NOVEMBER/DECEMBER 2011

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REGISTERED NURSE JOURNAL

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COVER PHOTO: JEFF KIRK

THE LINEUP

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

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EDITOR'S NOTE KIMBERLEY KEARSEY

Heroes in our midst

I've only found myself in one emergency situation where I truly felt the life of another individual was in my hands. In that instance, I actually surprised myself at how focused I was. Adrenaline was my drug, but I think natural instinct also took over.

Most people have the capacity to act when called upon, but a little bravery does not an RN make. The nurses you will meet in this issue demonstrate courage every day. For that, we can all be envious, and truly grateful.

Our feature about first responders (pg. 18) details how five Ontario nurses were called upon to provide care in unexpected situations. They were away from a hospital. They did not have the security of equipment and resources within arm's reach. They only had their instincts and knowledge to guide them. Most people can only hope to handle themselves well when faced with uncertainty and stress. These nurses did.

Our cover feature (pg 12) explores another kind of emergency: outbreaks of infectious disease in the hospital setting. We talk to nurses about the challenges of infection control, the stress that protocols can sometimes place on their ability to care for patients, and the help they need from colleagues – and the public – to ensure patient safety.

Emergencies are frightening situations that demand focus. They may happen inside or outside our health-care system. Regardless of the circumstance, it's reassuring to know there could be an RN right around the corner to help us through those moments of uncertainty.

None of the nurses we feature in this issue would describe themselves as 'heroes.' But I will. And I'll follow that up with heartfelt thanks. Here's wishing all of you an emergency free holiday season. **RN**

Are you traditional or digital…or both?

We are taking steps to ensure we continue to better serve our members and colleagues. This copy of *Registered Nurse Journal* has arrived at your doorstep thanks to Canada Post. The association will always offer traditional delivery of our flagship publication right to your door. However, we recognize some members may prefer a digital copy of the magazine.

When you renewed your membership for the 2011–2012 membership year, you may have adjusted your preferences as they relate to delivery of your magazine. Please know those changes have been recorded and will come into effect in the coming weeks. Should you wish to change the way you receive future issues of *Registered Nurse Journal*, please change your preferences at www.RNAO.org/RNJdeliveryoptions.

The truth about elder abuse must come out

The cover story in the last issue of the *Journal* was, for me, both a difficult and necessary read. The article focused on the work RNAO is doing to promote greater awareness of elder abuse, and featured the stories of four long-term care homes participating in the PEACE (Prevention of Elder Abuse Centres of Excellence) initiative. For those of you who read it, you know that RNAO is fully aware of the urgency with which we need to tackle this issue head on.

According to Statistics Canada, reports of elder abuse went up 14 per cent between 2004 and 2009. As many as 7,900 cases were reported, including instances of physical, sexual, emotional and financial abuse. Not all of them occurred in long-term care homes. In fact, many sadly took place in the so-called sanctity of a senior's own home. But instances of abuse do occur in our long-term care homes and we can't kid ourselves about that fact.

That blunt truth was revealed in horrifying fashion in a recent investigative series in the *Toronto Star*. Using Ministry of Health data, based on inspection reports, the newspaper found 125 instances of abuse and 350 cases of neglect. In about a dozen cases, acts of abuse or aggression were so serious that staff should have notified police. But some homes either delayed reporting, or worse, never notified authorities.

That's why RNAO felt compelled to send a memo to those of you we can reach by email. For those who didn't receive that message, I'm using this opportunity to speak to you about this important issue.

As nurses, we are the trusted guardians of the most vulnerable members of our society. However, when a member of our profession defies our values and knowingly takes advantage of their position of power to abuse or neglect a patient, or fails to act on an allegation of abuse or neglect, we feel a profound sense of loss and anger within our professional community. What we do with these feelings is critical. We can choose to hang our heads in shame, frustration and/or fear; a choice that helps no one and serves to perpetuate the problem. Or we must use our powerful sense of injustice and spring into action.

> "As nurses, we are the trusted guardians of the most vulnerable members of our society."

It is our legal and professional responsibility as nurses to report abuse and neglect to the appropriate authorities every time we see or hear anything about abuse. Zero tolerance is the only acceptable standard in our profession because we all know that one incident is one incident too many. The vast majority of nurses and administrators, as well as other health-care professionals, come to work every day to do their very best. Now, more than ever, this involves reporting instances of abuse and neglect, and we each have a different role to play.

Nurse managers must ensure front-line providers have accessible policies that clearly explain how to recognize and respond to abuse as it is seen or suspected. Training, evaluation and timely reporting to the appropriate authorities strengthen your efforts. Advocating for whistleblower protection in all settings will help staff do the right thing and report without fear of reprisal. We rely on front-line nurses to be our eyes and ears, to bring the experiences of abuse out from behind closed doors. The strength of your courage, values and leadership can stop and prevent the abuse.

Simply act, use your voice and report, per policy directives, as soon as you are aware. Abuse and neglect can be eliminated if we work together. RNAO is here to support you if you feel your concerns are being ignored, or worse, if you are worried about the repercussions of coming forward.

The story of Diane Shay (Nursing in the News, pg. 8) is a compelling one. She paid a heavy price to do the right thing in reporting an instance of abuse she discovered at a nursing home in Cornwall. But, in the end, her courage speaks volumes about the kind of health-care professionals we must be.

You should know that the association is working on several fronts to address elder abuse through policy, development of a best practice guideline on elder abuse, advocacy, and by speaking openly in the media.

If each of us as individual nurses is constantly vigilant and following up when signs of abuse are discovered, this combined with our efforts as an association to advocate and raise awareness, we can eliminate this most horrific crime. **RN**

David McNeil, RN, BScN, MHA, CHE, is President of RNAO.

Visit www.RNAO.org/elderabuse to find out more about the long-term care facilities involved in the PEACE project. They are: The Good Samaritan Society, Alberta and B.C.; Bow View Manor, Calgary; Porteous Lodge, Saskatoon; Winnipeg's Parkview Place Care Centre; Winnipeg Regional Health Authority; Residence St-Louis, Ottawa; Hillsdale Estates, Oshawa; Veterans Health Unit and York Manor, Fredericton; and Harbourstone Enhanced Care, Nova Scotia.

Members offer kudos and suggestions for improvement in fall survey

For 18 days this fall, members had an opportunity to participate in an online survey, sharing their opinions on RNAO's work, their thoughts on its strategic directions, and their recommendations for improvement. A big thank you to the 2,500 nurses who put time and thought into completing the membership survey; your contribution to the board of directors' strategic planning process is invaluable.

Almost 80 per cent of respondents to our survey said they are 'satisfied' or 'very satisfied' with RNAO. They value educational opportunities, the energy and insight the association devotes to political action, the voice we give to the profession, and the access they have to legal assistance. Respondents also expressed a clear sense of belonging to 'their' organization, and were pleased with the responsiveness of home office.

When asked where we can improve, respondents said they want to see staff nurses – who make up 60 per cent of our overall membership and represent more than half of those who completed the survey – reflected more in the work of the association. You've told us about your concern that RNs are being replaced by RPNs. You are so very right to be concerned, and it's time for RNAO to increase awareness of this troubling reality. Although there is a place for everyone on the health-care team, decreasing the number of RNs is counter to positive clinical and health outcomes. We have plenty of anecdotal evidence that RNs are being replaced by RPNs, and soon the College of Nurses of Ontario's annual data will bring this dangerous trend to light.

Armed with evidence about RN effectiveness on patients' health and clinical outcomes, as well as organizational and system cost-effectiveness, and backed by RNs' lived experiences, we will position this issue at the forefront of our work. We already have a track record for success with regards to health human resource and scope of practice issues as they pertain not only to RNs, but also to nurse practitioners, chief nurse executives, and chief nursing officers. We will use this expertise and determination to tackle RN replacement head on.

Fifteen per cent of survey respondents selected 'political action' when asked what they value most at RNAO. Ten per cent selected 'advocacy.' We are pleased that you value these aspects of our work, and we know you take pride in the results, including the substantive increase in full-time employment for all RNs – from 49.9 per cent in 1998 to 68.2 per cent in 2011. RNAO was the first to place on the political agenda in 1998 the urgent need to move to 70 per cent full time employment, and we have never let go. It's this same determination and focus we promise to tap into when we move forward with the concerns you've shared in the survey.

> "A big thank you to the 2,500 nurses who put time and thought into completing the membership survey; your contribution to the board of directors' strategic planning process is invaluable."

While we do this, we will remember your comments about action alerts: that there are too many, and they are too urgent. We hear you, and will limit action alerts to areas relevant to you. We will give you the choice to select which action alerts, if any, you want to hear about. As we do so, we will ask you to be generous with your time. We know your efforts make a huge difference to the lives of others. For example, in just one week this November, 2,000 nurses responded to RNAO's action alert demanding help for the residents of Attawapiskat. As a result, we have seen political movement.

To your concerns that educational offerings are too Toronto centric; we hear you and commit to expand our reach to communities across Ontario, especially those in northern, rural and remote areas.

In the spring issue of the *Journal*, we will bring you details of the board of directors' revised strategic priorities based on your voices. As an association that represents registered nurses who join voluntarily, we are accountable to you. This fall's survey – in combination with focus groups and strategic planning retreats with RNAO assembly members and senior staff – has allowed the board to reassess RNAO's direction. In some respects, the board has re-affirmed we're headed in the right direction. In other respects, it has re-shaped the direction we'll take in the future. A final report of the feedback is being drafted, and the revised strategic priorities will be finalized and approved by the board at its March meeting.

Be assured your voices have been heard, loud and clear. **RN**

Doris Grinspun, RN, MSN, PhD, LLD(hon), O.Ont, is executive director at RNAO.

MAILBAG

RNAO WANTS TO HEAR YOUR COMMENTS AND OPINIONS ON WHAT YOU'VE READ OR WANT TO READ IN RNJ. WRITE TO LETTERS@RNAO.ORG

Debate rages over wind power

Re: Out with coal, in with renewable energy, Nursing in the News, September/October 2011

We were disappointed to read of nurse practitioner Lel Morrison's wholehearted endorsement of wind power when the fact is, wind power projects are causing problems due to the environmental noise they produce. Morrison references a report that is quite out of date. We refer readers instead to the findings of the Environmental Review Tribunal (July 2011) which, after hearing evidence from more than 20 experts, determined: "This case has successfully shown that the debate should not be simplified to one about whether wind turbines can cause harm to humans. The evidence presented to the Tribunal demonstrates that they can, if facilities are placed too close to residents. The debate has now evolved to one of degree." Last year, a report prepared for the corporate wind industry suggested it recruit health professions and environmental groups to serve as "third party validators" for the industrial wind industry. We implore nurses to look deeper into this issue. There is much the wind industry is not telling you.

Debbie Shubat,
St. Joseph's Island, Ontario
Jane Wilson,
North Gower, Ottawa

EDITOR'S RESPONSE

RNAO believes wind energy, when appropriately cited, is one of several viable, renewable alternatives to coal and nuclear. The board of directors re-affirmed its support at its September board meeting.

Former RNAO president remembered

Re: RNs mark the passing of a true leader, September/October 2011

A few years ago, Joan Lesmond came to Kingston as the guest speaker for our annual RNAO dinner. I was asked to say the grace before the meal. I took this very seriously and was honoured to do my share for the evening's event. When Joan got up to speak, she mentioned that the grace I said was sensitive and meaningful. She went on to say that she had never thought to comment on grace ever before. I was pleased that my thoughts reached her. I'll always remember Joan for her appreciation and thoughtfulness, and her sense of being authentic.

Kathy Coulson
Kingston, Ontario

I would like to first mention how proud I am to be a member of this organization. I was, however, very disappointed after reading the fall edition of the magazine, as I felt that Joan Lesmond's tribute could have been better. As a previous president of RNAO, her picture should have been on the front page and her story given greater detail.

Marcia Fisher
Concord, Ontario

To help or to hurt

Re: The complexities of workplace bullying, Legal Column, September/October 2011

I loved the article on bullying in the workplace. I deal with this quite a bit when I do conflict resolution and mediation. It is sad that bullying takes place in a "helping" profession.

Linda Gravelle
Sault Ste Marie, Ontario

OBITUARY

Dorothy Hall

August 1924–November 2011

Dorothy Hall, honourary RNAO life member and Ontario's first provincial chief nursing officer, passed away on November 11 in Palmerston, Ontario. The 87-year-old was best remembered for leading the charge to reintroduce the role of nurse practitioner into Ontario's health-care system in the early 90s. Today, Ontario's 1,900 NPs have the authority to diagnose, prescribe drugs, order most tests and as of July can now discharge patients from hospital. "Almost everything she envisioned came to fruition," says Theresa Agnew, past president of the Nurse Practitioners' Association of Ontario.

Hall graduated from the University of Western Ontario in 1947. She began her career running Red Cross hospitals and clinics in remote Ontario outposts such as Dryden, Lion's Head and Rainy River. She delivered babies and provided emergency care on her own. Hall joined the World Health Organization (WHO) in 1950. She was first stationed in Thailand, then New Delhi, then Europe. She returned to Canada in the mid-1970s, and began to focus on maternal health and midwifery. In 1993, at the request of Ontario's NDP government, Hall became Ontario's first provincial chief nursing officer. "She was extremely good at building coalitions," Kathleen MacMillan, a friend and former RNAO president, recalls. "The regulatory bodies, professional associations, unions and academics ... she pulled them all together and laid out the framework [for] educational requirements, policy structures and legislation. She made some decisions that didn't satisfy everybody, but because she was very pragmatic, she knew what was going to fly and what wouldn't."

Hall's proudest moment came in 2002, when McMaster University unveiled the $1 million Dorothy C. Hall chair in primary-health-care nursing to focus on education and research. **RN**

NURSING IN TH

Cycling to good health

Elgin St. Thomas Public Health nurse **Darrell Jutzi** (left) is doing his part to ensure students at Mitchell Hepburn Public School have a safe – and healthy – way to get to class. In November, Jutzi and the school's vice principal led a delegation of students and parent council members on a trip around the neighbourhood to identify routes students might use to ride to school. The weather may be getting colder, but Jutzi wants to encourage kids to ride year-round. Hepburn is one of four schools that have been selected to take part in the *Wheeling to School* provincial initiative, which is supported by Green Communities Canada, Share the Road Cycling Coalition and the public health unit where Jutzi works. The initiative looks at the potential barriers families face in biking to school. In the spring, cycling safety training will be provided to prepare kids to ride in the warmer months. (*St. Thomas Times-Journal*, Nov. 17)

PHOTO: QMI AGENCY

Protecting the elderly means protecting whistle-blowers

Cornwall RN **Diane Shay** won a legal victory in October when her employer, the City of Cornwall, was convicted for retaliating against Shay when she pushed administrators to report a case of resident abuse at the Glen Stor Dun Lodge nursing home. The city was ordered to pay a fine of $15,000 in a case that recognizes whistle-blowers need to be protected when they come forward. The outcome is precedent setting and places the onus on home operators everywhere to ensure allegations of abuse are thoroughly investigated and reported.


Diane Shay

"It is ... nurses who are given the responsibility to ensure (residents') safety. To do so, we must be protected from personal attacks and discipline, including termination ...," Shay told the *Cornwall Standard-Freeholder*. (Nov. 2)

In May 2008, Shay, a health and safety officer in the human resources department at the city, learned a resident was abused at the home. She advised her supervisor that provincial legislation requires reporting of resident abuse to the Ministry of Health. She was warned to leave it alone. After repeatedly urging her supervisor to report the abuse, Shay began receiving retaliatory emails and was verbally intimidated. She was disciplined for being insubordinate and her position was eliminated. Shay sued her former employer, and after nine-months of civil action, was reinstated.

"This is an important decision for nurses and the people we care for," RNAO Executive Director **Doris Grinspun** said. "It enables us to speak out and protect residents without fear of retaliation." (*thecornwalldaily.com*, Oct. 28)

Gail Paech, head of the Ontario Long-Term Care Association, spoke to media about elder abuse in November, following a *Toronto Star* investigation that revealed vulnerable residents at some homes were being beaten, neglected and even raped. It will take a massive cultural change before the industry fully accepts that transparency leads to better care, Paech told the *Star* (Nov. 22).

A fair wage

RN **Ruth Walden** is one of more than 400 Canada Pension Plan nurses who have been awarded $2.3 million for pain and suffering caused by decades of sex discrimination by their employer, the federal government. In an order in October by the Canadian Human Rights Tribunal, the nurses received $427.50 in compensation for each year of service. Walden and her colleagues — who determine the eligibility of applicants for CPP disability benefits — can also expect a larger payout next year.

The nurses, 95 per cent of whom are female, perform essentially the same core functions as a male-dominated group of CPP doctors, paid twice the salary. Walden filed the original complaint in 2004. Next spring, the tribunal will hear arguments about how much compensation the nurses should receive for lost wages. (*Ottawa Citizen*, Oct 30)

E NEWS

BY STACEY HALE

Nursing in Somalia

Toronto public health nurse **Safia Nur Ahmed** travelled to Somalia in September to help residents devastated by famine. In July, the United Nations declared famine in several regions of the African country, and tens of thousands of people died while millions of survivors fled to seek aid in the capital city of Mogadishu.

Ahmed, who was born in Somalia and came to Canada during the Gulf War, volunteered her nursing skills in a Mogadishu hospital. She brought simple equipment, including thermometers, to care for malnourished children and families. She was inspired to become a nurse after watching children suffer during the Gulf War. "That's the reason I went into nursing, so if this ever happened again, I would be able to do something," she told *CBC Radio*. (Oct. 14)

Family practice certificate

Judie Surridge and **Sheilagh Callahan** have teamed up to develop a new certificate program that will prepare RNs to work in family practice. "Primary care is not really covered in any significant way in basic nursing school," says Surridge, president of RNAO's Ontario Family Practice Nurses interest group. Toronto's George Brown College launched the one-year program in September. "First and foremost, we want to serve RNs in family practice who haven't had any professional development opportunities," says Callahan, program co-ordinator. Family practice RNs play a unique role in health care, connecting patients and their families with health-care providers, and educating patients in prevention and treatment of illness (*Toronto Sun*, Nov. 6). Visit www.georgebrown.ca to learn more.

Understanding the NP role

Canadian Nurses Association CEO **Rachel Bard** spoke to the *New Brunswick Telegraph-Journal* in October about CNA's education campaign to help people understand what nurse practitioners do, and how they can improve care for patients. "We believe it is important to educate Canadians about how their access to health care can be improved ..." she said (Oct. 19). The campaign – *Nurse Practitioners: It's About Time!* – was launched in Fredericton in October.

According to NP **Jennie Humbert**, the public is not the only audience in need of further education about the role. Speaking out to educate insurance companies, Humbert said nurse practitioners still need

OUT AND ABOUT

Nurses across Ontario remember those who served in war

(top left) LeAnn White, president of RNAO's Grey Bruce chapter at a wreath laying ceremony in Chatsworth.

(top right) Wellington chapter members Mary Carley and Elke Ruthig mark Remembrance Day in Guelph.

(left) RNAO board member Norma Nicholson lays a wreath during November 11 ceremonies in Toronto.

NURSING IN THE NEWS

doctors' signatures to get insurance companies to cover some services, even though NPs can legally order them. "The problem is the insurance companies still haven't recognized that NPs are part of the primary health-care team," says Humbert, who practises at the West Nipissing Community Health Centre in Sturgeon Falls. It's a burden on patients and a waste of resources, she told *CBC.ca*. (Nov. 2)

Elder friendly hospitals

RNs **Ryan Miller** and **Laurie Ellis** are taking on leadership roles in their respective hospitals as part of a provincial initiative to make hospitals more elder friendly. Miller, who works at Orillia's Soldiers Memorial Hospital, is heading up a regional task force alongside representatives from all the hospitals in the North Simcoe Muskoka LHIN. "I think this work is imperative," she told the *Orillia Packet and Times* (Oct. 13). Purchasing beds with easier access to call buttons; installing large, easy-to-read clocks and calendars so elderly patients don't lose track of the date or time; these are just some of the ways hospitals are aiming to enhance care. Hospitals have historically done everything for the elderly, says Ellis, V.P. of Operations and Chief Nursing Officer at West Lincoln Memorial Hospital in Grimsby. A new emphasis on giving back responsibilities to patients should ensure they don't lose abilities. (*Niagara This Week*, Nov. 1)

Improving isolation rooms

Brantford RNs **Kim Pittaway** and **Marnie Seiveright** participated in a focus group with Brantford General Hospital in November. The nurses were among a group of more than a dozen weighing in on how the hospital constructs and operates isolation rooms. Nearly 10 new rooms are slated for construction over the next few months. "We seized the opportunity to examine how we currently care for patients in isolation but also with an eye to improving the process," Pittaway said. The group studied videotapes of themselves working in isolation rooms, with patients who often reveal life in the rooms can be lonely. The focus group identified close to 100 ideas for improving processes, including having a member of the care team ask at least once an hour about the patients level of pain, whether they need to use the bathroom or be repositioned in bed. (*Brantford Expositor*, Nov. 2)

Ryan Miller, (back row, second from left) discusses her new role as the Senior Friendly Hospital Strategy Coordinator for the North Simcoe Muskoka LHIN.

OUT AND ABOUT

RNAO TRANSLATES BPGs TO PORTUGUESE

Executive Director Doris Grinspun signed an agreement in November to translate RNAO's best practice guidelines into Portuguese. She was joined by Brazilian Nurses Association President Ivone Cabral (right), and Regina Santos (far left) and Margarita Unicovsky from Associação Brasileira de Enfermagem.

LETTER TO THE EDITOR

On Oct. 31, RNAO member and Grey Bruce chapter President **LeAnn White** *wrote a letter to the* Owen Sound Sun Times *to explain the important role public health nurses play in the health system.*

Public health nurses do behind the scenes work

Recent news of contract negotiations between the Grey Bruce Health Unit and the public health nurses has motivated me to respond to the frequently asked question, "What is a public health nurse?" Unlike the very visible bedside nurses at hospitals, much of the work in public health remains behind the scenes. Public health nurses strive to identify potential health risks and to prevent the potential for those risks to become dangerous, much like the old adage, "a stitch in time, saves nine." Prevention comes in many forms. In Grey and Bruce counties, assisting new mothers prevents health problems with babies, immunization prevents disease, identifying disease outbreaks prevents rapid and uncontrolled spread of disease, educational campaigns raise awareness of potential health risks (think of the smoking bylaws, car seat safety, alcohol and drug use, sun safety). To accomplish the goal of keeping our communities healthy, public health nurses rely on people within our communities, so partnerships or coalitions are formed. Nurses motivate people to do what they can to stay healthy. Public health nurses have been called the "public's safety net." Potential problems are identified, education and skills are used to weave the net, so that when crises do arise, you can be protected and our communities can return to health.

LeAnn White
Chatsworth, Ontario

NURSING NOTES

RN picks up award on behalf of team

RNAO member Sandra Dudziak said she was "extremely honoured" to accept an Ontario Long-Term Care Association (OLTCA) award in October for her work in skin and wound care at Revera Long-Term Care in Mississauga. The nurse practitioner, who is Revera's national director of clinical services, said "it is not a one person award," noting it takes a dedicated clinical team to provide wound care that is outcome driven rather than product driven. Dudziak accepted the award during Long-Term Care Week (Oct. 24–28).

Amendment restricts access to 'quality' information

Beginning in January 2012, Ontario hospitals will fall under the province's *Freedom of Information and Protection of Privacy Act* (FIPPA). This means members of the public can request access to hospitals' general records relating to operational functions, policy and financial considerations. In the spring of 2011, RNAO President-Elect Rhonda Seidman-Carlson appeared before a legislative committee to share the association's view that the amended legislation constrains the public's right to request information related to quality issues. More than 500 RNAO members wrote letters to the Premier and MPPs to remind them that high quality care means transparency and accountability in health quality information. Ontario is the last province to include hospitals under freedom of information legislation. For information, visit www.ipc.on.ca.

Giving youth a voice

For seven weeks this past fall, RNAO member and public health nurse Nicole Szumlanski encouraged youth between the ages of 10 and 24 to take photos that examine healthy living issues, including mental health, physical activity and sexual health. Their photos were considered for a *Photovoice* contest, launched at Kingston, Frontenac, Lennox and Addington Public Health Unit Oct. 11. Szumlanski said the contest gave youth a voice, and an opportunity to express how they view healthy or unhealthy situations. "It's a unique way for them to explain their thoughts and feelings through their pictures," she said. The initiative was organized by the Eastern Ontario Tobacco Control Area Network and six eastern Ontario public health agencies.

Work underway on the 2014 Canada *Health Accord*

In a presentation before the Senate Committee on Social Affairs, Science and Technology on Oct. 19, former RNAO board member and Canadian Nurses Association (CNA) President-Elect Barbara Mildon recommended the government focus on two key areas in the lead-up to renegotiation of Canada's *Health Accord* in 2014: a primary health-care system, and inter-professional teams. "A focus on primary health care contrasts with the way we have set up our system here in Canada currently," Mildon said. CNA Chief Executive Officer Rachel Bard was also present, saying Canada can do more to integrate RNs in a more responsive system of primary care. CNA's presentation before the committee followed an RNAO resolution at CNA's 2011 annual meeting that urged the national organization to lead in pushing for the immediate renegotiation of the *Accord*.

RNAO fights negative nursing images

Halloween has come and gone, but not without RNAO combating the recurring negative stereotypes of nurses that tend to emerge each fall. In October, CBC's *Battle of the Blades* featured a figure skater in a skimpy nurse uniform skating alongside a man dressed as a 'nerdy doctor.' The association responded with a letter, condemning the inference that nurses are sexually available. Executive producers of the show apologized in a letter to RNAO within a few days. In an October episode of CBC's radio program *Q*, host Jian Ghomeshi interviewed the managing editor of a women's lifestyle website, who suggested women can wear whatever they want on Halloween — including sexy nurse costumes. RNAO responded on an online CBC discussion board, noting that while the program attempted to enlighten listeners, the guest missed an opportunity to change views about nurses as sex objects.

To nurse and PROTECT

RNs are rising to the challenges posed by increasing rates of deadly, hospital-acquired infections.

BY LESLEY YOUNG

May 28, 2011. Just five months into Sue Matthews' role as interim president and CEO of Niagara Health System, the registered nurse and long-standing RNAO member was forced to declare an outbreak of C. difficile at one of the organization's seven sites (and later another two). Over the next five months, Matthews successfully navigated one of the most trying times of her career, facing challenges that no nurse could have been adequately prepared for, she says.

The hardest part of the outbreak, which officially ended Oct. 24, was the grief, she adds. The bacteria – spread by contact – took the lives of 37 patients (seven directly; 30 indirectly), leaving families and staff to cope. Relentless media attention also took a toll on Matthews and her staff, especially nurses.

"I barely remember the first two weeks," she admits. "I hardly slept."

Instead, the nurse of 28 years, and every single employee at the network of hospitals, hit the ground running, pulling in resources, assessing gaps, and implementing solutions to manage the growing threat. Matthews spent much of her time preparing for and hosting daily media briefings, fielding questions from reporters who, in those early weeks, were searching for blame – human blame.

"Patients and family members were going to the press, contending that they had seen nurses not washing their hands. They were pointing their fingers at nurses, accusing them of sitting on their duffs not doing anything," she says. "The lowest part of all this for me is knowing people died. The second lowest part was watching the staff being dragged through the mud. The negativity was emotionally exhausting."

This kind of media scrutiny is usually reserved for brand new outbreaks (such as SARS and H1N1). Niagara Health System, however, has been battling a wary and skeptical public since its restructuring in January 2009.

The reality, Matthews says, is that while hospital-acquired infections exist at every Ontario hospital all of the time, health-care professionals are facing tougher and tougher uphill battles keeping them contained. For example, between 1999 and 2006, the incidence of MRSA (methicillin-resistant Staphylococcus aureus) has doubled, while that of VRE (vancomycin-resistent enterococci)

PHOTO: JEFF KIRK

Sue Matthews, NHS Interim President and CEO (second from left), managed the outbreak with help from colleagues and fellow management team members (L to R) Anne Atkinson, VP, Patient Services, Donna Rothwell, Chief Nursing Officer, and Interim Chief of Staff Joanna Hope.

A Windsor Regional Hospital RN stands behind the yellow line drawn between isolation patients and others without infection. The line is a visual reminder that nurses and other staff must follow infection control protocols.

PHOTO: DAX MELMER

has tripled, according to the Canadian Nocosomial Infection Surveillance Program (see pg 15, *How does it all begin?*). Rising rates are the result of bacteria growing stronger. Hospitals across the province have also seen improved testing and hyper vigilance, she says.

"Without question, infection control is the job of every health-care professional," says Michael Gardam, Director, Infection Prevention and Control, at Toronto's University Health Network (UHN). That said, many responsibilities fall on nursing staff (both in day-to-day prevention and in outbreak mode) that pose challenges. These include risk reduction measures that increase workload, and educating a sometimes resistant public (and other health-care professionals) on hand hygiene practices. RNs are successfully facing these challenges, and developing innovative strategies and solutions for controlling hospital-acquired infections.

Matthews is the first to admit that NHS made mistakes during the outbreak, and she owned up to those mistakes when confronted by the media. She says she was able to handle the pressure thanks to help from another hospital's media expert who gave her several key strategies. The most important: be prepared and address problems before the media bring them to you.

While Matthews doesn't condone inappropriate infection control practices, she points out how risk reduction places a huge burden on nursing staff. "Research shows that on one 40-bed unit where 50 per cent of patients are in isolation, a nurse has to wash their hands 40 times an hour to meet infection control standards." At NHS, she says, hand hygiene compliance is nearly 100 per cent. The provincial average is 67 per cent. On top of that, there is the donning of personal protective equipment and sanitizing shared equipment. "I made it a goal to ensure this was not a monkey on the backs of nurses alone," Matthews says, adding she did this, in part, by using media briefings to remind the public about the virulence of hospital-acquired infections, and the public's role in hand hygiene.

These points are not well understood by the public or media, says Lynn Ronnebeck, an RN in the infection control department at Lake of the Woods District Hospital in Kenora. "Physicians or nurses get vilified because of inadequate hand washing or a deficient practice, but there are a host of other considerations at play," she says, including: "...how virulent the organism is, the type of patient it affects, how compromised they are, and the type of procedure being done. Most hospital-acquired infections I see come from patients in the intensive care unit, the sickest of the sick."

"We can do our darndest to prevent nonsocial infections, but some bugs are pretty stubborn," adds RNAO President David McNeil, Vice President of Clinical Programs and Chief Nursing Officer at Hopital regional de Sudbury Regional Hospital.

QUICK STATS

The rate of C. difficile infection in Ontario climbed **33 per cent** to .40 per 1,000 patients to reach a peak in May 2011. By the summer, it had dropped down to just more than .30 per 1,000 patients.

Ontario's worst C. difficile outbreak on record was at Burlington's Joseph Brant Memorial Hospital, where **91 infected patients died** in 2006 and 2007.

The Canadian Institute for Health Information suggests **one in 10 adults** and one in 12 children will contract an infection while in a Canadian hospital.

"C. difficile is an excellent example where there are complex issues that need to be tackled, including with the environment." (See pg 16, *Why private rooms are the gold standard*)

RNAO sent a letter of support to NHS during the outbreak, commending the work done by the nurses. "We know every nurse will continue providing the top-notch care you have provided without fail for years. Your knowledge, skill and clinical judgment are being pushed to new limits, but most certainly you are making a difference," wrote McNeil and Doris Grinspun, Executive Director of RNAO.

Hospitals are not alone when it comes to infection control. In fact, Ontario's Ministry of Health and Long-Term Care, through the Provincial Infectious Diseases Advisory Committee, has developed cutting-edge guidelines, says RN Ronnebeck. The ministry also requires hospitals to report infection rates monthly, and offers assistance to hospitals (through the Regional Infection Control Network) in determining when an outbreak is declared (a complex and variable formula). It also provides infection control practice assistance throughout an outbreak.

Provincial health authorities assisted NHS this past summer and fall, including reviewing a wide array of practices and providing a report. Health Minister Deb Matthews appointed a supervisor, Kevin Smith, on Aug. 31. Smith reported directly to the minister, which (Sue) Matthews says she welcomed as a way to "help reflect on our practices." One of the recommendations specific to nursing from the Provincial Infection Control Resource Team was to empower NHS nurses with the ability to isolate a patient. "Why wait for an infection control specialist to make a decision that (nurses) can make?" asks (Sue) Matthews.

QUICK STATS

Canada's health-care associated infection rate is at **11.6 per cent**, one of the worst among developed countries in the world.

A 2003 Canadian study (the most recent numbers available) puts the number of hospital-acquired infections in Canadian hospitals each year at 220,000. These result in **8,000 deaths annually**.

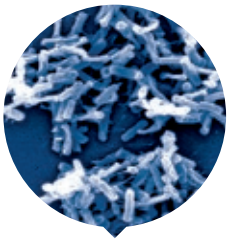
The U.S. Center for Disease Control and Prevention estimates there are **1.7 million hospital-acquired infections** in American hospitals each year. About 99,000 deaths can be linked to these infections.

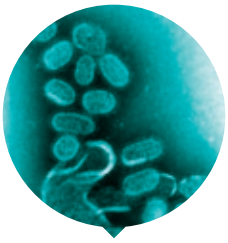
Other measures NHS took that assisted nurses during the outbreak included approving a boost in nursing and housekeeping staff. It assessed job functions to remove non-nursing tasks from nurses, and reduced visiting hours. Hand hygiene auditors also provided immediate feedback when errors were spotted. While NHS's antimicrobial stewardship program was in the works before the outbreak, Matthews admits she's "...not sure how much [nurses] were asking about overuse of antibiotics." Led by the Institute for Safe Medication Practices Canada, the program is testing a number of hospital interventions to stem the rise of antimicrobial-resistant organisms. One of its goals is to raise awareness and empower every nurse to question a patient's need for antibiotics.

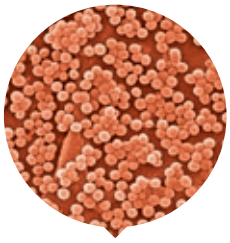
Policing infection control practices often falls to nurses and both UHN's Gardam and RNAO's McNeil agree that RNs may not always feel adequately empowered, especially if that policing involves confronting colleagues or physicians. One front-line, acute-care nurse who asked not to be named said, "Physicians are the most difficult to get to follow infection control practices, namely to wash their hands. They will tell you that you are being too particular and that in their judgment, that patient is past the point where those practices are necessary."

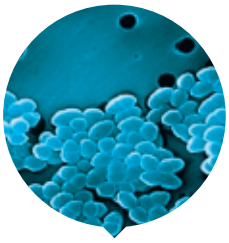
The public often comes in a close second to indifferent health professionals. Marie Morden, an acute-care RN at Lake of the Woods District Hospital, says the public's lack of education around infection control in hospitals can be a burden on nurses who have to take the time away from caring for patients to educate family members about the hospital's due diligence measures. "We are reteaching it, over and over again," she says. "When some families come to visit someone in

HOW DOES IT ALL BEGIN?









To spread infection, an infectious agent needs a reservoir where it can live, grow and reproduce, and a susceptible host. Modes of transmission include direct and indirect contact; droplet transmission; vehicle transmission (food, water or instruments); airborne transmission; and vectorborne (insects).

C. DIFFICILE (Clostridium difficile): Antibiotics reduce the normal levels of good bacteria in intestines and the colon, which allows C. difficile bacteria to grow and produce toxins. Transmission occurs through direct and indirect contact.

FRI (febrile respiratory illness) including colds, influenza and pneumonia: Droplets containing disease-causing organisms are either inhaled by the patient or touched by the patient who then touches a mouth, nose or eyes. Transmission occurs through droplet and contact.

MRSA (methicillin-resistant Staphylococcus aureus): S. aureas bacteria living on the skin, nose or in the lower intestine may cause an infection and resist a common class of antibiotics (people may carry the bacteria without having symptoms). Transmission occurs through contact.

VRE (vancomycin-resistent enterococci): Enterococci bacteria in lower intestine or other areas (e.g. urine, blood, skin) may cause an infection and resist antibiotics (people may carry the bacteria without having symptoms). Transmission occurs through contact.

Source: College of Nurses of Ontario Infection Prevention and Control Practice Standard; and Office of the Auditor General of Ontario Special Report: *Prevention and Control of Hospital-acquired Infections*, September 2008.

WHY **PRIVATE ROOMS** ARE THE GOLD STANDARD

North York General Hospital (NYGH) announced an expansion in the summer of 2011 that would include 40 additional beds, 80 per cent of which would be in single-patient rooms. "This really allows staff to put any patient in a private room rather than keep them waiting around not knowing where to place them in case of infection," says Karen Popovich, NYGH Vice-President and Chief Nursing and Health Profession Executive. "Single-bed rooms are the reality of the future."

Infection control experts contend that in an ideal world, all future hospital rooms would be 100 per cent private. Research suggests that single-bed rooms alone can reduce infection rates by up to 45 per cent. Michael Gardam, Director, Infection Prevention and Control at Toronto's University Health Network, says single-bed rooms reduce nursing workload because nurses have everything they need at their fingertips.

And yet, hospitals are slow to embrace the design.

RN Pierette Brown, Executive Director at Algoma Family Services in Sault Ste. Marie, wrote letters to her local media making the case for why the new hospital, which opened there last March, should have private rooms. "They brushed me off… said they were too far into the process to change," she says of hospital administrators. "But it's an 80–20 split, which is better than 70–30, what they were originally planning," she concedes.

Brown is confident awareness will grow, in part, because of the virulence of hospital-acquired infections. "It's just a matter of time before we will be forced to change the way we set up rooms."

isolation, it's almost as though they feel they are being punished by having to put on a gown, gloves and mask."

CEO Matthews recalls how one nurse at NHS received the following remark from a much taller male family member when asked to don personal protective equipment: "Make me." The nurse did, actually, by being firm, and by mentioning she would call hospital security if need be.

Gardam, who helped develop unprecedented infection control measures during the SARS outbreak in 2003, says education is just one piece of the puzzle when it comes to developing infection control improvements. Workplace culture is another important piece. "You can have the knowledge, but the workplace culture is such that you just don't pay attention to practice. It's not only nurses who aren't empowered in health-care settings. Many groups aren't empowered."

Karyn Popovich, Vice-President and Chief Nursing and Health Profession Executive at North York General Hospital, does regular walkabouts on units to engage nursing and housekeeping staff in conversations about infection control practices. "We want them to know we are proud of the work they are doing. That really helps build it into the culture." She adds that the hospital's experience during SARS offered some valuable lessons about infection prevention and control practices, including creating a culture of trust, openness and transparency between hospital administration and front-line staff.

In Matthews' experience, you can't underestimate the power of face-to-face communication for rolling out new policies around infection control, and for empowering staff to implement them. "We launched an initiative during the outbreak where each unit's manager, health program director and the V.P. did daily rounds." Knowing senior staff was involved and supportive bolstered morale and reinforced staff's responsibilities, she says.

May Abdalla, Windsor Regional Hospital's (WRH) infection prevention and control co-ordinator, shares that view. She says staff engagement at WRH has resulted in a number of nurse-led infection control solutions. One idea that originated from a front-line nurse at WRH addressed the need to reduce the risk of human error (for example, forgetting to wash hands or sanitize equipment). In high risk areas, one side of the hallway is used for isolation patients only, says Abdalla. A yellow line was literally drawn down the hall so that all staff would remember infection control protocols when they crossed it. "Instead of just a random area being in isolation, now a consistent area exists where all the equipment is kept. It is much easier and more effective."

Several nurse managers also stepped up with ideas to improve processes. They helped speed up necessary isolation of patient transfers by making incoming patients' infection status an element on the existing transfer forms. "When a patient arrives, we know right away if they have C. difficile, MRSA or something else," Abdalla explains, adding this eliminates the need to find somewhere to place them while they are being tested.

The hospital's ICU nursing staff also came forward with a solution to help alleviate workload and save the hospital money. They developed a patient supplies form at the bedside and have one nurse fill it out before each shift. "This nursing initiative is very effective in reducing the risk of transmission through contaminated patient supplies. It also reduces waste, since supplies left after discharge are discarded during the cleaning process," Abdalla says. "They committed to it because it really saves them time in the end. They don't find themselves all outfitted in personal protective equipment only to be missing a piece of equipment."

These kinds of measures are terrific examples of the kind of parting advice Matthews has for every organization. "Be proactive. Don't wait for something to happen to review your practices. You have to stay on top of it." And to front-line nurses, Matthews says this: "Remember: all of the stress totally outweighs the difference you are making in people's lives." **RN**

LESLEY YOUNG IS A FREELANCE WRITER/EDITOR IN AURORA.

QUICK STATS

In 2003, Ontario's SARS epidemic put **thousands into quarantine**, infected 375 and killed 44.

In Canada, roughly **10 per cent of the populace** of 3.5 million have been infected with H1N1, and in the 2009 epidemic, there were 428 confirmed deaths.

A World Health Organization report finds medical error and hospital infection rates run as high as **16 per cent worldwide**.

A shot in the arm

Fewer than 50 per cent of health-care workers in acute and complex continuing care got the flu shot last year. Efforts to boost interest in this tried and true infection control measure are underway, but are nurses interested? BY STACEY HALE

This flu season, Frances Cadogan did something she never thought she would. The nurse from London, Ontario rolled up her sleeve and got her very first flu shot.

A severe allergy to latex and sensitivity to medications, coupled with misinformation and fear, left the nurse of 10 years saying 'no' to the needle every year. "I was dubious about putting it into my body," she admits.

That anxiety gave way to reason this year, when Cadogan's manager recommended her for an infection control role at St. Joseph's Health Care. In her new position, Cadogan would be required to attend monthly meetings to learn about combating infection in the hospital. October's meeting focused on influenza, and everyone was encouraged to get vaccinated.

"My first reaction was 'oh, I don't know,'" she says of the moral dilemma. How can I encourage fellow nurses to get the flu shot when I've avoided it for years, she thought.

After watching a presentation by the hospital's infection control team, Cadogan was convinced. They did a great job educating us, she says. They dispelled myths about the shot, including: the vaccine causes the flu (not possible because it does not contain any live virus); the vaccine doesn't work (statistics show it can prevent illness in 70 to 90 per cent of healthy children and adults).

Last year in Ontario, less than half (42 per cent) of health-care workers in acute and complex continuing care got a flu shot. In long-term care, it was slightly higher at 58 per cent. Immunization rates among health-care workers have decreased over the last five years. Despite education and campaigns to promote the flu shot, it seems nurses are not following Cadogan's lead.

Peterborough nurse Joni Wilson is an exception. She gets a flu shot every fall. She says it's important for nurses to get immunized because it helps to reduce illness and death associated with influenza. As director of care for Peterborough's St. Joseph's at Fleming long-term care home, Wilson sees the negative impact of flu outbreaks on elderly residents. "The elderly are at greater risk of complications from the flu," she says, adding there are also psychological repercussions when an outbreak is called. Residents may be isolated, and kept from seeing their families.

Frances Cadogan gives a colleague the flu shot. To find out how you can get vaccinated, visit www.rnao.org/flu

Wilson educates her staff and encourages vaccination. Workers can carry the virus and not even realize they have it, she says. "I want staff to think of residents first." And it seems they are. Last year, 87 per cent got the shot.

According to Health Canada, an estimated 4,000 to 8,000 Canadians – mostly seniors – die every year from flu related complications such as pneumonia. Twenty-thousand are hospitalized. Higher rates of vaccination among health-care workers could help to curb these numbers. Wilson says the financial burden may decrease too. "It costs money to send residents to the hospital," she notes, adding there are also costs associated with personal protective equipment needed during an outbreak.

Barbara Yaffe, Director of Communicable Disease Control and Associate Medical Officer of Health for Toronto Public Health (TPH), believes getting the shot is a professional duty. In an effort to improve immunization rates, TPH launched an awareness campaign in October called the *Containment Challenge*, which includes posters and a video of well-known professionals in the health community, including RNAO's Executive Director Doris Grinspun. Each explains why it's important for health-care workers to get the flu shot. Mobile carts travelled around some hospitals offering on-the-spot shots. The *Challenge* was to vaccinate as many health-care workers as possible before Nov. 15. The health-care facility with the highest coverage rates, and the one with the most improved rates, will be recognized at the Toronto Board of Health meeting next spring.

In the U.S., history has shown the only way to improve rates of immunization is by making the flu shot mandatory for health-care workers. Yaffe hopes Canada doesn't have to go there. "There are a lot of legal and human rights issues with making it mandatory," she says. "It would be great if we could get the rates up without going there." **RN**

STACEY HALE IS EDITORIAL ASSISTANT AT RNAO.

You could be called upon to put your nursing knowledge into practice when you least expect it. How will you respond in an emergency situation?

BY LESLEY YOUNG

Medical emergencies happen every day. Riding a bike during rush hour, a man experiences a seizure. Coming around a sharp corner on an icy road, an oncoming car swerves to avoid an animal and flips onto its side in a ditch. At a dinner party, following a curling match, a team player turns ashen, incoherent and slumps in his chair. Think you won't be in these kinds of places at just the *right* time? Think again. Here are three stories of nurses in first responder emergencies. How did they cope? And what skills did they draw on to make a difference?

RN firm, not forceful, when advising cyclist to remain on scene

Public health manager Maureen Cava was coming up on a tricky traffic circle on a spring day in May 2011 when something odd caught her eye. "I saw a man lying on the sidewalk. Someone else was standing near him talking on his cell." Her first thought: "Someone's on the ground. I need to go help this person." Remaining calm, she rode up and got off her bike. She identified herself as a nurse to the bystander, who was an off-duty police officer. He had witnessed the man having a seizure, pulled over, placed him in the recovery position and called 911.

"He was able to speak," Cava says of the man who was regaining consciousness. "I asked questions and was able to determine his medical history." He had had a brain tumour, and was on anti-seizure medication. At the time, he was on his way to pick up his daughter from school. While waiting for paramedics, the man recovered, and was keen to get back on his bike and pick up his daughter, says Cava.

"He didn't even want to wait for the paramedics never mind go to emergency," she says. "I was not comfortable with that. I had to be firm, not forceful, but firm," she adds. "I told him, as a nurse, I felt responsible for him. I couldn't force him to stay and have an assessment, but I did not feel comfortable with him getting back on his bike." She convinced him to wait for paramedics, but he did not go to emergency. Once EMS arrived, she felt reassured, and left them with him to ensure he got home safely (other arrangements were made to pick up his daughter).

Cava tapped into a great deal of conviction during this crisis. She says she was able to do that because she trusted herself. After 35 years of nursing, some 24 years in managerial positions, Cava only recently returned to the front line when she was asked to assist during a labour disruption and help out at a shelter. "Out there in the street, without support around me, it did feel really different," she admits. "As the only experienced medical person on the scene, it was a big responsibility."

Cava is proud of her stay-calm approach and readiness to assist. "It's not about being a nurse. It's who I am as a person. I see someone in trouble, I just react," she says, adding, "You're never really prepared. Out on the street, anything can happen. You just have yourself, and your brain, and that's it."

Toronto Public Health RN Maureen Cava came to the aid of a man having a seizure.

Three RNs are better than one, for patient and for provider

Rosemary Enright

In March 2011, Belleville RNs Susan McConnell, Rosemary Enright and Susan Barchard were enjoying a post curling wrap-up dinner at their clubhouse in Tweed. Enright was sitting next to a fellow curler when she noticed he was slumped forward. "I called his name (Wray), and shook him a little." She pulled on his shoulder. "I felt dead weight. I knew he was non-responsive." Enright announced to no one in particular, "There's something wrong with Wray." Fear cut through both Enright and McConnell, and within seconds the entire room leapt into action.

Barchard, who was seated further away, saw McConnell running to the phone. "The next thing I saw was somebody lying on the floor." The semi-retired nurse practitioner, who had not worked in emergency for over a decade, said it was like strapping on ice skates after years away from the sport; it just came back to her. "Get the AED (automatic external defibrillator)," she shouted as she ran over.

The three nurses worked as a team, one on each side, one holding Wray's head. Within two minutes of the episode, the trio – who had minimal training on how to use an AED – took over CPR, applied the pads, and pressed the button. "I don't remember the crowd except for that moment, when they all gasped," says Enright. The three nurses kept up the CPR for what seemed like an eternity, and when they checked, Wray had a pulse and blood was returning to his face.

Susan McConnell

Barchard's memory of bystanders is clearer. Many, she says, were quite vocal about continuing CPR well after Wray's pulse had returned, and before the ambulance arrived. "I was able to filter it out," she says. "I do wonder if someone without medical knowledge would have bowed to the pressure. They might have caused more problems, like broken a rib…" The incident was an eye-opener, she adds. "I'm the type of person who will sit back and let others more experienced do something. I didn't see anyone like that here, and so I jumped into action. I am proud of that."

Enright and McConnell both work at Belleville General Hospital. They agree there is little on-the-job experience that prepares you for such a frightening situation. All the more reason they were grateful to have one another to rely on.

Susan Barchard

"Here are my angels," Wray said of Enright and McConnell when they visited him while on shift the next day. "That was really heartwarming," Enright says, adding that she's thrilled Wray made a full recovery and is back at the curling club. "As a nurse, I always wondered in the back of my mind if I would encounter something like this in my lifetime," she adds. "I hoped I would do the right thing, and I did."

Home care RN remains calm in the face of uncertainty

On a clear winter day in February 2011, home care nurse Lesley Anthony was on her way to her next appointment after visiting a patient in Brant County. She was following a truck along a familiar road known for a particularly sharp 45-degree turn. "Coming around the corner, I saw a blur of something. I had no idea what it was, but I knew something had happened," says Anthony. The truck driver slammed on his brakes. "As he pulled over, out of the corner of my eye, I saw a car in the ditch, on its side."

In that moment, Anthony felt absolutely no fear. "I knew something significant had happened. Possibly people needed my help. That was my only thought on the matter. There was no analysis, nothing else." She pulled safely off the road, grabbed her cell phone, and headed to the overturned car, now resting on its passenger side.

> "I talked to them calmly. I told them I was a nurse and that 911 had been called."

The truck driver was also heading to the wreck, as was another gentleman. Anthony didn't waste a second. She went right up and peered into the car. The male driver was alert, and unhurt. His wife, held in position by her seatbelt, was also okay.

"I talked to them calmly. I told them I was a nurse and that 911 had been called." That's when the driver told Anthony his sister was in the back, but Anthony couldn't see anyone. Pulling herself up to a better vantage point, she looked down into the car and saw a tiny, immobile body huddled against the rear door. "She wasn't moving, or answering my questions." At this point, the two adults in the front seat were panicking, asking about 'Doris,' adds Anthony. "I decided to crawl into the back window."

It was a good thing she did. The elderly woman was positioned with her head curled down near ditch level where cold water was quickly collecting. Anthony didn't move Doris, but positioned herself so she could curl her arm under Doris' head to support it up and away from the water. She was uninjured, but couldn't move.

For the next 30 minutes, Anthony, soaked in ice cold water, chatted with the passengers in an effort to keep them calm. "I don't think I stopped to think about anything. I just wanted to keep everyone talking. I asked them where they had been, if they had children." As time passed, she had to keep reassuring the driver (fraught with guilt and fear) that everything was going to be okay.

A few weeks later, the driver and his wife, Jack and Barb Muntz, invited Anthony for tea, and gave her a necklace with an angel charm. "[The experience] reinforces why I am glad to be a nurse. That I had the comfort level to stop and kick into action."

Anthony is genuinely unimpressed by her actions. "I wouldn't have done anything that was outside my proficiency." She does admit, however, that the impulse to help in an emergency is the same impulse that drove her to become a nurse. "We become nurses because we are compassionate people and we want to help others, whether it is in a hospital bed, at home or in a ditch." **RN**

LESLEY YOUNG IS A FREELANCE WRITER/EDITOR IN AURORA.

Windsor RN shows early signs of leadership

AT A TIME WHEN NURSES WERE ONLY BEGINNING TO FIND THEIR VOICE, LAURA BARR WAS NOT AFRAID TO BE VOCAL.

The organizational strength and political influence that RNAO enjoys today rests on a firm foundation built by Laura Barr, the association's executive director from 1960 to 1976. Barr's vision and leadership led to many important milestones that define the profession today. She is described by nurses as someone with political savvy, a keen respect for nurses and a collection of fabulous hats.

"People were devastated when she announced her retirement," remembers Mary Bawden, a board member during Barr's tenure. She was there when Barr announced her departure and recalls "the whole room was in tears. People wondered how we could continue."

Barr, who currently lives in a long-term care home in Windsor, never planned to become a nurse. She was working as a secretary at Salvation Army Grace Hospital in Windsor in 1945 when her aunt, who was the director for the hospital, phoned to tell her a first-year student had just dropped out. Barr agreed to take the spot, and started the next day.

After graduation, she attended the University of Toronto's school of nursing to get her certificate in teaching. Once complete, she returned to Salvation Army Grace Hospital and taught in the nursing program for three years. She left acute care for a position in a physician's office because she wanted a change. It wasn't long before she started to miss acute care, and eventually left family practice to become assistant director of nursing at Windsor's Metropolitan Hospital. This is where she met longtime friend Kay Arpin, now a retired nursing professor.

"Laura was quite well known in Windsor as a leader," remembers Arpin, noting that she was chair of RNAO's Windsor-Essex chapter. Barr's engagement at the chapter level led to her participation on the board of directors. Arpin says Barr was "somebody that people noticed" for her engagement both inside and outside nursing. Her most notable work outside the profession was as an organizer for Windsor's 100th anniversary celebrations. Both of these voluntary roles brought her leadership skills, intelligence and confidence into focus. Before long, she was being groomed to become the association's executive director (ED), Arpin says.

Laura Barr (top, right and below, centre)

Three things you don't know about Laura Barr:

1. She was born in Japan, where her parents were working as Salvation Army missionaries.
2. She helped organize the city of Windsor's anniversary celebrations in 1954.
3. She knitted beautiful sweaters and loved to bake.

Barr's vision was for nurses to function as independent practitioners, not as assistants to physicians, remembers Bawden. "She helped create the professionalism of nursing in our province. And because Ontario has the largest number of nurses, she was setting the development of the whole practice of nursing across the country."

Gail Donner sought advice from Barr when she took on the role of RNAO ED less than a decade after the highly respected Windsor native left. "She was incredibly progressive...and was quite a shrewd politician in the old way that people did politics...quietly and behind closed doors," explains Donner.

She says one of the most memorable lessons Barr taught her was the importance of showing respect for members by communicating openly. "In any leadership position, you have access to information that the broad membership doesn't have," Donner says. "You have to help members understand where you're going; you can't be too far ahead of them."

Barr led nurses through tremendous change during her 16 years as ED. She was involved in developments that continue to influence the profession today. In 1960, at the request of the Ministry of Health, she was involved in studying the feasibility of a college of nurses in Ontario. At that time, RNAO was responsible for the registration of nurses. Today, the College of Nurses of Ontario (which was formed in 1963) is the regulatory body. Barr also played an important role in the formation of the Ontario Nurses Association (ONA). Between 1965 and 1972, RNAO sponsored the organizing of 104 local nurses' associations that bargained as individual units. When those nurses asked RNAO to form a central union, ONA was born. In 1974, RNAO transferred its collective bargaining activities to ONA.

"Laura provided the stability, the continuity and the vision the association needed," says current ED Doris Grinspun. She counts Barr as one of her mentors, adding: "she was actively moving the association forward."

Donner says Barr will be long-respected for her contribution to the profession. "She was a very powerful force in nursing." **RN**

JILL-MARIE BURKE WAS MEDIA RELATIONS COORDINATOR AT RNAO.

Falling Short

Ontario has come a long way with its post-graduate offerings for RNs, but academics say there's some work to do to address the faculty shortage that looms on the horizon.

BY KIMBERLEY KEARSEY

Nancy Purdy says she's still not making the salary she earned as a chief nursing officer a decade ago, but the satisfaction and sense of accomplishment she feels teaching students makes up for any shortfalls in the pocketbook. A tenure-track associate professor at Ryerson University for three years, Purdy says she always knew she wanted to get her PhD and enter the world of academia, but it wasn't until eight years ago that she found herself in a position to make it happen. In 2003, she was offered a severance package when the hospital where she worked restructured. It was one of those 'now or never' situations, so she took the leap.

Graduate student Heather Thomson, on the other hand, never envisioned herself in academia when she finished her master's degree in 2009. Her vision for the future had her heading for the type of administrative role Purdy had vacated several years before. To reach that career milestone, Thomson decided to accept a fellowship doing patient safety research at the University of Toronto. Suddenly, she realized that getting a PhD, conducting her own research, and bringing it to students in a classroom was a much better way for her to leave her mark on the health-care system.

For some, the decision to pursue a PhD with the goal to teach is easy. For others, the journey may be a little less direct, and at times surprising. Regardless of how they arrive at their destination, nursing academics are welcome at the front of the classroom. In fact, their presence is needed because Ontario is facing a shortage of nursing faculty that is threatening its chances of producing the number and calibre of RNs needed for the future.

Statistics compiled by the Canadian Association of Schools of Nursing (CASN) (2008-09) reveal almost 14 per cent of nursing faculty in Canada is over the age of 60. Almost 35 per cent is over 55. And yet, admission rates for nursing schools across Canada reached a 10-year high in 2009. That year, more than 14,000 students began their degrees, almost 50 per cent more than a decade earlier. There are no signs this increasing interest in nursing will wane any time soon, which begs the question: what happens when these older nurses retire? Who will teach the next generation of RNs?

It's a question that sparks a lot of debate, especially when you consider the number of Canadian nurses pursuing their PhDs – a mandatory requirement for tenure at a university – has only increased incrementally over the last five years (from 76 to 84). Forty-two nurses graduated from doctoral programs in 2009. Given CASN estimates an annual need for 650 PhD prepared nurses, this pool of grads represents less than 10 per cent of the required total.

Conversations with members of the academic world reveal there are some conflicting views on whether or not we're actually experiencing a faculty shortage. Although some suggest we're okay right now, they don't deny the reality that Ontario is likely to find itself falling short on faculty in the not-too-distant future.

Ten years ago, RNAO's board of directors passed a resolution at the association's annual general meeting to call on the Ministry of Training, Colleges and Universities to provide more funding to

Nancy Purdy (right) and Heather Thomson take different journeys to academia, but end in the same place.

PHOTO: JEFF KIRK

universities to expand doctoral programs in nursing and to increase funding available to universities interested in developing such programs. In 2004, then Minister Mary Anne Chambers announced at an RNAO education conference that the government would invest $10 million over four years to fund PhD nursing programs. At the time, McMaster University, the University of Toronto, and University of Western Ontario were the only schools to offer PhD programs specifically in nursing. Since the funding was announced, three additional programs have started, at Queen's University, University of Ottawa and Laurentian University.

Betty Cragg was a nursing professor at the University of Ottawa when the funding was announced. She remembers the optimism it generated, especially since it followed an Association of Applied Arts and Technology survey that predicted almost 50 per cent of university faculty and almost 40 per cent of college faculty would retire by 2010. At the time, Cragg expected to be one of those retiring faculty members at the end of the decade. But the years that followed did not play out as she expected. Nor did they result in the number of retirements predicted in the survey.

Cragg retired in July 2011, at the age of 68. She says her later-than-expected departure was thanks to the abolition in 2006 of mandatory retirement at 65. She and three fellow faculty members retired in July, one of whom was older than Cragg. Their positions, she says, have not been refilled, but she's not sounding any alarm bells just yet. In fact, Cragg is one of those who suggests we are not experiencing a shortage at the moment. Two years ago, for the first time in her 20 years as a professor, there were no full-time, tenure-track vacancies at the University of Ottawa. All 32 faculty positions were filled. "Full time, tenure track, the whole ball of wax," she says. She credits the university with "growing its own" (seven of the 12 who have finished their PhDs in Ottawa have been hired as faculty), but reserves some healthy skepticism about how long the university can report such favourable numbers.

Although relatively new to the academic world, Purdy is also reluctant to say the "sky is falling," but she doesn't pretend the world of nursing academia isn't facing the threat of a troubling shortage. Purdy says she works as hard as she ever did as a chief nursing officer, but doesn't feel stretched or stressed for lack of faculty. In fact, she has colleagues who are having trouble finding positions.

Catherine Tompkins, Associate Dean of Health Sciences and Director of the School of Nursing at McMaster University, sees it differently. Tompkins, who is also chair of the Council of Ontario University Programs in Nursing (COUPN), admits it's startling just how many vacancies have been recorded in Canadian universities.

"I was just at a CASN meeting and they were giving the numbers (for 2010)...they reported 110 vacancies." The number one reason for this, she notes, is getting qualified people to fill the positions. There are issues with funding as well, she adds. "There are hiring freezes because the universities are in challenging financial times. It's complex to know exactly what the cause is...but there are vacancies."

Purdy suggests she and other professors have a role to play in addressing the problem. Ryerson, she says, is doing a lot of the right things to promote graduate studies among students with aptitude. "As faculty, we're always trying to support them," she says. "We try to find opportunities for students to be research assistants...to publish with us...so if they do want to pursue a PhD or a graduate degree, they're more competitive."

Purdy also believes there's a lot to be said for late bloomers who have more comprehensive practice experience coming in. Tompkins agrees.

> **"Student-to-faculty ratios are growing**. Before we used to have a class of 30...now it's gone to 60. We used to supervise four students clinically, now we're supervising half a dozen. **Everything has been increasing**, especially over the last decade."

Nurses who pursue graduate education are "not like those in the humanities or the arts where they come straight from a baccalaureate, to a master's to a PhD and they're graduating by the time they're 30," Tompkins says. Nurses "are, very often, people who are out there working in already established roles and who are planning to go back to those or planning to stay within their organizations. The career path is quite different."

RNAO, in its *Creating Vibrant Communities* document (released January 2010), urged the government to consider some key recommendations to address the looming faculty shortage (see sidebar below). Tompkins says the recommendations are important, but suggests it's equally important to entice more nurses to pursue their master's degree. "We need to put the emphasis on taking in excellent master's students because they're going to be our pool for the PhD."

Heather Thomson was one of those master's students who was drawn into a PhD program. Her passion to teach is clear. But she's the first to admit she stumbled upon that passion. She suggests that students – whether they're pursuing a baccalaureate, a master's or a PhD – don't have enough exposure to the kinds of things academia has to offer. "I think as a student, you are primarily exposed to the research side of things and not necessarily the teaching piece unless you're working as a teaching assistant (TA). If I wasn't a TA, I don't think I would be all that interested in it."

Students and faculty also suggest the lack of interest in the education sector can be linked to an increase in other opportunities for nurses who have graduate degrees. Management and administrative positions – chief nurse executive is one – will draw many PhD prepared nurses away from academia. Lower salaries in the education sector are also a deterrent, as are workload issues that leave some faculty feeling they're being asked to do more with less support.

Drawing more graduate students into academia is important. But equally important is the retention of existing academics. University of Ontario Institute of Technology RN and associate professor Wally Bartfay, along with RNAO member and Queen's University nursing professor Ena Howse, conducted research on the faculty shortage in 2007. Bartfay and Howse share concern about the way universities have adopted a corporate, for-profit model for education.

"At UOIT...we used to have a class of 30...now it's gone to 60. We used to supervise four students clinically, now we're supervising half a dozen. Everything has been increasing, especially over the last decade." He's incensed that while class sizes are growing, universities are sometimes hiring instructors for less. Seasonal lecturers can be hired for as little as $5,000 per course. The cost to deliver four courses – the expected course load for most faculty – is only $20,000 as opposed to a base salary of $80,000 for an entry level, tenure-track assistant professor, he says. "This raises questions about the quality and consistency of education, given contract lecturers are not held to the same standards and expectations as tenured professors," Bartfay adds. He worries that if you don't have tenured professors teaching core nursing courses, you are not providing students with "cutting edge, research driven, evidence-based" content.

Bartfay admits that Canada is about 10 years behind the U.K., U.S. and Australia when it comes to the supply of PhD prepared nurses, and the availability of doctoral and post doctoral programs. "We need a culture here to develop it," he says, adding the shift won't happen in the next few years. It will probably be another decade before we adopt a post doctoral training model that provides a bridging opportunity for people to learn how to write grants, teach and receive the mentorship they need to be successful in academia.

When members of RNAO debated and ultimately passed the resolution almost a decade ago to lobby the Ministry of Training, Colleges and Universities for more funding and better access to PhD programs for nurses, it was part of an ongoing effort to open up more opportunities for nurses, and to build the credibility of the profession. "I think we've come a long way," Tompkins says optimistically. "We still have a ways to go but we've got more programs certainly in Ontario. The difference between the late 90s and where we are now is huge." **RN**

RNAO RECOMMENDATIONS TO GOVERNMENT

RNAO, in its *Creating Vibrant Communities* document (released January 2010), urged the government to consider some key recommendations to address the looming faculty shortage:

- fund universities to increase their PhD entries by 10 per year, and their master's entries by 100 per year
- create an endowment for three-year doctoral fellowships for nurses to allow at least 15 applicants per year to advance their research and accelerate completion of their dissertations, with priority given to nursing faculty
- raise Nursing Education Initiative funding from $1,500/student/year to $2,000/student/year

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

POLICY AT WORK

A Red Cross worker loads sleeping bags onto a trailer at the airport in Attawapiskat

THE CANADIAN PRESS/ADRIAN WYLD

Nurses decry housing conditions in Attawapiskat

Details about deplorable living conditions in the Aboriginal community of Attawapiskat, near James Bay, prompted RNAO to write an open letter to Prime Minister Stephen Harper and Ontario Premier Dalton McGuinty on Nov 23.

Attawapiskat Chief Theresa Spence declared a state of emergency at the end of October and requested the evacuation of the community's 2,000 residents, stating she feared for the lives of children and elders with the onset of winter. Her plea for help led to a visit by area MP Charlie Angus (NDP). He reported seeing five families living in tents and up to 20 in sheds without indoor plumbing or adequate sources of heat. Another 128 families were living in houses condemned as a result of black mould and failing infrastructure.

More than 2,000 members responded to RNAO's call for letters to politicians urging them to intervene.

In its action alert, RNAO pointed out how freezing temperatures, a lack of running water, improper sanitation and overcrowding can lead to the spread of infectious diseases.

The federal government agreed to spend $500,000 for renovations, but Angus said that money won't go far enough, especially given the high cost of housing construction in the north. At press time, negotiations continued to increase federal funding by two million dollars.

Although reserves fall under federal jurisdiction, RNAO wants the provincial government to do its part to advocate on behalf of the Aboriginal community, and press Ottawa into action.

Meanwhile, the Canadian Red Cross stepped in to offer temporary help to the community.

Liberal government throne speech sets legislative agenda

Before the Christmas break, Ontarians got a taste of the Liberal government's key priorities during a throne speech delivered by Lieutenant-Governor David Onley.

The good news is that while the province's economy is still mired deep in recession, the government has pledged to protect spending for health and education. A special commission looking into government spending is expected to release its recommendations in January. Chaired by Don Drummond, a former senior economist with TD Bank, the commission is conducting a wide-ranging review of all program spending.

RNAO was among the first stakeholders invited to meet with Drummond and his team to give its views on health expenditures. The association emphasized its long-standing belief that the most efficient and cost effective health care is delivered in a publicly funded, not-for-profit system. Other recommendations included ensuring adequate numbers of RNs, expanded roles for nurses, and recognizing the value NPs bring to the health-care system.

> It's not too late to send an action alert. Visit www.RNAO.org/attawapiskat.

RNAO establishes task force on primary care nursing

Giving nurses a greater role in delivering primary care is the goal of a new RNAO task force. Almost 4,300 nurses (2,873 RNs and 1,412 RPNs) work in a variety of primary care settings throughout the province. RNAO believes their role is untapped and should be expanded to include group education, patient care coordination and common procedures such as pap smear exams. This will enable family physicians and NPs to focus on more patients in a timely manner, and in a more comprehensive way.

The task force wants to hear from a broad cross-section of nurses who work in community health centres, family health teams, family practice offices, NP-led clinics and remote health centres, as well as from family physicians. The task force will be chaired by the president of RNAO's Ontario Family Practice Nurses Interest Group and RNAO Executive Director Doris Grinspun. It will bring key stakeholders together to recommend revisions to this nursing role.

CALENDAR

JANUARY

January 25
HOW TO JOB SEARCH EFFECTIVELY
Webinar

January 31
MID-CAREER NURSE SYMPOSIUM
Ottawa, Ontario

FEBRUARY

February 1
LEADERSHIP AT THE POINT OF CARE
Workshop
Ottawa, Ontario

February 12–17
CHIEF NURSING OFFICER/ CHIEF NURSE EXECUTIVE PUBLIC HEALTH ACADEMY
Niagara on the Lake, Ontario

MARCH

March 1
13TH ANNUAL QUEEN'S PARK DAY
Queen's Park Legislative Building
Toronto, Ontario

March 2–3
RNAO ASSEMBLY AND BOARD OF DIRECTORS MEETINGS
Delta Chelsea Hotel and
RNAO home office
Toronto, Ontario

March 5–9
DESIGNING AND DELIVERING EFFECTIVE EDUCATION PROGRAMS
Toronto, Ontario

March 7–9
LONG-TERM CARE LEAGUE OF EXCELLENCE
London, Ontario

March 25–30
WOUND CARE INSTITUTE
Niagara Falls, Ontario

APRIL

April 16
HOW TO WRITE AN EFFECTIVE RESUME AND COVER LETTER
Webinar

April 26–28
RNAO ANNUAL GENERAL MEETING
Toronto, Ontario
(see advertisement on opposite page)

MAY

May 3
NURSING PROFESSIONALISM IN COLLABORATIVE TEAMS
Workshop
Toronto, Ontario

May 7–13
NATIONAL NURSING WEEK
Nursing – The Health of Our Nation

May 11
EXPO – CAREER FAIR
Toronto, Ontario

JUNE

June 11–15
DESIGNING AND DELIVERING EFFECTIVE EDUCATION PROGRAMS
Ottawa, Ontario

JULY

July 8–13
BEST PRACTICE GUIDELINES FOUNDATIONAL INSTITUTE
Best Practice Guidelines Advanced Institute
Blue Mountain
Collingwood, Ontario

SEPTEMBER

September 27
PRECEPTORSHIP FOR NURSES
Workshop
Toronto, Ontario

September 30–October 5
HEALTHY WORK ENVIRONMENT INSTITUTE
Hockley Valley

OCTOBER

October 15
LEADERSHIP FOR NEW GRADS
Workshop
Windsor, Ontario

NOVEMBER

November 1–3
NURSE PRACTITIONERS' ASSOCIATION CONFERENCE
London, Ontario

November 18–23
CHRONIC DISEASE MANAGEMENT INSTITUTE
Blue Mountain
Collingwood, Ontario

DECEMBER

December 3–6
DESIGNING AND DELIVERING EFFECTIVE EDUCATION PROGRAMS
Toronto, Ontario

Unless otherwise noted, please contact events@rnao.org or call 1-800-268-7199 for more information.

PLAN AHEAD

June 4–7
International Nursing Conference
NURSING: CARING TO KNOW, KNOWING TO CARE
A joint effort of the Hadassah Hebrew University Medical Center and RNAO
The Inbal Jerusalem Hotel
For information, www.israel.rnao.ca

CLASSIFIEDS

ANNUAL DIABETES CONFERENCE FOR HEALTH PROFESSIONALS

April 13 and 14. The Holiday Inn, Kingston, Ontario. Topics to include: Ontario Diabetes Strategy, Insulin Management Made Easy, Living with Diabetes, Cognitive Behavioural Therapy, E.D., Smoking Cessation, Ask the Doctor, Diabetes and the Elderly.
Contact: Margaret Little, 613-547-3438 or hartwork@kingston.net

BECOME A CERTIFIED CANCER COACH

The National Association of Professional Cancer Coaches (NAPCC) is a federally registered non-profit organization. We are seeking nurses and registered health-care professionals to assist cancer patients in communities across Canada. You will provide information on medical treatment options and guidance in proactive self care. Training as a certified professional cancer coach is your first step to this rewarding community service, or you may choose a successful career in private practice. For more information, please visit www.napcc.ca; e-mail napcc@cogeco.ca, or call (905) 560-8344.

INTERESTED IN PROMOTING YOUR EVENT?

RNAO members receive a 15 per cent discount on classified advertising. To find out more, or to book your space in an upcoming issue, email editor@rnao.org or call 416-599-1925/ 1-800-268-7199, ext. 233.

RNAO's 87th

ANNUAL GENERAL MEETING

THURSDAY, APRIL 26 TO SATURDAY, APRIL 28, 2012
HILTON TORONTO, 145 RICHMOND STREET WEST, TORONTO

Wondering what your association is doing to ensure there are enough nurses to care for patients? Curious about how RNAO sets its priorities for the coming year? Interested in meeting the next president of RNAO? Then consider coming to your association's Annual General Meeting. This is your chance to connect with your association, meet fellow nursing colleagues from around the province, and see what your professional nursing body is all about.

Call for Voting Delegates

Deadline: Monday, February 27, 2012
For appointment forms and/or more information, call Penny Lamanna, 1-800-268-7199 ext. 208 or e-mail plamanna@rnao.org

AGM registration

After Jan. 27, please visit www.RNAO.org to access online registration for *RNAO's 87th Annual General Meeting.* Or, download a hard copy of the AGM registration form, complete it, and fax back to RNAO. Questions? Call Bertha Rodrigues at 416-408-5627 or 1-800-268-7199, ext. 212.

Hotel accommodation reservation

RNAO has established a block of rooms at the Hilton Toronto at $178 per night (+ taxes). Rate guaranteed until *Friday, March 30, 2012.* After Jan. 27, a link to the Hilton Toronto reservations site can be accessed at www.RNAO.org

WWW.RNAO.ORG

EXCELLENCE

RNAO's ANNUAL AWARDS FOR EXCELLENCE IN HEALTH-CARE REPORTING

Honouring the best health-care reporting of 2011

At its annual Awards for Excellence in Health-Care Reporting, RNAO takes time to honour journalists who have covered a nursing, health or health-care issue exceptionally well.

We encourage you to suggest journalists in your community submit their work for consideration. Submissions must have been published or broadcast in Ontario during 2011.

DEADLINE FOR ENTRIES: JANUARY 18, 2012

FOR ADDITIONAL INFO:
- www.RNAO.org/mediaaward
- mdicostanzo@RNAO.org
- 1-800-268-7199 ext. 250

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FACULTY OF NURSING
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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 to advance healthy public policy and to promote the full participation of registered nurses in improving health and in shaping and delivering health services now and in the future.

The primary responsibilities of this role are to develop and formulate policy by identifying and analyzing critical nursing practice issues. The main focus of this role is public health nursing, primary care and home care, with participation in other sectors as needed. 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. You will 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 nursing practice, research, education and administration.

The successful candidate will be a member of RNAO and the College of Nurses of Ontario. A Master's degree in nursing, political science or a related field is required and PhD in progress or completed is an asset. You will bring at least five years progressive experience to the role with at least three years of clinical nursing practice. Experience in the area of public health nursing, primary care or home care as well as strong knowledge of health and social policy issues is a must in this role. The successful candidate will possess superior writing skills. This is a full-time position, salary commensurate with experience. RNAO is now a member of HOOPP.

Please submit your resume by January 13, 2012 to humanresources@RNAO.org or to Director of Finance & Administration, Registered Nurses' Association of Ontario, 158 Pearl Street, Toronto, Ontario, M5H 1L3, or by fax 416-599-1926.

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

IN THE END

BY CINDY PALLISTER

What nursing means to me…

I WILL NEVER FORGET THE DAY CAROL* APPROACHED ME TO TELL ME ABOUT her first CPR experience. As a teacher, I've grown accustomed to hearing how students are fascinated by the rapid response of health professionals during an emergency, the role each plays, and the sudden realization that nurses have an important responsibility when it comes to the lives and health of others.

But, this student was different. I was not prepared for what Carol would tell me. With tears in her eyes and concern in her voice, she began to share her encounter with a frail elderly man. Her shift began with routine morning care and a conversation with the patient only moments before the unexpected cardiac arrest and subsequent code blue. "When I was asked to take a turn, I could feel the ribs breaking with each compression and I'm afraid it's my fault he died," she told me. As I tried to console and help Carol, I reassured her that it was not her fault. I commended her for trying to save her patient's life. What I did not understand was how she related her care of the patient to an elderly parent who was terminally ill at home. When looking at the patient, she saw her father. When he died, she saw her father die.

DROP US A LINE OR TWO
We'd love to hear about what nursing means to you. Your story could appear in *RN Journal*. Email editor@rnao.org.

Carol was a second career student. She – and so many other students who have come to nursing later in life – has changed the way I see my students. Older students view nursing education so differently from their younger counterparts. Mature students want to join the nursing profession feeling prepared, but they are often challenged to achieve this. Perhaps this is because there is often more at stake with responsibilities associated with family, finances and employment that drive their desire to become successful in nursing education. Most draw on knowledge from their life experiences and are intrigued by the learning process.

With this growing appreciation for second-career students, my view of nursing and my role as a teacher has changed. Nursing, to me, means supporting second career nurses with the unexpected. I now take extra time to listen and provide support. I have become part of their cheering team as they work their way into nursing. I would like to believe I was able to provide that support to Carol, whose father passed away before she completed the program. She told me that he would have been proud to watch her finish. I reminded her that he was with her every step of the way. **RN**

CINDY PALLISTER TEACHES IN THE RPN PROGRAM AT ST. CLAIR COLLEGE, THAMES CAMPUS. SHE IS ALSO AN IN-PATIENT SURGICAL NURSE AT THE CHATHAM-KENT HEALTH ALLIANCE.

** A pseudonym has been used to protect the identity of the individual.*

ILLUSTRATION: GENEVIEVE SIMMS

Nominations for the 2012 RNAO Recognition Awards will be considered in 12 categories:

- Award of Merit
- Honourary Life Membership
- Honourary Membership (a friend of nursing)
- HUB Fellowship
- Leadership Award in Nursing Education (Academic)
- Leadership Award in Nursing Education (Staff Development)
- Leadership Award in Nursing Research
- Leadership Award in Nursing Administration
- President's Award for Leadership in Clinical Nursing Practice
- RNAO in the Workplace Award (a nursing organization)
- RNAO Promotion in a Nursing Program Award (a nursing school)
- Student of Distinction Award

To nominate a colleague, yourself or your organization, visit www.rnao.org/awards for a nomination form. Awards will be presented at the 2012 Annual General Meeting.

Deadline is February 2 2012

www.rnao.org/awards


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