shave prep tray; and a blood administration set. They all look to be well past their expiry dates, but discovering them made me smile. After all, besides the odd museum exhibit, where else could you find such artifacts?

Throughout this year, we'll be bringing you photos and facts from the past in each edition of the *Journal*. This issue kicks off the celebrations with a timeline of some important events in RNAO's history. I also hope you'll share your reflections with us. You can send your favourite RNAO memory, or what the association's 85th anniversary means to you, to jscarrow@rnao.org.

Of course, this issue is more than a look back. In our cover feature, you'll meet the members of the newly formed Palliative Care Nurses Interest Group who are crafting plans to make this specialized care a priority for policy makers, health providers, and nursing educators. We also look at the ways nursing continues to evolve. In our profile, we introduce Cathy Woldanski, who works with people who have hepatitis C. She helps them stick to their medications and cope with the poverty many with the illness live in. And we explore how nurses are catching a deadly disease early. RNs across Ontario are now performing flexible sigmoidoscopies to make colon cancer screening available to more people so they can spot the illness, and stop it before it kills. The RNs' stories in these pages are perhaps the greatest celebration of the legacy of this association's founders. Their dreams of a strong profession filled with knowledgeable women and men are realized every day through the work of each of you.

Jill Scarrow
Acting Managing Editor

RNs mourn nurse killed in Haiti earthquake

RNAO members were saddened to learn of the death of Yvonne Martin during the devastating earthquake in Haiti on Jan. 12. Work in Haiti became a passion for Ms. Martin after she retired from her career as an RN at a medical centre in Elmira, a small town near Kitchener-Waterloo. She died just 90 minutes after arriving in the island nation. She had planned to embark on her fourth aid mission to help people in the country.

In a condolence letter to her family, RNAO President Wendy Fucile and Executive Director Doris Grinspun offered their sympathies to Ms. Martin's family, and commended the work she was doing to ease the suffering of impoverished Haitians.

Anniversary celebrates years gone by, and looks toward accomplishments to come

Welcome to the start of a very special calendar year! This year finds us standing at the beginning of another new decade, and 2010 also brings with it RNAO's 85th anniversary – truly a landmark!

We are privileged to have a very few members who did themselves see the year 1925. For the rest of us, here are just a few other world and Canadian milestones of that year: the newest dance craze was the Charleston; women in Newfoundland won the right to vote; and Doris Anderson, long a champion of women's rights, was born in Calgary.

And in Ontario, the Registered Nurses' Association of Ontario took shape. Our founders saw, with great clarity and with real courage, the capacity of nurses to promote excellence in practice and to influence the political decisions that affect both nurses, and the public we serve, through concerted and sustained efforts to affect healthy public policy. They recognized that knowing government, understanding how government works, and actively engaging with government was the road to improving not only the well-being of nurses, but of every individual in our society.

As we move towards our anniversary celebration in April, you will see and hear much more about our past and our roots. It is very clear that one of the threads that has consistently run through our history, over all of these 85 years, is the recognition of the importance of political action as a means to achieve the ends of the association. While the greater ends we seek have not substantively shifted over time, the specific areas that we target for action have, reflecting both successes achieved as well as the needs and circumstances of the day. In the same way, the approach to action also shifts from time to time, reflecting the specific goals we seek and the circumstances of the time. Textbook authors call this 'situational leadership.' In real life, it is both the simple and complex act of recognizing the need to have a whole range of strategies, to thoughtfully selecting the strategy best suited for that moment in time, and to consistently demonstrating the courage to shift and shape strategy in an ongoing way. All of this work is built upon one fundamental and unchanging base – a rock solid commitment to the mission and values of the association.

One of the key roles of any Board of Directors is the ongoing and regular assessment of strategy, looking always to ensure that the mission and core values are observed. Your board members are fully engaged in this work and it is my pleasure, on your behalf, to participate with them in those discussions and decisions. It is also the role of the board, and of our leaders in the Assembly, to demonstrate through actions our own commitment to moving the organization forward.

> "As we approach our celebration of the past, we must also use this moment to determine what our preferred future is. That act of choosing, that decision to shape what lies ahead, will require a sustained commitment to action from each and every one of us."

In the field of political action, the most recent example of this is our very successful Queen's Park Day, held this year on Jan. 28. Without question, one of the highlights of that day was the release of our election platform. This thoughtful, evidence-based, visionary document is built on a deep understanding of the critical role social and environmental determinants play in health. The document provides politicians of every party with a road map for moving towards a truly healthy society.

For those of you who were able to come to Queen's Park, my profound thanks for your time, your energy and your support. Excellent ambassadors and representatives all! For those who were unable to be there, I would strongly encourage you to consider, at least once in your career, joining this exciting day. You will be left with a feeling of accomplishment, with a deeper understanding of the degree to which the views of RNAO are heard and respected within the halls of provincial politics, and with a renewed sense of confidence in the capacity of our association to achieve our shared mission … speaking out for health, speaking out for nursing.

Jane Goodall, noted researcher and advocate in primatology, once said "the greatest danger to our future is apathy." As we approach our celebration of the past, we must also use this moment to determine what our preferred future is. That act of choosing, that decision to shape what lies ahead, will require a sustained commitment to action from each and every one of us, and an acute and sensitive ability to tailor our actions to the needs of the time, the specifics of the situation. As an opportunity to demonstrate your own commitment to act, I invite you to join us in Toronto, from April 15 to 17, for our 85th Annual General Meeting and what will be a very special time in the history of this association. See you there! **RN**

WENDY FUCILE, RN, BScN, MPA, CHE, IS PRESIDENT OF RNAO.

Haiti earthquake brings despair, and demands for a better future

On Jan. 12, I, like many others, was shocked and deeply saddened to watch the tremendous devastation in Haiti unfold after a 7.0-magnitude earthquake shook the island nation. Most disturbing were the images that came to blanket media coverage in the subsequent days. Photos of bodies pulled from the rubble, children left orphaned, people with severe injuries, and haunting images of survivors desperately trying to find food and water filled the news.

Alongside the torrent of emotions was a tremendous pride in nursing. It only took hours for colleagues from across the province to contact RNAO looking for ways to help. Nurses' selfless desire to rush to the aid of fellow strangers reassured me of the great compassion that exists in humanity. Several RNAO members travelled to help in Haiti following the earthquake, including Valerie Rzepka, policy analyst at RNAO and chair of the Canadian Medical Assistance Teams (CMAT), a volunteer disaster medical relief unit that has responded to numerous other tragedies, including the 2004 tsunami in Asia. She was joined by many health-care colleagues, including RNAO members Carolyn Davies, Maida Mrakovic and Aric Rankin. Countless other RNs are also doing their best on the ground to relieve Haitians' suffering, while others are making donations to non-governmental organizations. Your association is also helping and has donated $2,000 to CMAT.

The work these brave nurses are doing is not without risk. That was a cruel reminder when I learned one of our own colleagues was killed during the quake. Yvonne Martin, an RN from Elmira, Ontario, had just arrived in the country to begin an aid mission when the earthquake hit. Yvonne, fully committed to working with the Haitian people, was about to begin her fourth visit to the country when the hotel she was staying in collapsed. Speaking with her son Luke, I expressed our deepest condolences for the family's loss, our loss, and our praise for Yvonne's determination to improve wellness for Haitians living in horrific poverty.

This most recent natural disaster has brought the world's focus to Haiti, but it has long been a country troubled by abject poverty, economic dependency, a troubled political history, and environmental degradation—all denying this country's nine million people their basic human rights. In Haiti, the poorest nation in the western hemisphere, 66 per cent of the population lives on less than $1 a day and 47 per cent of the people are undernourished, according to the United Nations World Food Program. More than two-thirds of the labour force is unemployed or underemployed, the inflation rate in 2008 was 15 per cent, and many people lived inside poorly constructed homes that collapsed on top of them when the earthquake hit. Given that these extreme conditions have existed for decades, all world leaders must share the shame that not all of Haiti's external debt had been cancelled. In large part, those debts contributed to the poor quality of life so many in the country endure, and the poor health many Haitians suffer.

> "We must advocate for Haiti...we can demand money be spent on homes, health care, education and other social programs."

Life expectancy in Haiti is just 61 years for men and women, as compared to 81 in Canada. In fact, Canada hasn't had a life expectancy rate so low since 1931. In Haiti, the infant mortality rate is 60 deaths per 1,000 live births. The last time it was that high in Canada was 1941. Today, Canada's infant mortality is just five per 1,000 live births. And 120,000 people in Haiti are estimated to be living with HIV/AIDS. Before the earthquake, it was a country that was already considered to have a high risk of infectious diseases. Now that so many people are living in temporary camps with limited access to clean water and proper sanitation, the chance of diseases like cholera spreading will only grow, threatening to devastate weakened people even further.

Haiti will continue to lie in a region that is prone to earthquakes and other catastrophes like hurricanes, and will also be affected by climate change aggravated by the country's awful deforestation, soil erosion and inadequate water supplies. However, there is much we can and must do to ameliorate these disasters, and even more to change their outcomes. Haiti is the second largest recipient of Canada's foreign aid – it is essential that our tax dollars be well spent. We must advocate for the immediate cancellation of all international debt owed by Haiti, and all emergency aid should be in the form of grants and not loans. We can demand money be spent on building safe homes, health care to provide for the sick, rural development for impoverished farmers, and education and other social programs to help build a country where people can stay well.

The international community must act responsibly. While the urgent task is to make sure humanitarian assistance is effective and reaches the people who are suffering, the kindness the world has shown in the last few weeks should not be short-lived. As global citizens, we have a responsibility to make sure the legacy of this tragedy becomes one of re-building, transformation and hope for Haitians. **RN**

DORIS GRINSPUN, RN, MSN, PhD (CAND), O.ONT, IS EXECUTIVE DIRECTOR OF RNAO.

Mailbag

RNAO wants to hear your comments, opinions, suggestions

Civilian physician assistants need closer examination

Re: Member responds to RNAO's views on physician assistants, November/December 2010

I am a fourth year nursing student at the University of Ottawa. I have been researching the issue of Physician Assistants (PAs) as part of a group project focused on political action. I am also an active member of the Canadian Forces.

I personally take issue with people attempting to substantiate the use of PAs by using the argument that the military has used them for quite a number of years. Even though this is true, it is not often pointed out that there are vast differences in the education and training of military and civilian PAs.

Before becoming a PA in the military, a member must first serve as a medical assistant for a number of years (usually a minimum of eight) gaining valuable education, clinical experience, discipline and leadership skills. On the other hand, a civilian can enter into the two-year PA degree program offered at McMaster University having only completed two years of an undergraduate degree that does not even have to be related to health care. To say that these two are equitable or even comparable is quite an exaggeration.

I do agree with Marilyn Crummey that RNs may not be fully informed on the PA issue. However, abandoning support for RNAO's position is not the answer.

Teresa Levesque, Ottawa, Ontario

RN shares experiences of double-duty care

Re: RNs take on twice the workload to care for family members at home

I found this article very interesting. The writer states that some organizations allow nurses to take family days. That is good. My parents are elderly and do not drive. As the daughter who lives closest to them, I see to their appointments and medications, but my employer makes me switch days or take vacation days in order to do these errands for them and make appointments on my days off, meaning I really do not get much rest. They don't acknowledge the definition of "family days" to include doctor appointments or other medical appointments. For our own sick days, we are called at home on the days that we call in sick. I had no sick days in 2008, and my reward from the hospital was coupons for six small cups of free coffee from the hospital coffee shop. Sometimes you just get tired of fighting to stay in the profession.

Name withheld by request

RNAO wins prestigious awards

RNAO's Best Practice Guidelines Program recently received three top awards from provincial, national and international organizations.

In November, the association's innovative approach to provide high-quality long term care received the Minister's Award of Excellence. Accepting the award were (L-R): Ontario's Chief Nursing Officer Vanessa Burkoski; long-term care BPG coordinators Saima Shaikh, Maryanne D'Arpino, Gina De Souza, Heather Thompson and Heather Woodbeck; RNAO staff Heather McConnell and Citlali Singh and Executive Director Doris Grinspun. Holding the award are Long-Term Care Best Practices team lead Josie Santos, left, and Health Minister Deb Matthews. RN

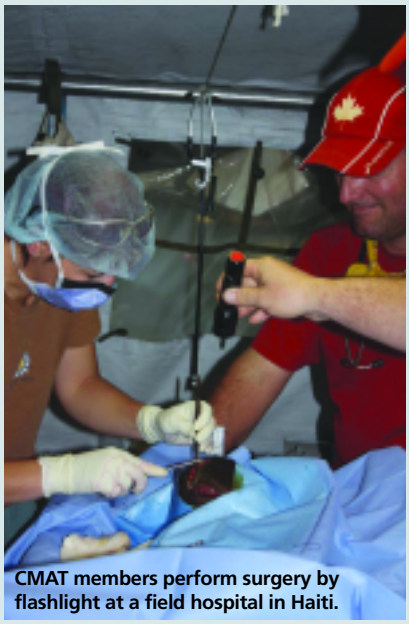
Also in November, RNAO, the joint RNAO/University of Ottawa Nursing Best Practice Research Unit and 21 Best Practice Spotlight Organizations received the inaugural Practice Academe Innovation Collaboration award at the Sigma Theta Tau International (STTI) conference. The award recognizes efforts between nursing practice and academia to improve health. Pictured receiving the award (L-R): Heather McConnell, RNAO; Barbara Davies, co-chair of the NBPRU; Irmajean Bajnok, RNAO; Doris Grinspun, RNAO; and Carol Huston, STTI.

The Canadian Dental Association recognized RNAO for its outstanding contribution to oral health through the best practice guideline, *Oral Health: Nursing Assessment and Intervention*. RNAO members accepted the Oral Health Promotion award in Ottawa. L-R: RNAO board member Nancy Watters; Una Ferguson, a member of the guideline's panel; Toba Miller, lead of the panel; and Dr. Don Friedlander, president of CDA.

by Stacey Hale

Nursing in the news

RNAO & RNs weigh in on . . .



CMAT members perform surgery by flashlight at a field hospital in Haiti.

Emergency aid to Haiti

Four RNAO members — **Valerie Rzepka**, **Aric Rankin**, **Carolyn Davies** and **Maida Mrakovic** — joined thousands of Canadian aid workers and health-care professionals who swiftly travelled to Port-au-Prince, Haiti following a deadly earthquake that rocked the country in mid-January.

The trio travelled to Leogane, a city about 30 km west of Port-au-Prince, to provide emergency medical care as part of the 16-member Canadian Medical Assistance Team (CMAT), which Rzepka chairs. With the help of a contingent of Canadian sailors, the group erected a hospital where health providers could treat hundreds of people with crush injuries and infections. "There is not a lot of infrastructure here. These people are the poorest of the poor, and now they are even poorer. So they need as much care as they can get," Rzepka told the *National Post* (Jan. 22).

Volunteer health workers also had to worry about fatigue. "We start at eight o'clock in the morning and we go until eight o'clock at night …you try to get a break when you can," Rankin told the *Post* (Jan. 22).

Canadian Medical Assistance Team members work to treat a burn victim in Leogane, Haiti.

CMAT members have experience responding to massive natural disasters, including the 2004 Asian tsunami, floods in Bangladesh and earthquakes in Pakistan and China. The work "really calls to me," Rzepka told the *Toronto Sun* (Jan. 14). **RN**

Olympic inspiration

In December, lucky RNAO members **Karen Michelsen** and **Linda Ready** got a once-in-a-lifetime opportunity to help kick off the 2010 Winter Olympics. The pair was selected to carry the torch through Cobourg, Ont., as it headed west for Vancouver for the games. "It is a great honour. I never thought I would be doing something like this," Michelsen told the *Kingston Whig-Standard* (Dec 14). To snag the role, she wrote a letter on how she keeps active, which is no challenge for the St. Michael's Hospital RN. She has run 30 marathons on all seven continents, including races in Egypt, Antarctica, Chile, Japan and Las Vegas. She finds time to run 32 km in between 12-hour shifts and holds an advanced brown belt in karate. Michelsen was inspired to become a marathon runner after fighting SARS as a member of an acute care team. "That is when I discovered life is really short," she says.

Ready's essay also earned her a spot on the torch-bearing team. The Ross Memorial Hospital RN jogged the 300-metre relay through Cobourg on Dec. 15. She admitted it would have been nice to run in Lindsay, her hometown, but said the opportunity to meet participants from other communities and hear their stories made up for having to go elsewhere. "It was humbling, inspiring and a huge honour…and one of the coolest experiences of my life," she told *Kawartha Lakes This Week* (Dec. 17).

Climate change

As the world's top political leaders met in Copenhagen in December to try and reach a much-needed agreement on climate change, Ontario nurses called the meetings a squandered opportunity. RNAO President **Wendy Fucile** called the lack of leadership and strong action from Canada deeply disturbing because "nurses know how global warming is dangerous for our health and our patients." Fucile pointed to the lack of targets for emissions cuts and the fact that the agreement isn't binding as evidence of how little was accomplished during the two-week-long conference (*CFOS-AM Owen Sound,* Dec. 23). RNAO Executive Director **Doris Grinspun** said the failure to act is inexcusable. "It's clear Mr. Harper wasn't listening, but we urge him to step up and lead on this issue," she said, adding, "Canada is a wealthy nation that is playing a negative role in global warming through decades of high per capita emissions," (*Canadian Business Online*, Dec. 21).

For complete versions of any of these stories, contact staceyh@rnao.org.

Leadership abroad

Nurses in Shanghai learned about the importance of a healthy work environment and nursing leadership during a conference in late November. **Irmajean Bajnok**, RNAO's Director of International Affairs and Best Practice Guidelines Programs, travelled to China to deliver workshops and speak to members of the Shanghai Nurses Association. The workshops focused on nursing management and drew material from RNAO's best practice guideline, *Developing and Sustaining Nursing Leadership*. "A better working environment has been an important issue globally, especially in nursing," Bajnok told *Sing Tao Daily* (Dec. 4). The visit was part of an ongoing partnership between RNAO, the Beijing Nightingale Consultation of Culture and the Chinese Nursing Association.

Running to become an MPP

RNAO member and well-known street nurse **Cathy Crowe** set her sights on provincial politics when she joined the race to replace outgoing Toronto-Centre MPP George Smitherman. Crowe represented the New Democratic Party in the Feb. 4 by-election. As of press time, the results of vote were not available. Crowe is a community health nurse who has worked with the homeless and disadvantaged for 25 years. "As a nurse, I've seen a lot of conditions worsen in the riding," she told the *Toronto Star* (Jan. 7). "I want to be able to speak of the need for more funding for social programs and better spending in terms of health-care dollars," (*Northumberland Today*, Jan. 8).

Cathy Crowe is the NDP candidate in a Toronto by-election this February.

Reducing wait times

RNAO member **Janet McCabe** says urgent care centres are one of the Toronto area's best kept secrets. McCabe is the clinical leader of the Trillium Health Centre's urgent care facility. In December, she spoke with the *Toronto Star* urging people to consider the centre as an alternative to busy emergency departments. "The public is gradually getting to know about us more and more. The secret is getting out," McCabe said (Dec. 28). The centre treats patients with minor emergencies such as fractures, sprains, burns, stitches and more. They don't take life-threatening cases, aren't open 24 hours and don't have in-patient beds to admit patients. But they're fast. Patients who are considered low acuity can wait up to five hours at Trillium's ER. The urgent care centre aims to treat and assess them in 60 to 90 minutes. The province is using these centres as part of a strategy to reduce long wait times in the ER.

Physician assistants in Ontario

RNAO President **Wendy Fucile** raised the association's concerns on physician assistants in January. She told the *Toronto Sun* RNAO is worried about the role because of a lack of education and oversight. "To belong to a regulated profession gives to the public a sense of assurance that somebody out there is taking a stand to protect their safety. The introduction of another health role without that protection is a disservice to the public," she said (Jan 21). Executive Director **Doris Grinspun** echoed those concerns during an interview on Jan. 26 with radio station *98 The Beach* in Port Elgin.

*On Dec. 18, RNAO member **Linda Bishop** wrote a letter to the* Brock Citizen *explaining the seriousness of peanut allergies.*

Peanut issue boils down to respect

I have been reading with some disgust the recent letters to the editor regarding peanut limitations in our schools. I am a mother of a child who is anaphylactic to peanuts. I am also a registered nurse. Peanut is one of the most severe food allergens and it can produce an anaphylactic reaction, which is life threatening. We send our children to elementary school because it is their right. But it is the school's responsibility, as well as that of all parents and fellow students, to contribute to a safe environment for everyone. Young children need time to learn, grow and be a kid. Anaphylactic children are not born knowing how to keep themselves safe, they need time and a safe environment to do so. Our schools are trying to give them this by asking everyone to avoid bringing peanut products to school. Many school officials are also trained in how to care for these children until they get to hospital. When our daughter was diagnosed, our family took on the responsibility of educating ourselves about her condition. I encourage you to get over the limitations of taking peanut butter to school and spend time explaining responsibility and respect for others to your child. If you need ideas for lunch boxes, I have lots.

Linda Bishop,
Beaverton

Nursing in the news

RNAO & RNs weigh in on . . .

Photo: Colin McConnell/GetStock.com

Treating mental illness

RNAO member and nurse practitioner (NP) **Donna Kydd** (right) works with patient Marion Harper at an NP-led clinic in Oshawa. The clinic is the Greater Toronto Area's first and the only one focusing on mental health patients and their families. "We see people who have not been successful in finding a family doctor," she said. It's not unusual for patients with serious mental illnesses to have a hard time keeping a physician, according to Kydd. They can miss appointments, take longer to interview, some are transient and some have trouble complying with treatment (*Toronto Star*, Jan 2). The clinic opened a year ago as a pilot, but was given final approval by the province in November, bringing the number of NP-led clinics announced to 11.

Dancing for health's sake

RNAO member **Bev Boyes** is lacing up her dancing shoes for a good cause. On Feb. 20, the Chatham-Kent Health Alliance NP is taking part in the third annual Dancing for the Stars fundraising event. She and five physician colleagues will be coupled with a professional dancer from Toronto and will learn two ballroom dances such as the Fox Trot or Cha Cha Cha. Donations will go towards purchasing new medical equipment and updating facilities and services that need it most at both the Chatham and Wallaceburg campuses. Last year, more than $14,500 was raised to help pay for an MRI scanner for the hospitals (*Chatham This Week*, Dec 9).

Cancer care

An interest in oncology nursing led RNAO members **Melissa Snell** and **Nisha Sutherland** to win fellowships from the de Souza Institute for cancer care in Toronto. Both are graduates of the University of Western Ontario in London. Snell received $10,000 to pursue her master's and Sutherland received $20,000 to put towards her PhD. "It is wonderful to have resources like this available," Snell told the *London Free Press* (Dec. 8). Along with receiving financial support from the institute – which is funded by the province – Snell will participate in monthly professional development seminars with other nurses. RNAO member **Mary Jane Esplen,** director of de Souza Institute says the "fellowship program … will potentially enable these nurses to make a tremendous future impact on cancer care in Ontario." **RN**

Out & About

On Jan.17, members of RNAO's Lakehead Chapter volunteered at the local Shelter House to serve dinner to nearly 200 homeless people living in Thunder Bay. Chapter members hope to help out at the dinner once a month to raise awareness of poverty in the city and around the province. The group also hopes to find volunteers to knit hats and scarves to be donated to the homeless throughout the winter. Here (L-R), Sally Dampier, Jan Seeley and Nicole Landgradd get ready to serve up vegetables.

Nursing Students of Ontario executive member Nik Broukhanski recently got an inside look at health issues affecting transit workers. The Lakehead University student completed a clinical placement at the Toronto Transit Commission (TTC) this winter. Broukhanski, shown here at a maintenance facility for buses and streetcars, worked with the Health and Wellness team. The team promotes healthy lifestyles among TTC employees and helps those who are currently on long-term disability return to work. He also helped out during a campaign called *Eat the Better Way*.

In November, RNAO's Nursing Best Practice Champions network welcomed its 3,000th member. Esmerelda Van Riemsdijk (right), a nurse practitioner at St. Michael's Hospital in Toronto, received the honour from Heather McConnell, associate director of RNAO's International Affairs and Best Practice Guidelines (BPG) program. Champions work in their organizations to encourage their colleagues to use RNAO's BPGs in their practice.

Inspirations for a career

A nursing student shares how a positive clinical experience sparked her enthusiasm for the profession. BY AMIE MCKAY

Whenever I begin a new clinical placement, I'm always a bit nervous about what I will find. Will the RNs be welcoming? Or will they feel burdened by my questions? Last fall, I was especially anxious when I started a placement on the cardiology unit at St. Mary's Hospital in Kitchener. I was going to a specialized floor, and I worried about how I would learn things right away.

So I was grateful when I met my preceptor, Anita Cressman. She made me feel welcome and introduced me to everyone on the team within my first two shifts. She made sure I was part of every different aspect of cardiac nursing. She also helped me learn new skills, especially telemetry. She sat with me during every shift and showed me how to identify normal arrhythmias and determine how they may be related to patients' diagnoses or symptoms. Because rhythms are very important in cardiology, I wanted to make sure I understood them. My preceptor reviewed them with me until I became more independent with my knowledge. As my confidence grew, I began to read the telemetry reports myself, but I could always ask my preceptor if I had any questions. Today, cardiology is my new passion.

The supportive and positive work environment I was part of on the unit was a nice surprise. During my four years in the Conestoga College-McMaster University nursing program, most of my placement experiences have been in medicine, surgical, and psychiatric areas. Sometimes, I have seen nurses burned out by heavy workloads show a lack of compassion toward students. Students can feel the negativity coming from nurses. I have even overheard RNs say "oh, students again … they really can't do much of anything." All those negative attitudes really contribute to students' perceptions of the profession. But my experience on St. Mary's cardiology unit got me excited to start my career. Now, I want to be part of the organization and to learn more about cardiology. I have never been on a unit that has affected me this much. I hope my experiences will give hope to other nursing students. There are compassionate, knowledgeable, welcoming RNs out there who will create positive learning experiences for students.

The nurses on the unit demonstrated all the elements of a healthy work environment that I've learned and read about in class. They have healthy, positive inter-collaborative practice, open communication with fellow team members, patients and students, shared decision making and goal setting, and the entire team has a strong knowledge base.

I always felt like a part of the team and a welcomed novice. The nurses wanted me there, and I could ask them anything. Even during the shifts when my preceptor wasn't working, I could always turn to another RN if I had a question. The first time one of my patients had chest pain, another RN jumped to my side right away. She helped me read the ECG and call the physician. Afterwards, we talked about the medications the woman was taking, and how they would affect her condition.

After being on the unit for a few weeks, I started to wonder how the staff members felt about their team. I created a confidential survey asking for the nurses' opinions on job satisfaction. Fourteen participants (all RNs) were included. They told me they think their unit runs so well because they all share a passion for cardiology, they respect one another, and there's a mix of older and younger nurses. They also think the team is strong because it includes nurse practitioners, they use a multidisciplinary, collaborative approach to discharge planning, and there are strong communication and professional relationships between staff members, who also have good conflict resolution skills. When I asked them to review things that did not run well, the nurses could not come up with anyhing they wanted to change or vent about.

I hope my story will show that students can have positive experiences that allow them to develop professional relationships, and become passionate about nursing. I still have one last placement left to complete before graduation this spring, and I can only hope that the qualities I have learned from the nurses at St. Mary's can be instilled and embraced wherever I work as a student or new grad. **RN**

AMIE MCKAY IS A FOURTH-YEAR STUDENT IN THE CONESTOGA COLLEGE-MCMASTER UNIVERSITY COLLABORATIVE BSCN PROGRAM.

Illustration: Kelly Schykulski

Guiding a peaceful end

RNs say the fine art and precise science of palliative care need support so more people have a dignified death.

Pat Hickman is often present during one of the most emotionally charged chapters in families' lives: the time they spend saying their final goodbyes to a loved one who is dying. Keeping a terminally ill client comfortable while also giving families the privacy they need is a delicate dance Hickman has spent an entire career choreographing. Sometimes, the home care nurse needs to be at the patient's bedside to administer medication for pain, breathlessness or anxiety. At other times, she'll sit quietly in the corner of the room to finish paper work and give the family an opportunity for private conversations.

"You need to blend into the background of things so families have their time – their words, being with their loved one, their memory-sharing," she says. "It's an opportunity for them to mend some bridges. To say sorry. To say goodbye. They won't have that chance again."

Hickman, who is a member of Saint Elizabeth Health Care's palliative care team in Brampton, Ontario, says clients often teach her about the best way health-care providers can meet their needs. She recalls one man who was told by doctors last spring that he wouldn't live to see Christmas. He knew his heart condition was so severe that he was no longer a candidate for a defibrillator or a pacemaker, and that his renal failure was in the final stages. But he didn't want to know when the end would come. As Hickman talked to the man and his wife about

BY JILL-MARIE BURKE • ILLUSTRATION BY SANDRA DIONISI

his impending death, they told her that hearing about his failing organs hadn't upset them half as much as being given an expiry date.

Hickman says his story is a powerful reminder that bad news must be delivered in a way and at a pace that's appropriate for each individual. "Palliative care patients teach us about the emotional and psychological suffering and pain that we often miss in our efforts to manage their physical pain and symptoms," she explains. Hickman says if physicians had asked her client how much more he wanted to know, and had only given him the information he asked for and could handle at the time, he wouldn't have been haunted by the knowledge that he would be dead by 2010.

Hickman believes people could be spared any unnecessary suffering if all health providers truly understood the complexity of caring for the dying. Although the Canadian Nurses Association has recognized palliative care as a nursing specialty since 2004, Hickman still meets people who believe the job is as simple as "patients get into bed, we cover them all up cozy, and they just stop eating and drinking and then they die." Years in the field have taught her that it is an intense, complex specialty that requires her to think on her feet and use knowledge, assessment skills and state-of-the-art medical interventions to provide excellent nursing care at a critical time. She may provide sedation or manage symptoms related to shortness of breath, bowel obstruction or hemorrhaging. But Hickman says empowering patients to make choices related to their care and providing support to the entire family are equally important aspects of her job.

RNs who work in palliative care say they would be able to meet the needs of their clients more effectively if the provincial government recognized palliative care programs and resources in community, hospital and long-term care settings as specialties that need funding and support in their own right. While dying is a natural and expected part of the life cycle, the lack of government funding, the limited number of RNs with the education needed to provide specialized care, and a general lack of awareness among both health providers and the public mean that not all Ontarians can die on their own terms, in the place of their choosing, with the dignity they deserve. They're issues that will be top of mind for RNAO's Palliative Care Nurses Interest Group as it begins its work in earnest this year. Hickman is part of the group which formed last fall, and says members want to ensure decision makers and the public understand that good palliative care begins well before the final days of life.

In the United Kingdom, where Hickman spent 20 years learning the art and science of palliative care, she was with patients when they received a diagnosis of lung cancer from their physician and followed them right through surgery to treatment and end-of-life care. She believes this philosophy of early nursing intervention needs to be adopted in Canada so people have more control over the final chapter of their lives. The earlier she is able to meet a client and his or her family, the sooner they can discuss medications, treatments, quality of life goals and symptom management. Being able to build trust and review wishes and plans early in a terminal illness makes it easier to talk about sensitive topics like resuscitation when the person is nearing death, she says. In Canada, however, Hickman's clients are referred to her by the Community Care Access Centre (CCAC), and she may only meet someone in the last few months or weeks of life.

Lesley Hirst says supporting RNs like Hickman, and giving them a unified voice to lobby for changes to benefit the people they care for, is one of the main reasons she wanted to create the new interest group. Hirst says part of the problem with the current system is the level of government funding isn't sufficient to pay for more nurses such as Hickman. This means that people who need more home care must supplement publicly provided services with additional support covered by private insurance, if they have it. It also means that because 90 per cent of people want to die at home, providing care takes a financial, emotional and physical toll on loved ones who are expected to become nurses and personal support workers.

"People should be able to be a wife, a mother, a son, a brother, rather than being a nurse or a PSW. We ask a lot of them and they get burned out quickly," Hirst explains. Expecting families to be the primary caregivers for loved ones who want to die at home can lead to stress, exhaustion, job loss and even guilt if the responsibility becomes too overwhelming and the person ends up dying in the hospital when his wish

RNs HELP CHILDREN DEAL WITH DEATH

Adults aren't the only ones who grapple with issues and emotions related to mortality and loss. Children are also among the terminally ill and bereaved. Lisa Pearlman is a nurse practitioner and clinical lead of Pediatric Symptom Management and Supportive Care at London Health Sciences Centre. She works with infants, children and teenagers who have life limiting and life threatening illnesses. She meets most families when the child is still receiving treatment for the disease. That allows her to focus on quality of life and pain and symptom management so families have more quality time together. Pearlman says developing the year-old program was a dream come true.

"I wanted to develop a service that would enable familes to talk about the most sensitive yet meaningful issues for them. Someone who would give them hope at the most difficult times, and assistance with making the most difficult decisions," she says.

Andrea Warnick also helps families grappling with the pain of death. As an RN and grief counsellor with Max and Beatrice Wolfe Children's Centre and the Dr. Jay Grief Program, located at Mount Sinai Hospital in Toronto, she teaches kids how to prepare for the death of a parent and then supports them as they grieve mom or dad's death.

Warnick says parents may think they're protecting their kids by not telling them what's happening. But when a parent is dying, children really need honest answers and accurate information. She says it's common for kids to believe that they caused the illness or to fear they'll catch it. They also tend to look at the situation in a very practical way. She recalls one four-year-old boy who asked his dying mother, "What's going to happen to me? I can't reach the light switch and I can't make scrambled eggs."

Warnick says teaching these children that their feelings and emotions are natural is the most rewarding aspect of her job.

"I'm not going to stop a child's mom from dying, and that's devastating," she says. "But I feel so empowered that I can shape that kid's entire story around the death." **RN**

was to spend his final days at home.

Hirst says another issue affecting palliative care is the fact that community nursing agencies have difficulty recruiting and retaining the nurses needed because their salaries are significantly lower than those of their colleagues who work for hospitals or other organizations.

"I feel really strongly that nurses should be rewarded equally for the services and care they deliver, based on their education, preparation and their duties and not just where they're based," she says. RNAO agrees and identified equal remuneration for all RNs as a key policy recommendation in the association's political platform document, which sets out priorities for candidates to adopt in the 2011 provincial election.

Given the challenges of offering comprehensive palliative care, Ildy Tettero feels lucky to be able to get involved with people who have cancer, amyotrophic lateral sclerosis (ALS), heart, or kidney disease early on in their illness. She's sometimes present when they find out they have pancreatic cancer or another incurable disease. As a nurse practitioner on the outpatient palliative care team at Joseph Brant Memorial Hospital in Burlington, she can then help terminally ill patients navigate the healthcare system and coordinate care with other members of her team, such as a social worker, dietitian and palliative care physician. She also works with family doctors, the Community Care Access Centre and home care nurses to help 83 per cent of her patients spend their final days at home.

If people are well enough to come to the clinic, Tettero will manage their pain and symptoms there. For others, she'll make home visits and provide support over the telephone. While the outpatient palliative care team at Joseph Brant is meeting many of its patients' needs, Tettero says there are a few changes that would further enhance care for the residents of Burlington. For example, as an NP, she isn't able to prescribe narcotics or opioids to manage her patients' pain.

"Nurses sometimes struggle to get hold of the physician to have medications changed because as people are dying their needs change fairly quickly. If I was able to prescribe more medications that are needed, I would be able to support patients' symptom control better," she says. She also wishes that her team could offer palliative care 24-hours a day, but there just aren't the resources to allow her or the physician to be on call during evenings or weekends.

But it will take more than just funds to find the staff to provide that kind of comprehensive care. Hirst hopes the new interest group will raise awareness of the special skills that are needed, because palliative care is a lot more than administering morphine.

"You have to coordinate the management from a pharmacological perspective and you have to really look at disease progression and the effect it has on the body systems," she says. "You have to be a detective and find out what has worked, what hasn't, then figure out a new plan."

Hirst says that by determining the best ways of keeping patients comfortable so they can enjoy the best quality of life possible, palliative care nurses enable them to focus on the important things in life, such as their relationships with family and friends, and clarifying their goals and objectives for the final phase of their lives.

That's why Hirst says getting palliative care on the syllabus in nursing schools is one of the top items on the interest group's to-do list. She believes that given the fact that most of us will die from a life-limiting, progressive illness and will need the care of nurses, it is surprising that most schools in the province spend very little time teaching students about palliative care, if it is discussed at all. She's heard the argument that the goal of nursing education is to prepare generalists, so specialties aren't on the curriculum.

"But death and dying are a part of general life expectancy," she counters. "It's not specialized like orthopedic surgery or plastics or burns. Dying is a part of living and it needs to be addressed."

Palliative care is on the agenda at the School of Nursing at the University of Ottawa, which developed the Nursing Palliative Care Research Unit (NPCRU), the first of its kind in Canada, in 2009. But Ottawa professor Christine McPherson, an RN and health psychologist who has been conducting research on the topic for the past 10 years, acknowledges that this is the exception and not the rule.

Hirst believes since most of us will die from a life-limiting, progressive illness and will need the care of nurses,it is surprising that most nursing schools in the province spend very little time teaching students about palliative care... "But death and dying are part of general life expectancy," she counters. "It's not specialized like orthopedic surgery or plastics or burns. Dying is a part of living and it needs to be addressed."

McPherson first became interested in palliative care when she nursed in acute care units and found that deaths often felt rushed because nurses were so busy and beds were in short supply. She realized that she was well prepared to care for people with heart disease or diabetes or those awaiting surgery, but felt unprepared to deal with death and dying. She says this lack of knowledge means that some nurses who don't know how to speak to relatives of the dying may say nothing at all, and others grapple with ethical issues related to pain. The situation is further complicated by the fact that nurses working in acute medical settings are trained to keep people alive. "Death is often seen as a failure by health professionals," McPherson says. "Yet, part of our role is to ensure patients who can no longer be actively treated die comfortably."

Next year, a resource will finally be available to give nurses access to the best evidence related to caring for patients nearing the end of life. Last May, McPherson began leading an expert panel that is devel-

oping a clinical best practice guideline on end-of-life care. She says the guideline is intended for nurses who work in a variety of settings and will provide the information and skills they need to identify, assess, intervene and evaluate patients during the last days and hours of life. McPherson says much of the literature related to palliative care focuses on cancer, but RNAO's guideline will also discuss deaths from such diseases like organ failure and dementia. Topics such as recognizing, assessing and managing common symptoms such as delirium, pain and breathlessness are among the issues addressed in the guideline.

McPherson says it's important for nurses to ensure that families receive the support they need and the patient dies with dignity. She says family members will never forget what their loved one's final days were like. If they see that person in pain or experiencing delirium, they have to live with the trauma associated with watching them endure that.

Anne-Marie Dean believes all health providers need to be more aware of the various types of care that are available to their patients during their last days. Dean is the executive director of Hill House Hospice in Richmond Hill, a three-bed facility that is one of 15 residential hospices in Ontario. Dean, an RN, and her staff of nurses and personal support workers care for people who are expected to live less than a month, and who have signed do not resuscitate orders. That means staff members don't give blood transfusions or perform CPR.

"Part of our job is to accompany them to a gentle death. We don't do anything to expedite death, but we don't do anything to prolong life either," she explains.

While some people choose to die in a hospice because their loved ones are no longer able to care for them at home, Dean says others don't want their family home to be associated with the end of their lives. That's especially true for young parents who don't want their children to live with the memory that mommy or daddy died in the living room or in bed.

"Residential hospice is a wonderful alternative because it's a home-like setting and the family can be together. It's a calm environment. We don't have the bells and whistles of the hospital," Dean says.

Dean believes there would be more pressure on politicians and other decision makers to make palliative care a priority if more families were aware of the resources that are available for their dying loved ones. In fact, she says a little knowledge could go a long way to ending the conversation about legalizing euthanasia. She says families who don't know that hospices and nursing consultants can help with pain and symptom management have seen their loved ones struggle and wished they could put them out of their agony.

"People say: 'we put dogs to sleep, don't we?' But this is different," she says. "Good palliative care can help people live comfortably until it's time to die. We need to heighten the awareness of palliative care so more people will access it."

Dean also says more nurses would be interested in working in this area if they realized they would have the support of colleagues when losing so many patients becomes emotionally draining. She tells her staff it's OK to cry at work, they don't need to carry the emotions home. Every six weeks, all the nurses and PSWs get together to talk about the residents who have died during that time. For each patient Dean asks: how did we make a difference here? What would we do differently next time?

Hirst says debriefing sessions like the ones Dean holds for her team give nurses an opportunity to acknowledge their grief and address the emotional toll that caring for the dying can have on their spirit. But, she adds, while the job is intense and challenging, the rewards of joining people on their journey through the end of their lives make it worthwhile.

"This is an amazing area to work in," she says. "It's really a privilege to be sharing the deepest, innermost parts of people's spirituality at this time in their lives. And you can have some of the funniest days. Patients still have senses of humour, and there's still laughter and joking." **RN**

JILL-MARIE BURKE IS ACTING STAFF WRITER AT RNAO.

PALLIATIVE CARE BEYOND PRISON WALLS

Mike had been an inmate at Bath federal institution near Kingston for 10 years when he was diagnosed with terminal lung and throat cancer and given seven months to live. He was allowed to leave the prison to receive chemotherapy treatments at a local cancer centre. But when he returned, he wasn't permitted to take his prescription medications and was locked in his cell from 6:00 p.m. to 6:00 a.m. The prison's health centre wasn't staffed overnight, so palliative care consisted of Tylenol for pain, Gravol and a bucket for nausea, and a bottle of water.

In July 2007, Mike had served all but a few months of his full sentence. He was given just six months to live, and entered a unique palliative care program for former inmates. New Beginnings Transition House, which is run by the Peterborough Community Chaplaincy, was featured in January in a TVOntario documentary that examined how ex-convicts adapt to life beyond prison walls. When Mike joined the program, a team of volunteers welcomed him, he received nursing care, and he reconnected with family members he'd been estranged from for years. Today, Mike is still living and looking forward to celebrating another birthday in June.

RNAO member Diane King is vice-president of the chaplaincy's board of directors, and played a key role in establishing the palliative program at New Beginnings. She says many men there also struggle with mental illness, drug and alcohol abuse, poor social skills and learning disabilities. Lack of trust is another common issue. "It takes us six months to convince these guys that we aren't going to abandon them," she says.

King, a recently retired instructor from Trent/Fleming School of Nursing, says Corrections Canada needs to change the way it treats and discharges those who are dying. She says compassionate parole does exist, but many inmates aren't aware it's an option. For those who do apply, it usually takes so long for applications to get through the system that most die while they're still in jail.

While the John Howard Society, the local hospice and hospital have been supportive of the program, King says the reality is that most people don't want to associate with ex-cons. "They are the most marginalized population I can imagine," she says, adding the men at New Beginnings have served their full sentences and have no intention of re-offending. "There's no reason for these people not to have palliative care." **RN**

Interview with the Minister of Health

On Oct. 7, Deb Matthews became Ontario's health minister. She discusses her first four months on the job with *Registered Nurse Journal*. BY JILL SCARROW

RNJ When you became health minister, the H1N1 outbreak was front and centre in the public's mind. What did H1N1 teach you about the health portfolio?
DM While we certainly had some bumps initially with the distribution of the vaccine, overwhelmingly we responded extremely well. We're in the process now of evaluating what worked, and what we need to do better. In about three weeks we vaccinated more than 30 per cent of the population. It was fast. It was complicated because we were dealing with uncertainty around the supply of the vaccine. We couldn't have done it without the nurses who worked overtime, weekends, and gave up holidays. I saw how extraordinary the response of the system could be at a difficult time.

RNJ During the H1N1 vaccination campaign, concerns were raised about for-profit clinics delivering the vaccine. At the time, you said you would examine for-profit clinics after the crisis. What can you tell us about the status of that review?
DM The issue was: were they following the sequencing (of the vaccine distribution)? I've asked the chief medical officer of health, Dr. Arlene King, to (review) that… (On for-profit clinics) I am a supporter of a single-payer health care system. But within the law, OHIP doesn't cover everything, so should people be able to buy services above and beyond that? I guess they should. But I firmly believe in the strength of our system and I will protect it.

RNJ Before coming to the health portfolio, you were Minister of Children and Youth Services and led the creation of the Ontario Poverty Reduction Strategy. How will you continue to advocate for poverty reduction as health minister?
DM That was a life changing assignment, developing the poverty reduction strategy. After I went through the whole process, I better understood the link between poverty and health. People living in poverty tend to have high health-care needs, and people with high health-care needs tend to live in poverty. We must break the cycle.

RNJ Over the last two years, 11 nurse practitioner-led clinics have been announced in Ontario in addition to the Sudbury clinic. When will they be opened? When will you be announcing the next 14 clinics to keep the promise of having 25 additional clinics by 2011?
DM Sudbury is up and running now. There are three more scheduled to open in January, 2010. The others we announced just before Christmas. Each one has a different time table. Getting them ready quickly is what everybody wants to do… We don't have a timeline (to announce the other 14 clinics) right now, but we are committed to moving ahead on this.

RNJ Nurse practitioners continue to be hampered by legislation that prevents them from admitting, treating and discharging hospital in-patients. What is the government's plan to address these concerns?
DM I've heard this is an issue RNAO thinks we should take a good hard look at … we haven't made a decision on it, but I always have an open mind.

RNJ RNAO is urging government to change the Public Hospitals Act to transform Medical Advisory Committees (MACs) into Inter-Professional Advisory Committees (IPACs) to improve inter-professional collaboration and patient care outcomes. When will this take place?
DM There's no announcement to make on this. I know this is something that's important to RNAO. I think we've come a long way on more collaborative practice. That integration needs to be supported.

RNJ In 2010, the government has committed to issuing a 10-year strategy on mental health and addictions. This work was a high priority for your predecessor, David Caplan. What kind of priority does this work have for you?
DM The link between mental health and poverty is very strong, so it's a high priority for me. We have the select committee on mental health. We also have the minister's advisory group on mental health. There's a lot of really interesting work happening. There's recognition now that we need to focus on mental health.

RNJ In late 2008, the government lifted the moratorium on competitive bidding for home care contracts. Our members are gravely concerned with this decision. Why would the McGuinty government continue to pursue home care this way when it was part of the Mike Harris agenda?
DM This is an issue that I haven't yet turned my attention to. But quality of care is hugely important, and home care is increasingly important as our population ages and we shift care out of hospitals and into communities. **RN**

JILL SCARROW IS ACTING MANAGING EDITOR AT RNAO.

Navigating colon health

Cutting-edge role allows RNs to increase patient access to cancer screening. BY STACEY HALE

After 16 years as an emergency room nurse and six years doing endoscopies, Tracey Corner found herself back in the classroom two years ago. This time, she was learning to steer a 60 centimetre-long flexible tube with a small camera and light at the tip through a virtual reality simulator shaped like a person's buttocks. Today, she's using the camera on real people as an RN who's qualified to perform flexible sigmoidoscopy, a test that uses a soft, flexible tube inserted into the rectum to examine the lower third of the colon to detect polyps or cancer. The procedure – traditionally performed by a physician – takes 20 minutes and detects 60 per cent of cancers. It's also considered safer than a colonoscopy.

Since Corner finished her education, she's completed 500 procedures and has helped catch cancer in people who otherwise would have found the disease much later, when it's harder to treat. The Hamilton Health Sciences RN spends a few days a week travelling to local family doctors' offices to educate people (those between the ages of 50 and 74) about the risk of contracting colorectal cancer and the benefits of pre-screening. The rest of her time is spent performing flexible sigmoidoscopy at McMaster University Medical Centre.

Corner is one of 11 nurses in Ontario to take on this cutting-edge role that's allowing RNs to use their knowledge and skills to open the door to care that can save lives. Her work is especially important because colorectal cancer is the second leading cause of death from cancer for both men and women. According to the Canadian Cancer Society, an estimated 8,100 Ontarians were diagnosed with the disease last year, and about 3,300 will die from it, despite the fact that there is a 90 per cent chance colorectal cancer can be cured.

That's why RN-preformed flexible sigmoidoscopy is one of many roles RNAO is calling on politicians to provide more funding for in its recently released platform, which sets out priorities for all parties to adopt in next year's provincial election. Ontario is the only province using nurses to do flexible sigmoidoscopies alongside a province-wide program called Colon Cancer Check, which aims to get the public to stop cancer in its early stages. Esther Green, Provincial Head, Nursing and Psychosocial Oncology at Cancer Care Ontario (CCO) says saving lives was in mind when the role was introduced in 2006 by the Ontario government and CCO as a pilot project. Prior to testing the role, the Ministry of Health and Long-Term Care and the Cancer Quality Council of Ontario were asking what Ontario could be doing differently about the disease.

Robin Wheeler (left), an RN at Hotel Dieu Hospital in Kingston, learns to guide a flexible sigmoidoscope through a virtual reality simulator with Dr. Andrew Petrakos, a general surgeon from Windsor Regional Hospital. The two worked together during training last fall.

"When you look at the numbers, the death rate was fairly high," Green says. "Ontario needed to address some significant issues, one of which is around screening, to try and manage patients earlier and identify them earlier… and to improve the outcomes so that people are not dying, so that they are actually surviving their illness."

Four years ago, the government started looking at how nurses could improve those outcomes. Green says nurses, physicians and gastroenterologists from the U.S. and United Kingdom visited Ontario to share how they identified and trained nurses to do flexible sigmoidoscopy. Key stakeholder groups including RNAO, the College of Nurses of Ontario, the Canadian Society of Gastroenterology Nurses Association, and the Ontario Medical Association then met for many months to answer questions, such as how Ontario could improve access for patients, and intro-

duce a new role like flexible sigmoidoscopy.

Ingrid LeClaire, Program Manager at CCO for the RN-performed flexible sigmoidoscopy pilot project, says nurses were selected to do the procedures because their scope of practice allows them to examine the lower part of the bowel. But, Green explains, they also fit the bill because the job is far more than a technical function.

"(The role) requires the knowledge, skill and clinical judgment that an RN has in terms of patient assessment, clinical assessment, counselling, teaching and the performance of that act," she says.

Corner, for instance, holds education meetings with patients at their family doctor's office to explain what colorectal cancer is and the benefits of pre-screening. Then she tells patients what happens during the procedure, and takes a full medical history to ensure they are eligible for the test.

Initial funding for the pilot came from a $100,000 research grant from the Change Foundation, an independent health policy think tank with the goal of improving the delivery of health care in Ontario. Two hospitals in Toronto were the first to participate in 2006. But the project met some challenges along the way. Each site either ran out of money or there weren't enough patients to carry on. LeClaire says that experience demonstrated that there needed to be a patient recruitment strategy to get people involved.

"Opening a clinic and making a service available is not always going to result in successful referrals. You have to get the word out there and create awareness," she says. Physicians also had to be educated. LeClaire says they need to understand that flexible sigmoidoscopy is an effective screening tool. Part of Corner's job is to work with doctors and teach them about the procedure. To do that, she meets with family practice physicians in her community and explains how the procedure works and how it will benefit them and their patients.

Today, six hospitals from all over Ontario are participating in the pilot. Nurses selected from each hospital receive advanced training at the Michener Institute for Applied Health Sciences in Toronto. For five days, they work from a thick textbook on gastroenterology nursing. They study pathology as well as the anatomy, physiology and anatomical markers of the bowel. The course covers so much detail in five days, the nurses also need to have a background in endoscopy to be considered for the new role. LeClaire says a lot of the education also focuses on improving dexterity and hand-eye coordination, so RNs practise guiding the camera through tiny holes in a box, and manoeuvre the tool from their right to left hand. She says manual agility and an ability to multi-task is important because the scope is inside the person and the nurse has to rely on a two dimensional image that is being projected on a computer monitor.

"As you are guiding the tool you are essentially blind," she says. "The virtual machines give you feedback, so if you are pushing too hard with the scope it will say 'ow!' and 'oh that hurt!' Or, it will tell you that you have perforated the bowel so you have a sense of how far you can go and if you have done something wrong."

LeClaire says the feedback is important because patients are not sedated during the procedure. To prepare, they take two enemas two hours before the procedure to clean their bowels.

After completing the course, nurses return to their respective organizations to complete the clinical portion with real patients under the supervision of a physician from their home hospital. To qualify for the final evaluation, nurses must watch the physician perform 25 procedures, complete 25 scope withdrawals, and then 50 full procedures solo. When they've completed those, a CCO gastroenterologist and another independent physician assessor will visit and evaluate nurses as they perform five additional procedures.

Robin Wheeler says the week-long session in Toronto is intense, but she was impressed by the patient simulators. "They really give you good training and an overview of what's going to be expected," she says.

The RN at Hotel Dieu Hospital in Kingston joined the program in the fall when the Ministry of Health funded an expansion of the pilot to three new sites, including Kingston, Windsor and Hearst, Ontario. Wheeler is working on her clinical training and hopes to begin screening patients on her own this year. She knows first hand that it will improve access to screening for the general public. And with the government's public awareness campaign – including TV ads – about the importance of early screening and detecting cancer, Wheeler hopes people will be more proactive and educated about colon health. Wheeler says she's excited to begin the work because, after working in endoscopy for more than 10 years, she's looking for a new challenge. She knew the role would be a good fit after she heard an advanced practice nurse from the United Kingdom speak at a conference about performing colonoscopies, and how such roles open a new frontier for nursing.

"This (pilot) specifically recognizes the skill level and the knowledge of RNs. It's going to open a lot of doors," she says. **RN**

BALANCING BENEFITS AND HARMS

While many people can benefit from flexible sigmoidoscopy, colonoscopies are also frequently performed to screen for cancer.

COLONOSCOPY

- examines the entire left side of the colon
- screening required every 10 years
- procedure takes 30 to 60 minutes
- chance of perforating the bowel 1/1,000
- one day prior to procedure patients must only consume clear liquids and then take a laxative
- patients must take one to two days off work
- patients cannot drive and must be accompanied by another individual to escort them home
- recommended for individuals at increased risk, such as having one or more close relatives (parent, sibling or child) who has colon cancer

FLEXIBLE SIGMOIDOSCOPY

- examines the lower third of the colon
- screening required every five years (alone or combined with Fecal Occult Blood Test)
- procedure takes five to 20 minutes
- chance of perforating the bowel is less than 1/20,000
- requires no sedation
- simple preparation (two enemas) the morning of the exam
- patient may drive and return to work immediately following procedure
- recommended for asymptomatic individuals who are at average risk for colorectal cancer

Source: www.ColonCancerCheck.ca

STACEY HALE IS EDITORIAL ASSISTANT AT RNAO.

MAKING TIME FOR ME

RNs say their own health is just as important as their patients'.

BY JILL-MARIE BURKE

ILLUSTRATION BY SOPHIE CASSON

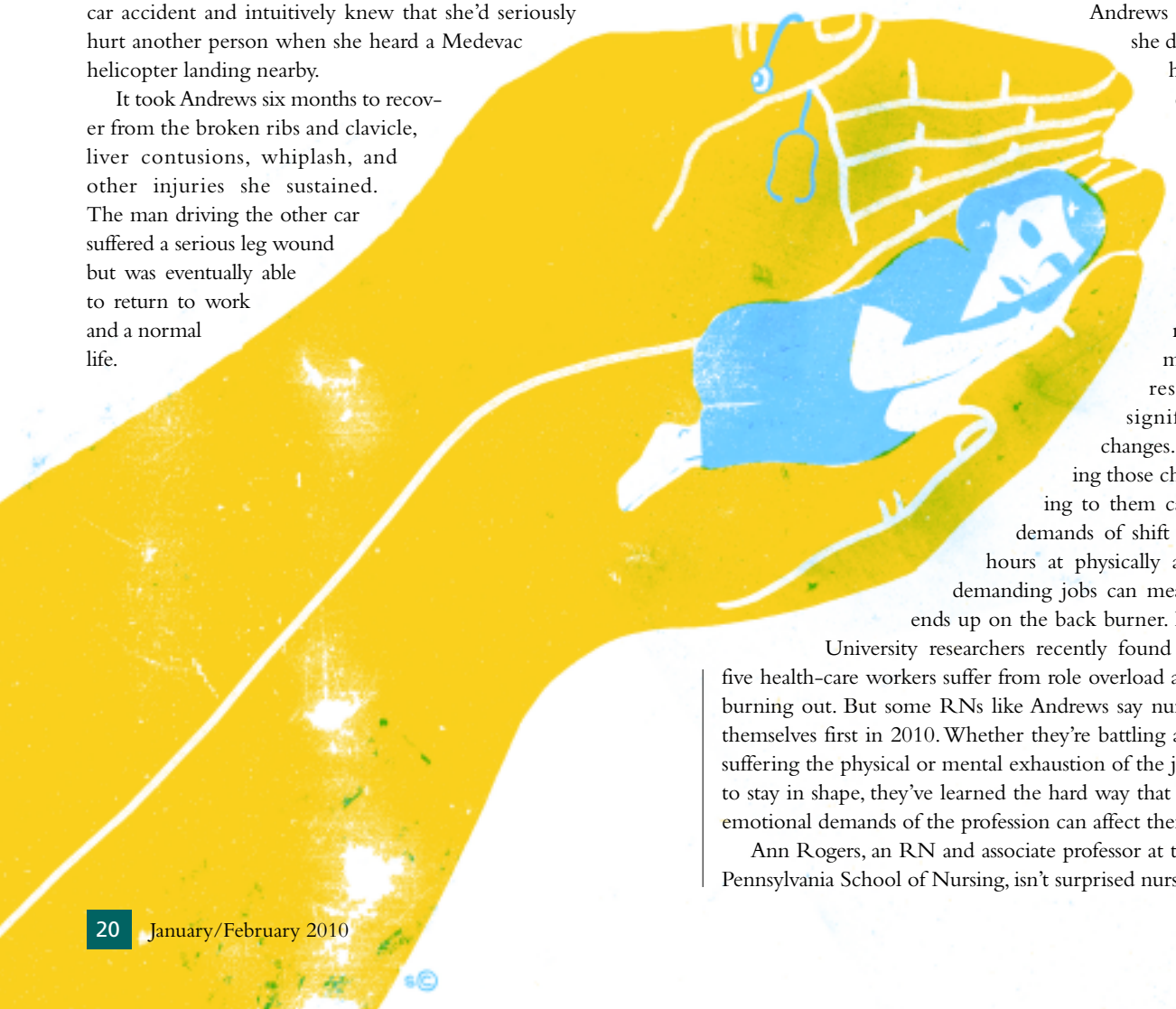
Janet Andrews was recovering from the stomach flu, but she'd made it through a busy night shift on a short-staffed obstetrics ward without breaks or food. She'd tried to call in sick, but Ontario was in the midst of the SARS crisis, and when a colleague questioned the seriousness of her illness, she'd felt obligated to come in to work. When her shift ended at 6:30 a.m. she took the wrong stairwell to the parking lot. She'd never felt so tired in her life. But her own health and safety needs weren't even on her radar. As she climbed into her minivan, the only thing on her mind was the fact that in just five minutes she'd be home helping her kids get ready for school.

The last thing she remembers about the drive is rounding a corner with the bright sun shining in her eyes and thinking "Wow, am I ever tired. If only I could just close my eyes. But I'm almost home." She woke up to see a fireman climbing through the passenger window. Andrews had severe chest pain and was having trouble breathing. She realized she had been in a car accident and intuitively knew that she'd seriously hurt another person when she heard a Medevac helicopter landing nearby.

It took Andrews six months to recover from the broken ribs and clavicle, liver contusions, whiplash, and other injuries she sustained. The man driving the other car suffered a serious leg wound but was eventually able to return to work and a normal life.

Seven years later, the physical injuries have healed. But Andrews is still haunted by the fact that her decision to drive while fatigued seriously hurt another person, and she could have killed herself or someone else. "My really stupid choice could have put my children in a situation where they didn't have a mom - just because I wanted to be Florence Nightingale and felt pressured to help someone other than myself," she says.

Something shifted inside Andrews on the day of the accident. She realized she needed to establish boundaries for her own safety so she would never put herself, or others, in danger again. She also vowed she would never again drive home from a night shift and decided to find a new job as a clinical educator in labour and delivery. She now works straight days at St. Michael's Hospital in downtown Toronto. Much of her time is spent working with new nursing graduates, and she warns them that fatigue is something that all nurses need to be aware of and manage.



Andrews learned that if she didn't take care of herself, no one else was going to do it for her. But putting your own health and needs first is easier said than done. As the new year begins, many people resolve to make significant lifestyle changes. For RNs, making those changes and sticking to them can be hard. The demands of shift work, and long hours at physically and emotionally demanding jobs can mean that self care ends up on the back burner. In fact, Carleton University researchers recently found nearly three in five health-care workers suffer from role overload and are at risk of burning out. But some RNs like Andrews say nurses need to put themselves first in 2010. Whether they're battling a chronic illness, suffering the physical or mental exhaustion of the job or just trying to stay in shape, they've learned the hard way that the physical and emotional demands of the profession can affect their health.

Ann Rogers, an RN and associate professor at the University of Pennsylvania School of Nursing, isn't surprised nurses sometimes let

their own well-being suffer to the point that they become dangerous drivers. She says Andrews' story should serve as a strong warning to nurses, and their employers, that fatigue is an issue that must be taken seriously. She has spent years researching the impact that work schedules and insufficient sleep have on nurses and their patients. Besides car accidents, being exhausted causes medication errors and mistakes related to procedures, charting and transcribing. As the panel lead for a new guideline RNAO is developing on nurse fatigue, Rogers urges nurses to make sleep a priority.

"Nurses should work no more than two or three 12-hour shifts in a row and they need to get seven hours of sleep," she says. "If they're rolling down the car window or turning up the radio or doing other things to stay awake, they should be off the road because they are already too sleepy to drive."

Working shifts can also wreak havoc on nurses who are trying to manage their own illnesses, not just their patients'. Sheila John was diagnosed with Type 1 diabetes when she was 10 years old, but the five years she worked in the mental health unit at Credit Valley Hospital in Mississauga proved to be one of the most challenging times for managing her condition. Working at night, sleeping during the day and eating breakfast later led to a fluctuation in blood sugars.

"The amount of insulin you need for a night shift is completely different than for a day shift," she explains. "I didn't feel like I was at my optimal health. I was tired a lot and my blood sugars weren't under control."

John, who currently works as a Program Manager in the International Affairs and Best Practice Guidelines Program at RNAO's home office, says if health-care professionals recommend that a nurse with diabetes only work during the day, the advice should be taken seriously. "You might not feel it right now, but there are so many long term effects of diabetes. You really need to listen to your body."

Brenda Hutton agrees that sometimes a change to when - or the way - you work is the best approach to taking care of your health, especially mental health. Hutton knew she was burnt out when she started having a recurring dream that she'd forgotten to visit a client who was waiting for wound care. She had worked for a community nursing agency in London for 10 years and was used to doing one to two hours of unpaid paper work each day, making phone calls and ordering supplies on her days off, being on call during evenings and weekends, and eating take-out sandwiches in her car between patient visits. She had always found the work rewarding, but with the endless demands of the job she was no longer enjoying it, wasn't as happy at home, and started to wonder if she might be depressed. She also wanted to have more time to do things that nourished her spirit.

At the same time, Hutton was also working casual shifts at Regional Mental Health Care (RMHC) in London. In the spring of 2008, she made a sudden and firm decision to quit the job at the community agency and work more often at RMHC. As soon as she made the transition, her daughter and close friends commented that she seemed more carefree and even laughed more. She now works seven shifts over two weeks and, as a unionized employee, she earns more money than she did when she had two jobs. She enjoys the work, finds it much easier than her previous job, and usually works in the same two units so she knows her patients well.

The decision to move to a more relaxed pace of life has finally given Hutton time to pursue pleasures she never had the time for before. She volunteers at a local performing arts centre and participates in sacred circle dancing. In January, she travelled to Bangladesh to teach nurses at a university in Dhaka. Leaving a job that was no longer right for her opened up a world of possibilities for Hutton, and she believes it can do the same for others. "Don't stay in a position where you're not happy. Some nurses may be afraid to make a change, but I would say 'take the risk,'" she says.

For nurse practitioner Beth Sweeney, finding balance in her life is all about making sure she walks the talk about the importance of proper nutrition and regular exercise. Long before a recent study reported that obesity has surpassed tobacco as the top cause of disease and death, Sweeney was telling the adolescent patients she sees at the women's health, sexual health and family planning clinics she runs at health units in Strathroy and nearby Clinton about the importance of proper nutrition. When Sweeney finishes her work at the clinics, she finds time to relax by pursuing her own passion for fitness. She's a certified fitness instructor who develops and teaches three group classes a week. All ages and fitness levels are welcome in the sessions she's been offering for 11 years, which include stretching, cardio, Pilates and yoga and work with weights, and stability balls. Sweeney enjoys physical activity so much that when she isn't teaching, she's running, biking or swimming with her husband and sons.

The demands of shift work and long hours at physically and emotionally demanding jobs can mean that self care ends up on the back burner.

Sweeney has always eaten healthily and enjoyed being active, but she understands that this can be a major challenge for RNs who work shifts. But no matter what your schedule, health or fitness level are like, she says getting seven to eight hours of sleep a night, taking a multivitamin, drinking seven glasses of water a day and basing meals and snacks on Canada's Food Guide will lay the foundation for a healthy lifestyle. She says you don't need to join a gym to exercise – you can follow a workout video or go for a walk – but you do need to schedule exercise the same way you would a medical appointment, otherwise it may never happen. If you haven't exercised in a while, start by briskly walking 15 minutes one way down your street and 15 minutes back. Each day, walk one house further. According to Sweeney, having a fitness buddy is a strong motivator. "If you're going to meet at the driveway to go for a walk, you can't let that person down, you can't sleep in," she says.

Sweeney believes nurses owe it to themselves to take care of their health. But they also need to take the steps to set good examples for their patients. "People don't want to have a nurse who doesn't look healthy. We need to focus on our health today because we can't take care of others unless we're healthy ourselves," she says.

Do you have tips for staying healthy, happy and balanced that would help other RNs? Send your suggestions and stories to letters@rnao.org. **RN**

JILL-MARIE BURKE IS ACTING STAFF WRITER AT RNAO.

An ally toward health

RN tackles the health and social issues that afflict hepatitis C sufferers.

BY HELENA MONCRIEFF

Cathy Woldanski calls her job with the Ontario Hepatitis Nursing Program "Pandora's Box."

Woldanski is one of 13 nurses across the province educating and coaching people with hepatitis C through treatment. But once she lifts the lid and peers inside their life "box," she often finds a raft of issues including other health ailments, poverty and addiction.

"It isn't just taking care of hep C. It's taking care of all their needs. They need help in their homes. They need jobs," she says. "Hep C? Holy cow. That's just the tip of the iceberg."

Woldanski serves Algoma Region from Sault Ste. Marie's Group Health Centre. More than 1,700 people in the area have the disease, the third highest prevalence rate in the province behind Kingston and Haliburton. Woldanski counts 200 of them as her patients, but the goal is to reach them all. It's a tough job given she covers a territory that stretches 1,235 kilometres north to Hornepayne and east to Elliot Lake.

Although she works closely with a gastroenterologist, the program is nurse-managed. So even if the patient is hundreds of kilometres away, it's the RN watching for any changes, problems or concerns with hep C treatment, which can be gruelling. Six to 12 months of pegylated interferon and ribavirin drug therapy can cause side effects including severe depression, fatigue, mood swings, anemia and flu-like symptoms. Without support, 70 per cent give up. With nursing allies, that number drops to 10.

Anyone can become infected through blood-to-blood transmission. But more than half of hep C patients are intravenous drug users. "Being on the Trans Canada highway means we have a more transient population," Woldanski says. "Many in that group are marginalized."

The opportunity to work with those people drew her to the program. Woldanski graduated from Sault College in 1981. She spent 26 years in the emergency department of the Sault Area Hospital, and often cared for people with mental illnesses. In 2000, she started working part-time for the Group Health Centre, first in obstetrics and gynecology, then in occupational health. But she missed caring for people with mental health issues.

NAME: Cathy Woldanski
OCCUPATION: Hepatitis Nurse
HOME TOWN: Sault Ste. Marie, Ontario

When the government announced the hep C program in 2007, Woldanski saw a fit. "I was eager to embark on another learning curve and felt my years working with a marginalized and mental health population would be helpful."

Some of Woldanski's patients are self-referring, but most learn about the program through a physician, counsellor, or social program. They won't all go through treatment. For some, other illnesses may be in the way. Still, Woldanski stays in touch with them, to monitor their condition and answer questions.

Woldanski meets with patients before they see the physician. She takes their history, provides information about hepatitis, explains the risk factors that may have brought them into contact with the disease, and orders blood work.

Diagnosing hep C is a two-part process. The first blood test determines exposure; the second shows whether the virus is still active. In as many as 20 per cent of people, the body rids itself of the illness.

"So many of them have been told they have hep C but haven't had the second test," Woldanski explains. "They may have cleared the virus all on their own. It's so exciting for me to share that with someone. They've lived so many years thinking they were positive."

Sometimes, the news comes too late. Woldanski remembers one woman who was sharing needles with a hep C positive partner, assuming she couldn't do any more harm. Her second blood test showed she no longer had the virus. But Woldanski hasn't been able to find her again. Woldanski says when you're working with people living on the edge, the best outcomes can be elusive. Poor nutrition, low self esteem, poverty and inadequate housing stand in the way of even the most basic steps toward health.

"Medication must be refrigerated," she says. "We hope that they are putting it in a proper fridge. And it's hard to tell them to go buy Ensure and fresh fruits and vegetables."

As an advocate, Woldanski knows when soup kitchens serve up meals and who she can count on to donate the sometimes costly nutrition-boosting drinks.

Despite the challenges, Woldanski is optimistic about her work. "I prefer to look at the glass half full rather than half empty. I continue to be excited about what our community can offer." She points to the community workers who know where all the resources are, and the many nurses dedicated to liver disease long before this program started. "They come with a lot of knowledge and wisdom…They continue to teach me so much." **RN**

HELENA MONCRIEFF IS A FREELANCE WRITER IN TORONTO.

Feeling the flu-shot frenzy

An RN reflects on working during the height of the H1N1 vaccination campaign. BY JILL SCARROW

Photograph: Dan Pearce/East York Mirror

Patrick Hannigan, 9, receives his H1N1 flu shot from RN Diane Nannarone while his family look on at a special clinic held at the East York Civic Centre.

For seven weeks last year, Toronto public health nurse Carol Lee spent her days inside a meeting room at the East York Civic Centre, where nurses armed with vaccine vials and syringes sat at 10 tables set up around the room. Shrieks of young children who'd just received a poke from the nurse's needle pierced the air, rising above the hum of voices emanating from the crowd in the hall. Outside, lineups of adults, pregnant women and families – armed with toys, snacks and books for small children bundled up in coats and strapped into strollers – stretched and twisted through the parking lot.

Lee was one of hundreds of nurses in Ontario who inoculated thousands of people against the H1N1 virus in late 2009. Usually, she works in Toronto Public Health's reproductive and infant health section. But she volunteered to leave that post and work in the clinics because, even after 26 years in the profession, she was eager to try new things. She quickly realized the H1N1 campaign was going to be different than anything she had worked on before. She was re-assigned to the civic centre in October, a week early, after more than 100 people lined up to get a shot before the first clinic had even opened its doors.

Everywhere people went for the shot, RNs worked tirelessly to answer questions about the virus or the vaccine's adjuvant, and provide them with a pinprick to protect them from the disease. In Toronto, thousands of people lined up for hours at clinics across the city. At the East York Civic Centre, some parents arrived as early as 4:30 a.m. one morning in October to stake out their places in the queue for clinics that opened at noon. But Lee says people didn't complain about the long wait. Most asked how the nurses were faring, and many were just relieved to finally be able to protect themselves – and their children – against the disease.

"By the time they got inside, they were just so happy, they didn't complain at all," she says. "Some people compared it to lining up for rock concerts when they were younger."

During the busiest shifts, Lee says 2,000 people would get a shot. Even on a slow day, hundreds of Torontonians rolled up their sleeves. Some days, Lee was the clinic coordinator responsible for making sure the nurses giving the shots had the information they needed to answer questions. Other days, she put needles into arms. Lee says the work gave her an adrenalin rush that carried her through the 10-hour shifts she sometimes logged seven days a week.

"The energy was frenetic," she says. "At the end of the day, when we saw the number of people we'd vaccinated, we really felt we'd accomplished something."

But the work could be wearing too, especially when she had to refuse to immunize people. Lee met one girl who couldn't be vaccinated because of an egg allergy, but her mother was adamant that she receive the shot. The woman began to cry when Lee told her that her daughter couldn't be vaccinated. Lee says the reaction wasn't surprising, especially after the news in October that children had died from H1N1.

"When people think their physical survival or the survival of their progeny is threatened, anxiety and fear set in," she says.

Of course, some were more willing patients than others. Small children could be particularly skeptical that a needle could actually be good for them. Lee remembers one four-year-old girl in particular who, after getting the vaccine, calmly told Lee it wasn't nice to hurt people and marched out of the room without waiting for her parents, who she felt had been accomplices to this plan.

Besides helping people stay healthy, Lee says one of the best rewards was watching everyone come together as a team. Nurses, Lee says, were either loading the vaccine, giving out the needles, screening people to make sure they fit into the priority groups, or watching people after they got the shot for any adverse reactions. Lee says she admired the way her colleagues tackled every new task.

"This was one of the best experiences of my career," she says. **RN**

JILL SCARROW IS ACTING MANAGING EDITOR AT RNAO.

Celebrating 85 years

Throughout 2010, ***Registered Nurse Journal*** will commemorate RNAO's landmark anniversary with photos of years gone by, and memories from our members.

1918 Members of the Graduate Nurses' Association of Ontario gathered in London, Ontario

1904 The Graduate Nurses' Association of Ontario (GNA), is formed by alumnae groups of various schools of nursing in Ontario to encourage professional development among nurses.

1925 The GNA changes its name to RNAO after the provincial government passes the Nurses Registration Act in 1922.

1951 The Nurses Registration Act 1951, is passed, giving RNAO responsibility for making regulations around nursing education and licensing.

1956 Construction begins of RNAO's office building at 33 Price St. in Toronto. Daisy Bridges of the International Council of Nurses lays the cornerstone of the association's new home.

1963 The Nurses Act establishes the College of Nurses of Ontario.

1965 In April, more than 1,000 nurses march on Queen's Park to call for the government to pass the Nurses' Bargaining Act. RNAO members adjourn the annual general meeting early on April 29 to take their call for collective bargaining for all nurses to MPPs at the provincial legislature.

1956

Daisy Bridges (second from right) lays a cornerstone for the new building that will be RNAO's home until 1995.

1973-74 The Ontario Nurses Association (ONA) is created and takes on responsibility for collective bargaining.

1998 Nurse practitioner legislation receives royal assent.

2000 Ministry of Health and Long-Term Care assigns RNAO to lead the Nursing Best Practice Guidelines program in Ontario.

• The association launches the *Take Your MPP to Work* campaign during Nursing Week to give politicians a first-hand look at nursing.

• RNAO holds its first Queen's Park Day.

2003 Ontario government commits to 70 per cent full-time employment for nurses.

2005 RNAO moves into its own newly purchased, and fully paid for, building at 158 Pearl St. in Toronto.

2007 RNAO celebrates with the staff and board of directors at the opening of the Sudbury District Nurse Practitioner Clinics, the first of its kind in Canada. Its success is followed by the announcement of 11 more clinics in 2008 and 2009.

• Ontario government commits to Nursing Graduate Guarantee program, providing full time work for, and improving retention of, new nurses.

2009 RNAO's best practice guidelines program receives prestigious awards. **RN**

1965

2000 **RNAO President Sue Williams (left) meets with Liberal Health Critic Lyn McLeod**

POLICY AT WORK

RNAO Executive Director Doris Grinspun (left) met with new PC leader Tim Hudak and health critic Christine Elliott in November. It was the first time they heard RNAO's position on nursing issues.

Creating vibrant communities

Even though the next provincial election is a year-and-a-half away, RNAO is gearing up for the political campaign. On Jan. 28, it released its pre-election document, *Creating Vibrant Communities* at a media conference at Queen's Park.

The document and technical backgrounder outline key priorities RNAO wants political parties to adopt as policies when drafting their platforms ahead of the vote scheduled for Oct. 6, 2011.

The priorities are backed up by extensive research and evidence. Recommendations focus on nursing human resource policy priorities and ways to strengthen the health system, as well as areas the association and its members say have a huge impact on one's ability to be healthy. The platform offers specific recommendations on affordable housing, social assistance and minimum wage rates, early childhood development, protection from toxics, climate change, and access to clean water. The report acknowledges the province's current fiscal realities. However, it also points out the long-term implications and costs if access to nursing services is not improved, social inequities aren't addressed and opportunities to create greener, sustainable communities aren't acted upon.

According to RNAO President Wendy Fucile, the months leading up to the election represent a critical period as Ontario emerges from a recession.

"There is no doubt the province is at a crossroads. Its manufacturing sector is reeling and public and social infrastructures are in great need of investment at a time when the deficit is at an all-time high," she says. "We're confident the recommendations contained in this report offer a prescription that will move the province forward by committing to greater and enhanced health care, more prosperity and a cleaner environment." To read the full report, go to www.rnao.org

A visit with the leader of the opposition

Last November, RNAO's Executive Director Doris Grinspun met with the new leader of the Ontario PC party, Tim Hudak and his new health critic and deputy leader, MPP Christine Elliott. Although RNAO regularly meets with politicians at Queen's Park, this was the first formal meeting since Hudak took over from John Tory and marked the first time Hudak and Elliott heard about the association's priority areas.

Given the recent passage of Bill 179, Grinspun thanked Hudak for his party's support for the role of NPs and changes to RNs' scope of practice. Grinspun also praised the government for recognizing the benefits NPs bring to the health-care system and its commitment to setting up NP-led clinics. She also asked Hudak to commit to opening more NP-led clinics in the PC party's upcoming election platform.

The effects of the recession were also discussed. Grinspun noted the association has serious concerns about how budget cuts announced last fall might affect new nurses coming into the system. She warned Hudak that any attempt to cut nursing positions would only send newly educated RNs to look for work elsewhere as many were forced to do after cuts by former Premier Mike Harris.

No action on climate change

As world leaders gathered in Denmark last December for the Copenhagen Climate Change conference, RNAO members were busy writing letters to Prime Minister Stephen Harper telling him that nurses expected leadership and strong action on the issue. More than 1,000 members responded to an action alert calling on the Prime Minister to take a lead in tackling climate change by committing to clear targets and, in doing so, being a role model for bold leadership to combat the dangerous impact of global warming on the health of the planet and its inhabitants. Immediately following the conference, RNAO issued a media release describing the failed talks as an embarrassment. President Wendy Fucile cited the lack of targets for emission cuts and the fact the agreement wasn't binding as evidence of how little was accomplished.

While the final communiqué reached by world leaders offered nothing substantive, the association's work on this issue will continue. Executive Director Doris Grinspun said nurses will continue to press for action on this issue because they know the environment is an urgent priority that can't be ignored. **RN**

NEWS to You to Use

RNAO is leading a project to help nurses from all sectors use technology in their workplaces and better understand eHealth and its relationship to quality care and client outcomes. With funding from Canada Health Infoway, RNAO is leading the Ontario Nurse Peer Leader Strategy. Fourteen peer leaders, each representing a LHIN in Ontario, are facilitating education and knowledge sharing about eHealth in the nursing community and promoting RNAO's Nursing and eHealth online education course. The goal is to get 20 per cent of nurses in each LHIN to access the course. For more information, contact Jackie Boyce at jboyce@rnao.org or take the course at www.rnao.org/eHealth_course/.

The number of nurses working in Canada is on the rise. According to a Canadian Institute for Health Information report released in December, there are now 341,431 nurses in the country. The report also found the proportion of registered nurses employed in the community health sector rose from 13.8 per cent in 2004 to 14.2 per cent in 2008, and the number of nurse practitioners rose to 1,626 from just 800 in 2004.

On Jan. 1, RNAO Executive Director Doris Grinspun became the co-chair of the Joint Provincial Nursing Committee (JPNC) for a two-year term. She will share the role with Vanessa Burkoski, Ontario's Provincial Chief Nursing Officer. The JPNC advocates and advises government on nursing issues and other policies that promote health. The group is made up of representatives from the College of Nurses of Ontario, Ontario Nurses' Association, Registered Practical Nurses Association of Ontario, Council of Ontario University Programs in Nursing, Colleges of Applied Arts and Technology, Nursing Health Services Research Unit, Practical Nurses Federation of Ontario, as well as senior representatives from the Ministry of Health and the Ministry of Training, Colleges and Universities.

A team of nursing researchers from Queen's University has received $1 million to study patient safety. RNAO member Margaret Harrison will lead the project, funded by the Canadian Institutes of Health Research, to examine how evidence-based nursing practices in clinical settings and the community can reduce errors in care. According to a 2007 study by Accreditation Canada, about 185,000 patients suffered an adverse event in hospitals that year. Harrison, far right, was joined at the study's launch by RNAO members and Queen's colleagues Jennifer Medves (left) and Christina Godfrey.

RNAO member Tanya Abrams added the title of author to her resume this winter when she published a new book called *So you want to be a musician? You can be!* The book was inspired by the nurse practitioner's own sons, who, along with a cousin, make up the Abrams Brothers, an Eastern Ontario-based country-bluegrass trio. Abrams hopes the book will inspire other kids to explore music and have fun with it.

In December, the Supreme Court of Canada denied an appeal by the Ontario Nurses' Association. The result means ONA cannot sue the Ontario government on behalf of 53 nurses who contracted SARS during the outbreak in 2003. Last May, the Ontario Court of Appeal ruled that while the government does have a responsibility to protect the public from communicable diseases, it can't be held financially responsible to those who become ill.

This year marks the International Year of the Nurse, timed to coincide with the centennial anniversary of Florence Nightingale's death. Throughout the year, nurses in Canada and abroad will be celebrated for their commitment to building healthy communities and global health promotion. On April 25, 2010, a commemorative service will be held at the National Cathedral in Washington, D.C. to honour this event. Find out more at www.2010iynurse.net.

In the November/December 2009 issue of *Registered Nurse Journal*, an item in *News to You to Use* incorrectly stated that Roberta Heale received a Chair in Advanced Practice Nursing (APN). Heale did not receive the Chair, but will be working with Alba DiCenso in the Chair Program. *Registered Nurse Journal* regrets the error.

Calendar

February

February 25
Mid-Career Nurse Symposium: Refresh and Refocus your Career
Hyatt Regency
Toronto, Ontario

February 28- March 5
Wound Care Institute: Minding the Gap
Sheraton Fallsview
Niagara Falls, Ontario

March

March 11
Leadership for New Grads: From Surviving to Thriving in the Work Environment
Toronto, Ontario

IT'S NOT TOO EARLY TO PLAN AHEAD!

October 18 to 20
Knowledge, The Power of Nursing: Celebrating Best Practice Guidelines & Clinical Leadership
Toronto, Ontario

For more information, visit www.rnao.org.

April

April 16
85th Annual General Meeting
Downtown Toronto Hilton
Toronto, Ontario

April 16 - 17
11th Annual Options for Diabetes Conference
Holiday Inn, Kingston, Ontario.
Topics: Diabetes and arthritis; periodontal disease; management of the diabetic foot; depression; use of Incretins; cardiovascular disease; presentations by people living with diabetes.
For more information, contact Margaret Little, 613-547-3438 or e-mail hartwork@kingston.net.
Toronto contact:
Joan Ferguson, 416-239-0551.

May

National Nursing Week 2010
Monday, May 10 to Sunday, May 16
This year's theme…**Nursing: You can't live without it!**
Registered Nurse Journal will once again publish its annual Nursing Week pull-out section in the May-June issue. Your photos from local events and activities can be sent directly to jscarrow@rnao.org for consideration.

May 13
Nursing Career Expo
Toronto, Ontario

June

June 13-18
Clinical Best Practice Guidelines Summer Institute
Nottawasaga Inn, Alliston, Ontario

August

August 8-13
Healthy Work Environments
Summer Institute
Location, TBD

RNAO CELEBRATES 85 YEARS!

RNAO is marking its 85th anniversary by showcasing the influence and success it has achieved since 1925.

Share your thoughts with us. What does membership mean to you? Tell us about a particular aspect of RNAO's work that has made you proud. What's your favourite RNAO memory?

Send your thoughts or historical photos or mementoes to Jill Scarrow at jscarrow@rnao.org.

UNLESS OTHERWISE NOTED, please contact events@rnao.org or call 1-800-268-7199 for more information

RNAO AT WORK

Speak out for nursing by representing RNAO at work. Become a Workplace Liaison today!

Visit www.rnao.org/wl or call 1-800-268-7199 to receive regular updates and materials.

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RETIREMENT FINANCIAL PLANNING

Retirement Planning issues which you may wish to discuss: HOOP Pension Plan, Canada Pension Plan, RRSP, RRIF, & TFSA, Taxation, Investments, and Estate Planning. As a certified and licensed financial planner I have over 20 years of consulting/planning experience with a fee-based practice.
For an appointment call Gail Marriott CFP, EPC at 416-421-6867.

DID YOU KNOW?

You can access the 'members only' section of the RNAO website to update your e-mail and mailing address. Never miss an issue of *Registered Nurse Journal* and stay connected with your nursing colleagues across the province. Update your profile today by visiting www.rnao.org/members.

Smart Medication Delivery Systems: Reducing Medical Errors Smart Infusion Pumps

Conference: Wednesday, February 17, 2010, Toronto

Whether your healthcare institution is planning to implement, is in the process of implementing, or has already implemented smart infusion pumps, this event is for you!

Stakeholders' failure to familiarize themselves with the correct use of smart pumps can result in many types of medical errors.

For further information visit
www.oha.com/conferences

Contact: Oana Matei
416-205-1314
omatei@oha.com

Join to learn more about:

- Medication incidents and infusion pumps
- Role of smart infusion pumps in the overall medication safety strategy
- Clinical implications and workflow impact
- Log analyses and drug library updates
- And much more...

OHA ONTARIO HOSPITAL ASSOCIATION

Get Involved with RNAO: COMMITTEE WORK OPPORTUNITIES

There will be vacancies on the following board committees (not the Board of Directors), effective June 30, 2010:

- Legal Assistance Program Committee
- Provincial Resolutions Committee
- Editorial Advisory Committee
- Membership Recruitment & Retention
- Nursing Education
- Nursing Practice
- Nursing Research
- Policy Analysis & Development

RNAO Board Committees 2010-2012. Term of office is July 1-June 30 (2-year term). For information regarding a specific vacancy or committee Terms of Reference, contact Penny Lamanna at plamanna@rnao.org, noting which committee you are interested in joining.

Interested candidates must submit their CV with a letter attached, outlining any relevant experience, and describing their interest in the position.

RNAO
Registered Nurses' Association of Ontario
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85 years

DEADLINE FOR SUBMISSIONS – Monday, May 3, 2010

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For the most current information about the Nursing Education Initiative, please contact:

RNAO's Frequently Asked Questions line
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DO YOU KNOW A SPECIAL NURSE?

Toronto Star readers are being asked to nominate someone in the Nursing Profession for the *TORONTO STAR NIGHTINGALE AWARD 2010.*

Information on Award Criteria and where to send your nomination will be published in the Star and online at www.thestar.com/nightingale

Deadline for nominations is March 22, 2010. Winner will be announced during Nursing Week 2010.

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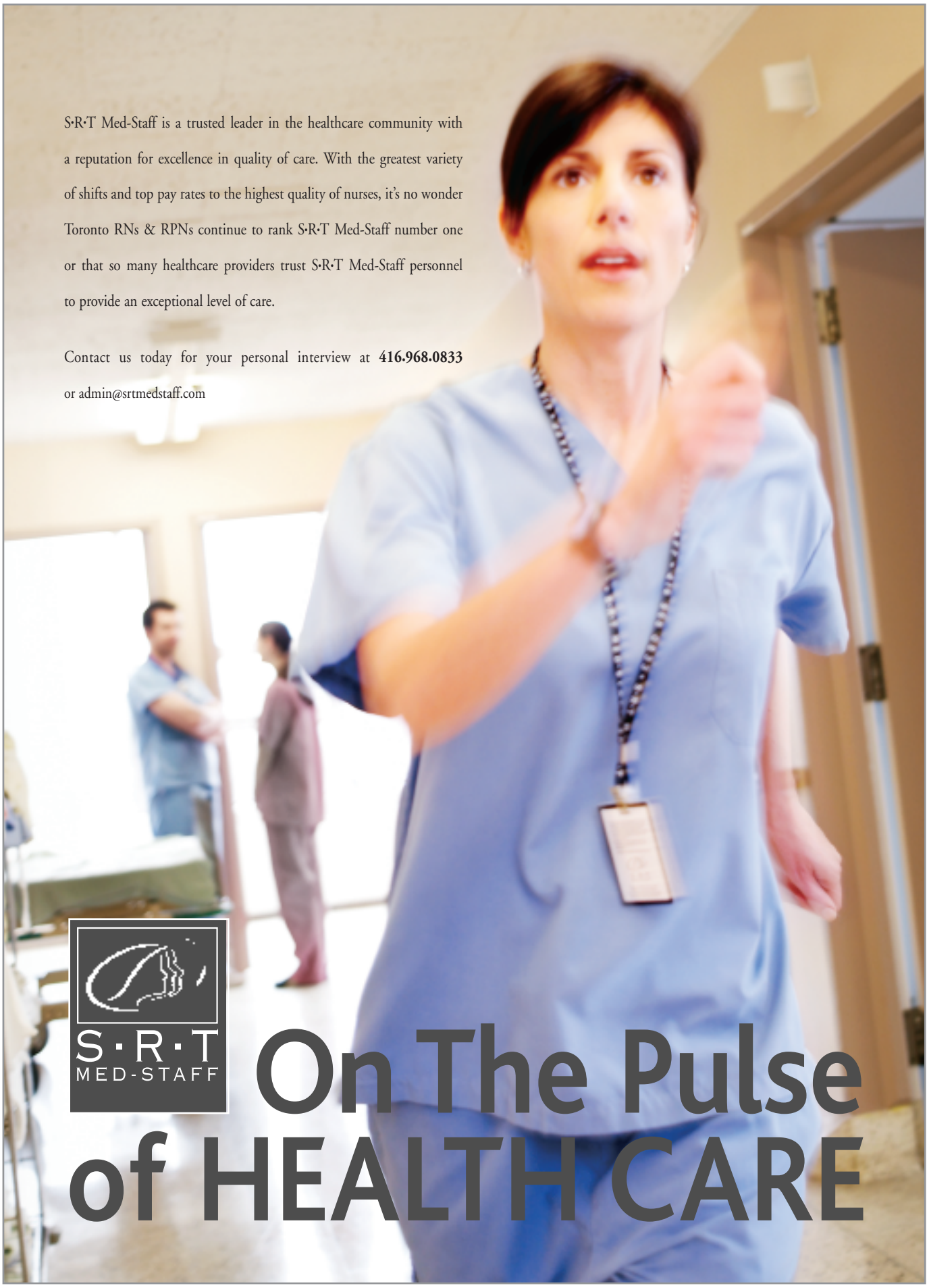

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