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Registered Nurse JOURNAL

November/December 2009

on the front line

As H1N1 spreads across Ontario, RNs are at the epicentre of plans to keep people well.

PM 40006768

RNAO Centre for Professional Nursing Excellence: Professional Development Opportunities

January

Developing and Sustaining Leadership: Working with Interprofessional Teams
January 20, Ottawa - available by OTN across Ontario

Leadership for New Grads: From Surviving to Thriving in the Work Environment
January 21, Valhalla Inn, Thunder Bay

February

Designing and Delivering Effective Education Programs
February 8-12, Toronto

Mid-Career Nurse Symposium: Refresh and Refocus Your Nursing Career
February 25, Hyatt Regency, Toronto

March

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

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

April

Professionalism and Collaboration: Making It Happen
April 22, Windsor

May

Nursing Career EXPO
May 13, Toronto

June

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

August

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

September

Preceptorship for Nurses Workshop
September 15, Sudbury - available by OTN across Ontario

Chronic Disease Management Fall Institute
September 25 - October 1, Venue TBD, Ontario

October

Knowledge, the Power of Nursing: Celebrating Best Practice Guidelines and Clinical Leadership
October 18-20, Toronto

November

Nurse Practitioners' Association of Ontario Conference
November 4-6, Doubletree by Hilton, Toronto

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RNAO
Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario
CENTRE FOR PROFESSIONAL NURSING EXCELLENCE

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Registered Nurse JOURNAL

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THE LINEUP

RNAO
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Cover illustration: Isabelle Cardinal

FEATURES

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Keeping pace with H1N1

This fall, it seemed like people were talking about just one thing: the H1N1 influenza outbreak. Whether I heard friends debating the pros and cons of the flu shot, or watched nightly newscasts filled with serpentine lines of people as thousands waited to be vaccinated, the topic was nearly impossible to avoid. So was the underlying message behind each news story. Every image of a terrified small child receiving a needle from a reassuring RN reminded us all that it's nurses who truly are the backbone of our health-care system, especially during a pandemic.

The H1N1 discussion also spills over into this issue of *Registered Nurse Journal*. Our cover feature looks at the roles RNs are playing in a variety of sectors to help their patients, colleagues and neighbours cope with a pandemic. It wasn't an easy story to tell. As the questions around who would get a flu shot – and when and where they would receive it – grew louder, it became harder to think of how we could keep a bimonthly magazine on top of a story that was changing by the hour. In fact, it's most likely taken another turn as you read this page. That's why we chose to focus on the one thing that's remained constant throughout: the dedication and commitment every nurse has had to keep us all as healthy as possible this fall and winter. The stories you'll find starting on page 12 are just a sample of the work every RN has done in the fight against H1N1, and we know each of you probably has your own story to tell of the way the virus has affected your own work.

Of course, there are still plenty of other health-care stories happening that have nothing to do with the flu. That's why, in this issue, you'll meet RNs who are leading new programs to keep older people living healthy, safe lives in their own homes for as long as possible. And we look at the creativity of some RNs who work in pediatric oncology. They've come up with some novel ways to communicate with patients and families who may not speak English as their first language, but who still desperately need to describe the pain or symptoms their children are enduring. These RNs' stories don't top nightly newscasts, but they're no less important than those of the countless nurses who have patiently doled out vaccines to try and keep everyone as H1N1-free as possible.

Jill Scarrow
Acting Managing Editor

RNAO celebrates 85 years

In 2010, RNAO celebrates its 85th anniversary. The association will be marking the occasion by showcasing the influence and success it has achieved since 1925. We want to get members involved and talking about their experiences with RNAO over the years. Please take some time to share your thoughts with us. What does membership mean to you? Tell us about a particular aspect of RNAO's work that makes you proud. What's your favourite RNAO memory? Send your thoughts or historical photos or mementoes to Jill Scarrow at jscarrow@rnao.org or via regular mail to 158 Pearl St., Toronto, ON M5H 1L3.

Taking the long view towards meeting our goals

Over the last few months, several issues regarding RNAO's advocacy have resulted in success, and in challenges yet to be conquered. As I look back on our work, I am struck by how easy it is for our vision and perception of things to be distorted by the ever-growing need for immediate results, gratification and success. This is a risky approach, particularly as it relates to the efforts of our association's members and staff to affect critical changes that will improve the health of Ontarians and the quality of work-life for nurses. It is an approach we must reject out of hand if we want to realize the long-term success we seek. I suppose this could be seen as a 'glass half full, half empty' sort of thing, but that comparison does not fully represent my concern. That image is too static, and I refuse to accept that we would ever be satisfied with a half-full option as an end point.

As RNs and members of an influential professional association, we have accomplished critical things together in the last several months. We have made gains, for example, through changes that have been proposed in legislation to allow RNs to dispense drugs, and the introduction of language that paves the way for open prescribing for nurse practitioners. Is this our half-full glass? Should we accept this as 'sufficient'? No way! We can still fill the glass. We need strong regulations that will allow NPs to admit, treat and discharge patients in hospitals and other in-patient settings. And if the government wants to see more collaboration among health-care professionals, it needs to replace hospital medical advisory committees with interprofessional advisory committees that include nurses and other professionals. This is a situation that requires a sustained commitment to continue to walk down a road, with obstacles in the way, to reach a destination we can see, but which is obscured for others by fear of change and loss of control. We should celebrate our successes in reaching this point on the road and strengthen our conviction as we continue to advocate and walk towards our full vision on this issue.

We have seen the same sort of thing in the area of environmental action. Remember the joy of celebration when the first community enacted anti-pesticide bylaws? What if we had stopped there? Would we have the legislation today that bans the cosmetic use of pesticides across the province? Almost certainly not. By taking the long view, we have achieved one stage in our journey to improve environmental health. Ahead on that road is toxics legislation, and the critical need to urge the province to enact a law that effectively removes them from our environment. This issue also requires a long view of the journey ahead. We are not yet at the end of this road.

> "As RNs and members of an influential association we have accomplished critical things together … we should celebrate successes, and strengthen our conviction as we continue to advocate and walk towards our full vision."

Over the last several months, we have also seen serious challenges and made real gains on an issue in which our journey is just getting started. Some health settings are implementing models of care in a way that does not reflect what the evidence tells us is best for patients and best for nurses. I'm referring to continuity of care and caregiver, and the need to ensure RNs deliver care for all patients who are unstable, complex and/or unpredictable and RPNs deliver care for stable patients with predictable outcomes, each working to their full scope of practice. This is a contentious issue, so the easy choice is to stop our journey where we have made early gains (see letter on page 23). Easy, but wrong. We must acknowledge that there will be times when the changes RNAO is pursuing won't be popular with everyone. In fact, that was the case when we first began calling for 70 per cent full-time employment. Conflict is a normal part of any change process, and avoiding it will serve neither us, nor the people of this province. We will continue to walk this long road, with a clear vision of a goal that is good for Ontarians' health, for nurses, and for the profession. It's never our intention to start a fight, create enmity, or foster discord. We will continue to walk respectfully, but firmly.

In some ways, the path RNAO is on is similar to another long journey currently underway. The Olympic torch is now travelling across our country to Vancouver for the Winter Games. That too is a long journey that is sometimes contentious. It is also a journey that occurs in 'legs,' one section of the road at a time. It involves the efforts of the runners who carry the flame, and the people who support the runner. It's also a journey moving towards a clear goal.

So we ask you to join in taking a long view, to growing steadily over time, to continuing to walk towards our goals as an association. We know we will get there with the commitment of members like you. **RN**

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

H1N1 reveals SARS' silver lining

This fall, reaction and response to the H1N1 virus dominated health-care news. Whether the stories have focused on the province's readiness for a flu pandemic, the tragic deaths of children struck down by the illness, or winding lineups at clinics all over the country, it's a story that's gripped every Canadian.

The story that's less often told is that of the nurses. Nearly every Ontarian who had a flu shot this year – including me, when I rolled up my sleeve during a visit to the Sudbury District Nurse Practitioner Clinics in October – has had contact with a nurse. The dedication of public health nurses who have worked long hours to vaccinate thousands of people this fall has been an important part of the plan to protect people from this new virus.

In fact, nurses in every sector of health care — whether they are in communities or caring for the ill in hospitals — are making sure the public gets the facts on H1N1. When people read about deaths of otherwise healthy children, fear and panic can set in. That's why it's so crucial for nurses to stay up-to-date on the latest information coming from reputable sources. RNs need to have the most accurate information so they can translate their knowledge about the pandemic, the vaccine and related issues into information that is easy for the public to understand.

For me, when news of this new pandemic influenza strain broke earlier this year, it was hard not to think back to the spring of 2003. Back then, our health-care system was caught flat-footed by SARS. Nurses bore the brunt of that outbreak. They worked long hours, risked their personal safety, endured quarantines, and two paid the ultimate sacrifice with their lives. The only silver lining of the SARS crisis is how much has changed this time around.

During the first month of the SARS outbreak, there was very little information from the government. Nurses were ringing alarm bells about the disease's resurgence in their workplaces, but by and large, they were ignored. This time around, however, governments have a strategy, albeit imperfect. Nurses are being listened to, and our concerns are woven into the government's influenza pandemic plan. RNAO participates in the provincial advisory committee for this plan, and we join in teleconferences to get the latest updates, which we disseminate to members and post on RNAO's website.

> "Nurses are being listened to and our concerns are woven into the government's influenza pandemic plan."

During a pandemic, as in any major public health challenge, there will always be questions. But this time around, our concerns are being heard – and acted on. Some of these questions have been raised by RNAO members. For instance, one member asked us whether patients who don't have OHIP cards can still access Tamiflu. Phil Graham, Co-Director for Operations with the Emergency Management Branch at the Ministry of Health and Long-Term Care, was quick to respond to our query, which we passed on to the member and posted online. The bottom line is that yes, there is a clear process to deal with this situation and it ensures that all Ontarians – whether they have a health card or not – receive antivirals if they are ill and it's clinically indicated.

Our level of readiness is also the result of the progress this province has made in building up the nursing profession. During SARS, just over half of Ontario's RNs were working full time, and about 18 per cent were working for more than one employer. When the province issued its directive that nurses could only work for one employer to try and stop the spread of the illness, many hospitals were left short staffed. It was a dangerous situation that exposed our health-care system's weaknesses.

Today, much has changed. We now have 65 per cent of RNs, 82 per cent of NPs and 59 per cent of RPNs working full time. It's welcome progress toward the goal of having 70 per cent of all nurses working full-time, a policy advanced by RNAO, and adopted by the Liberal government since its first mandate in 2003.

As well, we have at least 7,533 more RNs, 590 NPs and 4,372 RPNs than we did during SARS. And programs like the Nursing Graduate Guarantee, the Late Career Strategy and NP-led clinics have also moved from items listed in RNAO's pre-election platform to become key policy prongs of government with funded programs that send a clear message that Ontario's nurses are valued.

There's still a lot of work to do. To truly be prepared for a pandemic, we must make sure everyone has a liveable income, a roof overhead, and an adequate, healthy diet on the table. Our new health minister, Deb Matthews, demonstrated her commitment to these social determinants of health last year when she unveiled Ontario's Poverty Strategy as then Minister of Children and Youth Services. As nurses, we will continue to play a critical role to ensure we keep Ontarians safe; during a pandemic, and always. **RN**

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

Mailbag

RNAO wants to hear your comments, opinions, suggestions

Member responds to RNAO's views on physician assistants

Re: Nursing in the News, Policy at Work, September/October, 2009

Doris Grinspun is quoted saying PAs are more expensive than employing more nurses and nurse practitioners. Every day, we hear about the nursing shortage in Ontario, so I wonder, where would more nurses and NPs come from? NPs are very experienced and have a significant amount of education. They are at the high end of the salary scale and would likely be compensated at the same level as PAs with similar experience and education.


POLICY AT WORK

Why Physician Assistants aren't the answer

Broader powers for NPs

As for regulation, the Canadian Association of Physician Assistants (CAPA) states its goal is regulation through the provincial Colleges of Physicians and Surgeons.

RNAO's position is not necessarily the position of every member. I am married to a PA, who has been working in a demonstration project in our underserviced area. He served for more than 24 years in the Canadian Forces. Many PAs are retired from the military, have extensive education and have passed the national PA certification exam.

I had always been a proud RNAO member, but I stopped wearing my RN pin when RNAO's position on PAs was publicized. It is neither balanced nor fully informed.

I urge RNAO to fully investigate the PA profession and education, and talk to PAs and their patients. If a PA, as a physician extender, can help to significantly reduce ER wait times in an underserviced area, I don't think we'll hear much complaining from the residents of this province.

Marilyn Crummey
Frankford, Ontario

RNAO'S RESPONSE:

RNAO recognizes and is well aware of the history of physician assistants in the Canadian Forces and has no criticism of the fine and valuable service they have provided. Our position is that the role of PAs in Ontario is not supported by their level of experience and education. Consequently, patient care and safety are at risk of being compromised. Physician assistants in this province are not subject to the high standards of practice governing other regulated health professions. In addition, nurse practitioners, RNFAs and other RNs are able to do far more for patients, and introducing another health-care role only adds to public confusion.

RNs debate skill mix on front lines

Re: Executive Director's Dispatch collects concerns and kudos, July/August 2009

I was worried about Clarke, Trask and Roth's response to Doris Grinspun's column. RPNs hold a different basic education. To provide the safest care, it would make sense that RPNs work with more stable clients with somewhat predictable outcomes. Less stable clients require greater depth in critical thinking and knowledge application.

The focus of the letter should have been on the health-care team being "accountable for the entire care process." No one member of the team can claim independent accountability for high quality expected client outcomes, yet one also has to be accountable for one's own role and actions. I agree that "care from RPNs is no less stellar than care from RNs." "Stellar care" from each member of the health-care team is imperative to achieve the best expected client outcome.

Sutra Parmasad,
Toronto, Ontario

Re: Ringing alarm bells on changing models of care delivery, July/August 2009

We feel strongly that you have misinformed readers and possibly the public by wrongly defining the role of the RPN.

Educational requirements for the RPN and the RN have been transformed. This makes your research outdated. Updated RN and RPN competencies from the College of Nurses of Ontario no longer use old terminology such as the "stable or complex patient." We are all nurses with different skills, experiences and education. Client factors should lead our decisions of what skills mix is needed. To say that a mix of RN/RPNs within the practice setting increases morbidity and infection rates is irresponsible.

In addition, it was disturbing when you grouped the different RPN role together with unregulated health-care workers. You also state that heath-care organizations would fill vacant RN positions with RPNs or PSWs. This might be reasonable as RPNs have adequate skills and experience. We need RNAO and RPNAO to work together to advocate for all nurses.

Pat Chornaby,
Waterloo, Ontario
Helene St-Pierre,
Elora, Ontario

RNAO'S RESPONSE:

The Executive Director's Dispatch intended to draw attention to the need to safeguard models of care delivery that advance continuity of care and caregiver (primary nursing and total patient care). The column meant to stand up against versions of "team nursing" that fragment care by assigning RNs, RPNs and Patient Care Attendants to the same patient, with each delivering aspects of his/her care. It clearly states that both RNs and RPNs must deliver and be accountable for the entire care process of their assigned patients, as continuity of care and caregiver are essential to quality patient outcomes and nurse satisfaction. RNAO's position is that RNs be assigned the entire care of patients whose condition is unclear, complex and/or unstable, where outcomes are unpredictable, and RPNs be assigned the entire care of patients whose condition is stable and outcomes predictable. **RN**

by Stacey Hale

Nursing in the news

RNAO & RNs weigh in on . . .

Responding to H1N1

This fall, the second wave of the H1N1 virus officially hit Ontario. Thousands of people lined up outside clinics across the province, some waiting up to seven hours, to get a flu shot. Nurses have been at the forefront of the largest immunization campaign in Canadian history, and a number of issues surfaced as the program rolled out.

Queue jumping by professional athletes, hospital board members, private school students and others raised questions about the ethics surrounding the vaccine distribution. In early November, controversy erupted when 3,000 doses of the shot ended up at a private clinic in Toronto to be given to its high-paying members, and to any high-risk group at no charge, so long as they came equipped with a referral from public health officials. RNAO Executive Director **Doris Grinspun** called the move an "abuse of public trust," *(Toronto Star, Canadian Press, Hamilton Spectator*, Nov. 1). "Either we ask the proof from everybody or we don't ask from anybody, otherwise we

People in Oakville, Ontario, were among the thousands who lined up for flu shots across the province.

Photo: Jim Wilkes/*Toronto Star*

Mental health memorial

In October, RNAO member **Marilyn St. John** attended the unveiling of a memorial dedicated to people in the Niagara region who have suffered from a mental illness. St. John is the former director of the Niagara community mental health program that organized a memorial of 10 trees and mounted a plaque in a local nature park. "I feel a bit like a proud parent watching her child grow up and move on," St. John said of the display (*St. Catharines Standard*, Oct. 8).

Safe surgery

This fall, the Ministry of Health announced that starting next year, all hospitals must use a safety checklist to reduce the possibility of surgical errors. RNAO President-Elect **David McNeil**, who is also chief nursing officer at Sudbury Regional Hospital, said patient safety is a top priority. "Patient safety and quality improvement are a constant focus for our hospital, and ensuring we are doing the right surgery on the right patient speaks to both," he told the *Sudbury Star* (Oct. 12). In fact, the hospital has had its own checklist system in place since 2004. It outlines that prior to surgery, physicians and nurses must confirm and document the patient's identity, verify the surgery and surgical site, and collect pre-operative paper work. Any inconsistencies halt the surgery until they are resolved. The surgical team also does a final check to confirm patient and surgery-related information, including the availability of special equipment.

Medicine cabinet clean-up

In early November, fourth-year nursing student and RNAO member **Cheryl Prinzen** and Trent University classmates organized a Medicine Cabinet Clean-Up Day in Port Hope, Ont. For one day, Port Hope Pharmacy and nursing students collected unused or expired pharmaceuticals, including sharps and over-the-counter medications, to raise awareness about the safety hazards of unsafe disposal. "People usually pour medications down the drain, flush them down the toilet, put them in the trash or stockpile them," said Prinzen. Sewage and septic systems are not designed to remove pharmaceuticals, which means flushing or pouring medication down the drain puts drugs into water supplies. The toxic concentration is high enough to harm small aquatic life, Prinzen said, adding stockpiled medications also create a risk for children and pets (*Northumberland Today.com*, Nov. 6).

Barrie gets NP-led clinic

On Nov. 16, the provincial government announced its plan to fund a nurse practitioner-led clinic at Georgian College in Barrie, one of the country's fastest growing

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

create inequity," she said. Meanwhile, several Ontario private schools acknowledged some students and staff received the H1N1 vaccine even though they were not among the high-risk groups. RNAO member **Laura Mason** works at Pickering College where the vaccine was given to boarding students. They were deemed to be a priority because "they were in contact with a positive case," Mason told the *Toronto Star* (Nov. 11).

Another debate also surfaced regarding the duty of health-care professionals to be vaccinated. **Lorraine Sunstrum-Mann**, chief nursing executive and vice-president of professional affairs at Lakeridge Hospital in Oshawa, says the provincial average for staff being vaccinated is between 40 and 50 per cent, and Lakeridge is on par with that. "It's a critical discussion about whether or not we can mandate individuals to receive the vaccine," she told the *Ajax News Advertiser* and *Pickering News Advertiser* (Oct. 21).

In other parts of the province, residents were frustrated by mis-information and long lineups. In late October, seniors in Chatham hurried to get the shot, but learned they weren't eligible and would have to wait a few weeks until more vaccine was available. RNAO member **Cathy Bennett** said, "The large turnout shows people are concerned and are taking steps to protect their health," *Chatham Daily News* (Oct. 27). In Ottawa, the public health unit worked with RNAO member **Esther Moghadam** to create a Twitter account to give real-time updates on waits at each clinic (*The Ottawa Sun*, Oct 24).

Other residents worried about the safety of the H1N1 vaccine. After people in Woodstock cited allergies and long-term effects as reasons not to get inoculated, RNAO member **Mary Metcalfe**, acting director of Oxford County Public Health and Emergency Services, reassured readers of the *Woodstock Sentinel-Review* the vaccine is safe (Oct 28). **RN**

Nursing students joined Premier Dalton McGuinty, right, to announce the opening of an NP-led clinic in the Simcoe County area.

cities where nearly 30,000 residents don't have a primary care provider. "Nurse practitioners and all nurses take pride in this great achievement," said Wendy Fucile, President of RNAO. "This clinic will allow NPs working in collaboration with other health-care providers to provide residents of the Simcoe County area with the timely and high-quality primary care services they need and deserve" (*Barrie Examiner,* Nov. 17). The clinic will be open to students, faculty and the general public. It will have several NPs and collaborating physicians. It will also offer physiotherapy as well as dental, pharmacy and eye care services.

Climbing the ranks

A growing number of Toronto hospitals are being run by chief executive officers (CEO) who started their careers as nurses. It's a very different picture than 30 years ago. "It used to be an old boys' club," RNAO Executive Director **Doris Grinspun** told the *Toronto Star* (Nov. 15). Hospitals such as Women's College, the Hospital for Sick Children, St. Joseph's Health Centre, North York General, Trillium Health Centre, York Central and Markham Stouffville are led by nurses.

RNAO member **Mary Jo Haddad**, CEO of the Hospital for Sick Children, worked her way up within a single organization. Most of the RN-CEOs said they wanted to see their work have a wider impact on the hospital.

On Oct. 28, RNAO member ***Angela Connelly*** *wrote a letter to the* Milton Canadian Champion *to express her concern about the dangers of misinforming the public about the H1N1 flu vaccine.*

Warning about flu shot dangers off the mark

In her column, *Ask the Professionals,* chiropractor Dr. Angela Barrow warns people about the potential hazards associated with vaccination against influenza. Although she did not outright recommend that people not get a flu shot, comments such as "serious concerns over the safety of these flu vaccinations," and "many people who receive the flu shot immediately get the flu" may lead people to believe that getting the flu shot causes more harm than good. This is a dangerous and misleading message. The fact is that influenza is a potentially lethal infection … The vaccination has been stringently studied and shown to be both safe and effective at reducing the spread of the virus. Unfortunately, there is far too much misinformation circulating that leads people to believe otherwise. As an RN, I've seen the effects of influenza first-hand and know how devastating it can be. I'm asking people to educate themselves about this important topic so that they can make a truly informed decision.

Angela Connelly,
Milton

Nursing in the news

RNAO & RNs weigh in on . . .

Driven to succeed

Fourth-year nursing student and RNAO member **Daphne Belleau** grabbed headlines for the flurry of work she's done at Sault College and in the community. Belleau is president of the Aboriginal Student Nursing Association, carries a full workload at the college, and is raising her five-year-old son as a single mom. She is also a mentor to other students. "I want to help those who might think, somewhere along the journey, that they can't go on because the program is so difficult," Belleau told the *Sault Star* (Nov. 6). In October, Belleau attended the national Aboriginal Nurses Association of Canada conference in Edmonton with Sault College faculty members **Kay Vallee** and **Lori Matthews**, to share what the school is doing in aboriginal health care.

Photo: Jason Kryk, *The Windsor Star*

Kim Watson, right, performs healing touch therapy for a patient receiving her flu shot at Hôtel-Dieu Grace Hospital.

Healthy body, mind and spirit

RNAO member **Kim Watson** is spearheading an initiative to bring complementary therapies, such as healing touch, acupressure and reflexology, to Hôtel-Dieu Grace Hospital. The Windsor RN is taking advantage of RNAO's Advanced Clinical/Practice Fellowship to spend five months looking at ways to incorporate complementary therapies into the hospital's acute care setting, as well as studying their impact and educating others. "This is another way for us to improve quality of care for our patients," Watson told the *Windsor Star* (Oct. 28). **RN**

Out & About

On Nov. 5, members of the Nursing Students of Ontario took part in the Drop Fees for a Poverty Free Ontario Day of Action. Thousands of people attended the rally in Toronto to draw attention to how affordable, accessible education can lift more people out of poverty. The event was one of several NSO held during November to examine poverty and health.

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

On Nov. 11, RNAO member Mary Carley, pictured above in a traditional nurse's cape and hat, laid a wreath at the cenotaph in Guelph on behalf of Wellington Chapter. For the last five years, Carley has represented nurses' work during wartime in the local Remembrance Day ceremony and parade. She began taking part after learning that the last living local nurse who served during wartime could no longer participate due to health concerns.

Shifting communication

Bedside conversations are helping nurses get life-saving information. BY STACEY HALE

Two years ago, Barb Harvey's shift on the orthopedic unit at Trillium Health Centre in Mississauga began like any other. She arrived at 7:15 a.m., checked the assignment board to see which four patients she'd be responsible for that day, and headed to the nursing station to get a report from the outgoing night nurse. When her colleague went home, Harvey went to assess her first patient.

The RN was startled by what she found. The 84-year-old woman was complaining of chest pain and having difficulty breathing. Harvey called the hospital's medical emergency team and started her own assessment. The patient — who was recovering from a hip replacement — needed to be transferred to the ICU. She had suffered a pulmonary embolus, which comes on suddenly, but is a common post-operative complication for orthopedic patients.

Harvey was shocked. After all, the night nurse had conducted a head-to-toe assessment before going home and didn't have any major concerns. "I found (the situation) totally overwhelming because the major part of the morning was taken up with this and I hadn't seen the rest of my patients," she explains.

In fact, Harvey wasn't the only RN to have such a distressing experience. Others had found a patient with an unexpected symptom after shift change. Kathy Elliott, the unit's manager, and Marcella Honour, the Clinical Educator, say that's when the staff started looking for ways to do things differently.

Honour says part of the problem was how and where the nurses were exchanging information during a shift change. Both the incoming and outgoing nurses met at the nursing station, but there were inconsistencies in what was talked about, and what was being left out. To fix the problem, Honour and Elliott decided the report would have to happen at the bedside, in front of the patient. The *Transfer of Accountability-Safe Patient Handoff* program was pioneered last December in the orthopedic surgery unit, and has since spread across the entire hospital.

Photo: Courtesy Trillium Health Centre

Clinical educator Marcella Honour, left, and RN Barb Harvey, right, practise the safe patient handoff program at Trillium Health Centre.

Honour says the system mirrors high-risk industries, such as nuclear power plants. A key part of the program is a laminated template that is pinned on the bulletin board in every single patient's room. It prompts nurses to discuss the patient's plan of care, medications, test times, and when the doctor will be visiting. It also includes a safety checklist that asks nurses to, for example, make sure the correct IV solutions are hanging. And since everything happens right in front of patients, they can ask questions, or talk about the care they're receiving.

"Nurses now have the opportunity to visualize their patients and to clarify information and ask questions in the presence of the patient," Honour says, adding bedside reporting is even more important if someone doesn't speak English or is cognitively impaired because it allows nurses to look for non-verbal cues, like grimacing when patients are turned in bed. Honour admits nurses were reluctant to start the new process at first because it was a change in their routine. They were also concerned about patient privacy and confidentiality. What if their patient was sharing a room with a stranger, or if they didn't want their family members to find out about their health during the report? Elliott and Honour helped nurses through mandatory role playing so they could get used to talking openly right in front of patients, including asking their permission to do the report each time. Honour also created a patient brochure to explain the new program, and warn them that, since safety trumps sleep at Trillium, they'll be woken up if they happen to be dozing during the shift change.

Nearly a year later, Elliott says the program has caught on, and staff are starting to say that it's making their work easier. Most importantly, the new system is making life a lot safer for patients at Trillium. Harvey says that's made all the work to get the new system up and running worthwhile, because after that day when her elderly patient narrowly avoided tragedy two years ago, she knew she never wanted to experience a shift change like that again. **RN**

STACEY HALE IS EDITORIAL ASSISTANT AT RNAO.

on the front line

As H1N1 spreads across Ontario, RNs are at the epicentre of plans to keep people well.

If you were a nurse during sars, the H1N1 pandemic may be giving you a disturbing sense of déjà vu. While SARS was a hospital-based disease and H1N1 is spreading in the community, both sparked public fear and a media frenzy. But there are some stark differences, too. RNAO Executive Director Doris Grinspun says governments and health officials learned plenty of lessons during the SARS crisis that have been applied to H1N1 planning and operations.

"In Ontario, nurses' voices are being taken extremely seriously and our advice is being acted upon," says Grinspun, who sits on the Ministry of Health H1N1 provincial advisory committee.

Since so many nurses are involved in H1N1 planning, screening for the illness, immunization and the delivery of care across the province, Grinspun says they're ideally placed to help the public sort through all the information on everything from vaccination protocols to treatments needed.

"Nurses are information brokers and translators," she says. "People have lots of questions when they are fearful. We need to be adequately informed and accurate with our facts so we can alleviate fears, rather than feeding into them."

As the second wave of H1N1 unfolds across the province, *Registered Nurse Journal* looks at how nurses are taking on that leadership role. Whether they're inoculating thousands at flu-shot clinics or caring for the ill who find themselves in hospitals, RNs are coming up with creative and strategic ways to overcome the virus' unique challenges.

BY JILL-MARIE BURKE • ILLUSTRATION BY ISABELLE CARDINAL

BRINGING AGE-OLD TRADITIONS INTO THE H1N1 AGE

For more than a century, parishioners at St. Louis Catholic Church in Waterloo have been dipping their fingers in holy water as they enter the front door. But these days, hand sanitizer can be found beside the holy water fonts. Other long-standing customs that could spread nasty flu viruses have also been changed. Churchgoers now wave or nod instead of shaking hands, wine is no longer shared from a common cup, and people can't receive the communion wafer on their tongue.

Parish nurse Anne Marie Webster, who works for the church, is leading St. Louis' efforts to keep H1N1 at bay and often explains these changes to church members.

"I tell them that this is flu season and we can spread germs if we do these things," she says. The parish's 1,300 families know that Webster works hard year-round to look after their physical and spiritual well-being by providing health education and counselling, visiting people in their homes and in hospitals, and comforting those who've lost a loved one. She also organizes blood pressure screening and foot care clinics and leads support groups for parishioners. And a few times a year, she organizes lunch and learn workshops after mass to talk about topics such as diabetes or hypertension. In November, the talk focused on the history of pandemics, provided updates on the virus and stressed the importance of getting the vaccine.

"Because we're a parish, we also talked about faith and hope," she says of the session. "We know that no matter what happens, we have God and each other. We try to use our faith to help people relax and not panic."

Webster doesn't want to overwhelm her parishioners with information about H1N1, but she also wants to make sure those with chronic conditions, the elderly, and anyone else who lives alone will have the assistance they need if they get sick. For those who don't have anyone to call on for help, Webster and her team of volunteer visitors will make sure they have all the support they need.

Webster is also ensuring she can visit her parishioners if a serious outbreak restricts hospitals' visitor policies. Webster says during the SARS outbreak patients were limited to one visitor a day, and parish nurses couldn't see the patient if the person already had a visitor. When she recently attended a meeting with the city's hospital chaplains to review pandemic plans, she asked them to urge hospital administrators to acknowledge that parish nurses are not ordinary visitors because they provide spiritual guidance and health counselling in times of sickness.

Webster says it's all part of looking at how time-honoured traditions need to be revised while finding innovative ways to protect the physical and spiritual health of her congregation.

EASING FLU ANXIETY DURING EXAM SEASON

Nurse practitioner Elyse Maindonald has been opening doors with her elbow for years and she's been a stickler about washing her hands since her days as a surgical nurse. Now, as influenza coordinator at St. Clair College's south campus in Windsor, she's leading a campaign to protect students and staff from H1N1 and keep classes and campus activities running as usual.

This past spring Maindonald, who created a pandemic plan for the college in 2006 in case of an avian flu outbreak, was released from her teaching duties in the nursing programs so she could concentrate on H1N1 planning and monitoring. In October, when staff and students with flu-like symptoms began crowding the campus health centre where she works as an NP, the college asked her to devote all her time to managing the pandemic. Today, Maindonald is doling out H1N1 vaccines to people in high-risk groups, assessing and treating students and staff who have flu symptoms, updating college policies that are impacted by H1N1 and providing ongoing education and communication.

"We've had the flu plan for years and you think you're ready to go, but it's a living document and we're rewriting policies on a daily basis. We're flying by the seat of our pants," she says.

Rules around sick days have been among the first to change. Students, for example, who are off with the flu don't need to worry about falling behind on their work. They can make up missed assignments and tests when they return to campus. Staff are also being encouraged to stay home if they're unwell, but the way they call in sick has changed. Before the pandemic, faculty simply phoned their managers if they couldn't come to work. Now, since all possible cases of H1N1 need to be reported to public health, sick employees must also call the college's flu hotline and answer questions about their symptoms. Since this has never been done before, Maindonald sent emails to staff to explain why it is necessary and to assure them that the questions were being asked for statistical purposes only; their privacy is being respected.

In spite of the fact that the health centre staff are seeing three times as many students and staff with flu, colds and strep throat as this time last year, Maindonald says it's been a challenge convincing the ill to stay home so they won't infect others. Still, she says she's starting to make headway through her constant emails, one-on-one conversations and classroom presentations. "They're beginning to get the message," she says.

STAYING HEALTHY WITHOUT A HOME

Most of the people RN Keren Elumir sees in the health clinic run by Sanctuary, a Christian charitable organization in Toronto, are so busy coping with homelessness, mental illness and abuse that H1N1 isn't even on their radar. But she says they're at a greater risk of catching the virus and passing it on because their daily struggle for survival finds them interacting with dozens of people at various soup kitchens and drop-in centres throughout the city. Add in the fact that they often sleep in overcrowded shelters and lack the opportunity to maintain proper hygiene, eat well and get enough rest, and you have a recipe for spreading the virus.

Men and women of all ages who are unemployed, living on the street or coping with challenges like AIDS and drug addiction visit Sanctuary where Elumir says the staff and volunteers can help them access welfare, housing, legal advice or rehabilitation. They also come to eat a nutritious meal, socialize or visit the health clinic, which is staffed by nurses and a part-time physician.

Every year during cold and flu season, Elumir and her colleagues remind the guests to wash their hands and cough into their elbows. They've found that signs often go unread and formal educational sessions are poorly attended, so they communicate face-to-face when handing out vitamins during meals. "You see almost everybody in the room then and you mix it into the conversation at each table," she says. They also encourage the visitors to get flu vaccines and Sanctuary provides subway tokens so they can travel to immunization clinics. Elumir also tells guests that if they're sick, she or another team member will travel to them to make sure they're okay.

"Because members of the street community tend to know one another, we'll often get a message like 'Tony is sick, he wants to see you; he's in the alley.' If they're camped in the Don Valley, if they're in a rooming house, we'll go to them and make sure they have adequate fluids and resources," she says.

For the sick who are willing to sleep inside, Elumir will try to find a bed for them at the Sherbourne Infirmary, a short term health facility for the homeless, or a shelter that has special rooms for people who are ill. But many of the people she meets at Sanctuary won't stay inside at night, even if they're unwell. Some are claustrophobic and fear the cramped quarters at shelters. Others are afraid of the violence that can break out there. A handful won't sleep inside because it brings back bad memories of time spent in prison. The challenge is to keep them warm, dry and hydrated.

Although some Toronto street nurses began vaccinating the city's homeless population in November, Elumir says advocating for services for these people must continue to be one of the most important roles she can take on. That can mean finding housing for pregnant women or people whose immune systems are compromised by illnesses like HIV. Or it can mean writing a letter to a shelter to ask them to permit a sick person to sleep there during the day when the shelter is closed for cleaning. It also means working with groups like the Toronto Disaster Relief Committee and Streets to Homes to give the homeless a voice. But with flu season upon us, Elumir says until that advocacy work pays off with adequate housing for all, she'll continue to bring emergency blankets to people who sleep in alleys and brew endless cups of tea to try to keep Sanctuary's guests warm, comfortable and healthy.

OUTBREAK STIRS MEMORIES

Debbie Tirrul remembers lining up in a crowded church basement to get the polio vaccine. She was too small to see much beyond the patterns on the dresses worn by the mothers in the room, and she doesn't recall the needle's prick. But she can remember the feeling of near-panic in the room.

Today, as a nurse practitioner at Somerset West Community Health Centre in Ottawa, Tirrul is calming the fears of a new generation of parents terrified their children will be caught in the clutches of the latest pandemic.

"Every time a young person dies it frightens people – especially moms with small children," says Tirrul, who is able to reassure most parents that their little one is going to be just fine.

In the first week after Somerset West was designated a flu assessment centre in early November, Tirrul says 200 people of all ages streamed in to find out if their coughs and sneezes were anything to worry about. When patients arrive, they're greeted by the centre's social workers and triaged by RNs. People with coughs, muscle aches and fevers are sent to the flu assessment centre where they're examined by nurses practitioners and physicians wearing N95 masks, gloves, gowns and goggles. During the first wave of patients, Tirrul says many were prescribed Tamiflu or antibiotics, a handful needed chest X-rays and two people were sent to hospital. Tirrul says the assessment centre is being staffed by nurses normally responsible for seniors outreach or giving vaccinations and blood tests, but who are now masked and gloved and taking histories and doing assessments.

"It's stressful because they are working in different areas under different directives, but they are very keen, have learned quickly and are settled into a new role of collaborating with nurse practitioners and physicians," she says. In fact, keeping up with the latest information and protocols on H1N1 has been challenging for everyone, especially when they were changing on a regular basis this fall. Tirrul and her nursing colleagues worked extra hours to keep up with all the reading.

"We had tomes and tomes of things to read," she says. "Every day there was another 20 to 30 pages of procedures related to topics like protective gear and prescribing Tamiflu to pregnant women. This is stressful for nurses because it's a steep learning curve and every day there's more to read and a slightly different way of doing things."

LEARNING FROM SARS

When the World Health Organization declared the H1N1 outbreak a pandemic last spring, Bonnie Alexiou, an ER nurse at Markham Stouffville Hospital, started to feel scared and worried. She'd worked during the SARS crisis and spent two months as an inpatient at the hospital when she contracted the disease herself.

"H1N1 stirred up emotions I thought I'd dealt with and filed away. It was weird to feel the fear coming back. It was almost like a post-traumatic stress feeling," says Alexiou. She says she worried about her colleagues falling ill, wondered how the emergency department would cope if large numbers of people showed up with symptoms, and hoped that lessons learned from SARS would help the hospital handle things differently this time.

Julia Scott, Vice President of Clinical Programs and Chief Nurse Executive at Markham Stouffville, says a lot has changed since SARS. She says the hospital is listening to nurses, and has developed plans to cope with being short-staffed if employees are sick. There are also enough N95 masks for every employee, and a stockpile of Tamiflu.

"We have appropriate infection control practices, including making sure our staff have access to personal protective equipment," she says.

Scott says counsellors are also able to support employees who lived through SARS. Alexiou met with the same counsellor who comforted her six years ago, and she decided that working in the hospital's flu assessment clinic would be the best therapy of all. "It's a good way to overcome my fears, strengthen my mind and set an example for my peers," Alexiou says, adding she feels proud of her work.

Many of Alexiou's colleagues in the emergency room today didn't work during SARS and sometimes question why it is necessary to wear protective gear such as N95 masks, goggles, gloves, and gowns.

"I get on my soap box and say 'This is quite serious. This is is how we're going to protect ourselves, our families and our patients'," she says.

Although Alexiou and her colleagues are getting scabs on their noses from the masks, she vows that even when H1N1 has passed she will keep wearing the protective garb. "It's the uncertainty of what's out there. I don't want to be caught two steps behind," she says.

KEEPING COMMUNITIES WELL

Whether it's measles, mumps or bed bugs, RNs at the Victorian Order of Nurses (VON) for Canada have plenty of experience handling community outbreaks. Their infection control knowledge, the N95 masks they always carry in their vehicles, and routine practices like distancing and handwashing will serve them well during the H1N1 pandemic.

Irene Holubiec, the national director, clinical services for VON Canada, is co-directing the agency's pandemic planning. She says one of the biggest challenges of H1N1 is keeping up with what's happening in different areas of the country, and passing it along to VON's front line employees. She says staff need regular updates so they can help their patients sift through the facts and fiction that are reported in the media.

"The clients aren't reading the studies and the evidence, they're only seeing the media. So they're asking: Is it safe for me to get the vaccine? When can I get it? Where can I get it?... H1N1 is different because it's new. It will happen in waves, it will happen in our communities, and it will impact us," Holubiec says.

Arlene Lesenke agrees it's important for nurses to stay on top of all the latest news about H1N1 so they can answer people's questions. But she admits it can be hard to keep up with Ministry of Health guidelines that are being revised and updated regularly. "Nurses want to make sure they're giving the absolute best information they can, but it's very hard when it keeps changing," she says.

As the Director of Health Protection at the Northwestern Health Unit, Lesenke is coordinating the region's H1N1 planning and works side-by-side with fellow nurses in the Kenora office administering flu shots. It's no small task. Lesenke says within a three-week period, 35 nurses administered 13,000 doses of the H1N1 vaccine and almost 3,800 doses of the seasonal flu vaccine to residents in 14 communities spread across 166,514 kilometres.

Lesenke says transporting the vaccine from Kenora to the various satellite offices in coolers or containers that can be plugged into a car's lighter was not a problem. Staff making the drive to far-flung communities volunteer to take the vaccine every flu season to contribute to the success of the program. But administering a brand new vaccine posed other challenges.

When, for example, nurses discovered that the needle recommended for withdrawing the adjuvant was too short to reach the bottom of the vial — which had to be kept upright — they switched to a longer one. They also revised the way the vaccine was rolled out. Once children, pregnant women, people with underlying health conditions and others in priority groups received their shots, nurses offered the vaccination to everyone who was waiting in the line. Because some families drove hours from remote communities to get inoculated, Lesenke says it wasn't fair to ask those who didn't fall into certain categories to make another trip to the clinic later, when they qualified for the vaccine.

While the flu-shot campaign has kept nurses very busy, Lesenke says overtime has been kept to a minimum.

"We're really trying to make sure our nurses have time to rest and take care of themselves," she says. "Our number one goal is to provide safe clinics. We want to make sure our nurses are well-rested and not making mistakes."

Lesenke says it is especially important for nurses to be alert because in some clinics the H1N1 and the seasonal flu shots are being administered at the same time. In smaller offices, one nurse is working alone and providing both vaccines.

Lesenke admits the mass immunization campaign does pose some challenges for nurses and other health-care providers, but she says the benefits are well worth the effort. "As Canadians we are in the enviable position of knowing that there's a pandemic flu strain circulating and we have a vaccine that can prevent it. In past pandemics there was no vaccine," she says. **RN**

JILL-MARIE BURKE IS ACTING STAFF WRITER AT RNAO.

Coping with cancer

RN helps families deal with the reality of life beyond chemotherapy.

BY JILL-MARIE BURKE

IS it okay to hug Joshua?" "Can we catch cancer from him?" "Is he going to die?" These are just some of the questions Vicky Wilton fields from elementary school students when the RN visits classrooms to explain that a fellow student has been diagnosed with cancer and has just started chemotherapy treatments.

Wilton assures the anxious children that it will be okay to touch their friend; cancer isn't contagious. She also prepares them for the day Joshua will return to school. She explains he won't have any hair, but he'll still be the same boy inside. Then she tells them there is always a possibility that he could die, but the doctors and nurses are very hopeful he won't.

Today, 90 per cent of children survive leukemia, compared to 60 per cent just 15 years ago. But living with the disease is still an emotional roller coaster for the families who are touched by it. As one of 10 Interlink nurses with the Pediatric Oncology Group of Ontario, it's Wilton's job to accompany them on the journey to health and help them make sense of the twists, turns and dips along the way.

Wilton's relationship with a family begins when a fellow Interlink nurse or social worker at the Hospital for Sick Children in Toronto or the Children's Hospital of Eastern Ontario (CHEO) in Ottawa calls to say a child from northern Ontario is receiving chemotherapy at their hospital. Wilton says it's common for families to make the trip south because Sudbury doesn't have a pediatric oncologist. Wilton phones the parents to introduce herself, describe the help she can provide, and make arrangements to meet them when they return home from having treatments in southern Ontario.

Her first face-to-face meeting with families, who live anywhere between Thunder Bay and Parry Sound, normally takes place in the family's home. Since their child has just completed the intensive, initial round of chemotherapy called induction, Wilton says parents usually have a good understanding of their child's cancer and the maintenance treatments he will soon begin receiving at the regional cancer program in Sudbury. However, they're overwhelmed at the thought of coping without the team of health-care providers who were just a short walk away when they were in Toronto or Ottawa. "They need to be acquainted with what's available in their communities," she says.

NAME: Vicky Wilton
OCCUPATION: Interlink Nurse
HOME TOWN: Sudbury, Ontario

As a former home care nurse, Wilton says she jumped at the chance to become an Interlink nurse in 2007, because it allowed her to combine her experience in the community with the 12 years she spent working in adult medical oncology, palliative care and pediatrics at Sudbury Regional Hospital. Today, her role encompasses everything from finding the nearest lab where kids can go for tests, to helping families cope with the day-to-day realities of having a sick child at home.

Wilton says most parents need to figure out how they can afford to stay home with their child. She helps them access compassionate care benefits or arrange a short-term leave of absence from work. If school age children feel well enough to start learning again, she'll contact the school board to arrange for a teacher to come to their house. She also links them with child life specialists who can help children who've had an arm or leg amputated learn to live and play again.

Sometimes, Wilton is also a travel agent. If families need to go back to Toronto or Ottawa for appointments, she will help them access grants to offset travel costs, arrange accommodation, and link them with a support group that provides grocery coupons, long distance telephone cards and parking vouchers.

Wilton has also been involved in projects that would be more common for a general contractor than an RN. When one young boy couldn't be exposed to dust because he'd just had a bone marrow transplant, she called a local service club and arranged to have all the carpets removed from the family's home.

No matter what she does for them, Wilton says it's a privilege to help families get their lives back on track. "One of the biggest rewards is sharing this experience with families," she says. "Being able to go into their homes, being part of the school, being privy to their financial information – and knowing that they trust you."

Because Wilton knows the families she works with so well, she says it's hard to watch them struggle financially, mentally and physically and to know that she can only help them so much. "Cancer is like a big cloud hanging over their heads all the time. Even when the child seems better, you never know what's going to happen tomorrow. So it's always in the back of parents' minds."

Still, watching families tap into courage and resilience that some didn't realize they had fills Wilton the memories about her job that will always stick with her. "It's rewarding to see families overcome their struggles and their battles and be successful. A lot of families shine and really rise up to the challenge," she says. **RN**

JILL-MARIE BURKE IS ACTING STAFF WRITER AT RNAO.

TRANSLATING through trauma

Pain, nausea, vomiting and fever are words Karen Fleming says on a daily basis. In the early hours of the morning, when distraught children and parents find themselves on her unit, she'll sometimes hear these words uttered from the lips of an interpreter who is calmly explaining — in Cantonese, Mandarin or a myriad of other languages — a family's next steps in a battle against childhood cancer. Fleming works as a bedside and clinical support nurse in the oncology unit at the Hospital for Sick Children in Toronto. During her shifts, she often meets parents and children who are newcomers to Canada and who speak little English. These visits are often their first contact with the health-care system.

In Toronto, about 50 per cent of residents are born outside of this country, according to Statistics Canada. And as immigrants come to live, work, raise families and use health services, communication and health literacy can be a challenge for them. Fleming says it's hard for parents to think straight when they've just learned their child has cancer. But it's especially difficult for immigrant families to cope.

"There's so much that comes rushing at them and we try to communicate the basics of what's going to happen," she says.

Although Sick Kids has four staff interpreters available to translate for non-English-speaking families, these linguistic experts are busy and need up to 48 hours notice before they can help. In the meantime, nurses must find a way to communicate. Some nurses try to use fewer words, or shorter sentences, but Fleming says the problem is there is no way of assessing how much a family truly understands. "Their care can be so fragmented because they don't speak the dominant language."

Fleming and colleague Bukola Kolawole, an RN on the same unit, work with newcomers during every shift and see how they struggle through the system. The pair wanted to help, so they decided to investigate the issue further. In October, they presented their work at the Pediatric Nurses Interest Group's (PedNIG) biennial conference. They looked at how cultural practices and health literacy affect immigrant families, health-care providers and children with cancer.

Their literature review found there are serious gaps in the system that stop new Canadians from getting the best care possible. They determined more needs to be done to provide immigrants with access to care, and to help care providers communicate with their patients. Fleming and Kolawole want fellow nurses to understand that all families have their own cultural background that imbeds itself into how they perceive health.

To fill some of the existing gaps, nurses and other health professionals at Sick Kids are getting creative. For example, Fleming and two colleagues created five flashcards with pictures to convey common words cancer patients communicate, such as pain, nausea, vomiting, fever, and nothing to eat or drink. They tested them on a five-year-old girl who spoke Tamil. The hope was to try to increase health literacy using pictures, and feedback was positive; the family said they were clear and easy to understand.

Flashcards are a great clinical tool, but they aren't getting at the root of the problem. Kolawole says there are a number of key challenges non-English-speaking families and their care providers face. For starters, nurses need more time to work with these families. It takes longer to educate and care for these children, Kolawole argues, because someone has to translate the information. She says nurse managers need to allocate more time to help these families.

More time would also give nurses a chance to monitor families more closely for signs of increased anxiety and stress. Kolawole says research shows immigrant

Left: Angie Cabral helps a child at Sick Kids use flashcards to describe her cancer symptoms.

families whose children have cancer suffer a higher rate of post traumatic stress syndrome than non-immigrants, because these families are already under pressure as they try to find work and adjust to life in Canada, and many are also in a lower socio-economic class. And communication barriers make dealing with an emergency even more confusing and overwhelming. A family may not know what's going on and nurses cannot easily take them aside and support them, Kolawole says.

Nurses also need more time with interpreters, she says. The maximum amount of time they can spend with each patient is about two hours. That's not enough time to give a full picture of cancer and the complex science behind it. Kolawole also says some nurses don't know how to use interpreters to their full potential. "Nurses sometimes are not using the resource effectively," says the RN who has worked at Sick Kids for five years and is completing her PhD in health human resources and international nurse migration. She says because the interpreter is the one speaking directly to the patient, nurses need to make sure that everyone is equally engaged in the discussion. Kolawole says nurses should also keep in mind how fast they speak, who to face, and how to position their bodies. The objective is to connect with your patient, Kolawole says, adding "nurses have to start looking at how they interact with people."

If how RNs communicate with patients makes a difference, then it makes sense that Fleming prefers to be face-to-face with her patient and the interpreter. Unfortunately, because resources are limited, this can't always happen. So staff members at Sick Kids rely on a service called Language Line, which provides translation over the phone. The conversation happens over a speaker phone with everyone sitting, which means it's difficult to read patients' body language to see if they really understand what is being said.

Kolawole and Fleming also believe it's important to read into what cultural practices and values define a patient's idea of health care. Members of some cultures incorporate unconventional treatments in their health regimes. It's important for nurses to be open-minded and ask about complementary therapies because they could have potentially dangerous side effects, says Kolawole. She says some families use Chinese teas and herbs alongside western medicine and the danger is they can interact with cancer medications. To avoid unsafe situations like these, Fleming would like to see eastern medicine studied in more detail and incorporated into treatment.

"We don't explore that avenue and we are waiting for the research, because everything has to be empirically based on western scientific data," she says. "But that's not how everybody lives, it is how the western world lives."

End-of-life rituals also vary among different cultures and religions. Fleming argues that some traditions should be incorporated more readily for families grieving the loss of a child. Certain practices can happen in a safe way, she says. For example, for families who would like to light candles – which is not the most ideal in a hospital setting — nurses should be able to offer candles that are battery powered. Fleming insists it's about thinking in a culturally sensitive way instead of saying "no, we don't do that."

A change in thinking would help nurses approach patient education, too. Kolawole says immigrant families rely on social support networks to make it through tough times, whereas Canadian-born families want to read pamphlets or articles about the disease. Kolawole would like to see patient education information that is more accessible to all families. She says the literature needs to be written in plain English or translated so everyone can understand. She'd also like to have a parent support network for immigrants that is run by the hospital so families can talk and learn from each other.

Fleming says more resources are starting to become available for families, including the About Kids Health Family Resource Centre, a library where families can access books in different languages. They also have access to computers and online translation tools. In April, the hospital also received $9.2 million from the federal Ministry of Citizenship and Immigration to allow the pediatric teaching hospital to translate core patient documents, such as discharge and education papers and surgery information, into the most commonly required languages. The funding will also provide cultural awareness education for all health-care professionals at the hospital.

Rani Srivastava has studied cultural competency closely. She chaired the group that developed RNAO's healthy work environment best practice guideline, *Embracing Cultural Diversity in Health Care: Developing Cultural Competence*. She's also written a book on the topic that Sick Kids educators are using to develop the curriculum for some of their cultural awareness workshops. Srivastava says cultural competency is a set of behaviours, practices and policies in the workplace that respect all forms of culture and diversity, including skin colour, gender, age, race and ethnic identification, citizenship, sexual orientation, and physical and cognitive abilities. Srivastava says that if nurses really want to provide top-notch care, they have to understand where a patient is coming from, and agree that cultural awareness is a quality of care issue. Srivastava says some practitioners are attuned to issues of culture and diversity, but on the whole the system could do better. Health providers often struggle with what can and can't be done for a culturally diverse patient. "They wonder 'how do I start this conversation,' " Srivastava explains.

For Fleming, Sick Kids is heading in the right direction by talking about ways to improve everyone's cultural competency. But she wants to make sure the change is sustainable. She says health professionals need to be in place who can continue to champion the work, even once the education sessions are over. "We need to incorporate cultural competency into family centred care, to the point that it becomes natural, like everything else we do in nursing."

Is your workplace looking at new ways to improve cultural competency? Let us know by email to: letters@rnao.org. **RN**

RNs find new ways to communicate with families coping with a child's illness. BY STACEY HALE

STACEY HALE IS EDITORIAL ASSISTANT AT RNAO.

House Calls

RNs play a pivotal role in helping seniors stay at home for as long as they can.

by Jill-Marie Burke • Photography by Ruth Kaplan

RN Julie Cordasco's thoughts never stray too far from the seniors she regularly visits at home. It's hard not to worry that the woman with dementia who spends most of her time alone will burn herself when she's making tea. Or that the 92-year-old man with diabetes will eventually require dialysis and will have to leave his confused 89-year-old partner at home alone when he's receiving treatments. For two-and-a-half days a week, Cordasco, an RN at the Prime Care Family Health Team (FHT) in Milton, just west of Toronto, becomes an aging at home nurse who helps frail seniors with health concerns stay in their own homes for as long as possible.

For the 40 clients she sees on a weekly or monthly basis, Cordasco is much more than a visiting nurse who gives B12 shots and tests blood sugar levels. She's an advocate, a link to community services, and a supportive sounding board for spouses who have become caregivers. Cordasco also reviews clients' medications to make sure they are taking them correctly, and it's not unusual for her to pick up a prescription for clients or help them write a letter to an insurance company. If her elderly patients need Cordasco when she's working at the family health team, she's always just a phone call or a short drive away. Once, when it appeared one of her clients had suffered a stroke, the woman's husband called Cordasco right away and she accompanied the couple to the hospital to support the husband and to ensure that the wife, who had dementia, wouldn't be frightened in the unfamiliar environment.

Cordasco says the FHT created the Seniors' Home Visiting Program in February after physicians and nurse practitioners realized some of their elderly patients missed medical appointments because they didn't have a way to get to the clinic. Some don't have any family members, and others have children who are busy with their own lives or live in other cities or countries. Since many of Cordasco's patients are over the age of 80 and have chronic illnesses, skipping injections, blood pressure checks and other necessary procedures wasn't an option. Today, Cordasco spends about an hour in each client's home; much of that time is spent talking – answering seniors' questions about their disease, making them aware of supportive programs and services and listening to their concerns and stories. In many cases, Cordasco is the only person they confide in.

"They don't want to worry their kids," she says. "And they believe they can't talk to their family doctor because they feel the doctor is too busy. So that doesn't leave them many choices."

In October, Cordasco was among the RNs who presented their work to keep people living at home with health and dignity at RNAO's eighth annual elder care conference in Toronto. Many RNs say their work is making Ontario's Aging at Home strategy a reality for older people. Since it was launched in 2007, the program has aimed to help elderly Ontarians lead independent lives in their own homes with access to community-based health services and supports that can keep people out of hospitals and long-term care homes.

Sharon Penrose, who works for Saint Elizabeth Health Care in Barrie, believes spending the final years of life at home should be an option for anyone, even for those with mild cognitive impairments and dementia. Too often, the clinical educator, whose own mother has the illness, says caregivers assume that people living with dementia aren't able to learn new things, and can't do routine daily tasks by themselves. She says both are untrue. People with dementia may just need to take new approaches to doing something as basic as getting dressed.

At the conference, Penrose presented the results of her Advanced Clinical/Practice Fellowship — a 12-week program offered by RNAO — that allowed her to review research and RNAO's delirium, dementia and depression guidelines to give her nursing and personal support worker colleagues tools and information they need to help people with dementia live independently. Penrose says that's important, because research shows the more active people with dementia are and the more social support they get, the longer they're able to live at

home. She also found that while dementia can't be cured, getting people moving can slow it down.

Penrose says helping people stay active in their daily lives can be as simple as teaching them to inject insulin. While a nurse who has spent months trying to teach a woman how do it may assume she'll never master the task, Penrose says breaking it down into small steps that are repeated consistently could be all that's needed to help her. And while it might be easier and less time-consuming to dress a person with Alzheimer's instead of letting him put on the clothes by himself, Penrose says doing so limits his abilities and independence.

RN Sheila Simmons agrees more needs to be done to keep seniors in the community. For years, Simmons was a discharge planner in an emergency room, and says she hated sending people to long-term care when they didn't want to go. Today, she's the telephone triage nurse and educator for Specialized Geriatric Outreach Services to Homebound Seniors, a team including a social worker, occupational therapist, physiotherapist, dietitian, geriatrician and psychiatrist at North York General Hospital in Toronto. The group aims to ensure seniors have the supports they need to stay where they want to be – at home. If family physicians in the community or emergency room nurses identify a patient experiencing an ongoing problem like falls, confusion or incontinence, they can ask Simmons' team to visit the person at home in search of the cause of the problem. Simmons is the seniors' first point of contact. She'll phone them – and in some cases their primary care providers or family members – to gather as much information as possible and determine which member of the outreach team would be most appropriate to conduct the assessment.

Simmons says the majority of the seniors who come to the team have experienced more than two falls in the past two months. While the problem is obvious, getting to the root of it requires expertise, diplomacy and some detective work. Is improper footwear causing them to trip? Are they slipping on scatter rugs? Is their toilet too low or too high? Do they have to walk down rick-

Julie Cordasco, centre, works closely with seniors like Ron and Doreen Wilson to help them manage their illnesses so they can live independently.

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

Aging at home isn't possible for many seniors without the support of a family member who can help out with daily tasks or drive them to appointments. For many RNs, that reality means their work as a health-care provider doesn't end when their shift does. According to Catherine Ward-Griffin, an RN and researcher at the University of Western Ontario, about one third of nurses are not only caring for patients at work, they're also playing a major role in caring for elderly parents and relatives. Ward-Griffin calls this blurring of boundaries between paid nursing care and unpaid family care 'double-duty caregiving,' and she says it takes a toll on nurses' health.

Ward-Griffin is currently surveying RNs in British Columbia, Ontario and Nova Scotia to better understand the consequences double-duty caregiving has on nurses' health and on the profession.

She says the societal assumption that family members are personally responsible for caring for elderly relatives has an impact on all Canadians. But there is an even greater expectation that nurses will take on the role because of their knowledge and skills, and many of them see it as their responsibility. She wants to understand whether it's their occupations that turn nurses into double-duty caregivers, or if factors like gender come into play.

So far, she says study results show male nurses who care for family members have greater levels of support and, therefore, better general health than female nurses in similar situations. Ward-Griffin says some of them have trouble sleeping, feel physically exhausted and experience flare-ups of various illnesses.

"Nurses work very hard to look after people and ensure that we're promoting health and preventing illness in others," says Ward-Griffin. "I think we do that many times at the expense of our own health."

Ward-Griffin says that to support double-duty nurses, health-care organizations need to implement healthy work environment policies that ease some of their stress. While nurses in some workplaces can use 'family days' instead of their own sick days if they need to take mom or dad to an appointment, she says what's really required is a re-think of the assumption in our society that caring for older relatives is a personal responsibility, and one that nurses in particular should be expected to take on.

"Providing care to family members shouldn't be seen as a personal issue for individual nurses," she explains. "We need to be proactive to prevent or mitigate the health effects of double-duty caregiving because it will likely increase with our aging population and workforce." **RN**

ety basement stairs to do their laundry? Or could the falls be a side effect of one of the medications they're taking? After the visit, armed with answers and evidence, the clinician will consult with the rest of the team to decide whether the senior's needs could be best met by a geriatrician, the Community Care Access Centre, or another health-care provider.

Her team doesn't provide an urgent service, but Simmons feels strongly that it is an important one that prevents emergency visits and, in some cases, deaths.

"A member of our team might go out to talk to a person who is completely confused and discover that it's because he hit his head and didn't realize he had suffered a subdural hemorrhage," she says.

Many seniors know all too well that the best laid aging at home plans can be derailed by a fall. According to the Canadian Institute for Health Information (CIHI), for people 65 years and older, falls were the cause of 84 per cent of all injury admissions to hospital and 40 per cent of admissions to long-term care facilities.

In Simcoe-Muskoka, the problem is particularly troubling. According to provincial and national statistics, the region has the highest rate of hospital admissions for falls in Ontario (per 100,000 people) and the highest rate of hospitalization for fractured hips. While health-care experts in cottage country don't know why so many of their seniors are taking a tumble, Sandra Easson-Bruno says they're working on a unique program to reduce the frequency and severity of falls and cut down on the number of emergency visits and hospital stays they cause.

Easson-Bruno is Project Director for Regional Seniors' Health and has been working with local organizations to develop an Integrated Regional Falls Program in the North Simcoe Muskoka Local Health Integration Network (LHIN). The RN, who worked as a clinical nurse specialist in geriatric care for 12 years, says the new program is bringing together professionals from all sectors of health-care, including hospitals and the community. Easson-Bruno says the project, funded by the Aging at Home Strategy, will bring together and expand services including falls prevention and day hospital programs. She says RNAO's best practice guideline on preventing falls was a key part of the literature used to develop the project.

Julie Cordasco is just a phone call away for many patients.

Next year, the program will also get family health teams and community health centres working together to run community-based falls screening clinics. Seniors who are at an especially high risk of falling will be able to see a geriatrician or a nurse. And Easson-Bruno says four nurses will also be hired to work with seniors who have been discharged from emergency departments after falling to ensure that they access community supports that will help prevent future falls.

Easson-Bruno hopes the program will reduce the lineups in the emergency rooms, but for her, the real bottom line is keeping people safe and in their own homes for as long as they want to live there.

"What's important to seniors is their quality of life. It's staying in their own home, it's being able to get out and do their groceries," she says. "Seniors don't want to go to long-term care in most cases. From my perspective, the ultimate goal is allowing them to age in place. That's what seniors want." **RN**

JILL-MARIE BURKE IS ACTING STAFF WRITER AT RNAO.

POLICY AT WORK

RNAO member Pat Nashef, left, joined Executive Director Doris Grinspun at Queen's Park to call for improved services for people living with mental illness.

RNAO wins changes on HAPS

After intervention by RNAO, Ontario's Assistant Deputy Minister of Health undertook re-writing a section of a document hospitals use to design and deliver their services. The association objected to language in the Hospital Annual Planning Submissions (HAPS) guidebook that suggested targeted RN replacement could be undertaken under certain circumstances. RNAO found this unacceptable and raised the concern with Joshua Tepper and senior government officials. The offending section was removed and Dr. Tepper sent a letter to Tom Closson, President of the Ontario Hospital Association, and the CEOs of the province's 14 LHINs, directing them to let each hospital CEO know of the changes and the government's position. Here is a copy of the letter to the LHINs:

Dear LHIN CEOs:
As you are aware, the Hospital Annual Planning Submissions (HAPS) has been revised in response to concerns raised by the Registered Nurses' Association of Ontario (RNAO) and the Ontario Nurses Association (ONA).

This ministry remains committed to ensuring patients get the best care possible in all settings including hospitals and has consistently communicated the value of interprofessional, collaborative teams (nurses, doctors, pharmacists and other health disciplines) in the delivery of quality health care to Ontarians. Additionally, new and expanded health care provider roles have been integrated in the system based on the principle of augmenting, rather than substituting or replacing one provider over another. The ministry has supported nursing models of care delivery that maintain continuity of caregiver, including our ongoing commitment and our continuous movement to 70 per cent full-time employment of nurses.

Your assistance with communicating the ministry's position and the change to the HAPS document to all hospitals within your LHIN would be most appreciated. In your communication we would appreciate it if you would also direct hospitals to your website where the revised HAPS is posted. Thank you for your continued support and commitment to building a strong and stable healthforce in Ontario.

Sincerely,
Dr. Joshua Tepper
Assistant Deputy Minister

Practice changes for RNs and NPs

Long awaited changes to the scope of practice for RNs and NPs are on the horizon. On Oct. 19, a series of amendments to Bill 179 was passed by the Legislature's Standing Committee on Social Policy. The amendments affect the *Regulated Health Professionals Act,* the *Nursing Act* and a number of other acts related to health professions. The changes mean RNs will now be allowed to dispense drugs while NPs will be able to set and cast bone fractures. RNAO is also pleased that there is an opportunity to do away with a restrictive barrier that forces nurse practitioners to prescribe from a limited list of drugs, unlike their counterparts in the rest of Canada and other jurisdictions around the world where NPs can prescribe openly. RNAO will continue to push for changes to the *Public Hospitals Act* and regulations so that NPs will be allowed to admit, treat and discharge in in-patient settings. Another key demand would see hospital Medical Advisory Committees (MAC), comprised of physicians, transformed into Interprofessional Advisory Committees (IPAC) so nurses and other health professionals can play a fully collaborative role with their physician partners. **RN**

Why mental health matters

Mental health and addictions received some much deserved attention at Queen's Park in October when a special committee heard presentations from a number of groups, including RNAO. Executive Director Doris Grinspun appeared alongside Pat Nashef, then chair of the Mental Health Nursing Interest Group. As a psychiatric nurse with more than 30 years of experience, Nashef talked about the need to address the stigma in attitudes and perceptions that continue to exist and leave people with mental health issues feeling isolated and neglected. She also spoke about the need to create a more coordinated approach to mental health services with a single point of access so people know where to turn. Grinspun also reinforced the need for the province to keep its promise to reduce poverty and to fast-track its plan to build more affordable housing. Grinspun said action on these issues would go a long way towards alleviating human suffering. **RN**

Hands on evidence

NURSES ARE USING POCKET-SIZED DEVICES TO ACCESS VOLUMES OF EVIDENCE-BASED INFORMATION RIGHT AT THEIR FINGERTIPS.

BY JILL SCARROW • ILLUSTRATION BY JOSÉ ORTEGA

These days, there are few places Danielle Collier doesn't read best practice guidelines (BPGs). Whether she's scrolling through the documents' recommendations at work, or in her car while waiting to pick up her son after school, she always has access to RNAO's BPGs thanks to her new personal digital assistant (PDA). The tiny device is no bigger than her hand, and easily slides into her purse. But it gives her access to tools that would line an entire wall of library shelves in the real world. Collier uses her PDA to search for the latest information on drug interactions, and can beam the most recent research articles to her colleagues at Sioux Lookout Meno Ya Win Health Centre (SLMHC), where she's the professional practice leader. Last spring, 71 of the hospital's RNs received the devices as part of a Ministry of Health project to get PDAs into the pockets and practice settings of nurses across the province.

Collier says the technology helps RNs in her workplace span the 1,700 kilometres that separate them from BPG workshops in southern Ontario. Before the hospital became part of the PDA initiative last summer, Collier says keeping her nursing colleagues updated on the latest evidence-based information meant carting paper copies of articles and BPGs around in the back of her car between the health centre's eight different sites.

"Nurses up here don't feel connected to the outside world," she says. "We're so far away – it's a 22-hour drive to Toronto. When people can access best practice guidelines, they feel more a part of it all."

Today, nurses use their PDAs to quickly look up drug interactions, and receive emails about the latest research so patients instantly get the safest care. The devices are also being used in unexpected ways. Collier says some RNs have used the PDA's camera to take pictures of patients' wounds so they can track how well they're healing.

SLMHC's nurses are among the 1,300 RNs taking part in the two-year project funded by the province. Ontario's Chief Nursing Officer, Vanessa Burkoski, says she wanted to create the project to keep nurses at the forefront of the latest technology. "The future is in our hands, and once again Ontario's nurses are at the cutting edge of knowledge-based practice," she says.

Nurses are using PDAs, tablet computers the size of a small notebook that can fit into the crook of an arm, BlackBerrys and iPhones to access the latest knowledge, right at their fingertips. Each device is equipped with software programs that allow them to instantly look up medication doses and side effects, receive email alerts when a new study is available that could affect their practice, and scroll through condensed versions of the clinical and healthy work environment best practice guidelines. Twenty-five of the BPGs have been condensed so far, and all 42 are expected to be available next year. For the past year-and-a-half, staff from RNAO's Centre for Professional Nursing Excellence have led workshops to teach nurses how to use the devices, and provided ongoing technical support to keep the project up and running.

Irmajean Bajnok, RNAO's Director of International Affairs and Best Practice Guidelines Program and the Centre for Professional Nursing Excellence, says PDAs give nurses a glimpse of a future where technology will be woven into practice.

"I think the PDA initiative is a great example of how the information can be provided right at the point of care through technology," she says. "It supports nurses as knowledge professionals and sends a message that ehealth is alive and well in nursing and health care."

But Bajnok acknowledges that bringing BlackBerrys to bedsides requires more than showing RNs where the power button is. She believes the real challenges lie in addressing nurses' fear that stopping to click through a guideline in front of a patient will detract from the human element of the relationship, or give patients the impression that the nurse doesn't know everything she should.

"Nurses have to get to a comfort level so that when they're working with the patient, they can say 'let me double check that information for you.' The PDA can be a patient teaching tool that helps nurses address specific concerns," Bajnok says.

Diane Doran, a professor at the Lawrence S. Bloomberg Faculty of Nursing at the University of Toronto, says her research has also shown plenty of practical reasons that can hinder getting more nurses to be tech-savvy. Doran is the lead investigator on a team studying how technology improves nurses' ability to access information, and the effect it has on patient outcomes. She says things as basic as spotty wireless Internet access or having to carry around devices like the larger tablet could mean PDAs spend more time tucked in their cases than at a patient's bedside. But she says those are tiny obstacles when compared to the benefits. Doran says PDAs are improving the way nurses can communi-

cate with their colleagues on different floors or hospital sites because they can now send a quick text message. Nurses are also reporting significant increases in their awareness and use of research, and in the quality of care they can provide.

Doran says her data is also starting to show how the technology is improving the quality of nurses' work lives, especially in long-term care. She believes the increased benefit may be because the PDAs are giving RNs in long-term care and the community access to information hospital staff has long been able to find in the organization's library says. "We're able to provide better care."

George Fieber says better care motivates him to stick with the project. Fieber is the professional practice leader at Thunder Bay Regional Health Sciences Centre, and joined the PDA initiative when it began last year. He says RNs are using tablets across the hospital, with varying degrees of success. Nurse practitioners in acute care units, for instance, can now do research on the go, and lower nurse-to-patient ratios in the intensive care unit meant those RNs were able to spend time getting used to the tool. But he says it was harder for nurses on the busy

or by talking to another team member.

"In long-term care, there may only be one RN working, so she doesn't have ready access to other colleagues to consult with," she says.

Jill Geiger can attest to that. She usually works the night shift at Bluewater Rest Home in Zurich, 70 km northwest of London. That means she's the only RN on duty at 3 a.m., so if she has a question about a new medication a resident is on or wants to look up nutrition recommendations to prevent constipation in RNAO's best practice guidelines, she can do it quickly on her tablet instead of relying on cumbersome books that may be outdated before the ink on their pages is dry.

"The fact you've got current information at your fingertips, that's wonderful," she

medical/surgical floor to work tablets into their shifts. Fieber says more nurses got excited about PDAs once they were linked to patient information on the hospital's electronic health records, and when the hospital became a candidate to be an RNAO Best Practice Spotlight Organization and set out to implement five BPGs over three years. Now, for example, RNs can use the electronic health record to instantly see which patients will need information about caring for an ostomy when they go home, and show them an electronic presentation based on a newly released BPG on the topic.

Nancy Bauer can understand why it takes time to make PDAs an integral part of practice, but she believes that, one day, reading a BPG on an iPhone will be as indispensable to practice as a stethoscope is today. Bauer led some of the workshops to teach nurses how to use the tools, and she says if RNs start to feel frustrated with their PDA, they should just remember one thing: they master more complex nursing knowledge and skills during every shift.

"Each and every day of my nursing career, I learned things that were far more complicated than the PDAs," she says. "This is just a tool to do the other work, which is far more complicated."

In Ottawa, public health nurse Nadine Hodgins says it was easy to adapt to her tablet. Hodgins is a member of Ottawa's Live it Up team that visits high schools to promote healthy eating and exercise to students. During the school year, Hodgins is usually on the road. The tablet allows her to keep in touch with principals and teachers without wasting precious time travelling back to the office to read emails. Hodgins says she's also glad to have the tablet on hand so she can double-check her facts, or show students the city's website where they can get information on sexually transmitted infections. It's also handy if a teacher asks Hodgins to teach students about sexual health.

"We sometimes get requests from teachers about something that's beyond physical activity and nutrition. Then we can look at the school curriculum and see how the public health resources we have match up," she says.

Back in Sioux Lookout, Collier says the PDA is more than a tool that can save time and paper – it also shows the nurses management understands that they need the latest knowledge. She believes the devices are particularly helpful to recruit new graduates who won't want to work in isolated northern communities unless they're plugged into the latest research. Patients have also started to notice the PDAs. In fact, Collier says it's funny when a patient comments on how state-of-the-art SLMHC's nurses are, since they're using the latest technology in a building constructed long before computers became a must-have appliance in everyone's home.

"We're in a hospital that's 70 years old. So the fact that we're pulling out PDAs is pretty neat," she says. **RN**

JILL SCARROW IS ACTING MANAGING EDITOR AT RNAO.

Calendar

January

January 20
Developing and Sustaining Leadership: Working with Interprofessional Teams
Ottawa, Ontario – available by OTN across Ont.

January 21
Leadership for New Grads: From Surviving to Thriving in the Work Environment
Valhalla Inn, Thunder Bay, Ont.

January 28
11th Annual Queen's Park Day
Queen's Park Legislative Building, Toronto, Ont.

January 29
RNAO Assembly Meeting
Delta Chelsea Hotel
Toronto, Ont.

February

February 8-12
Designing and Delivering Effective Education Programs
Toronto, Ont.

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

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

RNAO holiday office hours

RNAO home office will be closed at 12:00 p.m. on Thursday, Dec. 24, 2009. We will resume normal business hours on Monday, Jan. 4, 2010.

Have a wonderful & safe holiday season.

From the staff at RNAO.

NEWS to You to Use

RNAO members Sandra Kuchmak and Jeanette O'Leary were among the inaugural recipients of the Ontario Long Term Care Association Nursing Leadership Awards this fall. Kuchmak, Director of Care at The Wynfield in Oshawa, was honoured for her commitment to resident-centred care and mentorship. O'Leary is a Care Innovation Coach at Shalom Village in Hamilton. She ensures residents with cognitive impairments feel at home, and is committed to best practices in her daily work. The awards were presented during the OLTCA's first-ever Long Term Care Week in October.

In September, the city of Ottawa re-named its city hall Festival Plaza after the late Marion Dewar, a well-known public health nurse and human rights and peace activist. Dewar was the mayor of Ottawa from 1978 to 1985 and later became an MP.

On Nov. 4, RNAO member Basanti Majumdar was inducted into the Hamilton Gallery of Distinction, an organization that publicly recognizes citizens' efforts to improve the city. The McMaster University professor was acknowledged for her work to improve health around the world and at home. She has been a part of international partnerships in South Africa, India and Pakistan in addition to creating a course at McMaster on international health and cultural issues.


Basanti Majumdar

People without a family physician or nurse practitioner in the City of Kawartha Lakes now have another option for primary care. The Unattached Patient Health Assessment and Referral Centre clinic opened in the fall to provide patients with a full physical exam, referrals, and follow-up care. The centre is a seven-month pilot project and is staffed by a team including a physician, nurse practitioner and registered nurses.

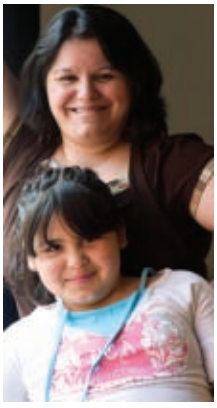
Photo: Courtesy Skyworks Foundation

This fall, *Home Safe Toronto* explored the effect the economic downturn has had on people who work in the manufacturing sector. The documentary is one of three that explore the experiences of families in different Canadian cities who live with homelessness, or the threat of losing their home. The film screening across Canada includes Myriam Canas-Mendes and Olga Munoz-Canas (pictured left). For more information visit www.skyworksfoundation.org.

In November, RNAO received the Innovations in Health Care Award. The association was honoured for its work to support long-term care staff using best practice guidelines in their work. The award was presented on Nov. 18.

Aileen Knip has been named as the Chair of the National Diabetes Educator Section (DES) of the Canadian Diabetes Association. The DES is made up of RNs, dietitians and other health providers who care for people with diabetes. Knip became the chair during an international diabetes conference in Montreal in October.

In October, RNAO member Roberta Heale received a Chair in Advanced Practice Nursing from the Canadian Health Services Research Foundation and the Canadian Institutes of Health Research. Heale will work with Dr. Alba DiCenso, a prominent researcher who studies the NP role. The chair is awarded to PhD students to help them improve their research and advocacy skills.

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RNAO Recognition Awards

The team from Sudbury District Nurse Practitioner Clinic received the RNAO in the Workplace Award at the April 2009 Annual General Meeting.

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RNAO's 85th ANNUAL GENERAL MEETING APRIL 15-17, 2010

CALL FOR VOTING DELEGATES

Deadline: Monday Feb.15, 2010. For more information, call Penny Lamanna, 1-800-268-7199, ext 208 or e-mail plamanna@rnao.org

SATURDAY KEYNOTE SESSION

We will be presenting a Saturday Keynote Session.
Details on the topic and speaker will follow, but please mark your calendars now, and plan to attend on **Saturday, April 17 at 11:30 am – 12:30 pm**, following the individual Interest Group breakfast meetings.

AGM REGISTRATION FORM

After Jan. 4, download your registration form at www.rnao.org or call Bertha Rodrigues at 416-408-5627 or toll free at 1-800-268-7199, ext. 212.
Deadline for AGM pre-registration: **Wednesday, April 7, 2010**

HOTEL RESERVATION FORM

RNAO has reserved a block of rooms at the Hilton Toronto at $169 per night (taxes extra). This rate is guaranteed until **Friday, March 12, 2010**.
The hotel reservation form will be available after Jan. 4, 2010 at www.rnao.org or call toll free at 1-800-268-7199, for more information.

MARK YOUR CALENDAR NOW!

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(3 units)
• 6 month course completion
• explores the types and processes of conflict in health care organizations and applies theory and research to conflict situations in the current workplace

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(3 units)
• 6 month course completion
• theories, concepts including safety culture leadership in creating a culture of accountability
• critically analyzes and applies paradigms to address quality and safety issues in the workplace

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(6 units)
• 9 month course completion
• builds on the Leadership/Management course
• topics include transformational and quantum leadership, emotional intelligence and organizational culture

Integrative Leadership Project (3 units)
• Final course integrates theories and concepts of the Program and provide opportunities to apply these to a real situation in the workplace
• Through the use of a champion leader, the student develops and understanding of managing key organizational processes

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For further information please contact:
Leadership and Management Program
McMaster University
Phone: (905) 525-9140 Ext 22409 Fax: (905) 529-3673
Email mgtprog@mcmaster.ca
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