

Registered Nurse

NOVEMBER/DECEMBER 2005

JOURNAL

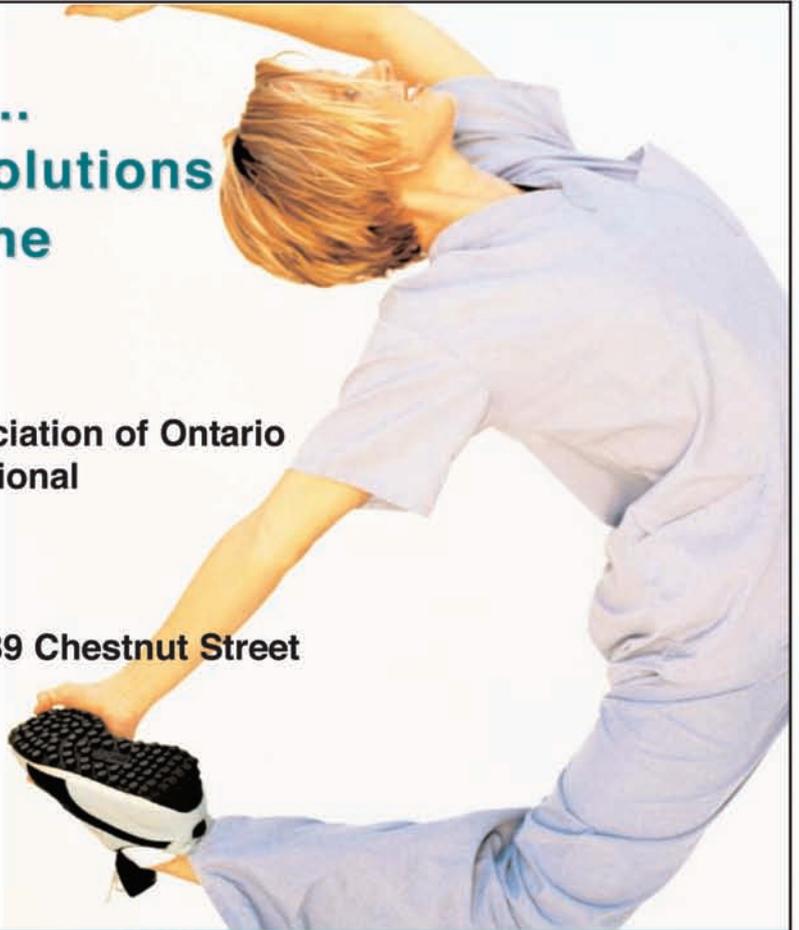
Wrestling with Wait Times



Fight or Flight... Professional Solutions to Conflict in the Workplace

Registered Nurses' Association of Ontario
RNAO Centre for Professional
Nursing Excellence

February 23, 2006
89 Chestnut Residence, 89 Chestnut Street
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"Anne helped us realize that we can be excellent mediators. I learned that I have the skills to do it! I really enjoyed the session. Too bad it was only one day."

Paul-André Gauthier
M.Sc.Inf., PhD (nursing),
RNAO Board of Directors
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Registered Nurse

JOURNAL

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Association of Ontario

L'Association des
infirmières et infirmiers
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Editor's Note

RNs embrace change, using technology to improve care



Diane Duff, principal investigator for the *East York Telehomecare Project* (pg. 16), reflects on the success of a project that helps elderly patients live more independently at home, and predicts the tiny, grey, cube-shaped patient stations RNs use to treat a handful of Scarborough seniors will soon become as commonplace as microwaves in our homes.

I may be dating myself, but I remember when microwaves started to make their way onto kitchen counters across the country, and I remember how much reticence there was at this new, novel, and unconventional piece of equipment.

Whether adorning kitchen counters or appearing in the workplace, new technological tools often cause uneasy speculation. There's always some reluctance to embrace these new tools touted as just one more thing we can't live without.

In this issue of *Registered Nurse Journal*, you'll meet several RNs who will not let trepidation with new technology get in their way of providing quality patient care. We'll introduce you to one of 11 NPs in northern Ontario who is using virtual stethoscopes and remote patient exam cameras to collaborate digitally with other health-care professionals and provide customized care to rural and remote residents in Port Loring. We'll share with you some of the solutions to shortening wait times across the province, including an innovative new government website that brings wait lines online. And we'll highlight RNAO's advocacy work over the Internet to help save imprisoned Bulgarian nurses. In our feature about children's health, we'll also reveal the troubling side of technology, and tell you how RNs are playing a role in keeping children safe from online predators.

Modern advancements in technology are vital not only to each of us living our lives, but also to each of you saving lives. As with any kind of change, it's going to take some time before patient stations and remote machinery become commonplace. Perhaps as we continue to advance, and as we try to incorporate change into our lives, we can always take comfort in knowing change is inevitable, and often good.

After all, how many times have you asked yourself: "What did I ever do without e-mail?"

Kimberley Kearsley
Managing Editor (Acting)

Casting a wide net to curb violence against women



The nursing community was shocked and saddened to hear that on November 12, Windsor RN Lori Dupont, 37, was murdered while on the job at Hotel-Dieu

Grace Hospital. She was killed by her former boyfriend, an anesthesiologist at the same hospital. Five days later, Lori's funeral was held in Amherstburg and an honour guard of 24 RNs lined the walk from the hearse to the service, each one holding a single, red rose over the casket in respectful remembrance of their colleague and friend.

Lori's tragic death, and the death of RN Lorraine Egan, 29, who was shot by her half brother in June, remind us of the pervasive abuse and violence that women face in our society – inside and outside the workplace. While violence affects all of us, Statistics Canada data for 2000 show that women make up 86 per cent of victims of sexual assault. Women also account for 85 per cent of the victims of spousal violence. And data for 2001 show four out of five victims of spousal homicide were women.

Lorraine and Lori's murders reinforce the critical importance of effective harassment, abuse and violence prevention programs everywhere, including health-care facilities. And they remind us that we need to educate people about what we can and must all do to prevent violence and abuse.

As citizens, nurses and members of RNAO, we must urge governments, employers, our own communities, and all society's institutions, including the courts, to make this a top priority. That's what RNAO called for on behalf of all nurses when we issued a public statement about Lori's murder. We expressed not only the profession's sorrow, but also our resolve to work on system

change. Members expressed their appreciation and support for that approach. We received more than a dozen heartfelt responses from members, one from a nurse in London who offered to travel to Windsor to cover the shifts of Lori's colleagues while they were at the funeral.

Members also rallied with RNAO to help bring the issue of violence against women to the public on December 6th, the *National Day of Remembrance and Action on Violence Against Women*. I attended a candlelight vigil in Amherstburg, and would like to thank Essex Chapter President Lynda Monik and University of Western Ontario nursing student Jennifer Verkoeyen for their initiative and help at the event. RNAO executive director Doris Grinspun spoke at several events in Toronto. And chapter presidents, their political action officers, and many other RNAO members participated in events in Kitchener, Cornwall, Kingston, Brampton, Ottawa, Sioux Lookout, and other communities across the province.

In their everyday practice, nurses have also shown their support for helping curb violence against women by embracing RNAO's best practice guideline, *Woman Abuse: Screening, Identification and Initial Response*, released publicly November 28. With routine screening of all women aged 12 and older, more education on woman abuse in nursing curricula, and enhanced skills and standardized approaches that nurses can rely on to help women open up, we can all do our part to help prevent further violence against women.

Studies have shown 22 to 40 per cent of women looking for help in a hospital emergency room are there because of abuse

inflicted by an intimate partner. We need to remember that we – nurses – are the first person they encounter when they enter the health-care system – whether we're in the ER, in the community, in schools, or in their homes as their friends and family. And they want – and need – to be helped.

Nurses in all sectors of the health-care system have an important role to play in providing that help not only by identifying victims of abuse, but by validating their experiences and framing abuse as a health-care issue, supporting them through physically and emotionally trying times, encouraging them to explore options for safety, and offering them access to resources that will help them protect themselves and any children who may be at risk.

The senseless deaths of Lorraine Egan and Lori Dupont serve as a poignant reminder to all nurses that we must be proactive in our nursing practice, advocating on behalf of abused

women at the bedside and beyond. We must partner with other health-care professionals, community service providers, and the justice system to get abused women the care, support and action they need. The women of this country – including nurses – need greater action and improved collaboration between hospitals, public health units, schools, police, mental health and other health-care professionals and politicians so they can live and work in safe and healthy environments. Let us never forget what is at stake if we fail to act.

Lorraine and Lori's murders reinforce the critical importance of effective harassment, abuse and violence prevention programs everywhere.

JOAN LESMOND, RN, BScN, MSN, Ed. D.(c)
IS PRESIDENT OF RNAO.

Mailbag



Seasoned and novice RNs see value in late-career initiative

Re: Windsor's late-career initiative exceeds expectations, improves patient care, September/October 2005

As fourth-year nursing students at the University of Western Ontario, we are about to enter the workforce. It is exciting to see initiatives that value older nurses who have the expertise and experience young nurses depend on. It is nice to see that hospitals are acknowledging the different roles that nurses can play. We feel that effectively retaining older nurses will help us to develop into better nurses. We hope the Windsor late-career initiative receives the necessary funding to ensure permanent roles for older nurses. Furthermore, we hope Windsor's initiative will become a model for similar programs in other hospitals. Kudos to Windsor's Hotel-Dieu Grace Hospital.

Heather Rickard and Angela Wilkinson,
Nursing Students, London

I was very happy to read your article about the Ministry of Health's late-career initiative. It means the government is finally hearing our concerns, and is using creative solutions for the retention of nurses. I only hope there is timely follow-through, and more funding. The chronic issue of the nursing shortage and retention cannot be overemphasized. The Canadian Nurses Association confirms the average nurse is 44.6 years old, and 68 per cent of all nurses are 40 or older. I feel this government initiative is particularly relevant to my nursing career. I'm in my 40s, and I do find the physical workload to be a challenge at times. If nursing positions are created for older nurses with physical limitations, there is hope for all nurses to continue to work into their 50s and 60s.

Zenia Kahan, RN, Toronto

WE WANT TO HEAR FROM YOU.

Please e-mail letters to letters@rnao.org or fax 416-599-1926.

In a memo distributed to RNAO board members at their September meeting, two Ryerson nursing students asked for understanding and assistance moving from novice to expert RN.

Memo

To: RNAO Board of Directors
From: Nursing students
Date: September, 2005
Re: Mentorship

My name is Regina B. Hernandez and I'm a fourth-year nursing student at York University. This memo is addressed to Sylvia Rodgers, RNAO's Member at Large, Nursing Practice, but we are aware it has ramifications for other departments.

Nursing students are looking forward to joining the force of nurses in the workplace and the community. Yet, in order for us to make a smooth transition from novice to expert, we wish to draw your attention towards implementing mentorship programs for new graduate nurses on a larger scale and in all levels of care. Depending on the unit and the type of care provided, embodying the role of an expert nurse takes time, proper training and a supportive environment. Due to staff nurse patient loads and a shortage of nurses, students are often thrown into the role of RN rather than being allowed to grow into the role. At the same time, we face immense stress due to the high expectations of our patients and fellow nurses.

Graduate nurses are the future of our health-care system. Many expert, passionate and knowledgeable nurses are planning to retire from the workforce in the foreseeable decade. Mentorship after graduation would enable new grads to ensure sustainability of the nursing profession. It would generate competent and confident nurses and ensure patient safety and satisfaction.

Institutions and nurses need to be made aware that we aspire to be the best we can. This transition can effectively occur if institutions and nurses make an effort to create supportive environments in which new grads can ask questions, be provided with guidance, and allowed to perfect their skills. This would enhance existing nurses' professional practice, forge teaching-learning relationships, and bond strong nursing teams on the units.

We realize that dedication, effort and a solid foundation are required on the part of graduating nurses. We also realize that willing and vital nurse-mentors need ongoing encouragement, incentives, and recognition. In return, mentorship after graduation has the capability to increase job retention and nurse job satisfaction, and therefore will facilitate recruitment for the institutions that implement and broaden mentorship programs.

Embedding mentorship programs into practice can be achieved. It would ensure partnership and collaboration between members of our profession, as well as enrich health-care delivery and patient outcomes as one generation of nurses passes the baton to the next.

Nurses offer solutions – and warnings – about wait times



For good or for bad, the latest political football to be pitched about in today's highly charged debate about medicare is wait times for medical and diagnostic services.

It will be for the good if the debate focuses on whether, why, and where we have problems with timely access to quality services that are not only medically necessary, but also keep people healthy. It will be for the good if we concentrate on what we can do individually and collectively to improve that access for all Canadians. It will be for the good if we broaden the debate to include access to interdisciplinary primary health care, home care and the basic determinants of health. And it will be for the good if that conversation with Canadians is firmly rooted in finding solutions within – not outside of – our universal, single-tier, not-for-profit health-care system.

It will be for ill if the issue of lengthy wait times is overstated and used irresponsibly to undermine Canadians' confidence in medicare. It will be for ill if wait times are used as a weapon to leverage more for-profit health-care delivery or to send patients out of province or country to get the care they should receive closer to home. It will be for ill if politicians and policy makers continue to turn a blind eye to the few but powerful for-profit pundits determined to exploit the vulnerability of ill people. And it will be for ill if a parallel system finally emerges, creating a deeper gap between society's 'haves' and 'have nots,' and decimating the public system by siphoning off the already too-few nurses, doctors, and technologists working in the public sector.

RNAO is working on all fronts to unravel the strands woven into wait times and to urge action on each of them.

RNAO is working on all fronts to unravel the strands woven into wait times and to urge action on each of them. In the fall, we called on the country's health ministers to meet the commitments their governments made when they signed the 10 Year Plan to Strengthen Health Care, including commitments to deliver the data they promised on wait times and health human resources. Your president reminded the public in a letter published in the *Toronto Star* that: "Money alone won't eliminate wait lists. That will take more health-care providers, working more collaboratively, with a better focus on disease prevention and health promotion. It will take the implementation of a successful wait list strategy that addresses what is a reasonable wait and what waits imperil the health of patients. And yes, it will take time for reforms already in progress to work, and for our system to catch up."

RNAO didn't wait for the June 9th Supreme Court ruling on *Chaoulli* to make the point that the introduction of a two-tier health-care system would exacerbate nurse and doctor shortages and result in longer wait lists. At every opportunity – royal commissions, first ministers' conferences, program reviews, standing committees, protests, back-room strategy meetings, and media conferences – we have been present, advising governments and leading advocacy efforts, using evidence, argument, and persuasiveness to secure the resources, conditions, policy and practice changes that nurses – and the public we serve – need to reduce wait times and sustain a strong, single-tier, not-for-profit health-care system.

RNAO is working with members, health-care organizations, and government health-care planners to implement practice changes to help tackle the problem of long

surgical lists. It's clear that nurses have much to contribute on this front. Nurses do everything from triaging patients toward the appropriate care, to helping patients on waiting lists navigate the health-care system, to providing nursing for patients before, during and after surgeries, to taking on more advanced roles as nurse anaesthetists or RNFAs (RN first assistants who have additional training to assist surgeons).

Nurses are not only essential to implementing the changes we need to reduce wait times; we are identifying those changes ourselves to increase timely access to high quality health care. Our cover story details the excellent work of Ontario RNs who are using their clinical expertise, organizational experience, and system knowledge to do just that. There's Valerie Zellermeier, chair of the *Surgical Process Analysis and Improvement Expert Panel*, who is helping reduce bottlenecks in surgery by ensuring all patients arrive at the OR ready for action. There is Joanna Schubert, president-elect of the peri-Operative Registered Nurses Association of Ontario (ORNAO), who is trying to ensure the most appropriate nurses are assigned to the most appropriate patients. And there's also Grace Groetzsch, the first full-time RNFA in Canada and president of RNAO's RNFA interest group, who is pushing for more RNFAs as part of the answer to easing wait times – and helping to recruit and retain more nurses.

These are only examples, but they highlight some of the contributions that our nursing colleagues are making to ensure we move from debating reductions in wait times to delivering them. And we can only do that if we protect medicare and strengthen it for all Canadians.

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

Nursing in the news

R N A O & R N S weigh in on . . .



Photo: Associated Press, AP

The Toronto Star, November 22, 2005, Letter to the Editor

Nurses do their part

Re: Guideline advises on how best to help mothers conquer the basics of feeding, and to continue with it. Nursing mothers deserve best care, Editorial, Nov. 18.

We agree with your recent editorial in support of saving a North York breast-feeding clinic. Hospital-based clinics like this one, run by Dr. Jack Newman, are part of a much-needed community support network new mothers need to start and continue breast-feeding.

Ontario nurses are also key to these front-line efforts. The Registered Nurses' Association of Ontario strongly believes that mother's milk offers the healthiest start for infants. It is now well documented that breast milk contains a perfect amount of fluid and nutrients, including valuable omega-3 fatty acids and alpha-linolenic acid, important for the development of a newborn's retina and brain.

This is why we released (September 2003) a Breastfeeding Best Practice Guideline to provide Ontario nurses with specific clinical and educational strategies to promote breast-feeding in health-care settings across Ontario. This proactive instructive aid for nurses and other health-care professionals (available online and in print), recommends exclusive breast-feeding for at least the first six months and then continuing the practice for up to two years (and beyond) while introducing complementary foods (as recommended by the World Health Organization).

The guideline advises nurses on how best to help mothers conquer the key basics of latching, positioning and assessing when your baby is full. The guideline also reminds nurses to develop follow-up plans for breast-feeding women to help them keep it up after they get home.

Nurses are doing their part to encourage mothers to breast-feed by doing what nurses do best – sharing their knowledge, expertise and caring – with nursing women and their satisfied babies across Ontario.

TAZIM VIRANI, RNAO NURSING BEST PRACTICE GUIDELINE PROGRAM DIRECTOR.

Pandemic planning

RNAO president **Joan Lesmond** talked to *Global News* about how nurses might respond to an anticipated avian flu outbreak (*CHL-TV-Toronto*, Oct. 19). RNAO member and ONA president **Linda Haslam-Stroud** also talked to *City News at Noon* about the possibility of an outbreak (*CITY-TV-Toronto*, Oct. 14).

- RNAO member and flu co-ordinator **Sheila Satchell** said a flu shot may help if a pandemic occurred during the usual flu season. "We would have as many people immunized as possible so that we wouldn't have a co-circulating of two viruses at the same time." (*The Daily Observer - Pembroke*, Oct. 21)

- RNAO member **Louise Hayes** told the *Northern Daily News* that fears of an avian flu pandemic may prompt more people to get a flu shot this year (Oct. 28).

- In separate interviews, RNAO members **Susan Ludgwig** and **Mary Anne Simpson** commented on the importance of getting a flu shot (*CKVR-TV-Barrie*, Oct. 26, *CJBK-AM-London*, Oct. 28, *CFPL-TV-London*, Oct. 30).

Standing up for strong, single-tier, not-for-profit health care

RNAO president **Joan Lesmond** and executive director **Doris Grinspun** were on-site at the annual conference of health ministers Oct. 22-23 to seek assurances from them that they will meet the commitments their governments made when they signed the 10 Year Plan to Strengthen Health Care. Lesmond told St. Catharines' *CKTB-AM* that nurses need political leadership on wait times and stopping two-tier health care (Oct. 21). Grinspun urged the health ministers to get on with the job to strengthen health care (*Global National*, Oct. 22).

- RNAO member and ONA bargaining unit president **Glenda Hubley** highlighted the dangers of private, for-profit delivery of health care. "The increased use of

For complete versions
of any of these stories, contact
Bonnie Russell at brussell@rnao.org.

for-profit agencies in the direct provision of health care seriously compromises access to quality patient care as funds are directed away from service delivery,” said Hubley, noting that privately-financed hospitals in Britain mean fewer beds and fewer nurses. Hubley urged the public to pressure the government to use public funds to build the new Sault Area Hospital (*The Sault Star*, Oct. 26)

- RNAO president **Joan Lesmond** responded to a *Globe and Mail* column that recommended “private and hybrid alternatives” to Canada’s “increasingly unsustainable” health-care system: “The views of for-profit pundits who insist that universal access to health care is unfeasible fly in the face of Canadian values.” (Nov. 16)
- In response to Health Minister Ujjal Dosanjh’s editorial “*What Would Tommy Douglas Do?*” RNAO executive director **Doris Grinspun** said: “RNAO urges both the federal government and NDP leader Jack Layton to put aside political wrangling over election writs, and begin again in

earnest to reach an agreement that will give teeth and truth to the claim that ‘all provinces affirm support for the principles of the CHA and the single-payer system.’” (*National Post*, Nov. 12)

Military nurses past and present

Renfrew Victoria Hospital (RVH) and the Department of National Defence joined forces to help military medics practice their skills while helping out the hospital. RN **Captain Christine Matthews** worked full-time for three weeks in RVH’s ER, then went to Pakistan as a member of Canada’s DART team. “It’s a win-win situation,” said RNAO member **Nancy Kelly**, vice-president of clinical services at RVH (*The Daily Observer* – Pembroke, Oct. 21).

- In interviews on *PRIME-TV*, RNAO member and nurse historian **Cynthia Toman** joined Canadian Nursing Sisters **Ida Crocker** and **Elizabeth Doe** to discuss the role of civilian nurses who volunteered during WWI and WWII. RNAO member **Major Lee-Anne Quinn**, with

the Canadian Forces, discussed what military nurses serving today do (Sept. 28).

Kashechewan’s water, health woes

RNAO member **Sandra Chapman** said E. Coli contamination problems with Kashechewan’s water problem has been ongoing since she began working there in March as an RN with Health Canada. She compared the community’s living conditions to Afghanistan and New Orleans after Hurricane Katrina. “I think it’s absolutely disgusting that this is happening in Ontario.” (*The Daily Press* – Timmins, Oct. 19)

What’s new(s) in the ER?

In response to a Canadian Institutes of Health Information study, which revealed most ER visits are non-emergencies, RNAO member **Rose Gass**, ER nurse manager at Norfolk General Hospital, said many ER patients don’t have family physicians, or can’t see them soon enough (*Simcoe Reformer*, Oct. 7).

- Last year, Windsor’s Hotel-Dieu Grace



RNAO President Joan Lesmond (left) and the Honourable Carolyn Bennett, Federal Minister of Public Health, joined the Canadian Nurse Practitioner Initiative (CNPI) on Oct. 11 to officially launch its *Be Healthy* bracelet initiative, which aims to support Canadians in practicing healthy, active living. Turquoise wristbands were created to help children, youth and adults recognize their role in keeping physically and mentally healthy.

RNAO Executive Director Doris Grinspun (third from left) provided a keynote address: *Celebrating Nursing: Learning from the past, acting in the present, and building the future*, at the Beijing 2005 International Nursing Conference in October. The Beijing Nursing Association hosted the event, and welcomed visitors from across the globe.



Hospital began tracking regular ER visitors. RNAO member **Lynda Monik** said the idea is to keep these patients healthy outside the hospital by doing home follow-ups (*Windsor Star*, Oct. 21).

- RNAO member **Margot Fitzpatrick** said Collingwood General and Marine Hospital's new electronic patient tracking system will give ER staff immediate access to patients' hospital records. "The benefits are huge, both to patients and to our team of caregivers." (*Metroland-Simcoe Division*, Oct. 21, *Enterprise-Bulletin-Collingwood*, Oct. 26)

Facing the diabetes challenge

In response to a *Toronto Star* story about the new diabetes epidemic, RNAO executive director **Doris Grinspun** reported that RNAO's best practice guideline on type 2 diabetes helps nurses provide personalized care. "As with many other emerging health-care challenges, we won't meet them without more nurses to provide health promotion and prevention, care, knowledge and expertise." (Sept. 24)

- Diabetes nurse educator and RNAO member **Anne McCarthy** said people with type 2 diabetes are less optimistic about making lifestyle changes because they have higher rates of depression than the general population. They also face challenges with

mobility, which may prevent them from being active (*The Packet & Times - Orillia*, Nov. 4).

- RNAO member **Laurel MacIsaac**, who has type 1 diabetes, told the *Toronto Star* diabetes is an expensive illness. "I still have to pay about \$150 a month for supplies, even after I get some coverage from the drug plan at one of my jobs." (Nov. 3)

Sound solutions to elder care

In response to a *Windsor Star* story about the problems at Versa-Care Place for elderly residents, RNAO executive director **Doris Grinspun** said RNAO's best practice guidelines focus on helping nurses and other health-care professionals provide the best care for seniors. Grinspun added the Ontario government responded to RNAO's lead on elder care by hiring eight regional RN co-ordinators to implement BPGs across the province. "This is the kind of investment that will set the bar high for seniors' care across Ontario." (Oct. 20)

- RNAO member **Doreen Bennink** said her business, *Seniors in Transition*, provides many options for families caring for seniors. "I help people look at all aspects of their life, and the corresponding services within their community, so that everyone can sleep at night." (*Metroland-Halton Division*, Oct. 14)

Battling breast cancer

In honour of Breast Cancer Awareness Month, RNAO member **Melody King-Smillie** shared her survivor's story. "I always figured I was going to beat it," said King-Smillie, who credited conscious monitoring as the key to the early detection of a pea-sized lump (*The Hanover Post*, Oct. 14, *Owen Sound Sun Times*, Oct. 25). King-Smillie also participated in a discussion about breast cancer with public health nurse **Karen Broker** (*CKNX-AM - Wingham*, Oct. 17).

RNAO member **Brenda Bonner**, a chemotherapy unit charge nurse at Northumberland Hills Hospital, said her mission is to treat the whole person, not just the cancer. "People with support do better. I know almost all of my patients' home telephone numbers by heart. I treat them as though they are family." (*Metroland - Durham Division*, Oct. 8)

After a decade at the corner of University and Dundas Avenues in Toronto, RNAO has moved south to 158 Pearl Street. Nursing Policy Analyst Lynn Anne Mulrooney (right) prepares for the big move. The new office is taking shape, and an open house is scheduled for Jan. 26. Please watch for your formal invitation, or come by and visit your new home any time.



On Nov. 12, RNAO's Huron chapter president Kimberly Van Wyk participated in a roundtable discussion in Clinton with Federal Health Minister Ujjal Dosanjh (left) and MP Paul Steckle. She spoke to the politicians about the importance of a single tier health-care system, the need to boost health human resources, and the necessity that all provinces be held accountable for health-care dollars handed out as part of the government's 10-Year Plan To Strengthen Health Care.



NPs use new tools for interdisciplinary care

RNAO member Terri MacDougall is the sole nurse practitioner (NP) at the Argyle Nursing Station in Port Loring, 100 kilometers south-west of North Bay and more than an hour drive to Sudbury. Fortunately for her patients, she is also one of 11 NPs in northern Ontario who are embracing their passion for primary health-care reform by participating in the *Teleprimary Care Demonstration Project*, an initiative that electronically links patients in rural and remote communities to a multidisciplinary team of health-care professionals.

“When you have a complex patient situation and you’re by yourself...you have to realize you have limitations within your scope of practice. This (project) helps facilitate the patient getting the care they need,” MacDougall says, adding that *Teleprimary Care* also addresses the issue of wait times for people in isolated areas. “It’s reduced travel time for patients and increased access to multidisciplinary care.”

Launched in the fall of 2004, the project is managed by NORTH Network, a not-for-profit, government program funded by the Ministry of Health and Long-Term Care’s Primary Health Care Transition Fund. The program uses technology to connect more than 200 urban and remote health-care sites across Ontario. The *Teleprimary Care Project* is one of many projects under NORTH Network’s umbrella, and it’s one that offers health-care professionals access to videoconferencing and virtual stethoscope and patient exam cameras through which they can provide primary health care to patients in three geographically remote areas known as clusters. The *North West Cluster* includes the NorWest Community Health Centre in Thunder Bay and two satellite centres in Armstrong and Longlac. The *North East Cluster* is based out of the West Parry Sound Health Centre, linking physicians in Parry Sound and Sudbury to nurses like MacDougall and others in Britt, Pointe au Baril, Rosseau and Dunchurch. And the *Eastern Cluster* links NPs in Keene and Havelock with physicians in Peterborough and Apsley.

Patients in these communities, who may be hours away from the nearest hospital, and days – even weeks or months – away from face-to-face appointments with physicians and specialists, can now rely on NPs to collaborate digitally with doctors, other NPs and RNs, and specialists to ensure quality, customized and consistent care. That means patients also save money and stress by staying close to home, and they can potentially receive care in a more timely fashion. MacDougall says one of her patients needed a psychiatry appoint-

ment and was able to see a specialist through NORTH Network in one month. To get an in-person appointment in Sudbury, it would have taken at least three months for a non-acute consultation.

This project also offers NPs and patients peace of mind.

MacDougall describes one situation with a young patient who had undergone surgery at the Hospital for Sick Children in Toronto.



“Rural and remote residents can rely on NPs to collaborate digitally with doctors, other NPs and RNs, and specialists to ensure quality, customized and consistent care.”

His parents, who brought him home to recover, weren’t sure if he was healing properly. “I had him come in and I wasn’t sure if what I was seeing was normal,” MacDougall admits. “So I got on the phone with the urologist at Sick Kids and we arranged for a consult that day through the NORTH Network. That helped the mom feel better...it helped me feel better.”

A collaborating partner, RNAO was involved in NORTH Network’s Nov. 8 *Teleprimary Care Demonstration Project* launch, which was focused around a mock consultation in Havelock. “Nurse practitioners are thrilled to be participating in this project,” Executive Director Doris Grinspun said. “They are clearly keeping their eye on the prize – and the prize here is better access to quality health-care services, no matter where you live in this province.”

In addition to promoting primary health-care reform and providing better access for patients, the *Teleprimary Care Project* is also helping NPs and physicians in rural and remote communities overcome some of the professional isolation they experience on the job. “It helps knowing you can

make a referral to a specialist, or you can get online with your consulting physician to gain support in your everyday practice,” MacDougall says.

The project also offers NPs an electronic environment in which they can mentor one another, and participate in professional development. MacDougall completed her first professional development session on Nov. 25, focusing on stroke management and prevention.

According to Gregg Brown, *Teleprimary Care Project* Manager, the project is slated to end in March, 2006. It is expected the equipment will then be gifted to each site.

“I love it. I think it’s just super,” Kerrigan McDonald, 57, says. “Having the clinic in the community has been really good.” A patient at the Argyle Nursing Station, McDonald says she prefers working with MacDougall and seeing the physician via videoconferencing. “It’s just as good as seeing the doctor in person,” she says.

Before MacDougall was introduced to the technology, which she says she uses at least once a month, she was collaborating with a physician over the phone. “Now we have something to augment that,” she says. “It is, in my mind, not just augmenting; it’s enhancing the service that we can provide.” **RN**

KIMBERLEY KEARSEY IS ACTING MANAGING EDITOR/COMMUNICATIONS PROJECT MANAGER FOR RNAO.

Wrestling



with Wait Times

Nurses weigh in with solutions to beat the clock and provide quicker quality care.

According to an Ipsos-Reid poll conducted in 2004, two-thirds of Canadians felt they waited too long for health services over the previous year. That finding begs several questions. How long is too long? And, as RNAO president Joan Lesmond asked in a letter-to-the-editor published in the *Toronto Star*, what is a reasonable wait time, and which waits imperil patients' lives? There may not yet be clear answers to those questions (though the recent announcement of pan-Canadian benchmarks for wait times for selected services will help answer some of them down the road), but one thing is clear. Whether wait times are the problem or simply the symptom of larger access issues, Canadians are watching the clock and losing patience with politicians who don't push for quicker action on reducing wait times.

Since the 2003 First Ministers' Accord on Health-Care Renewal, which entrenched timely access to health services as a goal for all provinces and territories, headlines about surgical wait times have been splashed across the front pages of newspapers. The coverage increased after June 9, 2005, when the Supreme Court of Canada found that Montreal-resident George Zeliotis' year-long wait for hip replacement surgery violated the Quebec Charter of Rights and Freedoms. Since then, the case has come to be known simply as "Chaoulli" after a Quebec physician, Dr. Jacques Chaoulli, a co-appellant in the case who hopes to open a private hospital. The decision applies only to the province of Quebec, but it has been widely used by proponents of two-tier health care who are watchful for new markets to sell their wares.

RNAO president Joan Lesmond and executive director Doris Grinspun were in Ottawa when Canada's premiers and territorial leaders reached a \$41 billion health-care deal with the federal government that included a \$5.5 billion Wait Time Reduction Fund. This deal requires all provinces to

provide evidence-based, medically acceptable benchmarks for wait times in cancer surgeries, diagnostic imaging, joint replacements, and sight restoration by the end of 2005. By March, 2007, meaningful reductions in wait times must be achieved coast-to-coast-to-coast.

RNAO wants to remind the public and the provinces' political leaders to seek solutions beyond doctors rushing to surgery, and remember that access to care, particularly primary health care, shouldn't suffer because of a focus on hospital-based surgeries. Wait times are a symptom of larger health-system problems that stem, in part, from too few health human resources. Last October, former Health-Care Commissioner Roy Romanow reiterated this point when he told the Canadian Press that measuring wait times may be a concrete way of demonstrating accountability to the public, but he reminded politicians it's perhaps more important to keep investing in health human resources.

In the midst of the federal-provincial political and policy debate about resources and reform, nurses must become more vocal about how their work with patients in communities and hospitals can help push the hands of the wait time clock forward.

Indeed, RNs have the knowledge, both clinical and political, to make an enormous contribution to reducing wait times. They triage patients toward appropriate care, help patients on waiting lists navigate the system, provide nursing care for patients before, during and after surgeries, and assume more advanced roles as nurse anaesthetists or registered nurse first assistants (RNs who have additional post-diploma or degree training to assist surgeons in and out of the OR).

RNAO has long advocated for better use of RNs in advanced practice roles as a way to decrease wait times.

Dr. Alan Hudson, lead of Ontario's wait time strategy, says the province is working on reductions

between the time surgery is established as a care option, to the time it is completed. His focus is on what he calls the 'Big Five' areas: cancer surgeries; MRI and CT scans; hip and knee replacements; cataract surgery; and cardiac procedures. He says many jurisdictions start measuring wait times at the surgical stage of care because it's the easiest to track.

In October, Hudson oversaw the launch of a key initiative in Ontario's wait time strategy: a new website that reports on waits for the 'Big Five' procedures in hospitals across the province. He spoke to RNAO's board of directors in September about the new initiative, and how it will keep patients involved and updated on the government's progress. Visitors can search the site (www.health.gov.on.ca) by proce-



Dr. Alan Hudson, lead of Ontario's wait time strategy, met with RNAO this fall to discuss how nurses in advanced practice roles can help decrease wait times.

Left to right: Patricia Mlekuz, 2005 Hub Fellowship Winner; Grace Groetzsch, Chair of RNAO's Registered Nurse First Assistant Interest Group; Hudson; RNAO Executive Director Doris Grinspun; and Sue Matthews, Provincial Chief Nursing Officer.

dures or location to find out how long the queues are, whether they live in Kirkland Lake or Kingston.

Not everyone welcomes the website's launch with open arms. The Ontario Medical Association said the new online resource would only create more work for already harried family doctors, who may not feel comfortable referring patients to surgeons they don't know. But Hudson says the website's goal is not to help physicians, as much as it is to bring access to surgery – and knowledge of wait times – to the patient. That means Ontarians don't have to rely on the names in their family doctor's Rolodex. Ultimately, Hudson would like to see patients triaged into appropriate centres rather than directed to certain surgeons.

"This is not about doctors, it's about patients...this is about empowering patients and giving them choice," Hudson says.

The few but powerful pundits for private care have claimed that the only way to provide patients with real choice is through a parallel system. Armed with evidence and passion, RNAO continues to expose the virtues and values of not-for-profit health care, reminding politicians it's the only sustainable system that will reduce wait times and improve access to care for everyone.

"The question is quite simple and quite basic: what kind of society do we want?" asks Grinspun. "Do we want a just and fair society with as much equal access to care as possible; or, do we want a two-tier society? If you can afford to pay, you will get surgery faster. But everyone else will get slower care and the public system will be haemorrhaged of its best professionals."

Terry Sullivan, president and chief executive officer of Cancer Care Ontario, cautions that just because some countries have turned to private-sector solutions to reduce wait times doesn't mean Canada should follow suit. While the UK's National Health Service (NHS) paid private-care providers from Europe and North America to provide diagnostic and treatment services, Sullivan is not certain a similar approach is necessary in Canada. He says there are enough general surgeons in Canada to complete the procedures in reasonable time frames. He also says it's more a question of allocating resources so that doctors and nurses are used appropriately and to the full extent of their abilities. Sullivan notes that surveys among Commonwealth countries show Canadians complain more about access to care than in other countries, and the Chaoulli case has finally alerted governments to the fact that they must start looking for solutions within the public health system – solutions that include nurses.

RN Valerie Zellermeier, program director for perioperative services at St. Michael's Hospital, agrees. Zellermeier is lead of the 23-member *Surgical Process Analysis and Improvement Expert Panel*, struck in 2004 to recommend improvements to make surgeries in Ontario hospitals more efficient. The panel's report on surgical efficiencies was submitted to Hudson in June.

Zellermeier says the document, entitled *Report of the Surgical Process Analysis and Improvement Expert Panel*, highlights how nurses are an essential part of a patient's

journey. By providing even minor-surgery patients with pre-operative information, nurses ensure patients arrive in the OR ready for action.

"The pre-operative assessment is so critical. If we don't do that, and don't do it well, then inevitably there are cancellations and delays because the patient isn't correctly prepared," Zellermeier says. Procedures can be cancelled or delayed when patients don't have a nurse to help them get ready for surgery, causing a ripple effect of inefficiencies that can increase the wait times for others.

Joanna Schubert, president-elect of the peri-Operative Registered Nurses Association of Ontario (ORNAO), says a shortage of peri-operative nurses in Ontario makes boosting the number of surgeries difficult. Schubert says the Ottawa Hospital, where she works, has received part of the \$240 million in funding from the Ministry of Health and Long-Term Care (MOHLTC) to boost the number of surgeries it performs.

She says the hospital has opened more surgical rooms, and allocated extra time to do more hip and knee replacements and oncology surgeries, but admits the general nursing shortage, and the extra education peri-operative nurses require, make it hard to meet the goals set out under the funding. She is relying on part-time RNs who have agreed to work extra hours.

In her position with ORNAO, Schubert says she has heard many stories of nurses feeling the pressure to perform more surgeries: "I think everyone is struggling with it a little bit...there just aren't enough people in peri-operative nursing."

The expert panel's report also notes that nurses can make a difference in decreasing wait times by taking on roles that bring them front and centre in the peri-operative process. For instance, nurses can become RNFAs. Zellermeier says the RNFAs are particularly beneficial in smaller community hospitals where they alleviate the burden on family physicians by assisting during surgeries and giving those doctors more time to care for their own patients.

As the first full-time RNFA in Canada, Grace Groetzsch has plenty of experience with the role, and its ability to ease wait times. She says the ideal situation is to build continuity by pairing RNFAs with an individual surgeon full time. She says when two professionals work closely together, their work during surgery is much more efficient.

"It's like dancing," she says. "If you've got

two people dancing all the time together, they understand each other's subtle idiosyncrasies and therefore the picture they present is very smooth. If you're constantly changing partners, it doesn't look as nice."

Groetzsch, who divides her own work time between cardiac and obstetrics surgeries at Trillium Health Centre, says the government's funding model for RNFAs, of which there are about 200 in Canada, is keeping them out of the OR. Currently, hospitals pay RNFAs' salaries. When a general practitioner assists with surgery, the cost is billed to OHIP and the hospital is not financially on the hook. Groetzsch is adamant that RNFAs are not meant to replace physicians in the OR, but the role can allow professional development for RNs. Groetzsch says many nursing students are interested in taking on advanced roles once they graduate, and having more options available to them will draw more into the profession.

Those recruits are vital to ensuring Canada's aging baby boomers, who will make up a significant portion of patients in the coming years, don't get stuck playing the waiting game. Grinspun says creating a strong health-care system that provides opportunities for RNs to grow will ultimately lead to more nurses, which means more resources to improve access and lessen wait times.

"The more opportunities there are for people, the more will come. It will become both a retention strategy and a recruitment strategy," she says.

Grinspun also says: "Nurses are vital at all stops along a patient's journey through the health-care system. From understanding determinants of health and working with governments, communities and individuals to keep people healthy, to easing their access to primary care, to the day they enter the OR, to the time they are rolled into the intensive care units and/or onto medical/surgical floors after surgery, and then hopefully back into their own communities."

Ensuring a timely and seamless health-care experience for patients is the main focus of Lesley Robertson-Laxton's work. The cardiology acute-care nurse practitioner helps cardiac patients at Guelph General Hospital get care through the provincial Cardiac Care Network. Set up in 1995, the network helps patients access wait times data from 13 regional care centres across Ontario.

Robertson-Laxton does everything in her power to ensure patients get through

the system as efficiently as possible. If a surgeon requires extra tests or X-rays, she can order them and possibly have them completed the same day. That, she says, speeds up the surgical process. Being in the thick of things also enables Robertson-Laxton to give patients what they crave most: information about when they can expect to be on the operating table.

"Patients have nothing to do in hospital while they're waiting," she says, adding they have extra time to think and worry about

promise in the government's plan to establish 52 family health teams, and to spend more than \$70 million for 22 new community health centres and 17 satellite centres where patients can access interdisciplinary care.

Once patients enter the health-care system, Kirenko says NPs can help them move through the process. NPs can order tests that may diagnose osteoarthritis in a patient with severe hip pain, provide a pre-operative assessment, and then follow-up care. According to Kirenko, more and more peo-

Waiting for a place to call home

While many Canadians worry about unreasonable wait times for hip replacements, or for appointments with local physicians and NPs, others are waiting for something far more basic and essential to health: a place to call home.

According to Kathy Hardill, one of the first street nurses in Toronto and an outreach NP at Regent Park Community Health Centre, the wait for subsidized housing, which can be anywhere from eight and 10 years, is truly life-threatening for some of the province's most vulnerable.

"We know homeless people have much shorter life expectancies," says Hardill, adding that many homeless have chronic physical and mental health problems. She says the chaos that comes with living on the street makes it difficult for this population to get the health care they need. Homeless people often only seek care when an acute condition sends them to the ER. While no one can be refused emergency treatment, Hardill says not everyone has proper follow-up care.

"We have universal health care, which means everyone can walk into the ER and get assessed, but we don't have a universal system to carry out your health-care plan," she says.

Hardill says the solution is to get roofs over people's heads. She says more affordable housing is needed, but until those structures are standing, rent supplements could be used so homeless people with serious illness can move into some of Toronto's many vacant apartments.

As she waits for the political will to improve supportive housing, Hardill helps the homeless fill prescriptions, devise medication schedules, and tend to wounds. She says she is concerned that the province's push for more home-based care – including withdrawal from drugs and alcohol, recovery from outpatient surgery, and palliative care – will leave those living on the street behind.

"We know that in the next 10 to 15 years, because so many homeless have chronic conditions, they are going to be dying in (unprecedented) numbers," Hardill says. "We need to make sure vulnerable people die with dignity."

Hardill wants to ensure these people aren't forgotten as the province and country explore solutions to wait times. She is part of a working group that meets regularly to push the government for hospice care, and says these people deserve access to as much health care and proper housing as any population. **RN**

the surgery. "If there's all that uncertainty, it makes the anxiety even higher."

But many patients worry about more than just surgery; they worry about accessing home or community care once they're out of the hospital. Other Canadians worry about accessing primary care before they're even in a position to expect surgery. Willi Kirenko, president of the Nurse Practitioners' Association of Ontario (NPAO), says NPs are central to improving access and reducing wait times. Kirenko, a primary health-care nurse practitioner in Chatham-Kent Health Alliance's ER, sees

ple are looking for that special treatment.

In the coming months, Canadians will be tuned into governments' plans to reduce wait times. But they're not just watching the clock. They're also looking for health promotion, disease prevention and reasonable access to health professionals working in a universally-accessible system that provides high-quality care whether patients need more timely access to an annual checkup, a new hip, home care or a home. **RN**

JILL SHAW IS ACTING COMMUNICATIONS OFFICER/WRITER AT RNAO

David MacDonald collapsed while mowing his lawn on a warm June day last year. He fell hard, hitting his head on the cement porch, but somehow managed to find his way inside the house. His panic-stricken wife saw the blood and called 911 immediately. The 66-year-old later discovered his heart wasn't pumping blood properly, it was just vibrating, and his left ventricle wasn't thrusting with its normal oomph. After some tests, he had a pacemaker installed at Toronto's St. Michael's Hospital, and has been taking medication and making regular trips to the cardiologist ever since.

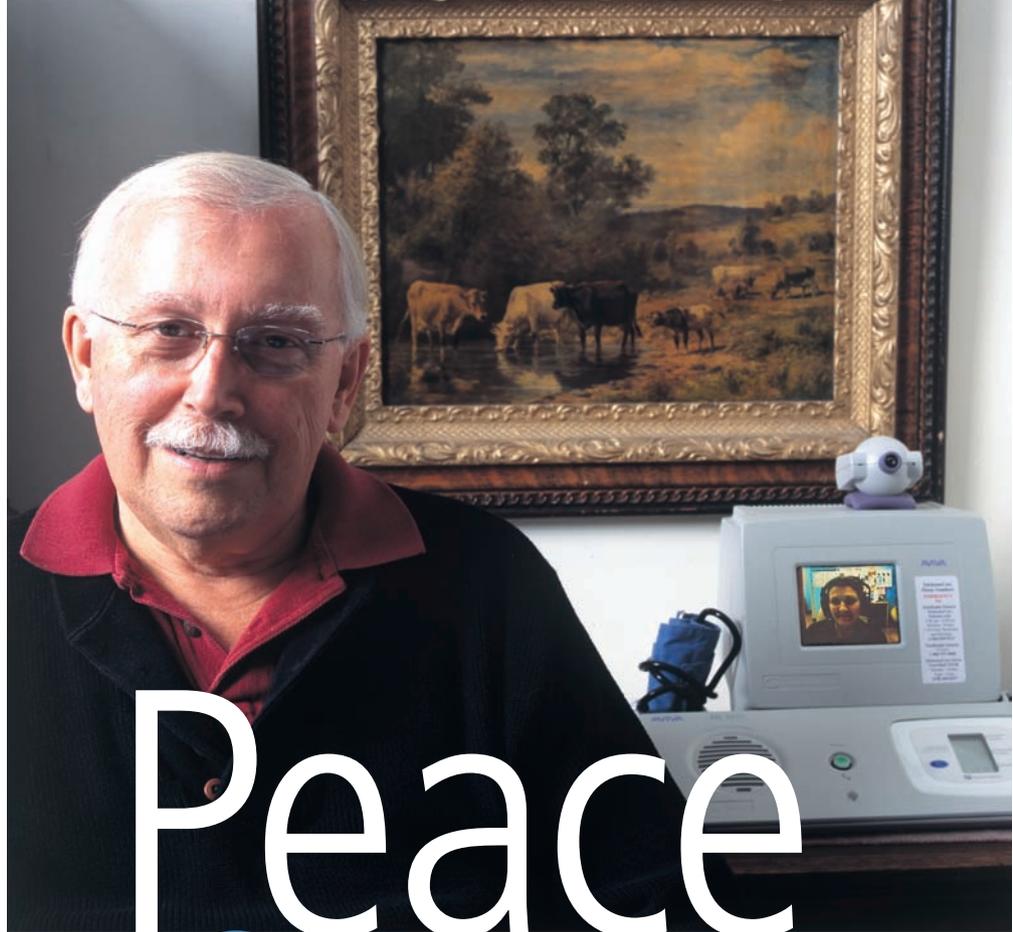
"There's a tendency to be a little depressed after a cardiac incident," he says. "(You wonder), 'what does this mean for my life?'"

Fortunately for MacDonald, the *East York Telehomecare Project*, launched two years ago to improve outcomes for patients with chronic illness, has helped him adapt to his new reality. Every two weeks, the retired school principal meets with RN Lisa Sparrow. MacDonald sits in his dining room and talks with Sparrow, who is four kilometres away at Toronto East General Hospital (TEGH). When Sparrow calls him at a designated time, all MacDonald has to do is push a button on the tiny, grey, cube-shaped patient station. The unit includes a blood pressure cuff, stethoscope, weigh scale, oxygen saturation machine, and a small screen through which Sparrow can peer into MacDonald's world, asking him questions about his blood pressure, his diet, and his exercise program. And, since the unit is now a part of MacDonald's dining-room décor, he can also monitor his own blood pressure and weight whenever he likes, increasing his confidence and his ability to live independently.

Helping the elderly live as independently as possible was part of the thinking behind the project, a partnership between several east-Toronto health-care practitioners, some of whom presented at RNAO's fourth annual international conference on elder care in September. Principal investigator Diane Duff says she wants to improve outcomes for patients with chronic illness while monitoring their experiences. The RN and York University nursing professor says telehomecare patients are far more likely to get the care they need and many of them learn as much as possible about their condition.

"Very few patients that we're following need to be admitted to the hospital," Duff says. "Between the patient self monitoring and the monitoring being done by nurses, they're just not having problems with their diseases. That's a huge benefit to the system and to the patient."

Telehomecare patients are referred from: TEGH; Woodgreen Community Centre, a Toronto supportive seniors housing complex;



Peace of Mind

AT THE PUSH OF A BUTTON

Community Outreach, a centre for mental illness and addiction survivors; and the East York Community Care Access Centre. Home-care patients and those referred by TEGH have a unit in their homes and are able to monitor their own health 24-hours-a-day. Those living at Woodgreen and Community Outreach connect with nurses with the help of volunteers or case workers who bring the patient station to them. Duff says even though these patients aren't able to constantly monitor their own health the way MacDonald can, the program provides continuity of care for people who may not be eligible for home care, and can't visit a health-care practitioner without arranging for special transportation.

"It gives a real opportunity for the nurse and the patient to interact on an ongoing basis. It promotes teaching patients to be better health managers of their own disease," says Duff.

If patients do find themselves in trouble, those with stations at home have the added insurance of being able to call Telehealth Ontario, whose nurses take the calls on a special phone line and ask patients to take their own vital signs. Duff says this capability saves a trip to the ER, but so far it's only been used twice, a testament

to the confidence the clients have using their machines.

Keeping people out of the ER is the part of her job Sparrow likes best. Her 25-year career in hospital nursing has given her a good eye for what to look for to prevent hospital admissions. "People don't take medications right, they push themselves too far and don't rest properly. They end up in the ER, the last place they want to be. I'm so happy to be able to ask them these questions and sort through these things in the comfort of the patients' homes, before they end up in emerg."

Sparrow is one of two TEGH nurses seeing telehomecare patients part time. She visits about 30 patients a week, many suffering from multiple chronic conditions, including chronic obstructive pulmonary disease, congestive heart failure, and diabetes. She says the telehomecare technology was fairly easy to learn. And most of what patients need to know is found in two buttons: one allows them to do things like take blood pressure; the other picks up the phone so they can begin their chat.

Telehomecare allows Sparrow to see patients in a unique way. When she meets with patients, she listens to their heart through a stethoscope patients apply themselves, discusses the foods they're eating, and answers questions about anything that might be troubling them.

Scott Daniluk, a Toronto home-care RN, says patients using telehomecare are curious about their condition, so he has to stay current on the latest treatments. He's developed the skills to meaningfully

RNs partner with elderly patients on a project that uses technology as an empowerment tool, and holds the promise of independent living and proactive, patient-centred care for people coping with chronic illness at home.

explain illness and health promotion to patients. Daniluk sees about 15 patients a week through the computer screen on the clinician station he keeps at home. This lets him attend to patients on their schedules, even if that's early in the morning or late at night. And everyone loves the system.

"Clients feel like they're receiving cutting-edge treatment," he says. "It gives them a sense of security...it empowers them."

Daniluk says the technology also offers patients an extra sense of security. Through the telehomecare camera, he recently saw a man with a swollen elbow. Concerned, Daniluk arranged to visit him in person the next day, and recommended follow-up care.

According to Ray Applebaum, a social worker, maintaining that level of human contact is essential to any senior's care. Applebaum is a member of the RNAO-led *Elder Health, Elder Care Coalition* that is advising the provincial government. He is also the executive director for *Peel Senior Link*, an agency that provides personal support workers, homemaking support, and health services to seniors in supportive housing. He says while telehomecare offers an opportunity for people to take charge of their own health, he cautions

against it replacing face-to-face exchanges.

"It's the human contact and the connection we make as individuals that really begin to make the differences in people's lives. Technology is secondary. I don't think it can ever be viewed as primary."

Applebaum says it's beneficial for the older population, many of whom live alone, to have the social interaction visiting a doctor or nurse brings. He says he would never want to completely replace human contact with technology. But innovations like telehomecare could fit into the province's health-care transformation plan if they

EXPLORING ELDERS' MENTAL HEALTH THROUGH FILM, FICTION

Behind every patient with Alzheimer's disease or dementia, you will find unique stories and experiences. Award-winning filmmaker Allan King, 75, explores those human experiences in a documentary, filmed in 2004 at Toronto's Baycrest. Entitled *Memory for Max, Claire, Ida and Company*, it captures the heart-wrenching reality of an elderly woman who must be told about her friend's death over and over again, and of a mother who no longer recognizes her daughter.

King says the inspiration to make *Memory* was threefold. He wanted to learn more about the inevitable death and dying process. His own mother battled Alzheimer's disease and, while making a 2003 drama about palliative care, he met an Alzheimer's patient who ignited his fascination and inspired him.

He says *Memory* highlights the compassion nurses have for their patients: "There's a different interaction between each nurse and each resident."

Catherine Kohm, director of long-term care nursing at Baycrest, will use a DVD version with commentary by psychologists and social workers to help teach health-care professionals and families about Alzheimer's disease.

RNAO board member Tricia Stiles, a clinical nurse specialist in geriatrics at the Wellington-Dufferin CCAC, agrees that using media to probe the relationships between caregivers and patients can be beneficial for nurses. Last fall, she and her colleagues at Hamilton's Regional Geriatric Program Central (RGPC) realized many health professionals were missing signs and symptoms of another prominent mental health concern for the elderly: delirium. So she and Cathy Sturdy-Smith, geriatric resource consultant for Wellington-Dufferin, created a case study of an 82-year-old fictional character named "Mrytle."

An actor who plays Mrytle visits nursing schools and organizations to help RNs understand the challenges of working with dementia patients. She engages RNs in role-playing exercises and provides instant feedback about the care she's received. Travel costs may prohibit Mrytle from visiting organizations outside Hamilton, but Stiles says a video of Mrytle's experience will soon be available to anyone. Stiles says these stories can help nurses empathize with patients the way textbook learning can't.

"I'm a big fan of that kind of education," she says "It doesn't have to be all quantitative – it's about stories."

Memory airs Feb. 15 at 9 p.m. and Feb. 19 at 10 p.m. on TV Ontario. To find out more about Mrytle, contact Stiles at tricia.stiles@wd.ccac-ont.ca. RN



“Clients feel like they’re receiving cutting-edge treatment...it gives them a sense of security...it empowers them.”

are used by family health teams to check on patients between visits. And he acknowledges that as the tech-savvy baby boomers and their children grow older, systems like telehomecare are likely to become more prevalent.

Since its inception, the *Telehomecare Project* has received funding from several sources, including the East York CCAC, TEGH, CANARIE (a national, non-profit Internet development organization), Ontario Innovation Trust, the Canadian Foundation for Innovation and, most recently, the Ontario Wait Times Strategy. With the latter monies, nurses at TEGH are working with physiotherapists, occupational therapists and pharmacists to determine if hospital stays

following hip and knee replacements and fracture surgeries can be reduced among patients with pre-existing chronic conditions. Using the unit’s camera, the physiotherapist looks at the joint while the nurse monitors the patient’s health. Duff hopes to secure more funding from the Canadian Institutes of Health Research to compare the

cost of telehomecare to traditional care. She knows the project saves health dollars, but wants the numbers to prove it. She hopes that evidence will help the project grow to provide services like speech pathology or post-stroke care in remote communities.

“I think this is the transformation you’ll see over the next 10 years,” Duff speculates. “We’ll all have one (of these units) the same way we all have a microwave. It will become a normal way of delivering health care.” **RN**

JILL SHAW IS ACTING COMMUNICATIONS OFFICER/WRITER AT RNAO.

DELIRIUM ACTION RESEARCH: A SUSTAINABLE BEST PRACTICE APPROACH

Although research shows delirium in older adults is a health emergency, elderly patients continue to be misdiagnosed and under-diagnosed in 32 to 67 per cent of cases. Mortality rates associated with delirium among the elderly range from 10 to 65 per cent.

Our experiences as nurses who provide care to older adults corroborated these research findings, and led us to develop a plan to address the problem. We would like to share our community hospital’s approach to identifying the risks associated with delirium, and the steps taken to increase identification and reduce mortality for hospitalized older adults.

In March 2000, the Cornwall General Hospital, currently the Cornwall Community Hospital, launched *Delirium Action Research* to assist nurses in identifying and appropriately responding to delirium by integrating delirium best practice into existing nursing structures, daily activities and documentation.

Initially, the delirium resource nurse role was established to educate other nurses, but we learned that education alone did not reduce the risk of delirium. We concluded that high patient acuity meant that nurses were unable to take on additional nursing risk assessment activities.

Mental status assessments, conducted by nurses, were identified as basic to detecting and monitoring the fluctuating course of delirium. A systemic clinical, educational and organizational strategy was also needed to sustain delirium best practice and minimize the risks for morbidity and mortality.

Our goal was to establish policies and procedures to support earlier identification of delirium. We remodeled systems, targeting delirium best practice towards the nursing staff, patients, families and physicians. We implemented the following:

- a delirium admission risk assessment tool to identify elders at risk;
- a mental status document and guideline to prompt nurses to record changes in behaviour, affect and cognition – hallmarks of delirium;
- a delirium policy to guide nurses on the actions necessary to manage delirium;

- routine orders for medical assessment with a ‘decision tree’ to help nurses consult with physicians, assess delirium, and develop an intervention plan;
- an online delirium self-study guide with case study AV resources targeting nurses;
- a delirium information pamphlet distributed to all hospital units and all pre-operative patients and their families; and
- biannual delirium pharmacological management updates.

Chart audits indicate increased identification of mental status changes in 96 per cent of cases, and an eight per cent increase in delirium diagnosis by physicians. The on-line delirium self-study curriculum, with 24-hour accessibility, has addressed the problem of staff access to delirium education sessions. Annual performance appraisals now include successful completion of the delirium curriculum. And the anecdotal evidence of the pamphlet distribution to all units and pre-operative patients has been positive.

This comprehensive approach is sustainable, of minimal cost, and can be adapted to all health-care settings. Nurses at Cornwall Community Hospital are demonstrating increased knowledge of their patients’ mental status, and are referring to behaviour, affect and cognition using the word ‘delirium’ rather than the word ‘confusion,’ which is a pivotal step in minimizing ageist views towards older adults.

Hospitals and educational institutions across Canada have used Cornwall’s approach and accompanying documents. The project is also referenced in the 2004 RNAO Best Practice Guideline: *Care Strategies for Older Adults with Delirium, Depression and Dementia*. The delirium best practice approach was presented at the National Best Practices Conference of the Canadian Coalition for Senior’s Mental Health, September in Ottawa. **RN**

DEBORAH BURNE, RN, BA, (PSYCH) CPMHN(C) IS AN EDUCATOR AND CONSULTANT IN GERIATRICS AND MENTAL HEALTH. KIMBERLY PETERSON RN, BScN, MCE IS DIRECTOR OF QUALITY PERFORMANCE AT THE CORNWALL COMMUNITY HOSPITAL.

RNAO REMEMBERS



Region 10 members, including regional representative Carmen Rodrigue (far right), thank veteran nursing sisters at Oct. 15 event.

RNs planned and participated in Remembrance Day events across Ontario this year, representing the profession and saluting veteran and peacekeeping nurses for their work at home and abroad.

RNs GATHER IN OTTAWA TO PAY TRIBUTE TO COLLEAGUES AND FRIENDS

By Anne Gilchrist, RN, MSc(A), and Bonnie Hall, RN, MScN, GNC(c)

Nursing sister Pauline Flynn recounts one experience she had during the Second World War as though it happened just yesterday. She was working in a military hospital in England when a young soldier came in for care. She looked into his eyes and saw a little boy who was just old enough to learn to shave. He couldn't have been more than 18. Flynn says she will never forget the pain in his young eyes when he learned both of his legs would be amputated...but she held his hand and nursed him through it all.

This story of nursing care in trying times was just one of 20 shared by nurses at a Remembrance Day event hosted by RNAO's region 10 on October 15 in Ottawa.

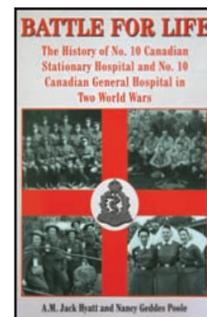
The day began with a candle-lighting ceremony and a moment of silence in remembrance of those nursing sisters who have passed away. All in attendance then heard about the rich careers of the 20 nursing sisters who so graciously shared their time and their experiences with us.

Retired Lieutenant Colonel Hallie Sloan was on hand to deliver a colorful history of their organization. To connect nursing of the past with nursing of the future, RN Suzanne Barnett was also invited to share the results of her RNAO advanced clinical practice fellowship in a long-term care psychiatric facility.

It was an honour to spend a few hours with these veterans who have contributed so profoundly to the health of Canadians. We all felt proud to be in the same profession as these amazing nursing leaders: our beloved nursing sisters. **RN**

FORGOTTEN HEROES RECEIVE RECOGNITION IN PRINT

Two little known south-western Ontario military hospitals and the hard-working nurses in their employ are featured in a *Laurier Centre for Military Strategic and Disarmament Studies* book entitled *Battle for Life* (www.canadianmilitaryhistory.com). No. 10 Canadian Stationary Hospital and No. 10 Canadian General Hospital served during the First and Second World Wars. According to RN Joan MacDermid, a retired nurse who coordinates the archives at Stratford General Hospital, neither hospital has received much attention in the history books. *Battle for Life* recognizes each hospital's important place in history by offering stories



of staff and surviving patients, MacDermid says. The book also features interviews with nurses about their experiences while at war. **RN**



RNAO REMEMBERS VETERAN AND PEACEKEEPING NURSES AT TORONTO'S OLD CITY HALL CENOTAPH

Executive Director Doris Grinspun represented RNAO at Toronto's Old City Hall Cenotaph on Nov. 11, laying a wreath in memory of Canada's nursing veterans and peacekeepers. RNAO was one of 109 participants at the event, which was organized to pay tribute to all men and women who have supported Canada's war efforts. The federal government designated 2005 – the 60th anniversary of the end of the Second World War – the Year of the Veteran.

DID YOU KNOW?

- During the First World War, 3,141 Canadian nurses volunteered their services. By the end of the war, 46 lost their lives: six killed or mortally wounded; 15 lost at sea (including 14 who died when their hospital ship was torpedoed); 15 died of disease; seven died after returning to Canada; and three in the deliberate bombing of a hospital in France.
- The only Canadian nurse to perish due to enemy action during the Second World War was a navy sister who died following more than two hours on a life boat after the sinking of the SS Caribou off the coast of Newfoundland.
- Two Canadian nursing sisters, Kay Christie of Toronto and May Waters of Winnipeg, were the first and only Canadian nursing sisters to become prisoners of war. After two years in captivity in Hong Kong, they were repatriated to Canada.
- After the First and Second World Wars, nursing sisters continued to serve in the armed forces. Nursing Officers, as they are now called, have served in the Gulf War, Bosnia-Herzegovina, Rwanda and Somalia.

Source: Veterans Affairs Canada, www.vac-acc.gc.ca

RN remembers mission to Sicily, reunion with brother

NAME: BETTY BROWN

OCCUPATION: RETIRED NURSING SISTER

HOME TOWN: OTTAWA, ONTARIO

Why military nursing?

Betty (Nicolson) Brown had just graduated and started work as an OR nurse at Winnipeg General Hospital in the early 40s when a surgeon from the army barracks at Fort Osborne walked into the hospital in search of new nursing recruits. At only 23, and still too young to go overseas, Brown was afraid the war would be over before she had a chance to serve her country. She realized this was her chance, and jumped at the opportunity to enroll. It was a job that made perfect sense to Brown, whose father, brother and two sisters served in the First World War.

By 1942, Brown was on her way to a Canadian Red Cross Hospital in England. She was there for a year before beginning her journey to the battlefields. "In the spring of '43, we thought something was in the wind because we started training," she says of the first signs of a secretive mission to the Mediterranean. "We went on long marches, had gas drills, and started learning tropical medicine."

Sure enough, the hospital was preparing

to leave for Liverpool in June. In the history books, Brown's hospital is referred to as "the first hospital of British and allied armies to make a beach landing in an army invasion."

And what a landing it was.

Ready for the toils of war, 50 nurses, a matron, and 24 medical officers poured onto just one of the many ships headed to Sicily that summer. They sailed to Algiers, docked for the night, and then headed to Augusta Beach to land. That's when the German Army started to attack. "All the nursing sisters were given life jackets and went below," Brown recounts. "We were fortunate, we weren't hit, but our supply ship beside us was hit and it went down."

Amid the chaos, the nursing sisters rappelled down the side of the ship, each clad in their trademark navy blue skirt, blouse, tie, fedora hat, stockings, and shoes. "We never, ever dreamt we would be on a boat in a convoy and going over to land with troops," Brown says, adding the landing officers on shore were "aghast when they saw nursing sisters coming off the ship."

Responsibilities

Once on shore, the hospital took over a building not far from the harbour. It was a small space and cots lined the inside and outside walls of the facility. Brown remembers that although the German Army continued to bomb the harbour, and soldiers on the



RNAO'S PERTH CHAPTER TO CONTINUE TRADITION IN HONOUR OF WWI NURSE

It's been almost 90 years since 33-year-old RN Elsie Gertrude Ross succumbed to pneumonia, but she still has at least one admirer.

Doug Johnson, a 79-year-old Southampton man whose father served during the First World War, has laid flowers on Ross' grave for the last three years, hoping this small token of respect will remind people of her important nursing work.

Johnson never knew Ross, but while he was growing up, his father often talked about Ross as the first Toronto Division nurse ever to be given a full military funeral, complete with a procession of officers carrying her casket through an honour guard.

According to a death notice in the *Toronto Daily Star* in 1916, Ross' funeral was attended by about 50 war-scarred heroes.

outside cots would be hit by shrapnel from the exploding shells, the greatest flux of patients were suffering from malaria and dysentery. Soldiers were also treated for post-traumatic stress disorder, or shell shock as it was known during the war. As an OR nurse, Brown was involved in all the surgical procedures at the hospital, treating burns and injuries from explosions. She remembers when penicillin was first introduced, and the profound effect that had on the care of the soldiers. "We did what we could with what we had," she remembers of the first days in Sicily without their supplies. It was difficult but she says they were fortunate enough to find a cache of German supplies left behind by the retreating army.

Challenges

Brown says her most vivid and troubling memory is one of a Sicilian man who died while plowing his land. This first and most troubling exposure to death came when she and the other staff were setting up supplies in the OR and heard the sounds of wailing getting closer and closer to the hospital doors. When they looked to see where the noise was coming from, they saw a donkey cart surrounded by mourning, screaming Sicilians who were hoping for help to save a man who had run over a land

"Many of the veterans hobbled behind the gun carriage on crutches, while others trudged along with the aid of a stick," the newspaper reported.

"What they must have thought of her...these guys came out, injured, in the cold, to walk with her," Johnson said. "That woman must have been something special."

RNAO's Perth chapter agrees, and will take over the tradition for Johnson.

"By laying flowers on Ross' grave, we're honouring the sacrifices of all nurses who contributed to the war efforts," Perth executive member Janet Heinbuch says, admitting she first heard about Ross when an article about Johnson appeared in her local newspaper. "I brought (the clipping) to the next executive meeting and we all agreed this would be a great way to honour all nurses in Perth County." **RN**



Photos from the 40s show Brown at work (top) and with fellow RNs in men's fatigues after their uniforms sank to the bottom of the ocean.

mine. "We realized there was nothing we could do," Brown remembers. "That was the first awful sight that I had seen there."

Memories of a job well done

In many ways, the tragedies of war affected Brown on a personal level, especially when she found out her 18-year-old brother, a fighter pilot, was shot down over the desert by enemy fire while Brown was training in England. She would later find out by telegraph that he had been found and taken to safety by Arabs in the desert. His rescuers took him to their tent, dressed him in Arab clothes, darkened his face, and moved him back to the allied forces over the span of a one-week period.

"One day I was leaving the OR and I always walked through the ward to talk to the boys before I left. I saw this young air force guy and I went over to him; he had just arrived from the desert," Brown recounts. "I said to this fellow, I have a brother in the air force and he was with the

450 squadron in the desert. He said to me 'the 450 squadron isn't in the desert, they're here in Sicily.'"

Brown was ecstatic, and later found out her brother was staying a short distance from the hospital. "I was absolutely thrilled. I couldn't believe it," she says, her voice cracking with emotion. Later that night she was sitting on her cot, sewing, when one of the nurses came into the

room and yelled from the opposite end: "Your brother's downstairs."

"I jumped off my cot, threw the scissors and ran down the corridor," Brown says. "There were these wide stairs and the guards were at the bottom of the stairs at a table to one side. I saw Donald at the bottom of the steps, covered in dust, with shorts on, and desert boots up to his knees and an Aussie hat because he was with an Australian air force unit. I got about six steps down and I jumped. I remember one of the guards at the table saying 'oh, it's alright...it's her brother.'"

Future plans

This year has been a busy one for Brown. She was selected last spring to represent the Canadian Nursing Sisters at the 60th anniversary of D-Day on Juno Beach. She joined then Governor General Adrienne Clarkson and the Prime Minister and his wife for a one-week visit with dignitaries from around the world.

"I'm very proud of all those girls (nursing during the war). It was incredible," she says, adding, "I am really proud of all the young men who gave the ultimate sacrifice. I get a really warm feeling when I think about all our boys."

Brown plans to continue her 11-year tradition of volunteering at Canada's war museum, where she talks to visitors about her experiences.

There are no signs this 88-year-old veteran is slowing down. And the requests keep coming. In early November she was invited to drop the puck at an Ottawa Senators hockey game.

"When I was first married and living in Ottawa, nobody even knew I was a nursing sister because we never talked about what we did during the war," Brown says. "I'm so happy that people have taken such an interest in the history of our nursing sisters." **RN**

RNs Lead by Example

Child advocates say government inaction and ignorance on the health needs of our next generation will only lead to longer, more costly lines for care in the future.

AS president and CEO of the Hospital for Sick Children, Mary Jo Haddad has some strongly held views on children's health. Last summer, she shared some of them in a commentary, *Diagnosing a blind spot: children's health care*, published in the *Globe and Mail*. In it, she noted that none of Roy Romanow's 47 recommendations to improve Canada's health-care system mentioned children. She also wrote that, with the exception of an immunization strategy, the 10-Year Plan to Strengthen Health Care, signed by Canada's first ministers in 2004, is silent on the health-care needs of the youngest Canadians.

Fortunately for Canada's next generation, Haddad is not the only RN who feels that way. Public and community health nurses continue to work tirelessly to increase awareness of how determinants of

health, such as poverty and housing, affect a child's health. And nurses who practice in Ontario's school system remain vocal about their role in keeping children healthy by educating them about smoking, teen pregnancy, sexually transmitted diseases, substance abuse and a range of mental health concerns including depression and suicide. RNAO's Pediatric Nurses Interest Group (PEDNIG) president, Bonnie Fleming-Carroll, says RNs must continue to advocate and advise on ways to improve primary and acute-care services for children, and strengthen injury prevention initiatives and health promotion.

Across Ontario, RNs are conducting research, engaging the public through awareness campaigns and surveys, and creating programs to keep children healthy. Here's just a snapshot of some of the work RNs are doing...

Before birth

Healthy babies start with healthy mothers, but it's not always easy for women, especially those living in rural or remote areas, to access care during their pregnancies. RN Jennifer Medves is a researcher who focuses on rural maternity care. She is also a member of the *Ontario Maternity-Care Expert Panel*, a 15-member panel launched by the Ontario Women's Health Council in the fall of 2004 to examine the availability and sustainability of maternity services.

"The problem for rural women is that many of the places that used to provide maternity care locally no longer do," says Medves, who is also a nursing professor at Queen's University. Medves says women in



remote areas are less likely than urbanites to have family physicians. Those who do struggle to find a doctor able to provide ante- and post-natal care. Medves says doctors who don't frequently attend births may lack the

confidence to take on pregnant patients, and if smaller hospitals deliver few babies, they may discontinue maternity care services as they are pushed to balance budgets.

Medves' research shows that most rural women acknowledge that small towns can't offer every available service. They believe, however, that expectant mothers should receive timely care from a variety of appropriate health professionals, including midwives.

"The main reason women go into hospital is to have babies. That is not an illness ... for most, it's a normal, physiological, joyful occasion," Medves says. She admits, however, that it is hard to keep maternity care on the radar when there's so much emphasis on other health-care priorities like reducing wait times and managing chronic diseases. **RN**

At birth

For a new mom, the joy of bringing home an infant can be clouded if she is among the 13 per cent of women who suffer from postpartum depression (PPD). RN and University of Toronto nursing professor Cindy-Lee Dennis says depressed mothers may not play with their babies or smile at them as often as non-depressed mothers, and, if the depression reoccurs, the child may have a higher risk of cognitive, social or emotional difficulties later in life.

With \$1 million from the Canadian Institutes of Health Research, Dennis is conducting a study to evaluate the effec-



tiveness of providing new mothers with telephone-based support from PPD survivors. Public health nurses in seven health regions across Ontario are using the *Edinburgh Postnatal Depression Scale* to assess women's feelings of sadness and anxiety 24

to 48 hours after they come home from the hospital. Women who score higher than nine on the scale are eligible to be included in Dennis' study. Dennis says most mothers, whether they are depressed or not, have felt frustrated and overwhelmed after bringing a new baby home, but moms with PPD are haunted by guilt arising from those feelings.

"PPD is the single most common form of maternal morbidity in the postpartum period, and we know that can directly affect the child," Dennis says, adding, "We want to make sure the mother is well and properly supported so she can take care of herself and her child to the best of her abilities." **RN**

In infancy

Putting babies to sleep on their back is routinely recommended to prevent some unexpected deaths like Sudden Infant Death Syndrome (SIDS). But the question of "where" a baby sleeps as opposed to "how" is becoming contentious.

Since 2004, the Canadian Pediatric Society (CPS), the American Academy of Pediatrics, and the UK's Foundation for the Study of Sudden Infant Death (FSID) have released guidelines encouraging parents to sleep in the same room as their infant (co-sleeping), but advise against sleeping in the same bed (bedsharing). RNAO Childbirth Nurses Interest Group (CNIG) president Nancy Watters, an Ottawa RN who visits newborns and moms at home as part of the

Healthy Babies, Healthy Children program, says breastfeeding and responsive care advocates welcome guidelines that encourage parents to be closer to their babies at night. And although suggestions to avoid bedsharing have stirred debate, parents are still being encouraged to cuddle and breastfeed in bed.

Watters explains that the guidelines are based on evolving research. She says studies show that the risk of unexpected deaths increases if a baby shares a bed with someone who smokes, is intoxicated, overly fatigued, or has fallen asleep on an unsafe surface like a couch or chair.

Watters says most parents she sees don't sleep in the same bed with their child, but usually share the same room. She says CNIG will evaluate new information on this issue so RNs can help parents decide. The group

will also continue to try to remove barriers to breastfeeding. For instance, it has lobbied against the pending closure of North York General Hospital's breastfeeding clinic, and promotes the use of RNAO's *Breastfeeding Best Practice Guideline for Nurses*. **RN**



In early childhood

RNAO member Anne Snowdon is a University of Windsor nursing professor driven to eliminate vehicle crashes as the number one cause of death among Canadian children. In 2001, Snowdon was awarded \$1.2 million in funding from the federal government and auto industry to survey parents and to determine what they know about child restraint systems. She found that between 92 and 96 per cent of parents try to keep their kids safe, but only 15 to 20 per cent get it right.

"Children will survive things adults won't," Snowdon says. However, those young survivors may suffer crippling disabili-

ties that can cost the education and health systems billions.

In April, Snowdon and three fellow researchers received \$865,000 from the same source to nationally test an education program for parents that Snowdon created and piloted in six Ontario nursing schools



from 2001-2004. The program is comprised of several learning tools: a children's story; a refrigerator magnet; and a CD ROM that uses computer simulations to show how violently children are jostled during an accident. Snowdon says this forces parents to recognize how restraint systems can save a life. This is especially important given new provincial regulations that make booster seats mandatory for children up to age eight.

"If I could get every family in Ontario using child safety seats appropriately and safely...we could decrease the mortality rates or the death rates in children due to crashes by 70 per cent," Snowdon says. "What a public-health coup that would be." **RN**

During school years

RNAO member Nicholas Kaduck, president of the board of directors for *Pathways for Children and Youth*, a children's mental health agency in Kingston, and a vice-president at *Children's Mental Health Ontario (CMHO)*, believes most people ignore children's mental health. To raise awareness that a child's mental health is as important as their physical health, CMHO launched an ad campaign pointing out almost one in every five Ontarians under the age of 17 has a mental health problem. The ads also remind people that bullying, self harm, defiance, substance abuse, and fire setting may be symptoms of



something more than just bad behaviour.

RNAO's Mental Health Nursing Interest Group chair Valerie Grdisa supports the campaign, noting CMHO's advocacy helps adults recognize that someone who suddenly shuts

herself into her bedroom might be experiencing more than teenage angst. She says CMHO's ads will also help reduce the stigma around mental illness. Grdisa wants organizational and government decision-makers at all levels to recognize the expertise nurses bring to the mental health-care system.

"I think (nurses) need to become visible in mental health," she says, adding that RNs help children and families learn to communicate in a way that is constructive for the child, and helpful in unravelling the stigma around mental health. Grdisa says the brain is a complex system, and, like any other part of the body, needs to be cared for and supported. **RN**

Late teens, early 20s

Perth District Health Unit (PDHU) RN Sandra McDonald thinks nurses have an important role to play when it comes to the sexual health of young Ontarians. According to PDHU, 30 per cent more Chlamydia cases were reported among 15-to-24 year olds in 2004 than in 2003. McDonald, who works in PDHU's Sexual Health Program, says young people are so overloaded with safer-sex messages, they've stopped paying attention. They've even started to let down their guard about HIV, assuming the disease can't be that serious if new drugs allow those suffering with the disease to live longer. There's also the belief HIV is an urban problem.

"If the media sensationalize sex and inti-

macy and young people don't take appropriate action – using condoms to prevent sexually transmitted infections (STI) for example – then they're not getting the full picture," McDonald says of the misinformation bombarding today's teens.

Drawing the rest of the picture was the health unit's goal when it began offering more sexual health clinics. Based in Stratford, PDHU offers weekly sexual health clinics, complemented by weekly or monthly clinics in other towns in the region. RNs and a local physician offer information and counselling about pregnancy, STIs, and low-cost birth control. McDonald says more people are being tested for HIV, and the nurses are finding more cases of Chlamydia.

"We want to get the message out...that it is important to use protection and that there

are people (available to) talk about issues or concerns teens may have," she says. "There are lots of STIs out there that are asymptomatic," she adds, meaning some teenagers and young adults may not even know something is wrong. **RN**



Protecting children's online health

In our increasingly-wired world, 99 per cent of children can navigate the World Wide Web. While the computers they're using may be housed within the secure walls of home or school, a child's safety can be compromised just as easily as it might be in a public place. Protecting children from child pornography on the Internet is a priority for acute-care nurse practitioners Karla Wentzel and Tanya Smith. Members of the *Suspected Child Abuse and Neglect (SCAN) Program* at Toronto's Hospital for Sick Children (HSC), Wentzel and Smith want everyone – from parents to fellow RNs – to protect children from online predators.

"There's a whole new level of education

needed for nurses, but also parents of children and youth," Smith says. She says traditional advice about not talking to strangers needs to move into the digital age.

To protect children, Smith suggests parents keep computers in common areas of the home, block access to chat rooms, and ensure a child's photo is not posted online. Wentzel says SCAN treats kids and teens in the acute phase following an assault, when it's too late for prevention. They want to reach out to their colleagues in public health to spread the word that child pornography can be stopped.

Smith acknowledges that while SCAN has not seen a noticeable increase in the number of children falling victim to online predators, they are expecting the number to rise as the Net becomes more intertwined in people's daily lives. They also anticipate that, over time, more and more front-line nurses will

start to automatically scan for signs of child or teen involvement in illicit online activity. Nurses at RNAO's *4th Biennial Conference, Pediatric Health Care: Child First, Patient Second* in October got an introductory lesson from Smith and Wentzel on what to look for when treating young patients, and received valuable input on some of the supports, such as the Children's Aid Society, available to RNs who suspect abuse.

"The Internet has many positive attributes, but there's also a side of it that...can put a lot of children at risk," Wentzel says. "As pediatric nurses, we hope to give some strategies and tools on how to prevent this from happening."

To learn more about SCAN and to find out more about the presentation at October's conference, contact karla.wentzel@sickkids.ca. **RN**

Policy at Work



RNAO offers input on regulatory issues in nursing

In October, RNAO submitted its views on the effectiveness and currency of the *Regulated Health Professionals Act 1991* to the Health Professions Regulatory Advisory Council (HPRAC), a seven-member, arm's-length agency of the provincial government that provides independent policy advice to Ontario's Minister of Health and Long-Term Care. In early 2005, Health Minister George Smitherman asked the council to examine the act, which governs 24 health professions in Ontario.

RNAO made eight recommendations pertaining to the regulatory process, the expansion of nursing scope of practice, and mandatory liability coverage to ensure equal access to legal assistance for all nurses. RNAO recommends, for example, that RNs be permitted to: set or cast a dislocated joint or fractured bone; communicate a diagnosis or cause of symptoms to patients or their representatives if it will provide patients with a better understanding of their condition and necessary medications; provide patients with information about why drugs or other treatments are being administered; and offer information such as emergency pregnancy-test results when a physician is occupied with more acute patients. RNAO also pointed out that since some RNs can dispense insulin in outpatient clinics, or antibiotics in an emergency room when the pharmacy is closed, they should be permitted to dispense drugs as defined in the *Drug and Pharmacies Regulation Act*.

RNAO also recommends protecting the title 'nurse practitioner' by law, and suggests giving NPs a broader, less restricted diagnostic and prescriptive authority. RNAO argues that expanding the scope of practice for RN(EC)s will not only increase access to care, it will also help recruitment and retention.

RNAO also recommended ways to ensure patient safety and healthy work environments. For example, if regulatory colleges find unsafe practice settings while investigating complaints against their respective professionals, RNAO urges it be mandatory for the colleges to report those conditions to the Minister of Health for further investigation. Regulated professionals should also be protected if they choose to speak out and report unsafe practice settings to the ministry.

RNAO members rally to save Bulgarian RNs imprisoned in Libya

RNAO joined the international nursing community in urging the Libyan government to release five Bulgarian RNs and a Palestinian physician who were sentenced to death. The six have been jailed for six-and-a-half years on charges of deliberately infecting hundreds of children with the HIV virus in a hospital in Benghazi. The health-care professionals maintain their innocence, saying the only evidence against them was obtained under torture. Expert medical testimony, supported by the World Health Organization, concluded that the virus was transmitted because of poor sanitation. On

Nov. 15, the Libyan Supreme Court heard the group's final appeal, and announced it would postpone its ruling in the case until early 2006. If the six lose the appeal, they will be executed by firing squad.

In an effort to secure their release, RNAO contacted provincial and federal politicians, as well as officials at the Bulgarian and Libyan embassies. Hundreds of members responded to RNAO's call to voice their concerns by sending a letter from RNAO's website to Libyan officials, including leader Colonel Muammar al-Qaddafi.

Revitalizing the fight against tobacco

Since the launch of RNAO's Tobacco Control Lobby Kit for RNs in 2002, actions at all levels of government have changed the landscape in the fight against tobacco. The lobby kit is being updated to reflect those changes, giving members the information to fight against the deadly, and costly, effects of tobacco use.

As of May 31, 2006, provincial legislation will, with limited exceptions, prohibit smoking in enclosed public and common areas, including workplaces (please visit www.rnao.org for our Smoking Cessation self-learning tool). The law also introduces stricter measures to prevent the sale of cigarettes to anyone under 19 years of age, bans countertop tobacco displays in stores, and prohibits promoting tobacco products at entertainment venues. Other provinces have also actively pursued anti-tobacco efforts. Last September, the Supreme Court of Canada upheld a British Columbia law that would allow the province to force the tobacco industry to pay for smoking-related health-care costs, paving the way for similar legislation across Canada.

Free to all members, the kit builds on a resolution unanimously passed at RNAO's annual general meeting in 2000 to encourage members to lobby all governments to strictly control tobacco product advertisements. The kit includes backgrounders and fact sheets on topics including tobacco and taxes, advertising and sponsorship, and second-hand smoke. It also includes sample letters to be sent to the prime minister and premier, and tips to understand the political process. To access the kit, visit www.rnao.org. **RN**

The policy department is revising its *Taking Action: Political Action and Information Kit* for RNs. This resource provides members with strategies for building alliances, lobbying politicians, working with the media, and becoming involved in elections. The revised kit will be released in January, and will be available to members on RNAO's website (www.rnao.org).

NEWS to You to Use



On Nov. 3, Hamilton's St. Joseph Immigrant Women's Centre won the Ontario Trillium Foundation's biennial *Great Grants Awards* in human and social services. The award honours the Centre for developing *Vocational Orientation for Foreign-Trained Nurses*, an intensive 18-month pilot project that helped all 14 of its foreign-trained participants find jobs.

Orillia RN Vickie Martin, a full-time nurse at Soldier's Memorial Hospital, was featured in a *Rogers Television* documentary entitled *Day in the Life*, which aired on Channel 10 in mid-October. A camera crew shadowed Martin while she was on a 12-hour shift in the paediatric in-patient unit and special care nursery. The show documented the challenges and successes in one nurse's daily practice.



On Oct. 17, Kimberly Peterson, president of RNAO's Seaway chapter, was appointed Director of Patient Care and Chief Nursing Officer at Kemptville District Hospital. Peterson brings 23 years of nursing experience to her new role, and draws on the leadership skills she developed while VP of Nursing at Cornwall General Hospital.

Shirlee Sharkey, President and Chief Executive Officer of Saint Elizabeth Health Care and former president of RNAO, won the Ontario Hospital Association's *Award of Excellence in Nursing Leadership* at the HealthAchieve2005 convention in early November. Sharkey was awarded for her exceptional leadership at both RNAO and Saint Elizabeth for more than 13 years.

On Oct. 12, the Canadian Institutes of Health Research (CIHR) announced the recipients of more than 1,600 health research grants worth more than \$354 million. The grants, which support research on SARS and avian flu, depression, and diabetes, are divided across all provinces and territories. In Ontario, 617 projects will be conducted, valuing more than \$138 million. For more information, visit www.cihr-irsc.gc.ca.

RNAO member Cheryl Yost was appointed Chief Nursing Officer and Director of Patient Care for the Manitoulin Health Centre on Manitoulin Island. Yost, past president of the Perth chapter, and the winner of the 2003 Hub Fellowship, will work with the Centre's two health-care sites, and with the community's Aboriginal population.

The Lanark, Leeds and Grenville Branch of the Victorian Order of Nurses (VON) was one of 31 finalists for the 8th annual *Donner Canadian Foundation Awards for Excellence in the Delivery of Social Services*. It was one of only three non-profit organizations nominated under the 'services for seniors' category.

On Oct. 31, the Nursing Best Practice Research Unit, co-led by RNAO and the University of Ottawa, was awarded a Canadian Health Services Research Foundation (CHSRF) grant for a program of research entitled *Evidence-Informed Nursing Service Delivery Models*. A multi-jurisdictional research team will complete the work, which entails five projects related to RNAO's best practice guidelines. For a full listing of the research team, visit www.rnao.org.

On Nov. 25, several RNAO members received awards from the Centre for Equity in Health and Society (CEHS). The awards recognize Canadian nurses who have demonstrated leadership nationally and on the world stage. Among the recipients: RNAO President Joan Lesmond; Executive Director Doris Grinspun; Angela Cooper-Brathwaite; I. McCallum; and Hilda Swirsky. For more information on the awards and other recipients, visit www.beforequality.com.



Retired Sarnia RN Bonnie Kearns was selected as the 2005 recipient of the *YMCA of Sarnia-Lambton Peace Medallion*. The award, which was presented Nov. 19, recognizes Kearns' work on eight relief missions that have taken her to Puerto Rico, Kosovo, New York, the Dominican Republic, Afghanistan, Africa, Louisiana, and Pakistan.

RNAO Executive Director Doris Grinspun was invited to present at *hispanoforum'05*, a forum that celebrates how Canadians and Hispanics have contributed to Canada's success. Grinspun presented *Medicare: The Best Canadian Asset* at the Nov. 22 event. A native of Chile, Grinspun has worked on several international projects funded by the World Health Organization in Latin and Central America.

Have a tidbit for *News to You/News to Use*? Send it to kkearsey@rnao.org.

Calendar

January

January 26

LEADING AND SHAPING
SUCCESSFUL CHANGE

Regional Workshop
Toronto, Ontario

February

February 23

FIGHT OR FLIGHT...
PROFESSIONAL SOLUTIONS
TO CONFLICT IN THE
WORKPLACE

89 Chestnut Residence
Toronto, Ontario
Video Conferencing
available for this offering

March

March 3

ONTARIO ASSOCIATION
OF REHABILITATION
NURSES CONFERENCE
Toronto, Ontario

March 9

EMERGENCY PREPAREDNESS
RNAO Office
Toronto, Ontario

March 30, 31,

April 3, 4, 5
DESIGNING AND
DELIVERING EFFECTIVE
EDUCATION PROGRAMS

Regional Workshop
RNAO/OHA Joint Program
RNAO Office
Toronto, Ontario

April

April 6

WORKING IN CULTURALLY
DIVERSE ENVIRONMENTS
Regional Workshop
Delta London Armories
London, Ontario

April 23-26

PERI-OPERATIVE REGISTERED
NURSES ASSOCIATION OF
ONTARIO FOUNDATIONS
OF CARE, 9TH
BIENNIAL CONFERENCE
Novotel Hotel
Ottawa, Ontario

April 27-29

RNAO ANNUAL
GENERAL MEETING
Sheraton Parkway
Richmond Hill, Ontario

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



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

2006 Annual General Meeting April 27-29, 2006

Call for Voting Delegates

DEADLINE: MONDAY, FEB. 27, 2006

For more information, contact Heather Terrence
at hterrence@rnao.org.

AGM REGISTRATION FORM

Please download this form from RNAO's website at www.rnao.org or call Bertha Rodrigues at 416-599-1925, ext. 212 for a copy. **Deadline for AGM pre-registration: April 18, 2006.**

HOTEL RESERVATION FORM

RNAO has reserved a block of rooms at the Sheraton Parkway at \$149 per night. **This rate is guaranteed until March 25, 2006.** The reservation form is available at www.rnao.org or call Carrie Scott at 1-800-268-7199 ext. 227 or 416-408-5637.

CLASSIFIEDS

KUNDALINI YOGA & MEDITATION TEACHER TRAINING COURSE

Satisfy yourself personally and expand professionally through this in-depth, 200-hour course through which you will learn many therapeutic health applications of yoga and meditation. Taught by internationally-renowned author, lecturer and naturopathic doctor SatDharm Kaur ND, and by cancer survivor, chiropractor and homeopath Satjit Khalsa DC. Held one weekend per month (Feb. to Nov., 2006) in downtown Toronto. Info: (519) 372-9212, sdk@log.on.ca, or see www.lotusyogacentre.com.

LAMP COMMUNITY HEALTH CENTRE

is opening a new satellite centre in East Mississauga in January 2006. We are looking for a nurse practitioner to join our team in this new practice. Be part of a collaborative team with doctors, nurses, social workers, and other health-care providers. Our clients are diverse and interesting and our staff is waiting to welcome you to our team. Salaried fulltime position with excellent benefits. This new facility is located at the corner of Dixie/Dundas Streets and is close to GO Transit. If interested, contact Russ Ford at 416-252-6471 or russf@lampchc.org.

LEARN HYPNOSIS

The Ontario Hypnosis Centre School is a government accredited education facility that offers hypnotherapy certification training, pain management training, hypnosis for birthing, stress management, and other accredited programs for the medical and wellness community. CEU's available. For workshop dates and times, call 416-489-0333, toll free 1-866-497-7469, or check our websites - www.ont-hypnosis-centre.com/ www.ohschool.com.

LICENSED 14-BED SENIOR HOME

Private, free-standing building – owner retiring. Turn-key operation – many upgrades. Toronto area (Etobicoke). \$799,900. Vendor take back, \$550,000 mortgage. Need \$250,000 cash or credit-line as down payment. Call Mike Khan: 905-471-0972.

ADVANCED CLINICAL/PRACTICE FELLOWSHIPS

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(416) 907 7950 or cvilla@rnao.org



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CALL FOR NOMINATIONS

Recognize RN and nursing students' accomplishments with a nomination for

RNAO's 2006 Recognition Awards

Nominate a colleague by January 31, 2006 and give them some well-deserved recognition.

Visit www.RNAO.org to browse the 14 awards now open and download nomination forms.

For more information, contact Jody Smith at jsmith@rnao.org or 416-408-5618.

Help RNAO find and CELEBRATE the best in health-care reporting

In 2006, RNAO's eighth annual *Award for Excellence in Health-Care Reporting* will once again honour superior health-care coverage in print and broadcast journalism.

- Keep an eye on local health-care coverage in your community newspaper or on local broadcast media stations; this competition can serve as a great opportunity to develop relationships with the media.
- Know of a reporter who is covering nursing issues effectively? Encourage him/her to submit stories for consideration in the competition.
- Items must be published in Ontario newspapers or magazines, or broadcast on Ontario radio or television during the calendar year of 2005.
- For more information and an application form, visit www.rnao.org or call 1-800-268-7199/416-599-1925 or e-mail jshaw@rnao.org.

Making Healthy Eating Easy!

New **FREE** resources to support healthy eating for families.



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Mission 5522: Finding Paradise Island
An engaging game that encourages and personalizes healthy eating for 8 and 9 year olds. Designed for independent play.

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This interactive wipe board with stickers helps parents encourage their children to meet recommended food selections everyday.



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Our healthy eating resources are developed by Registered Dietitians and produced in partnership and collaboration with organizations such as: Breakfast for Learning, Canadian Living Foundation, Dietitians of Canada, Registered Nurses Association of Ontario, SickKids - The Hospital for Sick Children and the Canadian Paediatric Society.



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- 4 month course completion
- concepts of financial management and budget preparation
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- 4 month course completion
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For further information please contact:

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McMaster University, School of Nursing
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Fax (905) 570-0667

Email mgtprog@mcmaster.ca
Internet www.fhs.mcmaster.ca/nursing/distance/distance.htm

Programs starting every January,
April & September

Nursing Policy Analyst

The Registered Nurses' Association of Ontario is seeking a committed, knowledgeable and passionate RN to join our Health and Nursing Policy team.

This is an excellent opportunity to contribute to RNAO's mission: *Speaking out for Health, Speaking out for Nursing.*

As Nursing Policy Analyst you will be an integral contributor to the development of policy positions, policy statements and a variety of other communications and reports. The primary responsibilities of this role are to analyze emerging nursing policy and practice issues, emerging health and social policy issues, and to represent RNAO in a variety of settings with other stakeholders and the government. You will also be responsible for environmental scanning of nursing practice, health and social policy issues, and conducting research for policy development leading to preparation of background and/or position papers regarding policy, practice and research.

The successful candidate will be a member of RNAO and the College of Nurses of Ontario. A Master's degree in nursing is preferred. Superior writing skills and strong knowledge of health and social policy issues are also among the skills you will bring to the association. This is a full-time position, salary commensurate with experience.

Please submit your resume by January 27, 2006 to the Director of Finance & Administration, humanresources@RNAO.org, or to Registered Nurses' Association of Ontario, Human Resources, 158 Pearl Street, Toronto, Ontario, M5H 1L3, fax 416-599-1926.



Registered Nurses' Association of Ontario

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

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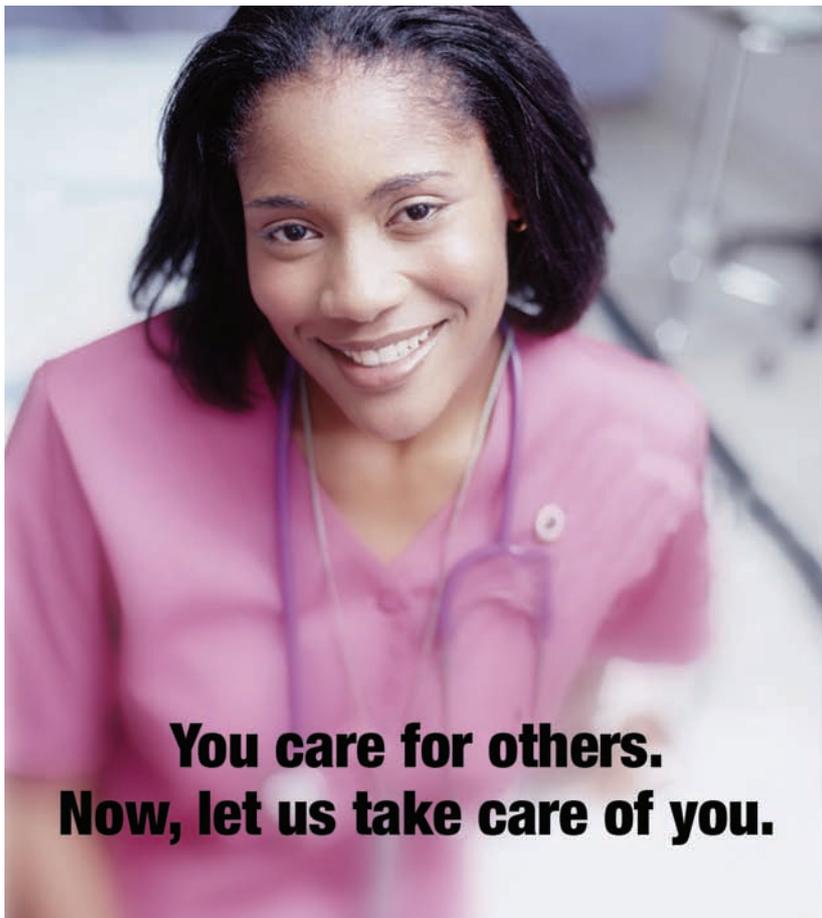
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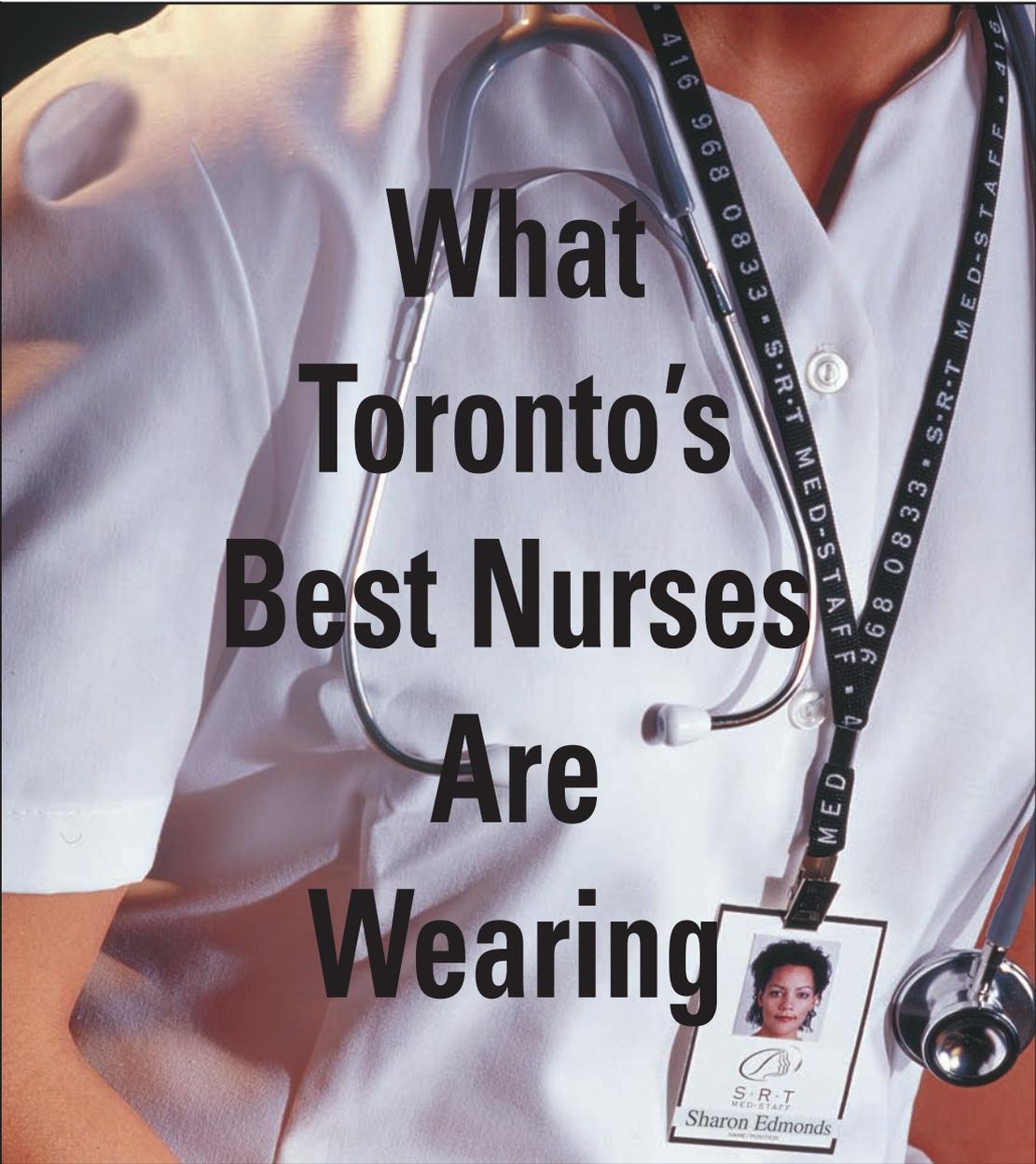
A new funding cycle has been approved
by the MOHLTC. For pertinent
deadline information or to obtain a copy
of the application form please
visit the RNAO Web site at
www.rnao.org

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

RNAO's Frequently Asked Questions line
1-866-464-4405

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e-mail Meagan Wright
and Lisa Beganyi at
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