RNs on Citizens' Assembly • The Making of a Nurse • Embracing diversity and inclusivity

July/August 2007

Registered Nurse JOURNAL

Managing chronic illness

RN Patti Staples provides resources and knowledge to patients with chronic disease.

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THE LINEUP

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If I win the lottery, I think I'll ...

On June 3, Barrie RN Terry Dempster experienced what most of us will only ever dream of experiencing. She cashed in a winning lottery ticket and found herself $32 million richer (pg. 7). Although most people have probably given some thought to how they might spend a windfall of cash, it's hard to imagine the enormity of that much money.

What's touching about Dempster's win is that she told reporters she would be spending her money on round-the-clock care for her 86-year-old grandmother. I'm not sure what kind of care Dempster's grandmother needs, but given that she's 86, she could be among the 80 per cent of people over age 65 who, according to the Ontario Health Quality Council, have a chronic disease.

In this issue of the magazine, we learn more about chronic illness, and we meet five nurses who are making a difference for those who need chronic care. Their experiences with the elderly, marginalized and low-income patients will resonate with readers because each of us knows that at some time in our lives we will come face-to-face with chronic disease. Some of us will help to manage it as health-care professionals or family members, and some of us will be managing it as patients.

As acute care nurse practitioner Patti Staples says in our cover feature (pg. 10), when it comes to making changes and managing chronic conditions, some of us will climb mountains and others will only make it over the foothills. Thanks to the work of so many nurses, we can all rest assured the climb will be manageable because we won't be doing it alone.

Kimberley Kearsey
Managing Editor

Intolerance of Ontario's cultural richness and wealth of diversity cannot continue

I live and work in the most culturally diverse city in North America. One hundred and three languages are spoken by people who call Toronto their home. It's not uncommon to hear people converse on the streets in Farsi, Tagalog and Somali. You can buy newspapers published in Portuguese, Sinhalese and Mandarin.

This is what I love about Toronto – its cultural richness and the wealth of diversity. The fact that I grew up on a farm outside Burlington and didn't meet a person of colour until I entered the University of Toronto at the age of 17 makes me appreciate our wonderful city even more.

And yet, there is a down side to the multicultural fabric I've just described. Many people in Toronto, and across this province, face barriers to education and employment, or wait in hope for opportunities that are out of reach. Their experiences with racism and discrimination are at odds with our goal of a tolerant society that embraces and celebrates diversity.

I call it the nether side of humanity. For whatever reason, many of us are not comfortable with people who are different from us. It upsets me because it's so divisive. In my view, intolerance is a weapon of mass destruction.

Sadly, our profession isn't immune to this reality.

As nurses, we are citizens of the world and we look after citizens of the world. That's why we must be genuinely inclusive. This isn't about white nurses respecting black nurses or Christians respecting Muslims. It's about all of us showing mutual respect and demonstrating that respect in our day-to-day dealings with one another.

During Joan Lesmond's presidency, RNAO set out to address the barriers that exist in our profession by launching the *Embracing Diversity and Inclusivity Project*. The Board of Directors and staff set out to develop clear positions and an action plan to ensure we live our mission statement in all of our activities. We also wanted to build policies that would give all nurses, including those from different racial groups, those with disabilities, and those who are gay, lesbian, bisexual and transgender, the opportunity to participate fully in nursing and in RNAO.

Members of the board, assembly, interest groups and staff took part in workshops and interviews. Difficult questions were asked and answered about ourselves and our inherent biases. We have committed as a board to demonstrating that we truly value diversity. For our purposes, diversity includes all 16 grounds upon which the *Ontario Human Rights Code* prohibits discrimination. In April, the board adopted an organizational statement on diversity and inclusivity that sets out a list of expectations for the association. In June, we approved a position statement titled *Respecting Sexual Orientation and Gender Identity*. RNAO is now looking at how to be inclusive in everything we do, from the services we offer members, to policy initiatives, to the work we do with our stakeholders and the programs we develop to encourage our members to bring diversity and inclusivity to their own lives and workplaces.

> "Members of the board, assembly, interest groups and staff took part in workshops and interviews. Difficult questions were asked and answered about ourselves and our inherent biases."

Our statement isn't exclusive to RNAO. We're merely taking the lead. We believe all nurses have a responsibility to ensure everyone has a voice in the kind and quality of care they need and deserve. We need to respect differences so effective care can be delivered irrespective of the patient's origin, their sexual orientation or gender identity. And our statement doesn't just address the needs and rights of our patients; it also takes a hard look at the discrimination that nurses experience.

You may ask, 'what are we trying to change?'

And the answer can be found in one telling example from my experience. The vast majority of nurses who occupy leadership roles in this province are white. In my career, I have met and worked with many committed, knowledgeable nurses from various cultures, but few of them have achieved positions of authority. And for those who have, the road has not been easy. They've struggled and pushed to get where they are, and once there, are still confronted with barriers and discrimination.

Although this is RNAO's document, we think it's important for health-care professionals and organizations to engage in this dialogue as well. We want a profession that doesn't discriminate but rather, reflects society at large. RNAO has an opportunity here to show significant leadership in a meaningful way by defining what the words diversity and inclusivity mean in symbolic and practical terms.

We need members to help us move this initiative forward by informing nursing colleagues and other health-care professionals where you work. We're charting new and important waters and are making progress. Join in and learn with us.

Together we can promote a society where diversity is valued and inclusivity is celebrated. **RN**

MARY FERGUSON-PARÉ, RN, PhD, CHE, IS PRESIDENT OF RNAO.

Building Medicare's next stage

Fifty years ago, Tommy Douglas introduced hospital insurance, the precursor to what we know as Medicare. He was clear that the initiative was only the first stage of Medicare, meant to protect Canadians from the financial burden of ill-health. In 1982, he reminded us that our work was not complete. He said: "Let's not forget that the ultimate goal of Medicare must be to keep people well rather than just patching them up when they get sick."

To achieve Douglas' dream, we must forge strong linkages between Medicare and social and environmental factors that have a decisive impact on our health. When people's health is at stake, these are inseparable.

Tremendous work is being done by researchers, policy experts, health professionals, and civil society advocates to strengthen health care in Canada. From wait times to primary care, the message is that teamwork and expanded nursing roles improve access. The social justice agenda is equally vibrant as the powerful links between poverty and ill-health can no longer be ignored.

While the focused work of each activist is crucial to a healthy future, it's important to remember we cannot improve our health-care system or the health of Canadians if we work in silos. Those of us, who are intent in protecting and expanding Medicare, must also speak about, and advocate for, environmental and social determinants of health (SDOH). If we don't, we are fighting an uphill battle where all we do – albeit important and necessary – is, as Douglas put it, 'patch people up.' The same is true for those of us whose work focuses on SDOH. These activists and researchers must also speak out for Medicare. By linking these two areas of focus, we have the capacity to empower politicians to advance healthy public policies.

I was inspired to witness the convergence of Medicare and SDOH at three events this spring. The first, in Saskatchewan, was *S.O.S. Medicare 2*, a two-day national conference in May. The discussions and ideas that made that conference so compelling will be published in a book entitled *Medicare: Facts, Myths, Problems, Promise* to be published this fall.

Next, in June, was *The Second Stage of Medicare* conference, hosted by The Association of Ontario Health Centres. It brought together researchers and policy and social justice experts to explore joint opportunities to articulate a vision for health and health care. The partnerships established at that conference will only grow stronger as we move forward.

> "Moving forward must include strengthening Medicare and strengthening programs to improve the environmental and social determinants of health."

The third opportunity to converge the traditional Medicare agenda and SDOH came with the release of RNAO's pre-election document, *Creating a Healthier Society*, on May 10. In our document – which is guiding the association's work through the provincial elections and for the next three years – we turn the discussion upside-down. We first focus attention and recommendations on what keeps us healthy and what makes us sick. We then address illness care. Indeed, isn't that what nursing is all about: promoting health, preventing disease, nursing people during illness, recovery, rehabilitation, and when inevitable, toward a peaceful death? As nurses we are well positioned to educate people on the connection between SDOH, health, illness and Medicare.

There are seven policy and political priorities that we must pursue to advance the next stage of Medicare. They include: addressing the growing social inequalities; responding to an aging population; resolving health human resource challenges; protecting Medicare from the forces of privatization; building a national pharmacare program; addressing environmental threats to human health; and securing funding to address both SDOH and Medicare.

As we connect with politicians during the election this fall, these are the issues we need to bring to the forefront. Let's ask politicians to explain their plans to relieve people from poverty. How will they spend on social programs to provide a livable income, housing, contribute to public health programs, and increase participation in our parks, schools and community centres? How will they protect Ontarians from toxins and pollution? What are their plans to address chronic disease management? How do they plan to support nurses in the workplace and attract more people into the profession? How will they protect Medicare from those who want to profit from the vulnerabilities of people? And how will they improve access to prescription drugs while keeping the rising costs for those drugs in check?

If they tell you these are worthy goals, but will cost more money than the government has, ask them what they think about taxes? Tell them nurses would rather strengthen Medicare and make poverty history than see tax cuts. Ask them to read RNAO's *Creating a Healthier Society* election platform document (www.rnao.org).

There are some who may worry we are casting too wide a net; that perhaps we should focus only on one goal, or just on nursing issues. But all of this is nursing. Moving forward must include strengthening Medicare and strengthening programs to improve the environmental and social determinants of health.

The time has come to break our silos and together engage the public and persuade politicians to build the next stage of Medicare. **RN**

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

by **Kimberley Kearsey** and **Tiffanie Ing**

Nursing in the news

RNAO & RNs weigh in on . . .

RNs lead coalition to get more funding for meals in long-term care

RNAO members **Angela Shaw** and **Julie Curritti** enlisted the help of Liberal MPP Peter Fonseca (Mississauga East) in their ongoing initiative to increase funding for meals in long-term care homes. This spring, the two nurses – who each have a parent in long-term care – collected signatures on a petition that Fonseca presented before the legislative assembly. The petition was endorsed unanimously by voting delegates at RNAO's annual general meeting. At the end of May, the Liberal government announced an increase that was considerably less than what was recommended and supported in the petition. A letter to the editor (right) was published in the *Toronto Star* on July 11.

Inadequate increase in seniors' food funding

Letter to the editor
Toronto Star, July 11, 2007
Re: Seniors in long-term care get extra 11 cents worth of food daily *(July 9, 2007)*

A province-wide campaign is continuing in the months ahead, focused on providing adequate nutritious food for seniors in local long-term care facilities – with additional direct support from the Ontario government.

The grassroots campaign began earlier this year after a major Dietitians of Canada study pointed to the inadequacy of the current $5.46 budgeted by the provincial government for the daily feeding of each long-term care resident. It recommended an immediate increase in the government's raw food cost budget to $7 per person per day.

A petition signed by 19,547 Ontario citizens representing 438 communities across the province strongly urging this increase was presented to the government in May. Soon after, the government announced that 11 cents would be added to its contribution, bringing the raw food cost funding to $5.57 per long-term care resident per day. Obviously, this is not enough. The funding still does not meet basic nutritional needs. Our colleagues are urging the Ontario government to take action now by boosting its funding to $7 per person per day.

Angela Shaw and **Julie Curitti,**
Raw Food Campaign Organizers,
Mississauga

Barrie nurses win $32 million in lottery

RNAO member **Terry Dempster** received a larger than expected birthday present on June 3 when she discovered one of the lottery tickets she received from her husband as a birthday gift had the winning numbers. The Royal Victoria Hospital RN and her husband Blaine, who also happens to be a nurse, were beside themselves when they discovered they were $32 million richer: "There is an anxiety that comes with it, just because of the enormity of it all," Terry said, "You can't really wrap your head around it." They insist they will continue working despite the winnings, particularly because of the nursing shortages facing hospitals in Ontario. "We want to live life as normally as we can…We're not extravagant people, but I'm sure we'll be a lot more fun." The family's top priority is to give Terry's 86-year-old grandmother around-the-clock care at home. (June 5, *CKVR-TV Barrie*, *CHWI-TV Windsor*, *CFPL-TV London*; June 6, *CFMK-FM Kingston*, *CHRO-TV Ottawa*, *Barrie Examiner*, *Toronto Sun*, *Globe and Mail*, *Toronto Star*)

Illustration: Jason Schneidier/Photograph: Tibor Kolley/The Globe and Mail

Nursing in the news

RNAO & RNs weigh in on . . .

Recruitment and retention efforts pay off

Across Ontario, health-care facilities are stepping up their recruitment and retention tactics to hire and keep more nurses in the system:

• RNAO members **Eleanor Rivoire** and **Colleen Cuddy** of Kingston General Hospital were happy with the results of a successful recruitment campaign entitled *100 Nurses in 100 Days*. Their efforts led to the hiring of 122 new RNs. "Retention is a huge issue for us…" Cuddy said (May 31, June 1, *CKLC-AM Kingston*; June 2, *Kingston Whig-Standard*). Rivoire, who is also Chief Nursing Officer for Quinte Health Care, spoke to the *Kingston Whig Standard* about a recruitment campaign launched there. The *Come Back Home* campaign was created to entice nurses from the Quinte area to return. Rivoire explained that a $5,000 bonus was being offered to each nurse who comes back to the community and stays two years. The nurses can leave after two years, but Rivoire hopes that won't happen. "If you recruit...you also have the staff to really focus in on the retention [part]." (June 6)

• **Brenda Elsbury,** RNAO member and Chief Nursing Officer for Brampton's William Osler Health Centre, has initiated a nurse recruitment drive for both William Osler and the new Brampton Civic Hospital. She's taking advantage of the provincial government's new grad initiative that guarantees employment to new grads for at least six months. One of the biggest draws to the area, she says, is the new hospital. "Of course recruitment is always ongoing in nursing. It is a profession that is constantly changing," she said. "But…how often does a nurse get to work in a brand new hospital?" (May 30, *Metroland – Brampton Division;* June 9, *CKWS-TV Kingston*)

Ontario lead laws hazardous to childrens' health

Ontario's Ministry of Health recently came under fire after reports that the amount of lead found in tap water exceeded provincial standards. RNAO member **Kelly O'Grady** is one of two Canadian nurses who have spent years researching the harm caused by lead, particularly on children. The Ministry, when confronted with statistics that found children in the U.S. are more likely to be diagnosed with attention deficit hyperactivity disorder if they are exposed to certain levels of lead, has so far rejected calls to screen children in Ontario. The Ministry explained that it believes average lead levels in blood have declined for decades and are now less than provincial standards. O'Grady and fellow experts disagree, stating that officials can't know what blood lead levels are in Ontario because there's been little testing. In response to a Ministry comment that

Out & About

Above: On June 11, RNAO President Mary Ferguson-Paré (right) and Executive Director Doris Grinspun received Membership Awards from the Men in Nursing Interest Group (MINIG). They were recognized with the honourary memberships because of their ongoing support for men in the profession. Presenting the awards were MINIG Vice President Mark Vimr (left) and Founder and Past President James D'Astolfo.

Below: On July 16, Liberal MPP James Bradley, Minister Responsible for Seniors (second from right), met with members of the Seniors Advocacy Partnership to discuss Ontario's elder health agenda. (L to R) Norm Shulman, Executive Director, Ontario Gerontology Association, Marlene Awad, Director, Regional Geriatric Program of Toronto, Joseph Bornstein, Senior Manager, KPMG, RNAO Executive Director Doris Grinspun, and RNAO Nursing Policy Analyst Gail Beatty.

Above: Sault Ste. Marie NDP MP Tony Martin paid a visit to Algoma Public Health on May 26. (Right) Heather Robson, an RN in the Genetics program, presented Martin with a token of appreciation for his interest in the work of public health nurses.

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

Canada can't be compared to the U.S. because environmental exposures differ, O'Grady said: "(The ministry's rationale) is absurd." (June 5, *London Free Press*)

Keeping seniors safe from falls

In an article about wait times for hip surgery at Peterborough Regional Health Centre, public health nurse Ann McLeod pointed out that falls are a very significant health issue for the older population. In response, **Tazim Virani**, former program director for RNAO's Best Practice Guidelines (BPG) Program wrote a letter to the editor noting recommendations found in RNAO's BPG *Prevention of Falls and Fall Injuries in the Older Adult*: "Preventing falls and fall-related injuries has always been a top priority for nurses. These days, nurses are using evidence-based best practices to identify patients in health-care facilities who are at risk of falling and to implement safety measures to prevent falls," she wrote. "These measures include communicating the risk of falls to other care providers and family members, reviewing medications with the doctor, using hip protectors, assisting with strength training exercise, etc. The recommendations found in *Prevention of Falls and Fall Injuries in the Older Adult*…ensure that nurses have the knowledge and support they need to keep our seniors safe." (May 31, *The Peterborough Examiner*)

RNAO launches smoking cessation website

On June 6, RNAO launched a new website designed to help nurses care for people who want to kick their smoking habit. The site (www.tobaccofreernao.ca) promotes methods for quitting as outlined in RNAO's best practice guideline (BPG) *Integrating Smoking Cessation into Daily Nursing Practice*. RNAO member and BPG panel member **Janet Nevala** spoke to *CBQ-FM Thunder Bay*: "Nurses [did] not always realize that if they take one to three minutes and ask people about their smoking, they'd find out that

people do want to quit." (June 7). Former BPG Program Director **Tazim Virani** commented that the website will be "a place where [nurses and health-care providers] can share ideas and techniques for supporting people who want to quit smoking." (June 11, *Welland Tribune*)

Sault College bidding for extra clinic

RNs teaching at Sault College are lobbying Ontario's Ministry of Health for permission to operate a clinic for college students and for Sault Area Hospital (SAH) patients who do not have a family physician and who require follow-up care. The clinic would be staffed primarily by three full-time nurse practitioners (NP), with one doctor providing consultation. The Sault College proposal also calls for support services to be provided by mental health professionals, social workers, pharmacists, a dietitian and a physiotherapist. SAH NP **Karen Scott** said the proposal is based on an NP model developed by North Shore Tribal Council First Nations. NP **Debbie Graystone** said, "We have a few nurse practitioners who've been unable to find full-time employment…in this community…it will provide an option for their employment." (June 14, *CHAS-FM Sault Ste. Marie, CJQM-FM Sault Ste. Marie, Sault Star*)

New anti-violence legislation

The Windsor Star included RNAO in its coverage of a petition calling for workplace anti-violence legislation that would be named after slain nurse Lori Dupont. The article notes that the petition, read into the legislative record by NDP MPP Cheri DiNovo, is "…backed by the Ontario Secondary School Teachers Federation and the **Registered Nurses' Association of Ontario**." (May 29)

In response to an article about whether or not Prime Minister Stephen Harper would support German Chancellor Angela Merkel's bid to cut greenhouse gas emissions by 50 per cent by 2050, RNAO President ***Mary Ferguson-Paré*** *wrote a letter that was published in the* Toronto Star *at the end of May.*

G-8 meeting a chance to put health first

Letter to the editor
The Toronto Star, May 31, 2007
Re: Canada to support 50 per cent cut in greenhouse gases *(May 29)*

The public's heightened concern about the environment deserves serious action. Every day, nurses witness the negative effects of environmental policies that fail to deal with the reality that we are polluting more and producing 35 per cent more greenhouse gases than allowed under our Kyoto obligation.

Asthma, lung cancer, cardiovascular disease and allergies are all linked to poor air quality. That's why Canada should take the most aggressive stance possible at next week's G-8 meeting to cut global output of greenhouse gases. To put it simply, staying healthy requires a healthy environment.

Mary Ferguson-Paré, President, RNAO

By Jill Scarrow
Photography By J. Michael La Fond

Managing chronic illness

RNs provide resources and knowledge to help those with chronic disease live fuller lives.

Last year, David* couldn't climb a flight of stairs, or shop without stopping to rest. His congestive heart failure (CHF) was getting worse. So much so, he was in and out of Kingston hospitals several times during 2006. That's how he met Patti Staples, an RN at Hotel Dieu Hospital's CHF clinic. Since he began working with Staples, David says he's developed a new outlook on life.

"Last year, I re-did my will, arranged everything," he says. The heart condition, which he'd lived with for several years, was sapping away his strength and his ability to live a full, independent life. "This year, although I still can't do a lot of things…I'm trying to enjoy what I can, while I can."

David, 61, says the clinic and Staples have allowed him to peer inside his heart to learn more than ever before. He's attended classes to learn about the way his ticker works, how the disease affects it, and how to make lifestyle changes that can keep his condition from worsening. David is also eager to do his homework. He uses the Internet to research the benefits and side effects of any new medications he's prescribed. While grocery shopping, he taps into his investigative abilities, studying labels to decode sodium levels in all his foods. David says what he's learned at the clinic makes it possible to take this proactive approach. But it's the time the nurses take to listen and understand him – and to educate him – that has given him the confidence to cope with his heart condition.

"I know I have congestive heart failure, there's nothing I can do about it," he says. "But I have a wonderful team that's working with me to control it the best we can."

Staples, a clinical nurse specialist and nurse practitioner, says the clinic has made a difference for hundreds of others like David, each with their own unique care needs. When it first opened seven years ago, one of the first patients Staples saw was a man caring for his wife who had Alzheimer's disease. When Staples told him that he would need to drastically alter his eating habits to follow a low-sodium diet, she saw the despair wash over this face.

"You need to look at what's realistic," she says, adding that it can be hard to convince patients to change long-established habits that may not be good for their health. "Some people will climb the mountains, and others, you'll do well to get them over the foothills …you want to make sure you build their belief that they can make the change."

Today, Hotel Dieu's clinic has more than 600 patients who are referred from the ER, inpatient units and family physicians. Staples says patients are taught about their medications, and what to do when their condition flares up. If they feel they're getting worse, they can call Staples or the clinic's RN for guidance. Staples and her colleague may be busy, but they've still found some time to evaluate the effect their work is having. After the first two years of operation, CHF-related ER visits and hospitalizations had decreased by 80 per cent for those who attended the clinic.

That kind of success should catch the attention of decision makers as the health-care system grapples to find the best way to cope with patients living with CHF and other chronic diseases such as hypertension, chronic obstructive pulmonary disease (COPD), diabetes and asthma. In the coming years, the pressure of chronic disease will swell as the population ages, and the system will feel the strain.

Last March, the Ontario Health Quality Council released its second annual report that described the challenges Ontario faces as it copes with chronic disease. The council found that approximately 80 per cent of those over the age of 65 have at least one chronic disease. Nearly 70 per cent have more than one illness. The council also revealed that marginalized populations, including immigrants and Aboriginal Canadians, are also affected. These populations have higher rates of diabetes. Low-income Canadians are also at risk because they are 50 per cent more likely than the general population to report having a chronic disease.

To care for the people behind these daunting statistics, the

* *A pseudonym was requested to protect David's privacy.*

Kingston acute care nurse practitioner Patti Staples heads up the congestive heart failure clinic at Hotel Dieu Hospital.

council says multi-disciplinary health teams, including nurses, will be integral. By using their knowledge and skills, nurses are already improving the quality of life for many with chronic illnesses. This spring, RNAO called on politicians to commit to making clinics like Staples' available to all patients across Ontario by establishing seven nurse-led clinics to focus on chronic disease management. The request was part of *Creating a Healthier Society,* a comprehensive document that outlined what RNAO expects to see all political parties include in their platforms during the upcoming provincial election campaign. The report says nurse-led clinics that help people manage chronic disease are cost-effective, lead to higher patient satisfaction, fewer deaths, better care, and an improved lifestyle for the patient. They also increase accessibility to care and reduce wait times.

RNAO Executive Director Doris Grinspun says RN-led clinics will address the health needs of patients and will help realize Tommy Douglas's dream of a second stage for Medicare (see *Executive Director's Dispatch,* pg.7, for more).

"We need to make chronic disease management a top priority, and back it up with programs and money to help Ontarians manage their chronic ailments and prevent complications," she says. "Doing so is good for our patients and begins to move us towards a health-care system that will be vibrant and sustainable well into the future."

As a young RN, Shamila Ali has a vested interest in solutions

that will keep the system healthy throughout her career. Last fall, as part of her master's work at Ryerson University, Ali completed a placement at RNAO to study how clinics led by advanced practice nurses reduce complications for those with diabetes. Her research revealed that nurse-led clinics decreased admissions to the hospital because they allowed patients to be seen before common diabetes' complications advanced to the point where the patient required hospitalization.

Ali says she was intrigued by the topic because, as an RN in cardiovascular surgery at Toronto's University Health Network, she sees how often diabetes can result in cardiovascular complications. She admits, however, that by the time patients are in her unit, there are limited resources to educate them about how they got there, and how they can avoid returning.

"A lot of communities close by have absolutely nothing for people with COPD. We really need to make an effort to make a difference for these people."

"We have so little space in acute care settings," Ali says. "Chronic disease patients spend days in the ER, then they get transferred to a unit to treat their immediate health-care issue, and then they are returned to the community."

Suzy Young believes patients with chronic disease shouldn't be alone as they make their way back into the community. The acute care nurse practitioner at St. Mary's General Hospital in Kitchener recently began an *Activation* program for COPD patients. Through the program, patients learn about smoking cessation, what to do when they become short of breath, how to effectively exercise, and how to link with programs around the city so they'll stay active. Young says there is plenty of evidence that those who are active have fewer problems with their lung disease because exercise keeps the respiratory muscles working. It keeps their social skills sharp too.

"People with COPD tend to isolate themselves," she says, adding the program will build self esteem by getting them involved in the community and exercising with others who also have the disease. "They're not exercising next to someone in spandex who's going six kilometres an hour on the treadmill," she says.

Although the program, funded by the Waterloo Wellington Local Health Integration Network (LHIN) is still new, Young says she has already seen encouraging results. One man began exercising just days after being discharged from the hospital. Young says patients in the Kitchener-Waterloo area are lucky to be able to receive this kind of care along with access to inpatient and outpatient programs at St. Mary's.

"A lot of communities close by have absolutely nothing for people with COPD. It's really quite disastrous," she says. "It's the fourth leading cause of death and growing. We really need to make an effort to make a difference for these people."

RN Jacqueline Geremia says nurses are well suited to make that difference because they have the clinical knowledge patients are hungry for, and they have the ability to tap into what's really going on in a patient's life. After listening to a story of one woman who was having severe asthma attacks, Geremia was able to determine an abusive situation at work was bringing on anxiety attacks on top of the asthma. Knowing this made it easier to help the woman control the disease.

Until last March, Geremia was the asthma educator at Scarborough Hospital. She did everything from follow up with patients, to the clinic's clerical work. She also created a project to

GLOBAL PERSPECTIVE ON DIABETES CARE HELPS DIVERSE POPULATIONS AT HOME

RN Sherri-Jo King says it doesn't matter where you are in the world, helping patients manage diabetes means understanding the role culture and lifestyle have on illness. For the past five years, King has been a diabetes educator in England, Saudi Arabia and the United Arab Emirates. She says her biggest challenge, particularly in Arab countries, was helping patients adjust their diets and medications without missing out on celebrations such as Ramadan, which requires fasting between dawn and dusk.

King says food is a big part of ritual and family tradition in every country she's visited. Good diabetes care, she explains, is "about helping them include it in their lives, with the ability to address (diabetes) along the way."

King has brought her global experience home and is now putting it to good use in Canada's multicultural communities. In April, she became diabetes team leader at the London InterCommunity Health Centre (LIHC). After spending much of her time overseas working in hospitals and private clinics, King says she was eager to reach out and make a difference in disease prevention and management at the community level.

According to the Health Council of Canada, at least 1.3 million Canadians have diabetes. Of those, ethnic minorities, new immigrants and Aboriginal Canadians bear the greatest burden, some of whom may be coping with the disease alongside other struggles such as poverty or adjusting to life in a new land.

For the past eight years, LIHC's Latin American Diabetes program has been helping ease that strain for immigrants in London, Ontario. King says the program began in 1999 after staff noticed a high rate of diabetes in London's Latin American community. LIHC's program offers culturally sensitive screening and education. For example, staff members help individuals plan their diet so they can continue to enjoy their traditional foods, but instead of eating two empanadas, they may eat just one along with salad. There are also children's programs to target young people to keep them active in the hopes of preventing diabetes.

The program has been so successful it has since expanded to include other communities in the area, including South Asian, Vietnamese, Cambodian and Caribbean residents. King says LIHC is also bringing diabetes education to women's programs and English classes to link with those communities and bring them information about diabetes and how LIHC can help them manage it.

King admits it's not just the patients who are learning more about their condition. Even after 14 years as a certified diabetes educator, she says she is still constantly learning too. She always listens to the solutions patients are finding in their own lives, because their lived experience makes them the real experts.

"My philosophy has always been that it's my job to make every person their own diabetes expert," she says. "I think that's what breeds success." **RN**

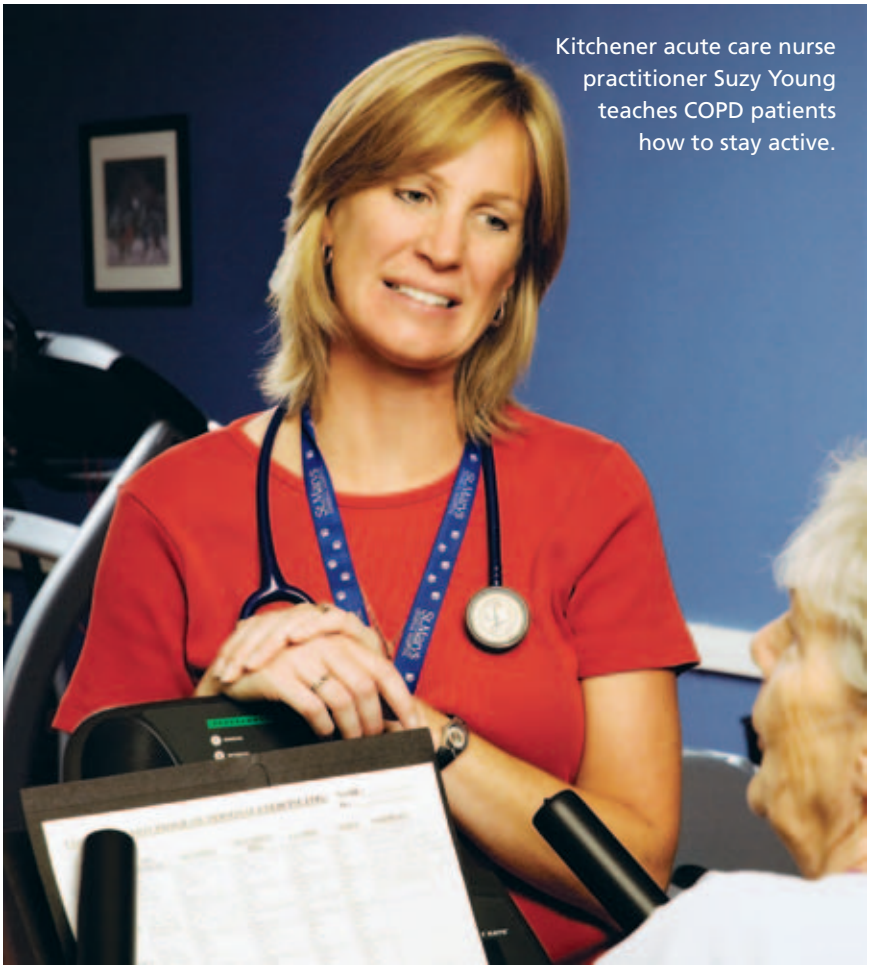
better understand the local South Asian population's beliefs about asthma. She worked with an interpreter to interview local families about their knowledge of asthma, and why they did, or did not, attend the clinic.

She found many members of the community saw asthma as a weakness their children would 'grow out of,' and so would rather keep them home from school than send them to class with an inhaler. Some adults who were new immigrants were also concerned that if their employers saw them with an inhaler, they would think them too weak to work. While Geremia stresses certainly not every member of the community held these beliefs, it was a very useful way for her to begin understanding the kind of information and knowledge some of her clients brought to their meetings with her at the clinic.

"People always understand something about their illness. It might not be correct, but they have something in their minds. I try to get a sense of what they already know, and re-direct that knowledge to something best-practice based."

Geremia says RNs should also share their knowledge with the general population so the public can learn about chronic illness before they end up in the hospital. She believes more information about chronic illness would also help nurses who work in places like the ER or doctors' offices, where many asthma patients have their first contact with the health-care system, but where health professionals may not have specialized knowledge about chronic conditions. Geremia admits it was sometimes difficult to get time-squeezed doctors and RNs in the ERs to refer patients to her clinic, but if ER staff had known more about the benefits of asthma education, they might have been more inclined to encourage people to visit her.

Geremia firmly believes that once people make the connection with an RN like herself, Young, Staples, or the countless others who are participating in disease education, they often wonder why they didn't do it earlier. She cautions, however, that allowing nurses to truly make a difference for the one in three Ontarians who live with a chronic illness will require more programs like the ones that keep people like David from bouncing around the hospital system, and help them live lives that are as full and rich as possible. **RN**



Kitchener acute care nurse practitioner Suzy Young teaches COPD patients how to stay active.

JILL SCARROW IS STAFF WRITER AT RNAO.

NEW BPG ENABLES PARTNERSHIP BUILDING BETWEEN NURSES AND THEIR PATIENTS

Nurses and patients are partners in the management of chronic illness. That's the philosophy behind a new clinical Best Practice Guideline (BPG) being developed by RNAO. Currently titled *Patients as Partners: Strategies for Self-Management Support in Chronic Conditions*, the BPG will provide strategies for helping patients to develop confidence when managing their chronic illness.

The guideline will encourage nurses to use critical thinking and problem solving to help patients set goals, develop action plans and identify barriers to managing their health. Nurses working in all settings will be able to use the strategies to empower patients coping with conditions such as diabetes, cardiovascular disease and respiratory illnesses.

Guideline development panel leader Patrick McGowan, who has been researching self-management strategies for 20 years, says: "We used to solve problems for our patients, but it's better if they use problem-solving processes to help themselves." He adds that health outcomes are linked to personal behaviour and evidence shows that when techniques are used to encourage people to play an active role in managing their conditions, it results in better outcomes.

While some nurses may find they are already using some of the recommended interventions, RN and panel co-leader Suzanne Fredericks says implementing the guideline will lead to more structured strategies and mentoring between RNs and clients. She anticipates the BPG will "give patients … more autonomy and enable them to be more self-directed and more involved in their care."

The guideline will be released early in 2008 and will complement other RNAO guidelines focusing on client-centred care, asthma, diabetes, COPD and hypertension. **RN**

6 RNs join the race for Queen's Park

RNAO checks in with nurses who hit the nomination trail this spring, each one hoping for a spot on the provincial election ballot.

By Kimberley Kearsey

It's a well-known fact that politics is not for the faint of heart. After this spring's nomination races – during which party members across the province selected candidates to represent them in an election – at least three Ontario RNs can now say they have first-hand experience to support that claim. Dorothyanne Brown, Norma Nicholson and Shirley McMillan, did not win their nominations in Kingston, Mississauga and Oxford, respectively. Although they agree the race for Queen's Park may not be pretty at times, none are giving up on their dreams.

Brown, a primary health care manager at North Kingston Community Health Centre, was one of three NDP candidates vying for the nomination in the riding of Kingston and the Islands. She recalls a troubling conversation with a male party member who said there was no chance a woman would win the election. But she didn't let the comment get her down. "The perception is that we're softer candidates; that we're not going to take it to the streets…I honestly think men and women are equally competent to do a whole bunch of different things. If women can accept that, why can't men?"

Nicholson, an assembly member at RNAO, and a service manager at Toronto's West Park Healthcare Centre, says she didn't face the same stereotypes in her riding of Mississauga-Brampton South, but she did see a side of the political process she didn't expect to see. After a month of campaigning to represent the Liberals in this new riding, party advisors notified her that they would forego the democratic nomination process and appoint, rather than elect, a candidate. In response to questions about whether she feels her efforts were in vain, she says: "Oh no, not at all. In my neighbourhood and surrounding areas I know so many people now, and they know that I'm a nurse."

> "It's great to go to fairs and picnics and political rallies and talk politics...engage people in the kinds of problems they're facing in their lives and talk to them about some of the solutions."

McMillan, who works for a non-profit association supporting children and adults with developmental disabilities, is also positive despite having lost. She hoped to become the Liberal candidate in her home riding of Oxford, where she has lived all of her life. "I think I only ran into one person who said no, I won't support you, and just hung up (the phone)," she says. "It takes you aback at first but you try not to take it personally. You have to brush it off and think maybe you caught them at a bad time, or maybe they didn't understand (what you were asking). You just go on."

Three other RNAO members are still in the running for the next provincial election, and we may see them next time RNAO goes to Queen's Park.

Hilda Swirsky, a board member who currently works as a casual nurse in high risk obstetrics at Toronto's Mount Sinai Hospital, is hoping to represent the Liberal party in the Toronto riding of Trinity-Spadina. She handed in her nomination papers on July 7, and is waiting to find out if she will be elected as the candidate.

RNAO members Angela Kennedy and Ross Sutherland, from Toronto and South Frontenac respectively, were both acclaimed during this year's nomination race, and their names will appear on election ballots this fall. Kennedy, who is a

school board trustee, will represent the Conservative party in Toronto's Don Valley East riding. Sutherland, who has been on the NDP federal and provincial riding associations, will represent that party in the riding of Lanark, Frontenac, Lennox and Addington.

It's taken almost a decade to get to this point in her political career, Kennedy explains, and she's thrilled. Sutherland too has participated in politics for most of his adult life. The two MPP hopefuls agree the ride has been rough at times, but the rewards are worth it. "I love going out and meeting people," Sutherland says. "It's great to go to fairs and picnics and political rallies and talk politics…engage people in the kinds of problems they're facing in their lives and talk to them about some of the solutions."

"You never know where life is going to take you," Kennedy explains. "During my nursing career, I've always been in advocacy roles…I just began to feel that I really like helping people. I like listening to people. I can problem solve well. There's a way that I can help people apart from nursing."

RNAO Executive Director Doris Grinspun beams with pride when she hears about nurses' increased political engagement. She is convinced that having more RNs at Queens Park will enrich public policy. That's why she envisioned the *RN Candidate Training Program* six years ago and worked with the policy and communications departments at RNAO to launch it in 2002. The training was offered for a second time last fall.

Swirsky, Nicholson and Kennedy participated in the program's six intensive weekend sessions, learning about everything from the nomination process, to establishing a team, positioning a candidacy, building support, and generating finances. It was immensely helpful, they say.

"I've learned so much that I can actually teach a part of this now," Nicholson says of the course and its focus on the political process. "Knowing the process and how to go out there and operationalize what you've been taught… there were tips in the training that I definitely utilized."

Despite her disappointment this spring, Nicholson still intends to get involved in the fall election. She has offered to help the candidate appointed in her riding. She says she'll also remain politically active in other ways. She's signed up as a volunteer on the Ontario Liberal Women's Commission and will facilitate a two-hour education session on RNAO's election platform in September. "Most people have asked, 'Aren't you upset?'" she says of reaction to the Liberal party's decision to appoint a candidate. "I'm disappointed, but I've learned so much out of this process that my knowledge is so broadened…anyone who comes with a question about the nomination process, I can give a response."

Swirsky is equally appreciative of the opportunity to run. "Handing in my nomination papers, I was so happy," she says. "I was on cloud nine all the way home because it's such an accomplishment. I have really done my best and I'm proud of what I've done."

Brown, who is not new to the nomination race (she threw her hat into the ring in 2003), says she may not be pleased about losing, but she's proud that she "did well enough to hold my head up." The vote went to a second ballot and the winner was a seasoned city councilor who had just wrapped up an almost successful run for mayor. "Name recognition is 90 per cent of the battle," she muses.

Brown's run for nomination this year was a little less "rushed" than it was four years ago. In 2003, someone asked her to run at the last minute and she submitted nomination papers the night before the vote. While Brown did not attend the training, she received the materials and says they have been invaluable.

"The package is very useful and I've shared it with other (political) colleagues of mine who are running on similar platforms," she says. "I love that RNAO has done this for candidates of all political stripes because it's a really good way to support membership. I think it's fantastic and much, much appreciated from my own personal perspective."

McMillan missed the training because she didn't decide until early this year that she would run for nomination. "I realized afterwards that there was training and that I missed it," she says, adding that she's expecting to be involved when it's offered next (probably in the fall of 2010). "I'd be

Illustrations: Jeremy Bruneel

looking for tips on how to do it (run for nomination) and get more organized."

For Kennedy, who has been involved in many campaigns, the training was more useful in that it "…made me look at myself and ask, 'where do I need to improve?' It helped me to figure out what I need to focus on during the nomination process and the campaign itself."

Kennedy's first order of business as she prepares to compete against Cabinet Minister David Caplan this fall will be to raise campaign funds and build a team of between 300 and 500 volunteers. "Over the years, I've worked on federal campaigns and provincial campaigns. I've helped candidates door knock, literature drop, make phone calls. I offered any help I could during elections and by-elections." She says she's now hoping for the same support from nurses.

And it seems she may just get it.

"In 2003, I didn't feel very supported by nurses," Kennedy admits. "But now, it's a lot different. We (nurses) are realizing that we need to be there for one another. I think it (the knowledge and interest in politics) is much stronger now…we were just getting our feet wet back then."

Sutherland agrees that his challenge heading into the election is not necessarily going to be in finding support from nursing colleagues, but rather from the general public. "The biggest challenge…is trying to talk to people and help them see issues in a different light," he says, noting that his riding has traditionally been Conservative. "People have real problems in their lives and they can blame doctors and nurses or they can look at different sources of the problem. How you see a problem structures how you see a solution."

He says his first order of business is to build a team of volunteers. Next, he's going to get out and meet people. "The really nice thing about being a candidate – win or lose – is that you have some credibility on the issues. You can go out and lend support to a particular struggle or issue, and you can really help out. To me, that's inspiring."

Brown may not be the candidate in her Kingston riding this year, but she feels just as inspired as Sutherland. She says many of the health-care discussions she had with constituents while running for the nomination focused on the cost of looking after chronic disease. "People are distressed out there because they can't afford to look after their diabetes effectively or they can't afford to look after their COPD," she says. "I was able to use a little bit of my nursing process to get them linked up with services. Even if they came and voted for me or came and voted for the other guy (during the nomination meeting), at least I was able to help one or two people as I went along with the campaign."

"We (nurses) are realizing we need to be there for one another. I think it (the knowledge and interest in politics) is much stronger now."

RNAO's Director of Health and Nursing Policy Sheila Block is thrilled about nurses' increased political advocacy and increasing interest in playing a role. "Nurses know first-hand that political decisions have a direct impact on policies that affect peoples' daily lives," she says. "It was obvious through the training program that even those nurses who might not be ready for the challenge of a political career, are ready and willing to help their colleagues in any way they can."

Nicholson says she felt that support, not only from fellow trainees but from nurses who are already involved in politics. Fellow RN Kate Wilson, who has spoken to RNAO members about her experiences as a candidate, contacted Nicholson to offer words of encouragement after she heard news that the Liberal party had decided to forego a vote.

"Don't even give this a second thought," Wilson wrote in an e-mail. "So many people…are talking about you. They've seen you in the news. You never know, you may just get a call one day saying 'here's a position we have for you.'"

Nicholson ponders the possibility that as one political door closes, others are bound to open. "It's an exciting journey…very exciting."

KIMBERLEY KEARSEY IS MANAGING EDITOR/COMMUNICATIONS PROJECT MANAGER AT RNAO.

by Kimberley Kearsey

Windsor NP takes the helm at Nursing Secretariat

Vanessa Burkoski, Ontario's new Provincial Chief Nursing Officer, talks about the road that's taken her to Queen's Park, and the challenges that lie ahead.

Vanessa Burkoski remembers the first time she ever visited a hospital. She was 14 years old and her grandmother was receiving care following a stroke. "As I observed what the nurses were doing…I thought to myself, this is the sort of setting that feels good to me," she recalls. "I could see the kind of care they were providing to my grandmother and the compassion they delivered that care with. I know it sounds corny, but it's true. That's how it happened for me."

A high school student at the time, Burkoski also discovered her love for science, which further strengthened her desire to pursue nursing as a career. Given some of the poignant memories she has of her own interactions with patients over the last 23 years, it's clear her patients are just as touched by her professionalism and compassion as she was during her grandmother's illness all those years ago.

Some of Burkoski's most precious memories take her back to the 12 years she worked at the Sandwich Community Health Centre (SCHC) in Windsor, first as an RN and then as an NP. She remembers establishing a group called *Mothers Offering Mothers Support*. Most of the women in this group faced social challenges, including poverty. One woman, who joined with only one child, soon became pregnant with her second. When the little girl was born, she named her Vanessa, after the nurse who had made such an impact on her life.

Burkoski says the new mother told her that "every time she called out her (daughter's) name, she would remember all the experiences we shared. That's a moment in my life that I will never forget," she says proudly.

That kind of one-on-one interaction with patients was a big part of Burkoski's practice immediately following her graduation from the University of Windsor's nursing program in 1984. In fact, she admits that, fresh out of the BScN program, she never expected to do anything else.

"If you had asked me when I graduated if I'd be sitting in this chair talking to you, the answer is no," she says candidly.

The chair she's referring to is the one situated at Queen's Park, in Ontario's Nursing Secretariat, where Burkoski has just become Ontario's Provincial Chief Nursing Officer. After a rigourous six-month application process, she says she was delighted to accept the position. "I thought this was a wonderful, once-in-a-lifetime opportunity to really make a difference in the profession of nursing. Even if it's small changes that you can push forward to advance the cause…I wanted to be involved in that."

NAME: Vanessa Burkoski
OCCUPATION: Chief Nursing Officer, Ontario Ministry of Health and Long-Term Care
HOME TOWN: Amherstburg, Ontario

In her role, Burkoski provides the Ministry of Health with strategic advice on health and public policy issues from a nursing perspective. "I have something definitive to offer," she says. "I've worked in community health…primary care…acute care…so my background provides me with a broad framework upon which to really address the concerns of nursing across health care."

She's reluctant, however, to be too specific about what she's got planned for the coming years. Having only arrived at her 'chair' in early June, she's still getting her feet wet. "I think building our vision of nursing really needs to encompass the ideas of all the nursing stakeholders and it needs to be a real collaborative effort. I don't want to emphasize any one particular component. I want to make sure I've given due consideration to everybody's issues and concerns."

That kind of level-headedness is perhaps what has helped Burkoski to build an impressive career. Straight out of nursing school, she began working at Windsor's Health Unit, but quickly moved on to SCHC. She left that position to work at Windsor Regional Hospital, and within a few years, moved from acute care nurse practitioner in the ER to program manager and eventually Director of Emergency and Critical Care. Burkoski has her master's from the University of Windsor and is working on her doctorate through the University of Phoenix.

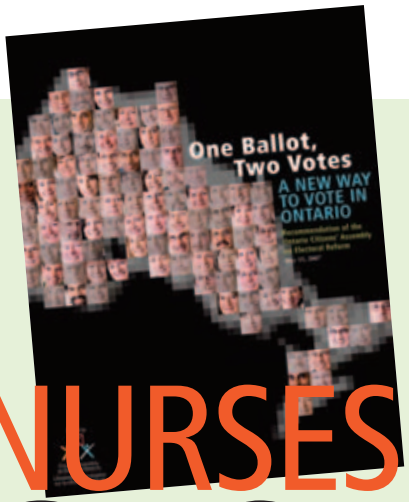
She admits to sometimes missing those days on the frontlines. "I had a hard time at first when I became program manager in the ER," she says. "I used to pass by the treatment area where I did a lot of assessments. I'd see someone with a wound that needed to be sutured and I'd think to myself 'no, that's not your role anymore but, boy, would you ever like to go in there and talk to that person.'"

Burkoski believes those clinical skills are vital to the work she does today. "It's a little bit hard to let go at first but you realize there are other rewards and, of course, other challenges in management and administrative roles." She can't help but reflect, however, on the patient experiences that have stuck with her over the years.

One elderly woman in the ER comes to mind. Dying, the woman told Burkoski she wanted her cross and rosary with her for spiritual support. Burkoski went out at lunch and bought a rosary and cross to put beside the woman's bed. Ten days later, the patient passed away in another unit of the hospital. Her family came back to the ER to give Burkoski the rosary and cross, along with a thank-you note. The woman wanted Burkoski to have the keepsakes to remember her.

Sitting in her chair at Queen's Park more than two decades later, she still does, and says she always will. **RN**

KIMBERLEY KEARSEY IS MANAGING EDITOR/COMMUNICATIONS PROJECT MANAGER AT RNAO.



NURSES CAST VOTES FOR CHANGE

Two Ontario RNs tell *Registered Nurse Journal* about their participation on a panel that could change the way Ontario's politicians are elected.

By Jill Scarrow

For eight months in late 2006 and early 2007, RNs Linda Barnum and Margaret Messenger proved you don't have to be a politician, professor or pundit to change the way Ontarians choose their Member of Provincial Parliament (MPP). You just have to be a dedicated citizen with an open mind.

Barnum and Messenger are the only two nurses on the 103-member *Citizens' Assembly on Electoral Reform*, a diverse group of volunteers appointed by the provincial government to look at how Ontario's voters elect provincial politicians, and recommend any needed changes to the process.

"I thought this was a great time to learn about (our political system)," says Barnum, a retired long-term care nurse from London. "It (was) a great opportunity to give back to the community…and I thought it's an interesting way to put an important mark on your life. It's an historic event for Ontario."

Messenger, an RN from Woodstock who teaches part time and owns a foot-care business, admits it can be difficult to pique people's interest in the political process, but she says her nursing colleagues have been quite interested in her Assembly work. She says that's because nurses are involved in so many areas of patient advocacy, from the frontlines to the highest political levels.

"Nursing is such a broad field," she says. "We're involved in making a difference for patients and trying to make a change within the province and Canada. I think people trust us."

This October, the Assembly's final recommendation, which was detailed in a report called *One Ballot, Two Votes* and presented to the government on May 15, will be the focus of a referendum to be held during the provincial election. When Ontarians go to the polls, they will be asked to have their say. The Assembly is suggesting Ontarians support a Mixed Member Proportional (MMP) system, which would allow voters to use one ballot to cast two votes: one to choose a local candidate to represent the riding; and the second to vote for a particular political party. Parties will then earn a number of seats equal to the number of votes they get (see sidebar for more information).

Although Barnum and Messenger's participation on the assembly was pure happenstance – the only prerequisite to being a panel member was to be on Ontario's voters list – Messenger says it's the type of work any nurse should get involved in if given the chance.

"(The Assembly's work) was much like a nursing process," she says. "We assessed and evaluated our current system. We learned about alternative methods of voting. We did simulations of the system and compared potential outcomes with our current system. Then we had input from the public. We did a lot of the nursing process, but under different titles."

According to Messenger, it's a good thing nurses were invited to partake.

"I think nurses are … looked at as being resourceful, honest and trusting. And that brings a lot to any situation you're in."

RNAO President Mary Ferguson-Paré says it's exactly those qualities that make nurses the ideal professionals to influence policy.

"Nurses see how systems and policies in this province have an impact on our patients," she says. "That's why it's so important that we continue to speak out and share our knowledge whenever possible."

Both Barnum and Messenger say their assembly work gave them the chance to learn more about the way politics works in Ontario. All they had to do was reply by mail to a letter from the Premier, indicating their interest in participating. About 1,000 of those interested were invited to locations across Ontario where they submitted their name into a ballot box. Messenger says finding out her name had been chosen in the final draw was a sign her participation was destined.

"Nothing like that had ever happened to me, so I figured it was meant to be," she says.

Once the selection process was over, the Assembly members – each representing a political riding in Ontario – began the process of learning more about how Ontario's political system works, and thinking about how it could change.

Over six weekends, the group learned about electoral systems in countries around the world. They also examined Ontario's current system, where the candidate who garners the most votes lands a seat at Queen's Park. Barnum says the group met in Toronto on weekends, often for 12-hour stretches on Saturdays, to hear lectures, watch videos and listen to guest speakers from as far away as Germany and New Zealand. The sessions were intriguing, she says, but often gruelling because they were absorbing so much information at once.

"Saturdays would go on forever. You were just exhausted, but you were wired by the time you got back to your room. People just did not sleep very well because their brains were so full of this stuff."

Still, all that knowledge came in handy when public consultations began last fall. Forty-one consultations were held in communities across Ontario. Messenger says the turnout was good, especially since most of the sessions took place during the winter when the threat of ice, wind and snow often combined to keep people at home. Both Messenger and Barnum attended the session in London, where nearly 80 people came to share their views on everything from leaving Ontario's current system untouched to calling for a democratic shake-up.

Citizens' Assembly members pose for a group photo after submitting their final report, *One Ballot, Two Votes*, to Marie Bountrogianni, Minister of Intergovernmental Affairs and Minister Responsible for Democratic Renewal.

From February to April of this year, the Assembly members reviewed the feedback from the consultations and began six weekends of deliberations. Messenger says the process gave her an appreciation of the size and diverse needs of such a large province.

"It really hit me how much I need to learn and understand the different areas and populations of our province," she says. "I'm just from Oxford County and there's a whole big other province out there. Any decisions that are made will have different impacts in different areas."

Most Assembly members voted to recommend MMP to Ontario's electorate. Both Messenger and Barnum say MMP is a good system that should be given a chance, even if it will likely result in more minority and coalition governments where parties must collaborate to get laws passed. In fact, Messenger says MMP would encourage more parties to work together on long-term policy instead of focusing on short-term plans to earn votes. She believes a new system could go a long way to encourage people to vote, especially young people and those disillusioned with politics.

But first, the public needs to get educated about MMP. Messenger says there are plenty of resources available on the Assembly's website, but people have to know they are there. She's hopeful the government will invest in television, radio and newspaper ads to spark the public's interest in the issue and encourage them to go online. Assembly members were also given brochures and other information to provide to local libraries. But Barnum says the level of interest among her family and friends varies.

"Some people think it's over their heads. Some people are really fascinated and intrigued by it. Some people think I'm trying to sell them a vacuum cleaner," she says. "But then you have people who say 'it's time for a change, tell me more about it.'"

To find out more about the Citizens' Assembly and Mixed Member Proportional Representation, visit the Assembly website at www.citizensassembly.gov.on.ca **RN**

JILL SCARROW IS STAFF WRITER AT RNAO.

The basics on MMP

When voters enter polling booths on Oct. 10, they will not only be asked to select their representative at Queen's Park. They'll also be asked whether or not they think it's time to change the way Ontarians choose politicians.

For several years, critics of Ontario's current electoral system have argued that majority governments are being formed without the support of a large percentage of voters. In response, Premier Dalton McGuinty announced the creation of a Citizens' Assembly in 2004. The group has since made recommendations about the need for a new system called Mixed Member Proportional (MMP).

MMP would move toward proportional representation by allowing voters the opportunity to use one ballot to cast two votes: one for their choice of a local candidate; and a second vote for a party. The number of seats a party wins will be about equal to the share of the vote the party earned. For example, if a party earns 45 per cent of votes, it will receive 45 per cent of the seats in the Legislature. If there aren't enough local members chosen to meet this 45 per cent quota, the remaining seats will be filled by candidates selected from a list of candidates – or 'list members' – from the whole province. Elections Ontario will widely publish the names of the people on that list, and the order in which they will be elected. Local candidates will be chosen the same way they are under the current system – the candidate who receives the most votes wins. Under MMP, there would also be an additional 22 seats in the Legislature in an effort to improve proportionality and offer better representation.

If most voters support MMP, it will become Ontario's electoral system beginning in 2011.

For more information, or to read the Citizens' Assembly report, visit the website at www.citizensassembly.gov.on.ca.

Your mother,

This spring, Tilda Shalof released her second book, ***The Making of a Nurse***. In this excerpt, she talks about the tendency of many nurses to "catch" patients' emotions as if they are contagious.

Illustration: Tracy Walker

IT takes a nurse to teach a nurse. There have been many teachers along the way for me and now I teach others. It's relatively easy to show someone how to insert a naso-gastric tube to decompress a patient's stomach. Adjusting the ventilator to improve a patient's arterial blood gases is a more complex skill. It's even more complicated to teach someone how to attend to the multitude of details required to manage a patient in multi-system organ failure. But I still haven't figured out how to teach another nurse to manage the emotions this work can evoke. I know many experienced nurses who still struggle with this challenge. How do you care, but not so much that it hurts? How do you make your care patient-centred, yet still keep your personal boundaries intact? There are huge emotional risks in caring for critically ill people. This work can break your heart.

I began to understand something about these boundaries one night a few years ago during a hockey game. It was the Stanley Cup playoffs, in a match between the Toronto Maple Leafs and the Detroit Red Wings. A Detroit player slammed into Maple Leafs goalie Curtis "Cujo" Joseph, who got angry and hit back. Well, the gloves came off and the punches started flying. The referees had to pry the players apart to end the brawl. Then, when they must have

your father

By Tilda Shalof

assumed the camera was off, Cujo lifted his goalie mask (that depicted a ferocious beast) and mouthed to his rival, "You okay?" The opponent nodded and pointed with his chin, "You?"

Seeing that tender, sincere moment helped me understand something about nursing, the place to which for me, all roads lead. Not that I ever saw myself as an adversary with any of my patients – not at all – but it is so easy to imagine that the gap between them, the sick ones, and us, the healthy ones, is much vaster than it is. Sometimes I took off my mask, too, and went over to the other side. But in my need for intimacy and my desire to rescue others, I often took on patients' emotions in ways that helped neither of us.

For many years, I took off my mask and crossed over frequently and sloppily. Perhaps it was how I learned as a child to care for my mother by sharing her sadness. I showed her my love by feeling her pain. Growing up, my personal boundaries were always uncertain.

So often, my own emotions blended and mixed with whatever others around me were experiencing. When I became a nurse, I continued on in that style of caring, even though it made things worse for me and sometimes for my patients, too. They needed to feel that I was steady and in control, but I couldn't always offer them that security. I caught their emotions as if they were contagious. Sometimes, merely being in the presence of a patient, family member, or even another nurse, who was flustered, anxious, or angry would affect me, and I would respond in tandem. Patients may even have felt they had to take care of me. Too often, I was a gushing, emoting heart that rendered me less effective as a nurse. Nurses are supposed to keep their emotions under control, but it's been a struggle for me.

When I think of Mr. Salvatore, I think of his daughter, Yvette. Mr. Salvatore was a seventy-two-year-old with esophageal cancer who developed abscesses throughout his abdomen. The doctors were hopeful that they could drain them and that he would then be well enough to undergo surgery to remove the cancer. In the meantime, he went into respiratory failure and had to be admitted to the ICU. Every day Yvette stayed at his side. She kept her eyes locked on me the whole time, watching every move I made. When I went to suction his lungs, she leaped out of her chair. "Should I panic?" she asked, searching my face for clues as to how she should react.

"No need to panic," I said extra calmly and slowly. "Your dad is doing just fine."

"Look, Daddy, your nurse is smiling. She wouldn't smile if things weren't looking good."

Yvette asked me if she could go home for a little rest. I knew she wanted my reassurance that nothing bad would happen while she was away from her father's side. With her eyes she implored me, I need to rest, shower, see my kids. Please grant me permission to do so. I wanted to tell her to go home and take care of herself but I didn't dare. If something did happen while she was gone, she would never forgive me. She left briefly only for a coffee and a phone call. "Take good care of him while I'm gone," she pleaded, throwing kisses at her father as she left. "He's special. He's my dad."

Later that afternoon, when Mr. Salvatore's heart suddenly went into an erratic rhythm, Yvette was right there at his side. When the alarm sounded, she grabbed my arm. "I'm panicking!" she shouted. I tried to calm her down and deal with the emergency at the same time. The doctor came in and ordered an intravenous beta-blocker to slow the heart rate. Shortly after I gave it, Mr. Salvatore's cardiac problem was resolved, but no amount of reassurance I offered eased his daughter's anxiety. Later that day, Mr. Salvatore had to be transported to another part of the hospital for the radiologist to drain the abscesses in his belly.

"Is this reason to panic?" Yvette asked, clasping my hand. In answer, I put one arm around her and pushed the bed along with my other hand as we made our way down the hall to the procedure room. There, the radiologist met with her and told her that if the "collections" turned out not to be fluid-filled then he wouldn't be able to drain them. "In that case, I can't do anything," he said as the technician spread out a green sterile drape over the patient's abdomen in preparation for the procedure.

"What does that mean?" she asked him. "Does that mean it's serious?"

"It means I can't drain it," the doctor said without further elaboration. Draining abscesses under fluoroscopy was his specialty, but for whatever reason he didn't explain that if there wasn't fluid to be drained, then it was probably a solid mass, such as a tumour, and in this case, likely malignant. But Yvette sensed the ominous implication. "Are you saying it would be bad?" The radiologist was preoccupied, already in the midst of the procedure, so she turned back to me, but I was busy giving her father sedation and assisting the doctor with the procedure. Out of the corner of my eye, I saw her terror-stricken face, her tiny, rigid body that looked like it might snap in two. She held on to her pale forehead. "I'm panicking," she said in a tremulous voice. I looked around the room for a chair and luckily, just then, the technician caught her as she keeled over. Full blown panic had finally done her in, but at least it allowed me to now focus my attention on taking care of her father. I exhaled.

I hadn't realized how shallow my breathing had become, how tight my chest was, how jittery I felt. I had caught a bad case of her panic.

From The Making of a Nurse*, by Tilda Shalof. Now available in bookstores. Published by McClelland & Stewart Ltd. Reprinted by permission.*

Linking evidence & experience

Cambridge Memorial Hospital integrates nurses' expertise with best practices to improve patient care.

By Jill Scarrow

Carol Henderson and Brenda Purdy have both been RNs for more than 30 years, but thanks to a new program for late-career nurses at Cambridge Memorial Hospital (CMH), they're not packing away their scrubs just yet. In fact, instead of looking towards retirement, these RNs are rekindling their passion for nursing.

"As I'm getting towards the end of my career, it's really nice to give something back," says Purdy, an RN in pediatrics. What she's giving back can't be put in a box and tied with a bow, but it will make a difference for dozens of patients and nurses.

Last September, Cambridge Memorial secured funding from the government's late-career initiative to get all hospital staff involved with RNAO's evidence-based best practice guidelines (BPG). Lorna Zubrickas, clinical educator for surgery and oncology at CMH, explains that when the hospital became an RNAO Best Practice Spotlight Organization (BPSO) candidate in 2006, the connection between the late career initiative and best practices became clear. The funding provided the perfect opportunity to use the expertise of late-career nurses to spread the guidelines across the hospital.

At an RNAO conference in June, Henderson, Purdy, Zubrickas and Amber Anderson-Lunn, a clinical educator for women's and children's health at CMH, presented the details of the hospital's new program. They explained how they are working with seven of 13 guidelines that will eventually be implemented.

> "I'm a better patient advocate... I have the evidence base, and it gives me back the enthusiasm for nursing."

Henderson is an oncology nurse who is working on implementing the *Assessment and Management of Pain* BPG. She is also involved in the smoking cessation guideline. She says before RNAO's BPGs were introduced at the hospital, it was hard for late-career nurses to learn more about evidence-based practice because finding the information was difficult. But since she started working with RNAO guidelines, she's gained more confidence on the job.

"I'm able to be a better patient advocate," she says. "If I see my patient in pain, I go to the doctor and say 'I think the patient needs a certain kind of analgesia.' Before, I kind of hung back a bit, but now I have the evidence base, and it gives me back the enthusiasm for nursing."

Henderson and Purdy are just two out of 15 late-career nurses at the hospital who are currently participating in the project. Anderson-Lunn says anyone who meets the late-career criteria can apply and will be linked with guidelines that pique their interest. Once enrolled, they can begin taking a day a week away from their clinical work to attend sessions where they learn about particular guidelines, discuss the recommendations, and look at new ways to promote change at CMH.

The hospital also uses RNAO's resources, including the clinical BPG toolkit, to help nurses use guidelines to their full potential. Late-career RNs attend workshops hosted

From Left to right: Cambridge Memorial Hospital RNs Brenda Purdy, Amber Anderson-Lunn, Lorna Zubrickas and Carol Henderson pose with their poster presentation during RNAO's International Conference on Evidence-Based Best Practice Guidelines held in June.

by RNAO. Once they have had the opportunity to understand the recommendations in a particular guideline, they help develop resources to share their new knowledge.

"This is really exciting because you can really take a look at what you do and why you do it," Henderson says. "You get so excited, you carry that back to your co-workers, and they become excited about it too."

Purdy, who has also worked on both the pain and smoking cessation guidelines, says participation in the program has provided a great opportunity to get to know nurses on other floors at CMH, including the newer nurses.

"It's nice to show the new grads that nursing isn't just…doing the same job for the next 30 years, that you can change the way things are done," she says.

According to Anderson-Lunn, nurses involved in the program have made many meaningful changes over the last year. For example, nurses have initiated breastfeeding education in the Women's and Children's Health Program so new moms are able to go home after 24-hours. With this new knowledge, moms are confident in their ability to breastfeed, and they're secure in the knowledge that someone will follow up. Henderson says patients all across the hospital are reporting that their pain is better managed, and the patient's average length of stay has also improved.

But these successes have not come without facing challenges along the way.

> "This is really exciting because you can really take a look at what you do and why you do it."

Zubrickas says scheduling the RNs for a late-career day is one thing, but actually making sure they take a full day is difficult. It's hard for nurses to be away from the unit, especially if they know it is short staffed, she explains. The hospital has tried to combat this by communicating with managers to make sure the BPGs are a priority, having nurses work in offices away from their units, or inviting them to wear street clothes instead of scrubs so they feel separated from the clinical world for a day.

Anderson-Lunn says it's also challenging to sustain the guidelines. She says the hospital has developed evaluation tools to monitor the number of staff members who are following recommendations such as completing the neo-natal pain score. And nurses are updated on CMH's guideline work during yearly education sessions to keep the BPGs fresh in everyone's mind. The hospital's orientation sessions also now include information about guidelines.

Anderson-Lunn says the hospital is continuing to implement all of the 13 guidelines it committed to, and hopefully will take on additional ones. Even if they no longer have access to late-career funding, she says the hospital will continue to educate front line staff by creating partnerships between novice and seasoned staff at the bedside. She says creating strong relationships for the betterment of patient care has been one of the best gifts of the whole project. RN

JILL SCARROW IS STAFF WRITER AT RNAO.

by Jill Scarrow

RESPECTING DIVERSITY AND INCLUSIVITY

New RNAO position statement opens discussion about sexual diversity in health care.

Highlighting the role RNs can play in respecting and supporting the rights and needs of lesbian, gay, bisexual and transgender (LGBT) people is the goal behind RNAO's *Respecting Sexual Orientation and Gender Identity* position statement, adopted by the association's board of directors in June. The statement highlights health and wellness issues affected by sexual orientation – how one thinks of one's emotional, romantic or sexual attraction for another person – and gender identity – one's sense of oneself as male, female, both or neither.

The position statement draws from a 2003 Health Canada survey that showed more than 20 per cent of people who identify as LGBT have health needs that are not being met, compared to 12 per cent of the heterosexual population. The statement also addresses experiences of discrimination that LGBT nurses face in the workplace due to stigma about their sexual orientation or gender identity.

Dianne Roedding, a member of the association's new Rainbow Nursing Interest Group (RNIG) and a public health nurse, was an invited guest at RNAO's board of directors meeting in June. She shared her expertise on LGBT health and nursing issues and provided board members with an exercise aimed at increasing empathy and understanding of the discrimination faced by LGBT clients and nurses. She also provided case studies that allowed participants to reflect on their experiences caring for LGBT clients.

Roedding is one of a growing group of nurses who are proactively advocating for LGBT people. One aspect of that ongoing work is the creation of RNIG. President Bonnie Lynn Wright says that advising on projects like the position statement is just one of the ways the group, created last year, hopes to make it easier for members to discuss sexuality in their own workplaces, and in an open and comfortable environment.

Judy MacDonnell is RNIG's policy and political action officer. She presented a resolution at the 2006 annual general meeting calling on RNAO to develop supports for sexual minority nurses and those who advocate for them. The resulting position statement challenges fear and hatred of LGBT people, and debunks the societal norms that assume everyone is heterosexual. MacDonnell hopes the position statement helps nurses begin to address diversity policies in their own workplaces and create welcoming environments. That can include making information about topics such as same-sex parenting available for staff, and displaying pamphlets and other resources specific for LGBT people in waiting rooms.

"It's about enhancing client care," she says. "We have to start looking…at how the whole profession recognizes or affirms those who are diversely identified."

MacDonnell has since completed a great deal of research on these issues, and her findings suggest many nurses working with LGBT persons feel isolated. Their advocacy is often not seen as legitimate nursing work. She says she hopes RNAO and RNIG leadership will start to relegate those fears and worries to the past, and make health care – and all of Canadian society – a place that is more welcoming to sexual and gender diversity. RN

JILL SCARROW IS STAFF WRITER AT RNAO.

RN RAISES LGBT ISSUES IN THE CLASSROOM

Rainbow Nursing Interest Group member Laurel MacIsaac believes making health care a more open, welcoming environment for LGBT clients and nurses begins in the classroom.

When she was in her third year of undergraduate studies at Ryerson University, MacIsaac, now an RN at the Hospital for Sick Children, reviewed how nursing textbooks, published in or after 2000, treated LGBT health issues. She found that most textbooks identified LGBT people as 'different' or 'abnormal,' including one mental health textbook that only discussed the topic in a chapter about sexual disorders. MacIsaac says broad changes are needed to make nursing education more inclusive.

"Textbooks need to be changed," she says. "When they're talking about parents and it's 'mother' and 'father,' there's no concept of the fact this person may just have one parent, let alone same-sex parents."

But while some textbooks may have ignored LGBT communities, MacIsaac says her fellow students did not. During her undergraduate studies, she worked with a professor to teach third-year students about LGBT health. She says most of her peers were very interested and intrigued by her research. Her efforts have also allowed her to get involved in the international community, including the U.S.-based Gay and Lesbian Medical Association. The 32-year-old had the opportunity last fall to link with the group when she won a scholarship from the association to attend a conference in San Francisco. She is continuing to work with the group – which works to achieve equality in health care for LGBT patients and health-care professionals – to examine how LGBT issues are integrated across all four years of the nursing curriculum. Her goal is to ensure knowledge about LGBT issues is not just dealt with in passing but integrated throughout the student's entire education. In fact, MacIsaac is so dedicated to the issue, she plans to make it the focus of post-graduate work beginning in September, 2008. In the meantime, she says she would encourage students to ask questions about LGBT health issues and share what they learn.

"Even sharing it with one person, and if that person shared it with another person, it would reach a lot of people," she says. RN

POLICY AT WORK

Bill 171: Health System Improvements Act

RNAO appeared before a legislative committee in April to present its views on *Bill 171, The Health System Improvements Act*. Organized into 17 separate sections, the bill makes significant changes to existing legislation as well as creating new laws and policies.

While RNAO welcomed title protection for nurse practitioners, the proposed changes to the *Nursing Act* fell short. The association was disappointed the government did not implement changes proposed by the College of Nurses of Ontario (CNO) that would have allowed acute and primary health care nurse practitioners to work both more autonomously and to their full scope in four streams: primary health care; acute care pediatrics; acute care adult; and anesthesia. RNAO had also hoped the government would have granted RNs in the extended class more autonomy around prescribing. Rather than accept CNO's recommendation for nurse practitioners to have broad prescriptive authority, the government decided to move to a model in which nurse practitioners prescribe medications from a list of drug categories. It is questionable whether this is an improvement on NPs' previous authority to prescribe medications based on a specific list of drugs.

While RNAO was pleased with several amendments to the act governing health protection and promotion, it was disappointed the government chose to ignore a key recommendation outlined in Justice Archie Campbell's final SARS report. Campbell argued the precautionary principle (which states every attempt to reduce or avoid risk should be taken into consideration even prior to scientific evidence being available) must be enshrined throughout Ontario's health-care system to ensure the health and safety of those who work in the system.

RNAO was also disappointed that its recommendation for language that reflects the importance of the social determinants of health and health disparities was not added to the act governing health protection and promotion so that the agency can better reflect the health needs of all Ontarians.

RNAO Executive Director Doris Grinspun (right) joined (L to R) Andy King, United Steelworkers, Katrina Miller, Toronto Environmental Alliance, and Rick Lindgren, Canadian Environmental Law Association, at a May 25 press conference to discuss links between the environment and health.

Bill 164: The Community Right to Know Act

RNAO added its voice to the chorus of environmental groups endorsing *Bill 164* this spring. The main purpose of *The Community Right to Know Act* was to compel companies to inform the public about exposure to toxins.

Introduced by NDP environment critic Peter Tabuns, and supported by RNAO and members across the province, the bill would have required companies to list cancer causing agents on the labels of consumer products. It would have also created an extensive online pollution inventory so people could find out which toxins are being emitted in their communities as well as the associated health risks.

"We know people are concerned about toxic chemicals and cancer. There is a lot of support for this kind of legislation because there is sound evidence that conditions such as asthma, cancers, developmental disabilities, and birth defects are associated with exposure to these toxins," said RNAO Executive Director Doris Grinspun.

Unfortunately, *Bill 164* has no hope of being passed, at least not in its current form. The Liberal government ended its legislative session at the beginning of June, before a final vote on the bill. "It's a shame they let this legisltion die on the floor," said Grinspun. "This was an important bill that would have made Ontario the first jurisdiction in Canada to ensure the public's right to know."

RNAO members gear up for the Ontario election

Although *Bill 164* didn't come to a vote, RNAO members will have plenty of opportunities to question politicians about their environmental priorities ahead of October's provincial election. Many of the recommendations outlined in *The Community Right to Know Act* are contained in the association's *Creating a Healthier Society* pre-election platform. RNAO released the document to highlight all of the issues it believes must be central during the upcoming campaign. Home office is working on several initiatives to help members participate in pre-election debates and to make sure nurses' voices are heard leading up to the election. One initiative will see staff members travel to chapter meetings to lead discussions on *The Ontario election and you: Our next government. What do nurses and patients need?* It will look at how the outcome of the election may affect the health of Ontarians and the working lives of nurses. It will also identify key campaign issues. If members in your chapter, region, or interest group are interested in this session, please contact Kate Melino at kmelino@rnao.org. RN

NEWS to You to Use

RNs pose for *Toronto Star* photographer

SiCKO, a documentary about for-profit health care in the U.S., by filmmaker Michael Moore, was released this summer. Its Canadian distributor, Alliance Atlantis Canada, offered free admittance to nurses across the country from July 16-19. A group of RNAO members took advantage of the free screening alongside *Toronto Star* reporter Ashifa Kassam. The nurses (left) then participated in a roundtable discussion about the film, discussing everything from the importance of protecting our universal health-care system to lessons Canada can learn from health promotion and disease prevention initiatives in France.

Lynda Monik, president of RNAO's Essex chapter, will receive the *Alumni of Distinction Award in Health Sciences* from St. Clair College on Sept. 28. The award is the highest honour handed out annually by the St. Clair College Alumni Association and St. Clair Foundation. "I love being a nurse," Monik said, adding "St. Clair College helped me to be what I am today." Now the Director of Utilization and Special Projects at Windsor's Hotel Dieu Grace Hospital, Monik graduated with a diploma in nursing in 1980.

After eight years in a Libyan prison, five Bulgarian nurses and a Palestinian doctor were set free on July 24. The health-care workers, accused of deliberately infecting 426 Libyan children with HIV while working at a Benghazi hospital in the late 1990s, were sentenced to death in December. After considerable pressure from the international community, Libya's High Judicial Council lifted those death sentences following a financial settlement with the families of the infected children. Throughout their ordeal, the health-care workers denied knowingly infecting the children and say their confessions were extracted under torture. RNAO thanks all members who responded to action alerts, and who sent letters seeking the release of these international colleagues from prison.

RNAO member and University of Toronto Nursing Professor Gail Donner was one of eight distinguished Canadians to receive honourary degrees from Ryerson University this spring. On June 14, she accepted an Honourary Doctor of Science recognizing her outstanding contribution to the field of nursing, and her prominent role in shaping health and educational policy at the local, provincial, national and international levels. Donner, who was executive director of RNAO from 1984 to 1989, was delighted. "It's truly thrilling to be recognized in this way for work that I've loved and from a university that has been an important part of my career. I feel terrific."

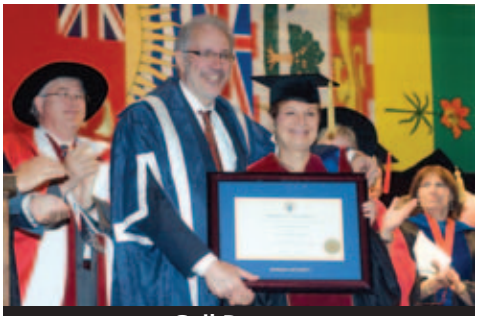

Gail Donner

Photo courtesy of Ryerson University

RNAO Immediate Past President Joan Lesmond will assume the role of Executive Director, Community Engagement, with Saint Elizabeth Health Care (SEHC) on Sept. 1. The newly established position will allow her to build community partnerships and provide people with the tools and resources they need to take control of their health. "The organization today is very different from the one I left (eight years ago)," she explains of her position with SEHC for 15 years before working at Casey House. "But the passion, commitment and core values are still the same."


Sue Coffey

In June, RNAO member Sue Coffey was among 13 individuals to receive Ontario's *Newcomer Champion Award* from Mike Colle, Minister of Citizenship and Immigration. The York University nursing professor was recognized for establishing Canada's only program for nurses arriving as immigrants. Two years ago, she launched York's BScN program for internationally educated nurses, to enable immigrant RNs to qualify to work in Ontario in as little as 20 months. The program includes language training and mentoring to help students make a smooth transition to the Canadian workplace.

Calendar

August

August 12-17
Creating Healthy Work Environments: Summer Institute
Delta Pinestone Resort
Haliburton, Ontario

September

September 27-28
6th International Elder Care Conference: Older People Deserve the Best
Hilton Suites Toronto/Markham Centre and Spa
Markham, Ontario

October

October 4
Thriving as a Practicing Clinician: Sharing and Shaping the Keys to Nursing Excellence
Acadian Court
Toronto, Ontario

October 11
Every Nurse a Leader: Regional Workshop, Video Conference
Sudbury, Ontario

October 11, 12, 15, 16 and 17
Designing and Delivering Effective Education Programs
RNAO/OHA Joint Program
Location TBA

October 18-20
15th International Nursing Conference of the Nursing Network on Violence Against Women
Contact: dmulvih@uwo.ca

October 19
Pediatric Nursing Conference: Child First, Patient Second
Courtyard by Marriott
Toronto, Ontario

November

November 1-4
Annual Nurse Practitioner Association Conference
Nurse Practitioners Celebrate: Shaping and Promoting the Role
Hamilton Convention Centre
Hamilton, Ontario

November 15
Ethics for Nurses: Regional Workshop
Video Conference
RNAO Home Office
Toronto, Ontario

Coming in 2008

January 7-11
South Florida Winter Best Practice Guideline Institute and Evidence-Based Nursing Conference
Bringing Best Evidence to the Point of Care
Miami, Florida

January 27-February 1
Best Practices in Wound Care: Minding the Gap
Fern Resort,
Orillia, Ontario

Unless otherwise noted, please contact Becky Bays at RNAO's Centre for Professional Nursing Excellence at bbays@rnao.org or 416-599-1925 / 1-800-268-7199, ext. 227 for further information.

WANTED:

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Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

WORKPLACE LIAISONS

Workplace Liaisons are leaders who choose to speak out for health and speak out for nursing by representing RNAO within their organization. Do you have what it takes to share the wealth of professional resources that RNAO offers? Contact Jody Smith at RNAO home office, jsmith@rnao.org or by calling 1-800-268-7199 ext. 220.

Classifieds

International Interprofessional Disciplinary Wound Care Course - October 19 to 22, 2007 & April 11 to 14, 2008.
The New Women's College Hospital, 76 Grenville Street, Toronto, Ontario. Course Description: Longitudinal course of eight days **and** self-study modules. For further information: Continuing Education, Faculty of Medicine, University of Toronto, 500 University Avenue, Suite 650, Toronto, Ontario, M5G 1V7. Telephone: 416-978-2719/ 1-888-512-8173, Fax: 416-946-7028, e-mail: ce.med@utoronto.ca, website: www.cme.utoronto.ca.

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Get Involved with RNAO COMMITTEE WORK OPPORTUNITIES

RNAO Board of Directors Committees 2007-2009
Policy Analysis & Development Committee
Two Vacancies Available
1 RN, 1 basic nursing student

Emailed submissions of interest are encouraged for all positions. Interested candidates must submit their CV with a letter attached, outlining any relevant experience and describing their interest in the position.

DEADLINE FOR SUBMISSIONS
September 30, 2007
Contact Penny Lamanna at plamanna@rnao.org for further details or for a copy of a Committee's Terms of Reference.

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• *theory and methods of teams by intergrating professional and leadership disciplines*

Decentralized Budgeting (1 unit credit)
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• *concepts of financial management and budget preparation*
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Total Quality Management/ Quality Assurance (1 unit credit)
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PROFESSIONAL DEVELOPMENT MANAGER

RNAO is seeking an enthusiastic RN to join the Centre for Professional Nursing Excellence. The Centre's mission is to promote knowledge development, management, and dissemination to enhance professional nursing and enable quality care. Our core principles are to lead change that is humanistic and evidence-based, maintain high standards of collaboration, ensure sensitivity to culture, diversity and geography, and promote continuous professional development.

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- You will also assist in promoting the Centre to health-care organizations, and will manage projects and conferences related to knowledge development and dissemination.
- Your leadership skills are recognized and you have experience interacting with a range of stakeholders in health care.
- A minimum five years experience in program development, workshop facilitation, presentations and research projects is essential.
- The successful candidate will be an RNAO member with current registration with the College of Nurses of Ontario, and will hold a master's degree in nursing or a related field. This is a full time position.

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L'Association des infirmières et infirmiers autorisés de l'Ontario

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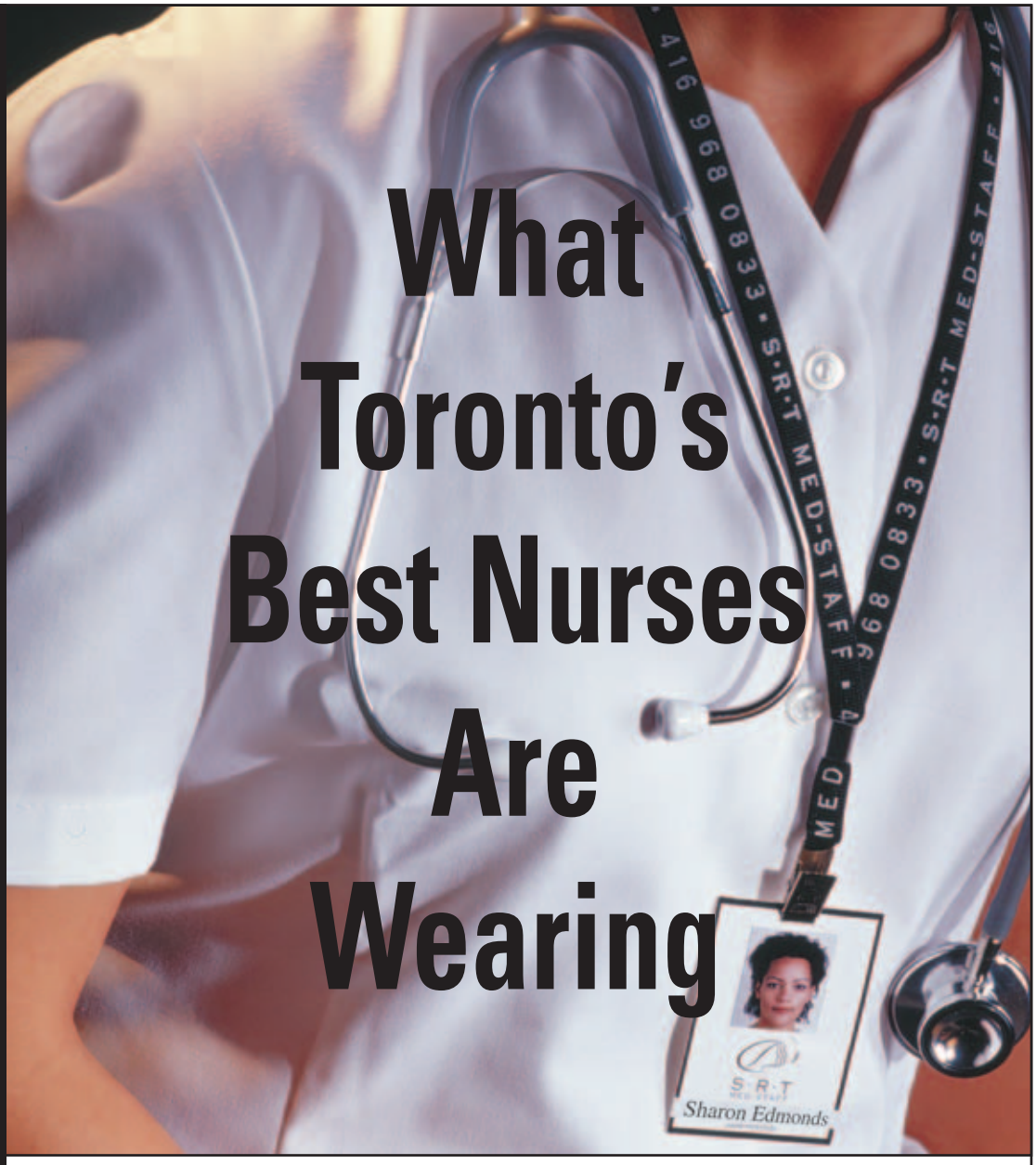

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