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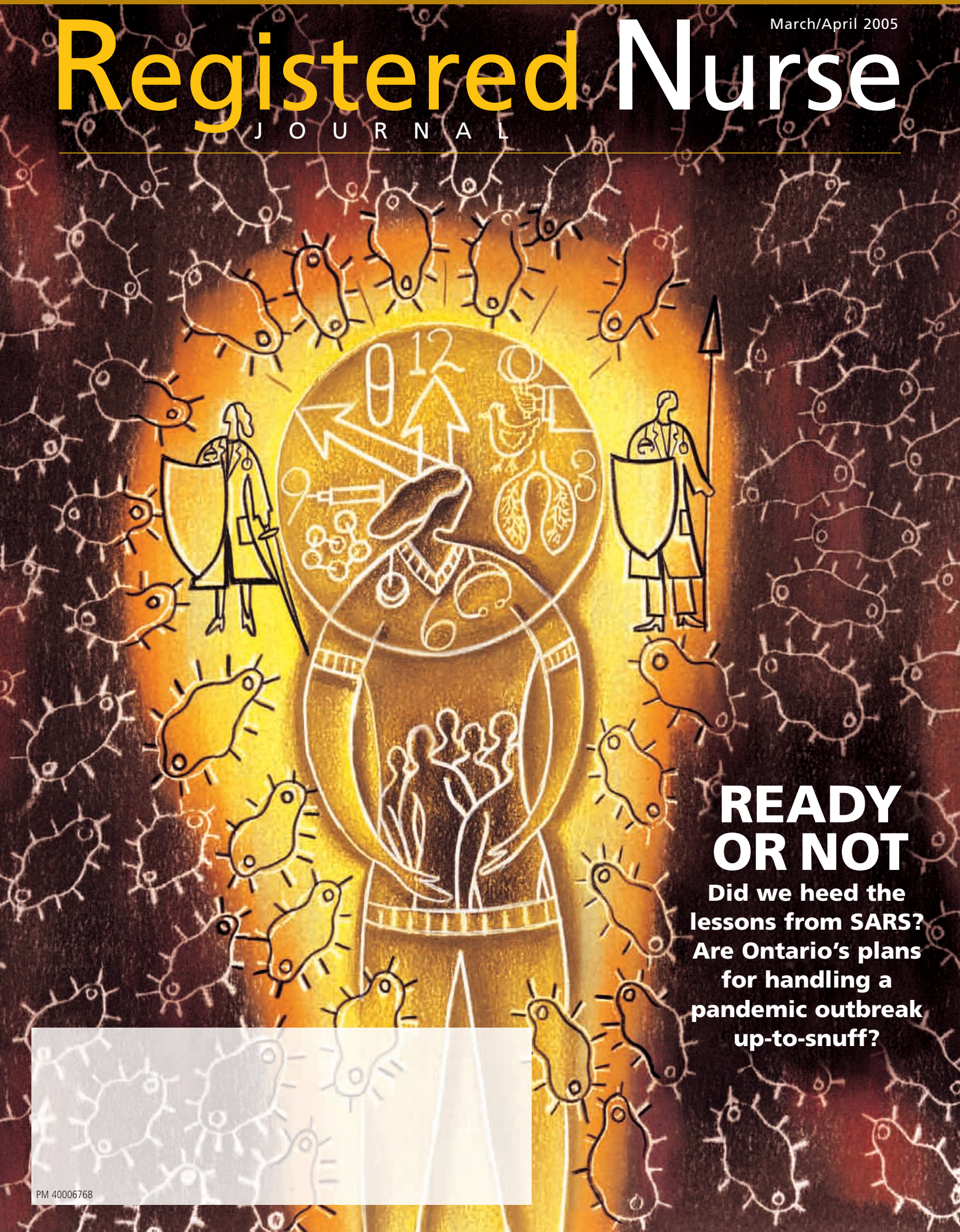
March/April 2005

Registered Nurse JOURNAL



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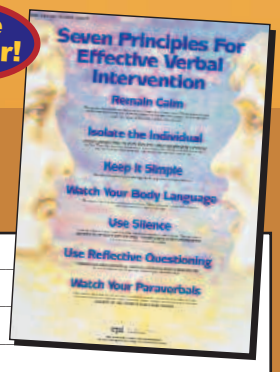

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THE LINEUP

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

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Achieving and maintaining health

In this issue, we examine why nurses need to be mindful of the complex factors that influence health and people's access to it. We celebrate the 10th anniversary of the Primary Health Care Nurse Practitioner Program and the launch of Ontario's first 55 Family Health Teams. We introduce you to RN Barbara Martin who is helping reduce and manage diabetes on a Six Nations Reserve, and we reveal nurses' efforts to resolve the ethical issues they face daily.

In our cover feature, we consider the possibility of a pandemic outbreak and look at Ontario's state of readiness. With the second anniversary of SARS upon us, there's no reason Ontario should be ill-prepared for the challenges we can anticipate – even predict – in the event of a pandemic outbreak. While planning for emergencies or pandemics is daunting, SARS has led officials to create action plans with measures to ensure the health and safety of nurses and other health-care professional. And, RNs are fully engaged in all levels of pandemic planning.

In a similar vein, the executive director's column takes a look at the multifaceted role public health must play in our lives. We must strike a balance between the need to prevent and respond to health-care threats while focusing on health promotion and disease prevention. We cannot lose sight of the fact that disease control is only one aspect of public health, and cannot overshadow achieving and maintaining health.

Recognizing and responding to the underlying factors affecting the health of individuals, families and communities day in and day out is just as important as responding to emergencies. As the nurses you will meet in this issue demonstrate, RNs are doing both: shoring up the health of Ontarians and preparing us for the challenges we will weather in the event of a future outbreak.

Lesley Frey
Managing Editor

Second term holds promise of more good work, partnerships

My first year as RNAO president was filled with opportunity, growth and partnership. It was a whirlwind of regional visits, site tours, meetings, missions and political activity to promote the association and the wonderful work of nurses across the province and around the world.

I relish this chance to reflect on the challenges, accomplishments and opportunities of the last year as I move into my second term as president.

As a member of a visible minority group, the beginning of my presidency offered many firsts. While RNAO members entrusted me with the responsibilities of president, Ontarians entrusted Dalton McGuinty with the responsibilities of governing the province.

A series of good-news announcements followed McGuinty's election to the Premier's office including: a commitment to hire 8,000 more nurses over four years; $50 million in hospital funding for full-time nursing positions and improved working conditions for nurses; $25 million to small and medium-sized hospitals to create 400 new full-time nursing positions; and $50 million to develop strategies to recruit and retain nurses.

Since those announcements, we have seen positive change. But, sadly, we've also been disappointed, in particular with the government's acknowledgement that 757 full-time nursing equivalents could be lost in the hospital sector.

Still, we must remain optimistic and continue to work as a team so that we can advance the individual and collective health of the nursing profession and the public it serves.

Teamwork and partnership were visible in much of my work in 2004. Perhaps one of the most powerful initiatives I was privileged to be a part of last year was RNAO's partnership with UN Special Envoy Stephen Lewis and the Ontario Hospital Association, which afforded RNAO the opportunity to build international relationships that improve the health of people in poor communities, and promote a culture of caring among Canadian nurses that is not defined by geography.

This idea of a global community is vital to achieving one of my other goals: continued promotion of diversity within the nursing profession.

Canada enjoys such a diverse population; it is our responsibility to ensure it is reflected in all areas of nursing, including senior management.

RNAO is hard at work developing an action plan on diversity for the coming year, and we encourage members to participate in the development of this initiative.

We need to also consider diversity in the context of professional practice, and demonstrate respect for the knowledge and expertise each of us brings to the care of patients.

By supporting each other and making the powerful collective voice of members heard, we will inspire those in power to support and respect nursing.

At last year's First Ministers' meetings in Ottawa and Niagara, the collective voice of nursing was heard loud and clear. Members joined executive director Doris Grinspun and me as we sent a message to the premiers and prime minister, urging them to secure an agreement that would protect, strengthen, expand and sustain our publicly funded, not-for-profit health-care system.

They left that meeting with just such a plan, clearly illustrating what we can achieve together.

During my first term, RNAO's accomplishments have been diverse and innumerable. Among them: policy statements on homelessness, patient safety, clinical nursing practice and case management; submissions on gunshot reporting legislation and pre-budget consultations; and presentations on Pan Canadian Public Health, competitive bidding in home care, and mandatory retirement.

" I promise RNAO will continue to concentrate on diversity, think globally and grow collectively."

The hard work and commitment of RNAO members and staff have helped increase RNAO membership by more than 50 per cent in less than five years. It speaks well of the growing strength of the association as the voices of novice and seasoned nurses come together to advocate for the profession and for patients.

We cannot and will not sit on our laurels. We will continue to speak out for health and speak out for nursing. We will proudly display our nursing week buttons and our pins, reminding everyone to "Protect your health. Protect nurses now!"

In the year to come, I promise RNAO will continue to concentrate on diversity, think globally and grow collectively – building on our reputation as a force to be reckoned with.

I look forward to representing you again this year, and to building on our achievements and hard work into 2006.

JOAN LESMOND, RN, BScN, MSN, IS PRESIDENT OF RNAO.

Mailbag

Layoffs dampen RN's dream of coming home

Re: Nursing layoffs a serious setback to patient care and profession's future, Jan/Feb 2005

I was shocked and disappointed to read this article. I am an Ontario graduate from 2001. While working in Ontario I had great difficulty finding work that I wanted, particularly full-time permanent work. After being laid off, I found myself working in psychiatry - a great experience, but not what I wanted to do with my nursing career. After two-and-a-half years of nursing, I moved to California where I was offered a full-time job with full benefits and great pay. Most of all I was able to work in the NICU, something that would never have been possible as a new nurse in Ontario. Here, I had four months of preceptorship to learn the basics of NICU - my dream job - and a two-year contract which will expire in January 2006. My goal was to gain experience with the hopes of being hired full time in an NICU in Ontario. After reading this article I find myself very discouraged. I always said that I would never move to the U.S. and be a "traitor" to my own country and its nursing shortage. How am I supposed to go back home now? I am single and cannot live on part-time employment without benefits. That isn't the life that I was promised when I entered nursing school. This situation saddens me and I sincerely hope to one day be an NICU nurse back home.

Karine Bilodeau, RN, BScN
Fresno, California

WE WANT TO HEAR FROM YOU.
Please e-mail letters to letters@rnao.org or fax 416-599-1926.

Mae Harman, MSW
1920-2005

ON Feb. 23, Mae Harman passed away peacefully at home after a lengthy illness. She was 84.

Those who knew Mae fondly remember her tireless efforts to speak out against social injustice through her extensive volunteer work, including her unique contributions as a member in the Coalition for Primary Health Care and the Elder Health, Elder Care Coalition.

Audrey Danaher, senior nursing policy analyst at RNAO, knew Mae through her involvement in those coalitions, and says Mae was committed to primary health care and the need to improve quality of life for everyone.

Gerda Kaegi was a long-time friend of Mae's, and remembers her as an advocate for a variety of causes ranging from long-term care issues to Campaign 2000, an advocacy group committed to ending child poverty in Canada.

"You name it, and Mae cared," Kaegi says. "She always believed that programs can change if you keep at it."

Kaegi first met Mae more than 20 years ago as a member of Canadian Pensioners Concerned, Ontario Division, to which Mae belonged, and later led. Kaegi says Mae worked tirelessly on many initiatives (even during her illness), most recently preparing a brief on mandatory retirement to present to the government.

Mae's advocacy work earned her many awards, including the University of Toronto's Arbor Award and the Dan Benedict Award from the Ontario Coalition of Senior Citizens' Organizations.

After graduating from the University of Toronto, Mae began her social work career in 1946 at the YWCA in Winnipeg. In 1950, she returned to Toronto to earn her Master of Social Work. She later served as branch director with the Toronto YWCA and ran the junior and teen programs at the University Settlement, a community centre in Toronto. From 1967-1973, Mae was the executive director of the Ontario Association of Professional Social Workers before being appointed to the University of Windsor's School of Social Work in 1973.

Mae's inspiration for her volunteerism is perhaps best described through her own words recalled recently at her memorial service: "I do so much advocacy work because I am driven. Retirement has empowered me to do what I want to do, and say what I want to say, and nobody can fire me."

Mae is survived by her nieces, nephews and a wide circle of friends. Her contribution to RNAO and advancing its values and vision will be dearly missed. **RN**

Striking the public health balance

The April 11th release of Justice Campbell's second interim report, *SARS and Public Health Legislation*, reignited discussion and debate about Ontario's state of readiness in the event of another – or larger – public health outbreak.

Indeed, this issue's cover feature (p. 12) asks the questions on everyone's mind as rumblings of a pending pandemic flu outbreak gain momentum. Did we heed the lessons of SARS? Are Ontario's plans for handling a pandemic outbreak up-to-snuff?

For its part, Ontario's nursing community – more specifically the Emergency Nursing Advisory Committee (ENAC) – has been hard at work since SARS rocked Ontario's health-care system in 2003. During the SARS outbreak, RNAO formed the SARS Nursing Advisory Committee (SNAC) so that the key nursing organizations in Ontario could respond to that outbreak in a coordinated fashion. SNAC provided valuable support to nurses in all roles and sectors, enabling nurses to provide necessary health-care services to Ontarians.

SNAC was later renamed ENAC and is now a vital link between government and the nursing profession in times of emergency. ENAC continues to meet regularly and has developed guidelines that will support nurses, and communicate timely, accurate information to nurses and nursing students in all sectors should a local, provincial or federal emergency be declared. These guidelines, which will be reviewed regularly, address a wide range of the communications deficiencies nurses experienced during SARS by spelling out specific protocols such as:

- Activating immediate communication between the chair of ENAC (Doris Grinspun) and the director of the Emergency Management Unit (Allison Stuart) in anticipation of or following declaration of a provincial emergency, and convening an ENAC teleconference within 24 hours of declaration of emergency.
- Activating the Voluntarily Immediately Available Nurse (VIANurse) upon government directive.
- Activating the emergency plan to place nursing students in appropriate clinical areas for the purpose of continuing to meet clinical learning needs and/or to provide clinical support.
- Linking chief nursing officers and heads of nursing programs in all relevant sectors to ensure communication flow.
- Activating the emergency response plans to support the psychosocial needs of nurses.
- Distributing government directives to nurses in a coordinated and timely fashion.
- Conducting formal evaluations of management effectiveness and responsiveness to emergencies.
- Reviewing and revising emergency plans on the basis of those evaluations.

"We need a system that helps us achieve and maintain our health and well-being."

While these guidelines are an essential step in the right direction, they are but one part of a much larger – municipal, provincial and national – emergency planning process underway across Canada. And, they address only a portion of what must be public health's role and responsibility. The central role of public health – health promotion and disease prevention with an emphasis on determinants of health – cannot, and must not, be forgotten as we strive for emergency preparedness.

The SARS outbreak underscored the fact that Canada's public health system lacks the capacity to anticipate and respond to new threats and has insufficient surge capacity to respond to short-term crises. However, shoring up our beleaguered public health system is more than a matter of reacting to new threats. Canadians need and deserve an integrated public health system that serves to prevent, manage and control illnesses and emergencies, and is able to help individuals and communities achieve and maintain health.

We strongly believe that a renewed emphasis on public health must ensure we are better prepared to prevent and respond to public health threats, and it must buy real transformation by focusing on health promotion in the broadest sense: eradicating poverty (after all, we are one of the richest nations in the world); ensuring every person has a permanent address with a roof over his/her head; closing the gap between rich and poor by addressing income distribution; increasing minimum wage and enhancing employment opportunities; increasing access to education; and creating healthy schools so our children can achieve their potential.

We must strike a balance between the need to prevent and react to health-care threats while focusing on a broad and ambitious agenda for public health. Public health has long been the orphan of our health-care system. SARS was a wake-up call that must be answered. Canadians need and deserve an integrated public health system with national standards and clearly defined outcome benchmarks; we need a system that protects us at all times, including emergencies.

And above all else, we need a system that helps us achieve and maintain our health and well-being.

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

by **Jill Shaw**

Nursing in the news

RNAO & RNs weigh in on . . .

Preparing for an infectious disease outbreak

AS the world braces – and hopefully prepares – for a possible influenza pandemic that the World Health Organization predicts could kill between 16 and 21 million people globally in just a few months, RNAO members have been offering their perspectives in the media. RNAO executive director **Doris Grinspun** discussed the importance of planning for a flu pandemic on *CBC Radio One* – Ottawa (March 1), and **Ornella Tolomeo** told the *Hamilton Spectator* preparations for a pandemic are ongoing, but many factors remain unknown." In the last 20 years in public health, we haven't had anything like that. The closest we came is SARS." (Feb. 14)

Meanwhile, RNAO member **Saverina Sanchez** responded to an influenza outbreak in a Cobourg nursing home in a letter to the editor. She encouraged readers to ensure the long-term care facilities their loved ones live in meet infection-control standards, and advised them to check that prevention isn't being sacrificed to bolster the bottom line in for-profit institutions (*Toronto Star,* Feb. 9).

Public support for investments in nursing

In February, RNAO responded to a poll that found 72 per cent of Ontarians think investing in nursing should be the provincial government's top health-care spending priority. "It shows the Ontario public knows what is required," RNAO president **Joan Lesmond** said. "Nurses are the front line, they spend the most time with patients." (*St. Catharines Standard, Cornwall Standard Freeholder, Sudbury Star, North Bay Nuggett, Timmins Daily Press, Lindsay Daily Post, Sarnia Observer, Welland Tribune, Kingston Whig-Standard* and *Sault Star,* Feb. 5 & 7)

Nursing layoffs

• In an article about Premier McGuinty's leadership style, RNAO executive director **Doris Grinspun** told the *Toronto Star* the announcement of nursing layoffs has shaken the "foundation" of RNAO's relationship with the government, especially considering a 2003 election campaign promise to hire 8,000 nurses. "For the first, almost full year, we were absolutely delighted … But the announcement by Smitherman of 750 layoffs came as a bitter surprise." (Feb. 12)

• RNAO member **Jewell Allington** expressed her frustration with nursing layoffs at Peterborough Regional Health Centre (PRHC) during a public meeting. "We're working at 150 per cent and now we're going to be picking up more." (*Peterborough Examiner*, Feb. 25)

• In response to a call from the Canadian Union of Public Employees urging hospitals to hire more RPNs and fewer RNs to save money, **Wendy Fucile** said PRHC must ensure the staff mix will adequately meet patient requirements. "RNs and RPNs have different breadth and depth of training and core programs … The scope of practice is quite different." (*Peterborough Examiner*, Feb. 17)

Illustration: Isabelle Arsenault/agoodson.com

For complete versions
of any of these stories, contact
Jill Shaw at jshaw@rnao.org.

Rural and remote nursing

• RNAO acting executive director **Irmajean Bajnok** told *CBC Radio One* – Thunder Bay and Sudbury that a study revealing a nursing shortage in rural areas is not surprising given that these areas often have difficulty attracting all health professionals (March 3).

• **Joan Edwards** said Health Canada decided to remove seven nurses from the Kashechewan First Nation on James Bay for security reasons and to provide them with a break from stressful working conditions (*Timmins Daily Press*, March 2).

• RNAO member **Darlene Furlong** said municipalities should fund some of the cost of educating nurses in Northern Ontario because locally trained nurses are more likely to stay. "We know we can home grow our nurses." (*Kenora Daily Miner & News*, Feb. 7)

Federal budget

• In the anticipation and aftermath of the federal budget released in February, RNAO acting executive director **Irmajean Bajnok** appeared on Citytv's *City Online* - Toronto and ROB TV's *Michael Vaughan Live* – Toronto (Feb. 23).

• A letter to the prime minister signed by numerous health-care associations, including RNAO, calling for the federal government to give Ontario its "fair share" of federal transfer payments to fund provincial priorities such as health care was covered by *The Globe and Mail, Canadian Press, London Free Press, Toronto Sun, Canada.com and CBC Radio One* – Toronto (Feb. 22, 24).

• RNAO member **Cathy Crowe** was disappointed the housing funds the Liberals promised during the election were not announced in the budget. "I really believed the promise of $1.5 billion … this is a betrayal." (*Toronto Star*, Feb. 28)

Virgin Mobile's Canadian launch

• RNAO president **Joan Lesmond** authored a letter to the editor in the *Toronto Star* demanding a public apology from Virgin Mobile for its demeaning depiction of nursing – including "nurses" wearing stiletto boots, mini-dresses and outdated nursing caps while chained to cars – during the company's Canadian launch. "Nurses are knowledgeable, dedicated health-care professionals. They are fighting layoffs and struggling to keep up with mounting workloads and the latest in patient care. They shouldn't have to fight this, too." (March 5)

• RNAO member **Laurie Clune** also expressed her outrage in a letter to the editor in the *Ajax News Advertiser* after seeing the advertisements at local retail outlets (March 23).

• RNAO's response to the campaign was also covered by the *Toronto Star, Cornwall Standard-Freeholder, Ottawa Sun, CHCH TV* – Hamilton, *CFRB AM* – Toronto and *CKLW AM* – Windsor (March 4,5,7).

Tapping into foreign-trained nurses' talents

RNAO member **Mahnaz Alibeiki** described the process of becoming certified to practice in Ontario, and the help she received from the CARE for Nurses program for foreign-trained

Out & About

On March 11, Liberal MPP for Mississauga East Peter Fonseca attended the launch of the RNAO/ University of Ottawa, School of Nursing Best Practices Research & Evaluation Unit. The Ministry of Health and Long-Term Care (MOHLTC) announced $150,000 to fund this joint initiative in January. Also in attendance, pictured left to right: RNAO executive director Doris Grinspun; RNAO NBPG program director Tazim Virani; Nancy Edwards, professor, University of Ottawa School of Nursing and CHSRF/CIHR Nursing Chair; Barbara Davies, associate professor, University of Ottawa School of Nursing, career scientist MOHLTC; and Provincial Chief Nursing Officer Sue Matthews.

Excerpt of letter to the editor,
Clinton News-Record, Wednesday, March 9, 2005

Privatization is not the way to go in health-care

IF Ontario allows private enterprise to make inroads into our communities, then we are not only going to have to pay the private companies more because they will need to make a profit, but also we will be creating two systems; private and public. This only increases the need for skilled workers like doctors, nurses and technicians during an already severe shortage in health-care human resources in Ontario.

Also, private for-profit companies will cherry-pick their clients and leave the more difficult, complicated patients for the public system.

In a time of great shortage of qualified workers, why would we try to spread them even more thinly around even more facilities? … It's a question of both access and quality. Two key reports have shown that private health care costs more and leads to higher mortality rates. Your care should surely not be based on what you can pay.

Kimberly Van Wyk, RN, President of Huron Chapter, RNAO

nurses. "I know that patients are patients and nurses are nurses wherever you go, but I doubt if I could have done the job without the extra training." (*Toronto Star*, Feb. 5)

Funding for patient care

• RNAO welcomed a Ministry of Health announcement of funding for 11,000 new mechanical patient lifts as part of a $340 million medical-equipment investment, but executive director **Doris Grinspun** reminded the health minister the equipment needs nurses to operate it. "We want to urge the minister that no layoffs, no reductions through attrition happen in terms of nursing services… If not, we'll end up having gorgeous lifts and unsatisfied patients who cannot use the lifts because there will be no nurses to take care of them." (*Canadian Press, Hamilton Spectator, Orillia Packet & Times, Timmins Daily Press, Barrie Examiner, Sault Star, CBC Radio One* – Toronto, Feb. 9)

• RNAO member **Sandra Moroso** said the funding will be used to purchase more than 30 ceiling and floor lifts for the long-term care facility where she works (*Sudbury Star*, Feb. 10).

Health-care reform

• RNAO member **Sylvia Scott** authored an editorial in the *Kitchener-Waterloo Record* calling on the government to reject a fragmented approach to health-care transformations, and commit to solving problems like health human resources shortages and escalating wait times. "It is equally discouraging for health-care providers when attempts to get decision-makers to resolve issues contributing to the health-care crisis, such as unbearable workloads, staff shortages and insufficient resources, are essentially ignored." (Jan. 16)

• In a letter to the editor, RNAO member **Riek van den Berg** said primary health-care reform is the most effective way to provide patient care, and health professionals should be working together in multidisciplinary teams instead of threatening to withdraw services (*Ottawa Citizen*, March 8).

RNAO president Joan Lesmond was in Ottawa on Feb. 18 to participate in Region 10's second annual nursing breakfast with politicians. Municipal, provincial and federal politicians attended the breakfast to discuss nursing and health care in Ontario. Pictured left to right: Lesmond, Liberal MP Ottawa-Orleans Marc Godbout, and RNAO's Region 10 Representative Carmen Rodrigue.

RNAO's executive team met with John Tory, leader of the Progressive Conservative Party of Ontario, on April 13 to discuss healthy public policy issues such as the need for more full-time positions, the impact of layoffs and the consequences of two-tiered health care. Pictured left to right: executive director Doris Grinspun, president Joan Lesmond, John Tory, and immediate past president Adeline Falk-Rafael.

by Helen Henry

Aiding Ukraine's quest for democracy

RNAO member Helen Henry travelled to Ukraine with 480 Canadians to observe three rounds of elections and ensure Ukrainians were allowed to exercise their right to a free and fair election. In the following reflection, Henry shares her experience with Registered Nurse Journal.

I'm sure many of you followed media reports of the events in Ukraine during the three rounds of elections. I had the good fortune to participate in these historic events as an official observer with the Canadian Ukrainian Congress - first, in Odessa; then in the capital, Kyiv. For the third election, I was part of the official Canadian mission, under the leadership of John Turner, and was assigned to Chernihiv, near Chernobyl.

I'm convinced that I was chosen in part because I am a nurse and have served on numerous community and professional committees over the years, including RNAO's Mental Health Nursing Interest Group. The selection committee reviewed more than 4,000 applications from across Canada before selecting 480 observers. Community health nurse and former mayor of Ottawa Marion Dewar was also a member of my team.

My nursing background, as well as experience in Ukraine as a nurse consultant with the Canadian Society for International Health, helped me understand the social and political issues that influence the health of the population.

During the third round of elections, my Canadian partner and I were assigned to polling stations in five villages just outside of Chernihiv. Many villagers could not believe that we had come to their little village from Canada to help ensure their elections were fair, or that the rest of the world cared about their right to decide their own destiny. Tears flowed as people spoke of how dehumanized and powerless they felt and how the only hope for change lay with a change in government. Many believed it was too late to make a difference in their own lives, but perhaps their children or grandchildren might have a better life. At the same time, they despaired that the deeply entrenched current regime would never give up its power, no matter how the citizens voted.

The polling stations, located in community centres, were unheated because there was no money for fuel. Election workers shivered in below freezing temperatures dressed in their full winter attire. They told us that the community centres were rarely used anymore because few people had time for leisure activities. Independence had brought an end to the collective farms and the machinery that came with them. People now work by hand or use horses; they spend most of their waking hours working the land just to provide the bare necessities of life.

One village had two births and 18 deaths during the previous year. Most of the remaining villagers were elderly, and many had health problems that they attributed to the effects of the Chernobyl disaster and the lack of health care. They predicted the demise of small villages within the next two decades. Many homesteads were already abandoned.

Each village had a nursing station served by a visiting nurse who came on designated days. Although I did not meet any of these nurses, villagers told me about their work and their involvement in the political process leading up to the elections.

In spite of the hardships and cold weather, a surprisingly high percentage of villagers voted. I vividly remember one woman - whose 80th birthday fell on voting day - walked four kilometers along snow-covered roads to vote. Another woman needed help to enter the polling station and fill out her ballot because she was permanently bent over from years of hard work in the fields. There was a celebratory mood and a sense of great occasion in and around the polling stations as people stayed on to socialize and discuss politics.

RNAO member Helen Henry (left) with a Ukraine volunteer at a polling station in Kyiv.

In spite of their poverty, people generously shared whatever they had. We were offered coffee and food from the often meagre lunches that polling station workers brought to help them through the 12-hour work day. We accompanied the ballot boxes to the territorial commission once the polling stations closed, waiting until the wee hours of the morning for them to be accepted. The head of the polling station commission invited us to his home for breakfast, apologizing that the family didn't have much, but promising that he would milk the cow for fresh milk. We were unable to accept his invitation, but agreed to visit his home if we were ever back in this area.

I feel blessed to be present for all three rounds of elections, and that I was given the opportunity to catch a glimpse of life in the rural area of north eastern Ukraine, an area that seems much more disadvantaged than the cities where I observed the first two elections. I only wish that I could have been there to see the villagers' reaction to the election results. May their dream of a better life be realized! **RN**

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by **Kimberley Kearsey**

READY OR NOT

On the second anniversary of the SARS crisis in Ontario, infectious disease experts are looking ahead to the latest threat: the possibility – some say probability – of a pandemic, the first since 1968 when the Hong Kong Flu killed more than 700,000 people worldwide. Are Ontario's plans for handling a pandemic outbreak up-to-snuff? Have we heeded the lessons of SARS? Or have we fallen asleep at the switch?

Emergencies – whether biological, environmental or the result of human error – are fraught with uncertainty and powered by unpredictability. Sometimes there's no way to see them coming, and there's no way to plan for every conceivable consequence.

Or is there?

When alarm bells sound at a fire hall, firefighters rely on their experience and knowledge, and on a tried-and-true plan of action that helps them manage the expected, anticipate the unexpected, and prepare for the worst.

Today's emergency planners must follow that philosophy as they prepare for the world's next pandemic outbreak – looming larger today than at any time in the past 36 years.

Dr. Frank Plummer, Scientific Director of Winnipeg's National Microbiology Laboratory, a division of Health Canada and the facility responsible for investigations into infectious disease epidemics, doesn't mince words about the possibility of a pandemic outbreak: "…we're not crying wolf," he says. "There is a wolf. We just don't know when it's coming."

Predictions from infectious disease experts put the number of deaths during an influenza pandemic at between 11,000 and 58,000 in Canada alone. These shocking numbers should help focus the mind around the real dangers associated with flu, and create a sense of urgency around the need to firm up action plans for a future outbreak.

Nurses need to recognize that the wolf is approaching the doors of our health-care system, regardless of sector or specialty. Some experts say it's as close as the front yard while others say it's still making its way through the forest. They all concur, however, that there's just no way to know when or how it will arrive.

The good news for nurses and all health-care professionals is that their experiences during SARS – anger, frustration, exhaustion, and isolation – have motivated pandemic planners to create action plans that strive to keep health-care professionals healthy, physically and emotionally.

The bad news, however, is that despite two years of preparation, there's still no guarantee that the hinges on the doors of our health-care system won't buckle when that wolf starts to push.

Referring to Ontario's public health system post-SARS, The Honourable Mr. Justice Archie Campbell, who released the SARS Commission's *Second Interim Report on SARS and Public Health Legislation* on Apr. 11, says "much more work remains to fix the broken public health system revealed by SARS in 2003." Although he believes there have been significant improvements to the

Illustration: Anson Liaw

system since the outbreak, "more financial and professional resources are needed; otherwise all the legislative changes and program reforms will prove to be nothing but empty promises."

The occupational health and safety of nurses and other health-care professionals, a major focus of Campbell's work, will be dealt with in the Commission's final report, due out at the end of this year. "It cannot be addressed adequately in the confines of this report," Campbell writes, "and it must be addressed together with the stories of the many health-care workers who sacrificed so much to battle SARS."

RNAO executive director Doris Grinspun says these findings can't come soon enough. Grinspun is no stranger to legislative or human resources battles or to emergencies on the front line. She has experienced both first hand in Canada, the U.S. and in Israel, where she first practised as a registered nurse.

"To be prepared for an emergency we need to have all the systems and processes in place and ready to go any minute, allowing us to focus on the unpredictable," Grinspun says. "That's the recipe for success."

With the lessons of SARS still so fresh in our minds, there's no reason Ontario should be ill-prepared for the challenges we can anticipate in the event of a pandemic.

"Systems are systems and processes are processes," Grinspun says. "It doesn't matter what kind of emergency we have, we need to have a clear plan and we need to know how and when to activate it. The only unknown should be the nature of the virus and the treatment of that virus. Everything else should be ready to go," she says citing as examples

"To be prepared for an emergency you need to have all systems in place and ready to go any minute."

nursing workforce deployment and redeployment, health and safety, and communications.

The question that needs to be at the top of nurses' minds today is: "Are we, in fact, ready to take care of our patients, ourselves, and our families during a pandemic?"

Dr. Karim Kurji, Ontario's Associate Chief Medical Officer of Health, describes pandemic preparedness as a work-in-progress. "There's certainly no quick fix," he says about the government's work in the wake of SARS. He adds, however, that "lots of pandemic activities are just bearing fruition now."

"I would say Canada is at the forefront with regards to two areas in particular. The first area is security of supply for vaccines and the second is putting together a pandemic plan. Canada's (pandemic) document has been praised by many in the world, including the World Health Organization (WHO)," he says.

Kurji is proud that Canada has the respect of the world when it comes to its plans for handling a pandemic, but he's not so confident, however, that we can maintain our lead.

"I would say that many other countries…have probably done better than us in certain areas," he admits. "For instance, some countries are putting more money into research of anti-virals and the development of cell-based vaccines, which have the advantage of more rapid production, and, hence, better availability."

Given the tremendous amount of broad planning work that has been done – and continues to be done – on pandemic planning at the international, national, provincial and local levels, the view of some experts and pandemic planners is that we are in fact ready to respond.

"Emergency plans are being put into place across the province. We just need to view them through the lens of a pandemic of influenza," says Gerilynne Nephew, RN and manager of the Communicable Disease Liaison Unit at Toronto Public Health. "I think progress has been made…we have to just keep planning one step at a time in order to enhance our ability to be prepared for an emergency like pandemic influenza."

"Are we better prepared than we were two years ago? Yes we are. Do we still have more planning to go through moving forward? Yes we do," she continues. "We also need to have opportunities to practice and test emergency plans so we're able to identify gaps and obstacles to enhance planning. To respond to and recover from an emergency, it's really critical that we prepare using our understanding of the history of pandemics, and utilizing the lessons learned from SARS."

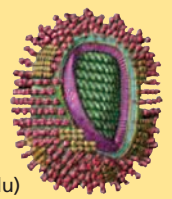
Not all frontline nurses, however, are convinced those lessons have been heeded, and if they have, whether they're transferable to a pandemic situation.

"I think there's a heightened awareness at hospitals that have already been burned once, but…I'm not convinced other hospitals have learned the lesson through Ontario's experiences," says Karen Ellacott, an ER nurse at North York General Hospital, and the author of a touching personal account based on her experience during SARS (*Registered Nurse Journal,* July/August 2003). "If a pandemic does hit, it will spread like wildfire in much the same way SARS did. But I think we need to be in a situation where we're not floundering, like I feel we were with SARS."

GRASSROOTS INITIATIVES

Despite some guidance on pandemic planning from WHO and from Health Canada,

The facts about influenza



- Avian influenza (H5N1) is the front runner for triggering the next pandemic. Scientists believe each time we see a new H1 antigen emerge we experience a pandemic of influenza. H1 caused the 1918 influenza (Spanish Flu) outbreak; H2 and H3 caused the 1957 Asian flu and the 1968 Hong Kong flu, respectively.
- H5N1 has a very high mortality rate; approximately 72 per cent of infected humans die.
- During "normal" influenza season each year, an average of five to 20 per cent of the population becomes ill. During a pandemic, that could go up to 30 to 50 per cent.
- Avian influenza patients do not always arrive at hospital presenting the respiratory symptoms typical of severe influenza cases, adding to the risk that health-care workers will fail to recognize it before others are infected.
- The World Health Organization (WHO) says measures that worked during SARS may not be effective against the influenza pandemic because flu is more contagious, has a short incubation period, and can be transmitted before the onset of symptoms. **RN**

there still seem to be far more lingering questions than firm answers for frontline health-care professionals. Fortunately, at the local level, working groups, committees, stakeholders and public health officials are meeting regularly to go over plans of action at the grassroots level.

Ann Corner is manager of the Communicable Disease Program for Simcoe County, which services a population of about 450,000. She is also on one of the Ministry of Health and Long-Term Care (MOHLTC) working groups providing input to the provincial pandemic plan.

"I know a lot of health units are working hard on their local planning processes," she says. "I was impressed (at a recent provincial meeting) with where people had gone, the detailed questions that people are now beginning to ask, and the fact that we've gone beyond the overview and big picture; we're getting down to the nitty gritty."

In Simcoe County, Corner and her team are answering questions like: How do we work with the ministry to get anti-virals for treatment of the ill? How do we keep staff well? What should we watch for in our communities to know we have something unusual? Do we know how many retired nurses we have in Simcoe County to help give shots?

Detailed discussions like these continue across the country and around the world. But, wherever they are held, and in whatever language, one reality shapes discussion: emergency preparedness and planning is not a static process.

"I see a pandemic plan as an "evergreen" document, it continues to grow as we get more information," Nephew says. "You don't develop a plan, write it all down in 200 pages, put it into a drawer, and pull it out when something happens. A good emergency plan is one that is constantly changing based on the best information available and best practices."

The federal and provincial governments describe their pandemic plans much the same way – evolving, just as viruses evolve. Keeping pace with this constantly changing environment, the government has created committees and advisory groups at the local and provincial level, each identifying what's needed to fight a pandemic, and exploring processes that will address those needs.

On April 12, the Ministry of Health's Emergency Management Unit (EMU) hosted a provincial consultation with pandemic planners across the province to review

Photography: Brooke Palmer

Producers look to nurses for expertise, experiences on the set of *Plague City* – a movie about SARS

RN Pat Tamlin never expected to be sharing her nursing experiences with actors, directors and producers on the set of a movie about SARS. But that's just what she was doing when she was invited late last year to be a consultant for *Plague City*, a made-for-TV movie about Toronto's experience with the disease.

A critical care nurse at The Scarborough Hospital (TSH), Tamlin worked the front lines during the SARS outbreak, and was among the first group of health-care professionals to contract the contagious disease. It was her dual experience as an RN and a patient that attracted the attention of producers at Toronto's Slanted Wheel Entertainment – who also consulted with RNAO executive director Doris Grinspun – as they began their intense research for the project.

"Nurses were essentially the front line in this battle," Collin Friesen, the script's co-writer, says. "They were the ones who recognized it first. They were the ones who sounded the alarm. They were the ones who were ignored. And they were the ones who essentially bore the brunt of what this disease can do."

Tamlin says she wasn't at all hesitant when producers invited her to play the role of consultant. "They really wanted to honour what we did during SARS. They were really good about listening and asking my opinion. I actually had some very busy days on set because I'd be called left and right."

Tamlin recalls one day when an actor playing a doctor inserted an endotracheal tube upside down during an intubation scene. "You better not use that scene," she told the director, laughing. That actor, Tamlin says, relied heavily on her when he was doing his scenes. "He was always saying 'Pat, would it look this way?' or 'Pat, did it look realistic enough?' He was really willing to utilize my experience."

Tamlin also offered tips on what a hospital looks like, how many patients would typically be in a room, and the level and kind of protective gear required in certain situations.

Tamlin recalls juggling her work schedule with filming, and feeling exhausted with only one weekend off between shifts and seven days of production. Still, "It was a great experience," she says. "It's probably the only opportunity I'll ever have to do something like this."

Described as "a human and political thriller that reveals Toronto's brush with a 21st century pandemic," *Plague City* chronicles the transmission of SARS from a small town in China to Ontario. The movie portrays nurses as heroes, similar to the firefighters of 9/11.

Tamlin says she'll tune in when the film airs on CTV on Sunday, May 29 at 9:00 p.m. "I was glad I was able to inject some of my experiences into the movie," she says, noting there is one scene that she predicts has come directly from what she told Friesen.

"All the nurses in the movie are composite characters," Friesen says. "If all of the things that happened to one of the nurses in the script happened to a nurse in real life, that poor nurse should be getting stress

Head nurse Kari Matchett, tends to friend and co-worker Rosie (Lannette New) during her battle with SARS.

leave for the rest of her days. That is the nature of screenwriting. You tend to take all of the experiences and put them into one character. It's economical, and it's often the way things are done."

"I really felt they were happy to have me there as a resource," Tamlin says. "How it (the movie) will come together and be packaged will be interesting to see." **RN**

If Canada is a leader in pandemic planning, where does Ontario stand?

IN the aftermath of SARS, the MOHLTC created the Provincial Infectious Disease Advisory Committee, comprised of infectious disease specialists, public health experts, and epidemiologists who advise the Chief Medical Officer of Health. It also:

- created regional infectious disease networks
- created screening and surveillance programs for febrile respiratory illness
- purchased and outfitted a 56-bed mobile hospital
- created an emergency medical assistance team
- maintained a stockpile of protective equipment for outbreaks
- maintained a stockpile of anti-virals for protection and prevention purposes
- established a province-wide hospital distribution system for supplies
- revised a number of the SARS outbreak directives offered by the SARS Commission
- offered tabletop test exercises to increase awareness of pandemic plans and identify areas for improvement
- hired 25 full-time equivalent positions for infection control practitioners

What MOHLTC is still sorting out, however, is how to address predictable system and human resources issues during an emergency such as:

- inadequate nurse-to-population ratios
- troubling workloads that leave little confidence the system can handle a sudden influx of sick
- too few full-time nursing positions
- insufficient education and public awareness programs that promote a culture of prevention and encourage public health practices to decrease the spread of disease
- deficient timelines for sector-specific pandemic plans that can be implemented on a moment's notice
- no clear testing procedures to take us through our response to emergencies, ensuring everything and everyone is seamlessly coordinated and dispatched. **RN**

" A good emergency plan is one that is constantly changing based on the best information available and best practices."

progress to date. The provincial steering committees have taken those progress reports and will release a revised *Ontario Health Pandemic Influenza Plan* in late May.

"I am impressed with the incredible efforts and work accomplished to date," Grinspun, who represents ENAC on the steering committee, says. "However, I would like to see more resources allocated to this initiative so we can accelerate our progress." Improvements such as the move to 70 per cent full-time employment in nursing, the creation of Family Health Teams, and funding for housing will help us deal with a flu pandemic or future emergencies, she added.

NURSING INITIATIVES

Local planning committees like the one Corner is on are assessing whether nursing has the surge capacity and the human resources needed to respond to a pandemic outbreak. "You can't stop everything if there's a pandemic," Corner says. "We can't ignore other public health issues. We have to think about key activities, we have to prioritize. If we have a chemical spill, for example, we have to still be able to answer to that. If we had a major illness outbreak in a long-term care facility, we'd have to deal with that."

Nancy Purdy, a nursing PhD student at the University of Western Ontario (UWO) and the consultant who led the team responsible for RNAO's SARS report, commends the government for its work since SARS. Still, she is concerned nurses' workplaces and workloads, described in the SARS report and largely unchanged since the outbreaks, could hinder response to a pandemic.

"I think the easy, procedural issues have moved forward because they've had to, and they've done some great work. I don't want to discount that. But my concern is that fundamentally we've not addressed the significant work environment issues," she says. "If you want a long-term solution, you have to have the health of your resources looked after first. That will help weather whatever kind of crisis comes forward."

Key to addressing the health human resources issues is shoring up our ability to mobilize nurses during an emergency. At the height of the SARS crisis, RNAO led the coordination of skills-based rostering through its VIANurse database. Since 2003, the database has been through two successful simulations, and it was used during the tsunami disaster at the end of 2004.

The MOHLTC is in the process of expanding on VIANurse and developing its own program for emergency deployment. VIANurse will be active until the end of June 2005, at which time its functions will be taken up by the ministry.

RNAO also chairs the Emergency Nursing Advisory Committee (ENAC), another invaluable resource. Originally called the SARS Nursing Advisory Committee (SNAC), the group – comprised of representatives from nursing organizations from all service sectors and academia – is a vital link and formal reference group between government and nursing professionals in times of emergency. With the release in October 2004 of *Emergency Preparation: A Working Document of Guidelines for Nursing Action*, the multi-organizational group has set out specific steps the nursing community must take in the event of a national or provincial emergency.

Individual nurses must stay informed about pandemic planning activities, and about the role they are expected to play in the event of an emergency. SARS taught nurses the value of communication during a crisis. It also taught nurses the importance of education and the power of knowledge when planning for the expected – and the unexpected.

SARS has been described as the dress rehearsal for something bigger, Ontario's wake-up call to the dangers of a pandemic flu outbreak. It gave us a glimpse of the potential power and impact of a pandemic, and precipitated some overdue progress in improving our health-care system. We can't forget, however, that even though we're more prepared for a pandemic today than we were yesterday, we still have to work on a solid plan for tomorrow. **RN**

KIMBERLEY KEARSEY IS COMMMUNICATIONS OFFICER/WRITER AT RNAO.

by **Kimberley Kearsey**

10 years young

From fledgling pilot project to respected certificate program, the Ontario Primary Health Care Nurse Practitioner (PHCNP) Program celebrates a decade of learning with more than 600 graduates who sing its praises.

Ten years ago, Luisa Barton was one of only 26 nurses to graduate from the Ontario Primary Health Care Nurse Practitioner (PHCNP) Program. By the end of the 2005 academic year, 600 nurses will have followed in Barton's footsteps, receiving NP certificates and completing the College of Nurses Extended Class (EC) exam. Offered by a consortium of 10 Ontario universities under the Council of Ontario University Programs in Nursing (COUPN), the program has gone from a pilot project to the largest comprehensive NP program in Canada.

Barton says her NP education and the PHCNP Program have taken her places she never thought she'd go, including her current administrative role as regional coordinator for the central region of Ontario.

"The doors have been opened for teaching, for administration, and also for consulting with other provinces," she says. "It might sound cliché, but for me, the program exceeded my expectations in terms of what I can do."

The timing of the program's 10th anniversary this September could not be more appropriate given the provincial government's commitment to creating 150 Family Health Teams (FHT) over the next four years, and the vital role NPs can – and must – play on those teams.

Theresa Agnew, immediate past chair of the Nurse Practitioners' Association of Ontario (NPAO) and a graduate of the program, says Ontario currently has more than 40 job openings for NPs, mostly in rural communities. Career options, however, will increase exponentially with the introduction of FHTs, she says.

In keeping its commitment to primary health-care reform, the Liberal government's 2004 budget included increased funding for additional positions, or "seats," in the program over the next three years, boosting the number of students from 75 to 150.

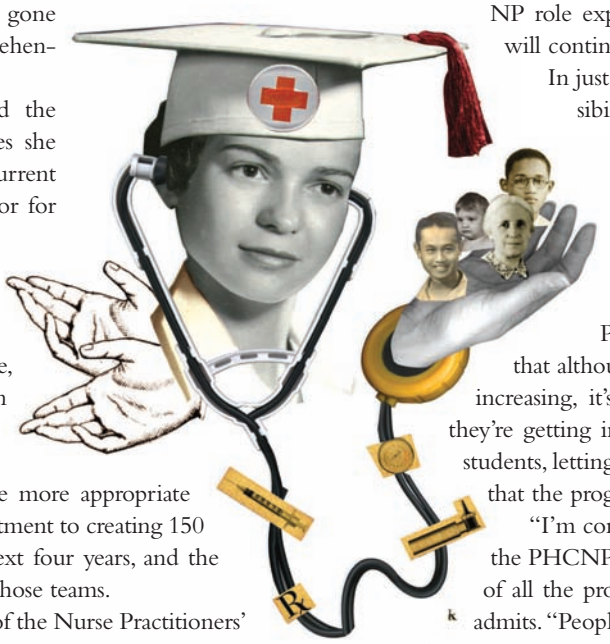
"Because of a lack of job security, we saw our enrolment rates in the program go up and down all the time," says Eric Staples, regional coordinator for the program's western region. "If we double our number of graduates, we'll be able to staff the (FHTs) and at the same time we'll be able to mentor students by putting them with graduates in clinical settings."

With this increase in job opportunities, however, comes mounting pressure to fill those extra positions in the program. Agnew is confident the plan to move the program from a post-graduate certificate to a master's level will attract more applicants. Barton agrees, but is reluctant to assume that shift will happen very soon. "I think we have to move into the graduate level," she says, adding that "nothing's firmed up."

RNAO, the College of Nurses of Ontario, and the Canadian Nurses Association all recognize NP preparation should move to the master's level. "We know from people who are calling us that they're looking for graduate level education," Staples says. "In the U.S., most of these programs are at the master's level and we're losing some learners to border universities."

With all of the promised opportunities in Ontario, it's hard for NPs like Ann Page to understand why students would want to go elsewhere to complete their education. A 2001 graduate of the program, Page has worked with homeless populations in Toronto and Hamilton, and with refugees and in the ER in the Niagara Region.

"I would say the opportunities are limitless," Page says. "I see the NP role exploding in Ontario. And I think it will continue to explode across Canada."



In just one example of those limitless possibilities, Page and a colleague recently received funding from Canada's Change Foundation to conduct a two-year project to look at how NPs in critical care can enhance clinical outcomes in community hospitals.

Page, Barton and Agnew all agree that although the growth potential for NPs is increasing, it's vital that applicants know what they're getting into. Barton is brutally honest with students, letting them know in no uncertain terms that the program is rigourous.

"I'm completing my PhD, and I have to say the PHCNP Program was the most challenging of all the programs I've done in academia," she admits. "People think a PhD is intense and difficult, and it is. I'm not saying it's not. But I do have to say the intensity of the PHCNP Program exceeds that. We think as nurses that we know this stuff, but in fact, we're learning a whole new language and content in a very short period."

In its 10-year history, the PHCNP Program has seen a 10-to-15 per cent attrition rate. It's not for the faint-of-heart or uncommitted.

"I worked hard and the rewards are flowing in. For me, I just feel my career was shifted to another level and it was definitely worthwhile," Barton says. "I would do it all over again."

A gala reception marking the PHCNP Program's 10th anniversary will take place Sept. 1, 2005 in Toronto.

For more information about the program and the gala, visit http://np-education.ca. **RN**

KIMBERLEY KEARSEY IS COMMMUNICATIONS OFFICER/WRITER AT RNAO.

Illustration: Katy Lemay/agoodson.com

by **Jill Shaw**

RNs EXAMINE ETHICAL DILEMMAS

ON FEB. 17, MORE THAN 50 REGISTERED NURSES ATTENDED RNAO'S *ETHICS FOR NURSES* WORKSHOP TO LEARN HOW TO APPROACH AND RESOLVE ETHICAL ISSUES IN THE WORKPLACE.

Last October, a local emergency department referred a woman in her late 80s to registered nurse Denise Simpson, a case manager with a Community Care Access Centre in rural Ontario. Simpson found the woman living alone in a cold, filthy home with no refrigerator; her only caregiver an elderly neighbour who visited once a day and provided her only meal. Simpson was alarmed, but the woman insisted she was capable of caring for herself. CCAC staff made several more visits, but by January 2005, the situation was worse. The neighbour contacted the CCAC to express concern about her friend's health, saying she couldn't keep caring for the woman because she feared for her own safety in the cold, dirty home. When Simpson went back, the situation had deteriorated. And, despite the obvious need for care, the woman suffered from a deep-rooted paranoia that made her suspicious of signing forms, including those needed to admit her to a hospital. Simpson consulted her colleague Elaine Palmer, also an RN, and the two made another visit. After confirming the woman could not walk (and reviewing the results of a medical assessment), Palmer and Simpson issued a Form 1, allowing the woman to be admitted to the hospital against her will. But she still refused care, and the police had to remove her from the home - an incident that left both Simpson and Palmer emotionally shaken.

"When you know you're taking away someone's right to make their own decisions, it's not done lightly, without some sort of consequence to the health-care professional," Palmer says.

Alleviating some of those consequences was among the topics discussed on Feb. 17 when nearly 60 nurses from across Ontario attended RNAO's day-long, nursing ethics workshop facilitated by Anne Moorhouse, an RN with a PhD in philosophy. Moorhouse, a nursing professor at Seneca College, RNAO representative on the Canadian Nurses Association's Advisory Ethics Committee, and a consultant for the CNA and CNO codes of ethics, says the ethical issues nurses face rarely change, but some, such as end-of-life care, are gaining more prominence as the population ages.

"Every day, nurses encounter ethical situations," Moorhouse says. "They want to do the right thing, but there may be barriers." Financial and human resource limitations can prevent nurses from doing what they feel is right, causing moral distress that can lead to frustration, anger and even burnout or depression.

Nursing ethics is broadly defined as how nurses should conduct their practice, and refers to the ethical values and standards that govern and guide nurses in daily practice, including truth telling, respecting confidentiality and advocating on behalf of the patient. Moorhouse has worked in a variety of areas including gerontology and mental health and says it's important to identify your own values

Illustration: Frederique Bertrand/wandanow.com

and understand basic ethical principles, such as autonomy and beneficence (the need to help others), to be comfortable coping with ethical decisions. It's also important to understand patients' experiences, she says.

Moorhouse uses a video called *Handle with Care* to help nurses gain insight into a patient's perspective. Produced by the psychosocial and behavioural unit of the Toronto Sunnybrook Regional Cancer Centre at Sunnybrook and Women's College Health Sciences Centre in Toronto, the video presents a live performance by metastatic breast cancer survivors who act out the experience of battling illness in the face of overwhelming medical information, grieving families and friends, and their own emotional struggles. Moorhouse says the video is an eye-opener for many nurses.

"We're always talking about patient-based care. Many nurses empathize with the women in the video, and want to know how they can make (their experiences) better."

Maureen Slade, nurse manager of the complex continuing care unit and the day hospital at Almonte General Hospital near Ottawa, is trying to ease the burden of making difficult decisions by chairing the hospital's newly formed ethics committee, made up of physicians, clinical staff, hospital board members and clergy. The committee, formed on the advice of the Canadian Council on Health Services Accreditation (CCHSA), has no formal ethical training, so Slade attended the workshop to guide her through the complexities of ethical decision-making. She plans to use Moorhouse's value-identification exercises with committee members to help them begin to under-

Resources

- International Council of Nurses. *Code of Ethics*
  http://www.icn.ch/icncode.pdf
- Canadian Nurses Association. *Code of Ethics for Registered Nurses.*
  http://cna-aiic.ca/CNA/practice/ethics/code/default_e.aspx
- College of Nurses of Ontario. *Ethical Framework for Registered Nurses and Registered Practical Nurses in Ontario.*
  http://www.cno.org/docs/prac/41034_Ethics.pdf
- Canadian Bioethics Society
  http://www.bioethics.ca
- RNAO: Best practice guideline regarding client-centred care
  http://www.rnao.org/bestpractices

stand themselves and each other.

Almonte's ethics committee will provide 24-hour support to patients and staff, but Slade says Almonte's small size and level of patient complexity means ethical dilemmas will largely be handled by available staff members, many of whom are also committee members. Those problems, which typically involve end-of-life decisions or arranging proper care for patients once they're discharged, will then be reviewed at committee meetings.

Nurses without access to ethics committees can find support in each other. Suzy (a pseudonym) is an RN from southwestern Ontario who cares for children who have suffered birth traumas, accidents or have genetic disorders that make them dependent on technological devices and 24-hour nursing care for survival. Suzy encounters ethical dilemmas daily, especially when she supports parents struggling with a child's multiple surgeries or the decision to let a child die.

"When a child dies, it seems out of time," Suzy says. "It can be very hard to deal with and support families when it's shocking to you as well."

Collegial support was important for both Elaine Palmer and Denise Simpson as they struggled to balance their elderly patient's needs with her independence. Without compromising the patient's confidentiality, they consulted an ethicist and a geriatric psychiatrist. The psychiatrist helped Simpson and Palmer see that the woman's repetitive answers and inability to prove she could care for herself likely meant a Form 1 would be needed. Once the woman was hospitalized, the health-care team consulted the patient and her neighbour about next steps, and when the neighbour said she would no longer care for the woman, she immediately realized the gravity of the situation and agreed to be placed in her preferred nursing home.

Palmer says both she and Simpson are pleased with how the situation was resolved, and their colleagues are now more comfortable discussing the challenges they face every day before they reach the breaking point. They've also held workshops to help staff cope with what Palmer says are an increasing number of elderly living in isolation in a rural area with a physician shortage.

"Ethical dilemmas are not black and white," Palmer says. "We're dealing with people, and people come in all shapes, sizes, thinking and background. At the end of the day it takes experience to be as objective as possible when you're working with people so you give them every benefit you can around their autonomy and the right to be independent." **RN**

JILL SHAW IS EDITORIAL ASSISTANT AT RNAO.

The case of Terry Schiavo

The case of Terry Schiavo, a 41-year-old Florida woman in a persistive vegative state for 15 years, made headlines recently when the courts approved removal of her feeding tube. She died on March 31.

Media-frenzy about an end-of-life decision is uncommon in Canada. The 1994 case of Sue Rodriguez was well publicized, but the identity of a patient wanting a ventilator removed was protected by calling her Nancy B. when the case was reported in the media in 1991/92. When Schiavo's parents went to the media, her case became a lightening rod for advocates for the sanctity of life, renamed the culture of life. Political agendas polarized the debate and clouded some of the important clinical, legal and ethical issues.

As nurses know, withdrawing treatment in Canada typically happens quietly and respectfully. Patients range in age from newborns to older persons, and nurses and the clinical team are guided by the patient's wishes. If not known, the substitute decision-maker must decide what is in the patient's best interests. Most often, these are private decisions made by families in consultation with the clinical team. When there is a disagreement between relatives, as in the Schiavo case, a mediation meeting may resolve the issues.

In Ontario, under the *Consent to Treatment Act*, family members and health-care professionals can ask for a legal review at the Capacity and Consent Board when they have reason to believe the substitute decision-maker is not following the person's wishes or when not known, acting in his/her best interests. If necessary, the board can appoint another decision-maker whom they think will respect the wishes or best interests of the patient.

Nurses should consider the following when dealing with end-of-life cases:

- Know yourself. What are your values and beliefs about removing treatment? We have an obligation to provide compassionate and competent care to patients who have treatment withdrawn. Reflect on your values to determine how you can provide excellent care when you may not agree with the decision.
- Ask your patients, their families or support network about their values and beliefs. They may not have had these discussions and need support to talk about how and when to die or continue living.
- Ask your patients if they have appointed a Power of Attorney for Personal Care (PAPC). If not, the hierarchy of substitute decision-makers must be followed. Under Ontario legislation, same sex partners are recognized.
- Ask if your patients have prepared an advance directive and if so, what are their wishes (written or verbal)? When prior wishes and values are unknown, the substitute decision-maker needs to decide what would be best for the person. This may mean deciding on the least tragic choice when all the options are bleak.
- Help patients and families understand and appreciate relevant clinical information. For example, what will happen if the treatment continues or ends? Will the patient be comfortable once the treatment is withdrawn?
- Respect privacy. Private health information can only be shared with the health-care team. To go beyond this circle requires consent from the patient or their substitute decision-maker.
- Let patients and families decide and give them the time needed. They will have to live with this decision for the rest of their lives.

ANNE MOORHOUSE, RN, PhD, IS A NURSING PROFESSOR IN THE SENECA-YORK COLLABORATIVE BScN PROGRAM (SENECA CAMPUS) AND CO-EDITOR OF THE BOOK TITLED *NURSING ETHICS*.

by **Kimberley Kearsey**

Ontario's answer to primary health care

Family Health Teams

More than one million Ontarians will have better access to health care thanks to Premier McGuinty's announcement (April 15) of 52 new family health teams (FHT) and three new FHT networks in communities across Ontario. These FHTs are an important step towards fulfilling the government's commitment to primary health-care reform – patients' first and most frequent point of contact with the health-care system.

Staffed by physicians, nurse practitioners, registered nurses and other health-care providers, FHTs will offer patient care 24/7, providing comprehensive care, closer to home. An FHT Action Group, led by Dr. Jim MacLean, executive lead for primary health care, was announced in the fall of 2004 to offer guidance on issues of governance, accountability and community engagement to ensure the government meets its target of 150 FHTs across Ontario by 2007/08. RNAO members Theresa Agnew, immediate past chair of the Nurse Practitioners' Association of Ontario, and Mary Anne Millson, member of the Ontario Family Practice Nurses (see sidebar), represent nurses and nurse practitioners on the action group.

In an interview with R*egistered Nurse Journal*, Agnew talks about how this innovative government initiative is good news for nurses and the public they serve.

RNJ: *Do you think this investment in primary health-care reform will benefit the system, health-care providers and the public they serve?*

Theresa Agnew (TA): I think this is huge actually. According to Roy Romanow, primary health-care reform is the single most important initiative in revamping the health-care system. I think we all see the effects when primary health-care services aren't accessible or aren't working well. More people end up in the emergency department, care becomes fragmented, and people aren't able to navigate the system. As well, you're not seeing the benefits of preventive health care and promotion, which need to be delivered through primary health care. In primary health care, even something as basic as a visit for a flu-shot becomes an opportunity to do some health teaching, check a blood pressure, or counsel somebody on smoking cessation.

RNJ: *What is the action group doing to help the Ministry of Health and Long-Term Care (MOHLTC) select sites for the new FHTs?*

TA: The action group has advised the ministry on the criteria used to evaluate applications for FHTs; we're not involved in the hands-on screening of the applications. We've certainly had input into what we would consider important features and significant elements that we feel should carry weight during consideration, but the review process is being conducted by ministry staff. They received 212 applications and they were really pleased with the enthusiastic response. We're anticipating that this is one of a three-wave application process. We anticipate two more waves through which people can apply for funding.

RNJ: *How is this initiative different from the Ontario Family Health Networks (OFHN) launched by former Conservative Health Minister Tony Clement?*

TA: With the OFHNs, there was a lot of emphasis on how physicians were going to

be paid and how they would come together to form group practices. There wasn't really a policy initiative around the true inclusion of other disciplines. Those agreements were negotiated between the Ontario Medical Association and the Ministry of Health. As soon as you start negotiating significant health-care reform with one labour group and not others, you've got problems. That's a key difference with this FHT model. This is a model that finally has the true potential to be interdisciplinary, and to have the most appropriate provider providing the most appropriate service in the most appropriate setting.

RNJ: *What does the government's commitment to FHTs mean to RNs, NPs and other health-care providers?*
TA: I'm just so excited to be part of this initiative because what we're seeing from the applications is that nurses and nurse practitioners will play a big part in these FHTs. FHTs represent a significant opportunity to really put together the kind of team of professionals people need: dieticians to help with better nutrition; pharmacists to help educate people on medication and treatment; RNs and NPs to shift the emphasis to health promotion and disease prevention. That's tremendous. I would like every person in Ontario to experience the same benefits my patients get to enjoy with access to an interdisciplinary team.

RNJ: *How does this initiative link to the federal health accord and promised improvements to primary health care?*
TA: In September 2000, the First Ministers agreed that improvements to primary health care were crucial to the renewal of health services. The government of Canada announced $800 million in funding through the Primary Health Care Transition Fund. In 2003, the First Ministers' Health Accord set out an action plan with clear benchmarks for success. The 2003 accord was accompanied by a commitment of $34.8 billion over the next five years. One outcome indicator that was agreed upon was that residents should have access to an appropriate health care provider, 24-hours-a-day, seven-days-a-week, as quickly as possible, with this target being fully met within eight years.

RNJ: *What has your biggest challenge been? What has been most rewarding about this experience?*
TA: Actually, I have to say it's been a real treat to be involved with this group because it's almost like having a dream and seeing everything come to fruition. It really is that good. It's good for patients, it's good for the health-care system, and I think it's going to be really good for all practitioners in the system, including nurses. The only thing I would say at this point is I'm still approaching it with a bit of cautious optimism in that the devil is in the details. We'll have to see the specifics of the government's announcement of these FHTs, and how they will be rolled out.

RNJ: *What challenges will there be in implementing interdisciplinary teams?*
TA: This model has so many good things about it. It's right in so many ways that I actually do think people will really want to see it rolled out on a larger scale. That might be a barrier in the end because the ministry might be a victim of its own success.

RNJ: *Response to this call for FHT applications was overwhelming. Does this mean the govern-*

The facts on FHTs

- FHTs are locally-driven organizations with physicians, nurse practitioners, registered nurses and a range of other health-care providers (i.e. dieticians, pharmacists).
- Each FHT is tailored to meet the needs of the local population it serves.
- Not all FHTs are created equal. In larger centres, for instance, they may include diagnostic and outpatient services such as x-rays, ultrasounds and minor surgery. The MOHLTC is looking for flexibility in size, scope and focus for FHTs.
- FHTs are described as "system navigators" for care coordination, a "one-window access point to our complex health-care system" that will link patients to acute care, long-term care, public health, mental health, and other community programs and services.
- FHTs will be equipped with specially funded information technology to organize patients' health information and share it securely with other health-care professionals.
- Enrolment of patients and professionals in FHTs is purely voluntary.

Source: Family Health Teams, Advancing Primary Care, Bulletin No. 1, December 2004

ment should change its policy to allow for more FHTs? How will the action group keep unsuccessful applicants from falling to the wayside?

TA: The ministry doesn't want successful applicants to come only from the most sophisticated communities. They want them to come from the communities that need services most, and sometimes those are the very communities that don't have the resources to put together an application. The first 55 FHTs were targeted communities that the ministry thought were ready to go. Certainly the next round will come from communities that are just getting things together now. And the government has set aside funding to help these communities complete the applications. If a community needs help doing the governance piece, for instance, there might be money available for that because you might need to hire a lawyer. The intent is not to leave anyone behind.

RNJ: *What's next for the action group? Will it be involved in the integration of FHTs into the system?*

TA: We'll continue to meet monthly. I think one of the things we saw with the applications was that they were geographically dispersed throughout the province. There were applications from under-serviced areas, urban areas, rural areas. At some point we're going to need to look at who hasn't applied and needs to apply, and how we can help communities along.

RNJ: *How will you know if FHTs have been successful?*

TA: The action group is working on the evaluation of the model. There are some really good people involved. We have Brian Hutchison from the Centre for Health Economics and Policy Analysis (CHEPA) at McMaster University. He's done a lot of the work around evaluating models of primary health care. We will work hard to see that this model meets the health-care needs of Ontarians, reduces wait times, and brings health services closer to communities.

RNJ: *What kind of leadership opportunities do you see for NPs in FHTs?*

TA: One thing I'm looking for in this model is the opportunity to shift decision-making. In OFHNs, only family physicians could be part of the governing structure of the FHN. Only a physician or a group of physicians could be an associate, a partner, a shareholder. It was set up that the physicians would be the key decision-makers. What I'm hoping we can achieve with the FHTs is somewhat of a shift in terms of the decision-making dynamics so other professionals are equally involved in the risks and responsibilities that go with running FHTs. The team might be community driven and look something like a community health centre, it might be provider-driven, or a combination of both. Each of those would have a different governance structure. We'd like to see it where the nurses are involved from the start, hopefully already working in the community, helping to work on the application and to be part of the vision. **RN**

KIMBERLEY KEARSEY IS COMMUNICATIONS OFFICER/WRITER AT RNAO.

Family practice nurses offer unique skills to FHTs

Mary Anne Millson is one of 3,000 RNs working in family practice in Ontario. And, like many of her colleagues, she's been doing it for decades. It is her 40 years of experience in the field that has afforded Millson the opportunity to represent her colleagues as the only family practice RN on the Ministry of Health's FHT Action Group, advising on the creation of 150 interdisciplinary FHTs over the next four years.

"The experience has been very enlightening, but intimidating at times," she says. "I was sitting back at first just to see how I fit in. But certainly I can contribute in many ways. Family practice nurses working in doctor's offices…we feel we've worked in a collaborative role with our physicians for a long time."

In fact, according to Ann Alsaffar, president of the Ontario Family Practice Nurses (OFPN), nurses in this role collaborate with a variety of health-care professionals and with patients on a daily basis. Laying the base for each patient visit, they take histories and weight, measure blood pressure and administer shots. Family practice RNs also develop relationships with a patient's family members, screen calls, talk to pharmacies, track down reports, consult with radiologists and ER physicians, and immunize hundreds of patients each year during flu season.

"It has been calculated that a doctor can see one extra patient per hour with an efficient RN on staff," Alsaffar says. "We've been doing all of these jobs…so long and so efficiently that it hasn't actually been spelled out that this is our role. People just forget because we don't wear uniforms. A lot of people think we're receptionists or secretaries when in fact we're registered nurses."

Millson believes family practice nurses occupy a relatively low rung on the nursing ladder in terms of recognition and acceptance of their specialty. "We're not neurological nurses, we're not OR nurses, we're not pediatric nurses. We're generalists so to speak," she explains. "We see FHTs as our baby step…towards recognition and acceptance of our important role in the health-care system."

In terms of the action group, and the overarching reforms to Ontario's health-care system, Millson admits: "I'm a very small cog in a huge, huge wheel…but I was honoured to be given the opportunity to represent registered nurses."

"I'm really happy that we now have members of our association on these FHTs," Alsaffar says. "We've always been here…we've just been such a blended part of the team that I think that's why we were forgotten."

Millson's priority on the action group is to educate people on the scope of practice for an RN working in family practice, so people appreciate the training and expertise they bring to the patient population. **RN**

by Jill Shaw

RN tackles diabetes on Six Nations Reserve

Why Nursing?

Barbara Martin's love of nursing began during high school when she spent two summers working as a hospital ward aid at Toronto General Hospital. That experience made nursing a logical career choice, and in 1966 she graduated from the Toronto General Hospital School of Nursing.

"It was a time when you could basically do anything in nursing," Martin says of her early career. "You could go anywhere."

Martin's career has taken her down many paths over the years, among them 15 years in various areas of hospital nursing, including cardiac care and surgery. Since 1988, she has been a clinic nurse in family practice nursing at the Gane Yohs Community Health Centre on a Six Nations Reserve near Brantford, Ontario.

Martin, a Six Nations band member by marriage, also earned her certificate in community health nursing through Lakehead University. Health Canada encourages nurses working within First Nations communities to obtain the certification, and although it isn't always entirely applicable to her family-practice work, it is still valuable because she treats patients of all ages with a variety of health problems. Martin says the aboriginal population has lower life expectancies and higher rates of heart disease, cancer and, most significantly, diabetes.

Name: Barbara Martin
Occupation: Registered Nurse, Gane Yohs Community Health Centre
Home Town: Brantford, Ontario

Responsibilities:

According to a McMaster University study, over 40 per cent of the approximately 10,000 band members at Six Nations suffer from diabetes, and a growing number of them are children with Type 2 diabetes. Martin says the increase is due to massive lifestyle changes in aboriginal communities over the past several generations. First Nations people today eat different foods than their ancestors and don't take part as frequently in activities like lacrosse, causing obesity rates and related health problems like diabetes to escalate.

In the mid-90s, Martin and her colleagues took on the diabetes epidemic. In addition to their regular work, they began providing community members with information on diabetes prevention and management, and raised money for the program by holding bake sales, yard sales and 50/50 draws. Today, the Gane Yohs Diabetes Program staff includes nurses, dietitians, physicians, lab technicians and a chiropodist. The program provides foot care, diabetes screening in schools, and classes about managing and preventing diabetes for both community members and other health professionals at the clinic.

Challenges:

While diabetes program staff can closely monitor people who are already patients at the health centre, Martin says they can only provide basic, educational information to patients using the program on the advice of physicians they see off-reserve in nearby communities. Martin says the number of people referred to the diabetes clinic by off-reserve doctors continues to grow, and there's a need for a fully-funded, full-time diabetes education centre. Martin believes it's important for community members to receive care on the reserve because it's difficult for residents to constantly travel to Brantford or Hamilton for treatment, so many simply stop going.

Memories of a job well done:

Martin says many patients and other members of the centre's health-care team are getting the message about how to manage diabetes.

"I really feel our program has made a difference. We've seen a decrease in the incidence of amputations … in the number of patients going on dialysis. I'd like to think more people are paying attention."

Health Canada certainly is. Last summer, Martin won the 2004 Health Canada First Nations and Inuit Health Branch First Nations Employee Award of Excellence in Nursing. Martin says she was surprised to find out her colleagues nominated her, but she was even more shocked to learn she won.

"It was a very humbling experience," Martin says.

Since the ceremony in Ottawa, she's received positive feedback from her colleagues and the attention her award received from the general public increased the profile of diabetes' severity within aboriginal communities.

Future plans:

Martin says her nursing career is winding down, but she is still looking to increase her knowledge about diabetes and share it with the Six Nations community. She also plans to continue to educate other health-care professionals about diabetes-related issues such as heart disease, and hopes community members and their health-care providers will keep learning more about the disease. "(Diabetes) is devastating … Even raising the awareness of the employees at the health centre is great." **RN**

JILL SHAW IS EDITORIAL ASSISTANT AT RNAO.

by Lesley Frey

Writing a wrong

Sir Richard Branson, the founder of U.K.-based Virgin Group, was in Toronto Tuesday, March 1 to launch his Canadian cell phone company, Virgin Mobile. As part of a publicity stunt, three "nurses" – models wearing white mini-dresses, stiletto boots and anachronistic nursing caps – were chained to cars so that Branson, in superhero garb, could rescue them.

RNAO responded immediately to these adolescent and injurious antics, issuing an action alert urging members to write Virgin Mobile to demand a public apology for this offensive campaign. In a letter to Virgin Mobile, the association asked the company to immediately withdraw its advertising which is degrading to women, insulting and demoralizing to nurses, and simply unacceptable.

Members should be aware that the Canadian Nurses Association has filed a Special Interest Group complaint on behalf of all its jurisdictions. Members responded swiftly and strongly, sending Virgin Mobile hundreds of letters. Here are some excerpts of what your colleagues told Virgin Mobile:

Using colourful iguanas and cute dogs to sell cell phones is entertaining. Exploiting nurses is cheap and degrading to our profession and women in general…Nurses are highly trained professionals who take pride in their work and what they give back to humanity.
Susan Castle, RN, Brampton

I suggest that every time you consider putting a nurse into a subservient, powerless role for the purposes of marketing your product, you try substituting in a man and see if the story board still makes sense. If it doesn't, then your campaign serves to reinforce the image of nurses as powerless creatures…If you insist on offending such a large portion of the population with the launch of your company, you may very well find that you have launched a sinking ship. **Nathalie Warmerdam**, Third-year nursing student, Ryerson University

I am outraged that you would degrade nurses with your offensive ad…We save lives, promote health and safety…This is not acceptable today or at any time. **Donna Phoenix**, RN, Thunder Bay

As a Canadian registered nurse and an intelligent, thinking woman who has seen women in my clinical practice who have been subjected to varying experiences of degradation, emotional, sexual and physical abuse I was appalled by the pathetic, immature, and frankly unintelligent theme of Sir Richard's campaign…It is most unfortunate that with the funds available to Sir Richard, he was not able to hire an advertising team that is more savvy, sophisticated and creative. **Pamela Jessop**, RN, Kingston

It is nurses' specialized knowledge, skill and expertise that supports healing and comfort when your loved one is lying in hospital extremely ill. Studies have shown that nursing care is directly linked to health outcomes of patients, and professional nursing practice is something that Canadians highly value and respect. Stereotyping nurses in this negative way is unacceptable. **Wendy Gifford**, RN, Ottawa

I have helped new moms learn to care for their newborn babies. I have cared for people after life altering illness and surgery. I have comforted patients who are dying, and cared for their bodies after they die. I have also continually advocated for more resources and better working conditions, in order to provide the best care possible for our patients…If you question our professionalism I challenge you to spend a day in any of our well-warn shoes.
Leslie Inglis, RN, Toronto

If it's nurses that you want to depict…then show how your telephone can assist a family in trouble by calling a nurse. Showing a community nurse calling a client to let them know she will be a few minutes late because she is assisting someone on the way would also be acceptable. I urge you to review your ill advised decisions to use nurses…in roles that are demeaning and insulting. **Ronald Charette**, RN, Sudbury

I doubt you would be as quick to demean lawyers, police, firefighters, physicians, or any other group that is predominantly male. I have colleagues in the UK who will also be outraged at how this misrepresents the image of nurses, as well as the image of people from the UK… I work in a field where we use cell phones regularly. We will never provide business for a company that abuses nurses and women in the way that your company has done.
Elsabeth Jensen, RNAO Member-at-Large Nursing Research

Virgin Mobile's response

Virgin Mobile sent a standard reply to RNAO members who demanded an apology for the offensive advertising campaign. The response read in part: "We in no way intend to offend you with our "cure the Catch" campaign…The character in our point-of-sale appears in a small number of our sales materials and at a limited number of retailers. It is important to note that same character does not appear in our print and television advertising campaign…We do sincerely apologize however if it was offensive to you." **RN**

by **Kimberley Kearsey**

Policy at Work

Nurses flex their political muscles, meet with MPPs

For the fifth consecutive year, RNAO members are taking politicians to work – flexing their political muscles and mingling with municipal, provincial and federal politicians on nursing turf. Building on the success of last year's *Take York MPP to Work* (TYMW) initiative, nurses across the province have extended a total of 95 invitations to 64 MPPs, 11 MPs and one mayor to participate in interactive workplace visits with RNs – a 76 per cent increase from the number of invitations sent in 2004.

Thirty-eight visits were confirmed just prior to Nursing Week. Among the participants: Minister of Health George Smitherman, the two opposition party leaders, eight ministers and 15 parliamentary assistants. Participants will tour hospitals and long-term care facilities, attend home visits, and meet with patients and nurses in rehabilitation and primary care settings to discuss key nursing and health-care issues. During their tours, politicians will see the valuable role nurses play in patient care. They will hear directly from nurses about the need for 70 per cent full-time employment, the use of nursing best practice guidelines, nurses' role in helping seniors navigate the health-care system, the role of RNs in health promotion, disease prevention and infection control, and mentoring and preceptorship opportunities to recruit and retain nurses.

Although TYMW is part of Nursing Week activities, members can arrange visits with local politicians any time. RNAO staff can help, and so can fellow members who have successfully hosted events in their own communities. Nurses interested in doing the rounds with their local MPPs should take advantage of this opportunity to get up close and personal with Ontario's decision-makers and legislators.

For more information and support, contact Jane Sanders at 416-599-1925/1-800-268-7199, ext. 237 or jsanders@rnao.org.

Competitive bidding bad for your health

In October 2004, Minister of Health and Long-Term Care George Smitherman appointed former Ontario Health Minister Elinor Caplan to lead an independent review of Ontario's competitive bidding process. As part of that review, Caplan invited health-care stakeholders – including RNAO – to present recommendations and provide positions on the competitive bidding process, which currently sees home-care services put up for tender every three to five years.

RNAO's submission to Caplan's CCAC Procurement Review describes the negative impact the current system has on home care. "Ontario's experiment with competitive bidding in home care has been a failure," it notes. "It has resulted in the following: a large shift to for-profit providers; a loss of the social infrastructure associated with not-for-profit providers; a loss of community nursing staff; and grave concerns about the continuity and quality of care."

On March 7th, RNAO submitted 11 recommendations to Caplan, outlining changes to the procurement system for home care that will increase the quality of care and the continuity of care and caregiver. Among those recommendations:

- not-for-profit providers have right of first refusal on all new home-care contracts;
- incentives for employment models that foster continuity of care and caregiver, including such human resource management benchmarks as percentage of full-time employment, length of orientation, compensation including pensions and benefits, and no elect-to-work employment relationships;
- longer contract periods;
- provincial standards throughout the RFP process, including mandatory site visits, debriefing and access to successful bids; and
- annual, arm's length client and staff satisfaction surveys and complaint processes.

RNAO met with Caplan on several occasions and we remain hopeful that our recommendations will influence her final report. For a copy of RNAO's full submission to the *CCAC Procurement Review*, visit www.rnao.org and click on *Health and Nursing Policy*. **RN**

KIMBERLEY KEARSEY IS COMMUNICATIONS OFFICER/WRITER AT RNAO.

Gunshot reporting compromises confidentiality

IN June 2004, Monte Kwinter, Ontario's Minister of Community Safety and Correctional Services, introduced legislation (Bill 110) that could impose an obligation on health-care professionals to report to police when they treat a person for a gunshot wound.

RNAO believes Bill 110 could have chilling and detrimental effects not only on patients with gunshot wounds, but also other vulnerable clients such as abused women, families and their children, and teens. In a presentation to the government's Standing Committee on Justice Policy in March, Irmajean Bajnok, director of RNAO's Centre for Professional Nursing Excellence, voiced nurses' concerns about the legislation, primarily around confidentiality issues between the RN and the patient.

Standards of Nursing Practice, as set out by the College of Nurses of Ontario, allow RNs to use their professional judgment to decide when it is in the public interest to report gunshot wounds. RNAO believes these standards are sufficient.

For more information, and to access RNAO's speaking notes to the Standing Committee, visit www.rnao.org and click on Health and Nursing Policy.

Calendar

June

June 2, 3
NURSING BEST PRACTICE GUIDELINES: THE KEY TO KNOWLEDGE PRACTICE SYNERGY
3RD BIENNIAL INTERNATIONAL CONFERENCE ON NURSING BEST PRACTICE GUIDELINES
Hilton Suites
Markham, Ontario

June 7
DISCOVERING THE LEADER WITHIN YOU
RNAO Home Office,
Toronto, Ontario

June 23
CLINICAL NURSE SPECIALIST INTEREST GROUP EDUCATION AND NETWORKING
6 p.m. – 9 p.m.
Trillium Health Centre,
Etobicoke, Ontario
Contact: Mitzi Mitchell at mitzi.mitchell@rogers.com

August

August 7-12
BEST PRACTICE GUIDELINES INSTITUTE 2005
Nottawasaga Inn
Alliston, Ontario

September

September 28
RNAO HEALTHCARE EXPOSITION 2005
Ottawa Congress Centre
Ottawa, Ontario

September 29-30
ELDER CARE 2005
4th Annual International Conference,
Hilton Suites
Markham, Ontario

October

October 13, 14, 17, 18, 19
HOW TO DESIGN EFFECTIVE EDUCATION PROGRAMS
RNAO/OHA Joint Program
RNAO Home Office
Toronto, Ontario

October 28
PEDIATRIC NURSING (PEDNIG) NATIONAL CONFERENCE
89 Chestnut Residence
Toronto, Ontario

November

November 11-12
NATIONAL NURSE PRACTITIONER CONFERENCE
Hilton Suites
Markham, Ontario

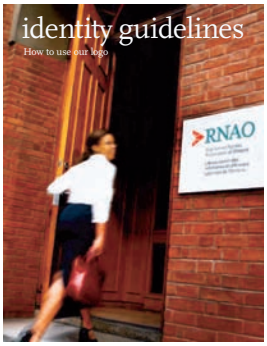
November 17-18
HEALTHY WORKPLACES IN ACTION
5th Annual International Conference
Hilton Suites
Markham, Ontario

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

Unless otherwise noted, please contact Vanessa Mooney at the RNAO Centre for Professional Nursing Excellence at vmooney@rnao.org or 416-599-1925/ 1-800-268-7199, ext. 227 for further information.

What's new at RNAO?

RNAO's (re)newed visual identity



The Communications Department is pleased to announce that RNAO launched its (re)newed logo on April 21, 2005. The department has prepared a users' manual which is available, along with the files for the improved logo, in the Members Only Section of the RNAO Web Site. RNAO has been working with a design and marketing company since last summer to strengthen the association's visual identity. At its January meeting, the Board of Directors approved the modernized logo, which was shared with assembly members the following day. We hope chapters, interest groups, members and staff will use the refined logo with pride!

Any questions about logo applications should go to Lesley Frey at 416-599-1925, ext. 210 or lfrey@rnao.org. Please note: We have taken advantage of the change in visual identity to correct a grammatical error in our name: The Registered Nurses' Association of Ontario now has an appropriately placed apostrophe after Nurses'. Please make the correction in all subsequent references.

Telementoring Program

RNAO has partnered with the NORTH Network to develop a telementoring model and tools for nurse practitioners practising in rural and remote communities as part of the Teleprimary Care Project, funded through the Primary Health Care Transition Fund. We are pleased to announce that the site is now live and available for telehealth activity.

This project utilizes telehealth technology incorporating two-way videoconferencing and electronic medical devices over a virtual private network. It helps with the purposes of NP-initiated interdisciplinary consultation, delivery of primary care services to rural/remote and under-serviced populations, and continuing professional development and mentoring support. The Telementoring Development Team has been established and its first meeting took place in early February. The team will work under the guidance of project manager Gayle Mackay through March 2006, when this project is scheduled to be complete.

For more information contact Sarah Milanes at 416-907-7964 or smilanes@rnao.org.

New Web site— rnaoknowledgedepot.ca – to provide one-stop info-shopping!

On March 1, RNAO launched a new Web site called the RNAO Knowledge Depot to give members quick and easy access to information RNAO has amassed on a wide range of health-care subjects and issues. This site of consolidated information gives members, students, health-care professionals, researchers, politicians, academics, the media, and the general public streamlined access to the analysis, research and knowledge we've generated over the years. We hope you will turn to www.rnaoknowledgedepot.ca first and frequently in your search for the latest comprehensive information on a wide range of health-care issues. Look for it today; bookmark it; and happy surfing!

CLASSIFIEDS

ARE YOU LOOKING FOR A SUMMER JOB THAT'S BOTH FUN AND REWARDING? Then a camp staff position might be just right for you! We are currently hiring registered nurses and nursing practitioners to work in our Health Centre with our physician. Nurses should be fun loving and enjoy working with children for this challenging and rewarding opportunity. Visit us online at www.manitoucamp.com. To apply, fax your resume, cover letter and references to 416-322-3635 or e-mail to staff@manitoucamp.com.

ARE YOU LOOKING FOR THE CAMP NURSE EXPERIENCE OF A LIFETIME?
Are you a registered nurse with a current College of Nurses of Ontario certificate or equivalent? Are you energetic, enthusiastic and committed to providing campers and staff with the best in health care, first aid, medication distribution, emergency treatment and health education? If you answered "Yes" to these three questions, then Camp Walden may be the place for you! Camp Walden is looking for nurses: RNs, RPNs, and new graduate nurses. Competitive camp nurse salaries, room and board, great accommodations and much more await you! For more information, visit www.campwalden.ca and call us at 1.888.254.4274.

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OLYMPIA SPORTS CAMP near Huntsville needs RNs or nursing grads waiting for registration. July and/or August. Family lodging and meals provided plus salary. Your children attend camp for free. Full use of all recreational facilities and equipment. Nightly social gathering in coaches' lounge. Health Centre Team includes one doctor, four RNs, and four athletic therapists caring for a lively community of 575 campers, staff, coaches and their families. Spend your summer with us in the heart of beautiful Muskoka. Call collect 905-479-9388.

THE OFFICE OF THE ONTARIO INFORMATION AND PRIVACY COMMISSIONER is holding seminars for health professionals on the Personal Health Information Protection Act: Timmins – Sept. 29, Location TBC. To RSVP or confirm upcoming seminar details, contact Karen Hale, 416-326-4804 or Karen.hale@ipc.on.ca. All other inquires contact Bob Spence, 416-326-3939 or bob.spence@ipc.on.ca.

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GET INVOLVED

CALL FOR SUBMISSIONS

RNAO Board of Directors' Committees 2005-2007

The following vacancies exist on Board of Directors' committees:

Member Education Committee
- Two members representing staff/continuing education

Membership Recruitment and Retention Committee
- Three members from three different chapters

Nursing Practice Committee
- One basic nursing student

Nursing Research Committee
- Two members currently conducting research as an investigator and publishing in peer-reviewed journals
- One basic nursing student

To view the Terms of Reference and requirements necessary to fill each vacancy, visit RNAO's Web site at www.rnao.org/about/committee_vacancies.asp. E-mail submissions are encouraged for all position. Interested candidates must submit their CV with a letter outlining any relevant experience and/or their interest in the position to the person(s) listed on our Web Site.

DEADLINE FOR SUBMISSIONS: JUNE 24, 2005

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

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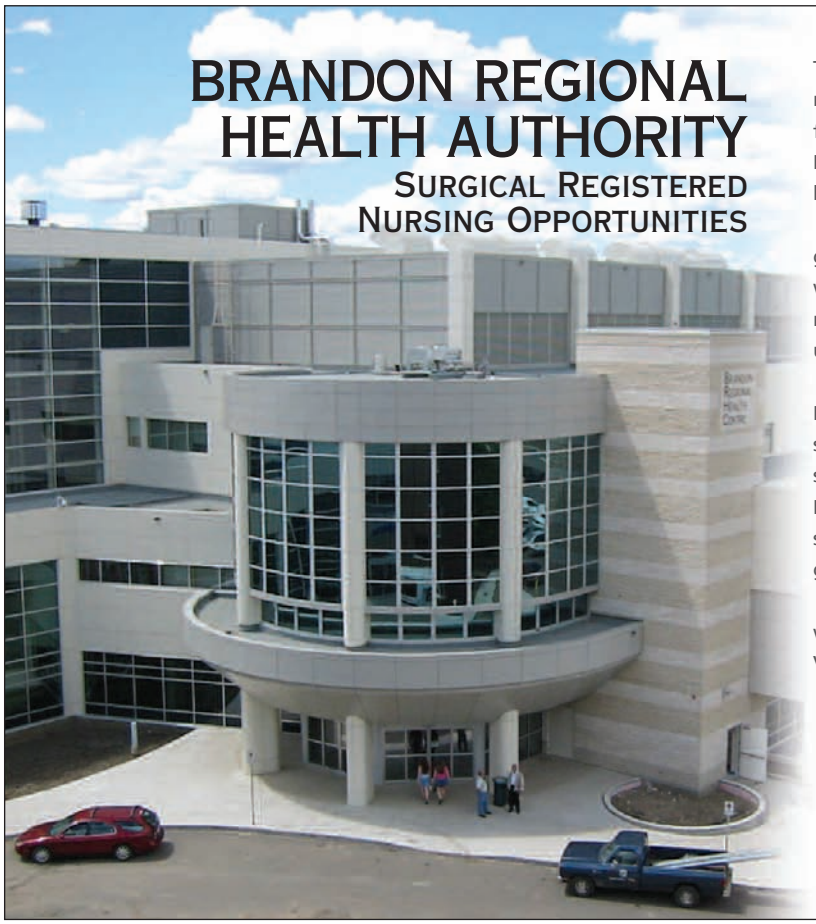

BRANDON REGIONAL HEALTH AUTHORITY

SURGICAL REGISTERED NURSING OPPORTUNITIES

The Brandon Regional Health Authority is a model region, responsive to the community through teamwork and a focus on "health." Our health services are provided to Brandon and surrounding communities – a population base of approximately 180,000.

Brandon Regional Health Centre is located within the growing City of Brandon, which offers large city amenities with a small town atmosphere! With only a short drive to nearby parks and lakes, Brandon offers art galleries, museums, golfing, skiing, cycling and many other sporting events.

With the expansion of our Inpatient Surgical Units, Brandon Regional Health Centre is currently offering surgical RNs the opportunity to work in newly developed space with innovative technology: Electronic Health Records, PACS, Order Entry. We encourage nurses to specialize in various surgical fields, such as orthopaedics, gynaecology, urology, and general surgery.

To view current postings, visit our website: www.brandonrha.mb.ca ('Nursing' or 'Ongoing Vacancy' Sections)

For more information, contact:
Cathy Morgan, Patient Care Coordinator
Phone (204) 726-2146 Fax (204) 727-9006
Email: morganc@brandonrha.mb.ca

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Fax: 416-243-3422. E-mail: hr@westpark.org.
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For further information please contact:
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DEADLINE FOR PROPOSAL SUBMISSIONS: TUESDAY, JUNE 14, 2005

Visit www.rnao.org/acpf to download RFP forms and the 2nd annual newsletter.

Contact Darren Dressler for more information: 416-907-7961 or ddressler@rnao.org

Made possible through funding from the Government of Ontario

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

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Educator:
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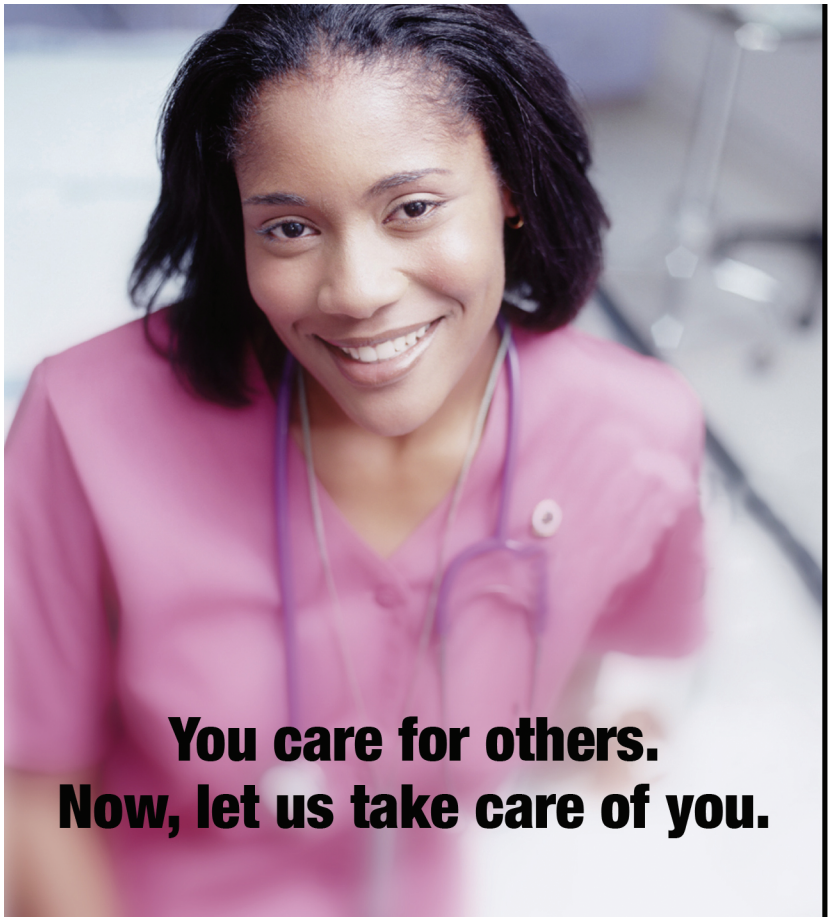
Check out our Web Site for other conferences.



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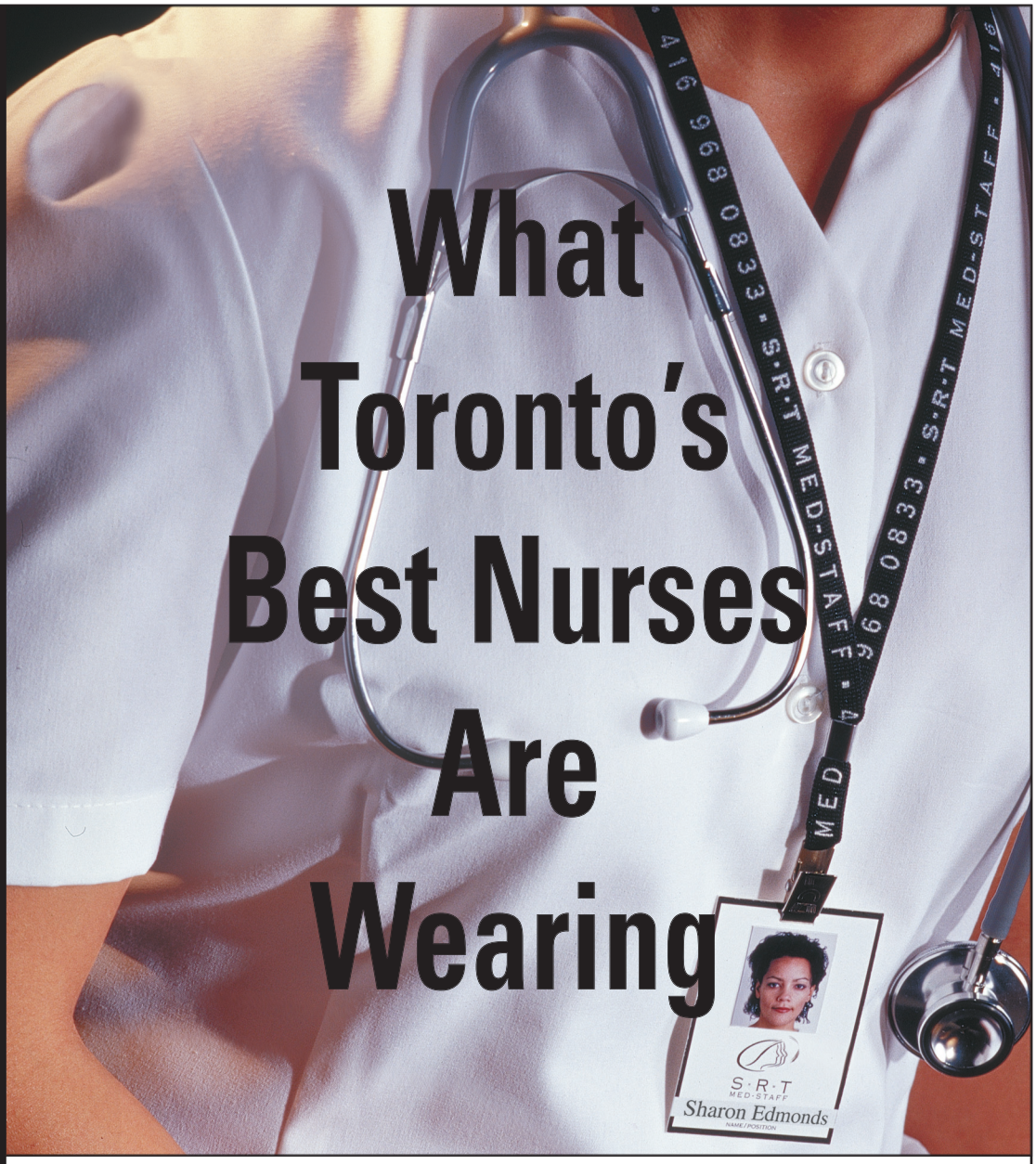

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